Recovery Devon

Pushing the boundaries

Spring 2009

Workshop topics

Developing a manifesto for change

Over 30 people met at Dart Farm, Topsham on 6th March 2009 to consider recommendations made by two distinguished observers about how Devon should consolidate and build on its already considerable achievements in promoting recovery.

In June 2008, Mary O'Hagan, retired commissioner from New Zealand's Mental Health Commission spent a week in Devon and wrote an inspirational report on Devon's progress. In July, Dr Mike Slade visited in his capacity as a researcher into recovery, following a year long tour of recovery focused services in the English speaking world. Recommendations from both were considered and built upon in the Recovery Devon meeting.

Recovery Devon is an open group without members or officers. It is simply a group of people with a passion for promoting recovery who meet.

The meeting marked the fifth year of Recovery Devon, which has met regularly and consistently over that time, staging meetings, conferences and training events.

The day was a great success, brimming full of innovative ideas and unbridled enthusiasm.

The day started with a presentation from the Community Care Trust in South Devon, which is an organization that has committed itself to transforming every aspect of their work towards recovery supportive practice.

Six workshops then considered six themes contained within the reports and identified what should happen both urgently and in the longer term.

This report details the work of this group recorded on that day.

Five years in Recovery - one organisation's experience

Eilis Rainsford and **Mark Angoy** from the Community Care Trust South Devon (CCT) gave an honest and inspirational account of the experience of an organization committed to change towards recovery.

CCT is a voluntary provider of a range of residential, inpatient and community services.

Eilis talked of a continuing process of re-inventing the Trust and re-starting the process of change as the realisation of how profound the implications of recovery sunk in.

Following Mary Ellen Copeland's visit to Devon at a conference in 2003, CCT managers made a commitment for the whole organisation to become recovery focused. A conference in 2004 for all staff launched a programme of transformation.

The immediate challenges were about self doubt - had the past 15-20 years of training been completely wrong? Did our work mean nothing anymore? What would happen to our credibility as 'professionals'? Did recovery mean handing everything over? What conversations would we now have with people who looked to us for support? Could we talk about symptoms and medication? What words were no longer OK and what words did we have to learn?

The implications were huge - all training and learning had to be re-visited with recovery spectacles. All staff went on Support, Time and Recovery (STR) training; All staff learned about the Wellness Recovery Action Plan (WRAP) approach and applied it to themselves; files were held by the people they related to; all policies and procedures were reviewed and updated to fit with recovery; recruitment procedures and criteria were changed to reflect the positive value of lived experience. The implications of seeing recovery as a shared process rather than what is 'done' to people were far reaching.

By around 2007, more incisive questions were being asked - what does my being alongside someone really mean? What do I need to **be** to provide hope? When and what do I share about my own recovery journey? What do I do/say /ask to support someone to believe in their potential? What do people who look to us for support want in a recovery relationship? What does a recovery relationship look like? Its not just about being a nice person, is it?

These challenges led to CCT and MIND designing and putting all staff through a 'Recovery Qualities Experience' and 'Recovery Coaching' training.

(Continued on page 14)

Crisis response, inpatient provision and community alternatives to hospital

Outside looking in……Mary O'Hagan and Mike Slade

Mary O'Hagan:-

- Acute inpatient wards need to be downsized and the pressure taken off them through the development of intensive home treatment and community crisis houses

- When people are in crisis they need people with training in crisis support, to care for them, listen to them, and attend to their spiritual, psychological and social needs. They have the support, values and skills to ensure their safety without habitually using forced treatment or inadvertently re-traumatising people when they are at their most vulnerable

- Younger people who have not been disabled by long stays in institutions should not live in staffed housing except for active short to medium term rehabilitation

- Residential crisis or acute services are small and homelike. There are few hospital based services. The community residential services do not have the institutional trappings of closed circuit television and other heavy security features but rely more on the presence of staff and their negotiation skills to keep people safe. Environments are emotionally safe as well as physically safe

- Qualitative research shows that the majority of service users prefer alternatives to hospital as places of support. Community based crisis houses and home based treatment produce equal or better clinical results to inpatient treatment and also improve service user and family satisfaction.

Mike Slade:-

- Though Mike made no specific recommendations, he shared different models of crisis response from other countries – creating a peaceful and pleasant environment (New Zealand), changing the context of the identity – as students rather than patients in Boston – as farm workers on the Peace Ranch in Canada. Peer led crisis services in California.

Crisis response, inpatient provision and community

Devon already has some excellent crisis and inpatient services, both in statutory and voluntary organisations, but these are not consistent. There is a central access number, though this is not widely known. (**01392 823172** available 8.00am to 6.00pm Monday to Friday)
Information needs to be routinely available at each stage e.g. Carer's packs, information on treatments.

Greater awareness is needed of what impact environment has on recovery e.g. nutrition, furniture / decoration which values people.
'Outsider witnesses' should be encouraged to introduce an external viewpoint and pick up daily issues, such as those currently provided by ward visitors from service user groups in Exeter and Torbay.

Priorities from Recovery Devon

- Reduction of fear, negative anticipation and stigma through media campaigns and sharing of recovery stories.
- More support at home through developing 'home treatment' and crisis peer support. Allowing people to retain choices and control as far as possible is crucial.
- People in distress should not be handcuffed and placed in police cells. Alternative places of safety should be developed, designed to reduce trauma rather than escalate it.
- Reduction of the number of people admitted for whom admission is likely to represent a traumatic event antithetical to getting well e.g. bi-polar, depression and those who have already suffered trauma or aggression.
- A staged and strategic approach should be adopted towards providing non hospital sanctuary and the development of third sector alternatives such as those provided by the Community Care Trust.
- An early, preventative response to an emerging crisis through WRAP and advanced plans designed when the person is well. Person to person arrangements so that help can be found earlier with someone who is known and trusted through self referral.
- A range of community alternatives to hospital and proactive introductions when a person is well to reduce fear and develop meaningful choices
- The setting up of paid peer roles within in-patient units to work alongside newly admitted people to; introduce newcomers to the other people on the ward, offer hope through their own experiences– 'being alongside someone who knows'; be advocates if necessary; help identify needs and visit the facilities which are most likely suit the person e.g. music, quiet room, smoking area.
- Enhanced support for staff to improve morale, allow time for people rather than tasks and for recovery coaching (qualities, active listening and motivation) training
- Transition back into the community after an admission should be given much higher priority than at present.

Risk assessment, risk taking and safety planning

Mary O'Hagan:-

Outside looking in ……Mary O'Hagan and Mike Slade

- A continuation of deinstitutionalisation needs to be done in the context of reframing risk – to emphasise positive risk taking, the role of service users in their own 'risk management', and a greater focus on the risk services can pose to the individuals who use them

- For the last two hundred years or more, communities have abdicated their responsibility for people with serious mental distress to mental health experts and services. These experts and services are expected to take total responsibility for people with mental distress, particularly those in crisis, who should be contained and tightly controlled. Therefore, when something goes wrong, mental health services are fully to blame for not containing and controlling the person

  There are some implicit assumptions in this consensus that are unsustainable. Firstly, that people with mental distress are not capable of taking any responsibility for their actions; in many cases people, even when in crisis, have capacity for personal responsibility. Secondly, that mental health services can avert every disaster; clearly human beings, no matter how skilled, are fallible in their predictions. The third assumption is that coercive practices are requires to keep the community safe from violent, unpredictable people. The truth is that only a small percentage of people with mental distress fir this category, just as a slightly smaller percentage of people without mental distress do.

  Unfortunately, this unrealistically demanding consensus has led to risk-averse practices in mental health, such as compulsory treatment, locked doors and other restrictions on liberty. Sometimes these responses are driven more by possible risk to the reputation of the organisation or professionals than to what is optimal for the person experiencing mental distress. In addition to this, mental health practitioners and spokespeople in the public arena, who are understandably on the defensive, tend to publicly collude with this consensus instead of questioning it.

Risk assessment, risk taking and safety planning

A lack of awareness in the general public about mental health increases fear and stigma, which creates moral panic, which services often respond to.
The current system of 'objective risk assessment and management' often results in a 'parent to child' dynamic which individuals rebel against.

An 'adult to adult' dynamic is one in which safety is negotiated and seen within the context of WRAP- what keeps us well? - what usually happens when things start to break down?

What would we like others to do that would help reduce tensions? What would we not like others to do which is likely to escalate the emotion? What concrete plans can be put in place to avoid escalation?
What have we learned from previous experiences? How can we reduce the trauma for all concerned if it happens again?

A preventative approach to avoid rather than just respond to crises would reduce high risk situations.

Priorities from Recovery Devon

- The development of risk assessment, negotiated safety planning paperwork and procedures which are person led and based on self management knowledge.
- People should be encouraged to take responsibility for their own safety and for asking others for what they need to keep themselves safe.
- A responsible balance of a range individual perspectives and objective appraisal needs to be achieved
- Everyone needs to accept a shift of responsibility towards shared responsibility around people's safety. All risk cannot be eliminated, but a blame culture within organisations increases risk and reduces positive risk taking.
- Advanced statements and WRAP plans need to be honoured in all parts of the services
- The quality of relationships is crucial in working with safety and risk
- A range of safe places and choices need to be developed to avoid 'either / or' conflicts
- Organisations need to provide what it is that people want e.g. more out of hours services.
- Social inclusion, citizenship, community support and information needs to be part of everyone's agenda
- The development of alternatives for people who feel excluded

Workforce Culture

Outside looking in……Mary O'Hagan and Mike Slade

Mary O'Hagan:-

- Staff need to be recruited for their recovery values and humanity as well as for their skills.
- Staff need training and supervision in all aspects of recovery – including the recovery philosophy, collaboration with clients, human rights, hospitality community development, and working across agencies and communities.
- People with experience of mental health problems should be encouraged to apply for jobs or training in the Devon mental health services. They need to be in generic roles as well as roles that can only be fulfilled by people with lived experience.
- Consideration should be given to employing or contracting people with lived experience to join the senior management team, to provide advice, training and consultation, and to feed back the views of people with lived experience to staff and management.
- Employers need to develop a good understanding and processes for staff who have experience of mental health problems to get support they might need, such as workplace adjustments and peer support options.
- New workforces need to be to be scoped, developed, recruited and trained, as a broader range of responses is developed.
- Education emphasises emotional competence, reflective practice and self-care, as much as theoretical and practical competence.

It is best to recruit for values as well as skills and to find staff who have the self-efficacy and resilience to easily accept change. Training on its own does not improve performance. It must be combined and coordinated with coaching and performance appraisal.

Mike Slade:-

Develop a shared focus on hospitality across the network, with attention to (apparently) simple things like welcomes, what they first meeting with someone new to a service involves discussion of (and who it is with), and how to amplify hope for a good future at each encounter with the service.

- Develop specific training for mental health workers in three specific key recovery skills:
  - Assessing and amplifying strengths – there is a developing literature on how to identify and maximise strengths, and training followed by supervised practice to develop this skill may help to redress the deficit bias in how mental health professionals assess service users
  - Supporting the search for meaning – there is a clear understanding in Devon that some traditional concepts like 'insight' are not helpful for recovery, but it may be possible to more actively support the individual in their search for meaning. This is likely to involve initiatives around spirituality (both in the religious and secular senses) and mutual self-help groups.

Care planning around consumer-based goals rather than clinician-based goals – creative approaches are needed to balance the political reality of expectations on mental health services of doing some things which work against recovery with the need in a recovery-focussed service to orientate action around the individual's goals.

Workforce Culture

All staff need to be supported in moving towards a recovery focussed approach. For some this will be a smooth transition. For others this will mean 'unlearning' some of what they previously 'knew'. Help and support should be provided in this process of transition as many people are confused about the implications and the reasons for change. Recovery must not become a new system which starts to oppress staff through targets which reinforce a blame culture. The aspirations attitudes and skills needed to work with people in a recovery focussed way need to be replicated throughout organisations and systems. Recovery is fundamentally different, not just the latest fad for middle management to have to 'adapt to'.

Priorities from Recovery Devon

- There is a huge task to change the culture of established staff as well as new staff. This should be achieved through training in qualities and attitudes, hope enhancing relationships, peer support, peer coaching and the 10 Essential Capacities, though e-learning is not a substitute for experiential learning
- Each organisation needs to value their staff and support them in working in a recovery focused way as a 'recovery focused organisation'.
- Relationships are the most important aspect of being alongside people on their recovery journey. Through respect and being in the right place at the right time, choices are opened up.
- One way of abolishing the 'them' and 'us' culture is to employ people with lived experience to work within teams and change the culture from within.
- New staff should be given a period of probation with support and training to see if they demonstrate recovery qualities. A 360° appraisal, including people who they have worked with, should inform whether or not they are retained.
- More recovery courses are needed within a wider strategy involving all staff, not just those which are already interested.
- Courses on welcoming and hospitality should be compulsory for those in appropriate positions - e.g. Working on in-patient wards.
- New ways of holding people to account and recording effectiveness need to be developed in line with recovery values
- Feedback into training from people who have lived experience (including family and friends) should be routine
- Volunteering leading to STR or other paid work should be a supported route for people wishing to get back into work and use their experience

Stigma, discrimination and language

Outside looking in……Mary O'Hagan and Mike Slade

Mary O'Hagan

- Discrimination is the major barrier to social inclusion but Devon does not appear to have any links with local or national stigma and discrimination initiatives, apart from the time-limited 'On the Edge' programme for schools. A recovery based system in today's society needs to be complemented with an active high profile local and national anti-discrimination programme.
- The Devon partnership Trust needs to build a relationship with 'Time to Change' (formally called 'Moving People') and the CSIP 'National Social Inclusion Programme' to utilise their advice, services and resources
- More people with mental distress are visible and valued members of their communities. There is an ongoing anti-discrimination campaign that uses social marketing, media monitoring, policy development and local initiatives to advocate the full human status of mad people and zero tolerance of discrimination. The emphasis has shifted from awareness raising to behaviour change. The underlying message in all anti-discrimination work is the legitimisation of madness, and the rationale for action comes from human rights and recovery perspectives rather than a medical perspective.
- The media regard discriminatory coverage on the basis of mental distress as unacceptable. The specialist and primary mental health workforce takes responsibility for ensuring they and other agencies have a clear focus on social inclusion and responding to internalised stigma.
- As time has gone on the emphasis has shifted from awareness raising to behaviour change. The media regard discriminatory coverage on the basis of mental distress as unacceptable as discriminatory coverage on the basis of ethnicity or gender. The mental health workforce takes responsibility for ensuring they and other agencies have a clear focus on social inclusion and respond to internalised stigma.
- The old language in mental health settings valued the objective over the subjective and external authority over internal autonomy. The new language values both subjectivity and objectivity, and emphasises internal autonomy over external authority. Some of the old hospital language mimics military and criminal justice language. People are detained, they go AWOL (absent without leave), they are discharged. It no longer makes sense to use this kind of language. In the context of a mutually informed and respectful dialogues between mental health workers and service users, the workers feels uncomfortable describing service users with terms like 'noncompliant', 'lacking insight' and 'inappropriate'.

Stigma, discrimination and language

Discrimination and stigma are internalised, often at an early age. Continuous education and awareness raising are needed to chip away at attitudes which impact negatively on others.

Moving away from 'them and us' attitudes does not happen overnight, but a process of reinforcing the reality that, as human beings, we are all vulnerable to periods when we feel overwhelmed and we all have different levels of resilience according to both internal and external factors.

Recovery and WRAP have described the processes we all share of struggling on a daily basis to keep well. Stigma is fed by a sense of different ness. Commonality in the experience of being human brings us closer and makes us more tolerant.

Priorities from Recovery Devon

- Champions, leaders and liaison are needed to bring together a range of initiatives.
- Schools are the most important target for the reduction of stigma and prejudice . Educators should be found who can promote emotional well being and give helpful messages about wellness.
- Stronger links need to be made between initiatives in the voluntary and statutory sectors, including the CSIP national anti stigma campaign.
- National campaigns should be encouraged and we should seek to be involved. Individual stories of recovery, TV, GP surgeries and libraries are some focus areas
- We all have a responsibility to challenge stigma, discrimination and inappropriate language on a daily basis.
- Recovery is greatly helped by having helpful knowledge about mental health issues to move away from unhelpful myths
- Language sticks. Changing the language can lead to change and vice versa.
- People should have a right to describe how they are feeling or what is happening, without this being translated into 'professional jargon'.
- Social inclusion and non segregation leads to acceptance and a reduction in discrimination based on fantasy. Discrimination, unhelpful beliefs and prejudice are part of the human condition, but can be confronted and can be changed.
- Conferences in which people from different perspectives can share conversations, views and experiences and meet as human being rather than stereotypes can be helpful.

Support from peers and staff support in assisting recovery

Outside looking in……Mary O'Hagan and Mike Slade

Mary O'Hagan:-

- Staff need good supportive work conditions and the opportunities to reflect together in safety.
- People with experience of mental health problems should be encouraged to apply for jobs or training in the Devon mental health services. They need to be in generic roles as well as roles that can only be fulfilled by people with lived experience
- Peer-run services delivered by others who have been through similar experiences, are available to all people with mental distress as well as to families. Peers only can deliver peer support services but they can also deliver services that don't have to be delivered by peers such as service navigation or housing support
- Peer support is routinely offered to all service users and families when they first start using services. Peer support services can include:
  - telephone support services
  - peer mentoring
  - web based Internet support
  - self-help groups
  - employment programmes
  - drop in centres
  - crisis care
  - individual and systemic advocacy.

Mike Slade:-

- In discussing a person with drug issues there was no mention of involving recovered drug users or the person attending a mutual self-help group, which might be a more powerful approach to helping the person to confront their actions than the behavioural reinforcement approach being used.
- There was not a consistent understanding of the potential role of peer support workers as a distinct job in the mental health system, *e.g.* to provide a visible role model of recovery. Their potential role was described more in terms of how they would be able to contribute to existing tasks.
- The issue of medication is very difficult for clinicians to address in a neutral way, and this may be a role for peer workers to support consumers experiencing decisional uncertainty (e.g. using the Common Ground approach)

Support from peers and staff support in assisting recovery

Recovery Devon delivered a five day Intentional Peer Support course in April 2007 with Shery Mead and Chris Hanson. Several initiatives resulted from this, but it has not taken off in the way it has elsewhere and more work is needed to develop this important component of recovery.

Being paid to provide peer support compromises the 'peer' status, but on the other hand, the skills and experience that people have should be valued and rewarded.

Both paid and unpaid peer support should be encouraged.

Peers can help change the culture and expectations in the wider community and the community of those with lived experience. They open up possibilities closed to mental health professionals and can achieve greater levels of trust.

Priorities from Recovery Devon

- More clarity is needed to map out what is meant by peer support and where resources should be placed to develop peer support. It is multi-layered and not an easy concept to pin down.
- The whole workforce should be moving towards a more peer (i.e. reducing power imbalances) way.
- There are already many staff who have lived experience. Over a third of the STR workers in Devon have lived experience and form an 'undeclared' paid peer workforce. There is some merit in not having to identify or be identified as staff with lived experience if that is a person's choice.
- All inpatient units should have paid peer supporters as part of the skill mix
- Funding should be sought to send people interested in peer support to courses such as that being developed by the Scottish Recovery Network.
- Connections should be made with other services in the UK and abroad where peer support has been developed.
- Commissioners should fund innovative projects of peer or self help groups
- Peer support groups should be encouraged and supported as a sequel to group work and treatment e.g. eating disorders, drug and alcohol support, following Dialectic Behaviour Therapy.
- Independent peer support groups such as bi-polar support groups should receive or continue to receive funding
- WRAP groups should continue to be encouraged and supported.
- The model developed by the COOL House in Torquay and the Women's Network should be used as an examples of peer support in a non-stigmatising environment.
- Each service and team should consider how peer support can complement the service they provide

Promotion of Wellbeing and Strengths Based approaches

Outside looking in……Mary O'Hagan and Mike Slade

Mike Slade:-

- There does not yet appear to have been great attention paid to celebration rituals. In traditional practice there is a predominance of degradation rituals – the conferring of diagnosis, increased involvement when less well, *etc.* Some recovery-focussed services internationally hold graduation ceremonies for consumer who are moving through or leaving services, or annual award events to celebrate achievements. There was some discussion of coming-off-section celebrations, which would be a positive development, but celebrating achievements in domains unrelated to mental illness might be a more potent approach to amplifying an identity other than 'mental patient'.

- I did not hear sophisticated understanding about how to promote well-being. What I did hear was rooted in a 'removing illness' metaphor, *e.g.* through nutrition and exercise advice. Well-being is not the same as absence of illness or other problems. There may be an opportunity to bring local psychology staff more into the recovery tent by drawing on their expertise in this area, and linking in with the emerging science of well-being – positive psychology

Mary O'Hagan:-

- The majority of funding in most mental health service systems goes into clinical services for people with a diagnosis of mental illness. While these services are crucial to many people, service users consistently say they need a lot more support and practical assistance - such as peer support, day-to-day assistance, support in employment, housing and education, and advocacy.

- A recovery based service system must provide access to a broad range of both clinical and support services. It should sit in the context of active wellbeing promotion for the whole community, which includes those with lived experience. The funding for support and wellbeing services does not nearly meet the demand for them in Devon and elsewhere. The demand for a broader range of responses can be met through individual budgets, broadening the range of responses provided by existing services, or commissioning a broad range of responses from different sectors and agencies.

Suggestions

- Devon needs to correct the balance between clinical and support services through the phased development of new core services that are <u>available to everyone who needs them</u>:
- Peer support and recovery education
- Day-to-day assistance
  - Support to choose, get and keep housing, employment and education
  - Advocacy services.

Note: The development/expansion of peer support, recovery education and employment support should take priority**.**

Promotion of Wellbeing and Strengths Based approaches

An unhealthy focus on people's problems has dominated the 'treatment and cure' approach to mental health.

Recovery challenges this by recognising that hope is generated by positive affirmation and active encouragement. Language of failure and 'relapse' and dire predictions have undermined and sometimes destroyed hope.

Maintaining wellness, and promoting wellbeing rather than merely treating illness has implications for the future deployment of resources.

Greater value is placed on the world of community, education, employment, individual resilience, leisure activities, social networks, personal interests and hobbies.

"Traditional priorities are turned upside down". Sainsbury Centre 2008

Priorities from Recovery Devon

- All staff should adopt (supported by education and training) a holistic approach, looking at well being, meaning, happiness, strengths, coping resources, life beyond and before mental health services.
- Organisational development and governance structures should be redesigned to enable staff to work holistically and in a strengths- based way
- Establishment of celebration rituals. Inviting people to think about how to acknowledge the achievements they may have made and encouraging staff to participate in this, as a person, rather than a professional.
- Making full use of people's strengths by inviting them to share with others and contribute to other people's recovery
- Inviting people to share their journey's and learning with others; either in peer support, staff training or in e.g. schools
- Well being is life long, for everyone. Wellbeing promotion can happen in antenatal classes, surgeries, schools, workplaces etc. It can be done on an individual level or on an organisational/strategic level.
- More focus on what gives life unique meaning to the person (e.g. families, spirituality) through WRAP or holistic assessment.
- Asking about what has helped in the past; what works and what doesn't; how people have got through similar difficulties and acknowledging successes. Acknowledge that aspects of life such as sexuality, diet, exercise, pets, hobbies, dance, music are all important in individual stories of recovery, yet professionals sometimes don't value these sufficiently
- Thinking outside the box (or straight jacket) of professional models and assumptions about what is relevant or not.

Five years in Recovery - one organisation's experience *(continued from page 1)*

Mark Angoy from the Community Care Trust

This is a summary of Mark's presentation in which he describes his vision of a recovery service

What do people need from us?

- Respect for their recovery goals
- Support to achieve these goals
- Mutually respectful relationships
- Negotiated/collaborative plans
  - Action/daily routine
  - Safety
  - Crisis
  - Contingency
- Respect for advance directives and wishes
- Positive risk taking so individuals can learn and grow
- To respond quickly to need
- To be available
- To listen
- Creativity

How will we do it together?

- Flexible, adaptable, creative service
  - Respite/longer placement beds
  - Working with people in their homes or communities
  - Increased support when needed
- Conversations based on emotional need
- Support to put together self management plans, being creative, flexible and individual focussed
- Team development
  - Support, Time and Recovery
  - Investment in skills training (Recovery Qualities Experience)
  - Continuing development of coaching skills
  - Understanding and embracing of the qualities needed to be alongside someone (angelic qualities)
  - Willingness to grow and develop effective coaching skills
  - Support when team members struggle to embrace coaching skills
- Monitor how we are doing and a willingness to change things if they are not working
- Using peer support
  - Encouraging people with lived experience to become part of the team
  - 'outsider witnessing' (with permission) to support individuals in therapeutic meetings

Mark Angoy with Wyn Smithers.

Wyn, along with Karl Cann, started up a bi-polar group in Exmouth recently called **Polar Bear** with £100 of their own money, a lot of commitment and a lot of heart.

What do people want from the community?

- To be able to access services available to everyone
- Make informed decisions
- To be able to share their stories and experiences
- Contributing to the community
- Access to suitable accommodation, work, education and recreation to support well being
- Choice to be with family or other significant people

The importance of what we say

- It is through our conversations that people using our services share, negotiate, learn and grow
- The language we use and how we use it has an impact
- The tram must understand the importance of how we communicate with others, other agencies and, most importantly, individuals using our service
- We can use language to influence the positive development of our recovery service
- Use recovery language in our meetings- 'take a stand'
- Having an awareness of where others are in this process

Recovery Standards and Outcome Study Report

Under the project leadership of Alison Moores, the Standards and Outcomes Pilot Project report has recently been published and can be requested through:- melanielong@nhs.net.

Commissioned by Devon Primary Care Trust and Devon County Council, the project aimed to explore processes or measuring:-

The aim of this pilot project was to explore processes for measuring:

- Personal outcomes for recovery and wellbeing.
- An evaluation of how recovery supportive services are: by the people using them.
- The progress of services towards meeting the 10 core standards for the networks.

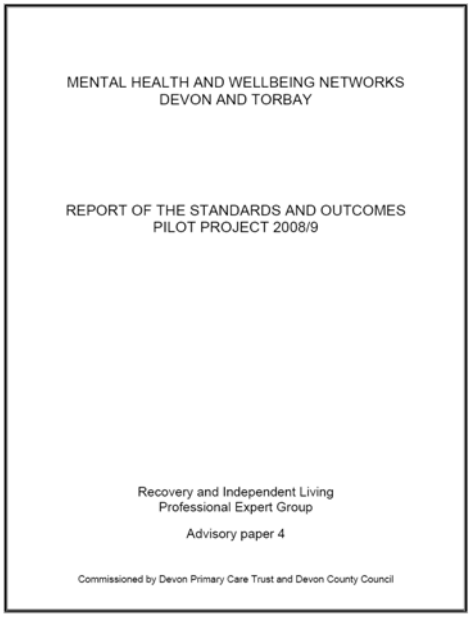
"The approach taken by the pilot project represents a fundamental shift in our understanding of outcomes measures from that of information collected in the interests of the service (and therefore the collective good) to the ethic of measurement which is of prime interest to the individual. This is a complex transition which will require a significant amount of preparation and training for practitioners, providers and contract managers."

15 pilot sites completed the project covering a spectrum of network provision:-

- Statutory and third sector providers.
- Small teams and independent practitioners as well as one of the largest and busiest community recovery and independent living teams.
- Young people's services through to services for older adults
- Psychological therapies in primary care through to assertive outreach, inpatient and forensic services.
- Social care services such as vocational reablement, community networks and housing support as well as specialist mental health services.

The pilot measurements had a high level of reliability and validity. Many recommendations were made on each of the three focal areas and although the recommendations were different for each measure, they include the following (sample only) :-

- All service specifications should incorporate a requirement to embed the measurement of personal outcomes for recovery and wellbeing, the experience of using recovery services by the people who use them and the 10 core network standards into routine practice
- Commissioners, providers and contract managers should agree an annual cycle of audit which provides evidence that the measurement of (the three elements) are embedded in routine practice.
- Providers and contract managers should receive training in the purpose and application of this measure.
- The continuing development of the measure and the learning from wider implementation should be supported and monitored.
- Providers and contract managers should receive training in the purpose and application of the self evaluation framework.


MENTAL HEALTH AND WELLBEING NETWORKS
DEVON AND TORBAY

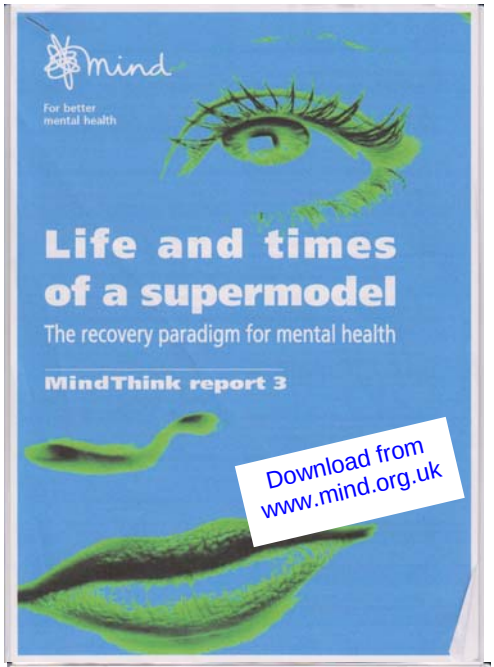
REPORT OF THE STANDARDS AND OUTCOMES PILOT PROJECT 2008/9

Recovery and Independent Living Professional Expert Group

Advisory paper 4

Commissioned by Devon Primary Care Trust and Devon County Council

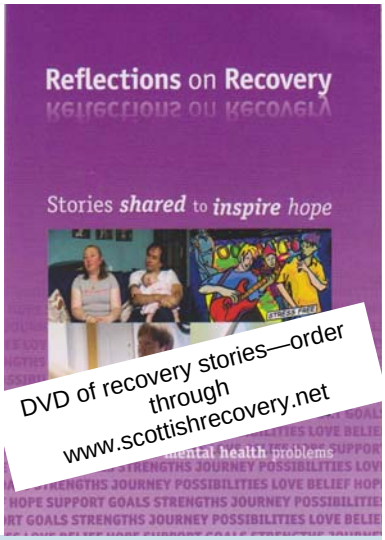
Recovery Publications



Devon Recovery Stories and DVD

Over 30 contributions have been submitted towards the Devon Recovery Stories Project of a very high standard. Although the project is now closed for stories, anybody who has ideas or expertise in photography , film making, sound, direction, programme design or other skills useful in developing a DVD are encouraged to get involved

Contact:- laurie.davidson@btopenworld.com (yes, even after his retirement)



Hello and Goodbye

Hello to **Chris Long**, who will take over the admin role for Recovery Devon of; making sure meetings take place with a good supply of biscuits; letting everyone know when and where; coordinating and sending out agendas; sending out recovery documents; making sure that a record is kept of developments/ achievements and helping in the process of identifying next steps and the tasks which go with them.

Chris works as Development Officer for Rethink in Devon. One claim to fame:- he ran a sub post office before coming into mental health.

He can be contacted on 01822 610946 or 07918 739400
christopher.long@rethink.org

Goodbye to **Laurie Davidson** who retires in March 2009 after five years of keeping the wheels of Recovery Devon oiled and recording the progress of recovery in Devon though a series of seasonal newsletters.

"Having started working in mental health in 1968, I have been involved with setting up a range of community mental health services and closing down several institutions all over the UK. Community Care was about the style and delivery of services and played a vital role in emphasising the importance of environment and civil liberties.

Recovery is even more important than de-institutionalisation, because it challenges the way people are treated and the way mental health staff work; it challenges the attitudes and beliefs we hold and it starts to address the historic power imbalances which have been so damaging for so many for so long."

Recovery challenges the established order and as such, is a 'great idea' along with the ideas of evolution or a 'round earth'; turning all our thinking upside down. Recovery challenges every thing we 'knew to be true'.

Recovery shifts our main focus away from 'treatment and cure' of symptoms towards how people can live well and stay well with or without symptoms

Recovery challenges the sacred cows of the establishment including questioning the validity and role of diagnosis, the use of involuntary treatment and the legal framework, the books we have read, long held attitudes and assumptions, the 'truth' of learned dogma and the medicalisation of social and personal experience. Unlearning becomes as important as learning.

Recovery challenges the settings in which help is provided informed by the personal stories of what helps or hinders recovery. It questions the current deployment of funds into services and approaches where people say their needs are not being met.

Most of all, recovery challenges the nature of relationships; moving away from 'parent to child' towards 'adult to adult', away from the disempowering aspects of 'expertise' towards the sharing of knowledge and more of a peer relationship; away from designing care plans or risk assessments 'for' people towards following individual goals and negotiated safety planning.

Seeing the world through recovery glasses challenges the way staff are trained and treated. Supervision, work management, outcome measurement, job planning, recruitment, training strategies, policies and procedures, support services, governance and incident management all have to be revisited in the light of recovery values.

There is a good reason why all mental health policy in the English speaking world has signed up to recovery. It works as a set of values (not a model) which are based on common sense and respect for individual choice. Recovery ideas will evolve and develop as their revolutionary implications are more fully recognised. Good luck to Recovery Devon in the future. You are very special people. I will miss you all"