ADULT MENTAL HEALTH SERVICES IN DEVON
A HIGH LEVEL RECOVERY ASSESSMENT

MARY O'HAGAN
November 2008

COMMISSIONED BY
Devon Primary Care Trust
Devon Partnership Trust
Torbay Care Trust

INTRODUCTION

Purpose of this report

The purpose of this report 'Mental Health Services in Devon: A high level recovery assessment' is to:

- assess the recovery orientation of mental health services in Devon
- share some suggestions on increasing the recovery orientation of the services.

The purpose of the accompanying generic background paper 'Recovery in Progress' is to:

- Provide a framework for a recovery based service system
- Illustrate parts of the framework with explanations, examples and evidence

Both reports are intended to dovetail each other.

Limitations of this report

This report is based on a one week visit to some of the mental health and related services in Devon as well as discussions with managers, service users, frontline staff and the commissioner in June 2008. I have a reasonable though not intimate knowledge of the mental health system in England, and a week is not long to fully grasp the complexities of a large service system. As an outsider there is a risk that some of my observations and suggestions will not quite hit the mark, but I do have the advantage of being able to see the services in Devon with fresh eyes. As a consequence this report is both high level and concerned with what needs to happen rather than the detail of how it should happen.

The views on recovery represented in this report

There are at least two versions of 'recovery' in the mental health world today; they come from the user/survivor movement and psychiatric rehabilitation. These two views of recovery overlap and some of the differences are in emphasis only. But the ownership of the versions differs and so do some of the fundamental beliefs they rest upon.

Psychiatric rehabilitation sits on an historical (and contemporary) platform that views people with lived experience predominantly as victims of their own pathology and the deficits that arise from it. Their role is to help people overcome their deficits.

The service user movement sits on a platform of self-determination that views people with lived experience as predominantly autonomous beings who have been limited by services and society. Recovery happens when people are able to move beyond these limitations, to find their own autonomy, and a valued place in the world.

At the risk of over-simplification, these two different starting points appear to generate some important differences. The user/survivor movement tends to view 'mental illness' as a social construct that can limit people's chances of recovery, whereas the psychiatric rehabilitation sees mental illness as a very real attribute that must be treated and rehabilitated in order for people to achieve recovery. Psychiatric rehabilitation is more at ease with the 'medical model', risk management and compulsory interventions, which are still a big part of today's mental health system. The user/survivor movement view suggests a more radical shift is needed, such as the demotion of pathological explanations, a greater emphasis on achieving the lives we want than in reducing symptoms, a sizeable shift from institutions and professional experts to peer and community supports, and an emphasis on fostering personal responsibility.

The views and suggestions in this report come from the user/survivor movement end of the recovery spectrum.

Visits and discussions

During the week I visited:

- COOL House in Torbay where I met with some people with lived experience
- The Haven where I met Community Care Trust and Mind staff
- Barnstaple where I met with North Devon third sector agencies, people with lived experience and families
- North Devon District Hospital where I met with 'Access and Wellbeing' leaders
- Russell Clinic at Wonford House in Exeter
- Local service user leaders at Wonford House
- Senior staff forum at Wonford House where I gave a recovery presentation
- Senior staff for informal discussions at Wonford House
- Senior NHS and local authority executives in Devon County Hall
- Recovery Devon at Wonford house where I gave feedback and talked about recovery

I also had substantive discussions with Ian Pearson, Glenn Roberts, Laurie Davidson, Alison Moores, Natasha Garland and Sinead Partridge. I would like to thank these people for their time, generosity and hospitality during my visit.

RECOVERY ASSESSMENT
OF COMMISSIONED ADULT MENTAL HEALTH SERVICES IN DEVON

The assessment is organised into the themes, with discussion followed by suggestions for change.

A. Service user views of the services
B. Deinstitutionalising services
C. A balance between clinical services and support for recovery and wellbeing
D. Third sector agencies
E. Workforce culture
F. Recovery leadership
G. Outcome measures and research
H. Rural/urban inequities
I. Commissioning
J. Inter-agency and inter-sector collaboration
K. Stigma and discrimination
L. Connections with good recovery practice

A. SERVICE USER VIEWS OF THE SERVICES

Like everywhere else I have visited, the people with lived experience I listened to in Devon believed that services in general are not very recovery-based.

The people I met at the COOL House, North Devon and the Wonford House service user leaders were particularly critical of the crisis teams and acute wards. The crisis teams had the attitude that they 'do crisis not recovery', and the home-based treatment they offered sometimes amounted to just a daily phone call or a visit to give people their medication. Although there are crisis houses and beds available in south Devon, people with lived experience said the crisis teams do not use them enough. People using the acute inpatient service complained that the staff didn't talk to them enough and some felt they were treated like children by staff. People with lived experience said the acute service was understaffed and the threshold for getting help in a crisis was too high.

The service user leaders at Wonford House believed that the Russell Clinic did much better in its recovery orientation than the acute services. It had a very different culture with much more interaction between staff and service users. But they said that in the rest of the services, particularly the statutory services, clinical staff were often resistant to recovery, though they acknowledged that some of the staff tried.

People with lived experience said they wanted to be asked what they want out of life by the staff and given more practical support. They also wanted peer support services but felt that the people running some of the current peer services need to be more skilled and better role models.

Service users supported Recovery Devon but felt that people with lived experience could have a higher profile in it, while acknowledging that some professionals in Recovery Devon were open about their own lived experience. One service user went as far to say that Recovery Devon is 'professionally owned'.

B. DEINSTITUTIONALISING SERVICES

Coming from New Zealand, where all of the old psychiatric hospitals have closed, I was struck by Devon's continuing reliance on acute inpatient services for people in crisis, and inpatient wards for its specialist rehabilitation services. Devon was internationally renowned for its deinstitutionalisation in the 1980s, but efforts to continue the process seem to have stalled. Devon's own strategic framework for health and social care ('The Way Ahead') acknowledges an 'over-reliance on a bed based and institutional models of care and under-provision of appropriate community alternatives'.

I gained the impression that the acute inpatient service is unpopular, overcrowded and un-therapeutic. There are few home or community based options for people in crisis.

Though inpatient rehabilitation services like the Russell Clinic are making valiant attempts to be recovery oriented, the institutional environment inevitably limits some important components of a recovery-based approach, such as the regaining of the identity and roles of citizenship and the reduction of stigma and discrimination. An institutional rehabilitation service is limited in its ability fulfil the Recovery Devon's standards on 'social inclusion' and 'challenging stigma and discrimination'.

Reorienting the scale and location of services is important and needs to be accompanied by a change in philosophy, values, attitudes and behaviour. There is a tendency throughout the world for people to picture mental health services as buildings, but in the recovery era we need to picture services as relationships that happen in many different community and home settings.

Suggestions

1. *Devon should consider selling Wonford House or failing that – use it just for administration.*

2. *All rehabilitation services need be community based – either in staffed housing or working with people who live in their own homes. The only exception to this would be forensic services where people are detained, sometimes for long periods.*

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

4. *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.*

5. *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.*

See 'Recovery in Progress' sections 4.4, 5.4 & 5.7

C. A BALANCE BETWEEN CLINICAL SERVICES AND SUPPORT FOR RECOVERY AND WELLBEING

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

6. *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.

See 'Recovery in Progress' sections 5.2, 5.3, 5.5, 5.6, 5.7, 5.8, & 5.12

D. THIRD SECTOR AGENCIES

Much of the demand for support services, as well as clinical services, could be met through increasing the funding for the third sector. This sector is less bureaucratic, more able to establish services quickly, freer to innovate, and closer to people's communities. Only seven percent of mental health services in Devon are provided by third sector agencies, though there is a government target for fifteen percent. In North Devon at least, many third sector agencies are tiny and rely largely or wholly on volunteer labour. Some of them could provide a valuable service if they were adequately funded. Devon's Community Care Trust, one of the larger third sector agencies in South Devon, is reputed to provide high quality recovery-oriented services.

Suggestions

7. *More high quality voluntary services like the Community Care Trust are needed throughout the county.*

8. *Devon needs to increase its funding and infrastructure support for third sector agencies to provide sustainable services, resources and opportunities for recovery and wellbeing to people with lived experience as well as the whole population.*
   Note: Wellbeing promotion has to be a whole of government responsibility, not just the responsibility of health and social services.

See 'Recovery in Progress' section 7.4

E. WORKFORCE CULTURE

Everyone agrees a lot more needs to be done to create a truly recovery focused workforce and culture. Some features of a traditional mental health service inhibit this - institutional environments, loss of morale, a deficits-based view of people with lived experience, and risk management based upon concerns about professional and organisational reputation. All these background features need to be remedied as well as specific actions to change the workforce cultures such as the following.

Suggestions

9. *Staff need to be recruited for their recovery values and humanity as well as for their skills.*

10. *Staff need good supportive work conditions and the opportunities to reflect together in safety.*

11. *Staff training, supervision and performance appraisal need to be linked – otherwise the learning from training will be lost.*

12. *Staff need training and supervision in all aspects of recovery – including the recovery philosophy, collaboration with clients, human rights, hospitality (as outlined in Mike Slade's report), community development, and working across agencies and communities.*

13. *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.*

14. *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.*

15. *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.*

16. *New workforces need to be to be scoped, developed, recruited and trained, as a broader range of responses is developed.*

See 'Recovery in Progress' sections 3.3, 4.8 & 8.4

F. RECOVERY LEADERSHIP

A big strength in Devon is its recovery leadership and the guidance given to staff on practicing a recovery approach. It is also admirable that at least one senior psychiatrist is open about his experience of mental health problems. Recovery Devon is an informal network of committed people. It has initiated and supported forums, training events, recovery guidance, the development of recovery based outcome measures and helped to bring international recovery experts to Devon. It has a good reputation as a leader in recovery within the UK and needs to keep up its momentum.

Suggestions

17. *Recovery Devon needs to foster more visible service user leadership.*

18. *Recovery Devon needs to consider some of the more profound implications of the recovery philosophy and debate the need to reframe our views on such things as madness, compulsory treatment, risk management, personal responsibility, institutional services, the breadth of mental health services, the roles of people with lived experience and so on.*

19. *Recovery Devon could initiate and support a stock-take of outmoded language and introduce new language into documents and into the verbal communication of senior staff.*

20. *The Commissioner, statutory services, third sector agencies and people with lived experience need work together to ensure the sustainability of Recovery Devon's role as an independent driver of change in Devon.*

See 'Recovery in Progress' sections 1, 4.1 & 4.8

G. OUTCOME MEASURES AND RESEARCH

Devon is currently piloting two service user-assessed recovery outcome measures that focus on personal wellbeing and the recovery orientation of the service. This is a positive development. There are other higher level measures that could be useful to measure recovery outcomes. At the other end of the spectrum there is a need for qualitative research that seeks a deeper understanding of people's experiences, needs and aspirations.

Suggestions

21. *If the pilot is successful the recovery outcome measures should be implemented throughout the service.*

22. *Consideration should be given to measuring interventions and outcomes of the whole population of service users, such as:*
    - *Rates of compulsory interventions (which should decrease in a recovery oriented system)*
    - *Rates of employment (which should increase in a recovery oriented system)*
    - *Rates in independent housing (which should increase in a recovery oriented system)*

    Note: These measures do not necessarily suggest that no-one should ever be placed under compulsory intervention or that everyone should work in paid employment or always live in independent housing. However, we would expect to see these trends in a service that is moving towards a recovery orientation.

23. *Consideration should be given to building up the local qualitative recovery research capacity, especially among people with lived experience and families. This could be done in partnership with a university.*

See 'Recovery in Progress' sections 8.2 & 8.4

H. RURAL/URBAN INEQUITIES

The people in North Devon have historically had less funding for services than other parts of the county. They believe their services are getting 'cut and cut'. I was told the voluntary services in North Devon have strong networks and partnerships but that service delivery is a challenge in a wide-flung rural area. The people in North Devon were more critical of the Devon Partnership Trust than others I came across.

Suggestions

24. *The inequitable funding for North Devon services needs to be remedied (I believe this is starting to happen).*

25. *Consideration should be given to developing more accessible services in rural areas like North Devon, such as video-conferencing of clinical consultations and meetings, or online services.*

See 'Recovery in Progress' section 4.7

I. COMMISSIONING

The commissioning of services in Devon demonstrates both a structural partnership between health and social services, and also good functional relationships between the commissioner and the services he commissions.

Suggestions

26. *The commissioner needs to ensure there is a strategy for recovery based service development that includes:*
    - *The continuation of deinstitutionalisation.*
    - *A broader range of services, resources and opportunities for recovery and wellbeing.*
    - *An expanded third sector.*
    - *Self-directed care pathways and individual budgets.*
    - *Incentives for different agencies and sectors and agencies to collaborate in providing services, resources and opportunities for recovery and wellbeing.*

27. *The commissioner needs to evaluate the recovery orientation of funded service through the joint development and use of the measures and research suggested above in 'Outcome measures and research'.*

See 'Recovery in Progress' sections 5, 7 & 8

J. INTER-AGENCY AND INTER-SECTOR COLLABORATION

Devon is fortunate to have a joint commissioning structure that can practice and role model collaboration at the top. The new access and wellbeing function should improve access to specialist mental health services as well as collaboration between primary health and mental health.

Collaboration with other agencies, sectors and communities is essential in a recovery-based system that provides access to a broad range of responses and is as serious about promoting social inclusion as it is about decreasing symptoms. Responses to people with lived experience need to be more integrated, in both a conceptual and practical sense, with wellbeing promotion for the whole community.

Suggestion

28. *The Devon Partnership Trust needs to dedicate significant resources and staff time to evaluating the degree and quality of its collaboration with other agencies with a focus on recovery and wellbeing, removing any barriers, and up-skilling staff to work with other agencies and communities.*

See 'Recovery in Progress' section 5

K. STIGMA AND DISCRIMINATION

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.

Suggestion

29. *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.*

See 'Recovery in Progress' section 6.3

L. CONNECTIONS WITH GOOD RECOVERY PRACTICE

Much of the national direction in health and social services in England, if well implemented, is consistent with the recovery philosophy eg personalisation, self-directed care and individual budgets. Devon itself is recognised as a leader. Larger countries sometimes fail to look beyond their own borders for new thinking and examples of good practice, though I sensed a more outward focus in Devon than some other parts of England. The accompanying paper ''Recovery in Progress' section/s' provides a reasonably comprehensive description and some examples of international recovery based thinking and practice.

Suggestion

30. *Devon should continue to seek and share its recovery best practice both nationally and internationally.*

CONCLUSION

Mental health services in Devon have put recovery firmly on the agenda and are leading other NHS Trusts in England. But the achievements to date are just part of a long process of attitudinal, behavioural, cultural and structural transformation. There is some evidence and wisdom (see Change References p 10) on what works in organisational change or transformation, which may be useful to reflect upon:

Create a rationale, vision and strategies
Generally people are not motivated to cooperate with change unless there are compelling reasons supported by an ongoing sense of urgency. The vision, and any deficiencies it addresses, provides the rationale for the change. The vision then needs to be translated into set of values, strategies, processes and outcome expectations, with measurable short-term goals that create quick wins.

Focus on the internal as well as the external
Individual thoughts or feelings and organisational culture are often hidden and hard to quantify. In this way they are unlike behaviour, organisational structures, policies and rules. Many change processes fail because they focus on the tangible externals at the expense of internal experience and culture. Both need attention.

Get leadership support

Sustained and highly visible governance and management support is essential for organisational change to succeed. Leaders need to both champion and role-model the changes they are working towards**.** They need ensure reliable funding streams, including funds for the additional costs of implementing change.

Use dedicated change management staff
It is unrealistic to expect staff with other responsibilities to manage significant organisational change. Success is much more likely if there is a dedicated change management team, made up of change management experts and key stakeholders, to address both task and process issues.

Get the best out of the workforce
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.

Involve stakeholders
Leaders need to ensure the involvement of stakeholders from the start as co-creators of the change. Frontline and middle managers can make or break the change process and are important to get onside. People with lived experience, followed by families need to be viewed as the primary stakeholders in the mental health arena. Other stakeholders include the community, especially those groups that are most at risk of loss of wellbeing or of needing mental health services.

Continuously communicate
The leaders and change management staff need to continuously communicate and share information, targeting their approach for different stakeholders. Engagement with stakeholders needs to allow for open dialogue and disagreement. This is the best way to ensure ongoing buy-in and cooperation.

Build on successes and embed change
Leaders need to use short term wins to keep up momentum to move on to new stages of change, and reinforce the connections between the new practices and success. They should not let up until the change is fully embedded.

CHANGE REFERENCES

Fixsen, D., et al. (2005). *Implementation Research: A Synthesis of the Literature.* Tampa: University of South Florida.

Green, M. (2007) *Change Management Masterclass: A Step by Step Guide to Successful Change Management*. London: Kogan Page.

Harvard Business School (1998). *Harvard Business Review on Change.* Havard Business School Press.

Iles, V, et al. (1999) *Organisational Change: Managing Change in the NHS.* Available at www.sdo.lshtm.ac.uk/files/adhoc/change-management-review.pdf

Kotter, J. (1996). *Leading Change.* Boston: Havard Business School.