Report by: Mike Slade
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I had the pleasure of visiting services in Devon from 21 to 24 July 2008. During the visit I had individual meetings with Peter Aitken, Graeme Barnell, Laurie Davidson, Alison Moores, Ian Pearson, Ann Redmayne, Glenn Roberts and Rachel Webb. I also met and made presentations to Trust psychologists (chaired by Joe Miller and Elina Baker), CSIP Regional Leads (chaired by David Dickson), and Recovery Devon. I visited the Russell Clinic, the Cool House (with Claudia and Martin) and Granvue (with Jane). I received a warm welcome from all the people and services I met with. The universal openness and willingness to engage in discussion was very appreciated.

This report presents my comments on current progress towards a recovery orientation in Devon. I only of course saw a partial picture of activities, so have organised my reflections into what I did see, what I did not see, and some suggestions for moving even further forward.

The pro-recovery things I did see

1. The central place of values – Devon is unusual in England in having a visible, owned and lived set of values and resulting standards
2. The importance of change is recognised – there is a recognition that recovery involves doing things differently and an orientation towards developing empowered staff and services, which is unusual (especially in the NHS)
3. A sophisticated view exists about organisational change and development. There was good understanding of strategies emerging internationally for system transformation, *e.g.* making values explicit, the importance of visible leadership
4. Several strategies have been used to support staff to work differently:
    a. The use of 20 team coaches to support the work of 57 teams across Devon Partnership Trust
    b. Skills training in using coaching skills in the Community Care Trust
    c. Making values explicit and shared across the network, which supports partnership working and shared expectations
    d. A commissioning approach which models partnership working, by involving third sector partners in lead positions and actively supporting the development of approaches to measuring performance against recovery standards
5. The people with whom I met had a strongly pro-recovery orientation, both in knowledge and in their respectful, partnership-based, human-focussed ways of talking about people receiving support from services.
6. The third sector in Devon is at the forefront internationally of harnessing the power of networks. An understanding of the distinction between involvement and partnership, and that someone can simultaneously be a person in need and a resource to help others, stands out as features of how recovery has evolved.
7. There is a resource of leaders who have the potential to inspire the wider system
8. The development of a cadre of people trained in WRAP, intentional peer support and supporting self-management is a key human resource in Devon

The things I did not see

The aspects I identify here are things I did *not* see, which may well be present in parts of the system I did not encounter. So these should not be taken as criticisms!

1. Some people with complex health and social needs in the context of mental illness will require long-term support. A real strength of the service is having high rather than realistic (*i.e.* low) aspirations, but there is also a need to develop an acceptance (and, more challengingly, valuing) of the need for long-term support – dependency is not a dirty word!
2. 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'.
3. There was sometimes a flavour in the discussions with statutory mental health services that the goal was internal transformation. This is necessary but not sufficient. There are some aspects of recovery which statutory mental health services may find particularly difficult, and may need help with. For example:
    a. 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.
    b. 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.
    c. 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 CommonGround approach[1])
4. 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 (See for example the Warwick centre –www.cappeu.org)

Some suggestions

1. Focus more on work

There was some ambivalence about focussing on work. This may come from a concern about oppressing people in a different way by imposing a model of normality and / or expecting them to be economically productive, but my view is that supporting pathways into work could be more consistently addressed, whilst still remaining mindful that employment is not the choice of all. I heard the term 'work-readiness',

[1] Deegan P, Rapp C, Holter M, Riefer M. A Program to Support Shared Decision Making in an Outpatient Psychiatric Medication Clinic. *Psychiatric Services* 2008;**59**:603-5.

which is a concept which has been actively challenged by some services internationally. For example, at the Village (www.village-isa.org) work-readiness is defined as "the person expresses some interest in work" – it is a judgement made by the person, not their worker. The approach used at the Village to supporting the people they work with into work is world-leading, and came about because they decided to stop spending money on acute and residential services and instead spent it on work-related services.

2. Publicise the identity of Devon as a centre of recovery even more widely

This may be an aim worth committing some DPT resources to, since this will reinforce the Trust's identity as a national centre of excellence in recovery. This creates a virtuous cycle of increasing in-house engagement in recovery-focussed working. Approaches might include:

   a. hosting an annual national conference
   b. sending individual invitations to all Chief Executives of Mental Health Trusts in England to visit the service
   c. developing a social enterprise business to offer WRAP training to other Trusts
   d. developing a consultancy service to support other mental health services to move towards a recovery focus

3. Collaborate with quantitative researchers

One key omission from the recovery world is quantitative evidence of a form likely to end up in clinical guidelines. An audacious goal would be to evaluate the development of recovery in Devon, with an aim of influencing clinical guidelines

4. Develop specific training for mental health workers in three specific key recovery skills:
   a. Assessing and amplifying strengths – there is a developing literature on how to identify and maximise strengths[2], 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
   b. 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.
   c. 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.

5. Develop a shared focus on hospitality across the network, with attention given to (apparently) simple things like welcomes, what the first meeting with someone

[2] Rapp C, Goscha RJ. The Strengths Model: Case Management With People With Psychiatric Disabilities, 2nd Edition. New York: Oxford University Press, 2006.

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.

6. Go further down the line of exploring the implications of networks. The expertise I encountered was more developed in the third sector than in the NHS. Could this experience with networks and partnership relationships be imported into the statutory mental health system? I don't know what this would look like – I don't think anyone does – but if we're serious about transforming mental health services into supporting recovery then this kind of fundamental shift will be necessary. Devon is better placed than perhaps anywhere else to lead this process.

Please feel free to contact me (m.slade@iop.kcl.ac.uk) about any of the above comments.

Two things I took away from my Devon visit were the potential of networks and the possibility of system-wide shift through partnership. I am grateful to the people I met for the chance to learn from your experiences on the recovery road. Good luck in the future journey!

Mike