



**Trinity College Dublin**  
Coláiste na Tríonóide, Baile Átha Cliath  
The University of Dublin

# **Building capacity in mental health services to support recovery**

***An exploration of stakeholder perspectives:  
Pre and post intervention***

## ACKNOWLEDGEMENTS

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## FOREWORD

In recent years there has been an increasing focus in Ireland and internationally on approaches to improve the quality, consistency and safety of care in mental health services and a growing recognition across all healthcare systems of the importance both of the culture of organisations, and the role of service users, non-professional carers and practitioners in the improvement process. *'Building Capacity in Mental Health Services to Support Recovery; an outline for an all-Ireland pilot programme'* was funded through the 'Capacity Building' stream of the Genio Trust in 2012 following a successful application by a consortium comprising mental health advocates, service users and professionals interested in applying Quality Improvement methods to mental health service development in Ireland.

The purpose of this report is to communicate the experiences of participants (service users, family members, professionals and managers) in this 18 month pilot project, the first systematic approach to delivering a core part of Irish mental health policy using a comprehensive organisational change methodology. The report's authors bring both academic and lived expertise to the work and provide an incisive perspective on the current state of our national mental health services. The work describes in accessible, comprehensible terms how a representative set of regional services in Ireland (rural, urban and mixed) approached the complex challenges involved in implementing policy, meeting regulatory standards and delivering evidence based practices in partnership with service users, family members and relevant stakeholders. Uniquely therefore, this report provides essential guidance for the future development of mental health services, both in terms of achieving authentic person-centred treatment and support and invaluable information on the application of a Quality Improvement methodology. The authors' findings do not provide a set of outcomes or measurements relating to recovery but rather, offer the learning derived from a process of organisational change in the real life context of contemporary mental health care in Ireland. Therefore, the report will be of interest to those who wish to achieve systematic reform for the improvement of services and those tasked with integrating quality improvement for mental health into service management and service delivery.

It was my privilege to lead this pilot project and I am indebted to those service users, colleagues, managers and family members who chose to contribute their enthusiasm and time to the work. It is hoped that the recommendations in this report will be implemented and that enduring quality improvements which are now within reach are realised in mental health services in Ireland.

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## EXECUTIVE SUMMARY

A recovery-oriented approach to mental health care has emerged as a core part of Irish mental health policy in recent years. *A Vision for Change: Report of the Expert Group on Mental Health Policy* espoused the values and principles embodied in a recovery ethos (Department of Health and Children 2006) while subsequent documents have explored its implications for practice (Higgins 2008; McDaid 2013). In recent years, a number of initiatives informed by a recovery-oriented approach to service provision have been piloted in Ireland. These initiatives targeted greater service user representation and involvement, opportunities for peer advocacy and peer-led education as well as focusing on leadership and management skills required to initiate recovery-oriented approaches to mental health care (Watts 2014; Higgins & McGowan 2014).

It is recognised that the development of recovery-oriented services hinges on the confluence of a number of factors all of which are not easily amenable to change, including shifts in cultural attitudes as well as changes to organisational structures and processes. To date, the process of implementing change in Ireland has been characterised by piecemeal approaches dependent on individual recovery champions as opposed to a systematic approach towards the implementation of system wide recovery-oriented services (Higgins & McGowan 2014).

The focus of this report is the 'Building Capacity in Mental Health Services to Support Recovery' pilot programme, an eighteen month project aimed at supporting seven mental health service sites to build capacity to implement a number of key recovery concepts. The initiative represented the first systematic approach to developing recovery-oriented services at a national level, using a comprehensive organisational change methodology. The initiative was based on and guided by principles of the Implementing Recovery through Organizational Change (ImROC) methodology, a framework for service transformation outlining ten key organisational challenges which mental health services must address if they are to become more recovery-oriented (Shepherd *et al.* 2010). The initiative was to focus on service level structures, systems and practices that could maximise personal recovery opportunities and outcomes for service users. Seven sites throughout Ireland from over forty applications were selected to participate in the initiative on the basis that they had already shown an interest in the area of recovery and could demonstrate a track record through existent recovery-oriented initiatives as well as guarantee the support of decision-making management personnel.

The overall aim of the study was to describe the roll-out of the recovery capacity building initiative as experienced by the key stakeholders involved in its implementation and to identify facilitators and barriers to implementing organisational change for recovery in the Irish mental health setting. Qualitative research methods, involving both face-to-face interviews and focus groups, were used to meet the study aim. Data was collected during

the early days of the initiative's implementation and also after its completion. Ethical approval to conduct the study was granted from the Research Ethics Committee of the Faculty of Health Sciences in Trinity College Dublin.

Stakeholders within each of the seven sites who agreed to be part of the initiative and who were willing to participate in the research were interviewed as part of the study. This included project leads in each site and representatives from service users, family members and service providers. Seventy participants were interviewed in the pre initiative phase and forty-three participants were interviewed post initiative.

The pre initiative data also revealed variability in the extent to which recovery-oriented services were available. Participants collectively identified examples of recovery-oriented services, such as greater service user involvement and control in care planning, the availability of non-medical forms of help, the development of links with community-based, peer-led initiatives, more accessible and responsive community-based services, and positive attitudes towards recovery among professionals. While participants identified examples of recovery-oriented services they also identified a range of barriers to these services, most of which pertained to the system of mental health care provision. In this context, they spoke of a system that was oppressive, stigmatising and which contributed to and perpetuated social isolation. They were of the view that professionals subscribed largely to the medical model view of mental distress and that alternative models of understanding or treatments were not explored sufficiently. A lack of resources within the system was viewed as contributing to service provision that was reactionary and crisis-led and where staff were often extremely over burdened. In addition, participants were of the view that negative media, public and professional attitudes towards mental distress/illness and the prevailing risk averse culture inhibited a recovery approach to care and marginalised both service users' and carers' voices. A lack of co-ordination and leadership was also cited as preventing recovery-oriented services from being implemented. Stakeholders viewed the recovery initiative as representing an opportunity to foster an approach to mental health care founded on stakeholder (service user, family, and practitioner) and interagency partnership and as an opportunity to develop appropriate, acceptable and accessible supports and services.

Out of the ten challenges identified by ImROC, nine challenges were selected as site goals by the seven sites involved. The ability of each participating site to begin a process of transformational change was contingent on the recruitment, support and sustained inspiration of a range of recovery champions including service users, family members, practitioners from a number of disciplines, management personnel within each site, and community based organisations and individuals. While all of sites were at different stages of ImROCs' change model which incorporated three stages: engagement, development and transformation, the post intervention data found that collectively the seven participating

sites evidenced many creative recovery initiatives in each of the challenges selected. The process of implementing change varied within each site with some sites developing initiatives internally and adopting a systematic strategic approach to change while other sites sourced initiatives externally, adapting them to suit locally emerging needs and tended to operate at a project/initiative level with limited strategic planning. In addition, there was varying levels of managerial, team and individual commitment, with differences in the degree to which changes in practice, policy or culture had taken place.

Nonetheless, there was evidence of capacity building within each of the stakeholder groups and within all sites. One of the positive outcomes of the project was the opportunity for both service users and family members to assume new roles and to develop positive identities through a range of initiatives, particularly the development of peer support roles. At the same time, one of the challenges emerging from the findings was involving sufficient numbers of service users and family members in the recovery process, with many initiatives reliant on a small number of service users and limited family member involvement.

The study findings clearly demonstrated a number of conditions which facilitated an increased capacity for the development of recovery-oriented service provision, including commitment to co-production and the inclusion of service users and family members; an appreciation of the educative power of open dialogue at all levels; involvement of senior management and senior medical personnel; fidelity to the ImROC methodology; good communication and coordination of different recovery initiatives and the inclusion of different organisations and disciplines. In addition, a systematic and strategic process driven by senior management and involving actions, such as conducting mapping exercises, developing action plans and allocating funds and resources, was identified as instrumental to facilitating organisational change. Interviews also revealed a number of barriers to change which in many cases represented an absence of those same facilitators. Each of the elements identified in this report will need to be carefully considered and addressed in any future quality improvement initiative if recovery-oriented services and practices are to become the norm within the Irish mental health services.

#### **Priorities for future action include**

- The ongoing support and engagement of senior management in the process and ongoing involvement of service users and family members at management level
- The inclusion of all disciplines within mental health as champions of recovery
- A commitment co-production and the open acknowledgement of the value of lived experience
- The provision of adequate resources (financial and time) to sustain progress
- The provision of ongoing education on recovery that is co-produced and co-delivered
- The development of a strategy to build capacity of service users and family members

- The cultivation of meaningful roles and identities for service users and family members and the provision of suitable rewards
- The development and ongoing evaluation of the ten IMROC challenges

While there are grounds for optimism and there is a sincere appetite for, commitment to and enthusiasm among participants for ongoing change, participants were fearful that without sustained inspiring leadership, resources and an authentic commitment to co-production by all involved, real and lasting change that embodies all elements of recovery oriented services would remain an aspiration, or worse still recovery would be considered a *'fad'* or *'latest buzz idea'* with little to offer the mental health community.

## Chapter 1. Introduction

This chapter sets the context for this report by briefly describing how the recovery approach has emerged within Irish mental health policy and practice. A brief summary of the literature on the challenges to implementing recovery oriented practice is outlined before the framework for Implementing Recovery through Organisational Change (ImROC) is described. The chapter concludes with a description of the 'Building Capacity in Mental Health Services to Support Recovery' pilot project (a component part of the Advancing Recovery in Ireland initiative) which is the focus of this report.

### Recovery in Ireland

As elsewhere, the concept of recovery has become central to mental health policy and service planning in Ireland in recent years. A discussion paper on Recovery in Mental Health Services was first published in 2005 (Mental Health Commission 2005) and soon thereafter the principles and values of the recovery ethos were espoused as a core part of Irish mental health policy with the publication of *A Vision for Change: Report of the Expert Group on Mental Health Policy* (Department of Health and Children 2006). A *Quality Framework for Mental Health Services* enshrined the recovery approach by establishing recovery as one of the standards of care for mental health services in Ireland (Mental Health Commission 2007). More recently the Mental Health Commissions' *A Recovery Approach within the Irish Mental Health Service: A Framework for Development*' (Higgins 2008) and the Mental Health Reforms' *Recovery: What you should expect from a good quality mental health service* (McDaid 2013), developed the concept of recovery and explored issues in relation to practice. Both of these documents recognised that the development of recovery-oriented services hinges on the confluence of a number of factors all of which are not easily amenable to change, including shifts in cultural attitudes as well as changes to organisational structures and processes (Higgins & McGowan 2014). The recently published *Health Service Executive National Service Plan 2015* identifies the delivery of recovery focused services as a priority area for mental health. In addition to a number of actions aimed at enhancing the development of quality mental health services across primary, secondary and tertiary care, the plan also identifies recovery and the involvement of service users, families and carers in the design and delivery of mental health services as a priority, and includes building capacity among services users, family and carers to facilitate their participation and representation at local and national levels (HSE 2014).

To-date, a number of initiatives that embody the recovery ethos have been piloted in Ireland in an effort to implement changes to service provision, such as the Irish Mental Health Trialogue Network, Hearing Voices Network, and the Cooperative Learning and Leadership Programme, which is a collaboration between DCU and the HSE which focuses

on fostering the leadership and management skills that stakeholders need to instigate change within services. Furthermore, greater service user involvement is promoted by Wellness Recovery Action Planning (WRAP) which has become increasingly available within mental health services (IMG 2012), while peer educators are becoming increasingly involved in services through initiatives such as EOLAS, a peer and clinician led informational programme for people who experienced psychosis and their families, and through service user and family representation on local management groups, policy groups, recruitment panels and research groups. Peer advocacy and a greater acceptance of peer support organisations, such as GROW, Recovery Inc and BodyWhys, is also beginning to develop (Watts 2014). The establishment of National Service Users Executive (NSUE) and more recently of consumer panels has demonstrated a real effort to include service users and family members in the policy making processes needed to herald a shift in the nature of recovery practice. Other approaches required for a recovery-oriented service, such as recovery-oriented prescribing practices and a partnership approach towards positive risk taking have been identified in Irish documents (Higgins & McGowan 2014). Although some Irish research into recovery exists, it is at an embryonic stage of development (Shah *et al.* 2014; Kartalova-O'Doherty *et al.* 2006; Kartalova-O'Doherty and Tedstone Doherty 2009; Cleary and Dowling 2009; Watts 2014). While noting that 'the initial scepticism that greeted recovery is slowly being eroded and replaced with practical concerns around implementation and debates around meaning' (IMG 2012: 84), the IMG commented on the continuing dominance of biomedical approaches, the absence of recovery plans, poorly developed recovery competencies in service delivery, and the inconsistency of service user and family involvement. Others note how efforts at implementing recovery-oriented services are locally driven by individual recovery champions as opposed to a systematic approach towards the implementation of system wide recovery-oriented services (Higgins & McGowan 2014).

### Challenges to Recovery

Working towards a recovery-oriented service does not occur without tensions and challenges for all involved. Slade and colleagues (2014) identify what they perceive as seven misguided and misinformed beliefs and practices pertaining to recovery which act as barriers to implementing recovery-oriented services, including:

- A disregard for the peer support worker role
- A belief among clinicians that a recovery approach cannot be implemented with service users who are considered 'acutely mentally ill'
- A belief that personal recovery cannot be achieved without clinical recovery and the subsequent emphasis on medical interventions focused on symptom reduction and elimination
- A belief that compulsory detention is an effective intervention which facilitates recovery

- A reduction in service availability and accessibility on the basis that recovery-oriented services demand less service provider involvement
- The dominance of a medical model of mental illness which focuses on normalising the person with mental illness so that they can be socially acceptable rather than adopting a social model which focuses on the ways in which the absence of social and economic supports as well as the experience of stigma can exclude people from full participation in society
- A belief that people with a diagnosis of mental illness cannot work until they are recovered (Slade *et al.* 2014: 12-14)

Other writers, such as Kidd and colleagues (2014) in their study identified challenges related to service users encountering a lack of dialogue, partnership and shared decision-making in mental health services, in conjunction with an inflexible mental health system that adopts an unsystematic approach to recovery-oriented services. In addition, lack of time, demanding workloads, clinical responsibility to manage risk, and a lack of critical reflection on practice were identified by clinicians as barriers to recovery-oriented practice (Kidd *et al.* 2014). In setting out their recommendations on recovery, the IMG (2012) note the urgent need for a national implementation framework, leadership, and education.

### **Implementing Recovery through Organisational Change (ImROC) methodology**

The Implementing Recovery through Organisational Change (ImROC) methodology was developed by the Sainsbury Centre for Mental Health following stakeholder input into how best to achieve recovery-oriented services. ImROC provides a framework for service transformation by outlining ten key organisational challenges which mental health services must address if they are to become more recovery-oriented (see table 1). The purpose of the framework is primarily to initiate dialogue between stakeholders to enable them to identify how the key issues affect their services at a local level and what strategies may be implemented to overcome the challenges.

**Table 1: Implementing recovery: A new framework for organisational change**

Changing the nature of day-to-day interactions and the quality of experience
Delivering comprehensive, service user-led education and training programmes
Establishing a 'Recovery Education Centre' to drive the programmes forward
Ensuring organisational commitment, creating the 'culture'
Increasing 'personalisation' and choice
Changing the way we approach risk assessment and management
Redefining service user involvement
Transforming the workforce
Supporting staff in their recovery journey
Increasing opportunities for building a life 'beyond illness'

(Sainsbury Centre for Mental Health 2009)

It is suggested that ImROC is carried out in two phases. Phase one involves stakeholders classifying their organisation in terms of its stage of development in relation to each of the challenges by building a shared understanding of the underlying concepts entailed in each challenge and arriving at a consensus on how their service measures up. This provides a benchmark against which future progress can be evaluated and feeds into phase two which involves the identification of priorities and the development of SMART (Specific, Measurable, Agreed-upon, Realistic, Time-based) goals to define the priorities and monitor progress. Acknowledging the time consuming nature of organisational change to take effect, a limit to the number of priorities agreed is suggested with no more than five priorities to be taken on board at any one time. Furthermore, challenges 3 and 4 are singled out for priority as these address issues of both leadership and organisational commitment which are deemed to be of fundamental importance in the drive to implement organisational change. In recognition that changing organisational structure and culture is a slow evolutionary process, the Sainsbury centre suggest that change will occur in three stages (see table 2 for a definition of the three stages of development).

**Table 2: Stages of development of recovery-oriented services**

Stage 1: Engagement

The organisation is clearly engaged in its intent to deliver recovery-oriented services. At a Board level there is an acknowledgement and ownership that the organisation needs to change towards more recovery-oriented services. There is an awareness of existing good areas of practice and the commitment to build on these. Plans to deliver recovery-oriented services have been agreed and a timetable for implementation is in place, but there has been little progress as yet. We envisage that most trusts will start at this level on most dimensions.

#### Stage 2: Development

Action is being taken with some evidence of significant developments in practice, policy and culture. Good progress is being made in delivering recovery-oriented services in some areas, but this is not consistent throughout the organisation. We envisage that some of the more advanced trusts will be rated at this level for at least some of the dimensions.

#### Stage 3: Transformation

The vision for achieving significant change has been fully realised. The necessary policy, processes and practice to deliver a recovery-oriented service are embedded at every level of the organisation – from Boards to teams and front line workers. There are processes in place to achieve continuous improvements based on learning from ongoing review. The organisation works proactively with a range of other partners in supporting positive mental health and wellbeing. We envisage that this level will be aspirational for most trusts on most dimensions.

(Sainsbury Centre for Mental Health 2009)

#### **Advancing Recovery in Ireland (ARI) Initiative**

The 'Building Capacity in Mental Health Services to Support Recovery' pilot project (project lead Dominic Fannon) was a component part of the Advancing Recovery in Ireland (ARI) initiative which also incorporated the roll out and further development of the 'Recovery Context Inventory'<sup>1</sup> (project lead Tom O'Brien). ARI was funded by the Genio Trust for an eighteen month period and was aimed at supporting seven mental health service sites to implement a number of key recovery concepts. The project which was completed in July 2014 was implemented in partnership between Mayo Recovery Consortium, EVE (a programme in the HSE) and the National Mental Health division of the HSE.

The 'Building Capacity in Mental Health Services to Support Recovery' pilot project was, throughout its implementation, to be based on, and guided by principles of the ImROC methodology. This process was to involve services benchmarking themselves against the ImROC ten organisational challenges, selecting three of the challenges, agreeing priorities for action on each challenge, assisted by expert training and consultancy support. The process was to be based on co-production: those with lived experience of mental health problems, family members/carers, managers, mental health practitioners and members of community and community groups would engage in dialogue, share decision making around priorities and actions, and collaboratively implement and evaluate the impact of actions

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<sup>1</sup> The Recovery Context Inventory is not the focus of this report.

taken. It was anticipated that the implementation of these planned changes would help local mental health services be more supportive of people in their recovery.

Seven sites throughout Ireland were selected from over forty applications on the basis that they had already shown a real interest in the area of recovery and could demonstrate a track record through existent recovery-oriented initiatives. Importantly, prior to selection, each site had to demonstrate that they would have the full backing of decision making management personnel, thus ensuring that the initiative would have access to resources needed for a successful outcome. The 'Building Capacity in Mental Health Services to Support Recovery' pilot project was to focus on service level structures, systems and practices that could maximise personal recovery opportunities and outcomes for service users. It aimed to achieve this by facilitating the development of recovery focused mental health practice within the service. It recognised the service provider, service user and family as equal stakeholders.

The initiative was rolled out on a phased basis in order to allow each site to gain maximum benefit from their participation. The initial phase began in May 2013 with the introduction of the ImROC methodology to the sites and with the establishment of project teams. These teams consisted of a project lead (a service provider from within a range of disciplines) and representatives from service providers, service users and family members.

The first task of each team was to identify and work towards the achievement of three challenges or goals<sup>2</sup> selected from ImROC's list of ten over the period of the project. The teams were brought together periodically for six learning sets where they were first introduced to the ImROC methodology and offered an opportunity for mutual sharing of knowledge and progress. The learning sets were coordinated by International Consultants and ImROC pioneers Julie Repper and Geoff Shepherd in collaboration with Dominic Fannon, project lead and Michael Ryan, project coordinator.

In order to gain some understanding of the processes used, actions taken, achievements made and barriers involved in change of this kind semi-structured narrative interviews were conducted with a range of people at the beginning and end of the project. The focus of the interviews was on exploring peoples' perspectives on services pre and post intervention, as well as documenting what changes occurred and the barriers and facilitators encountered.

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<sup>2</sup> One site selected 5 challenges or goals because it had made substantial progress in achieving two of these before the commencement of the project.

## Chapter 2. Methodology

### Introduction

This chapter provides an overview of the methodology and methods employed in this study. It includes information about the study's overall objectives and research design. The two phases of the study are outlined, specifying data collection methods, recruitment of participants, sampling, and data analysis. Ethical considerations for the study are also addressed in this chapter.

### Objectives

The objectives of the study are as follows:

#### Module 1 Objectives: Pre Intervention

- To ascertain stakeholders' understanding of the meaning of recovery and its role in mental health services in the context of their own organisation
- To describe stakeholders' views on whether the principles of recovery and recovery-oriented practice is embedded within their organisation
- To explore stakeholders' hopes for the initiative

#### Module 2 Objectives: Post Intervention

- To describe the interventions taken to meet the challenges identified.
- To identify the stakeholders and processes involved in meeting the challenges identified.
- To identify the barriers, facilitators and challenges to embedding recovery-oriented practice in services.

### Research design

The study employed a qualitative research design to meet the research objectives. A qualitative approach was deemed most appropriate to enable the research team to explore key stakeholders' perspectives on recovery and the processes and barriers involved in attempting to engender an organisational shift towards recovery-oriented services.

### Selection of study sites

Seven sites throughout Ireland (see table 3) were selected from over forty applications on the basis that they had already shown an interest in the area of recovery and could demonstrate a track record through existent recovery-oriented initiatives. Importantly, prior to selection, each site had to demonstrate that they would have the full backing of decision making management personnel, thus ensuring that the initiative would have access to

resources needed for a successful outcome. Within each study site, project teams were established. These teams consisted of a project lead (a service provider from within a range of disciplines) and representatives from service providers, service users and family members.

**Table 3: Study sites**

Site	Project lead
Site A	Nurse
Site B	Nurse /Psychologist
Site C	Social Worker/Psychiatrist
Site D	Nurse
Site E	Nurse
Site F	Nurse
Site G	Manager/administrator

## Module 1: Pre Intervention

### *Inclusion criteria*

The inclusion criterion for module 1 was:

- Stakeholders within each site who agreed to be part of the initiative and who were willing to participate in the research (project lead, service user lead, other service users, family members and members of the multidisciplinary team).

### *Data collection methods*

#### *Interviews and focus group*

Data for module one were collected using a combination of face to face interviews and focus groups. Interviews were chosen to facilitate an in-depth exploration of stakeholders' accounts and perspectives on recovery-oriented services. In addition the focus group allowed for a greater number of stakeholders to participate. A semi-structured interview guide was developed to guide both the face to face interviews and focus groups (See appendix one). A semi-structured approach to interviewing was chosen because while it provided a guide for the interview, it was also sufficiently flexible to allow participants to deviate from the questions and raise issues or points that were personally relevant and important to them as well as facilitating flexibility in the order and phrasing of questions.

Following the first few interviews, it was decided to give participants the interview guide in advance of the interview to allow them to reflect on the questions prior to the interview.

## **Recruitment**

Participants for the interviews were recruited through the study sites. A minimum of five individuals were required for interview from each study site. Participation in the interview was a pre-requisite of formally agreeing to be a project lead or service user lead, therefore these individuals were automatically selected for interview. In addition, a minimum of three other individuals from the project team and four service users were to be interviewed.

To recruit the other potential participants all project leads were provided with an information sheet which requested them in consultation with the service user lead to:

- Select a minimum of three people who would be willing to be involved in a face to face interview. One was to be a family member representative and the other two people could be any other members of the project team.
- Recruit and organise date and venue for a focus group composed of 4-6 service users.

All potential participants were provided, through the project lead, with an information sheet (see appendix two) outlining the purpose and process of the interviews. Service user participants were also given the option to be interviewed individually or be part of the focus group discussion.

## **Sample**

A total of 70 people were interviewed: 43 service users, (9 individual interviews and 34 members of focus groups); 8 family members and 19 service providers. (See table 4).

The service users interviewed represented a wide cross section of people at very different stages of recovery. Many were young, in their twenties and early thirties; most had a long history of 'mental illness' (more than five years), however, some had become 'mentally ill' quite recently. Although diagnoses were not always mentioned, there was a sense that the group was composed mainly of people with a diagnosis of schizophrenia and bipolar disorder rather than depression and anxiety. Between them many of the interviewees had experienced multiple or long term hospitalisations, spoke of being prescribed many drug treatments, lived in various levels of supported hostels and had been involved in many efforts at what they termed 'rehabilitation'. People in this group spoke of not being routinely consulted about their experience or their views on recovery but welcomed the opportunity and were thoughtful and articulate about their views and wishes.

The sample also included a minority of people who were much more independent, involved in society and who had been involved in the recovery movement for some time. This group had more reflective views on what recovery meant to them and their journey to their

current point. They too described experiencing prolonged and serious forms of mental ill health.

The eight family members/supporters (6 women and two men) interviewed comprised parents, spouses and children of people who they described as experiencing ‘enduring forms of mental illness’. While a minority had been involved with the services for less than two years, the majority had many years of contact with the services.

The professional group was composed of ten nurses, four psychiatrists, three occupational therapists and two social workers. Most of the nurses had many years of work experience. The only discipline not represented was psychology. The majority of representatives from each discipline were mainly women while four of the eight project leads were men.

**Table 4: Interview profile**

Region	PL	SU	FM	N	OT	SW	P1	P2	FG	Total
Site A	1N	1	1	1	1				4	9
Site B	1N	1	1	1	1				5	10
Site C	1SW/1P1	1	1	1					5	10
Site D	1N	1	2			1			4	9
Site E	1N	1	1		1		2		5	11
Site F	1N	2	1						5	9
Site G	1P1	2	1	2					6	12
Total	8	9	8	5	3	1	2	0	34	70

PL Project Lead

SU Service User

FM Family Member

N Nurse

OT Occupational Therapist

SW Social Worker

P1 Psychiatrist

P2 Psychologist

### **Data analysis**

Interviews were audio recorded and subsequently transcribed in preparation for analysis. Data from the interview transcripts were analysed manually. The first stage of analysis involved reading of the transcripts which allowed for a general overview of the participant’s accounts and facilitated the emergence of common trends using the interview questions as the initial framework. At this stage it was decided to use a triologue approach to organise and present the data. This approach reflected the three distinct voices emerging from the data: the service users’ voice, the family members’/ or friends’ voice, and lastly the service

providers' voice. This was followed by a form of thematic content analysis to identify core themes or patterns across the questions, and to reduce data where overlap or repetition was evident (Newell and Burnard 2006). The findings from these interviews are presented in chapter 3 and supported with exemplary extracts from the data. All quotes appear in italics.

## **Module 2: Post Intervention**

### ***Inclusion criteria***

The inclusion criterion for module two was:

- Stakeholders within each site who participated in the recovery initiative and who were willing to participate in the research (project lead, service user lead, other service users, family members and members of the multidisciplinary team).

### ***Data collection methods***

#### ***Focus groups***

Data for the post intervention phase of the study were collected using focus groups. A focus group was conducted in each of the seven participating sites. The research team devised an interview schedule that would be used as the framework to explore developments around the ImROC targets chosen by each site (see appendix three). The focus group interviews were conducted by two researchers, with one taking the lead in facilitating the discussion while the second person took notes, interjecting with questions as areas of particular interest or issues requiring further clarification arose. The focus groups were audio recorded and lasted between 1.5 and 2.25 hours.

#### ***Recruitment***

It was anticipated that each focus group would include the project lead plus a minimum of one service user, one family member and one service provider, all of whom had been involved in the development of the recovery initiative within their particular area. A letter was sent to each project lead outlining the purpose of the interview. The project lead was requested to decide on a date and venue for the focus group and invite all relevant stakeholders to the focus group.

#### ***Sample***

The minimal attendance of the project lead plus one service user, one family member and one service provider was achieved in all but two sites. Attendance varied between three and ten people. In total 46 people took part in the focus groups interviews and this number included seven project leads from various disciplines, 12 service users, seven family members, seven nurses, three occupational therapists, three social workers, two psychologists, four people representative of management or administration and one person from a voluntary sector organisation (See table 5).

**Table 5: Composition of focus groups**

Site	Project Lead	Service users	Family	Practitioners	Other	Total
Site A	1 N	4	1	1 OT		7
Site B	1 P2	1	1			3
Site C	1 SW	1	1	2 P2 & 1 N		6
Site D	1 N	2	2	2 SW		7
Site E	1 N	1	1	1 OT & 2 N		6
Site F	1 N	2	1	3 N	3 A/M	10
Site G	1 P1	1		1 OT + 1N+ 1SW	1 A/M & 1V	7
Total	7	12	7	15	5	46

OT Occupational Therapist  
P2 Psychologist  
V Voluntary Sector

SW Social Worker  
N Nurse

P1 Psychiatrist  
A/M Admin/Management

In comparison to the tone of the interviews undertaken at the beginning of the initiative the majority of the focus group interviews were characterised by tempered enthusiasm, hopefulness and energy. There was often a sense that a worthwhile and exciting journey had been started. Different participants described various projects situated in their particular site with a sense of pride, and there was a sense in the majority of sites that recovery-oriented services were no longer aspirational, but had the potential to become a reality if given the support and resources.

### **Data analysis**

Each focus group interview was recorded and subsequently transcribed after which each transcription underwent a thematic analysis. Analysis began by identifying concrete examples of recovery oriented practices that represented progress within each site. It then went on to identify: what happened over the duration of initiative; who was involved and what were the main facilitators and barriers to change.

### **Ethical considerations**

Ethical approval for the study was granted by the Research Ethics Committee of the Faculty of Health Sciences in Trinity College Dublin. All proposed participants were given both written and verbal information about the study. Participants were informed that their participation in the study was voluntary and were assured that they could decide to discontinue the interview at any time and if they wished any part of the interview not to be included that request would be respected. They were also assured of their anonymity. This

was considered important for two reasons: to protect those who were critical of services, and secondly by not naming sites it might allow a more open reading of the results by all involved.

## Chapter 3. Module 1: Pre intervention findings

### Introduction

This chapter of the report presents an analysis of the interviews conducted with stakeholders before the intervention. The findings are presented under the following headings:

- Meaning and understanding of recovery
- Perspectives on local mental health services as recovery-oriented
- Barriers to facilitating recovery-oriented practices
- Hopes and aspirations for the initiative

Each theme is presented from the perspective of service users, family members and mental health practitioners.

### Meaning and understandings of recovery

#### *The service user voice*

Many service users were united in their view of recovery as a journey to be undertaken in a series of steps or stages. For one service user, this journey was a continual process involving the ability to negotiate life, for another service user the journey culminated in a sense of completeness. An important element of the journey was achieving tangible outcomes which would facilitate people to cope and live life well. Thus, depending on where the person was at, recovery might mean 'being symptom free', moving from a supported hostel to independent living, successfully 'coming off medication', getting a job, getting married or being able to go to the cinema without being afraid. The comments below illustrate some of these viewpoints:

*'It's a journey with different outcomes like getting a place to live, getting a job, or becoming increasingly able'.*

*'Dealing with problems and having hopes such as meeting a girlfriend, getting a place of your own'.*

One service user expressed the view that recovery was about reclaiming their life while another spoke about recovery as *'about not going back to where you were but about building something new'*. One participant perceived that the beginning of a journey of recovery, regardless of where the person is, must be rooted in a sense of hope and the belief that things can get better.

Many people spoke about recovery as an educative process or a *'learning and enriching experience'* or as a process of *'getting wiser'*. In their view learning about mental health, learning about themselves, learning to take control of their symptoms, learning to deal with set-backs and choices and learning to take risks were key elements of the recovery process. People were of the view that through learning and education their identity was gradually transformed from one of passive dependency on services, medication, and the support of others to that of a progressing equal, with unique potential for the future and someone who could reasonably take legitimate risks at life and living.

An interesting and very common aspect of recovery was the notion that it was something that was co-created. There was a general acknowledgement that although recovery was something that *'I alone could do'*, it was also something that *'could not be done alone'*, or as this person said: *'it's the co-creation of a process, creating a plan for the future'*. Participants described how other people, such as friends or friendly practitioners were central to the recovery process. Participants' families were identified as being able to provide encouragements such as hope, warmth and a belief that recovery was possible while friends were able to see and visibly demonstrate or reveal to them their hidden worth by calling forth talents and potentials that remained hidden by a screen of symptoms, labels and side effects of medications:

*'I couldn't have recovered without my friends it would be unthinkable that it could happen without them'.*

*'Without friends and family you are nowhere'.*

Participants' comments reflected the importance of the involvement of key people who can provide the necessary supports to enable recovery and meeting people with whom a shared connection or bond can be established. In this respect, many people specifically mentioned the value of meeting with peers, or other people who had similar experiences. Meeting people with similar experiences who were more advanced in terms of recovery provided hope and inspiration. Peers were seen almost as a second self, cutting easily through the sense of otherness and alienation that was part of their experience of mental illness. Meeting peers who were in recovery allowed in the healings rays of hope creating a real belief that recovery was possible. Peers also acted as ongoing accessible resources that could be constantly revisited along the rocky recovery road:

*'It started through peer support, seeing someone like me who had a job and was well gave me hope'.*

*'The most important thing for me was to talk to other service users, people who would listen. You learn a lot by talking and they tell you their story'.*

While peer support was highly valued many people also mentioned professional relationships that had been key to recovery, such as a particular psychologist, psychiatrist, nurse or counsellor. What appeared to be key to whether a professional relationship was helpful or not was its quality rather than the particular qualifications or skills of the professional involved. Professionals who were interested, who listened, were warm, who understood, and who could build a hopeful picture of the future became sources of hope and resilience. For example, one person spoke of an encounter with an inspirational art teacher:

*'It can be as simple as another person's tone of voice and attitude towards you, he reminded me that I am an imaginative, worthwhile creature'.*

While recovery was seen as involving others many people described a number of attitudes and actions that a person had to take for themselves. Recovery always involved effort and struggle on the person's behalf, starting with a realistic acceptance of the need to change as well as being rooted in hope for the future. People spoke of *'fighting for recovery'*, *'challenging oneself'* and it being an *'ongoing thing'*, a struggle that can be *'overwhelming at times'*. In particular, several participants emphasised the importance of taking ownership and responsibility for recovery:

*'It's about taking responsibility, taking your power back, managing your symptoms and living wisely'.*

*'Taking ownership of the problem and being willing to try things and learn'.*

Participants also considered their own contribution to becoming hopeful was an important factor in recovery. While other people can offer you hope, reassurance or encouragement becoming hopeful involves an internal act of acceptance and a willingness to accept help from others:

*'When I took ownership I got hope very quickly'.*

*'You are not given hope but you have to take it'.*

In addition to describing recovery as an outcome and process, when asked the question participants also spoke about what they needed to recover from, which was not always about recovering from 'trauma' and 'symptoms'. Many mentioned that recovery involved a process of recovering from the negative impact of the mental health system. The mental health system was perceived as being dysfunctional and configured in such a way as to meet mental health practitioners' agenda first and foremost. In addition, participants spoke of recovering from the impact of services which were experienced as deeply de-humanising, adding to rather than ameliorating their sense of despair and worthlessness. One participant recounted how she felt the importance she placed on her religious faith during the recovery process was not understood. Others spoke about a lack of respect for them as people, a lack of meaningful professional help and a fear of being hospitalised. The comment below illustrates how a mental health system which dehumanises service users has consequences for a persons' ability to engender hope in their lives:

*'Overcoming the spirit crushing effect of the system when they lose sight of the fact they are dealing with a human being'.*

While some people acknowledged that medication was helpful in overcoming symptoms of mental illness, many mentioned the negative impact of side effects, such as weight gain, difficulty with concentration and tiredness. Medication was frequently seen as being a means of control, which from the service users' perspective benefited the system rather than the person, with some people talking of medication being *'used to keep people quiet and then everyone is happy'*. Service users also spoke of medication as *'robbing life of its joys as well as its horrors'*. Many mentioned their anger at the lack of information they received and gave examples of being *'told I will be on it for life'* when medication was questioned by them. Others saw medication as being part of the business agenda of a powerful pharmaceutical industry whose main agenda was profit.

Participants spoke of having to recover from the isolation that is fostered by deeply engrained stigma. Stigma from the self and from others was frequently mentioned as a barrier to recovery. Public and professional ideas and attitudes about mental illness and the derogatory language in which it is sometimes framed was identified by service users as being stigmatising, demoralising and engendering feelings of shame and guilt which had to be addressed throughout the recovery process.

Many participants highlighted the struggle to avoid being labelled by their diagnosis and for that diagnosis to subsume their entire identity. Participants suggested that the effect of being labelled as 'mentally ill' was akin to being called a *'paedophile'*, or been seen as *'some kind of criminal'*. Others talked about the negative effect that receiving the label of 'mental illness' can have on identity, suggesting that finding a new identity is central to recovery:

*'Reconsider or discover an identity that facilitates involvement in society'.*

To summarise recovery, as understood by the service users who took part in these interviews, can be described as: a co-created, unexpected and often difficult journey, starting in hope and leading to greater levels of personal freedom and involvement. It involves an acceptance of the need to change and a willingness to struggle and learn, to take legitimate risks and to be involved in inspirational and trusting relationships. While recovery is an individual journey it includes others and happens in the spaces between people, be they family, friends, peers or helpful practitioners.

### ***The relatives' voice***

Relatives defined recovery in a number of ways, ranging from: returning to a previous state of well-being, being medication free, to regaining independence, and being in control of life. In contrast to service users' narrative which tended to view recovery as a transformative process in which something new is created, relatives' expectations for recovery appeared to be more modest, in the sense that some spoke of recovery in terms of the hope that the person would be able to live a 'normal life' or have 'a viable life' in society. At the same time, some of the comments reflected a hope and expectation for their relative to recover to how they used to be prior to the onset of illness:

*'I would like him to recover... to be trained and to be able to look after himself to whatever limited extent so he is viable in society'.*

*'Recovery is getting him back to where he was...'*

Inclusion in society and the development of relationships outside the mental health service was viewed as vital to a person's recovery:

*'He needs to mix with people, he is a very sociable ...but he is isolated'.*

A relatives' personal knowledge of and relationship with the person meant that in their view they had a very different experience of the person compared to practitioners who encountered the person during their illness. This enabled relatives to have different perspectives on and expectations for the persons' recovery:

*'They [practitioners] only knew her when she was unwell, they never experienced her when she was well, her enthusiasm. People who know her now never see that person'.*

*'A relative's idea may be different from their loved ones. There are 3 types. My mum might be happy with the way things are at moment, the doctor might be happy, I see the difference of who she was and the ideal of what she could or should be. We look from outside and she looks from the inside and these views don't always match up'.*

However, relatives frequently spoke about the erosion of their own hope over time and their growing disillusionment about the prospect of recovery for their relative. When the kind of recovery they had envisaged at the beginning of the persons' journey did not materialise it resulted in a reluctant acceptance that their hopes may have been unrealistic as well as a tempering of their future hopes and expectations for the person:

*'I used to be much more hopeful, that he would get back to who he was, but now I know it's a condition'.*

*'What I would like for him is recovery but down the years I have come to modify my hopes and visions'.*

Just as service users identified that recovery involved an ongoing struggle, relatives acknowledged their own difficulties. They spoke of recovery as also applying to themselves and their need to recover. Many spoke about a lack of care for the carer and expressed feelings of powerlessness and not knowing what to do to help, as well as their own sense of isolation. They felt they too were not listened to and never had their own pain witnessed by a sympathetic other. Many carers reported that they *'often felt invisible'* and, at worst that they were seen as *'interfering nuisances'* by practitioners. Consequently having others with whom they could share their burden was central to their recovery journey. Indeed, those who had access to family support groups spoke very positively about them:

*'I had a lot of issues with my family I found that really hard so recovery involves my support relationships'.*

*'In the carers group everyone became aware that we all needed to recover and we all needed support'.*

To summarise, relatives acknowledged that they see things from a different perspective because of their knowledge of and relationship with their family member. Like service user participants, they viewed recovery as a journey towards normality and involvement in life and society, however, their expectations were also characterised by a desire for the person to return to their *'previous self'*. In addition, the relatives' voice included an acknowledgement that recovery was a part of their own lives and many spoke of the benefit of belonging to a carer's group where they could access ongoing and regular support.

### *The practitioners' voice*

Practitioners conceptualised recovery as either a clinical process or a journey of personal discovery. Those who spoke of clinical recovery spoke of it in terms of outcomes such as the control of symptoms through medication, a reduced reliance on medication, reduction in service utilisation or discharge from services:

*'Recovery is taking the next step getting out of hospital if you are in hospital and then getting out of the service'.*

*'It will mean being able to dispense with medication'.*

*'In terms of controlling symptoms, no longer hearing voices means you are well'.*

For others recovery was spoken of as a personal journey that involves *'realising full potential'*, *'discovering a meaningful role in life'* and *'living a fulfilled life'*. The individuality of this process was stressed by a number of practitioners, reflecting the view that recovery may mean different things to different people depending on what is important to them. There was also an acknowledgement that recovery can be a difficult process, can involve addressing traumatic and painful experiences, and for some may encompass setbacks.

While there were two different perspectives on recovery spoken about some people questioned if both perspectives were compatible or could reside seamlessly within the mental health service. There was also an acknowledgement that recovery is still an emerging and evolving concept with a great deal of uncertainty and inconsistency existing in its interpretation and meaning. There was much discussion on the need to develop a shared understanding of recovery within mental health services:

*'Someone said does everyone understand the concept of recovery, there was a long silence then one brave person said does it mean that someone won't relapse, there was no clarity around what it was'.*

*'We want a service wide notion of what recovery is, a number of staff are left behind... it's a real learning curve'.*

Many practitioners viewed their role in supporting peoples' recovery journeys as one of partnership, empowerment and facilitation, an idea that fits with the service users' view that recovery is a co-created process. Central to this was the quality of the relationship with service users:

*'I suppose for me it is mostly about an approach where I am more in partnership with people in their treatment, its more in the nature of the relationship'.*

In order for practitioners to act in a facilitative role in the recovery process, *'compassion', 'understanding'* and *'being inspirational'* were identified as key qualities which professionals need to possess. Practitioners also identified their role as encouraging service users to engage in society, trying alternative forms of therapy in lieu of medication, such as psychotherapies, and putting people in touch with resources, especially those outside mainstream services, such as local peer support groups. In addition to facilitating a persons' transition to recovery, participants also acknowledged the importance of recognising when to step back and allow the person undertaking recovery to continue on their journey unaided and without interference. This appeared to emerge from a recognition that past attitudes or views of service users as permanently disabled or unable to change ultimately served to keep people institutionalised, stigmatised and *'prevented people achieving their potential'*:

*'When people came out of the institution the institution came with them. [In the past] we enabled people to be patients so we have to step back and allow people to move on'.*

*'We have to have the confidence to step back and realise this person doesn't need to be with us and be stigmatised by us'.*

Thus, participants recognised the need for a revision of their role in recovery. There was general agreement that there needed to be a move from a custodial type of relationship with service users, where responsibility for well-being lay with the institution and professional, to a professional role where decisions were made in collaboration with service users and control was progressively handed back to the service user: in other words *'a lot more involvement in the management of their symptoms'* and distress.

While acknowledging that a risk averse culture existed, risk taking was perceived as a necessary part of learning how to recover and an area in which mental health practitioners needed education to help them learn how to manage risk in the context of recovery:

*'Managing risk is a big impediment to recovery... what might happen... it's about educating nurses'.*

*'This notion that if risks are taken and they go wrong the team has failed ...it's the team's fault so risks aren't taken because they might go wrong'.*

The discourse of recovery also featured in practitioners' narratives of their personal and professional lives. There were frequent references to the fact that everybody faces life

difficulties at times and everybody needs to develop a personal recovery strategy. In this context a need to be aware of the ways in which they practice recovery in their own lives was discussed. Recovery was also cited as important in their role as practitioners in the sense that it was part of reclaiming their humanity and personal integrity in their interactions with service users that had sometimes been eroded:

*'We are on a recovery journey ourselves, recovering from the medical approach we have been indoctrinated in'.*

*'Recovering your sense of personal integrity...Sometimes we become so clinical we lose our humanity'.*

Personal recovery for practitioners who experienced mental health issues was deemed challenging due to negative reactions by colleagues. A number of participants described high levels of prejudice among practitioners if colleagues admitted a personal experience of 'mental illness'. In their view any practitioner found to be 'mentally ill' was immediately cast in the role of 'other', which resulted in questions around their competence and trustworthiness:

*'I told people a few years ago [that I suffered from mental illness] and had a really negative experience, I thought it would combat stigma but they went to my managers behind my back suggesting I was unfit for work'.*

*'If anyone finds out someone has experienced mental illness themselves they will be rubbished, 'what would she know''.*

*'If you are a professional you would be very slow to admit to experiencing depression'.*

In summary, the practitioner group was perhaps the least homogenic of the three in terms of their understanding of the meaning of recovery, with two perspectives emerging, namely clinical and personal recovery. Practitioners perceived that recovery was a concept in transition. At the same time, participants were aware of the role change that a commitment towards recovery required. From being ongoing custodians or managers in charge of their 'patients' there was a desire to move towards a partnership approach whereby practitioners seek to get to know the person and develop a cooperative relationship. Against the background of a risk averse culture practitioners viewed their role as one of facilitation and encouragement in supporting the person to become involved in society. Paradoxically, while acknowledging their own vulnerability to 'mental illness/distress', they revealed a negative attitude among co-workers towards colleagues who experienced mental health problems. They also spoke about recovery in the context of recovering from aspects of their work that threatened their view of themselves as caring human beings.

## Conclusion

Collectively the insights put forward by members of each of the three groups provide a rich kaleidoscope of words which might be woven into the following definition of recovery:

‘Recovery from mental distress is a universal concept that applies to everyone. It never clearly divides people into those who are well and those who are ill. Recovery is an ongoing, rewarding and often difficult journey which is always co-created with others. It begins wherever a person is at in life and progresses through identifiable non-linear stages. Born and nurtured by hope recovery flourishes through the warmth and encouragement of friendly others, especially others who have similar experiences, and through opportunities to give as well as to receive help. It always leads to greater levels of personal freedom, wisdom and involvement. It involves an acceptance of a common human limitation, the humility to recognise the need to change and a willingness to struggle and learn from one another. It also involves taking legitimate risks and being involved in inspirational and trusting relationships’.

## Perspectives on local mental health services as recovery-oriented

During the interviews participants were asked a number of questions on their experiences of services as recovery-oriented. Hope, an increased sense of self control and enhanced involvement are considered the cornerstones of a recovery-oriented service therefore emphasis within this section is on the stakeholders’ perspective on what aspects of the services they experienced promote these values. While there was an overall acknowledgment by all groups that *‘services are very hit and miss’*, positive encounters were occurring, and this section focuses on these encounters and views.

### The service users’ voice

Service users’ accounts of recovery-oriented services emphasised the importance of good quality relationships with mental health professionals which are characterised by good communication and partnership. Service users recounted positive encounters with staff in services in which they felt listened to, encouraged and supported. Service users described the ways in which professionals they met could foster a sense of hope by adopting a positive and encouraging attitude, by acting as a source of emotional and practical support and by reminding service users of the progress they had made:

*‘They see the smallest thing you have done. They reflect and help you to see progress, ‘a year ago you couldn’t have done that’.*

*‘I do find it hopeful. People are very helpful. They encourage you, tell you you are well able to do things. This is something you can get through’.*

In addition to practitioners' attitudes and relationship skills some participants mentioned practitioners who were willing to challenge them to get involved outside the mental health services and to help them connect with community activities and groups as well as employment opportunities:

*'I think they are good. If someone wants to join local groups or a choir they would be supportive'.*

*'There is an employability service that is helpful'.*

Other aspects of services that participants considered as recovery-oriented were home based services, day hospitals, and the existence of a good and easily accessible outpatient services, which included after-hours facilities. Valued aspects of these services included their availability for support and encouragement within the community where service users are trying to adjust following inpatient stays. Community-based services were viewed positively by service users for enabling them to become involved in the community and to access resources. Other services that were valued included hostels as they were seen as half way houses that facilitate independent living:

*'There are weekend services. I can ring any time, it happens immediately as I need it'.*

*'I find the day hospital very helpful after hospital. I need a lot of encouragement to motivate me'.*

Many participants stressed the value of services that had a positive attitude to mutual help and enabled people to have the opportunity to meet and interact with others with similar experiences in what was described as *'a non-judgemental space'*. Peer support services were especially valued because they provided a place where other people really understood where they were coming from and actively helped them to begin to move forward and gain a sense of personal responsibility and control over their lives. Feeling that you were accepted, encountering a positive approach from peers, being able to share, having others listen, being part of a 'family' and accessing information were all identified as aspects of peer support which engendered hope. Some participants described how peer support groups acted as a source of inspiration for them by nurturing hope and providing living proof that recovery was possible and by being warm, accepting, supportive, positive and encouraging:

*'Peer support workers give hope because they have come through'.*

*'The service provides you with a way to see others getting better and that benefits both'.*

*'You have the [names peer support service] where you get encouragement and praise for any small thing you do. There is free counselling and lots of options. Information on things like housing'.*

*'The mutual help center provides a place you can fall apart. You can be yourself and there is no judgement. ...but you are not allowed to wallow in self-pity'.*

Peer groups also provided service users with the opportunity to enhance their involvement outside mental health services. Peer support enabled them to become mentors and sources of support to other peers. In addition it enabled them to have the confidence to take on other roles and activities such as involvement in a consumer panel or participation on a leadership course. Furthermore, participation in decision-making structures and leadership roles were cited as meaningful activities which engendered hope, developed social networks and facilitated recovery. Being encouraged by others to set goals was identified as an exercise which gave people hope. Peer support groups were also valued for giving people the courage to challenge the status quo, such as, questioning practitioners about medication and care decisions.

Again many people described how involvement in many different forms of help, such as education and peer support also enhanced their sense of control:

*'Classes like well-being for mental health. They give you self-help tools to take over your own health, they aren't anti-medication but emphasise what you can do'.*

*'I got great help from programs like Table Lodge. I was able to resolve issues. I realised drinking was a form of self-punishment same as cutting yourself'.*

*'They do help you gain control. They help you to learn. They ask have you noticed this or that? They talk about life balance. They help me make decisions but allow the decisions to be mine. They make me feel human rather than someone who is different'.*

In summary, service users provided many examples of practices that were recovery-oriented, that helped nurture hope, and enabled them to have a sense of control. They listed professional attitudes, some aspects of the mental health system, peer support, and their own attitudes as contributory factors.

### ***The relatives' voice***

Positive aspects of services identified by relatives as recovery-oriented included: practitioner attitudes towards their family member and themselves; services that encourage

their family member to become involved with other services and activities; and being able to access services quickly in times of crisis.

Similar to service users, family members identified a warm, personal and positive attitude from mental health practitioners as facilitating the development of good quality relationships with their loved one and providing a sense of hope for themselves. They spoke of practitioners that *'made [them] feel human'*, made them *'feel respected'* and where *'there was no us and them'*:

*'He trusted his nurses and they were wonderful to him and were his friends'.*

*'A new doctor spent time with him and talked from his own experience. I felt that is brilliant. He suggested my son should go away and look up courses and come back. He has also agreed to do the WRAP program. He felt he had a connection with this guy. He sent him for psychological assessment. Changed diagnoses from schizophrenia to social anxiety. Considered then ruled out aspergers. I felt hopeful'.*

Many people praised efforts made by service providers that encouraged their family member to become involved with other forms of helps, including peer support:

*'She [my daughter] is being encouraged to join hearing voices'.*

Family members were also able to provide some concrete examples of efforts to encourage involvement outside the services and to enhance control. Participation in employment and activities, such as, FÁS, cookery or the local gym were all seen as beneficial:

*'They encouraged every kind of involvement. He worked with FÁS ...they helped him and facilitated him'.*

*'They encourage her to structure her life her day. Even little things like cooking, planning what to make. OT came out for a few weeks to help her learn to cook and gave her great confidence'.*

*'She [Nurse] tries to get him involved in projects and courses'.*

Relatives were also encouraged by changes in mental health service provision, such as the closing of old psychiatric hospitals and the availability of home care services and 24 hour support, which for families indicated an improvement in the quality of services. Some family members thought that the advent of and promise contained within the recovery initiative was already creating an atmosphere of hope that a recovery-oriented service would become the norm.

### *The practitioners' voice*

Practitioners were very speculative in their responses about the degree the services were recovery-oriented and acknowledged that there is *'huge room for improvement'*. While acknowledging the limitations of current services, the majority indicated a strong hope and genuine desire to strive for this into the future and gave examples of recovery-oriented practices which they or others were involved with. Many people described leading out on projects or initiatives (care plans, education programmes) that they were personally motivated to do, as they believed that these initiatives were key to making services recovery-oriented:

*'I realised that education was a key point so I have developed a psychological education program'.*

*'We are using e-mails with young people, making contact. This is the way in Australia and Canada. A special outreach team is discussing the methods we use and [our choice of] language'.*

Practitioners mentioned a number of changes from within the wider mental health system that now worked in favour of recovery, including more efficient appointment systems and a new emphasis on person-centred planning. Efforts at involvement and returning control began with enabling service users to become involved in planning their own care based on their individual needs and included encouraging service users' involvement in different programmes within the services which were recovery oriented:

*'It's a new approach... for us we are definitely making a big effort. We tailor everything round the person, decide nothing without them'.*

*'We are developing care plans within the home based team but this should be happening for everyone. We started a year ago. It's very important. It means people in crisis get what they need immediately'.*

*'We try to involve and educate service users about what they are, to move them towards where they used to be'.*

*'We run education programmes and information sessions on medication, managing symptoms and expectations'.*

Personal control and involvement was also actively enhanced through encouraging people to be part of the decision-making process about what type and levels of medication they are

using, to take legitimate risks or to share their thoughts about the quality of the therapeutic relationship and services:

*'Letting people voice concerns'.*

*'If a client wants to reduce medication then we would look at it'.*

*'We try to [involve them in decision making]. That's where risk comes in making their own decisions. Some people want more direction but most want to have the freedom to try'.*

Others reported newly developed ways of relating to service users as hopeful, such as focusing on ability rather than inability, and working in a goal oriented manner:

*'We concentrate on strengths of individuals. We are good at it but we need to improve'.*

*'When people have set backs or when they risk things if we can support them it gives them a sense of 'look what I have done'.*

*'They would have been told 'you can't go back to college', we tell them 'you can do whatever you want lets plan an approach together'.*

Others spoke of the centrality of relationships and the values of respect, empathy and human connection. Many of the attitudes and values mentioned matched what service users and family members said, such as being friendly, nurturing hope through the use of positive language and actively supporting peoples' efforts to become involved in relationships outside the mental health services:

*'All the team try to be very friendly maybe it's part of the culture'.*

*'We would always emphasise hope with users and their families through our interactions and communication and therapeutic relationship we would always emphasis hope.'*

*'Our message is you can be reintegrated. You aren't some kind of alien. As far as possible it's a humanising process'.*

*'We spend time developing a therapeutic relationship. We might meet people in a café or in their home'.*

The willingness of practitioners to address issues of housing was also mentioned:

*'Absolutely. [names discipline member] on team has done huge work in relation to housing. There has been a perception that people with mental health needs might not need the same kind of housing as I would. She has reduced the stigma in the locality and done a huge amount of work... She will challenge people and we take our lead from her'.*

The most frequently mentioned issue that was viewed as recovery-oriented was the active development of links with community-based, peer led initiatives. In addition to providing a recovery resource for service users these provided much needed hope for staff as well:

*'Having Aras Folláin [peer led service] has oriented us more towards recovery. It's the way to go, seeing what people are able to do. Feedback from people who have found it marvellous. It generates hope for us as service providers. Many of my people with major mental illness have made phenomenal recoveries. Our team has bought in'.*

*'People are encouraged to get involved in different things such as Hearing Voices. We ran it ourselves'.*

Significantly many practitioners spoke about their own need to be hopeful if services were to be developed in a recovery-oriented manner, with some suggesting that seeing people recover and being involved with peer services gave them hope:

*'We have come out of an institution which remains in the background, sometimes we have to recover and come out of that...Service providers need hope as well'.*

*'I feel empowering people to take control of their lives does give me hope'.*

*'Seeing someone like [mentions a peer worker's name] is hopeful for staff as well'.*

A number of professionals stressed the importance of leadership coming directly from the senior psychiatrist, as in their view where this was happening services were beginning to move forward in a recovery-oriented manner:

*'We had a recovery approach. It came from (the) clinical director and has carried forward among leadership in all professions'.*

*'Our psychiatrist will talk directly to service users if they query medication issues and he has embraced the recovery model'.*

## **Conclusion**

All three groups were in agreement that whether a service was recovery-oriented or not was a post code lottery. All groups valued the role of peer support workers, efforts at

community integration and the availability of non-medical and professional help that was respectful, supportive and encouraging involvement of the person and their family. For family members access to services in times of crisis was central. There was broad agreement among the three groups that hope was critical and was most available through meeting with and working with peer support workers or service users who had recovered or with staff who were friendly and had a realistic belief in the possibility of recovery and who formed meaningful relationships with people with whom they were working.

### Barriers to recovery-oriented practices

The previous section explored participants' perspectives on aspects of services that were recovery-oriented. This section presents the findings related to the elements of the services that were considered not recovery-oriented and that actively prevented services from developing an ethos that encouraged hope, control and involvement.

#### *The service users' voice*

Many participants perceived that mental health services were inadequate and did not offer people the kind of support they need to recover. The most common reason identified for services to be non-recovery-oriented or to be what some described as '*hope or recovery sapping*' related to peoples' lived experience of staff attitudes and the quality of relationships encountered. Participants recounted staff attitudes that communicated scepticism, low expectations, a lack of belief in recovery, negative beliefs about the nature and outcomes of mental illness, and personal negative attitudes towards people experiencing mental distress:

*'There is a profound culture that having a mental illness diagnosis means you are not going to get better'.*

*'Hope can disappear in response to statements like 'Don't bother applying for that job' 'you are always going to be like this'. 'You will be on medication for life''.*

*'People are seen as hopeless cases by staff...they [staff] don't believe in recovery...'Hope' isn't a word used'.*

*'You spend hours and hours with nothing to do; no one to talk to and no one to listen'.*

*'The biggest barometer [for recovery] is staff relationships, in some places it's fine and in others it's 'us and them' and that's where the rot is. You can have policies and initiatives but if there is coercion or dismissiveness such as 'I'll be with you in a minute' 'don't bother me now' people feel ignored'.*

There was a perception that services seek to control the person rather than risk encouraging the development of self-control. This was seen as being an outcome of a paternalistic risk averse culture in which professionals decided what was best for the person. This problem was perceived to be most acute within hospital settings where it was believed that services main concern is protecting themselves resulting in a culture which prevented risks being taken:

*'Definitely not in the acute setting. You are restricted if someone else decides whether your dreams can be followed or not. Even like finding out you can't leave even if you are voluntary. There is no risk'.*

*'There is no effort to help people learn self-management. It is risk averse ...you are denying the person the dignity of failure, a lesson we all learn from'.*

*'Some professionals completely dominate people...[they] think they know what is best and this can be harmful' .*

Many participants were critical of many aspects of the services they experienced including the lack of stimulation in the environment, being treated like a 'criminal' with civil liberties rescinded, and encountering multiple different professionals who had little knowledge of them as a person and little time to be able to develop that knowledge. In addition, some service users perceived that seeking other alternative therapies to medication was discouraged or left largely up to themselves to do without support while people in crisis might have to wait for months to see a therapist, which rendered such an intervention ineffective. A lack of information on all aspects of care and treatments, a medicalised approach to care within mental health services and an overt lack of encouragement or help for people to become integrated into their local community, were all criticised for promoting social isolation as opposed to recovery and inclusion:

*'The things they offer are in isolation not in (the) community'.*

*'I was only encouraged to use service based activities. It's a holding bay. People remain socially isolated'.*

A lack of support for and facilitation of peer support within the mental health system was also cited as a negative aspect of services:

*'I think the real carriers of hope are people who have recovered and there are no structures for them [service users] to meet someone like that within the system'.*

Participants also highlighted the ways in which professionals' attitudes and practices could be de-humanising and how bureaucracy meant that nurses could spend more time filling in documentation rather than engaging with the service user:

*'If you want anything you have to beg. The nurses won't even look you in the eye'.*

*'They [professionals] spend all their time writing notes'.*

Some participants felt that many problems stemmed from a lack of understanding of the nature of recovery and a lack of co-ordination and leadership to drive the recovery agenda forward. The attitudes of senior management were seen as part of the problem, with many people mentioning the challenge of getting psychiatrists involved in recovery-oriented development:

*'Attitudes of senior management are appalling, the big narrative is these people are dangerous, sexually deviant and not to be trusted'.*

*'The consultants think the consumer panel is (a) waste of time or worse'.*

Some participants expressed the view that negative attitudes towards recovery from staff is sometimes due to frustration with their own role and a lack of commitment to their role, while others were of the view that staff were feeling threatened by the involvement of peers support workers:

*'Many people who work in the system don't want to be there and are angry. I am taken aback by this and about how people are treated'.*

*'I worked as a peer support worker and was described by staff as 'a half trained monkey' in very derogatory way. I think (staff) wonder what is happening to their role'.*

Others blamed the organisation of the system for a lack of recovery orientation and hope, citing locked doors, the dominance of biological psychiatry and the overuse of medication:

*'The system drinks up any hope. ...Locked doors are disempowering'.*

*'Overuse of medication and power of psychiatry the main problem'.*

*'You are coerced into doing these things or you are seen as non-compliant. It was 'take your medication''.*

Service users perceived that the stereotypes about people with mental illness in society stemming from negative media attention caused them to be viewed with fear and mistrust and to be marginalised and isolated in the community:

*'There is a deep rooted ideology in the community that people with psychiatric labels are 'other', are different'.*

*'If someone is mentally ill lock them up and give them meds, on no account listen or trust what they say'.*

Others commented on how family could also be a barrier to recovery noting how their voice becomes marginalised as the family, albeit with good intent, take over. If there was a crisis then family members' views and opinions are given priority and believed rather than those of the person:

*'I think that if someone is a long-term patient and a row develops at home it will automatically be assumed that the person is the cause of it, the barrier is the culture that would immediately mean they would be hospitalised'.*

*'Relatives can be barriers. Sometimes carer and service users are lumped together as one homogenous group and if there is a disagreement the carer will be listened to'.*

Service users felt that such negative attitudes and practices from practitioners and the public made it very difficult for them to maintain a belief in themselves, their own value or in the possibility of recovery. As a consequence the service users interviewed spoke of how they begin to internalise the negative attitudes of society and the pessimistic attitudes of staff.

Service users also reflected on how broader factors at a political and social policy level were influencing how mental health services are configured. For example, the lack of political will to move mental health services forward and the many competing agendas within the services were viewed as barriers to a recovery orientation. In addition, funding cutbacks were viewed as a challenge to creating recovery-oriented services, however, some were also of the view that the current cutbacks could also motivate people to find creative ways to implement recovery services. Others also reflected on how the social welfare system can prevent people from taking up employment as a part-time job could result in the loss of the medical card or other entitlements.

In summary, factors that prevented locally based services from being recovery-oriented included the existence of a range of negative and hostile public, professional and cultural attitudes. A mental health system that provides little choice of treatment, a risk averse

culture and an extremely fragmented and limited range of services with poor levels of communication between practitioners and service users. Service users also gave examples of unhelpful attitudes and behaviours among professionals, a failure to see the person behind the diagnosis, an over-reliance on medication and little encouragement to become involved in services outside mainstream mental health services.

### *The relatives' voice*

Whether family members perceived a service as recovery-oriented appeared to be dependent on the particular individual or team which they encountered. Thus, recovery-oriented services were seen as *'very patchy'*. Criticisms by family members mainly focused on the narrow range of treatments available, the emphasis on medication rather than talking therapies, and the lack of alternative forms of help, even when specifically requested by the service user:

*'It's all based on prescriptions there is no counselling, no psychology'.*

*'They see it as a purely medical problem'.*

*'It is all about medication. A psychiatrist actually refused to discuss the effects of a very traumatic incident involving a break in and was only interested in checking symptoms and changing medications'.*

Some went so far as to say that services were actually harming those they set out to help:

*'These places were supposed to equip people with some training, building up their skills ...but it became a dead end. It started to create another institution'.*

*'You go into a hospital with a person you know who is distressed and come out with a total stranger'.*

Even when requests for specific types of help were respected by service providers and service users were encouraged to get involved within the community, the unwieldiness of the bureaucracy involved sometimes rendered family members hopeless:

*'They asked her what she wanted and she said she would like to work with elderly in hospital so she went up a couple of times to see a place and then to volunteer ...and they said she had to apply for garda clearance. That was 5 months ago and there has been nothing. She is just left there'.*

In this context relatives viewed professionals' efforts to imbue hope and facilitate recovery potential as inadequate and considered that the mental health system contributed to the

person remaining ill rather than facilitating their recovery. In their view, a medicalised approach to the treatment of mental illness/distress dominated and the range of help and support needed to facilitate recovery was inadequate in many cases. Relatives spoke of a tendency among mental health practitioners to discourage involvement in counselling, non-professional relationships or peer run organisations which in their view was potentially beneficial to recovery.

Relatives also perceived that there was a lack of opportunities for people experiencing mental health issues to expand social networks and to develop relationships with people outside of the mental health system. In their view the only relationships supported were with other people experiencing mental health issues or with professional carers, thus reinforcing the idea of difference and dependence. Relatives also articulated the view that a risk averse culture prevails in services and denies service users the opportunities to engage with people outside of the system, thus fostering institutionalisation and a sense of isolation.

While relatives felt that involvement in social, employment and education activities were important aspects of a recovery-oriented service, they were also mindful of their family members' vulnerability. Family members expressed a desire for the person to be protected and for mental health practitioners not to foist situations on people without listening to their concerns, and identified the need to support some people when they were involved in employment initiatives:

*'People are sometimes encouraged to do things they really feel are beyond them, for example a full time course when you aren't able. There is absolutely no room for dialogue any questions are met with the response 'I am the expert'..... so do what I say''.*

*'My son was involved in an employment initiative. He was treated pretty badly. He was not supposed to work overtime or start before nine. He was verbally abused. A lot of it was due to one individual. They didn't pick it up. In employment people like my son need a guardian, someone appointed to look after him'.*

Relatives were critical of what they perceived as their exclusion from the recovery process by professionals. Family members felt that at times their own knowledge of their loved one could be very useful in averting a crisis but that this information was often ignored:

*'When he was manic signs are there and when I said it they would delay and disagree so it wasn't picked up'.*

*'I felt I wasn't seen as part of (the) team ..[I was] seen as a nuisance'.*

A lack of belief in and support for recovery, and a lack of knowledge of what each person needs and wants, were cited as other examples of barriers to recovery. Furthermore, cutbacks to finances and staff numbers were blamed for the lack of appropriate resources, and the lack of staff time to engage with families. The lack of resources was also seen to be eroding staff morale. However, there was an awareness that whether recovery, hope and control were nurtured was dependent on whom they happened to meet:

*'Again there are people who do and people who don't generate anything'.*

*'Depends on team and individual even in a team it depends how each individual sees things'.*

In order to redress this, relatives identified the need for more resources in the form of afterhours services, more talking therapies, more personal support for their family member and themselves and a greater recognition of their role.

In summary, themes that emerged from family members were consistent with those that came from service users. Negative staff attitudes together with low levels of morale and burn out as well as an 'us and them' attitude were mentioned as barriers. A culture which discouraged seeking help from any other source and a system that favoured a medical view were also noted as problematic. A lack of counselling, and other forms of help were seen as major problems within an over-loaded system. There was a general agreement that the service users' and the carers' voice needed to be listened to more.

### ***The practitioners' voice***

Practitioners' answers to questions around barriers to recovery developments reflected a keen awareness and an open acceptance that significant barriers lay within their own attitudes and knowledge, the inherited culture of the mental health system, as well as prejudice among members of local communities. Practitioners recognised that peoples' experiences of services are often shaped by the staff they encounter and readily admitted that the variability in the quality of staff can result in negative experiences for services users and their families.

They were in agreement with service users and family members that one barrier to recovery lay in their own lack of understanding of the meaning of personal recovery and they openly acknowledged that their own knowledge of recovery was indeed very limited:

*'Understanding what personal recovery is and how services can be recovery oriented is difficult, most professionals are not anti-recovery but don't understand [recovery]'*

They also acknowledged that they needed to change if they were to become recovery-oriented with some making the point that if staff don't believe in recovery or aren't hopeful themselves it is very hard to develop positive and hope inspiring relationships.

They also recognised that some legacies of the mental health system impacted negatively on peoples' potential for recovery. There was some reference in the interviews to the dominance of the medical model within mental health care, in particular the hierarchical approach to decision-making, power residing within disciplines, and entrenched thinking that portrayed service users as unable to recover. The education and training of practitioners, especially doctors and nurses, which was perceived to focus on an 'illness' and 'symptom control' model, was seen as a contributing factor to the current struggle to move beyond a purely medical view of recovery:

*'I think we are still a little in medical model in the team. We are moving slightly away from professionals can cure you and medication, we are seeing it more as an adjunct, providing different types of therapies and sometimes that can be difficult for some aspects of the team'.*

Similar to families, practitioners noted the prevalence of a risk averse culture, borne out of a system concerned with protecting itself against litigation. The risk averse culture which was considered to dominate professional practice resulted in practitioners having difficulty in embracing the concept of positive risk taking. In a risk adverse culture practitioners were of the view that even if they did understand personal recovery their work could be undermined by the fear of litigation as in their view *'we live in litigious times where the finger of blame can be easily pointed'*. In this context practitioners identified the need for discussion on *'legitimate risk'* and *'positive risk taking'* as well as the development of policies to support practitioners to engage with positive risk and safety management:

*'This notion that if risks are taken and they go wrong the team has failed ...if something goes wrong its team's fault so risks aren't taken because they might go wrong'.*

Similar to family members, practitioners viewed a lack of resources as a significant barrier to developing recovery-oriented services, as it resulted in services which were oriented towards crisis management and were essentially reactionary in nature. In addition practitioners were of the view that the lack of resources and inability to replace members of the multidisciplinary team if they resigned was not only impacting on the quality of service provided but was eroding staff morale:

*'I don't think they [mental health services] are hopeful for service providers, I feel morale is terrible. Staff numbers have halved in last few years..., ancillary services like community welfare have all been cut'.*

*'Because we are so poor its very hard to do anything except stop-gapping [crisis management] quite often you lose sight of recovery stuff'.*

*'In general we aim to empower people but the contradiction is that as OT's leave we can't replace them'.*

Some practitioners thought that although public attitudes, fuelled by sensationalist media coverage, had improved, there remained a deep fear of people with a diagnosis of 'mental illness', which made it difficult for people to integrate and be accepted by others in their communities:

*'Public attitudes are still a barrier...people have fear of people they think they are dangerous and a risk to their children, it's improving but still there'.*

*'We would get phone calls saying why aren't you doing something about so and so, he is wandering round. Take them off the streets there is that feeling still'.*

Practitioners also commented on the challenge facing service users to become more involved or take more responsibility for their own recovery, having been socialised into a paternalistic service that has previously worked from a control rather than partnership model:

*'It can be hard [for service users] changing from a medical approach and the idea that the practitioner knows best'.*

*'...some of service users are so used to having things done it's hard to get them to take control back'.*

Service providers also saw families as sometimes discouraging efforts in the recovery direction:

*'One of biggest barriers is relatives. They think you know what people are thinking and can ensure that service user does what you say'.*

The trade unions were also mentioned as a possible barrier as they were perceived to be more concerned with their political agendas than with the welfare of services users:

*'In relation to support from union context there can be a lot of unrest from professionals. They are heavily unionised...it has become ingrained into our system'.*

*'I blame unions they are the biggest problems...I remember being warned that you could be frozen out'.*

There was a growing awareness that some of these barriers could be removed through education, the inclusion of service users as members of the workforce and leadership by local and HSE management who needed to play a key role in developing both a vision and strategy for the service.

### **Conclusion**

There was broad agreement about the nature and existence of barriers to recovery among the three stakeholder groups. These stemmed mainly from negative attitudes and lack of knowledge among all concerned, fear of change, a risk averse culture, and a lack of resources which meant that the quality of service provision was inconsistent and very much dependent on key people. Secondary to these barriers a lack of choice over treatment and a lack of therapies other than medication all worked against recovery. These barriers were amplified by the media which tended to portray people experiencing 'mental illness' in extremely negative ways. Education or learning together about the nature of recovery was seen as the way forward, with service providers emphasising the need to have senior management on board.

### **Participants' hopes and expectations from the initiative**

This section outlines stakeholders' hopes and expectations in relation to outcomes of the initiative.

#### ***The service users' voice***

Service users repeatedly highlighted the need for a change within their day to day interactions with professionals and at a wider level with members of the general public. They were hopeful that the initiative would serve as an educational tool that would prompt a rethink of how both 'mental illness' and recovery are conceived among service users, families, service providers and the public and that strategies to enable services to become more recovery-oriented would be implemented in practice.

Service users also expressed a hope that mental health would be viewed as something universal and applicable to everyone so that those with a diagnosis of 'mental illness' would not be perceived as *'other'* or *'alien'*. They also hoped that professionals would learn to adopt a more humane, kind and empowering attitude towards them and their recovery:

*'If I can see the person in my consultant, and he can see the person in me, it changes the relationship completely. To tap into the inside of people, the human being behind the label, two hearts talking. Recovery happens in relationships. I get belief in myself through others. It's in cultivating human relationship(s) between provider, family and service user that recovery happens'.*

The establishment of real partnerships between service users, their families and service providers, as embodied in the triologue approach, was viewed as key to facilitating understanding between the different partners and realising recovery for service users. One of the biggest hopes expressed by service users was to see a culture where people would be offered alternative treatments to medication and where their wishes would be respected. Service users also expressed a sincere hope that the way forward would lie in an honest sharing of ideas with real value being placed on their voice and experience.

There was an appeal for a much more community-oriented approach with more practical help to engage in meaningful activities, involving more community connection with others. Practical help with issues such as housing, education and employment were also desired. It was felt a change like this would help remove the current fear many people have of seeking professional help.

In addition, there was an appeal for services to expand beyond their current level of 9 to 5 provision. Many people criticised the fact that current services are not available at weekends or in the evenings - times when perhaps crises are most likely to happen and help is needed. Participants also expressed a wish that there would be *'more information made available, and better co-ordination of what is currently available'*.

Service users also expressed a hope for increased funding to support the development of peer led crisis houses, recovery colleges, and the promotion of peer help organisations. The establishment of a recovery college was a concept that people found exciting, one which awakened hope and something in which many service users wished to be involved with as, in their view, it provided a personal opportunity for *'meaningful involvement'* and perhaps could act as *'a stepping stone to real college'*. The expansion of the role for peer workers was also seen as key to improving services with many viewing this as a role which they could fill as a means of easing the transition to paid employment and also as a means of re-educating service providers.

In addition, it was hoped that the initiative would cultivate *'inspirational leadership'* which was viewed as essential to implementing change. It was felt that this source of inspiration could be derived not only from recovery peers and professionals, but also from service users themselves if presented with the opportunity:

*'We need enthusiastic leaders, they could be service providers or users, but this [inspirational leaders] is totally missing at the moment'.*

In summary, service users were hopeful that the initiative could successfully re-educate all stakeholders about the nature of mental illness and the meaning of recovery. Service users identified several practical outcomes they would like to result from the initiative, including the establishment of recovery colleges, an expansion in service provision, more involvement of service users and peer support workers, more efforts to include service users in their community, the provision of practical help with issues such as employment and a move towards more equal and respectful partnerships between service users and service providers. Ultimately service users hoped to be able to see their efforts reflected in evidence of positive and real change.

### ***The relatives' voice***

Carers hoped that the whole system of mental health care would be reformed and transformed and that the dysfunctions of the system, such as negative attitudes towards them and their family member, and the lack of communication by practitioners would become a thing of the past. There was an expressed hope that services would become more genuinely person-centered so that whatever help was offered would be based on each persons' unique needs. This meant spending more time and effort getting to know the person behind the label:

*'That people get to know [names daughter] and don't label her. That would be ideal'.*

*'Services provide great help but need more community integration and getting to know who the unique person is'.*

They also hoped that their own needs for support and recovery would be recognised and that formal peer support for carers would become available:

*'I would like to see a way of connecting with other people..., I feel disconnected from other people'.*

In addition, they expressed a desire for the recovery initiative to establish links with the community to facilitate their family member to participate in employment and social life. Carers also articulated hopes for a radical change in the options for therapies, with a move away from *'an over reliance on medication'* as in many cases they viewed medication as being a part of the problem rather than a part of the solution.

They also hoped that the initiative would provide a forum for the expression of different perspectives and offer a means to re-humanise the system by revealing the faces behind the different labels of service user, carer and professional:

*'More connection so you see faces and make connection between three groups, maybe to have a talk, then discussion, that would be powerful, you would learn a lot'.*

Like service users, carers valued the concept of recovery colleges articulating the idea that being a student would provide a more hopeful identity than the label of *'mental patient'*. They saw a college of this kind as providing a stepping stone to other opportunities and a place where alternative forms of help might be explored, thus representing a whole new and exciting pathway to recovery:

*'I would be hoping for something like a recovery college which could be used as a stepping stone. Because it is meant to be separate from services, maybe attached to local campus.'*

Many carers saw the role of peer support worker as providing a recovery route for their own family member who would benefit from having the opportunity to use their experience to help others. They also expressed a desire to see the peer support worker role become more embedded in services, while stressing the need to have all service providers on board so that these roles would be supported.

In summary, carers identified more support for themselves and their relatives as one of their greatest hopes for the outcome of the initiative. They wanted to see more efforts to include their family member in the community and the development of a broader array of therapies and supports. Recovery colleges and the creation of peer support roles were identified as important outcomes associated with the initiative. Like service users, carers also expressed a real desire to see change move beyond the aspirational and become a reality, with tangible improvements to services offered.

### ***The practitioners' voice***

Practitioners were clear that the project was a *'huge project involving cultural change'* that would not be achieved overnight. One of the key outcomes and hopes identified by them was a change in attitudes of all practitioners. It was felt that if real learning and long lasting change was to take place, the recovery initiative had to begin with a commitment to discussion and collaboration between all stakeholders, as embodied in the triologue approach. Without this service providers were of the view that the cultural shift required within the services and each individual would never take place. Service providers hoped that the initiative would commence the process that *'infused recovery across whole system'*:

*'My hopes would be that this is a start of shifting culturally in the way we view service users and that all staff will learn a recovery value based system ... and that at (an) organisational level we can be assured that this is happening'.*

Practitioners acknowledged a need for them to reflect on and critically evaluate their own attitudes and practices and to adopt new practices in line with recovery principles. They also hoped that the process would help them to begin to encourage service users to take legitimate risks and to enable them to become more independent, but at the same time to be available to them if needed:

*'I think its about the whole thing about services being on tap not on top'.*

*'People are able to live their lives have dreams and ambitions but to know if they need help we are there. We all need that'.*

Practitioners also expressed the view that they themselves experience the mental health system as inhumane and uncaring and expressed the hope that they would receive more support to enable them to change this culture. An acknowledgement of every persons' potential for mental distress was identified as a starting point for building a supportive environment:

*'I think it would help equalise the system if we acknowledged we can all break down, and we all need support'.*

Professionals concurred with both service users and carers that services needed to become much more community focused, less risk averse and actively involve a whole range of organisations in recovery and mental health. It was felt that only if the whole community was involved could a real recovery approach be achieved.

The establishment of recovery colleges was considered to be one of the positive developments that would emerge from the initiative. Other positive developments which professionals hoped for included: the inclusion of service users on management committees, and the creation of paid and voluntary roles and peer support worker roles.

Furthermore, a number of professionals made reference to personal benefits for themselves that might come about as a result of the initiative. These included the opportunity to learn and a reduction in paper work in favour of working in a worthwhile way with people:

*'From a personal point of view I hope I get to meet people again rather than paper work and management'.*

In addition to the anticipated benefits arising from the implementation of the initiative, service provider participants also foresaw potential stumbling blocks to its successful implementation. Firstly, there was a recognition of the incredible contribution that service users are already making and a fear was expressed that unless this was acknowledged through some kind of financial reward it would become a form of abuse. Secondly, despite the stated value of working in partnership, a number of professionals identified potential challenges, including, role territoriality and resistance to peer workers. Thirdly, a lack of resources and 'real' support for the initiative at a managerial level was viewed as potentially inhibiting change from taking place. In particular, the lack of engagement by psychiatrists in the process to date was anticipated to be a real challenge to rolling out the recovery initiative.

In summary, service providers perceived that the recovery initiative could achieve changes in attitudes and practices through stakeholder partnership and education. Reflection and critical evaluation were perceived as being crucial processes required to instigate change on a personal level while organisational and managerial support, resources, collective professional commitment and community partnerships were considered necessary pre-requisites for implementing change at a service level.

### **Summary of Module 1 Pre Intervention findings**

A shared understanding of recovery emerged from stakeholders' descriptions in so far as all groups envisaged the process leading to a life in which expectations for employment, relationships and social inclusion are realisable. Hope and encouragement were underlined by both service users and their families as important elements of enabling recovery. In this context, support and positive attitudes from professionals and peers as well as the development of therapeutic relationships with them was viewed as instrumental to the recovery process. For their part professionals recognised their role in the recovery process as that of the facilitator fostering the empowerment of service users and trying to maintain a delicate balance between protecting vulnerable persons and facilitating them to take risks. Empowerment also featured in service users' understanding of recovery with it being described as a learning process enabling better management and control of their 'illness', 'symptoms' or distress. Service users, while acknowledging the challenges, also acknowledged that taking responsibility and ownership were important aspects of recovery. Together, the stakeholders understood recovery as an individualised process involving addressing difficult experiences, setting goals, taking risks, encountering and overcoming setbacks, and revising expectations.

Service users experienced some aspects of professional help as recovery-oriented, including positive encounters with professionals in the mental health system in which a sense of hope was derived. Experiences with peer support were overwhelmingly positive and its value was

emphasised throughout service users' accounts of their experiences. Service users' also spoke of encountering active efforts by professionals to involve them in the community and to link them to community-based supports and services and were positive about their experiences of support groups and education classes targeting self-management. Professionals could cite examples of being involved in or leading recovery-oriented initiatives, practicing a partnership and person-centred approach to care, focusing on the strengths and wishes of service users, empowering service users through the provision of information and education, fostering hope and developing therapeutic relationships with service users.

Stakeholders broadly agreed that the orientation to a recovery approach within the mental health service was inconsistent and largely dependent on the individual or team approach encountered. Thus, while stakeholders were able to recount positive encounters of recovery-oriented practice, they were also able to identify a range of barriers which prevent the development of recovery-oriented services. Dysfunctions of the mental health system were identified as problematic by all stakeholders. The shortcomings identified included the dominance of the medical model of care, the overuse of medication, systems and processes which dehumanised service users and marginalised their voice, negative attitudes about mental illness, inherent bureaucracies, a limited range of supports available, an aversion to risk taking, a lack of stimulation in the environment, a lack of involvement of and time to engage with service users and their families, a lack of information on all aspects of care and treatments and a lack of co-ordination and leadership to drive the recovery agenda forward. At a broader level, funding cutbacks, depleted resources, a lack of political will and trade union resistance were identified as impeding the implementation of system-wide recovery.

In spite of the presence of these barriers, stakeholders expressed a hope that the advent of the recovery initiative would herald significant changes in cultural attitudes towards mental health and mental health care practices. It was hoped that the recovery initiative could provide a platform to develop a shared understanding of the concepts of 'mental illness' and recovery, identify strategies to implement recovery-oriented services and develop the leadership skills needed to instigate change. The recovery initiative was identified as having the potential to foster an approach to mental health care founded on stakeholder and interagency partnership as well as to develop appropriate and accessible supports and services. The potential initiatives associated with the project, such as the Recovery College, were deemed to represent a real opportunity for meaningful involvement of service users and their families which was most welcome. All stakeholders identified the desire to see reform of the mental health service reflected in improved processes and outcomes for service users on a personal level.

## Chapter 4. Module 2 Implementing change: Post intervention findings

### Introduction

This section documents the findings from the post intervention focus groups which were held in each site approximately 18 months after commencement of the recovery initiative. It contains a brief description of who was involved and each site's efforts to increase their capacity to deliver recovery-oriented services by using ImROC's ten key organisational challenges without identifying any site specifically. In keeping with the aim of the report there is no attempt to comment on the outcomes for service user, family members or practitioners.

The outcomes of the focus group analysis are presented under the following headings:

- Who was involved
- Organisational changes: What happened
- Facilitators and Barriers
- Overall views

### Who was involved?

The ability of each participating site to begin a process of transformational change was contingent on the recruitment, support and sustained inspiration of a range of recovery champions who worked collaboratively together over the 18 month period. These recovery champions included service users, family members, practitioners from a number of disciplines, management personnel within each site, and community based organisations and individuals.

**Service users:** Some sites managed to successfully recruit and sustain the involvement of large numbers of service users who subsequently became involved in a variety of recovery-oriented initiatives. Some of these service users were already involved in leadership roles in other recovery initiatives such as peer support centres like Solas, Aras Follaín, Le Chéile or in community based organisations such as IAN, SHINE, MHI, NLN and GROW. They were attracted to the recovery initiative and got involved because in their view it *'was much further along the recovery road'* and offered *'exciting possibilities'* for the future, such as the employment of peer support workers, the establishment of Recovery Colleges and the possibility to effect change through involvements at a management level within the mental health service. Others, who had been previously involved with services, were more sceptical at the outset and questioned if it would be 'tokenism' or collaboration, while others joined on the encouragement of other service users as projects unfolded.

During the focus groups a number of examples of how service users were involved and then supported were discussed such as:

- Establishment and funding of training courses and support groups aimed at enabling service users to play their part in organisational change.
- Creation of leadership roles for service users in new recovery initiatives (Recovery College, Involvement Centre, Care-Ring (a telephone contact initiative), Schools Programmes, Education Programmes for practitioners.
- The creation of meaningful roles for service users on some management teams and a consumer panel.
- Support of service users to attend Nottingham's Recovery College, learning sets and site visits.

However, where sites relied on a very small number of service user champions, they reported finding it difficult to attract other potential service users and any changes brought about were described as *'fragile'* with progress being described as slower.

**Family members and other carers:** In addition to the involvement of family members and carers who already had experience and leadership input through previous involvements in initiatives such as the National Service User Executive (NSUE) or carer support groups, many sites reported the establishment of new initiatives aimed specifically at the recruitment of family members and carers as recovery champions. However, there was an overall recognition in all sites that family members are perhaps the most neglected stakeholder voice within the ARI programme, and the one group that requires much more investment of time and resources to enable them to become involved in a meaningful way. Similar to service users during the focus group, examples of how family members and carers were supported to become involved were discussed:

- Development of leadership roles for family members and carers on some of the ARI and HSE management and government committees
- Inclusion of carers in a number of initiatives: education, support
- Support for carers to visit Nottingham's Recovery College and Irish based learning sets
- Establishment of a family support group or information workshop for family members

**Practitioners:** There was a varied mix of practitioner involvement across all sites, with some sites being very dependent on one or two disciplines. While practitioners from all the different professions - nursing, OT, social work, psychology and psychiatry could become effective recovery champions, and be part of the project team the involvement of senior clinical psychiatrists and clinical directors was considered especially influential in promoting the recovery initiative. In some sites clinical psychiatrists were very engaged at project team level and in the whole process, however, in others they were described as *'not obstructive'*

*but not very involved*'. While practitioners from all aspects of the service could have become involved, in the majority of the sites practitioners, especially nurses, appeared to be working in practice development or community positions, with very few sites making a significant effort to engage staff working in acute units or other residential services.

Very similar to service users and family members many of the practitioners involved were already doing work in the area of recovery, and became involved voluntarily in the recovery initiative as in their view *'it had potential to move the services forward in a more robust and speedier manner'*. In a small number of cases practitioners reported that they were assigned roles by management, which they felt not to be in a position to refuse. Irrespective of how practitioners came to be involved they were all positive about their experience. Different sites made reference to a variety of ways through which clinical practitioners had come to assume the role of recovery champion and identified the various initiatives which ensured that they remained convinced leaders over the period involved. These initiatives included:

- Co-facilitating education programmes, involvement in open dialogue projects or peer led initiatives
- Establishment of courses specifically aimed at educating clinical practitioners in principles of co-production and recovery which valued the experience of service users and family members as a valid form of knowledge
- Encouragement of leadership roles for clinical practitioners within new initiatives

**Senior management:** In some sites members of senior management, such as Director of Nursing, Senior Clinical Consultant or other members of the site management team were actively involved in the recovery initiative. In other sites senior management were involved in a more passive way, merely receiving feedback from project leads, or chairs of groups set up to action initiatives. Where senior management were less involved initiatives for change were less well developed and grounded. In sites where senior management took a personal interest in the recovery initiative or attended ImROC project management meetings or other initiatives, recovery projects tended to flourish. The unique and vital role of senior management included:

- Provision of resources at a local level (time, finances, rooms, buildings, administrative and IT support).
- Sharing of management expertise and assistance with navigating through organisational systems.
- Provision of affirmation and acknowledgment of efforts of all involved.

**Community partners:** Recovery champions in the form of community based individuals or groups also played an important role in advancing the work of recovery initiative. During the focus groups participants mentioned organisations and groups such as: Mental Health Ireland, GROW, SHINE, SOLAS, Aras Follaín, IAN, and NLN. In some cases this led to an *'expansion'* of existing initiatives run by existing partners such as GROW and SHINE. It also

led to the creation of a vast array of new community partnerships with individuals within educational institutions, sporting bodies, county councils, grant awarding bodies, locally based art and music groups, local radios, graphic designers, business people as well as schools, the Gardaí and local Mental Health Ireland groups. In addition to capitalising on the experience and expertise of these groups, the partnerships played key roles in:

- Helping to begin the process of normalising the experience of mental illness or emotional distress within communities, thus helping reduce the stigma of 'mental illness'.
- Providing the public with examples of non-medical types of involvement that can be instrumental in recovery.
- Encouraging participation by the general public in recovery initiatives being organised due to their more intimate local knowledge and their extensive networks of community relationships.

### Organisational challenges: What happened?

Out of the ten challenges identified by ImROC, nine challenges were selected as site goals by the seven sites involved (See table 6 for breakdown in order of selection). The only challenge not prioritised was '*Changing processes for risk assessment and management*', yet the interviews revealed that a number of sites had nonetheless realised the importance of change within this area. It also became apparent during the focus group interviews that there is a lot of overlap between the different challenges. For example the establishment of a recovery college (C3) was instrumental in changing the nature of day to day interactions and the quality of experience (C1). This challenge also played a part in transforming the workforce (C8) through the employment of a peer worker and by delivering comprehensive user-led education and training programmes (C2). During the focus group interviews it was also evident that participants from different sites described similar initiatives to achieve different challenges.

While the actions and initiatives described by participants in each site were varied, it was clear that all sites were at very different stages of ImROCs' (Shepherd *et al.* 2010) three stage change model: engagement, development and transformation, with varying levels of managerial, team and individual commitment demonstrated. There were also significant differences in the degree to which changes in practice, policy or culture had taken place. Some of the sites involved had a previous history of recovery development and had completed significant ground work, consequently during the focus groups they spoke of the challenges of distinguishing between what occurred as a direct result of recovery initiative and what was simply building on previous recovery developments.

Having said this there was clear evidence of capacity building with service users, disciplines involved, and to a lesser degree family members. There was also a commitment to and enthusiasm for ongoing change. Indeed, in contrast to the pre intervention interviews, the

post intervention focus group interviews were characterised by enthusiasm, pride, and celebration, which suggested a sincere desire to keep the changes commenced in motion.

**Table 6: Key organisational challenges selected**

Organisational Challenge	No. of sites
Establishing a 'Recovery Education Center' to drive the programmes forward (C3)	4
Delivering comprehensive user-led education and training programmes (C2)	4
Changing the nature of day-to-day interactions and the quality of experience (C1)	3
Transforming the workforce (C8)	3
Redefining user involvement (C7)	3
Increasing 'personalisation' and choice (C5)	2
Supporting staff in their recovery journey (C9)	2
Ensuring organisational commitment, creating the culture and the importance of leadership (C4)	1
Increasing opportunities for building life beyond illness (C10)	1
Changing the way we approach risk assessment and management (C6)	0

### **Establishing a 'Recovery Education Centre'<sup>3</sup>**

*'As everyone went into the recovery college you weren't a psychologist anymore, or a psychiatrist, you were all students. So you were all there to learn. Staff came out thinking 'oh my god I thought we were going to be bashed..... And it just wasn't like that at all'. A completely different feeling' (Service provider).*

*'The recovery college really seems to have caught people's imagination'*

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<sup>3</sup> The number applied to each sites within the presentation is random. While Site 1, 2 and 3 appears in each challenge it is not the same sites that are being referred to.

Establishing a recovery education centre or recovery college was one of the most popular of ImROCs' challenges and was prioritised by four out of seven sites. While progress has been made by each of these four sites, each one is at a different stage of development.

**Site 1** In this site a college is up and running. Situated within a restored old psychiatric hospital it offers a range of co-produced courses to a mixture of service users (including service refusers<sup>4</sup>) family members, members of the public and a cross section of service providers. Its paid coordinator is a service user with personal experience of recovery and the skills and qualities necessary for this position.

Key to its development was the establishment of a steering group, the development of links with local educational institutions, key community groups and service user groups. HSE support was secured and the necessary funding and accommodation to support its development guaranteed. In addition, public consultations with a mix of service users, family members, community representatives and service providers were held. All courses developed and delivered are done on the principle of co-production. Close links with ImROC and visits to Nottingham's flagship college provided a model and practical guidance for the colleges' development.

Currently the college offers 12 courses under four separate headings: Recovery Skills and Self-Management; Developing Life and Social Skills; General Mental Health and Medical Issues and Getting involved. At the time of data collection this site reported that the courses had 121 enrolled students.

**Site 2** Prior to the arrival of the recovery initiative this site had developed a unique mobile unit which *'aims to provide physical, mental and social well being services for the community through initiatives rooted in recovery and social inclusion'*. During this initial period of the initiative a decision was taken to develop this resource into a travelling recovery college that would run co-produced taster sessions on various aspects of recovery rather than seek a permanent premises. Already the site has successfully delivered a number of co-produced courses such as 'What is recovery?' and a much sought after schools programme. It has formed links with art, music and drama organisations in a wide variety of rural and urban settings and is seeking to formally link in with library services. The site still plans at some stage to develop a central recovery college in a permanent premises and to adopt a hub and spoke approach towards delivery of programmes.

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<sup>4</sup> Service refuser is a term coined by Paddy McGowan to describe someone with mental health difficulties but who has not engaged with mental health services.

**Site 3** reported that they also secured funding for the establishment of a recovery college which will be based in a peer led involvement and education centre that has developed in the area over the past number of years. Prior to the successful funding application, a recovery needs analysis was conducted throughout the HSE area by representatives from each county. Service users and family members were asked what they would like to see becoming available in a college of this type. This survey and the proven effectiveness of the peer run center have led to funding for a recovery college with one and a half paid positions which *'will be a place where enthusiasm is captured'*. It is envisaged the college will be able to run courses in each of the regions' counties.

**Site 4** tackled this challenge by forming a large working group composed of 22 people including: service users, family members, service providers, representatives of local third level educational institutions, senior HSE management and influential community groups, such as GROW, the National Learning Network (NLN) and Mental Health Ireland (MHI). They have been successful in obtaining funding for a college through Genio and have already secured a premises. Visits have been made to existing colleges in Ireland and Nottingham and at the time of the focus group a job description was being prepared, so that a service user coordinator could be recruited. Uniquely, before the college officially opens each area is looking for a commitment from local management that all service providers will be exposed to co-produced recovery-oriented training through the college which incorporates the experience of service users and family members

### ***Delivering comprehensive user-led education and training programmes***

This challenge was also chosen by four of the seven participating sites.

**Site 1** delivered a community education programme by running a wellness festival. The festival was led by a partnership of service users, family members and locally based community organisations, with invitations extended to professionals to become involved. In addition to offering co-produced courses such as *'the nature of recovery'* and *'mindfulness'* the festival explored ways in which art, music and drama could be used as resources for recovery and social inclusion. The festival was viewed as a means of reducing stigma associated with mental illness and as a way of demonstrating that mental health and recovery involve the whole community. It was also viewed as demonstrating that while service providers may have a role to play in supporting peoples' recovery journey, recovery is primarily about reintegration into the local community.

Key to its development was a slow process of empowering service users and family members to have a voice within the services, which commenced before the recovery initiative's arrival. The involvement and discussion of service users and family members with members of HSE management and service providers ensured full backing:

*'So what you had was this wonderful building block of progress....like the week was amazing on its own, but it was the result of a process' (peer worker).*

*'I think that week in particular was the biggest change, in that service users and carers and the general public in the community took the entire week, they programmed it, they rolled with it and just asked for the support and assistance of the services. It was a very well attended week. And I think it's had a huge knock on effect on the general public...it was a major success with very high levels of participation' (service provider).*

**Site 2** concentrated on enabling service users to feel empowered to engage as equals through the commissioning of a peer-led education programme. Rather than trying to design their own course this site asked the Irish Advocacy Network (IAN), an organisation composed entirely of people with lived experience of 'mental illness', to produce and deliver the programme. The recovery initiative team in this site, through their links with a committed management team were able to secure financial resources which greatly helped with the successful delivery of the programme. The course content is a practical model for empowerment. It provided information to equip service users to engage effectively with many levels of involvement in management teams, such as: effective communication; the courage to speak up; current policy; HSE structures, functions, responsibilities and commitments; critiquing and analysing documents; building resilience; developing professional alliances and team building. The course is to be followed up with a similar course aimed at family members.

Key to its development was the approval of funding and the engagement of 'experts by experience' with the necessary skills to co-produce a course, the successful recruitment of service user participants and the establishment of links with a local educational facility:

*'We found funding for it through HSE. We paid a facilitator and we paid travel and other expenses for participants. It was fully backed by (the) management team' (project lead).*

*'The training really helped both with bonding as a group but also with individual empowerment' (service user).*

**Site 3** engaged with REFOCUS, a recovery training initiative pioneered by Dr Mike Slade in the UK to deliver a training programme for peer support workers. The content of the programme has been put together through extensive consultation with service users, using their experience as its guiding principle. The goal of this sites' educational initiative was two-fold: to equip peer support workers with skills to meet with service users in their own social contexts such as home or the coffee shop, rather than bringing people to centralised

locations such as a day hospital or acute units; and to educate service providers through a process of dialogue with service users and family members.

Key to its development was the establishment of links with REFOCUS and the guarantee of resources to employ a significant number of service users once training had been completed.

At a practical level the site now has a significant number of part-time peer support workers (approx. 5 full-time positions) who have been trained in this way and who are engaged with a growing number of service users as they go about their daily lives and pursue individual paths to recovery. This initiative is also producing change in the way service users are perceived by staff:

*'I found it absolutely fascinating... I had long nursing experience and had my own very entrenched personal opinions and ideas and what not, which were pretty much torn apart' (nurse).*

**Site 4** did not go about developing their own education programmes but described examples of engaging with other services and initiatives to assist them with this challenge. They reported developing links with EOLAS and delivering their peer and clinician led programme to service users and family members, and spoke of engaging with DCU's triologue programme. They were also in the process of expanding their WRAP education, which to date has primarily focused on staff efforts to include service users as facilitators:

*'Having a service user facilitating WRAP means that we no longer see a 'schizophrenic' but a real person with leadership skills' (service provider).*

Work was also underway to introduce a co-produced recovery induction programme for all new medical appointments within the site, which would be *'co-facilitated by service users and staff'*. The site also reported that a service user was involved in co-facilitating a wellness information programme being pioneered within an acute unit in the hospital.

**Site 5** which had not included the development of user led education programmes as one of their stated goals also described an initiative of note: a recovery story telling project. The project involved a ten week course composed of two hour modules and included content based on personal narratives of recovery, different types of professional help available and community involvements that people could consider on discharge from hospital. Each module also had a fun involvement section which involved dancing, singing, music, clowning and storytelling. The project was co-produced and co facilitated by a sub team of the local recovery project steering committee composed of a service user, family member and service provider and which consulted with attendees on a weekly basis. The programme

was delivered as part of the weekly activities within the acute unit of a mental health service. The course was attended by 235 people including service providers, service users from the unit and community, family members and representatives of community groups.

Key to its development within this site was getting agreement and approval from the clinical director of the service. The inclusion of peer support groups whose members provided recovery narratives, such as GROW, NA, AA, and Phrenz (a peer support group aimed at people with a diagnosis of schizophrenia run by SHINE<sup>5</sup>) was instrumental in setting up the initiative. In addition, a wide range of professionals such as Cognitive Behavioural Therapy (CBT) counsellors, mindfulness addiction counsellors and community organisations, such as employment, art and leisure agencies were involved.

A number of other developments are in the process of being established which are directly linked to the successful experience of the initiative:

- A weekly 'going home' group which helps people identify challenges they may experience and resources that might help support them.
- A five week peer support course for people immediately after discharge from hospital.
- A number of activities in the acute unit such as story telling, clowning and relaxation which will be run by volunteers involved in the original project.
- The approval of a full-time recovery resource practitioner (the service provider involved in the sub group) who will be based in the acute unit.

### *Changing the nature of day to day interactions and the quality of experience*

This challenge was prioritised by three of the seven participating sites.

**Site 1** described an initiative which took place in the acute in-patient unit of the hospital, which involved a regular weekly open forum between service users and staff. Each session lasted for less than an hour and included outside speakers, with an emphasis on the active involvement of service users who were on their own recovery journey or were involved in peer led initiatives. The topics addressed were identified by service users and staff. During the sessions, staff endeavoured to remove their professional identity and set aside their professional tasks and engage with service users (presenters and clients) as equals and the holders of important knowledge that can help both the service users attending and themselves in exploring ways of improving the services provided. Previous attempts at

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<sup>5</sup> Phrenz is open to anyone with a diagnosis of mental illness. Originally it was designed to introduce the resource of peer support to those with a diagnosis of schizophrenia.

dialogue between staff and service users always ended up as *'a meeting of complaints'*. Now both staff and service users have become partners as they look at *'non medical'* alternatives to recovery suggested by speakers.

Key to its development was the active support of the wards' mental health manager who became convinced of the potential of the recovery initiative. He and a colleague attended *'an ImROC training session in London'* and came back determined to establish a regular open forum between members of staff and service users within the acute unit. Prior to its commencement negotiations and discussion took place to ensure that staff were on board and that they were afforded the time necessary to take part:

*'It's a break from the medical model, while the medical model is still quite strong. It's very evident to our service user group that there are other avenues that they can choose in managing their own destiny...It's also a paradigm shift from being a negative to being constructive' (Unit manager).*

**Site 2** reported the development of a peer run phone link service in a rural setting. A team of trained service users who receive support and supervision from a local psychology department regularly maintain friendly contact by phone with service users who live in isolated areas. The phone calls are not about offering advice but serve to ensure that those receiving them know that they can expect regular contact and that *'someone is interested in their well being'*. The format of the calls is one of availability and slowly getting to know each person's personal circumstances. If someone is experiencing real difficulties then other forms of help can be arranged. This initiative is viewed as a major change in day to day interactions for people who might only receive a visit from a community nurse for a limited time. It also shifts interactions from professional monitoring and support to friendly concern and inclusion.

Key to its development which began as an idea in the consumer panel was gaining the approval of the local HSE management which was readily forthcoming. This was followed by negotiations with members of the local community who at first objected to the idea of a peer led phone service. Having the project embedded in a local family resource centre and arranging training and supervision from the psychology department reassured those who were doubtful of the capability of volunteer peer workers to build this service:

*'The ironic thing about the peer phone support service is that the resistance has come from the community. It's a tough one to swallow'.*

**Site 3** reported a significant change in attendance at recovery courses. Before the recovery initiative these had been produced by service providers and although a very wide range of subjects were explored it was difficult to get people to attend. Now the number of topics

has been greatly reduced and those on offer were co-produced, which resulted in an awakening of interest from service users and family members. While this initiative could have been included under challenge 2 the major change that took place was in the day to day relationship between service providers and service users.

Key to its development was the change to a model of co-production. The idea of providing recovery education within a centralised site was relatively unsuccessful in attracting participants until co-production was introduced.

### *Transforming the workforce*

ImROCs' own definition of transforming the workforce refers specifically to the employment of peer workers alongside traditionally trained professionals so that expertise by experience as well as professional knowledge becomes readily available to service users. In ImROCs' view peer support workers come from two different sources:

- service users who have recovered and who have been trained in specific peer support roles
- service providers who have a personal experience of mental illness and recovery and who are given special roles based on that experience.

Transforming the workforce was a challenge that was chosen by three out of the seven participating sites.

While there is some progress in the employment of peer support workers there is as yet little evidence that professionals with experience of mental illness are being valued or that their invaluable expertise is being seen as a positive resource.

**Site 1** now employs 12 part-time paid peer support workers, the equivalent of five full-time personnel. The majority of these are employed to work individually with service users in their own preferred environment rather than in a centralised location. One is employed as the coordinator of a recovery college. This site has its own training programme for service users co-produced as part of REFOCUS. The site reported that initially there were some challenges in the integration of peer workers into the workforce with some staff feeling threatened by the creation of this new role. Peer support workers are not employed or paid directly through the HSE but through Mental Health Ireland.

**Site 2** is currently actively seeking funding for one full-time peer worker to coordinate a wellness programme that is currently delivered by professionals. They intend to divide this salary among two peer support workers so that there will be some peer support for the two people employed.

**Site 3** has taken a very strategic approach to the employment of peer support workers who are regarded as *'a very powerful way of getting into the heart of a system'*. The site first established a working group that looked at all the issues and challenges around training, confidentiality, job descriptions, contracts, wages and then secured management approval to actively pursue the creation of paid positions. It is intended to employ two peer support workers. Discussion is currently under way within the service and with Trade Unions to pre-empt any problems or resistance. A presentation has been put together around the financial benefits of employing a peer support worker and this was presented to senior management personnel. In addition funding has been secured for a peer coordinator of a recovery college that is currently being established within this site.

Two other sites reported the existence of paid peer workers. One works in the community and the other in a peer led resource centre. One of these sites had recently obtained additional finance for the creation of 1.5 new posts within a recovery college.

While progress has been made in the employment of peer support workers, the stated goal of Nottingham that a minimum of 1 out of 6 employees throughout the workforce have a personal experience of mental health difficulties is still some way off.

### ***Redefining service user involvement***

While this challenge was specifically chosen by three of the seven sites, it was evident that all sites had made some inroads into a redefinition of user involvement. Some sites could provide real examples of efforts to enable service users and carers to successfully cope with a re-definition of their role. In addition some described how service users and carers had become involved: in management teams; in the co-production and facilitation of educational programmes and in voluntary and paid leadership roles. One region was able to report that the recovery steering group which was originally composed mainly of service providers was now equally representative of service users and family members. All of which indicated a commitment to a re-definition of user involvement and which provided new and positive identities for service users and carers. A redefinition of 'user identity' in turn led to the development of new types of relationships between service users, family members and service providers.

However, despite one sites' efforts to ensure that recovery was part of management agendas there was evidence of resistance with the senior management team declining co-produced presentations of the work of the recovery initiative and opting instead for reports from the project lead:

*'I asked to co present to senior management with [names service user] and [names family member] but they weren't ready for it. Said 'Great idea but not just now'' (project lead).*

Evidence that a transformation of user involvement has taken place can be seen in individual examples within the sites.

- Developing roles and job specifications so that service users and carers are seen as equal partners and have clearly defined responsibilities (e.g. voluntary coordinator of an involvement center)
- Getting significant service user and carer representation on various management committees so they become politically aware and can influence policy development
- The employment of peer support workers and the provision of training and support
- The adoption of co-production as a guiding principle of change
- The re-education of staff through open dialogue so they learn to value the expertise of service users as a valid form of knowledge.

The success of Michael Ryan in his role as the ARI national project lead also appeared to help influence the redefinition of service user involvement.

### *Increasing personalisation and choice*

ImROC defines this challenge as *'ensuring that care plans move away from an emphasised management of symptoms to the active pursuit of service users' chosen goals and the provision of a variety of alternative pathways such as WRAP, or Mindfulness, peer support and social involvements'* (Shepherd et al. 2010:12).

This challenge was selected by two sites.

**Site 1** reported an increase in the availability of WRAP education for staff and were in the process of widening WRAP so that service users and carers were actively encouraged to become facilitators. The site was also involved in sending staff on hearing voices training and reported having links to DCU's triologue programme. However, work to ensure that care plans move away from an emphasis on management of symptoms to the active pursuit of service users' goals was not overtly evident.

**Site 2** reported two initiatives within the area of increasing personalisation and choice:

- The creation of two peer led involvement centres that provided a warm welcoming environment and introduced those attending to various activities and social involvements. One of these centres is managed by an unpaid service user and offers other leadership roles to both service users and family members.
- The introduction of peer support for family members which provides a forum through which families can seek information and advice from others with personal experiences of dealing with the mental health system and of living with a family member through various phases of 'mental illness' and recovery.

### *Supporting staff in their recovery journey*

ImROCs' guidelines for supporting staff in their recovery journey limits the concept to enabling staff to openly acknowledge that they may have personally struggled with mental health difficulties and have experienced recovery. Progress within this challenge begins with *'an awareness that many staff have their own experiences of living with mental illness and of recovery'* (Shepherd *et al.* 2010:16).

While the presence of negative attitudes towards staff with personal experience of 'mental illness' was highlighted in round one interviews, this challenge was only chosen by two sites but two additional sites reported addressing this challenge indirectly through various initiatives.

**Site 1** reported undertaking groundwork aimed at defining what the term *'staff recovery'* meant. During the focus group interviews some heated exchanges occurred between members of different professional disciplines. Objections were raised to the term *'staff recovery journey'* because it was seen as implying that staff were in some way mentally ill and in need of recovery themselves. This tension gave rise to a number of questions being raised about the meaning of the challenge:

- *'Is it just about supporting staff in their day to day work especially because everyone is overloaded and there is very little support, no extra time allowed to engage with ARI.'*
- *'Is it about helping staff de-stress or even recover from the changes that are occurring within the system?'*
- *'Or is it about staff admitting their own vulnerability to mental health issues?'*

There was agreement that in order to be able to support staff in their recovery journey conversations on the meaning of the challenge needed to happen.

**Site 2** reported promising beginnings to the creation of a culture where it would be safe for staff who had personal experiences of 'mental illness' to publicly acknowledge it. This came about through service users and service providers getting to know each other through regional recovery initiative meetings and together exploring the concept of self-care:

*'Service users began to sense that we [service providers] are much more vulnerable than they had thought. It allowed a conversation to start around the importance of self-care. People began to get the idea that experience of mental illness by a service provider could be a positive asset. It used to be the elephant in the room and yet in this region we have many tragedies involving staff.'*

Members of the steering committee who had visited Nottingham from this site reported how refreshing it had been to hear staff there acknowledging their own mental health

struggles and of the 'two hat' project which explored personal experience of mental illness as a valuable resource for service providers. Another site noted that as well as seeking ways to allow staff to openly talk about their own vulnerability preventative work was also important:

*'There is a growing awareness of the need to develop ways to show appreciation of both staff and volunteers so as to avoid burn out'.*

**Site 3** a site which had not listed this challenge as one of their goals also acknowledged making an exploration of the concepts' meaning:

*'The meaning of staff recovery is currently being actively explored. There is a growing recognition that the concept applies in many ways to those working in the mental health system as well as service users'.*

They went on to describe measures that are being taken to assist staff, noting that service providers can sometimes need to recover their own sense of value and dignity as caring human beings:

*'Attempts are being made to provide time and support for staff to become reflective, to reawaken the original values that brought them into this kind of work. To allow them to develop a 'three dimensional view' of recovery and to be changed by listening to service users and family members'.*

There was also an acknowledgement *'that the system [itself] needs to recover'*. At present the system was experienced as an uncaring place in which to work. Staff it was felt:

*'need to be cared for as individuals and allowed to use their personal creativity and integrity in their interactions with service users. They need to be constantly aware of their own giftedness and personal growth and allow this to shine'.*

This site was actively exploring a life coaching approach to staff support pioneered by UK recovery specialist Dr Mike Slade. The site is currently running taster sessions in service provider support.

**Site 4** noted that involvement in open dialogue and the co-production of various initiatives was helping to create a culture where staff were tangibly appreciated by service users, which countered feelings of 'vocational alienation' and contributed to their ability to recover:

*'One real benefit [of ARI involvements] is that staff are being made aware that service users appreciate what professionals are trying to do. This affirmation is further feeding a desire for change'.*

It became evident through the focus group interviews that the concept of staff recovery is much wider than recovery from mental illness. Staff often need to recover core values underpinning a recovery ethos such as dignity, respect, person centeredness and partnership and recover from:

- changes within the system
- stress and a lack of resources
- criticism by service users
- stigma and a negative image of who they have become.

### ***Ensuring organisational commitment, creating the 'culture' and the importance of leadership***

Only one site selected this as an organisational challenge. While some sites provided evidence of securing the support of senior HSE management and local management groups, which ensured that funding, time and other resources such as premises were available, overall each site falls far short of the ultimate outcome of this challenge which are enumerated by Shepherd *et al.* (2010:11) as:

- Recovery concepts are evident at all levels of the organisation
- There is [universally] strong leadership and action at Board level which is reflected at all levels of management and by front line staff
- There is a recognised need to develop partnerships working with service users so that professional expertise does not dominate over the wisdom of lived experience
- The service promotes an environment of hope and optimism.

The site in question reported a number of initiatives designed to bring about cultural change through organisational commitment:

- All four service provider teams within the site began ongoing discussions with service users about their wants and needs. This led to small projects such as information leaflets within GPs' surgeries about the mental health service. The recovery initiative project team started work on a website explaining who and what the mental health team are and how people enter and exit the mental health team.
- A peer support project aimed at family members has been funded through Genio and co-produced between recovery initiative members from the site, Shine and a Genio funded project worker. 23 family members from across the region have just completed a training programme, learning how to be peer supporters for other family members. In the next phase families who have just come into contact with services will be referred to trained family members.

- A variety show around service users own mental health issues and what recovery meant to them, involving songs, dance, music and poetry has been co-produced and performed in various venues. Not only do projects of this kind provide hope, enjoyment and meaningful involvement for those service users who took part, but they normalise the experience of mental illness, creating a stigma free culture within the local community.

### ***Increasing opportunities for building a life beyond illness***

This challenge was selected by one site, and this site spoke of one specific initiative aimed at increasing opportunities for building a life beyond illness, which used an adaption of an existing local partnership with DCU's Triologue course to explore this challenge:

*'It was felt this was a good way to help people engage with the community. By bringing people together you reduce stigma and generate enthusiasm'.*

The course is to be advertised locally and it is hoped that a range of people experiencing mental health difficulties will engage to explore selected mental health topics through open dialogue. Communication, education and involvement were seen as key activities that can help combat stigma, one of the main barriers to building a life beyond illness.

However, other sites provided examples of having created many meaningful involvements for service users which served as opportunities to build a life beyond illness through:

- membership of management teams within the recovery initiative
- membership of consumer panels and HSE committees
- co production/facilitation of educational programmes
- paid and voluntary leadership roles as peer support workers
- a wellness festival that allowed service users to explore recovery through a combination of art, drama, poetry and song
- courses run by recovery colleges and peer run education centres aimed at encouraging social involvements and life interests.

### ***Changing the way we approach risk assessment and management***

ImROC suggests this challenge involves *'the organisation [becoming] aware of the value of systems and procedures that support open, transparent risk assessment and management policies within a recovery framework..... [and] the value of 'positive' risk taking is addressed at a Board/general policy level'* (Shepherd et al. 2010:13).

While no site specifically chose as their goal the challenge of changing their approach to risk assessment and management many focus group participants spoke of a growing realisation that there needed to be a radical change in the traditional approach to risk taking to

incorporate positive risk taking. In addition, two sites gave examples of initiatives being pursued.

**Site 1** reported an intervention to reduce the use of seclusion and physical restraint in an acute ward that was considered unacceptably high. A visit to an ImROC training session by the unit manager, who was committed to recovery-oriented change, and the practice development coordinator led to the implementation of an education programme for staff and the introduction of a new audit process. Part of the education process involved staff exploring the use of open dialogue with the service users to prevent issues escalating rather than immediately resorting to the use of seclusion. The implementation of these changes brought dramatic results in the use of seclusion and physical restraint:

*‘And the emphasis on our training was on our management of the client prior to having to use the physical restraints or seclusion....Within three or four months we had dropped from very high to extremely low. Nearly so low that people were afraid to use seclusion’ (Unit Manager).*

**Site 2** reported holding a workshop with Finnish experts in open dialogue which provided ‘a real U turn in positive risk taking’. This kind of positive risk taking is centred around professionals listening to the needs and wants of service users and carers and allowing a new way of working to evolve. Signs of positive risk taking described within the site included:

- sharing a kitchen between staff and service users
- not locking doors
- asking people which medication they would prefer and negotiating around preference
- allowing people to take risks and make mistakes but supporting them along the way.

These small steps have been accompanied by an open acknowledgement that staff will be supported if they encourage positive risk taking:

*‘Responsibility for decisions now lies with the service user and all others are subordinate advisers’ (peer worker).*

### **Enablers of and barriers to change: Multiple and varied**

IMROC is basically a change initiative and this section explores the enablers of and barriers to this change initiative. There was broad agreement across all sites that, despite each sites’ unique character and circumstances, the presence of certain conditions actively facilitated a growing capacity to bring about change, while the presence of others slowed progress and has the potential to undermine any future work if not considered. The first part of this

section discusses the enablers of change and this is followed by a brief outline of the challenges or potential barriers to future progress.

The enablers of change identified broadly fell into the following categories:

- Inclusion of service users and family members
- Involvement of senior management and senior medical personnel
- Use of ImROC methodology
- Good communication and coordination of different recovery initiatives
- Inclusion of different organisations and disciplines

### *Inclusion of service users and family members*

All sites were in agreement that the formal recognition of the experience and expertise of service users and family members was a vital ingredient in progressing the recovery initiative. Thus, the inclusion of both service users and family members at all levels of management, education and service provision, was fundamental to creating a context for organisational change. Inclusion came about through an investment of time, training, support, listening and a re-deployment of resources to support education/training and in some cases the reimbursement of expenses incurred by service users and family members.

There was evidence across all sites at different levels that such inclusion had taken place through:

- The creation of paid peer support worker and other non-paid leadership roles.
- The inclusion of service users and family members as members of management teams and other committees throughout the service.
- The inclusion of service users and family members as educators within the service and the community.

The positive outcomes of this inclusion of service users and family members can be found in a significant increase in peer support groups, a widening of WRAP facilitator training to include members of both groups, the development of paid peer support workers and the creation of peer support volunteer leadership roles. A second positive outcome was the creation of a range of new and positive identities for service users and family members including *'intelligent possessor of knowledge'*, *'educator'*, *'member of management'*, *'equal colleague'*, *'active leader'* all of which served to counter the identity of *'passive other'*. The third outcome was a real sense among service users and family members that their voices and experiences mattered and that they were worthy of being invested in as partners in the recovery initiative:

*'It was the opposite of tokenism. It wasn't expecting people to become involved without training and support' (SU).*

*'The Director of Nursing said 'I need you involved and I want to invest in you'. That was a different approach than the one I was used to' (SU).*

*'People are afraid of change but through ARI we are being given back our power' (FM).*

*'You feel you are involved at every level there are no private decisions made after the management meetings by an inner core [of HSE staff]' (SU).*

### ***Involvement of senior management and senior medical personnel***

The active involvement and personal commitment of members of senior management and of senior medical consultants was also a vital element in facilitating change. Senior management involvement not only demonstrated leadership by example, but it gave the recovery initiative an authoritative voice. Where senior management was involved sites incorporated ImROC developments into strategic plans and systematically created the co-produced management structures necessary to fulfil the aims of those plans, thus enhancing the sites' capacity to become recovery-oriented.

The management voice was a voice containing many voices. It was a voice that enabled access to a wide range of resources and different types of expertise and a voice that had the power to authorise reallocation of resources such as 'protected' time to practitioners to lead out on the recovery initiative, or financial resources for training programmes for service users/family members. It was a voice that ensured that executive decisions were likely to be carried through, and would be actively supported by staff. Management involvement also sent an encouraging message to service users and carers who were not directly involved at management level, assuring them that their voices were being heard and were being treated with respect. In addition, people who normally would never meet (senior managers, service users, family members) became colleagues, and management structures which are often viewed as impersonal and uncaring became more personalising. There was evidence of management involvement through:

- The creation of management structures based on the principle of co-production
- The incorporation of recovery principles into site specific strategic plans
- The attendance of senior managers at recovery initiative meetings and at the ARI focus group
- The allocation of resources to ensure recovery initiatives had the necessary personnel, finances, and space to achieve their challenges
- The creation of a plan and vision for moving forward when the current phase of recovery initiative came to an end.

The positive outcomes of management involvement was evidenced in the fact that the recovery initiative was being incorporated into service level plans and budgets, and staff, service users and family members were being given necessary resources to support

meaningful involvement. In addition evidence of effective strategic planning and the creation of effective management structures can be seen in the success of sites to obtain grants to establish recovery colleges, and an increased number of service users and family members serving on a network of committees and groups such as the recovery initiative project and sub teams, consumer panels, and governance panels. In addition to creating a context where a recovery approach could emerge, senior management involvement provided all stakeholder groups with a sense of ownership of the initiative and with the dignity that comes from being treated as a valuable equal:

*'As a management team we are looking at drawing up a five year strategic plan underpinned by ImROC and the Quality Framework from the Mental Health Commission. We will include all stakeholders' (Service Provider).*

*'The management is supportive too they gave us the premises and they gave us anything we needed in terms of equipment or decoration. The local director has been evident at our meetings and we felt that he was supportive' (Family Member).*

*'And it became very, very clear to most people involved that there would be no future in any of this unless there was very explicit support from management and it became part of the service not just an add-on' (Project lead).*

### **The ImROC methodology**

The ImROC methodology which incorporated learning sets, a visit to Nottingham, and visits from key people during the 18 months was appraised by participants as a significant facilitator of the change process. The recovery project appeared to benefit from people encountering others who they perceived as inspirational and who had a vision for a different way of doing things. Through seeing projects already up and running in other places the people involved in the recovery initiative appeared to create achievable dreams of their own. All sites sent representatives to Nottingham and people considered these visits to be critical in terms of vision and motivation, with people returning with informed, sustainable enthusiasm and all *'fired up with possibilities'*. The learning sets that were facilitated by Julie Repper, Geoff Shepherd and Michael Ryan from the recovery initiative, not only helped people maintain motivation, but they gave people an opportunity to share what they were doing and get ideas from others.

Those sites who took a planned strategic approach towards the change, benchmarked themselves at the beginning, developed action plans to meet each of their challenges, followed a systematic 'Plan-Do-Study-Act' process and had subgroups/task groups working on each challenge, which fed back to the overall ARI group tended to report more success in their overall outcomes.

The attendance of and personal interest of people like Kathleen Lynch (Junior Minister), Steven Mulvaney and Tony Leahy (representing HSE's senior management) at learning sets or site visits also helped to give people a real sense that they were involved in something 'radically different' and that their work was being valued.

There was evidence of the success of aspects of the ImROC methodology through:

- progress made within each site in achieving specific challenges
- comments made by members about the invaluable inter-pollination of ideas experienced as a result of attending the learning sets
- participants organising many cross site visits independent of the learning sets
- service users and family members reporting that they built friendships and coalitions with other service user/family groups around the country.

*'Nottingham was hugely inspiring. We came back buzzing. It was a huge catalyst for change. It was contagious everyone heard about it when we got back, we shared our stories and the enthusiasm rubbed off' (Practitioner).*

*'To meet at learning sets, for people to meet each other and to have these conversations and these connections, that would never be, you know, before' (Service User).*

*'I would have spoken about [names peer support group] nationally and been asked to help out in different places. A delegation from [names another service] came and visited us and now we mentor them. This is a link through ARI as a national venture' (Volunteer Peer Support Worker).*

*'It was great to have everyone there at the learning sets especially the market place, seeing where each site was and identifying common difficulties' (Service User).*

*'Hearing challenges that other sites had faced made us think about how to successfully support people, what ground work needs to be done. There is no need to reinvent the wheel we can learn a lot from each other. The learning sets gave you insight into how to do various things' (Practitioner).*

### **Good communication and coordination of different recovery initiatives**

Good co-ordination of different recovery initiatives within each site and good lines of communication facilitated a growing capacity to effect organisational change. A frequent criticism of current management practices and previous recovery-oriented initiatives is that they tend to work in isolation from each other and there is little or no collaboration between them. Services that developed good communication strategies (verbal, online and print) and successfully coordinated a range of recovery based activities were enabled to

advance the work of the recovery initiative and to increase their capacity to bring about meaningful change.

It was evident in the focus groups that services that kept all people up to date, even if they were not yet directly involved, developed a synergy and motivation within the wider system. Keeping people informed not only affirmed what people were doing and achieving, but it attracted interest from various individuals who were potential enthusiasts for future phases of development. Good communication also helped to minimise the risk of a 'them' and 'us' culture developing around the project and nurtured the different stakeholder representatives taking part. Where communication strategies extended into the community they awoke the positive curiosity of those who witnessed initiatives from the outside, including local media, the general public, and people with mental health issues who were not engaged with services. In addition services that mapped out all the recovery-oriented initiatives that were happening both within the mainstream service and within communities appeared to have a sense of purpose and coordination. Mapping exercises helped increase synergy and collaboration between groups and individuals, reducing overlap of effort and enabled people that might otherwise have remained in silos to meet. While some of these recovery initiatives were the direct result of the work of the intervention, others, which were already in existence, aligned themselves in some cases with the recovery initiative.

There was some evidence of good communication and coordination strategies such as:

- publication and distribution of recovery initiative newsletters
- sharing of minutes between key individuals and committees
- invitations to people to present progress at different fora
- publicising and celebrating each new initiative within services and local media.

*‘Different recovery groups have been brought together because of the presence of ARI. We made a list of all the different groups and voluntary organisations. There is a surprising synergy ...it made us work together and learn from each other’ (Service Provider).*

*‘Clear and effective lines of communication are being established between the consumer panels, the steering group, regional management and other areas of work. Very clear minutes are distributed to significant stakeholders who have the responsibility to pass this information on to their own groups’ (Service User).*

*‘Everyone gets the same information through a regular newsletter. We had very positive feedback nationally on its value and it has since been replicated elsewhere. It is most useful with staff who are not involved. It also reports concrete examples of recovery work’ (Practitioner).*

*‘A picture of what is happening (a list) went out to everyone....We recognised a need to consolidate all this information’ (Practitioner).*

### **Inclusion of different disciplines and organisations**

Those sites that appeared to have greater levels of success consciously brought members of all disciplines to the ImROC strategic group table and had representation from acute, residential and community services. In addition they actively sought out community groups and invited them to the strategic group. However, in a number of sites there was an absence of certain disciplines and the focus appeared to be on community services. In addition, services that engaged at the outset in a strategic way with voluntary and others organisations outside mainstream services appeared to have more success. Having a broad mix of people that spanned organisations, disciplines and included practitioners from various areas of the services ensured that a planned organisational approach to the recovery initiative was taken from the outset, as opposed to seeing change at a unit or project level. It also helped create an integrated approach to any of the changes being instigated.

There was some evidence of inclusion of different organisations and disciplines:

- Inclusion of staff from acute services on strategy groups as well as voluntary organisations such as Mental Health Ireland, SHINE, GROW, and third level institutions:

*‘The hub of the activity is in the community... you need to replicate that in the residential services because they need to hear, they need to sit in on these discussions’ (Peer support worker).*

### **Barriers to ongoing change**

In the same way that focus group interviews revealed common principles and practices that were enablers of organisational change, they also identified a number of behaviours and conditions that created barriers and slowed the process of change. In some cases the issues identified have the potential to work against any future development or indeed undermine the ground gained, if left unaddressed. Some issues will work against the ongoing involvement and support of service users and family members; others will result in difficulties in engaging practitioners and communities while others will result in the necessary resources not being allocated. The issues identified include:

- Despite management signing up to the recovery initiative at the outset, a lack of *'real'* commitment and involvement by members of senior management and an unwillingness to embrace the principle of co-production at management level.
- A failure of management to sanction protected time for project leads or other staff to successfully lead and manage site projects. Lack of simple resources for some project leads like access to technology, administration support, photocopying facilities.
- An over-reliance on some disciplines to lead the recovery initiative with minimal meaningful involvement of other disciplines.
- Lack of resources needed to provide ongoing training and support for service users and family members together with challenges within some sites in providing basic expenses for service users and family members involved, such as the cost of attending meetings or travelling to training sessions.
- Lack of adherence to ImROC methodology in terms of devising a clear action plan to meet each of the challenges identified.
- A reliance on a small number of service users or family members with too many demands on their time, and no overall strategy on how to build capacity within this group.
- A lack of built-in support or mentoring systems for service users and family members leading to burnout, exhaustion, feelings of being used, and ultimately leaving thus leading to a loss of the wisdom and knowledge of service users and family members that have been involved in the learning sets or other education programmes.
- A lack of development of meaningful leadership roles for service users and family members, especially in sites where service users or family members are not represented at management level or in sites that do not have well developed consumer panels.
- Negative reactions by service users and practitioners to the sudden *'priority'* of the recovery initiative and a failure of those involved to provide affirmation and recognition of valuable work that was already being done within the participating sites. This led to some practitioners and service users who were already involved in recovery initiatives feeling excluded.
- Failure to communicate the aims of the recovery initiative throughout the services thus creating feelings of exclusion from an *'elitist recovery'* movement, and the development of a *'them and us'* attitude between staff.
- A lack of time and an overload of work which turned the recovery initiative into just another thing for practitioners and services to do.
- The failure to involve all the key stakeholders at the beginning, including community groups and the wider community, thus opposition to projects was encountered as people viewed recovery initiatives as encroaching on other professional or organisational mandates.

## Chapter 5. Discussion and conclusion

While many services around the country have been involved in recovery initiatives, the 'Building Capacity in Mental Health Services to Support Recovery' pilot project represented the first systematic approach to developing recovery-oriented services at a national level, using a comprehensive organisational change methodology. While it is at a very early stage of development and it is difficult to say if the changes identified represent first or second order change, collectively the seven sites selected to pilot this project have evidenced many creative recovery initiatives in each of the ImROC challenges identified. All sites were able to provide descriptions of very different initiatives and describe how they evolved. Some services were at the very early stage of the change process while others were further along the road as they were building on recovery conversations and initiatives commenced before the arrival of the recovery initiative. Some of the initiatives described were developed within services while others were sourced externally and adapted to suit locally emerging needs. Some sites took a system wide approach to the change from the outset, while others appeared to operate at a project/initiative level with limited strategic planning to achieve the cultural and practice changes required.

Interviews within each site revealed that, despite each site being unique in its level of recovery capacity and its choice of the way forward, a number of conditions and principles facilitated an increased capacity for organisational change, including: commitment to co-production and the inclusion of service users and family members; involvement of senior management and senior medical personnel; fidelity to the ImROC methodology; good communication and coordination of different recovery initiatives and inclusion of different organisations and disciplines. Interviews also revealed a number of barriers to change which in many cases represented an absence of those same facilitators. Future service developments will benefit from careful and detailed consideration of the barriers to, and facilitators of change identified in this report.

Furthermore, the initial interviews pre intervention revealed a strong appetite for change among all those interviewed, with many viewing the intervention as an important initiative and one within which they had invested many hopes and aspirations for real change. Their involvement in the recovery initiative has not weakened their hope or appetite for continuing the organisational change process commenced; however, they were fearful that without leadership, resources and an authentic commitment to co-production by all involved, real and lasting change that embodies all elements of recovery-oriented services would remain an aspiration, or worse still recovery-oriented services would be considered a *'fad'* or *'latest buzz idea'* with little to offer the mental health community.

However, while there are grounds for optimism the interviews also revealed a mental health system that is beset with problems. To be certain that services are really journeying towards

the 'promised land' of a radically new model of mental health care, much more work needs to be done. Change, if it is to become meaningful and permanent will come about organically, as the relationship between all the stakeholder groups creates a culture of hope, personal responsibility, and a willingness to explore new and unknown relationships. This organic growth however needs sustained inspiring leadership and the necessary resources.

Finally, this study did not set out to evaluate the impact of the initiative on stakeholder outcomes or organisational processes and practices; however, should such an evaluation be undertaken it needs to i) be planned in a co-produced manner (practitioners, service users, family members) within the spirit and ethos of Recovery ii) incorporate methodologies such as interviews, observation, surveys, diaries, documentary analysis to capture the complexity of issues iii) gather data from all key stakeholders iv) capture change over time with a recognition of the time required to implement and consolidate change and v) use an organisational change model, such as ImROC as a guiding theoretical framework.

*'It's very exciting working alongside service users and carers because we're not the experts. And really listening to their experience and their expertise. And moving forward hand in hand so to speak' (Practitioner)*

*'There are more and more individuals becoming convinced that the recovery way can work, there is a sense that they are reaching a critical mass...all members of the multi-disciplinary team have bought in' (Project Lead).*

*'Barriers are being broken down, people's opinions are changing they recognise we can contribute positively' (Service user).*

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## APPENDICES

### Appendix 1: Interview schedule for Pre recovery initiative Intervention

- What do you understand by the term recovery (from 'mental illness')?
- How do you currently rate your local mental health service in terms of facilitating recovery?
- Do they generate hope, a sense of gaining control and do they enhance involvement?
- What are the barriers that might stop your local services becoming more recovery oriented?
- What are your hopes or expectations from this ImROC project?

## Appendix 2: Information Sheet for Interviews



### INFORMATION SHEET FOR INTERVIEW PARTICIPANTS

#### Implementing Recovery in Mental Health through Organisational Change (ImROC)

As you are aware the ImROC projects aims to advance a culture of recovery within mental health services through organisational change. Your organisation has agreed to be part of the action learning process that has been designed to nurture this change. Part of the process will involve the team getting an understanding of what the three groups of people taking part in the process (service users, service providers and family members or concerned friends) think about recovery in the context of their own organisation. This will be done through a series of semi-structured interviews with a small number of people from each of the seven sites involved in the project. Initially, each site will be asked to select five or six people for interview. These will be members of the project team and must include the project leader, someone nominated as service user lead and a family member.

What will participation involve?

If you agree to be involved, you will be asked to take part in a short interview. This interview will involve you reflecting on your views on recovery and where you think your organisation is at in terms of recovery and recovery oriented practice. The interview will also ask you about your expectations for the project. There are no right or wrong answers to these questions. You may choose to be interviewed individually or may be part of a focus group discussion. Participation in this part of the process is entirely voluntary unless you have formally agreed to be project lead or service user lead.

How long will I be interviewed for?

Each interview may take anything from twenty minutes to one hour. The interviews will be tape recorded as it would be impossible for me to remember or take accurate notes on everything that you say. One interview should be sufficient but hopefully you would allow me to contact you if I wished you to elaborate on any particular area that you addressed.

Where and when will the interview take place?

The interview will take place at a time and place arranged by the project leader and convenient to you.

What will happen to the information once collected?

Once the interview is over the information will act as a reference point for an analysis of its content. The team will be looking for common themes and any particular insights that you may have

provided. All interviews will be anonymised. At no stage will your name appear on any written report or notes.

Who will organise and conduct the interviews?

The project lead in each site will organise the time and venue for the interviews. Dr Mike Watts will conduct the interview and he will travel to meet you at a prearranged time.

Many thanks for taking the time to read this leaflet.

### Appendix 3: Topic guide for focus groups

1. What service level changes have occurred within your site? Please try and think of concrete examples e.g. different ways of working, collaborating etc.
2. How did these changes come about? (What needed to happen, who was involved). Please give concrete examples.
3. What factors/conditions facilitated these service level changes? Please give concrete examples.
4. What factors/conditions inhibited these service level changes? Please give concrete examples.
5. What is needed to continue and progress these changes so they become everyday practice?