Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

HSE Mental Health Services

ARI
Advancing
Recovery in Ireland

Advancing Recovery Ireland

A Guidance Paper on Implementing Organisational and Cultural Change in Mental Health Services in Ireland

Contents

ACKNOWLEDGEMENTS

The path to Recovery can be, as we know, a long one. Furthermore, it is a journey that's best undertaken with friends. Thankfully in Ireland there has long been a community of similarly minded individuals who have supported each other in advancing Recovery ideals in our mental health services.

Many of the ideas contained in this document derive from the work of such passionate individuals. We are also indebted to ImROC and their leadership in the UK in setting out how such ideals can be realised into practical changes at a frontline level. Particular praise needs to be directed to the visionary aspect of Mayo mental health services in applying core Recovery concepts to develop their services. This early work has acted as a real model to the rest of the country and those involved in the early Recovery initiatives in Mayo have demonstrated real leadership in this regard. We are grateful for their ideas, their ongoing work, and its contribution to this document.

Similarly, ideas in this document derive from a process of reflection on the international literature and the learning from the experiences of the initial Advancing Recovery in Ireland sites i.e. West Cork, Mayo, Dublin South Central, Roscommon-East Galway, Cavan-Monaghan, the Mid-West, and Carlow-Kilkenny-South Tipperary. We have learnt from the experiences of each of these sites (and continue to do so) and are grateful to them for sharing their experiences and thereby helping to shape this document. Similarly the work of Advancing Recovery in Ireland would not be possible at all without the support of the National Mental Health Management team for which we are extremely grateful, or without the strong leadership of Tony Leahy in this regard.

Some of the proposed structures and processes described in this document would have been initially trialled in Roscommon-East Galway area (the REGARI site) e.g. the concept of helping build capacity through developing a large group forum – a 'Senate'. Some of these ideas were forged in vibrant conversations with those involved in the work of REGARI; special thanks to them for their contribution to our thinking.

Particular thanks must in the end go to the many, many service users and family members who have contributed (predominately in an entirely voluntary capacity) their thinking to this process. Their views have been crucial in shaping the thinking of this document and helping find the balance between suggesting a clear structure and acknowledging the need of every area to find, collaboratively, their own solutions to these challenges. We are grateful for the wisdom that they have shared with us.

June, 2016.

Executive Summary

Recovery is important to everyone. Individuals presenting at our mental health services seek support both for managing ongoing distress but also with building a future that is better – a future that involves 'recovery', both personal and clinical. The acknowledgement of this, along with recognising the immense expertise with which service users present (and those who support them), has driven the momentum towards developing "recovery-oriented mental health services".

Advancing Recovery in Ireland is the HSE national initiative aimed at bringing about the organisational and cultural change necessary to support our mental health services in becoming more "Recovery-oriented". This recognises the reality that true partnership between those who provide our services, those who use them, and those who provide support, invariably provides better outcomes than care driven by one party alone.

Utilising the best international models of organisational change the initiative has applied Kotter's (2007) widely used model on "Leading Change" in organisations, in conjunction with the HSE's own bespoke organisational change model ("Improving Services", 2008). The HSE model resulted from an extensive process of reviewing organisational models internationally and identifying the key elements of a successful change initiative. The HSE Systems Reform Group similarly promotes successful organisational change through a methodology "Benefits Realisation" that dovetails closely with the HSE model. The ARI model for organisational change is laid out in detail in this document and diagrammatically in Appendix II.

While internationally recognised models of organisational change provide a helpful overarching structure for a successful change initiative, the "how we should do it" of organisational change, the content of the process is invariably specific to the initiative itself. In terms of promoting a Recovery-focus, the ImROC methodology is a widely used model of cultural and organisational change for mental health services, with over half of all UK mental health trusts utilising this model. Consequently the ImROC 10 Organisational Challenges provide a helpful guide to "what we should do" when it comes to achieving successful change in these areas. These 10 challenges are described and interwoven into each phase of the organisational change process.

The ARI approach has sought to utilise the best of these models to design a programme that is pragmatic, bespoke to Irish services, and in keeping with best practice in organisational change. The four phases of this process are: (1) Building Capacity: This involves ensuring we have a critical mass of key stakeholders committed to working in partnership to promote recovery-oriented practices. (2) Recovery Planning: This is where, in each area, a guiding coalition of committed stakeholders collaboratively develop a practical plan for implementing change as guided by the ImROC challenges. (3) Recovery Actions: At this stage the organisation begins implementing the planned

changes and seeks opportunities for further developments. (4) Recovery Services: At this point the organisation focuses on embedding the new change and ensuring the key principles are institutionalised across all practices.

Furthermore, the ARI initiative is committed to undertaking an ongoing evaluation of its work in a way that helps continuously inform the process to maximise positive outcomes. We actively seek open dialogue and feedback from all our partners, as we work together to collectively make our mental health services more Recovery-oriented.

Finally, this document re-states the key principles which we feel lie at the centre of all good Recovery-focused services. This is to ensure that in the challenging process of organisational change we do not lose sight of the key values that drive this work.

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INTRODUCTION

"I believe it is a spirit of hope that gathers us here together today."

(Pat Deegan, 1991)

What are "Recovery-oriented Mental Health Services"?

Recovery itself has many definitions. Central to these is an individual's account of their own personal journey from distress to wellbeing. The literature surrounding Recovery tends to cover two areas; the process by which an individual journeys towards personal and clinical Recovery and the organisational or societal conditions that may facilitate their Recovery (Mental Health Commission, 2008). Recovery is not a linear process but instead involves a number of steps and goals combined with setbacks and advancements. As Recovery is essentially an individual process, what constitutes recovery will therefore differ amongst individuals depending on their goals, dreams and values (Mental Health Commission, 2008). However, our interdependent nature means that an individual's Recovery journey can be assisted or impeded by the organisational and societal structures they encounter. Supporting organisations in becoming more Recovery-oriented is, therefore, a crucial factor in supporting individuals in achieving their Recovery goals.

Recovery in practice can take many different forms. However, as originally outlined by the Devon Partnership NHS Trust (2012), in more Recovery-oriented services the following elements will be more clearly visible:

A positive attitude towards the concept of Recovery for all

- All levels of the organisation, thinking, behaving and talking in a way that actively promotes the Recovery agenda and embraces Recovery principles.
- Demonstrating passion and commitment to fostering and implementing Recovery practices through pragmatic actions to bring about change.
- An obvious striving to create a culture and atmosphere of wellness and optimism for all involved with the service.

A commitment to involving service users and those who support them at the heart of service delivery

- Ensuring that the voices of people using our services are heard in all major decision making forums within our organisation.
- Involving people further in the design and delivery of services that they use.
- Inviting people who use services to participate in staff appraisals.

- Ensuring there is appropriate training, remuneration and reimbursement of expenses for all experience-based contributors.
- Reviewing the costs and benefits of employing peer support workers.
- Encouraging people (e.g. through clear statements in job advertisements) with lived experience to apply to work within our organisation.
- Developing and implementing a carers' charter.
- Involving families and the supporters of people using our services wherever possible and appropriate. Adopting a "nothing about us without us" ethos as a guiding principle in this work
- Increasing voluntary and paid opportunities for experience-based workers in roles such as advisors, advocates, trainers and peer support workers.

Supporting and celebrating positive Recovery-oriented practice

- Celebrating examples of good practice.
- Valuing the contribution of staff who have experiences of using mental health Services.
- Empowering and supporting all staff to challenge behaviours and practices that are not Recovery-oriented (encouraging people not to turn a 'blind eye').
- Training all staff in basic Recovery principles and all clinical staff in recovery practice, skills development and understanding.
- Evaluating the quality of supervision and appraisal, and considering recovery focussed supervision.
- Supporting staff experiencing mental health difficulties.
- Valuing and learning from the personal experience of staff who have used mental health services and encouraging staff to use this in their daily practice.
- Equipping key staff to train, educate and develop skills in others.

Two of the most central Irish national policy documents in mental health, "A Vision for Change: Report of the expert group on Mental Health Policy" (Department of Health & Children, 2006) and the "Quality Framework for Mental Health Services in Ireland" (Mental Health Commission, 2007), promote Recovery as a guiding principle in terms of service development, delivery and evaluation.

Taking a lead from this guidance, more Recovery-oriented mental health services actively acknowledge the unique contribution that experiential knowledge can bring. National policy is increasingly moving away from an exclusive focus on maximising professional expertise to understanding the importance of combining professional competence with a valuing of people's lived experience and the valuable expertise that this brings. The combination of lived experience and the skills of mental health professionals can act as a channel for the attainment of positive outcomes vastly superior to that achievable by service providers or service users operating on their own.

RESEARCH INTO RECOVERY

Recovery is a complex, multidimensional construct and as such the research in this area has many strands. In crude terms, it can be categorised into two groups. The first is research related to the process of recovery and the individual's personal experience of this. The second is research that attempts to evaluate the clinical and cost effectiveness of particular Recovery initiatives (e.g. Peer Support Workers or Recovery Colleges).

In terms of the published literature on personal accounts of Recovery, Leamy, Bird, Le Boutillier, Williams and Slade (2011) conducted a wide-ranging meta-analysis and narrative synthesis of the qualitative and quantitative research to date. The papers examined all pertained to conceptualizations of personal recovery from mental illness. The framework developed by the authors identified 5 key recovery processes which comprise of: Connectedness, Hope, Identity, Meaning in life and Empowerment. These processes are referred to as the "CHIME Principles" (Leamy et al, 2011). The evidence-based framework identified in this meta-analysis provides an empirical basis for future research.

An additional large scale analysis of the large volume of personal accounts, Ralph (2000), identified four similar dimensions of Recovery. These broader themes included the importance of particular internal factors (insight, determination), self-managed care (how to live a fulfilling life in the face of adversity), external factors (interconnectedness, supports by friends and professionals), and empowerment (internal and external factors combined with interconnectedness and self-advocacy) (p 484). This findings of this analysis are reflective of the process identified by Leamy et al (2011), with each of the four dimensions identified by Ralph (2000) relatable to the CHIME principles.

In addition, we are now at a point where randomised controlled trials (RCTs) have been undertaken highlighting the value of a number of specific Recovery-oriented initiatives. Repper and Carter (2011) identified seven RCTs which demonstrated the positive impact of peer support workers across a range of clinical, subjective and social outcomes. Equivalent outcomes for peer support workers and professionals working in similar roles have been identified by a Cochrane review of 11 randomized trials, which utilised data from 2796 people in Australia, the UK and the USA (Pitt, Lowe, Hill, Prictor, Hetrick, Ryan & Berrends, 2013). Compared with current services, the employment of Peer Support Workers was associated with equivalent effectiveness, no additional harm, and there was some evidence that their employment reduced the use of crisis services.

There is also strong empirical support for the involvement of service users in their own care through Advanced Directives. These allow people to plan for how their health is managed should the loss of capacity for decision-making occur (Slade et al., 2014). Joint Crisis planning, in which a plan for managing crises is developed in conjunction with a clinical team, have similarly been evidenced by RCTs as being beneficial for people experiencing psychosis (Henderson, Flood, Thornicroft, Sutherby & Szmukler, 2009). The

research around Recovery-oriented risk planning indicated that joint crisis planning leads to less compulsory treatment (Henderson et al, 2004) and that more Recovery-oriented risk assessment approaches can reduce levels of seclusion and restraint in crisis services (Ashcraft & Anthony, 2008).

The evidence around 'Wellness Recovery Action Planning' indicates that it facilitates people to develop a collection of wellness tools which benefits their recovery (Cook, Copeland, Jonikas, Hamilton, Razzano, Grey, Floyd, Hudson, Macfarlane, Carter, Boyd, 2011). In a recent RCT, the WRAP programme has been show to produce positive outcomes across symptom profile, subjective experiences of hope and quality of life when compared to the control group (Cook et al., 2011). Illness Management and Recovery (IMR) is an empirically based intervention which teaches self-management strategies techniques to people experiencing mental illness (Mueser et al, 2006). RCTs have evidenced the positive impact IMR has had across outcome measure such as functioning, symptom profile and goal setting (Levitt, Mueser, Degenova et al, 2009).

There is also strong support, in the form of 4 RCTs, for the efficacy of the Strengths Model of Case Management (Bird et al, 2012). This model facilitates individual goal setting and attainment by moving towards a focus on the individuals existing and potential personal and environmental resources. In addition, there is now a considerable body if evidence to support the positive impact of 'Individual Placement and Support' which facilitates people who are experiencing mental illness, in sourcing, attaining and maintaining employment. A Cochrane review of 18 RCTs showed this methodology to be effective in supporting people to make the transition to paid employment (Crowther, Marshall, Bond et al, 2001). Supportive Housing, whereby people are facilitated in living independently in safe and permanent accommodation, is another recovery based initiative which has been evidenced by research as being correlated with improved outcomes (Padgett, Gulcur, Tsemberis, 2006).

Furthermore, in assessing the benefits of Recovery Colleges (a setting where service providers and users co-produce and deliver a range of courses) non-randomised studies have found that 70% of students go on to mainstream education, employment or volunteering (Perkins, Repper, Rinaldi & Brown, 2012), there are significant improvements in friends, social support and social roles as well as significant reductions in use of community services e.g. CMHTs (Perkins & Slade, 2012). This is in keeping with broader literature on self-management of chronic conditions which has demonstrated the clear utility of such approaches (e.g. Norris et al. 2001).

In conclusion, there is a significant and growing volume of high quality qualitative research relating to the personal experience of Recovery. The quantitative research also reports encouraging findings and is developing from an initial base of uncontrolled, prospective cohort studies to increasingly include a significant number of RCTs. Therefore, while additional research will continue to be required, there is a clear positive trend towards an emerging evidence base for specific Recovery initiatives being

clinically and economically effective. It may finally be worth noting that there is some research (Andresen et al, 2010) that illustrates that outcomes traditionally emphasised by service providers (e.g. symptom reduction) may not always be associated with Recovery outcomes prioritised by service users (e.g. quality of life – see Shah et al, 2014), thus highlighting the importance of ongoing evaluations encompassing both.

OVERARCHING MODELS OF ORGANISATIONAL CHANGE

The Advancing Recovery in Ireland initiative has sought to use the best models of organisational change and the best models of promoting Recovery in devising its strategy.

Consequently it has utilised the Kotter (2007) and HSE (2008) models of organisational change, along with the ImROC (Sainsbury Centre, 2010) methodology on fostering Recovery practices, to guide the development of a model of change that would be appropriate to the Irish context.

KOTTER AND ORGANISATIONAL CHANGE

- ***Establish a Sense of Urgency***

For Kotter, it is in this initial stage that many organisations will fail. Reasons for failure may stem from executives underestimating how difficult it may be to bring people out of their comfort zones.

- ***Form a Powerful Guiding Coalition***

Kotter refers to the point that in successful transformations, the support of the chairman, president, or general manager as well as an additional 15 or 50 people is necessary in order to foster a shared commitment to the renewal of services.

- ***Create a Vision***

Without a vision for where the organisation is going, the support of staff or senior team members may be hard to attain. A vision for an organisation may initially be quite simple, perhaps blurry, but with work and discussion amongst the team a more focused plan will emerge and it may take 5, 6 or 12 months for an organisation to refine their vision, but the end product will result in a distinguished plan, as well as a strategy for its achievement.

- ***Communicate the Vision***

Developing a vision requires time, discussion and imagination. However, a vision that is poorly communicated will inevitably plummet and fail.

- ***Empower Others to Act on the Vision***

Kotter notes the importance of empowering those who are prompting change with the necessary authority to achieve it. Every obstacle will not be challenged in the beginning, as services do not have the power or time to tackle each one, but any major obstacles should be challenged with the backing of senior figures within the organisation.

- ***Plan For and Create Short-Term Wins***

Transformations take time so it is crucial that organisations have short-term goals that they can celebrate once met. Short-term wins reignite momentum and add pride to the efforts of those involved in the change movement. Credibility will be established and efforts to further accommodate the change process will be rejuvenated.

- ***Consolidate Improvements and Produce More Change***

Kotter encourages using the credibility from the successes of short term goals to drive momentum to tackle more challenging obstacles. He cautions against declaring victory too early (Kotter, p 130).

- ***Institutionalise New Approaches***

This is only achieved when finally change becomes embedded into “the way we do things around here” (Kotter p 130).

HSE CHANGE MODEL

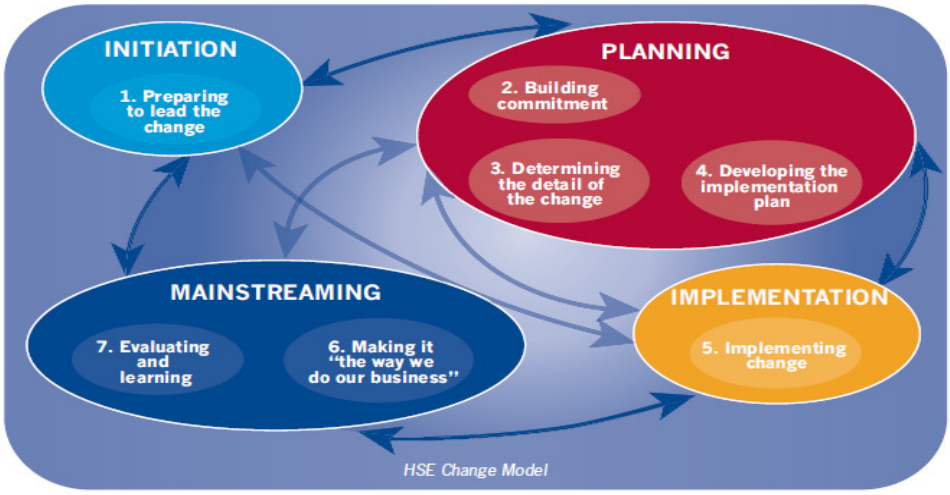


Figure 1: ***HSE Change Model (2007)***
Model adapted from: Kolb, D. and Frohman, A. (1970), Huse, E. (1980), Neumann, J. (1989), Kotter, J.P. (1995), Ackerman, Anderson, L. and Anderson, D. (2001), McAuliffe, E. and Van Vaerenbergh, C. (2006), and Project Management Institute (2004)

The HSE Change Model (2008) is based on a comprehensive review of international best practice in organisational change. It noted that a common misconception is that change is a linear process, steadily improving as time goes on. It argues that instead, organisational change generally does not work in a linear fashion, and usually consists of a number of setbacks and achievements intertwined, and fundamentally depends on the people within the organisation changing too. It noted that people's initial reactions to change may be influenced by a number of issues including concerns over what change means for them personally, complacency or attachment to the way the service is ran as well as the quality of interactions between management, staff and trade unions. Resistance to change should be viewed seriously and as Kotter (2007) mentioned – trying to avoid or rush the phases where uncertainty exists may only lengthen its duration. The HSE Change Model outlines four stages of the project management lifecycle:

Initiation
During initiation the key groups and people directly impacted upon by the change, or who are essential to carrying it out, should be identified. Issues such as the degree of urgency, instigators for the need for change, readiness, capacity for change and what the initial objectives will be should be discussed in this stage. Organisations are therefore advised to create a business case for change.

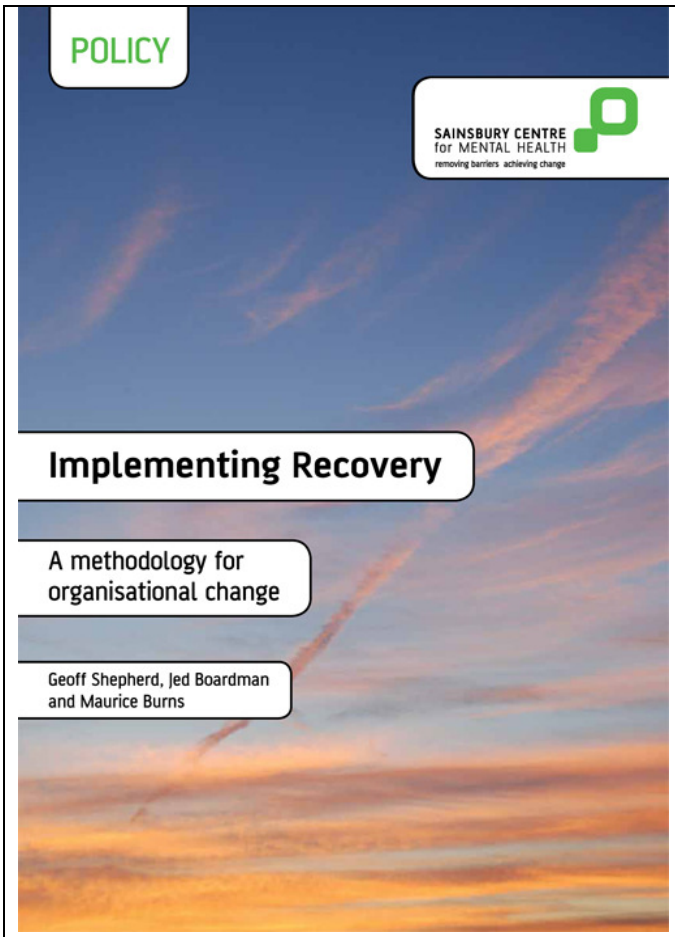
Planning
The planning stage focuses on the specific details of the change. Key elements here are the building of organisation-wide commitment, momentum and capacity for change. Participation and engagement are emphasised as is communicating the plan and the implications for effectiveness. This stage provides a roadmap for implementation.

Implementation
The next stage focuses on implementing and monitoring the project plan. Key to this stage is the careful monitoring of whether old practices are continuing or if new ones are being utilised. Flexibility in adapting the implementation to changing circumstances and in response to feedback on implementation take-up is also stressed.

Mainstreaming
During this stage, there is focus on highlighting successes as well as integrating and sustaining new ways of working. Reflection and learning from the process provides a solid basis for continuous improvement.

THE IMROC MODEL OF RECOVERY-FOCUSED ORGANISATIONAL CHANGE

The Implementing Recovery through Organisational Change (ImROC) programme has established "10 Key Challenges" to guide organisations is developing more Recovery oriented mental health services. The challenges provide a roadmap for organisational changes as well as a means of measuring progress in these areas. They promote active engagement with services around identifying barriers to organisational change and supporting services in overcoming these by conducting workshops and "Learning Sets". "Learning Sets" are events which combine informative presentations with services coming together in a mutually supportive environment to discuss achievements and setbacks. The ImROC methodology is used in well over half of all English Mental Health NHS Trusts.



Implementing Recovery through Organisational Change (2008) – The 10 Key Challenges

1. **Changing the nature of day-to-day interactions and the quality of experience.**
2. **Delivering comprehensive, 'co-produced' learning programmes.**
3. **Establishing a 'Recovery Education Centre' to drive the programmes forward.**
4. **Ensuring organisational commitment, creating the 'culture'.**
5. **Increasing 'personalisation' and choice.**
6. **Transforming the workforce.**
7. **Changing the way we approach risk assessment and management.**
8. **Redefining user '*involvement*' to create genuine '*partnerships*'.**
9. **Supporting staff in their recovery journeys.**
10. **Increasing opportunities for building a life 'beyond illness'.**

Bringing about Organisational and Cultural Change: An ARI 4-Stage Approach

The Advancing Recovery in Ireland approach

The Advancing Recovery in Ireland initiative has taken the most helpful and applicable elements of the best evidence-based programmes on organisational change (Kotter, HSE & ImROC) and applied them to the task of promoting organisational change in Irish mental health services (see Appendix II for how the ARI Model links directly with the models of change outlined above). Consequently the ARI model is bespoke to the Irish context. The model consists of four clear stages while acknowledging that organisational change is not a linear process, i.e. the work of the earlier stages (such as capacity building) will continue apace even when engaged in the tasks of the later stages. The four key steps of this process are:

1. Capacity Building
2. Recovery Planning
3. Recovery Actions and
4. Recovery Services.

The following section of this document will discuss the importance of each of the steps in more detail, as well as providing practical guidance on how best to implement this process at a local level.

STEP 1: "CAPACITY BUILDING"

"Everyone I've introduced to ARI has taken to it. And that's because they've been asked their opinion, felt heard and seen people actually do something about it!"

E. M. (Service User)

Stage One: Key Tasks

1. **Publicise the work widely and develop partnership networks.**
2. **Appoint a Project Lead and Co-Lead**
3. **Develop a Recovery Committee**

Stage One: Key Concepts

- **Building Capacity**
- **Establishing a Guiding Coalition – A "Recovery Committee"**
- **A local communication strategy on Recovery. "Why Recovery Matters".**

- *Building Capacity*

"Capacity Building" is fundamentally about developing a network of partnership relationships. In these relationships service providers work as equals with service users/family members in improving our services. In certain areas, well established service user and family member groups will be in existence, with whom you can link. In other areas, the process may need to start with raising awareness of Recovery principles and publicising the eagerness of mental health services to have input from those who use the services. Similarly, on the service provider side, capacity building is about raising awareness of how Recovery principles could translate into changes in everyday practice. Success in this process can be defined by how many service providers define Recovery in vague aspirational tones versus how many refer to concrete actions that could occur locally that would make the service more Recovery-oriented. Where this has been successful "Recovery champions" naturally emerge and seek to influence the process.

- *Establishing a Guiding Coalition – A "Recovery Committee"*

Recovery Committees are typically composed of engaged service users and family members, service providers in senior and 'frontline' positions in the organisation, and often representatives from community or academic groups with expertise in Recovery. Importantly, they receive their mandate for engaging in change directly from the Area Mental Health Management Team, to whom they report.

As outlined above, an initial stage of organisational change can involve forming a powerful "guiding coalition" which can bring together key stakeholders and be a forum where "Recovery leaders" can emerge. Ideally Recovery Committees will consist of individuals from across different levels of seniority in the organisation, as well as having strong input from the service-using and family member carer groups. In this regard it is important to find individuals on the Recovery Committee who both have some authority to implement change but who will also embody the values of the vision for change.

- *A local communication strategy on Recovery. "Why Recovery Matters".*

Why does 'Recovery' matter? Hopefully, an established Recovery Committee will already have attended to this question in some fashion during the formation of the group. However, it is vital that the group formulates a clear, concise explanation of why Recovery matters. This will allow them to communicate this message consistently to important stakeholders. In Slade's (2009) document "100 ways to support recovery", he mentions a number of points which service providers can utilise in order to communicate the importance of Recovery locally.

In essence, a core task of the Recovery Committee will be to utilise all means of communication to ensure that the greatest proportion possible of the service-using and service providing populations know about this local initiative and that they are invited to become involved.

Implementation Guide 1: Choosing A Project Lead and Co-Lead

The choice of a Project lead (service provider) and Co-lead (service user/family member) is an important one, as well as ensuring they have protected time in which to lead on this work. It is important that the ARI recovery committees model the kind of structures and culture we hope to develop across the service. The lead need not necessarily be from any particular discipline, or particular background, but the following criteria would be considered desirable in their choice.

- **Good understanding and commitment to Recovery**
- **Credibility with colleagues (service using or service providing community)**
- **Position of influence within the organisation (project lead)**
- **Connections with the service-using community (project co-lead).**
- **Team working and collaborative skills**
- **Leadership skills**
- **Links with broader voluntary and community groups.**
- **High level communication and interpersonal skills**
- ***Availability of dedicated time to give to the role.***

Positive Practice 1: The East Galway-Roscommon Senate

Developed by the East-Galway and Roscommon Recovery Committee the Senate was developed as a means of allowing the community of service users and family members to debate, as equals, with service providers on the organisational challenges this area should prioritise.

The Senate consists of representatives from the local service-using community, family members, voluntary, academic and charitable organisations and HSE staff.

- **The first Senate heard presentations of all 10 IMROC organisational challenges and then voted on which 3 challenges this area should prioritise.**
- **3 working groups were then formed that co-produced proposals in each of these 3 areas.**
- **These proposals were debated and voted on in the second meeting of the Senate and successful proposals brought to the Area Management Team for consideration.**

The Senate continues to be…

- **A highly representative large group forum which debates and votes on the major initiatives to make mental health services more Recovery-focused locally.**
- **It includes service users, service providers, family members, carers and voluntary organisations from every sector in the region, meeting as equals in this forum.**
- **It meets 2-3 times a year.**
- **It is one of the key decision-making forums of the local "Advancing Recovery in Ireland" project and, as such, decides which key initiatives are prioritised.**
- **It is one of the few fora nationally in which the local community is able to have a strong voice in influencing the direction that the mental health service takes.**

STEP 2: "RECOVERY PLANNING"

"We developed a plan that costed up everything, from the furniture, to the time of Admin and other staff. Having it all clearly on paper showed that we were serious about making this happen"

A C (Service User)
on the Business Plan for the Recovery College

Stage Two: Key Tasks

4. **Create a Vision of the service desired**
5. **Choose 3 organisational challenges to advance this vision**
6. **Develop credible business plans for advancing these three areas.**

Stage Two: Key Concepts

- **Partnership in action: Co-creating a Vision of 'What we want our services to be like'.**
- **Collaboratively choosing the first key Recovery challenges. Knowing where to start.**
- **Co-designing credible business plans for change.**

- *Partnership in action: Co-creating a Vision of 'What we want our services to be like'.*

To develop Recovery-oriented services, first of all it's important to have a vision of what this may look like. Having a shared vision is crucial in ensuring that everyone is putting their energy towards achieving the same goals. This may be challenging as it can feel like there is a lot of different directions a service could go in and many different models that could be used. Consequently, spending some time together is vital in developing a vision that everyone on the committee, and those who need to support their work, can sign up to.

What some Recovery Committees have found helpful in the regard is to break the task down into 'scoping, summarising and presenting' and having a set time-frame in which to achieve this. "Scoping" simply refers to members taking responsibility for finding out what is going on elsewhere. Literature searches, visiting neighbouring services and using pre-existing professional and service user networks can be helpful. "Summarising" refers to reducing this large body of information into a small number of key examples that can be shared with the committee. "Presenting" is simply the process of communicating to the committee, and potentially to important external stakeholders, the findings. As always, engaging in these processes in a joint, co-produced fashion helps model Recovery principles to all.

Finally, it can be helpful if the vision of the type of the desired services is written down in a simple, easily comprehensible fashion that can be broadly shared.

- *Collaboratively choosing the first key Recovery challenges. Knowing where to start.*

The choice of the organisational challenges with which to commence should be informed both by the passion for change in this area (organisational commitment) and what's feasible in the short and medium term (the pragmatic capacity of the organisation to make these changes).

The passion for change commonly comes from the powerful voice of service users and family members being explicit about what they need from their services. When supported by key individuals within the service, this provides a powerful coalition for change that can be highly influential. Consequently one core element in this stage of the process is identifying and communicating what service users and their family members are stating that they need (exercises such as that engaged in by the Enhancing Teamwork process or the Listening exercises by the Office of Service User engagement, can be helpful here).

The second, and equally important, part of this process is the voice of the service providers who have a good sense of what types and level of change may be possible both right now, and in the medium-term. Their input is vital in helping the committee "pitch" for the level of change that both maximises the value for service users and family members and is achievable by the group. Commonly the advice will be that certain features of change may be eminently achievable immediately and others may require a longer-term strategy.

- *Co-designing credible business plans for change.*

Once the organisational challenges being prioritised have been identified, then the service may wish to consider how best to progress the development of business plans in the relevant areas . A common strategy has been to establish key working groups for each challenge identified and to set a timeframe for the group to report back its proposals. Commonly the stages are:

- Forming a working group (with adequate membership from the key stakeholders).
- Agreeing terms of reference and a work plan for the set period.
- Scoping best practice elsewhere.
- Formulating multiple proposals for advancing practice locally.
- Agreeing which proposals seem most feasible.

- Development of a small number of key proposals (in the form of a business plan including associated costs, benefits and method of evaluation).
- Communicating these to the Recovery Committee.
- Recovery Committee communicating these to the Area Management Team.

Implementation Guide 2

Key Features of a Recovery Business Plan

- **Vision: Clear vision and outline of the service development involved.**
- **Benefits: Clear depiction of Recovery-oriented potential benefits.**
- **Policy: Clear links with local and national policy objectives.**
- **Challenges: Noting potential challenges and how they may be overcome.**
- **Plan: Clear steps of implementation**
- **Costs: Clear costing and resource implication**
- **Evaluation: Clear plan on how the benefits of the project will be evaluated.**
- **Buy-in: Indication of required stakeholder buy-in and partnership arrangements**
- **Sponsorship: Outline of the support of key sponsors (e.g. Area Manager).**

International Example

The Audit Tool from "Implementing Recovery through Organisational Change" (UK)

The imroc paper:

Shepherd, Geoff, Jed Boardman, and Maurice Burns. "Implementing recovery." *A methodology for organisation change. London: Sainsbury Centre for Mental Health* (2010). Accessible at http://www.imroc.org/wp-content/uploads/Implementing_recovery_methodology.pdf

provides a helpful guide to auditing your service from a Recovery perspective. It lists their 10 Recovery organisational challenges and suggests that you rate your service on each of these challenges according to a 3-stage model i.e. 'Stage 1 = Engagement', 'Stage 2 = Development' and 'Stage 3 = Transformation'. It provides a helpful framework and comprehensive guide to undertaking this initial rating.

Positive Practice 2:
When exploring the possibility of employing peer support workers, plans were developed that encompassed many of the key features of an influential business plan.

Business Plan for the Employment of Peer Support Workers

Introduction

- What are Peer Support Workers?
- What are the benefits of Peer Support Workers?
- What are the Challenges Inherent in Employing Peer Support Workers?
- What has been the experience internationally of Employing Peer Support Workers?
- What is the Irish National Policy context around employing Peer Support Workers?

Business Proposal

- The regional context: Recovery initiatives in this region.
- The quantity and the proposed role of employed PSWs.
- How we feel they will add value and meet service needs in our local regions.
- How we intend responding to the challenges highlighted above of employing Peer Support Workers: Preparatory work.
- The phased timetable around the employment of Peer Support Workers in our region.
- The process of evaluating the impact of Peer Support Workers in the service.
- The Financial implications of this proposal

Conclusion

- The key elements of this proposal in brief.

STEP 3: "RECOVERY ACTIONS"

"Helping create a Recovery College has been one of the most positive things I've been involved in, in my time in mental health services"

O.D. (service provider)

Stage Three: Key Tasks

7. **Commence implementation of agreed plans.**
8. **Ensure all parts of the service are getting at least some training in Recovery.**
9. **Publicise short-term wins and commence work on longer-term goals.**

Stage Three: Key Concepts

- **Taking time but maintaining momentum**
- **Empowering the right groups to bring about changes**
- **Planning for short-term wins and long-term challenges**

- *Taking time but maintaining momentum*

Refocusing a team to work within a Recovery oriented model will take time. Although a sustained sense of urgency is required as an initial catalyst in bringing about change within an organisation, the levels of urgency will naturally fluctuate – the crucial factor is that a recognition of the importance of this work continues to exist. Individuals who are neither convinced nor against the proposition of a recovery-focused service will await initial results before making their mind up about the benefits or challenges associated with such a change. "Change initiators" and "change resistors" will be influenced by the results in deciding whether their stance continues to be credible. As mentioned further below, short-term wins aid in sustaining momentum and motivation in both the Recovery Committee's work as well as in influencing potential stakeholders and other group members' ideas about the initiative. It is crucial, however, that organisations recognise the importance of time in the process. Many organisations may have been through significant reconfigurations in the recent past and are just coming to terms with these changes. In this regard, Julie Repper (2014) noted that in some respects the organisation itself may have to recover and as you would not rush the recovery of an individual you should not rush the recovery of the organisation. Developing a pace of change that is sustainable (and doesn't falter at the first sign of difficulty or distracted by other demands) is a crucial challenge for those driving the change.

- *Empowering the right groups to bring about changes*

While the Recovery Committee will lead on overseeing Recovery initiatives, much of the transformation on the ground may be led by other groups e.g. specific care teams, or specific centres, or specialist working groups set up to advance a project (e.g. a Recovery College working group). In this regard the function of the Recovery Committee is to ensure the *right group* is leading on the change (e.g. changing practice in an acute unit may need to be led by the acute unit's own governance group rather than an external group attempting to impose change) and that they *inspire and enable* this group to bring about the change. Making the case persuasively for Recovery practices helps "inspire" the motivation for change and providing practical guidance (e.g. by linking the group in with similar change initiatives elsewhere or national guidance) can help "enable" the change.

- *Planning for short-term wins and long-term challenges*

Any change process should never underestimate the need to see returns quickly on the effort and energy expended. Enthusiasm and energy quickly turns to cynicism and fatalism in those who feel their efforts have been rejected or were in vain. Consequently a core task is for the Recovery Committee to identify at least one obvious, practical change that they can easily achieve in the first 12 months and that they can point to as a demonstration of the success of the project. There are many aspects of Recovery-oriented practices that require no additional resources and which are broadly agreed with (e.g. empowering service users to play a greater role in their care through providing more information or by involving family members). Having methods to evaluate the benefits of any initiative can be crucial in providing concrete evidence to others of any benefits arising.

As short-term gains are achieved, the process can gain more credibility and commence to tackle more challenging issues. Again having a clear vision of what is desired and a pragmatic grasp of the obstacles involved, allow a greater number of people to believe in the process and to become interested in advancing the longer-term goals.

Implementation Guide 3

What is a Recovery College? Outline of a Recovery College Introductory Course

<table>
<tr><td>Title:
Length:
Duration:</td><td>What is a Recovery College?
1 session
2 ½ hours including breaks</td></tr>
<tr><td>Aims:</td><td>The aim of this session is to explore and discuss some key components and the character, nature and ethos of the Recovery College Concept.</td></tr>
<tr><td>Intended Learning outcomes:

Each outcome corresponds with a learning task associated with the indicative content below.

Co delivery requires a balance of emphasis on personal and professional understandings</td><td>At the end of the session the group will have begun to:

1. Distinguish and differentiate a Recovery College from a conventional college or place of education.
2. Deliberate on the role and value of education as a recovery tool.
3. Discuss some basic definitions of Recovery.
4. Consider the key Recovery College constructs of Hope, Control and Opportunity.
5. Be introduced to the key concepts of co-production and co-delivery
6. Understand the basic application and enrolment process.
7. Consider some basic functions of the RC.
8. Discuss some design features of the RC
9. Discuss the structure of the curriculum and the learning areas described</td></tr>
<tr><td>Indicative course content:
<u>Delivery notes</u>:
The pedagogical aim of the session is to present professional, factual and theoretical understandings that elicit and provoke personal narrative understandings and commentary on recovery at a level of analysis and evaluation</td><td>
<table>
<tr><td>Learning Tasks</td><td>Information, Knowledge and Narratives from lived Experience</td></tr>
<tr><td>1.</td><td>Exposition of 3 typical features of a conventional educational establishment and treatment of unique Recovery College features.</td></tr>
<tr><td>2.</td><td>Description of and analysis of the Recovery positive benefits of education</td></tr>
<tr><td>3.</td><td>1-2 established definitions of Recovery discussed.</td></tr>
<tr><td>4.</td><td>Examples of Hope, Control and Opportunity identified and contextualised in the Recovery College</td></tr>
<tr><td>5.</td><td>Demonstrated examples of co-delivery and co-production</td></tr>
<tr><td>6.</td><td>Description of process</td></tr>
<tr><td>7.</td><td>Discussion on location and anticipated effects of the RC</td></tr>
<tr><td>8.</td><td>Treatment of Hub and Spoke construct and Pop-Up College idea.</td></tr>
<tr><td>9.</td><td>Description of prospectus, terms, sessions and schemes of work</td></tr>
</table>
Questions and answers
</td></tr>
<tr><td>References:</td><td></td></tr>
<tr><td>Session plan by:</td><td></td></tr>
<tr><td>Date</td><td></td></tr>
</table>

Positive Practice 3

The Mayo Recovery College is in its third year of operation. Since opening its doors to students in February 2014, it has enrolled over 220 students with a variety of over 20 courses offered including topics such as "*Understanding psychosis"*, "*What is recovery?*" and "*Making the most of your doctor's appointment*". The courses take place in the local third level institution the Galway and Mayo Institute of Technology, where Recovery college students have access to everyday college services such as a student card and the college library. All courses are co-produced and students include all stakeholders groups (Service Users, Family and Service Providers). An accredited Peer Support Working training module is also available at the MRC.

STEP 4. MAINSTREAMING CHANGE: MAKING IT STICK- "RECOVERY SERVICES"

"The real task is to end up with a service that you'd be happy for your family, your loved one or yourself to receive. Because any of us, at some stage, may need this service"

E. B. (Service User)

Stage Four: Key Tasks

10. Support newly established initiatives.
11. Audit all aspects of the service from a Recovery perspective.
12. Build in self-sustaining audit and reward mechanisms for promoting Recovery.

Stage Four: Key Concepts

- **Consolidating improvements and working on new changes.**
- **Embedding the core principles in every aspect of service delivery**
- **Development of mechanisms to highlight and reward progress and achievements.**

- *Consolidating improvements and working on new changes.*

It is a truism that half of all businesses fail within the first 5 years (Headd, 2003) and similarly as pointed by Kotter (2007), a large proportion of major change initiatives in organisations similarly do not succeed. Kotter emphasises that one source of failure is that of claiming success too early and putting insufficient resources into consolidating new initiatives. Systems commonly default to the traditional and more familiar ways of functioning if not provided with ongoing support to maintain new practices.

In this regard, maintaining a Recovery committee, beyond the initial establishment of a project, can be helpful in providing ongoing support and to ensure regular review and audits of the projects progress. Having ongoing deadlines for reporting back to senior management can be helpful in keeping momentum at a local level while reminding senior management of the importance of their ongoing support. Similarly formally acknowledging and celebrating anniversaries (the first year of a Recovery College, an annual review of our new risk policy, one year into our family liaison project etc) can be a way of reinvigorating the projects as well as identifying challenges before they prove seriously detrimental.

- *Embedding the core principles in every aspect of service delivery*

Another significant challenge is when Recovery initiatives become split-off from "business as usual". This can occur when a small cohort of enthusiastic service providers and service users, family members take exclusive ownership of the initiative with it being associated solely with this group. Again leaders in the Recovery Committee and on

the Area Management Team may have a role in helping successful initiatives "give Recovery away" to the broader groups of those who use and provide mental health services. This may involve practices such as ensuring all service providers at some stage co-produce a course in the Recovery College or work alongside a peer support worker or help co-produce a new policy document. Having "Engaged in a Recovery Initiative" as an element of every service provider's appraisal could help facilitate this. In parallel, the aim of the service should be to increasingly ensure that all service users and family members are aware of and facilitated in engaging in partnership working in promoting Recovery practices. Similarly at a senior level, ensuing that in every management and governance meeting there is a standing item on "Advancing Recovery Practice" can help ensure that progress continues sustainably in these areas. Finally, entrusting key individuals (e.g. project lead and co-lead) in engaging in an annual service-wide audit of Recovery practices can help highlight areas of deficit as well as areas in which progress is being made.

- *Development of mechanisms to highlight and reward progress and achievements.*

It remains well documented in organisational psychology that acknowledging and rewarding individuals for positive practice is the single most powerful way of ensuring safe and positive practices in healthcare (cf: Leape, 2013). While audits tend to result in actions around the highlighted deficits, the real value of such work may lie in providing the opportunity to acknowledge positive practice and thereby copper-fasten it in place. It may be helpful, therefore, for services to consider formal (e.g. publicising in newsletters) and informal methods (e.g. personal phone call of appreciation by senior managers) of acknowledging positive practices when they are identified. Leaders in this process may actively seek opportunities to publicise progress made and to thank those who have contributed to it. Similarly service users and family members who contribute time and effort should receive, not only appropriate remuneration for their input but also formal thanks by senior service providers in the organisation acknowledging the value that such work has brought to the service. This may be an area that is relatively straightforward to organise (e.g. ensuing a phone call of thanks is made) but can, very commonly, be neglected to the detriment of the whole process.

Implementation Guide 4:

Putting Recovery into Every Plan: The Team Recovery Implementation Plan (TRIP)

Having practical tools to assess and guide Recovery oriented practice in our teams is invaluable. The "TRIP" is an example of one such tool.

Description of TRIP:

The Team Recovery Implementation Plan is described as a tool for successfully embedding recovery ideas and practice into the day-to-day work of individual teams.

This requires two parallel processes:
1. Empowering teams (their staff and people using services) to translate abstract ideas about recovery into practice.
2. Utilising the skills and resources of everyone at the front line (staff and people using services) to develop innovative ways of promoting recovery and recovery environments.

Available free from the ImRoc website:

www.imroc.org

Positive Practice 4:

The Kilkenny Recovery Nurse Practitioner

The Carlow, Kilkenny and South Tipperary Area Management Team have made a strong commitment to fostering and further developing Recovery practices in their area.

Their commitment was further seen when at the beginning of November 2014 a Nurse Practitioner was appointed with lead responsibility for developing Recovery-orientated initiatives on the inpatient ward in Kilkenny Acute Unit. The nurse is an additional staff member who complements the regular Acute Unit team. Her role includes the development and delivery of co-produced 'Recovery education' workshops for patients and staff as well as offering protected time to engage in personal recovery planning for those individuals using the services of the Acute Unit. Having specialist roles, at the heart of service provision, for advancing Recovery principles, is one key way of ensuring Recovery-oriented practice sustainably becomes "how we do business around here".

Implementation Guide 6

Considerations when seeking to evaluate a Recovery initiative

1. What are we trying to achieve?
2. What has been done in this area before?
3. Who can help us in designing an evaluation process?
4. How are we going to measure progress on this?
5. Who is going to measure the progress?
6. Who is going to collate the results?
7. Who needs to receive feedback on our progress?
8. How can we ensure that the results give rise to learning and meaningful change in a cyclical process?

Implementation Guide 6

Considerations when auditing the Recovery-orientation of a service

Engaging and empowering service users and family members

- *How is lived experience incorporated into service design and delivery?*
  I.e. Are service users and family members consulted on service design or service development initiatives? (If not, how might they be consulted?)

- *Are there structures within or external to the service to support engagement with service users and family members?*

- *Are service users and family members provided with the necessary training and information to empower them to work collaboratively with the service?*

Engaging and empowering service providers

- *Do all service providers within the service have a sufficient understanding of recovery, and its relevance to their role?*

- *What training or support have they received?*

- *What further training or supports might be required?*

- *How, and by whom, should it be provided?*

Transforming services

- *What are the key challenges and priorities that the service faces in becoming more recovery oriented?*

- *What will help continuously challenge us to keep making progress in this area and not 'settle' for the status quo?*

- *How do we collectively translate challenges into action plans that will make a meaningful difference? Who do we need on board? What has worked before?*

A Learning Process

Organisational change, as with an individual's Recovery, is very much a journey. The Advancing Recovery in Ireland process promotes ongoing learning in two ways. The first is by monitoring and evaluating the *hard evidence* of change. This involves determining at set periods whether services are meeting 'Key Performance Indicators' (e.g. the appointment of a service user on their Area Management Team) but also by supporting an external evaluation process which is looking at change over time across key variables (e.g. service providers' knowledge of Recovery principles). Incorporating this information in an ongoing PDSA ("Plan-Do-Study-Act") review process can bring real benefits. Similarly, building in ongoing methods of evaluating a project's progress and any benefits arising is crucial to learning and sustaining any recovery initiative.

The second method, however, is through the ongoing promotion of a reflective process among key champions of change as to what they feel is working locally and what is not. This is crystallised in ARI quarterly Learning Sets where we bring together Recovery Committees from across the country to share together their expertise. We also ask the Committees to discuss and review on an annual basis their experience of promoting Recovery. This reflects our commitment to the Recovery principle of valuing the lived experience of people engaging in a process of change (both service providers and service users, family members) as ultimately we feel that it is their expertise, working in partnership with their Area Management Teams, which will provide the key solutions to local challenges. It is also an acknowledgement that change is not a linear process and unless we reflect upon and learn from local experiences then our capacity to implement real change will always be limited.

Some of the learning acquired in the roll-out of this work in the original seven sites (e.g. Watts & Higgins, 2015) has included highlighting the importance of:

- Senior Management and Senior Professionals within the services supporting the initiative and the development of a strong working relationship between them and the local Recovery Committee.
- The development of a strong, empowered service user and family member voice in co-creating this process.
- The importance of good communication and co-ordination of the different elements of the work.
- Inclusion of all disciplines and services (e.g. acute and community).
- A recognition that Recovery principles are applicable to all stakeholder groups (service users, service providers, family members) and to the organisation itself.
- A commitment to a reflective, iterative process of examining what is working and not, and adapting the approach to meet local needs and strengths.

In the spirit of the latter point, we remain committed to learning from service users, service providers and family members on how we can best advance Recovery in Ireland.

Conclusion: Key Principles and Values

We acknowledge that in engaging in any organisational process there can be a danger that by focusing exclusively on the specific challenges of implementation we can lose sight of the core values that drive this process. We believe that when making difficult decisions in complex organisations then invariably some compromises will need to be made. In making these compromises, it may not always be clear whether one is advancing Recovery principles by being pragmatic and moving slowly or whether one is damaging Recovery practice by compromising too much on core values. We do not believe there is a simple answer to this. We do believe, however, that returning repeatedly to some of the core principles of Recovery can help aid any decision-making process and provide guidance on whether any change initiative is indeed worthwhile.

The Principles of Recovery

- Building a meaningful and satisfying life, as defined by people themselves
- Enabling and supporting people to become active in taking responsibility for decisions about their life, their care and the services they use
- Focusing on strengths, solutions, health and wellness
- Working with people to identify and support progress towards their personal ambitions and goals
- Inspiring hope for the future; sometimes holding hope for people when they are unable to hold it for themselves
- Developing relationships between professionals and people using our services which is based on mutual respect and partnership working
- Enabling people to take on meaningful, satisfying and valued social roles and relationships, and to take advantage of opportunities to participate in local communities
- Supporting the wellbeing of staff and cultivating their capacity for hope, creativity, compassion, realism and resilience
- Including family and other supporters as partners in people's recovery wherever possible
- Adopting respectful, non-stigmatizing and clear language in all of our communication

Devon Partnership NHS Trust (2014)

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Appendix I: SAMPLE AUDIT TOOL* : Key Performance Indicators

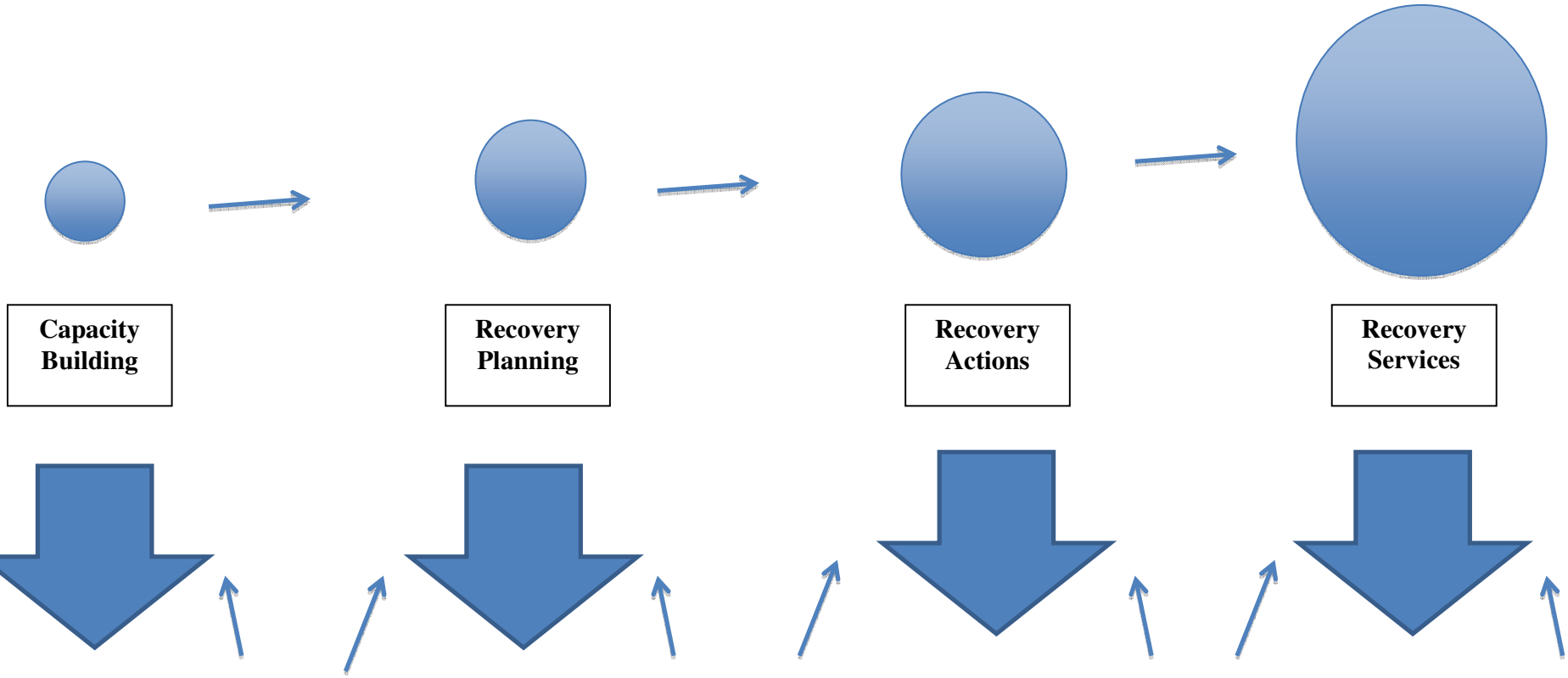
Phase	Domain	KPI	Yes	No
Capacity building	• Stakeholder engagement	1. Did the key stakeholders consisting of the Area Management Team, Service User and Family representatives and local Community groups all agree to engage in the ARI process?		
	• Recovery Committee established	2. Has a Recovery Committee been established with a mandate from the Area Management Team?		
Recovery planning	• Three key organisational challenges chosen	3. Were three recovery-orientated organisational challenges identified and agreed upon by stakeholders?		
	• Feasible business plans for challenges formulated	4. Have business plans for implementing change in these three areas been formulated?		
	• Plans signed off by AMHMT	5. Have these business plans been agreed by stakeholders and signed off by the Area Management Team?		
Recovery actions	• Key proposals being implemented	6. Are the proposals contained in the business plans being implemented?		
	• Training strategy for staff in recovery principles agreed	7. Has a strategy for the training of all staff in Recovery principles been agreed?		
	• Implementation of training strategy	8. Has a strategy for the training of all staff in Recovery principles been implemented?		
	• Further challenges identified	9. Have additional Recovery-oriented organisational challenges been identified for further work?		
Recovery services	• Changes to date being supported appropriately	10. Have measures undertaken to date been supported and sustained?		
	• Overall audit of services for compliance with Recovery principles	11. Has a mechanism for an ongoing audit of the entire service for compliance with Recovery principles been agreed?		

* Tool will need to be adapted in accordance with goals and timeframes agreed at local level.
- See also audit tool in "*Implementing recovery. A methodology for organisational change"* www.imroc.org

Appendix II: ARI's Model of Organisational Change

Kotter (2007)	HSE Change Model (2008) / Systems Reform Group		ARI Phase	ARI Nationally	ARI Site-Specific	Evaluation (Key KPIs)
▪ Establish a sense of urgency ▪ Form a powerful guiding coalition	**Initiation** Preparing to Lead the Challenge	**"Making it Essential"**	**Capacity Building**	-Communicate how Recovery underpins positive outcomes. -Establish effective national structures.	**-**Communicate Recovery as a national imperative. - Develop Recovery Committee.	**1.** AMHMT engaged. **2.** Recovery committee established.
▪ Create a Vision ▪ Communicate the vision	**Planning** -Building Commitment -Determining the detail, including evaluation. -Developing the plan	**"Making it Ready"**	**Recovery Planning**	**-**Develop a vision of Recovery-focused services with key stakeholders and communicate widely. - Provide national guidance on key initiatives and process of evaluation.	**-** Co-develop a vision of Recovery-focused services communicate this widely. -Develop practical proposals for local change. - Outline evaluation	**3.** Three key Org. challenges chosen. **4.** Feasible business plans for challenges formulated. **5.** Plans signed off AMHMT.
▪ Empower others to act on the vision ▪ Plan for and create short-term wins	**Implementation** -Implementing Change	**"Making it Happen"**	**Recovery Actions**	**-**Empower and support AMHMTs and local Project groups in making changes. -Provide guidance on quickly achievable change.	-Empower key working groups / Recovery committee to implement change. - Publicise areas of immediate success.	**6.** Key Org. challenges being implemented. **7.** Training of all staff in Recovery principles. **8.** Further challenges actioned
▪ Consolidate improvements and produce more change ▪ Institutionalize new approaches	**Mainstreaming** **-**Evaluating and learning -Making it "the way we do business"	**"Making it Stick"**	**Recovery Services**	**-**Acknowledge and publicise positive changes. **-**Provide guidance on auditing all aspects of service provision on Recovery.	**-**Continue to embed new changes and seek further progress. -Audit all practice against Recovery principles.	**9.** Changes to date being supported appropriately. **10.** Overall audit of services for compliance with Rec. principles.

Appendix III:A Roadmap to Recovery-Oriented Services



1. Engage services:
Introductory Events
National Objectives
Sharing Information

2. Provide Guidance on **Engaging Service Users/Family members/ developing a Recovery Committee**

3. Support Recovery Committees in collaboratively developing their **ImROC challenges**.

4. Support Recovery Committees in developing **feasible business plans** for these changes, including processes of evaluation.

5. Support AMHMTs /Recovery Committees in **implementing change**.

6. Support the **widespread training** of all staff in Recovery Principles.

7. Support sites in taking **further Recovery actions** to continue the progress towards Recovery-oriented services.

8. Support AMHMT / Recovery Committees in **embedding any new changes**.

9. Support AMHMT / Recovery Committees in **mainstreaming change** e.g. audit of Recovery principles in all aspects of the service.

1**0.** Support AMHMT / Recovery Committees in **establishing self-sustaining structures** providing ongoing feedback from users of the service.

Notes