APPENDICES
APPENDIX 1

TEN KEY ORGANISATIONAL CHALLENGES

AND

DORSET WaRP STRATEGY
**Sainsbury Centre for Mental Health: Implementing Recovery: A New Framework for Organisational Change**

The Sainsbury Centre for Mental Health has produced a new guidance document to support organisation change. (It is available at [www.scmh.org.uk/pdfs/implementing_recovery_paper.pdf](http://www.scmh.org.uk/pdfs/implementing_recovery_paper.pdf).) At the steering group in October 2009 the importance of this document was discussed and it was decided to link it to our strategy. They highlight 10 key organisational changes required and in the table below we have outlined how we aim to address them and how they overlap with the WaRP 10 key priorities. These principles have been embedded into the project plan.

<table>
<thead>
<tr>
<th>Sainsbury Centre: Ten key organisational challenges</th>
<th>What are we doing?</th>
<th>Related area(s) in WaRP ten key priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Changing the nature of day-to-day interactions and quality of experience</td>
<td>Informing people about the principles of recovery and how this translates in practice, through meeting with individuals, groups, and teams and the newsletter. Celebrating good recovery orientated practice and looking to build a culture that challenges poor attitudes and practice</td>
<td>1) To effectively communicate how and why the partnership is promoting recovery and wellbeing 7) Ensure that spirituality is linked to recovery in a way that is meaningful to the whole community</td>
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<tr>
<td>Delivering comprehensive, service user-led education and training programmes</td>
<td>There is some training but we are already looking to increase this and also to develop education-based programmes for people with lived experience</td>
<td>5) To ensure there is effective and consistent recovery training across Dorset</td>
</tr>
<tr>
<td>Establishing a “Recovery Education Centre” to drive the programmes forward</td>
<td>We have agreed to establishing a “Recovery Education Centre”, in principle and are looking to how this would work in practice</td>
<td>5) To ensure there is effective and consistent recovery training across Dorset 8) Evaluate the experience of service users through the use of recovery stories and robust recovery-based outcome measures 9) Supporting staff in their recovery journey</td>
</tr>
<tr>
<td>Ensuring organisational commitment, creating the “culture”</td>
<td>The commitment is present from the all the partnership organisations and the project plan has a whole systems approach to support a “cultural” change</td>
<td>3) To develop a recovery co-ordination strategy and review all paperwork so that it supports a recovery approach 4) To change workforce culture so that recovery is the dominant approach</td>
</tr>
<tr>
<td>Increasing “personalisation” and choice</td>
<td>We are increasing our understanding of how this links to recovery and how we can be more flexible and offer choice. People have been supported to access direct payments to purchase goods or services to support their recovery</td>
<td>6) Continue to develop the role that recovery plays in acute (Enhanced Recovery) services – with a focus on development of alternatives to inpatient treatment for those in crisis 7) Ensure that spirituality is linked to recovery in a way that is meaningful to the whole community 10) To promote wellbeing and recovery throughout Dorset</td>
</tr>
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<td>Changing the way we approach risk assessment and management</td>
<td>NHS Dorset: Community Health Services, with Support from the Dorset Mental Health Forum are reviewing their risk policies and will be redeveloping them in line with recovery principles</td>
<td>2) Develop clear guidelines that integrate risk management, safety planning and recovery 6) Continue to develop the role that recovery plays in acute (Enhanced Recovery) services – with a focus on development of alternatives to inpatient treatment for those in crisis 7) Ensure that spirituality is linked to recovery in a way that is meaningful to the whole community</td>
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<tr>
<td>Redefining service user involvement</td>
<td>Approach of the forum has moved away from tokenistic user involvement to meaningful partnership working and consultation. The development of the WaRP is testament to this</td>
<td>3) To develop a recovery co-ordination strategy and review all paperwork so that it supports a recovery approach 8) Evaluate the experience of service users through the use of recovery stories and robust recovery-based outcome measures 9) Supporting staff in their recovery journey</td>
</tr>
<tr>
<td>Transforming the workforce</td>
<td>The Wellbeing and Recovery Partnership Steering group are in the process of developing a position paper that will outline the vision for the development of peer specialist roles</td>
<td>4) To change workforce culture so that recovery is the dominant approach</td>
</tr>
<tr>
<td>Supporting staff in their recovery journey</td>
<td>Members of the WaRP steering group will be meeting with Human Resources to look at how we can become more recovery orientated in how we support and develop our staff.</td>
<td>3) To develop a recovery co-ordination strategy and review all paperwork so that it supports a recovery approach 4) To change workforce culture so that recovery is the dominant approach</td>
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<tr>
<td>Increasing opportunities for building a life beyond illness</td>
<td>Continue to ensure service developments across the partnership aim for and meet this expectation</td>
<td>7) Ensure that spirituality is linked to recovery in a way that is meaningful to the whole community 10) To promote wellbeing and recovery throughout Dorset</td>
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## Wellbeing and Recovery Strategy

<table>
<thead>
<tr>
<th>Goal</th>
<th>What it means in Practice</th>
<th>Action</th>
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<tbody>
<tr>
<td>To effectively communicate how and why the partnership is promoting recovery and wellbeing</td>
<td>For people in Dorset to be aware of the key concepts of Wellbeing and Recovery and to understand the importance of taking care of your physical and emotional health. There will be a visible commitment to Wellbeing and Recovery in every mental health unit and GP practice and an explanation of what recovery means in practice. All staff to be able to articulate the key principles of recovery and the changes required to service delivery. This will be supported by a Wellbeing and Recovery Partnership (WaRP) website.</td>
<td>Launch a poster campaign. Continue to meet with staff teams to “get the message out there”. Engage with local press and have articles in local newspapers and NHS publications. Develop a WaRP website.</td>
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<td>To create a culture that provides the opportunity to be creative and promotes discussion on how to embed the principles of recovery in mental health service provision across Dorset</td>
<td>For every interaction to be characterized and underpinned by recovery principles using SCMH (2008) Ten Top Tips. Learning from lived experience workshops in each locality will embed the experience of individuals in the development and evaluation of services. These workshops will be where individuals share their experiences which enhance recovery and can influence service provision and delivery at a local level.</td>
<td>To set up learning from lived experience workshops in each locality. To develop local implementation plans which focus on how all people can be involved in the culture change required. To run recovery leadership workshops. To involve supporters in discussions about recovery at all levels.</td>
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<tr>
<td>To promote self management and develop a recovery co-ordination strategy to ensure the approaches of staff create a recovery enhancing environment</td>
<td>Wellbeing toolkits will be available to all (via the website – paper copies will also be available) and people will be encouraged to complete them to develop their ability to self manage. They can be completed by an individual on their own, with staff, a peer specialist or in a training group. People can decide to use the local tool or a tool of their own making or choosing to promote their self management. The importance is that they own it and that it is their personal plan. For those in secondary care, mental health care co-ordinators should encourage people to complete and share their toolkit to inform the CPA care plan using a coaching approach.</td>
<td>Wellbeing Toolkits under development (plus on-line resource) to be launched by end of summer. Training (people who use services, their supporters and staff). Supervision for staff to support the process; under development are the peer specialist roles to support this.</td>
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<td>To change workforce culture so that recovery is the dominant approach</td>
<td>Peer Specialists will be supporting statutory staff in the delivery of services. Changes to be made to Human Resources process to support the implementation of recovery principles. Existing staff with lived experience will be supported as they utilise their experiences.</td>
<td>Development of peer specialist roles across all elements of the service. Development of Human Resources to support attitudinal shifts in relation to recovery principles.</td>
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<tr>
<td><strong>Goal</strong></td>
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<td><strong>To ensure there is effective and consistent recovery training across Dorset</strong></td>
<td>Training on the Wellbeing Toolkit, Recovery, and Peer Specialist training to be delivered by people with lived experience to people who use services and staff.</td>
<td>Recovery Education Centre (REC) to be established to develop and deliver training.</td>
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<td><strong>To ensure that spirituality is linked to recovery in a way that is meaningful to the whole community</strong></td>
<td>That people’s spiritual understandings and needs will be taken into account at all stages of their recovery journey.</td>
<td>To raise awareness of the role spirituality plays in a person’s recovery through publishing recovery stories and to build this in to all elements of service design and delivery (wellbeing toolkits, acute care recovery strategy, locality implementation plans, learning from lived experience meetings).</td>
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<tr>
<td><strong>To evaluate the experience of people who access the service through the use of recovery stories and robust recovery-based outcome measures</strong></td>
<td>To use and develop measures that reflect people’s personal recovery journeys and their own goals. To move away from clinical outcomes to social inclusion outcomes and to evaluate the recovery orientation of service delivery.</td>
<td>To build into daily practice the development and rating of clients’ personal goals. To undertake an audit of staff and people who access the service on how “recovery orientated” the service is using SCMH (2010) <em>Methodology for Organisational Change</em>. To work with commissioners and engage with national projects on the development of recovery orientated service delivery.</td>
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<tr>
<td><strong>To develop clear guidelines that integrate risk management, safety planning and recovery</strong></td>
<td>Risk assessment and management will become an increasingly collaborative task with a sharing of responsibility. To support this process good practice guidelines and a safety planning and crisis management toolkit will be developed.</td>
<td>Staff to be supported by team leaders in supervision, and through training to develop more collaborative approaches to risk assessment and management. Once the good practice guidelines and toolkit are developed these will be launched to support the process.</td>
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<tr>
<td><strong>To continue to develop the role that recovery plays in Acute Care Recovery Services – with a focus on development of alternatives to inpatient treatment for those in crisis</strong></td>
<td>The Acute Care Recovery Service to work with people in crisis in ways that they would like, by increasing the use of Crisis Response and Home Treatment services. To work with people around crisis plans and advanced decisions about how they would like to be worked with when things start getting out of control. For people to have opportunities to give feedback and influence the experience to people admitted to hospital.</td>
<td>An acute care recovery strategy is under development which will build on the use of tidal model, star wards, motivational interviewing training, and opportunities to build people’s views on how they experience the service. To aspire to zero-restraint and develop peer specialist roles in crisis and acute services.</td>
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APPENDIX 2
KOTTER’S 8-STEP CHANGE MODEL
Kotter's 8-Step Change Model*

Step One: Establishing a Sense of Urgency
- Examine market and competitive realities
- Identify and discuss crises, potential crises or major opportunities

Step Two: Creating the Guiding Coalition
- Assemble a group with enough power to lead the change effort
- Encourage the group to work as a team

Step Three: Developing a Change Vision
- Create a vision to help direct the change effort
- Develop strategies for achieving that vision

Step Four: Communicate the Vision for Buy-in
- Use every vehicle possible to communicate the new vision and strategies
- Teach new behaviours by the example of the guiding coalition

Step Five: Empowering Broad-based Action
- Remove obstacles to change
- Change systems or structures that seriously undermine the vision
- Encourage the risk-taking and non-traditional ideas, activities, and actions

Step Six: Generating Short-term Wins
- Plan for visible performance improvements
- Create those improvements
- Recognise and reward employees involved in the improvements

Step Seven: Never Letting Up
- Use increased credibility to change systems, structures and policies that don't fit the vision
- Hire, promote, and develop employees who can implement the vision
- Reinvigorate the process with new projects, themes, and change agents

Step Eight: Incorporating Changes into the Culture
- Articulate the connections between the new behaviours and organisational success
- Develop the means to ensure leadership development and succession

APPENDIX 3
SCOPING REPORT SUMMARY
Scoping Exercise October 2010

Summary

“If adopted successfully and comprehensively, the concept of recovery could transform mental health services and unlock the potential of thousands of people experiencing mental distress. Services should be designed to support this directly … This will mean substantial change for many organisations and individuals.” (Future Vision Coalition – A Future Vision for Mental Health, July 2009)

We believe that Dorset HealthCare University NHS Foundation Trust (DHFT) has a fantastic opportunity to transform how it delivers services. From our interviews it is apparent that the majority of staff are committed to recovery principles, although there are varying levels of understanding of what the principles of recovery are. It is evident that there is a huge array of talent within the teams and people have some fantastic ideas on developing innovative practice.

The Centre for Mental Health, Scottish Recovery Network and other key leading thinkers on recovery identify the essential ingredient to implementing recovery is organisational change. A key element of this organisational change is addressing the dynamics of power. We would argue that it is a move from services being client-centred to becoming person-led, and for those people who are able to lead their own service, being coached to do so. Services need to move to a position of facilitating a person’s recovery rather than delivering recovery. Staff also need to be able to be innovative and creative in their practice and feel the support of the organisation in taking this action.

In addition, people with lived experience need to have a lead role at every stage of the development and delivery of services. This role should include feedback on quality, design and effectiveness of services for people experiencing mental distress. It is only through this partnership-working that real change can take place. From our interviews it is evident that there is a major piece of work for DHFT and Dorset Mental Health Forum (DMHF) around establishing the credibility of the expertise of those with lived experience and people who have used or continue to use the service. We also believe this work is essential in influencing the culture and nature of mental health service delivery, combating stigma and redressing power imbalance.

The findings of our scoping exercise were that despite there being some good opportunities and examples of recovery orientated practice, there was a perception that there were significant organisational barriers. Two key strands were identified. The first was an emphasis on delivering outcomes, collating data, working to new initiatives and reporting on action plans leading to a “tick box” culture. Whilst this was recognised as important, it was felt that the need to “feed the beast” information is often prioritised over other operational and organisational aims. The second strand was how the organisation looks after the emotional wellbeing of its staff. We believe that in order for an organisation to be truly recovery focused it needs to pay attention both to the recovery journeys of the people who access the service and also to those of its own staff. There was recognition that this was not perhaps prioritised as much as it should be. A few respondents made comments about staff attitudes in general and that people do not always treat their colleagues and the people accessing the service with dignity and respect.

The combination of these two strands leads to people perceiving the organisation as not having a “recovery culture”, with some describing it as “controlling”, “patriarchal”, and
“hierarchical”. Several respondents felt that this was further accentuated by inter-professional rivalries and a perceived dominance of the bio-medical model.

Although DHFT believes it supports and even promotes innovation, and staff recognise the positive intention to benefit the people they serve, there appears to have developed in some staff a sense of fear, both in regard to being blamed if tasks are not completed and/or that if they were to be innovative or creative, this would be criticised. This has led them to be reluctant to embrace or lead local change unless it is centrally driven.

The majority felt that recovery orientated practice, alongside other areas of best practice, occurred in isolation and there has been an emergence of service silos. No-one interviewed felt that there was effective joined up working throughout the Trust, which enables a person accessing the service to have a guaranteed, consistent experience on their recovery journey. This theme has been echoed in the recent QIPP work.

We feel confident and optimistic that through embedding the principles of recovery throughout the structure of the organisation, improvements to the experiences of both staff and people who access the service can be achieved. We are proposing, through the use of Kotter’s Model of Change, a series of steps which will enable this organisational transformation to take place. This will allow effective joined up working, improved staff morale and a better experience for the person accessing the service. These will be evidenced through direct feedback and staff and patient surveys. The implementation of recovery cannot be rushed and we envisage a programme of incremental change to ensure these concepts are fully embedded throughout the organisation. This report details the specific steps required for organisational change. Overarching and underpinning these recommendations is the development of partnership working with people with lived experience and their supporters. This is the key task in ensuring the success of this project.

Jackie Lawson   Phil Morgan  Becky Aldridge
APPENDIX 4
ImROC APPLICATION FORM
Implementing Recovery – Organisational Change (ImROC)

DEMONSTRATION SITE APPLICATION FORM

Organisation Name:

Dorset Healthcare University NHS Foundation Trust in partnership with NHS Dorset: Community Health Services and Dorset Mental Health Forum

Date: 28/9/2010     Completed by: James Barton

Job title: Director Adult Mental Health Services

email: james.barton@dhft.nhs.uk
tel.  01202 492033

1. Is there a current Organisation-wide recovery strategy? Yes
   When was this produced? June 2010

   Comments:

   The Recovery Strategy was first developed in partnership between NHS Dorset Community Health Services (DCHS) and Dorset Mental Health Forum. It has now been adopted as the recovery strategy for Dorset Healthcare University NHS Foundation Trust (DHUFT). This partnership of organisations is known as the Dorset Wellbeing and Recovery Partnership (WaRP).

   The Dorset Mental Health Forum are a local third sector organisation led by people with lived experience of mental issues and have been working closely with both NHS mental health providers in Dorset. From 1st April 2011 DHUFT will be hosting DCHS. There is complete agreement and sign up from both organisations to commit to embedding recovery through all elements of the service and to be guided by the expertise of the Dorset Mental Health Forum.

   The recovery strategy produced in June 2010 is an updated version of an earlier strategy developed by the WaRP in April 2009.

2. What will be the focus for the project?

   Whole of Organisation? ☑

   Comments:

   This project has and will be concerned with transforming the whole organisation across all the parts of the service, including services such
as: Forensic, Older Persons, Child and Adolescent Mental Health Services. Tentative steps have also been made to engage with physical healthcare colleagues around promoting the philosophy of wellbeing and recovery in those services and there has been enthusiasm around developing these links.

During the initial work that has been undertaken, it has been recognised that in order to fully embed recovery principles a whole systems approach is required and this includes support services as well as clinical services.

The partnership work with Dorset Mental Health Forum is central to this process and integrating their perspectives into all elements of service design, delivery and evaluation. It also involves our relationships with other agencies and organisations including the third sector and other statutory bodies and having a shared understanding of the principles of recovery.

3. Who will have **lead responsibility** for delivering the project?

   Name: Phil Morgan  
   Position: Lead for Recovery/ Lead Occupational Therapist for Mental Health

4. How much **time** will the Responsible Manager give to the project each week?

   8 sessions

   In addition, there is a full time Recovery Development Worker to support this project.

5. Who will they be **accountable** to?

   James Barton (Director, Adult Mental Health Services DHUFT)  
   Brian Goodrum (Director of Operations, DCHS).

6. What is the current state of inter-agency partnership working in the local services?

   Consider:
   - User representatives/groups? Carer representatives/groups?  
   - Primary Care providers?  
   - Local authority partners?  
   - Local independent sector providers?  
   - Commissioners?  
   - Others? (specify)

   Comments:
The Dorset Wellbeing and Recovery Partnership and recovery strategy has been developed in partnership with people with a lived experience. Partnership has been developed through working alongside Dorset Mental Health Forum. We see the role of the Dorset Mental Health Forum as integral to delivering recovery orientated services. We feel that we have established a sophisticated and strong relationship with The Forum and view this to be a particular strength of the WaRP.

Through this partnership and our relationship with other 3rd Sector organisations people with lived experience and carers sit on a significant number of service development and service evaluation groups, are involved in service delivery and there is a commitment to expand upon this involvement. Other key 3rd Sector organisations who have close links to our organisations include Rethink, MIND, Richmond Fellowship as well as local Carers Forums.

Strong links have been developed with commissioners and commissioners are committed to the principles of recovery. This is evident as they are members of the WaRP steering group, thus this process has been one of co-commissioning. Both DHCS and DHFUT are committed to the Quality, Innovation, Productivity and Prevention (QIPP) agenda and recently held a care pathways event which was co-hosted by DCHS and DHUFT. This involved service users, carers, GPs, commissioners and multi-disciplinary staff from both organisations as well as Local Authorities given the integrated status of the organisations. A management consultancy organisation (Alturos) facilitated the event and focused on the principles of Lean thinking. One of the key outcomes was the commitment to apply recovery principles as a model for future service delivery.

As integrated trusts there is well established partnership working with the local authorities. The local authority commissioners are working collaboratively through this change process.

The Connecting Health and Social Care agenda are also an integral element with strong partnership working. Strong links have been developed through personalisation and the use of direct payments. The developments around the WaRP also include working closely with primary care mental health services, including GPs. This includes GP representation on the WaRP steering group. The steering group is in the process of strengthening these links.

7. Is there anything else you think we should know regarding the development of recovery-oriented services in your locality? (include supportive documents).

Whilst there is commitment to embed recovery across all of the organisations it is acknowledged there is a large amount of work required to achieve this level of organisational change. The Dorset Mental Health Forum and DCHS have been undertaking this work since April 2009 and have made some progress in aligning services with the principles of
recovery and the initial cultural shift has begun (see attached Annual Report, Executive Summary and WaRP Strategy).

DHUFT are keen to mirror this shift in culture and the WaRP Recovery Strategy is now shared across all organisations.

Across both of these organisations, there are pockets of good practice; however we keen for this to become more common place across the whole of Dorset.

Further work is required to both address the culture and the practical implementation of recovery principles. In addition, we are keen to maximise the opportunity to be led by the expertise of people of lived experience in service design and delivery.

8. Please mark your availability in order of preference against the following interview dates (1 = first choice)

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<thead>
<tr>
<th>Date</th>
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<tbody>
<tr>
<td>21 Oct 2010</td>
<td>13</td>
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<td>22 Oct 2010</td>
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<td>9 Nov 2010</td>
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Signed: _______________ Date: __30th September, 2010
ASSESSING CURRENT PROGRESS TOWARDS RECOVERY-ORIENTED SERVICES

This assessment should be completed in collaboration with your local partners (user/carer groups, independent sector providers, local authority partners, commissioners).

How would you currently rate your organisation (or the area you have chosen to target) according to the following dimensions? Add qualifying comments, including references to supporting papers.

1 = Not yet reached this stage    2 = Reached this stage    3 = Exceeded this stage

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<thead>
<tr>
<th>Organisational challenge</th>
<th>1 (✓)</th>
<th>2 (✓)</th>
<th>3 (✓)</th>
<th>Comments</th>
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<tbody>
<tr>
<td>1: Changing the nature of day-to-day interactions and the quality of experience</td>
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<td></td>
<td>There is recognition that recovery principles and values are important, but few systematic attempts have been made to implement them by changing staff behaviour. Staff (and service users and carers) are familiar with the general principles, but unclear about their implications for practice. Users are not generally consulted regarding the quality of services delivered and staff performance.</td>
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<td>2: Delivering comprehensive user-led education and training programmes</td>
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<td>User led training is being supported, beginning to take place and some funding is available. Some recovery training is available, however, the full transition to comprehensive user led training has yet to take place and less than 50% of the staff have received specific recovery training.</td>
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<td>3: Establishing a ‘Recovery Education Centre’ to drive the programmes forward</td>
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<td></td>
<td>There is a commitment to develop a REC and steps are being taken to develop this. It is planned that the REC will be run by people lived experience and they will deliver all recovery training across Dorset.</td>
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<td>4: Ensuring organisational commitment, creating the “culture”. The importance of leadership</td>
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<td></td>
<td>The organisation recognises the importance of recovery and the need to embed these principles across the Trust. Central to this been the partnership with the Dorset Mental Health Forum and their involvement in all elements of service review and design. Staff have been allocated leadership roles in order to implement recovery orientated practice.</td>
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### 5: Increasing personalisation and choice

There is recognition of the need to develop partnership working with service users so that professional expertise does not dominate over the wisdom of ‘lived experience’. There is recognition that traditional care planning must be changed to give a much greater emphasis to users’ priorities and the achievement of ‘life goals’, but this is not monitored. There is some use of instruments like WRAP, but not generally. There have been some attempts to increase the use of ‘personal budgets’, but this is not widespread.

| ✓ | The use of WRAP plans is sporadic. However, to support the use of WRAP there is the development of peer – led self management training for service users and pilot projects are being undertaken. There is an increasing emphasis on direct payments, personalisation and choice however service users do not always feel actively involved in determining the content of their care plan. The North Dorset Locality are involved in a national research project examining personalisation led by Rethink, University of Birmingham and the King’s Fund. |

### 6: Changing the way we approach risk assessment and management

The organisation is aware of the value of systems and procedures that support open, transparent risk assessment and management policies within a recovery framework. Some staff are conversant with this approach and some attempts are made to involve service users in the process, but it is ‘patchy’ (less than 25% of staff involved). There is ambivalence about the value of ‘positive’ risk taking and this has not been addressed at a Board/general policy level. Staff remain preoccupied with risk as a staff issue alone.

| ✓ | There are clear statements on how risk and safety planning should be undertaken in a recovery-orientated approach and guidelines and training are being developed to support this. However, this has not been implemented across the whole of Dorset. |

### 7: Redefining service user involvement

The organisation has accepted that service users (and carers) should play an important part in the planning and delivery of care, but it is still apparent that the final decisions remain with the ‘professionals’. There is some evidence of systematic changes to enhance the role of users and carers as partners in care; but their knowledge and expertise is still seen as secondary, rather than primary. The principles of ‘user involvement’ are accepted, but this is not reflected in true ‘partnership working’.

| ✓ | Through our relationship with the Dorset Mental Health Forum there are examples of excellent partnership working particularly at senior levels within Dorset, however further work is required in moving the staff position from a clinical to a coaching one. |

### 8: Transforming the workforce

The Board and senior managers have recognised that transforming the workforce may require a change in the skill mix and balance between traditional mental health professionals and people whose expertise comes from ‘lived experience’. There are examples of staff with ‘lived experience’ being employed in care-giving roles (e.g. ‘STR’) workers, but these are isolated, with little managerial support and supervision. HR and Occupational Health services have not been reformed and no thought has been given to issues of ‘career progression’ for peer staff.

| ✓ | A commitment has been given to developing peer specialist roles and there is a working group looking at development of these roles including HR and Occupational Health involvement and the development of a career structure. At present there are 4 pilot peer specialist positions. However, employment of people with lived experience is generally in support work and STR worker roles. |

### 9: Supporting staff in their recovery journey

There is awareness that many staff have their own experiences of living with mental illness and of recovery journeys, but this remains largely unacknowledged and they are not encouraged to use these experiences to inform their work practice. There is still considerable stigma among staff regarding revealing mental health problems this is not addressed (privately, or in the context of recovery training). Staff have been given little help in

| ✓ | DCHS has launched a “hidden talents” programme which seeks to support existing staff with lived experience and enabling them to utilise this expertise and challenge stigma within the NHS. This project is being developed alongside occupational health and human resources |
developing different ways of delivering their expertise.

| An aspiration of the DHUFT locality is to be in line with the DCHS; acknowledging those with individual recovery stories have a unique and valuable contribution to make, to the development, and day to day delivery of services. |

| 10: Increasing opportunities for a ‘life beyond illness’  
The organisation has an inter-agency strategy to promote social inclusion, but little concrete progress has been made. The organisation is reviewing (or has reviewed) with service users and carers what needs to be in place in the community to support recovery. Some effective partnerships exist with independent sector providers (housing, employment, education, etc.) but this is patchy. Similarly, some work has been done to reduce stigma in the community, but this is relatively unfocussed and too general to have specific impact. Evidence-based, supported employment (IPS) is not widely available. |

| ✓  
There are some excellent examples of partnership working particularly around vocational services and social inclusion but these are not consistent across all areas. Further work is required in developing operational policies particularly around acute care and to reduce stigma and discrimination among key agencies. |
APPENDIX 5
WaRP NEWSLETTERS
Welcome to our summer edition of the Newsletter. The focus of this newsletter is to update you on the current developments, the most significant of which has been the completion of the Wellbeing and Recovery Partnership Annual Report 2009/10 and its subsequent endorsement by the NHS Dorset Community Health Services Board.

Following Becky Aldridge and Phil Morgan’s presentation of the report to the board they issued a statement saying “we commend this report as evidence of a major transformation programme for mental health services, which most importantly unlocks the potential in the people we serve and our staff, to deliver improvements in the wellbeing of individuals and their families”.

We are about to circulate the Annual Report, Executive Summary and promotional posters. So watch out for the leaflet; the cover looks like this (see below). If you would like a copy please contact either Becky or Phil.

At the beginning of the first year of this project our aim was to create a critical mass of people who were interested in recovery. We also wanted to look at a whole systems approach and get recovery embedded in all aspects of mental health service provision.

Lou Gerstner, who transformed IBM, writes in his book *Who Says Elephants Can’t Dance?* about the importance of culture change:

“I came to see, in my time at IBM, that culture isn’t just an aspect of the game; it is the game. … no enterprise – whether in business, education, healthcare, or any area of human endeavor – will succeed over the long haul if those elements aren’t part of its DNA.”

The cultural change he described was putting the needs of the customer at the forefront of everything that is done. We need to put the expertise of those with lived experience at the forefront of our work.

We are looking to embed recovery into the DNA of the NHS and into all approaches to mental health and wellbeing across Dorset. This last year we have laid the foundations and there are a significant number of people who are passionate about recovery. The goal for the rest of this year is to change individual experience, for people who access services and for staff, so that everyone can fulfill their potential and be hopeful.
Recovery Journeys for Staff

We believe that recovery journeys are not just for people who access the service but also for staff. If the emotional wellbeing of staff is not taken into consideration, if staff are not hopeful about their own lives, how can they inspire hope in others? With this in mind we are looking to do two things. Firstly, we will be working with the NHS Dorset Human Resources and Occupational Health departments to embed the principles of wellbeing and recovery into all approaches to staff. Secondly, we are looking to develop support structures for existing staff who have lived experience of mental health problems, as well as exploring ways to utilise this expertise in the workplace. We plan to send out further information about this soon.

Wellbeing and Recovery Strategy 2010/11

Alongside the Annual Report the Wellbeing and Recovery Strategy has been launched and this specifically outlines the key areas of development for the forthcoming year. The following areas are being targeted:

Recovery and Self-Management Training delivered by those with lived experience: This training will be piloted in the Weymouth and Portland Recovery Team for both staff and people who access the service in a shared audience. It will focus on how people are able to take control over their lives and how staff can best work alongside them. This training will then be rolled out across all services and localities.

Peer Specialist Roles and Training: We currently have two peer specialist posts within NHS teams and others are under development. DCHS are committed to developing this role to complement existing staff structures. Peer specialists are people with lived experience who utilise their expertise to coach others in recovery (see November 2009 Newsletter for more details). We are also in discussions with Bournemouth University and Dorset Healthcare NHS Foundation Trust about having REC training courses accredited.

Learning from Lived Experience Groups: We have disbanded the WaRP steering group for two reasons. Firstly, it was becoming increasingly “top-heavy” with a growing interest from service managers. Secondly, last year was very much about developing the vision and now we are focusing on implementation. We have now incorporated the steering group function into the DCHS Operational Management Group so that the priorities of the WaRP are part of the core business of the Mental Health Management Team. This has left a need for groups with a local focus that can incorporate the views of people with lived experience on how services are delivered and run. These will be called learning from lived experience groups (a term we have borrowed from Nottingham Healthcare NHS Trust) and they will be open to staff and people who access the service and their supporters. We plan to have more information about these groups soon and will be sending out open invitations.

Partnership Working with Supporters (Carers): This year we plan to have a strong focus on how we engage with supporters. We have recently launched our first newsletter specifically aimed at supporters and will be working on a strategy to support these developments.

Wellbeing Toolkit: As outlined in the Spring 2010 Newsletter, we are developing a local toolkit and we plan to be piloting it in the Autumn.

Recovery Leadership Workshops: We will be running leadership workshops for team leaders to support them in embedding recovery principles within their teams and practices. These will start in the Autumn.

Evaluating Our Progress: We plan to monitor and evaluate our progress through using the Sainsbury Centre for Mental Health (2010): Methodology for Organisational Change. This is available on the Sainsbury Centre Website www.scmh.org.uk.

Contact Details:  Phil Morgan – Philip.Morgan@dorset-pct.nhs.uk  ☎ 01305 361371 or  Becky Aldridge – beckyaldrige@dorsetmentalhealthforum.org.uk  ☎ 01305 257172
Welcome to the autumn newsletter. We would like to introduce Jackie Lawson who is the Recovery Development Worker for Dorset HealthCare University Foundation Trust (DHUFT). She is now co-leading the Wellbeing and Recovery Partnership together with Phil and Becky, to cover the east of the county. DHUFT have now become a formal partner of the WaRP. This newsletter will outline in more detail the work we are undertaking in DHUFT, providing an update on the work that is happening in Dorset Community Health Services (DCHS), and feeding back from the Refocus on Recovery conference that Jackie, Phil and Becky attended in London in September.

The WaRP is a partnership between DHUFT, DCHS, and Dorset Mental Health Forum (a third sector organisation led by people with lived experience of mental health problems). Its aims are to embed the principles of wellbeing and recovery into services through putting the voice and experience of people with mental health problems at the heart of their design and delivery. We aim to improve the experience of people accessing services so that they feel more hopeful, have more opportunities and more control over their lives. Alongside this we aim to improve the experience of staff through paying increased attention to their wellbeing. Furthermore, we seek to engage with the wider community to challenge stigma and to help people be aware of and address their own emotional health.

Jackie, Phil and Becky have been asked by James Barton the Director of Mental Health to undertake a scoping exercise with DHUFT. This has involved interviewing senior managers to explore the opportunities for developing recovery orientated practice, identifying what some of the barriers and challenges are, and to celebrate good examples of recovery orientated practice. An example of this would be the wellness workshop within the crisis team day hospital run by people with lived experience.

Dorset HealthCare University Foundation NHS Trust Joins the Wellbeing and Recovery Partnership (WaRP)

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Recover is not about ‘getting rid’ of problems. It is about seeing people beyond their problems – their abilities, possibilities, interests and dreams – and recovering the social roles and relationships that give life value and meaning. Repper and Perkins (2003)

A report and recommendations will be written and presented to the Director of Mental Health and the Executive Management Team. Once the recommendations have been agreed upon the report will go out for consultation with people who access the service, carers and staff. This approach has been chosen to ensure that there is top level sign up and commitment. Once this has been agreed it will be essential that any changes are driven, guided and owned by the staff, people who access the service and carers.

We will also be looking to integrate the work of East and West Dorset so that there is a pan-Dorset approach to recovery. Due to the changes to the status of Primary Care Trusts following the coalition government’s white paper, DHUFT are in the process of hosting DCHS and thereby enhancing opportunities for closer working. This has already been evidenced by a joint bid to the Centre for Mental Health (formerly know as the Sainsbury Centre for Mental Health) to become a pilot site for their implementing recovery methodology.

*NEWS FLASH! From 35 applicants, the WaRP has been shortlisted to 1 of 9 in its application to become a national pilot.
Refocusing on Recovery

The Refocus on Recovery conference held late September in London did exactly what it said on the tin: it gave us a chance to refocus on where we felt the priority areas are. There were many inspirational speakers but two key presentations that influenced our thinking were by Simon Bradstreet from the Scottish Recovery Network and Lindsay Oades, Clinical and Health Psychologist from Australia, on the Collaborative Recovery Model. Both of these presentations and others are available on the Research Into Recovery Website www.researchintorecovery.com. The key messages for us were: that embedding recovery is going to be a slow process, therefore it is important to make incremental steps in order to consolidate progress. Recovery affects everyone, therefore everyone needs to work in a recovery orientated way. This means that there is a need for the whole organisation to embrace recovery principles, not just clinical staff and people with lived experience; there is also a need to consider the recovery journeys of carers and supporters. Simon Bradstreet describes recovery as a contagion – something that is caught and transmitted – and this produces enthusiasm.

Update from the WaRP from Dorset Community Health Services

Following the launch of our Annual Report, Executive Summary and Strategy we held a launch event to coincide with World Mental Health Day on 10 October, 2010. We put together a week of events highlighting how people can look after their wellbeing and demonstrated that recovery is possible. Central to this was the telling of recovery stories. We ran these events with Rethink, Time for Change and with support from the Arts and Health Network, with coverage from the local press and BBC Radio Solent. Thank you to everyone who took part in this successful week.

We have now run three Recovery Leadership workshops. These have focused on how the organisation can support team leaders in becoming more recovery orientated and being able to lead the changes to services required to transform the experience of the person accessing the service. Central to this was how team leaders can overcome the pressures of demands from senior management, staff and people who access the service. We are developing a report and we plan to roll out the workshops across the whole organisation, including administration and support services.

We have also had our first meeting of our Hidden Talents project which is looking at supporting statutory staff with lived experience and being able to utilise their expertise and challenge stigma. This followed an email from Brian Goodrum, Director of Operational Services, and endorsed by the Chief Operating Officer Tim Archer, stating “We view having staff with lived experience as an asset”. We had 10 people at the initial meeting and 20 in total expressing an interest at this stage. We are in the process of collating themes from this meeting which will be circulated to everyone involved so far. The key themes were: the difficulties in sharing ones experiences including how people had hidden their experiences from colleagues; opportunities to learn about how we can make the organisation more responsive to the wellbeing of all its staff. People also felt there were positives from having a lived experience, for example, being able use their experiences to enhance their clinical practice. Others stated that their experience had been the very reason why they came into their field of work in the first place.

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Apologies to everyone for the late arrival of this newsletter. You may recall in our last newsletter we spoke of the Wellbeing and Recovery Partnership being shortlisted in our application to the Centre for Mental Health to become a pilot site in order to implement their methodology for organisational change (ImROC). We have waited for the results of this before sending out the newsletter.

We are delighted to announce that we have been selected to be a national demonstration site. Put simply, this means that the work of the WaRP is deemed to be a few steps further on than those organisations awarded pilot site status. The Centre for Mental Health is keen to input into and consult with us further regarding the development of recovery within our services.

The ImROC project is delivered by a partnership between the Centre for Mental Health, the NHS Confederation and the National Mental Health Development Unit. A team lead by Rachel Perkins (who was voted MIND champion of the year last year) visited us on 17 November 2010 and we put on a whole day of recovery events to support our application.

We would like to thank everyone who participated in this event and enabled the assessment process to be such a success.

The Centre for Mental Health has given the WaRP and the work of the WaRP the accolade of being a demonstration site. This is an immense achievement and a huge recognition of the recovery orientated practice that is going on within Dorset.

The ImROC team were particularly impressed with:

- The strong partnership working especially with Dorset Mental Health Forum
- The progress made towards addressing the organisational challenges and embedding recovery principles

On the day, the team reflected back to us that they were encouraged by our attention to risk and recovery, to the commitment of the medics and the high level organisational sign up.

Being selected to be a demonstration site is a huge honour and opportunity, but with this comes a great responsibility. We do not see this as recognition that we have all the answers. Rather, we view it as recognition of our potential and we must now work together – staff, people who access the service and their supporters – to realise this. We will not feel we have achieved our goal until we have transformed the experience of the people who access the service and those who work in it.

As a great man with lived experience said, “Now this is not the end. It is not even the beginning of the end. But it is, perhaps, the end of the beginning.”

(Sir Winston Churchill, 1942)

The WaRP began in Dorset Community Health Services (DCHS) and we viewed last year as our developmental phase and this year we are moving into the implementation phase. With Dorset Healthcare University NHS Foundation Trust (DHUFT) we are still in the developmental phase but we believe that we will move rapidly into the implementation phase due to existing staff skills, pockets of positive recovery orientated practice but especially from the experience gained in implementing the recovery orientated organisational change that has taken place in DCHS.

As a reminder, the Centre for Mental Health’s publication ‘Implementing Recovery: A methodology for organisational change’ (Shepherd, Boardman and Burns, 2010) is a framework that identifies 10 key challenges to embedding recovery across an organisation. This can be downloaded from: http://www.centreformentalhealth.org.uk
Eastern Update

On 26 January the WaRP gave a presentation to the Board of DHUFT regarding Recovery and the embedding of its principles across the organisation. This presentation was extremely well received and continues to demonstrate high level commitment and sign up to implementing recovery.

DHUFT held a Celebration event on 16 December to celebrate the talents within the organisation and the services which have already displayed recovery orientated practice. The event was held following completion of a scoping exercise which, as well as acknowledging current recovery orientated practice, also established challenges for the organisation in utilising these principles.

From the Celebration event an impressive number of people volunteered to become members of the Recovery Reference Group. The first Recovery Steering Group will be held in early February and following this meeting a date will be set for the Reference Group. The purpose of the group is:

- To support the implementation of the Wellbeing and Recovery principles within mental health services in Dorset
- To create the opportunity to learn from lived experience
- To strengthen partnership working between professionals and people with lived experience, sharing and recognising the expertise of both groups.

We need you! The Reference Group is open to anyone interested in Recovery. Please contact Jackie or Becky (see below).

The essence of the recovery approach is to give personal control, hope and opportunities to those experiencing mental distress – the challenge is that it demands a radical change in attitude to mental illness and to those suffering from it. (Maddock and Hallum, 2010)

Western Update

Exciting things are happening in DCHS and we are entering the implementation phase. We are currently developing and piloting training materials for staff and for people who access the service. Having visited a number of teams we are now seeing evidence of Recovery orientated practice filtering through. Well done!

We have established a Recovery Advisory Network which has the same aims as that of the DHUFT reference group. It was attended by NHS Staff and Dorset Mental Health Forum (DMHF) members. We looked at some training materials mapping the process of recovery and at the wellbeing toolkit. Bob Shaw from the Forum, who has developed the toolkit, describes it as “a self-help book you write for yourself”. We view it as an adjunct to a WRAP as it focuses much more on a person’s narrative and their values. Over the coming months we will be piloting these materials within Adult and Older Persons Teams; these will include workshops for people who access the service.

In tandem to this Gary Hawker has established a Carers Network for Professionals and Carers, with a view to ensuring recovery orientated practice with carers/supporters.

We fed back the Recovery Leadership report to the Operational Management Group, and it was well received. We will now be working with team leaders to support them in implementing Recovery.

The Hidden Talents project for statutory staff with lived experience of mental health problems is continuing to grow and we are in the process of developing a project plan. If you would like minutes from the last meeting please contact Phil Morgan (see below).

New Publications:

There are two new publications out that may be of interest:

Recovery Begins with Hope (2010) by Su Maddock and Sophy Hallam:

Recovery is for All: Hope, Agency and Opportunity in Psychiatry (2010):
http://www.rcpsych.ac.uk/pdf/Recovery%20is%20for%20All.pdf

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Jackie Lawson – Jackie.Lawson@dhft.nhs.uk ☎ 01202 492855
The Dorset Wellbeing and Recovery Partnership continues to experience ‘not enough hours in the day’! Exciting projects are happening pan-Dorset and we will update you on them in the next newsletter, to follow shortly. This will include an update of our work with the ImROC team. Meanwhile, we felt we would use this issue to talk about recovery in a more global sense with a summary of our response to the government strategy ‘No Health Without Mental Health’ and a dedicated piece on the application of recovery principles to dementia services. We are currently writing our annual report and executive summary outlining the work of the previous year. We continue to welcome new enquiries relating to our work, so please feel free to get in touch.

Response to ‘No Health Without Mental Health’

The Wellbeing and Recovery Partnership welcomes the recent publication of the government strategy ‘No Health Without Mental Health’ and its commitment to the mental health and wellbeing of the entire population. Alongside the Centre for Mental Health’s methodology for organisational change the WaRP will be drawing on the six shared objectives outlined in ‘No Health Without Mental Health’, to develop project plans for 2011/2012. We therefore felt a response to this document was required.

Objective 1: “More people will have good mental health”: Our work so far has been predominantly within adult and older person’s mental health services. The WaRP will try to work with any request from any group or area of service in order to promote the principles of wellbeing and recovery.

Objective 2: “More people with mental health problems will recover”: The partnership working of the WaRP places the expertise of lived experience at the centre of service developments, promoting the concept of ‘Nothing about me without me’. This enables services to support people to make informed choices and take control of their own lives.

Objective 3: “More people with mental problems will have good physical health”: The WaRP promotes the culture shift needed to ensure both physical and mental wellbeing are being considered and the programmes and screening that support this, in order for it to become routine practice.

Objective 4: “More people will have a positive experience of care and support”: The partnership work of the WaRP between professionals and those with lived experience is central to this promotion of hope and culture of innovation. We believe partnership working will transform the experience of those accessing services and those who work within it.

Objective 5: “Fewer people will suffer avoidable harm”: WaRP recognise that in order to transform mental health services it is integral that we change our approaches to risk. Risk assessment and management need to be increasingly open and transparent through collaborative working.

Objective 6: “Fewer people will experience stigma and discrimination”: The WaRP are committed to challenging discrimination on all levels. We are closely involved with the Time for Change campaign and are committed to raising awareness of mental health conditions and sharing recovery stories to promote a positive message.

A more detailed WaRP response to ‘No Health Without Mental Health’ is available upon request. Please contact Becky, Phil or Jackie.
Recovery and Dementia? How does that work then?

When discussing the principles and concepts of recovery within older people’s services the WaRP is often questioned about how these concepts apply to people with degenerative conditions such as dementia.

This is an example of where the term ‘recovery’ is a misnomer and it is more useful to consider terminology such as ‘wellbeing and recovery’, or ‘recovering a meaningful life’. It is also important to differentiate between clinical recovery and non-clinical recovery.

Perrin and May (2002) say that “a state of ‘wellness rather than health’ is a more appropriate goal in dementia care, because it is found in dynamic process rather than in a fixed state”.

There are striking parallels which can be drawn between the principles of recovery and those of person-centred dementia care (Kitwood 1997). These parallels and comparisons have been usefully tabulated within the literature (Hill et al 2010).

<table>
<thead>
<tr>
<th>Recovery</th>
<th>Person-centred care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recovery is fundamentally about a set of values related to human living applied to the pursuit of health and wellness.</td>
<td>A value base that asserts the absolute value of all human lives regardless of age or cognitive ability</td>
</tr>
<tr>
<td>The helping relationship between clinicians and patients moves away from being expert–patient to clinicians being ‘coaches’ or ‘partners’ on an individual’s journey of discovery.</td>
<td>The need to move beyond a focus on technical competence and to engage in authentic humanistic caring practices that embrace all forms of knowing and acting, to promote choice and partnership in care decision-making.</td>
</tr>
<tr>
<td>Recovery is closely associated with social inclusion and being able to take on meaningful and satisfying roles in society.</td>
<td>People with dementia need an enriched environment that both compensates for their impairment and fosters opportunities for personal growth.</td>
</tr>
<tr>
<td>People do not recover in isolation. Family and other supporters are often crucial to recovery and should be included as partners wherever possible.</td>
<td>Recognises that all human life, including that of people with dementia, is grounded in relationships.</td>
</tr>
<tr>
<td>Recovery approaches give positive value to cultural, religious, sexual and other forms of diversity as resources and supports for wellbeing and identity.</td>
<td>An individualised approach – valuing uniqueness. Accepting differences in culture, gender, temperament, lifestyle, outlook, beliefs, values, commitments, taste and interests.</td>
</tr>
</tbody>
</table>

We acknowledge that putting these principles at the heart of day-to-day practice is challenging. The person-centred approach and recovery orientated practice require a cultural shift within an organisation as a whole, not just within individual professional practice.

“Prescriptiveness can cultivate dependence” (Perrin and May 2002) therefore we do not aim to prescribe how person-centred dementia care should be. However, below are some ideas of how this philosophy can be reflected in day-to-day intervention:

- **Individual goal plans**
  - Constantly allowing plan to change to enable people achieve desired targets.

- **Life stories**
  - Reflecting strengths and achievements.
  - Documenting identities.

- **Self management and advanced statements / directives**
  - Understanding and documenting preferences to enable decisions to be made when person is no longer capable.

- **Documenting likes, dislikes and preferences**
  - Preparing for the need for future professional care.
  - Advanced directive for how someone wishes to be cared for in the future.

(SW London & St George)

References:


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Jackie Lawson – Jackie.Lawson@dhft.nhs.uk ☎️ 01202 492855
Hello and welcome to the Autumn 2010 issue of Reflections magazine.

Similar to our last edition, our Reflections magazine continues to provide “Reflections on Recovery” and is dedicated to showing what recovery looks like in practice for people. In this issue, the focus is on the impact of creative arts, vocational activities and employment in a person’s recovery journey. We would like to thank people for sharing their personal narratives, which illustrate how people find meaning, purpose and wellbeing through creative expression and getting back to work. We hope you will find people’s stories hopeful and inspiring.

The Forum’s work in the Dorset Wellbeing and Recovery Partnership (WaRP) remains integral to the Forum’s activities and ethos. Read about our progress in the last year and the future direction on pages 2 and 3. Also, Hannah’s Chair’s Report on page 8 provides an overview of the Forum’s activities and challenges. The Forum’s collective voice continues to grow. If you would like to share your views or maybe get involved with the Forum’s work, then consider becoming a member of the Forum, see page 9.

If you would like to make a contribution to a future edition of Reflections, such as sharing your recovery story, please contact the Forum. Other readers have told us that they find people’s views and narratives inspiring, supportive and profoundly helpful.

The Editorial Board
Our main aim is **culture change in Dorset**, and this is happening.

Many **staff have embraced the principles of recovery** and feel hopeful and motivated about their role in future service delivery.

People with lived experience are increasingly feeling that their expertise is **valued** and that they have a lead part to play in the shaping of services. This is empowering, validating and rewarding; it gives individuals hope, meaning and purpose in their own recovery journeys.

Working in partnership with people with lived experience within mental health services is **challenging stigma and raising everyone’s expectations** of what we can achieve.
Transforming Experience … Unlocking Potential

We have done this through robust project planning coordinated by the WaRP steering group. This group is made up of people with lived experience, supporters of people with lived experience, clinicians, managers, and commissioners covering all aspects of DCHS mental health service delivery. This is all described in the WaRP annual report 2009/10.

We are confident that we have now completed the groundwork and have exceeded our expectations in beginning to develop a “critical mass” of people passionate about recovery. This coming year we are looking to create a “tipping point” in order for the services to become truly recovery focused and transform the delivery of mental health services.

We would like to thank everyone who has supported us and worked with us on this journey and have contributed to our feelings of hope and inspiration for this project to move forward. The proof of the effectiveness of this approach will be when we are transforming the experience of the people who access the service and the staff and that everyone is able to have the opportunity to fulfill their potential.

Future Directions
The Wellbeing and Recovery Partnership (WaRP) strategy 2010/11 has been launched and it details how we are planning to build on our achievements. The strategy includes:

- The introduction of Recovery and Self-Management Training for both staff and people who access services (delivered by those with lived experience)
- Running Recovery Leadership Workshops for team leaders
- The further development of peer specialist posts (people with lived experience working in NHS teams modelling recovery) and accredited training
- Establishing locality based Learning from Lived Experience groups
- Launching the Wellbeing toolkit and online resource
- Developing partnership working with the supporters (carers) of those with lived experience
- Plans to evaluate our progress using the Sainsbury Centre for Mental Health (2010): Methodology for Organisational Change

Becky Aldridge – Assistant Services Manager, Dorset Mental Health Forum
Phil Morgan – Recovery Lead, Dorset Community Health Services
June 2010

Contact Details:
If you would like a copy of either the WaRP Strategy or full Annual Report please contact:
Denise Bilton denise.bilton@dorset-pct.nhs.uk 01305 361371
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Wellbeing and Recovery Partnership
Dorset Community Health Services and the Dorset Mental Health Forum
‘Transforming Experience...Unlocking Potential’
Annual Report 2009/10 . Executive Summary
Art in Recovery

"Art for me has always been a central aspect of my being, the way I view the world, and the fluctuating fire of creativity has often corresponded with my illness. In the past, I could only draw or paint when the urgency of deep depression was upon me, pouring out my frustrations, fears, unspoken self and imaginations. It was a projection of my psychology, a visual vomiting that would purge me, make me cleaner, make me feel healthier.

I was never concerned with who would see the piece, as far as I was concerned no one should, it was too exposing of the aspects of self I needed to suppress. Although cathartic, I could never look at these pieces with pride, the after taste was too painful.

As my journey along the road of recovery has continued, my use of art has changed and untangled itself from the dark depths. It is far more objective, capturing scenes and ideas that inspire me, validate my creative vision, and I now produce pieces that I can be proud to display.

I had to re-learn art’s particular meaning to me in order to reach this space, slowly learning to manage and channel the fire of creativity so its voice of hope and inspiration can be heard. My inner censor still challenges me, trying to divert the flow into my more destructive aspects of self. But I remind myself that recovery is a work in progress and the light is so much stronger when viewed in contrast with the dark." ES

Examples of Recovery Art work are on pages 4, 5 and 15

The Forum Gallery

The Dorset Mental Health Forum has a gallery space at its Durngate street office. It is currently a blank canvas, and as the arts can play a powerful and cathartic role in addressing mental health, planning is underway to exhibit work to create an environment that promotes wellbeing and will cultivate the capacity for hope, creativity, care, compassion, resilience and empowerment.

We have gathered a collective of local artists to work as a committee to run the gallery selling work, running workshops and creating an aesthetic community space for all.

If you would like to join the artists committee, or wish to contribute your work to the Gallery space, or have experience running creative workshops, please contact the

Dorset Mental Health Forum on 01305 257172
Recovery and Employment

“I had been out of work for about 2 and a half years when I got into doing woodwork. I really enjoyed it and thought this was what I would like to be employed to do. I applied for a job at a local timber yard. To begin with I started off splitting the wood using a cutting machine, and making the kindling for fire wood. Although I found this quite boring and monotonous at times, I stuck with it. After a while I moved on to helping with the deliveries, which I enjoyed. There was someone at the timber yard who helped me out a lot, for which I am very grateful. When this job came to an end I decided to go it alone and work for myself and be my own boss. I am currently working full time, 2 days a week paid and 3 days a week voluntary. Since working on my own I love being my own boss, not having to answer to anyone and not having anyone on my back all the time, telling me what to do.

It was all trial and error and learning from experience. I have picked things up as I went along. Like when I started making garden sheds, at first I had to be shown what to do, but now I can make one on my own. I will soon be building an aviary, laying patios and other various gardening work. I don’t like chopping up wood to make kindling, but if that’s all there is to do then I do it. Because I really love my job so much.

I have been working for 4 and a half years and during that time have got stronger, and getting better all the time. I feel I have been very lucky and had lots of support from friends and family and someone from Stepping Stones. No one has held me back, giving me lots of encouragement. Even when times are bad I have stuck at it. I am so glad that I did because I love working so much and have gained confidence.

In hindsight I would never have taken drugs, I was young and didn’t realise how much damage it would do to me. I have not used any drugs for 10 years now and am very proud of this great achievement. It’s thanks to my Mum who never gave up on me and having faith in me that has kept me going, and got me to where I am now.

My advice to anyone else in the same situation would be, don’t give up, keep going and try your hardest. Believe in yourself and others will then believe in you.”

“Don’t give up, keep going and try your hardest. Believe in yourself and others will then believe in you.”

“I had been off work for 4 or 5 years. When I initially returned I trained as a welder, unfortunately this only lasted for 5 or 6 months before I had to leave and signed on for a couple of months until I saw an advert for a full time process operator at a Dairy. Although when I started they put me in the cheese plant room with someone I couldn’t get on with, so I left after a week. Then someone phoned and asked me if I wanted to work as a process operator, which was what I had wanted to do, and it made all the difference. I get on with everyone at work it is a very friendly factory.

I do feel quite lucky to of found the right job, even though the shifts are quite long and tiring I really enjoy it. The training took about 3 months. About 6 months after I started working there I was diagnosed with diabetes which meant I was sometimes off sick but they were very understanding.

I would much rather be at work earning good money and meeting people than staying at home on my own all day. I don’t get depressed anymore because I am more active, which is great. I have managed to find and stay in work by myself because I thought work would help me out of the rut I was in. All in all it has worked very well for me, it gets me out of my place. I have more money and have made new friends.

It’s not always brilliant having to go to work but it’s much better than doing nothing all day and just watching telly. There was a time I thought I would never get back into work, but I’m so pleased I did.”

CN

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CC
My personal Journey ..

My story begins when, at 6 years old, I was abused while living in a care home; this went on for 2 years. From then on I knew the only way to survive was by hiding my fear, burying it deep. I swore I’d never be a victim again. That’s when the Cheryl all my friends knew emerged. The tough cookie. The woman who never cried, never hugged, never let anyone treat her like dirt. If life got tough, I’d laugh in its face. Either that or I’d lamp it one.

And believe me, my life was tough. After leaving care, I went from one rotten relationship to another and had two kids by two different men. Then when I was 26 and eight months pregnant with my third child, things got a whole lot worse. As I slept on the settee (my two girls, then 6 and 16 months, were sleeping upstairs) I woke with a start to find someone standing over me. It was pitch black and around 2a.m, and in the gloom I could see a man wearing black.

‘Give me your money’, he growled. As I struggled to my feet I replied ‘I haven’t got any money’, even though I did have some hidden in the kitchen. But I wasn’t going to give it to him. ‘Just get out’ I spat, adrenalin pumping through my veins. Never mind afraid, I was furious. I’d been bullied by men enough. How dare he think he could do this? ‘OK’ I fumed, stomping into the kitchen. Thankfully, he seemed happy with the 15 pounds I shoved in his hands.

After he ran off, the shock hit me. I ran to a neighbours house and banged on the door. ‘Call the police’ I sobbed, hysterical. ‘I’ve been robbed’. The police dusted for fingerprints, but I never heard from them again, and assumed I’d become just another burglary statistic.

And, like always, when the going got tough, Cheryl got even tougher. I gave birth to a son, and whatever else life threw at me, I took it all on the chin – three more kids, marriage, divorce. When giving advice to mates I’d say ‘Life ain’t fair’, ‘Deal with it’. That’s what I’d been doing all these years, at least, on the surface. But deep down, I was a mess. I’d often have nightmares.

Then, when I was 40, I met Paul. A fireman, he was quiet and kind, not like the men I’d dated before. But I still couldn’t bring myself to share my feelings. Then, after we married I had a phone call from the Police. ‘It’s about the robbery when you were pregnant’ the officer told me. ‘We’ve reopened the case’. ‘Why?’ I asked, stunned, it was 22 years ago. By now I had moved away from the area, but it seemed they had new evidence of a man who had raped 2 women. ‘We’d like you to come on Crimewatch to help us catch him’, the officer told me. For a second I hesitated. But then I thought back to my other abuser, and anger burned. ‘I’ll do it’, I told the officer.

So here I was, watching one of the worst nights of my life being played out on national telly. ‘You’re so brave’, Paul said. Brave? I could have laughed. Not showing fear isn’t the same as not feeling it. Right now, I was terrified this monster would get away. Two weeks later the police called to say they were questioning a man over the attack, and waiting for DNA results. However, four days later, I got another call telling me the man had committed suicide along with his wife. His DNA samples were a perfect match, so we’re closing the case.

It was the final straw, I collapsed, sobbing and screaming with rage. Paul took me to the doctor and I was given antidepressants. But when the local papers reported the story, my despair grew deeper. I shook as I read about his history. There was no doubt he would have got life. But at least it’s made me realise one thing. ‘Good old Cheryl’ died along with him that day. The tough old bird who hides her feelings is gone. I’m going to be honest with myself from now on. With Paul’s help, I’m going to get counselling. It’s time to face up to the past and confront my demons; I refuse to take the easy way out.
Since then I applied for loads and loads of jobs but nobody bothers to reply to you. I had been out of work for 3 years before restarting work. But when I did get a job I couldn’t keep it because I couldn’t get up in the mornings. Now though, I enjoy working in a factory. I find it is therapy, I can switch my brain off, and I love it there because they leave you alone to get on with it. I do find that I need a daily routine of cleaning out and feeding the animals, work etc.

I did find writing poetry very therapeutic. I don’t know why this happened as I had completed the second book, and as I was ready to take it to the printers I had a real sweep of tears, maybe it was because it was finished or maybe it was just the day I had had. But it just came out and I had to put this one in for you just to show you how quickly Post Traumatic Stress Disorder can affect your mind. It’s a shame really because I was just beginning to get on with my life. So I guess my next book’s going to be pretty deep. I was also selected to appear for an audition on Britain’s Got Talent this ear, telling one of my poems and I hope to be on television.

It has taken me less than a year to achieve my goals and the person who helped me the most was Lynne from the North Dorset Community Resource Team.

On top of all my other successes I have recently been sworn in to be a local Councillor, after winning a by-election, to represent Gillingham Rural Ward. In my new role I hope to bring a new attraction to Gillingham to help it compete with neighbouring Shaftesbury. My personal mission is to have a market in Gillingham once a month, to bring back trade at the bottom end of the town. We could have stalls selling all sorts of locally made produce and I think it would be really popular. I aim to put Gillingham back on the map!!

All in all, the only thing I would have done differently would to have been a better mum, but because I was brought up in care I didn’t know how to be a mum. My advice to other people would be don’t give up, and see a counsellor. CH

In the midst of winter I finally learned that there was in me an invincible survivor.
Albert Camus

OVERWHELMED

It comes when you least expect it
When out of the blue it arrived in waves
Depression engulfing me

When will my life return to me
When will it give me hope
When will I say to myself one day
I can do this, I can, I’ll cope

It seems to me as things get good
Depression invades my brain
As much as I try to be normal again
Will my life ever be the same

Each day is like a time bomb
I wait will I explode?
Will the memories deep inside my brain
Let loose of their deadly hold

I can’t answer for myself
I don’t know what to say
Just please give me just once in life
A simple normal day
C.H.

I am involved in an exciting new project – to co-edit a book of narratives entitled “Our Encounters with Madness”

In contrast to mainstream approaches, this text will consist of a wide selection of ‘stories’, narratives and vignettes of varying length (rather than realist scientific or quasi-scientific accounts) illustrating the rich, contextual lived experience of negotiating and struggling with mental health problems along with maintaining self-definition, self-esteem, family and relational life. From this perspective, instead of a narrow focus on ‘disorder’ or ‘problem’, the book will be divided into chapter-relevant sections deliberately designed to give a sense of the trajectory or life course of ordinary, and sometimes extraordinary, human beings living and struggling with what are described as ‘mental health difficulties’.

Following the forward and introduction (Chapter One), the second chapter will contain Stories of process, and will include first hand accounts such as ‘On admission to the asylum’. Chapter Three, Stories of treatment, will describe accounts of receiving psychological and physical treatments such as antidepressants, anti-psychotics and ECT. Chapter Four, ‘On disease’, will include accounts of what it is like to experience a range of mental health difficulties such as ‘On the black hill: stories of depression’. Chapter Five, ‘Stories of acceptance and rejection’, will deal with the lived experience of stigma and will include, for example, a section entitled ‘An autoethnography of alcoholism and the impact of psychotherapy culture’. Chapter Six, ‘Stories of Change’, will focus on those who have rejected mental health services and found their own way to deal with mental health problems and lead fulfilling lives.

If any Reflections readers would like to contribute to the book, please get in touch with me, Hannah Walker, on 07502 405579. I look forward to hearing from you!

Hannah Walker
Forum Changes ...  Report from the Chair

Most of our readers will be aware that these are changing and challenging times, both politically and economically. There are changes afoot at the Forum as well, as we undergo a management restructure.

On 1st October 2010, Shaun Byatt changes his role at the Forum, becoming part time Specialist Services Manager. Becky Aldridge will become the Forum’s General Manager and Sue Forber will undertake the role of Development Manager. These changes are internal and will not affect the day to day running of the Forum.

I would particularly like to thank Shaun for everything he has done for the Forum and beyond over many years. Shaun has been our mainstay with his calm and dependable manner and his wide ranging knowledge, bringing us to the robust position that we have now.

I wish Becky and Sue the best of luck in their new roles at a challenging time for voluntary organisations. We are well placed to cope in these difficult times. I would also like to welcome the new staff and volunteers that have joined the Forum this year. There are too many to mention here, but one person who has made a huge contribution to our team is Erica, our new administrator, whose enthusiasm and commitment is Inspirational.

In preparation for challenging times ahead and to meet ever increasing demands, the Forum continues to review its vision and purpose, in line with the needs of people with lived experience of mental health problems.

The Forum’s partnership working with statutory service providers has developed significantly over the last few years, particularly with the development of WaRP (the Wellbeing and Recovery Partnership). This work now extends to working with Dorset Healthcare Foundation University Trust in East Dorset where the Forum is beginning to engage with people who access services in that area. We continue to work closely with Dorset Community Health Services, our strategic partners.

This year we have been concerned in Dorchester with the unforeseen closure of 20 Cornwall Road, and the building of the new hospital at 30 Maiden Castle Road, working hard to ensure that the best quality care is available, particularly with developing services such as Home Treatment and Crisis Response.

The Forum is also busy developing peer specialist roles for people with lived experience. Service User Representatives (SUR’s), our “Experts by Experience”, work alongside mental health professionals, within NHS teams, showing Recovery by example. In particular we must mention Mary Luker’s work with the North Dorset Community Resource Team and Bob Shaw’s work with the Dorchester and Bridport Community Resource Team.

More examples of where peer specialists might work include: assisting in the development of independent peer led groups; raising awareness of mental health issues in a variety of settings; assisting in the recruitment and training of mental health staff in the statutory and voluntary sectors, and representing the Forum and the views of people with lived experience in many areas of service planning and delivery and other local arenas.

As part of the work of the WaRP, we are also looking for people to get involved with a new project, Hidden Talents, aimed at harnessing the expertise of existing NHS staff with lived experience of mental health problems.

As usual, there are many other things of interest going on. We have started up a Hearing Voices group, which meets on Fridays at 2pm in the Durngate Street Gallery in Dorchester. This has been most successful – everyone is welcome; come along and get a wristband! Be Loud and Proud of the fact that we have different experiences.

For more information about the Forum’s activities, please take a look at our website, and for all his hard work on this, our show case, a big thank you to Merrick.

Hannah Walker

“Particular thanks to Shaun Byatt … and good luck to Becky Aldridge and Sue Forber at this challenging time”
SCULPTURE WORKSHOP
At Forston Clinic

Forston Clinic Occupational Therapy department recently had the privilege of hosting and co-facilitating a one day sculpture workshop for people who use mental health services across the trust. This included people currently using inpatient services and services in the community.

The workshop was part of three ‘taster’ sessions, the feedback from which will inform future workshops. The benefits gained from the use of arts in recovery are well documented; for example: improved mood, increased self esteem and confidence.

Within minutes of introducing us to the ‘vital ingredients of the day’ the department and OT garden was a hive of activity, with sawing, rasping and riffling producing a range of sounds, chatter, laughter, smells and dust!

For many of us, our formative experiences of craft (often through school) have been an expectation of becoming competent in technical aspects of using a medium rather than the freedom to create. The aim of our session was not to create a perfect sculpture but to create opportunities for discovery. That could be discovering new skills, new friends, new confidence or improved self esteem.

During our workshop, ideas were tested, discussion and sharing took place, risks and challenges were positively embraced and the excitement of revelation was experienced. Gains were experienced by the participants and the staff.

“Stimulating and fun! I didn’t think I was creative but I was proved wrong!” (Workshop Participant)

“What a fantastic day! I’ve made new friends and discovered a new talent!” (Workshop Participant)

It’s Your Forum
The Forum voice is growing! Over recent years, we have become more and more involved in consultation with mental health service commissioners and providers, representing the views of people with lived experience of mental health problems and mental health services.

Your views help to shape the provision and delivery of local mental health services.

Are you a mental health sufferer, a person who uses mental health services, a carer, or someone who is interested in mental health issues?

Do you have views that you wish to share? Would you like your voice to be heard?

If you find yourself answering ‘Yes’ to any of these questions, why not think about offering your help to the Forum? There are a range of opportunities available and much work to be done. You don’t need experience — we will help, train and advise you. Why not contact the Forum office to have a chat and find out more about how you can join in?

Forum Membership:  To get your FREE Membership card, please return this form to the Forum

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<th>Title</th>
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Would you like to be involved in the work of the Forum? Yes ............

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The REACH Course

REACH Dorset is a successful initiative that has been rolled out in Bridport this year, with transformational results for the course participants. The eight week courses for people experiencing low mood, anxiety and depression have utilised creative writing and arts to connect people with nature and essentially to themselves. These short term recovery orientated courses have evidenced the effectiveness of alternative approaches to helping people to gain some control of their lives.

“I suppose in some way, it has helped to release me a little, see a different kind of life, with colour and freedom at times. Something I need to learn to continue, to find some sort of peace amongst the mayhem.”

“This course provided a doorway into the world of self expression by connecting me and the others in the group to that exquisite realm called “Nature”. As it turned out, it was much better than I had anticipated — no miracle cure — of course, but a small and significant step towards seeing myself in a different, more respectful way. I think that’s what I’ve gained most from the Reach course — that I am a survivor. I will find a way through; it’s ok to ask for help. I have resilience and perseverance and commitment. I still have a lot more to give. I have a unique talent; we all have. The Reach group and its facilitators have helped me to get more fully in touch with those qualities — I began to feel a part of something — to feel like I belonged.”

“I went on the Reach course to build my confidence up and to give me some more self-esteem. I would like to say thank you to the tutors for the course and for getting me to do things I wouldn’t usually do. I think I have become more creative as a result of doing this course. I think this will add to my bow for when I start work again wherever that will be, and in whatever capacity. I am more knowledgeable now I have completed this course — I think I can do more things than I thought I could, and should have a go at new things more often. I praise myself for taking the change to come along and achieve the things I have done.”

“When I entered the first lesson on loosening up, I felt relief and a sense of being with beings that maybe felt a little of what I felt. I went home quite elated and felt a surge of creativity sweeping over me. The personalities are quite different, but all boil down to the same substance: A need to express and be heard. The exhilaration of freedom from writing, painting and using colour wildly has released a determined demon. I have reached new heights in my quest for a miracle, only a tiny miracle. The freedom to express without judgement is invaluable, the miracle now will be to discipline myself and keep to goals that are now within my grasp.”

The REACH Course

“A doorway into the world of self expression”

“We all have a unique talent …”

“The Reach group … helped me get more fully in touch ..”

“A need to express and be heard …”

Membership of the Forum

You can become a member of the Dorset Mental Health Forum, free of charge. It is open to anyone who wishes to join. Members are entitled to take part fully and have voting rights. They are informed of meetings and relevant events taking place in and around Dorset. They also receive a copy of our Reflections newsletter regularly. A 24 hour telephone answering service is available when the office is not staffed.

To apply for your free Membership card, cut out and complete the form on the back of this page and return it to the Forum. The information you send in will be completely confidential at all times and will be subject to the 1998 Data Protection Act.

To get your Free Membership Card please cut out and complete this form and return to the Forum at:
29-29A Durngate Street, Dorchester, Dorset DT1 1JP
# The Self-Help Page

## Help/Support/Information Lines

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<th>Service</th>
<th>Contact Information</th>
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<tr>
<td><strong>Cruse-Bereavement Care</strong></td>
<td>0844 477 9400 (Mon-Fri, 9:30am-5pm) Or (Dorset) 01305 260216</td>
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<tr>
<td><strong>Carers UK</strong></td>
<td>(Formerly Carers National Assoc.) 0207 378 4999</td>
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<tr>
<td><strong>Dorset Carers Forum</strong></td>
<td>01305 257172</td>
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<tr>
<td><strong>Depression Alliance</strong></td>
<td>0845 123 2320 (Info. pack request line)</td>
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<tr>
<td><strong>East Dorset Mental Health Carers Forum</strong></td>
<td>01202 481730</td>
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<tr>
<td><strong>Eating Disorders Association</strong></td>
<td>0845 634 1414 (Helpline) 0845 634 7650 (Youthline)</td>
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<tr>
<td><strong>First Step to Freedom</strong></td>
<td>01208 851608</td>
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<tr>
<td><strong>Healing Voices Network</strong></td>
<td>0845 122 8642 (Helpline) 0845 122 8641</td>
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<tr>
<td><strong>Help &amp; Care</strong></td>
<td>(Help for the Elderly) 0300 111 3303</td>
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<td><strong>MDF – The Bi-polar Association</strong></td>
<td>(Formerly Manic Depression Fellowship) 08456 340 540</td>
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<tr>
<td><strong>Mindline (Bristol)</strong></td>
<td>0117 983 0330</td>
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<td><strong>Mindline (Somerset)</strong></td>
<td>01823 276892 (Wed, Fri and Sat 8am to midnight)</td>
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<td><strong>MIND Helpline</strong></td>
<td>08457 766 0163</td>
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<td><strong>NHS Direct</strong></td>
<td>0845 4647</td>
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<td><strong>National Self Harm Network</strong></td>
<td>PO Box 16190, London NW1 3WW</td>
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<tr>
<td><strong>No Panic</strong></td>
<td>01952 599545 (Recorded message gives numbers)</td>
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<td><strong>OCD-UK</strong></td>
<td>0845 120 3778 (Enquiries)</td>
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<td><strong>ParentLine Plus</strong></td>
<td>0808 800 2222</td>
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<td><strong>Prisoners Advice Service</strong></td>
<td>0845 430 8923, or 020 7253 3323</td>
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<tr>
<td><strong>Relate</strong></td>
<td>0300 100 1234 (To find your nearest Relate)</td>
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<tr>
<td><strong>Relate</strong> (Dorset)</td>
<td>01305 262285. (Mon 9am — 9pm, Tues -Thur 9am — 9.30 pm, Fri 9am — 5pm)</td>
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<tr>
<td><strong>Relate</strong> (Yeovil &amp; District)</td>
<td>01955 472485</td>
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<tr>
<td><strong>RETHINK</strong></td>
<td>(Helpline) 0207 840 3188</td>
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<td><strong>Rethink</strong></td>
<td>(Mon, Wed, Fri 10am—3pm, Tues &amp; Thur 10am—1pm )</td>
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<td><strong>Samaritans</strong></td>
<td>(National) 0845 79 90 90 (Weymouth) 01305 771777 (Yeovil) 01935 476455</td>
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<td><strong>SaneLine</strong></td>
<td>0845 767 8000 (6pm—11pm)</td>
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<tr>
<td><strong>Shelter</strong></td>
<td>0808 800 4444 (Free Housing advice)</td>
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<tr>
<td><strong>Triumph Over Phobia</strong></td>
<td>0845 600 9601</td>
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<td><strong>Victim Support</strong></td>
<td>0845 30 30 90</td>
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<td><strong>Wand Support Line</strong></td>
<td>0808 800 0312</td>
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<tr>
<td><strong>Youngminds</strong></td>
<td>0207 338 8445 (Enquiries)</td>
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## Domestic Violence

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<th>Service</th>
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<tr>
<td><strong>Dorset Women’s Outreach Project</strong></td>
<td>0800 5877480 (8am -1pm weekdays. Answering machine at other times)</td>
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<tr>
<td><strong>Christchurch &amp; East Dorset Domestic Violence OutReach</strong></td>
<td>0800 328 4457 (Mon to Wed 10-12noon) or in an emergency 01202 547755</td>
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<tr>
<td><strong>National Domestic Violence Helpline</strong></td>
<td>0808 2000 247</td>
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<tr>
<td><strong>Police</strong></td>
<td>(in an emergency dial 999)</td>
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<td><strong>Police East Dorset Domestic violence Officer</strong></td>
<td>01202 226089</td>
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<td><strong>Police West Dorset Domestic Violence Officer</strong></td>
<td>01305 226547</td>
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<td><strong>Women’s Aid Advice Line</strong></td>
<td>01305 226444</td>
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<td><strong>Women’s Refuges</strong></td>
<td>Bournemouth 01202 547755</td>
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<td><strong>North Dorset</strong></td>
<td>01747 858555</td>
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<td><strong>West Dorset</strong></td>
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<td><strong>Weymouth</strong></td>
<td>01305 772296</td>
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<td><strong>Yeovil</strong></td>
<td>01935 427594</td>
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<tr>
<td><strong>Rape Crisis Line</strong></td>
<td>01202 547 445 (Mon 1-3pm, Tues 10-2pm, Wed, Thur, Fri 8 -10pm, Sat 4-6pm)</td>
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<tr>
<td><strong>Elder Abuse Response</strong></td>
<td>0808 808 8141</td>
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## Drugs & Alcohol

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<tr>
<td><strong>Alcoholics Anonymous</strong></td>
<td>0845 769 7555 (National Helpline) 01904 644026 (to find local group)</td>
</tr>
<tr>
<td><strong>Al-Anon Family Groups</strong></td>
<td>0207 430 0888 (10am — 10pm)</td>
</tr>
<tr>
<td><strong>Battle Against Tranquillizers</strong></td>
<td>01179 863629</td>
</tr>
<tr>
<td><strong>CADDAS</strong></td>
<td>01305 265635</td>
</tr>
<tr>
<td><strong>Dorset Drug Intervention Programme</strong></td>
<td>(DIP Team) 01305 780087 (24/7 advice &amp; info.)</td>
</tr>
<tr>
<td><strong>Drinkline</strong></td>
<td>0800 917 8252</td>
</tr>
<tr>
<td><strong>National Drugs Helpline</strong></td>
<td>0800 77 66 00</td>
</tr>
<tr>
<td><strong>PADA</strong></td>
<td>(Parents Against Drug Addiction) 08457 023867</td>
</tr>
</tbody>
</table>

## Advocacy / Mediation / Advice

<table>
<thead>
<tr>
<th>Service</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Citizen’s Advice Guide</strong></td>
<td><a href="http://www.adviceguide.org.uk">www.adviceguide.org.uk</a></td>
</tr>
<tr>
<td><strong>Bridport CAB</strong></td>
<td>01308 456594</td>
</tr>
<tr>
<td><strong>Dorchester CAB</strong></td>
<td>0845 231 0400</td>
</tr>
<tr>
<td><strong>Gillingham CAB</strong></td>
<td>01747 822117</td>
</tr>
<tr>
<td><strong>North Dorset CAB</strong></td>
<td>01747 822117</td>
</tr>
<tr>
<td><strong>Sherborne CAB</strong></td>
<td>0844 8467939</td>
</tr>
<tr>
<td><strong>Weymouth &amp; Portland CAB</strong></td>
<td>01305 782798</td>
</tr>
<tr>
<td><strong>Consumer Credit Counselling Service</strong></td>
<td>0800 138 111</td>
</tr>
<tr>
<td><strong>Dorset Advocacy</strong></td>
<td>(For people with Learning Disabilities) 01305 25103</td>
</tr>
<tr>
<td><strong>Dorset Mental Health Advocacy</strong></td>
<td>01305 261483</td>
</tr>
<tr>
<td><strong>Dorset Family Mediation</strong></td>
<td>01305 751781</td>
</tr>
<tr>
<td><strong>Mediation Dorset</strong></td>
<td>01305 257717</td>
</tr>
<tr>
<td><strong>Skeffhasey Advice Centre</strong></td>
<td>01747 855822</td>
</tr>
</tbody>
</table>

## Children

<table>
<thead>
<tr>
<th>Service</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Childline</strong></td>
<td>0800 1111</td>
</tr>
<tr>
<td><strong>Children’s Legal Centre Advice Line</strong></td>
<td>01206 873820</td>
</tr>
<tr>
<td><strong>Children’s Society Waves</strong></td>
<td>01305 768768</td>
</tr>
<tr>
<td><strong>Connexions (Dorchester)</strong></td>
<td>01305 260600</td>
</tr>
<tr>
<td><strong>Kidscape</strong></td>
<td>0845 1205 204</td>
</tr>
<tr>
<td><strong>National Youth Advocacy Service</strong></td>
<td>0151 342 7852</td>
</tr>
<tr>
<td><strong>Outlooks – NCH Action for Children</strong></td>
<td>01303 823794</td>
</tr>
<tr>
<td><strong>Routes (Dorchester)</strong></td>
<td>01305 261318</td>
</tr>
<tr>
<td><strong>The Shaftesbury Young People’s Project</strong></td>
<td>01747 850860</td>
</tr>
<tr>
<td><strong>Tides (Weymouth)</strong></td>
<td>01305 780563</td>
</tr>
<tr>
<td><strong>Treads (Young People)</strong></td>
<td>01258 455449</td>
</tr>
</tbody>
</table>

## Local Authority Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Community Mental Health Teams (CMHTs):</strong></td>
<td>Blandford 01258 450610</td>
</tr>
<tr>
<td><strong>Bridport</strong></td>
<td>01308 421236</td>
</tr>
<tr>
<td><strong>Dorchester</strong></td>
<td>01305 367000</td>
</tr>
<tr>
<td><strong>Shaftesbury</strong></td>
<td>01747 856711</td>
</tr>
<tr>
<td><strong>Sherborne</strong></td>
<td>01935 816552</td>
</tr>
<tr>
<td><strong>Weymouth &amp; Portland</strong></td>
<td>01305 786905</td>
</tr>
<tr>
<td><strong>Dorset Social Care and Health</strong></td>
<td>(Out of Hours) 01202 657279</td>
</tr>
<tr>
<td><strong>Dorset PCT Crisis Response</strong></td>
<td>01305 361269</td>
</tr>
</tbody>
</table>
Hope! There’s always hope...

“Hope! There’s always hope. According to the dictionary it signifies: “A feeling that what is wanted will happen, the thing that one has a hope for, a reason for hope.” I had hope, I also had severe depression and anxiety so I am writing this story in the hope that it will give fellow sufferers the desire and courage to fight to get well.

I suffered a breakdown 15 years previous and was hospitalised (sectioned) for my own good and on my discharge there was nothing apart from a very caring O.T. who visited me once a week for two years, and medication. From then until the beginning of 2008 I struggled with short spells of stability and longer spells of depression of varying degrees.

Looking back now I can see that I had suffered bouts of depression and lack of self worth for much of my life and can understand some of the reasons for it. In early 2008 I was feeling more depressed than usual and tried to come out of it with relaxation, breathing exercises and others that I had learnt, plus my medication but it was not helping. As the year went on I became lower and more insular. There were times when I did not go out and times when I was afraid to go out and anxiety was taking over me.

By late summer for the first time since my breakdown I began to realize that no matter how I tried I could not stop my fall into deep depression, as I now know it. I was spending my days racing through my daily chores so that I could spend the rest of the day sat down with my eyes closed, pretending that I was no longer on this planet and always hoping I would not wake up. Eventually I told my wife that I could not get through another day and she immediately arranged for me to see my G.P. and my psychiatrist and within 48 hours I was asked to admit myself to Stewart Lodge in Sherborne as an informal client.

During my stay in S. L. quite a bit of the time is lost to my memory, due to the medication, the ECT treatment I was to receive later and the severe depression and anxiety I was diagnosed with. However I do know that for the first four weeks or so I spent my time sitting in corners, reading and just going through the motions of life. A couple of times when it was warm I went up into the garden to sit where a girl and fellow client would talk to me and they wrote me a poem, the significance of which I did not realise at that time.

Then one day I woke to hear the staff on changeover all laughing over something or other and it suddenly hit me that that was what I never did, but wanted to do. I had no emotions whatsoever; I could neither laugh nor cry or feel anything inside except fear. When deeply depressed the fear of life oddly made me acutely aware and suspicious of my surroundings and people’s movements around me, but from that morning on I knew I wanted to get well and to live what I would term normally, like most other people, without the pressures that depression brings. I also became aware of the value of that poem, a simple act but so dear to me it stayed where I could read it each day.

I began to go to the group sessions that the staff held, I went for several sessions of ECT that was recommended for me and I immersed myself in O.T. crafts, which as an ex. cabinet maker I found I was good at and enjoyed. I tried anything and what worked for me I would continue with in a bid to get well. I even knitted my dog (who loves playing football) a football T-shirt in the colours of Yeovil Town; anything that would occupy my mind so as not to be constantly thinking bad or negative thoughts until I was considered well enough to go home.

The first couple of days were euphoric and then my mood settled down to where I am in a comfortable happy place and enjoy every day. I know I have lost a lot of my life through this dreadful illness over the years, but I do not intend wasting any more. I accepted Nancy’s (head of
... what is wanted will happen

Stewart Lodge) challenge to go back a couple of days a week to help others in the situation I was in and I love it. I help run a couple of groups, go shopping for clients, accompany them on a walk, sit and talk, or just play a game such as scrabble.

Now, 16 months since I first came home I am still well and enjoying every morning instead of dreading them and still working as a volunteer at Stewart Lodge. Looking back I am in a way glad I had this illness. It is good to be free of it and to understand something of depression and mental illness and to be able to help other sufferers.

My life is full now and I know myself, who and what I am and I am happy being me; all of which is down to the skill and dedication of the wonderful staff at Stewart Lodge (and others like them throughout Dorset), which I can now say from working there, as well as being an ex-client, is set up and run perfectly for it’s purpose and I have made so many friends there.

Then of course I have been so fortunate to have a wonderful wife who has not only cared for me, but has stood by me during the 15 years or so of this illness and now fortunately I am able to love and care for her. My big regret is that there is little or no help available for husband or wife carers whose burden over many years must be intolerable; I have much to make up for. And so you see, if you hope and work for something hard enough you may find it. “ ML

The Sherborne Centre for Wellbeing

With a new name and visual image, ‘The Sherborne Centre for Wellbeing, incorporating the FLCC’ continues to focus on being a resource for the whole community. The very successful Zest Café (open on Thurs to Sat), already popular with local residents and tourists, is being refurbished with a serving counter and extra seating.

With a new Support Group—‘Just Us’ - for parents of people with eating disorders; people with Learning Disability socializing at the Zest Café on Thursdays; courses on Computers for the over 50’s; Creativity and Reading Groups; Peer Support evenings and the Credit Union available on Thursdays, the programme is busy and varied. It’s all Go at the Wellbeing Centre!

“After being out of work for a considerable amount of time I am now a Manager at Zest Café, working 3 days paid and 1 day voluntary a week. My duties are varied but can include the day to day running of the café, dealing with staffing matters, cooking food and serving the public. It has taken me approximately 10 to 15 years to achieve my goal.

I had been out of work for 8 or 9 years and being a volunteer at the Four Leaf Clover Club inspired me to apply for the position of Manager for their café. The majority of people who use the Club helped me out the most. Since getting the job I do seem to get on better with people, and it has brought me out of my shell as I was quite a shy person. But now I have lots more confidence. Sometimes things can be stressful though when volunteers are unavailable and when it is really quiet and there is a lack of customers. The only downside is my house has suffered as I don’t spend as much time cleaning as I used to.

The reason I love my job so much is because I am working in an environment with similar people to myself and I have increased what I was doing already. I stay there because I like the people and the work and I’m very excited about what will happen in the future as business is growing all the time.

Looking back I probably would have done things differently or maybe sooner. My advice to other people would be to give it a go because you don’t know what you can achieve unless you try.” CB
Poetic Therapy

‘I’m not a poet. I’m just a bloke struggling to understand his feelings or I’ll never get out of the pit I’m in. I love working with the people at the Forum; so many times over the last two years, kindred spirits that are battling or have battled with their own demons, have buoyed me up when I’ve been drowning.

But at the end of each day, I go home, alone. What had been the biggest fear in my life, surrounded me each evening until I went to sleep, only to haunt my dreams till when I woke. I looked forward to death like a young person might look forward to a new lover.

One evening, sleep elusive once again in spite of a multitude of grape, I just sat down with a pen in hand and as everybody does at sometime in their lives, pondered the question love and relationships. I woke next morning feeling strangely refreshed. I was still sitting on the sofa. As I stood up, something fluttered from my lap. It was a piece of paper with something written on it. I bent down to pick it up and barely recognised the handwriting. In front of me was a poem from a man coming to terms with the loss of the woman he loves

“…….One last kiss - shared
One last touch - goodbye
One last dream - died.”

I’ve written many, many more since then. I know so much more about myself, only to recognise that there’s so much more to come. It’s not poetry; it’s mind laundry. I don’t have to harbour all these endless questions - once they’re on paper I can move on.

When I feel moved to write, I have at last found a way to cut out all those damned filters and the voices perpetually saying ‘it’s not good enough’. I have no-one to please but myself. It’s what I imagine automatic writing to be. I have a child’s sense of wonder when I read what I’ve written the night before. I don’t care what anyone else thinks about it.

And am I any closer to a solution? No, but through my scribblings, I am getting closer to what the question is. Is love an antidote for or an avoidance of feeling alone? Is there such a thing as a soul mate? And do you know what - my depression is beginning to lift! The thing I’d dreaded all my life had now become my friend.

Since that time, my mental wealth has porpoised steadily upwards. Yes, I still get periods when I’m really down, but I seem to have developed a coping strategy that works for me, and the depths are never as deep as they used to be.” JPH

It’s as if
I’d been devoting
enormous energy
all my life
in order to keep
these thoughts and
feelings
suppressed …

I decided to
try again …

That is what learning is.
You suddenly understand something you’ve understood all your life, but in a new way.
Doris Lessing
Musings of a Closet Bipolar

"A closet Bipolar? Which aspect is closeted I hear you ask. Is it the fear of judgement created by the stigma attached to mental health issues? Utter the term mental health and alarm bells ring in most heads, until recently, myself included.

Naturally confident and bubbly (...ahh but how much of that is natural? – or a product of the illness? - - see how the label can infiltrate and undermine all aspects of self?) I would hide myself away in deep depressions when my carefully constructed camouflage crumbled from the exhaustion of holding together the facade of "normality". I would hide from the eyes that I feared could perceive the gaping nothingness that was my core in that mindset – tis not unusual, in fact a symptom of depression; social isolation.

But it also became a response to the other polar of my being. I would isolate myself in hyper-ness, finding my awareness of my over working erratic and impulsive brain too painful and the perceiving eyes around me once again judging – "Ah she’s manic" - labelling all that was said as 'delusional', a product of my illness.

I still hold that all that is said is valid, if somewhat jumbled and fast. Is it my fault that others can’t see and perceive on the levels of clarity my overactive brain leaps around on? But then that statement itself would be labelled grandiose! I do not adhere to the label Bi polar. I suffer from a unique and exquisite illness/blessing, which is myself. It is authentically me when I’m in the deepest depths of the black gunky and it is authentically me when I am at the highest burning creative peaks of euphoria. I refuse to let them neatly package and label that me-ness.

Don’t get me wrong. The label has its benefits, once I got over my aversion to the currently hip terminology and started researching into the meaning and vast spectrum of levels that lies within the term, I had an “Ahhhh, that’s why.” moment. It took away some of the self critical judgement, blame and shame I had heaped onto myself during my addictively non-existent states, despite having every reason to be. It gave rhyme and reason to the roller coaster that had been my life to date and I could slowly learn to let go, or at least start to ignore the drill sergeant censor within that would shout and scream at me with disapproval and hatred: "WHAT’S WRONG WITH YOU JUST PULL YOUR SOCKS UP. YOU’RE STRONGER THEN THIS. STOP BEING WEAK", or the self pitying woe is me that would try and convince me to just give up. But instead I coat it all with a hard learned layer of self compassion.

I found myself transformed from the lethargic plodding camel with the weight of the world on its back to the proud lion roaring my presence. Wearing Bipolar as my badge; defining myself by my illness. I now attempt to let go of all that was, to approach each situation and person with fresh eyes, without preconceived perception or judgements, unlabeled. Trusting that my internal experiences will give me clarity to see which labels the other holds on to, but to give them the open space to show it themselves. And if it is destructive to myself? I walk away.

My unconditioned authentic self is continuously morphing and flowing, finding ways out of the boxes and judgements placed onto me (more often than not by myself). I’m lucky I have a mental illness that acts as a barometer for when I’m straying too far off the path of immediate authenticity! ES

I don’t know what I may seem to the world, but as to myself, I seem to have been only like a boy, playing on the sea shore, and diverting myself now and then finding a smoother pebble or a prettier shell than ordinary, whilst the great ocean of truth lay all undiscovered before me.

Isaac Newton
**SELF-HELP GROUPS, SOCIAL CLUBS + DROP-INS**

<table>
<thead>
<tr>
<th>Group Name</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Willow Tree Group</td>
<td>Castleman Bungalow, Blandford. Meets Wed 10am to 2pm (incl. lunch). Contact: Florence Spencer on 01747 825400. Mobile: 07979 437076</td>
</tr>
<tr>
<td>Weymouth Peer Support Group</td>
<td>Meets weekly, daytime and evenings. Contact group member on Mobile: 07505 383743</td>
</tr>
<tr>
<td>Hope Drop-In Centre</td>
<td>1 Bimport, Toby’s Court, Shaftesbury. Tues, Wed, Thurs 11am to 4.30pm. Fri 2pm to 5pm. Contact: 01747 852224</td>
</tr>
<tr>
<td>Four Leaf Clover Club</td>
<td>1 Abbey Road, Sherborne. Mon to Thurs 10am to 4pm. Zest Café Fri/Sat 9.30am to 3pm. WiFi available during opening hours. Contact: Liz McGaw on 01935 389192</td>
</tr>
<tr>
<td>Oak Tree Clubhouse</td>
<td>Crossroads Centre, Weymouth. Meets weekly. Fri 7pm to 9.30pm. Wed 6pm monthly for outings. Sun lunchtimes once a month. Contact: Andy Court on 01305 362094</td>
</tr>
<tr>
<td>The Lantern</td>
<td>2 Ranelagh Rd, Weymouth. Open Mon to Fri. Support, Advice on Benefits, Housing, Advocacy and Counselling. Contact: Mick Branham on 01305 787940</td>
</tr>
<tr>
<td>Club 57. RETHINK Drop-In Group</td>
<td>The Gallery, Durngate Street, Dorchester. Meets Tues 10am to 2pm. Contact: Joan Evans on 07918 692120</td>
</tr>
<tr>
<td>First Tuesday Self-Help Group</td>
<td>(Manic Depression Fellowship) Monthly. 1st Tues at The Friends Meeting House, Holloway Rd, Dorchester. 7pm to 9pm. Contact: 079 0555 0768 (National MDF, 08456 340543 or 020 7793 2630)</td>
</tr>
<tr>
<td>Lyme Regis Social Club</td>
<td>Woodmead Hall, Lyme Regis. Meets every Wed 10am to 1pm. Contact: 01308 459762</td>
</tr>
<tr>
<td>RETHINK – Variety of Groups</td>
<td>5 Downes Street, Bridport. Open Tues 10am to 3pm. Contact: Deborah Rodin on 01308 459762</td>
</tr>
<tr>
<td>Bridport DBSA Support Group</td>
<td>Wed 6.30pm to 8pm. Centre for Local Food, Unit 17, St Michaels Trading Estate, Bridport. Contact: John on 07767 76595 (free phone)</td>
</tr>
<tr>
<td>Moving On</td>
<td>Meets weekly Tues a.m. and twice a month on Fridays (includes lunch) at Millennium Centre, North St, Bridport. Contact: Debbie on 07812 128085</td>
</tr>
</tbody>
</table>

**CARERS + RELATIVES GROUPS**

<table>
<thead>
<tr>
<th>Group Name</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weymouth Carers Group</td>
<td>Leon Centre, Fernhill Rd, Weymouth. Meets 2nd Wed 2 to 4pm. Contact: Karen Withers on 01308 459762 or Mobile: 07866 252046</td>
</tr>
<tr>
<td>Independent Carers Forum</td>
<td>Meets last Thurs 3pm to 5pm. Forum offices: 29 Durngate St, Dorchester. Contact: Karen Withers on 01308 459762 or Mobile: 07866 252046</td>
</tr>
<tr>
<td>Shaftesbury &amp; District Carers Group</td>
<td>Hope Drop-In Centre, 1 Bimport, Toby’s Court, Shaftesbury. First Wed 7pm. Contact: 01747 852224</td>
</tr>
</tbody>
</table>

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**See our Reflections magazine online – Visit the Forum Website at www.dorsetmentalhealthforum.org.uk**

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APPENDIX 7
RECOVERY PROCESS TABLE FOR TEAMS
<table>
<thead>
<tr>
<th>For a Team</th>
<th>Resources to support this</th>
<th>For an Individual</th>
<th>Resources to support this</th>
</tr>
</thead>
<tbody>
<tr>
<td>Listen to the person’s story.</td>
<td>What is it like to be a member of this team? How does it feel? Are the team supportive? Is the work difficult? Do people feel satisfied in their jobs?</td>
<td>Team Meetings, Supervision, Reflective Practice. Support advice from WaRP team.</td>
<td>Ask a person to tell what is happening for them at the moment, what they want from the service. Why are they here? What is important to them as a person?</td>
</tr>
<tr>
<td>Introduce and develop a shared understanding of Recovery – instil hope.</td>
<td>Introduce the concept of recovery, provide definitions and describe how it is different from clinical recovery. Give examples of teams or services who work in a recovery orientated way. Identify the benefits for staff and people who access the service.</td>
<td>Introduce the concept of recovery, provide definitions and describe how it is different from clinical recovery. Give examples of people who have or are in recovery.</td>
<td>锻</td>
</tr>
<tr>
<td>Look at “a life beyond illness”.</td>
<td>How does the service take into consideration non-clinical goals? How much is the service focus on the person building a meaningful life?</td>
<td>Explore a person’s housing situation, whether they have a job or are interested in working. Do they have any hobbies or interests? Do they have any</td>
<td></td>
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<tr>
<td>For a Team</td>
<td>Resources to support this</td>
<td>For an Individual</td>
<td>Resources to support this</td>
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<tr>
<td>Develop a vision for the future.</td>
<td>Discuss the purpose and function of the team – develop shared vision statement based on recovery principles. Describe the role and limits of the service and what the service can do to facilitate a person’s recovery.</td>
<td>Discuss with a person how they would like their life to be, what their hopes dreams aspirations are/could be. Describe what the service can do to facilitate a person’s recovery journey.</td>
<td></td>
</tr>
<tr>
<td>Identify strengths and resources.</td>
<td>Discuss what has made the team strong and resilient to this point. What are the things that the team does well?</td>
<td>Introduce the idea that a person is or can be an expert in their own illness. Help them identify their strengths and resiliencies.</td>
<td></td>
</tr>
<tr>
<td>Look at key areas for development</td>
<td>Discuss as a team one or two specific projects that they would like to work on to develop the service.</td>
<td>Find out what is important to that person and what they would like to change and whether they want to look at any specific areas.</td>
<td></td>
</tr>
<tr>
<td>Look at ensuring safety and</td>
<td>Identify and evaluate threats,</td>
<td>Discuss with the person what they feel</td>
<td></td>
</tr>
<tr>
<td>Identify any risks or threats</td>
<td>Develop strategies as a team to manage risks and promote safety. Promote positive risk taking and build in structures to support this.</td>
<td>They need to do to keep themselves and or others safe. Explore positive risk taking – if people change their behaviour what might they be able to achieve? Draw up safety plans and crisis plans collaboratively.</td>
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<tr>
<td><strong>For a Team Resources to support this</strong></td>
<td><strong>For an Individual</strong></td>
<td><strong>Resources to support this</strong></td>
<td></td>
</tr>
<tr>
<td>Involve partners in all areas of development.</td>
<td>Communicate the vision and recovery principles to key partners, other parts of the service, other agencies. Embrace partnership working where possible.</td>
<td>Identify who the important people in the person’s life are. Encourage the person to involve or engage with these people in supporting their recovery. Explain the concept of recovery to people’s supporters and carers and make them aware of their own recovery journey.</td>
<td></td>
</tr>
<tr>
<td>Build in the opportunity to learn from mistakes.</td>
<td>These are new approaches and it is unlikely that we will get it</td>
<td>Explain to the person that recovery is a challenging process and that this is not</td>
<td></td>
</tr>
<tr>
<td>For a Team</td>
<td>Resources to support this</td>
<td>For an Individual</td>
<td>Resources to support this</td>
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<tr>
<td>right first time so try to understand the whole process as a learning one.</td>
<td>about getting it right or wrong but that there opportunities to develop and grow.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Celebrate successes</td>
<td>Celebrate success, build in positive feedback into meetings and supervision. Where people have been discharged or moved on or gained employment or made changes celebrate these.</td>
<td>Celebrate success, ensure people are given regular positive feedback. Where people have been discharged or moved on or gained employment or even made small changes, celebrate these.</td>
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<tr>
<td>Look at how changes can be measured and plans re-evaluated</td>
<td>Identify mechanisms that can support client feedback and how the specific projects are progressing. Identify indicator (either practical or attitudinal) that can demonstrate change. How will we know if things have changed?</td>
<td>Identify with the person how they will know that things are changing. Will it be about how they feel or what they are doing? Discuss outcome measures and whether these are useful. Get feedback on the service, and value the person’s perspective.</td>
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TERMS OF REFERENCE FOR THE WELLBEING AND RECOVERY PARTNERSHIP STEERING GROUP

1.0 Aims of the Group

- The purpose of the Group is to inform and support the co-ordination of the development of mental health services within Dorset in line with the principles of Wellbeing and Recovery.
- To support the organisational transformation that is required to become a recovery orientated service. Not just focusing on the experience of people who access the service but the experience of staff and the recovery journey of the organisation itself.
- The group seeks to challenge stigma and support creative ways the promotion physical and mental wellbeing of the whole population of Dorset

2.0 Primary Tasks of the Group

- To create the opportunities and support steering group members to model recovery orientated behaviours and attitudes
- To oversee and co-ordinate the implementation and development of the WaRP strategy plan
- To identify, prioritise and action plan specific workstreams related to WaRP strategy plan
- The group will act as a hub to inform and be informed by other service developments that are taking place across Dorset.
- The group will ensure the implementation of the principles of wellbeing and recovery are embedded in all other DHUFT meetings
- Evaluate the implementation of the strategy plan and using the Sainsbury Centre for Mental Health (2010) document: A
Methodology for Organisational Change, Outcomes of the patient survey and staff survey. In addition, to review and develop other outcome measures in order to capture the experience of people who access the service and staff and efficacy of the service in supporting people’s recovery journeys.

- To celebrate successes and positive achievements

3.0 Membership

- In the spirit of partnership working Jackie Lawson and Becky Aldridge will jointly chair of the meetings

- The membership of the steering group is through invitation only and consists of the following:
  - James Barton
  - Jackie Lawson
  - Becky Aldridge
  - Debbie Stevenson
  - Laurence Mynors-Wallace
  - Ciaran Newell
  - Colin Hague
  - Nick Plumbridge
  - Richard Peacocke
  - Sarah Watson
  - Sue Clarke
  - Phil Morgan
  - Penny Smith
  - Helen Le Marechal
  - Tim Devine
  - Sarah Tilbury
  - Liz James
There may be occasions when specific individuals or organisations are invited to the meeting.

4.0 Frequency and Duration of the Meetings

- Initially meetings were monthly however this has been reviewed and the meeting is now held bi-monthly. Frequency remains subject to review and need to change meeting frequency in line with the progress of the Strategy plan.

- Meetings will be structured to ensure that the agenda focuses on principle aims of the group and will not exceed two hours in duration.

5.0 Accountability

- The meeting is accountable to both James Barton and Becky Aldridge
APPENDIX 9
RECOVERY LEADERSHIP REPORTS
Recovery Leadership Workshops Autumn 2010

Four Recovery Leadership Workshops were held between October and November 2010, the purpose being to support Team Leaders in implementing the Recovery Strategy. The workshops were provided in recognition of the pivotal role team leaders have to play in implementing recovery principles in practice and influencing culture change, and in order to explore what support team leaders may need with this.

The aims of the workshops were to:

- Develop ownership of the Recovery approach by team leaders
- Identify the key barriers to recovery-orientated leadership
- Develop peer support and shared understanding between team leaders
- To start to identifying the skills required for recovery orientated leadership
- To examine the psychological processes of change and how services can unintentionally contribute to the differential reinforcement of dependence behaviours

The leaders of each clinical team were invited to attend one workshop. The workshops were facilitated by Phil Morgan and Becky Aldridge, and included presentations by Peter Thorne, Paul Maxwell-Bown, Jackie White and Kate Antell.

**Attendees:**

<table>
<thead>
<tr>
<th>29/9/10 Weymouth CMHT</th>
<th>30/9/10 Fred Treves House</th>
<th>7/10/10 Yeatman Hospital</th>
<th>29/11/10 Fred Treves House</th>
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<tr>
<td>Sally Branch</td>
<td>Jane Malcolm</td>
<td>Sarah Chubb</td>
<td>Steve Albon</td>
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<tr>
<td>Carol Freeman</td>
<td>Susan Gibson</td>
<td>Simon Coombes</td>
<td>Jacqui Andrews</td>
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<tr>
<td>Nicola Goeting</td>
<td>Ellie Madden-Crosby</td>
<td>Gary Cure</td>
<td>Julie Bartlett</td>
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<td>Geoff Holt</td>
<td>Rosemary Dewhurst</td>
<td>Natalie Hastie (for Liz Rose)</td>
<td>Debi Bowes</td>
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<tr>
<td>Philip Kelly</td>
<td>Peter Thorne</td>
<td>Jackie Lawson</td>
<td>Barbara Goodchild</td>
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<td>Barbara Lilley</td>
<td>Paul Maxwell-Bown</td>
<td>Peter Thorne</td>
<td>Simon Martin</td>
</tr>
<tr>
<td>Chris Mandy</td>
<td>Jackie White</td>
<td>Paul Maxwell-Bown</td>
<td>Garry Bond</td>
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<td>Heather Stacey</td>
<td>Apologies: Jackie Andrews</td>
<td>Jackie White</td>
<td>Rosemarie Picton</td>
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<td>Stuart Mead</td>
<td>Apologies: Steve Albon</td>
<td>Kate Antell</td>
<td>Katherine Price</td>
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<td>John Duffin</td>
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<td>Liz Rose</td>
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<td>Peter Thorne</td>
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<td></td>
<td>Michelle Selby</td>
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<td>Paul Maxwell-Bown</td>
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<td>Apologies: Sarah Humby</td>
<td>Phil Snook</td>
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<tr>
<td>Jackie White</td>
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<td>Jane Kinson</td>
<td>Ron Wilson</td>
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<tr>
<td>Kate Antell</td>
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<td>Liz Rose</td>
<td>Seth Rowles</td>
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<td>Apologies: Jane Abbott</td>
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<td>Michelle Selby</td>
<td>Peter Thorne</td>
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<td>Amanda Humphries</td>
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<td>Paul Maxwell-Bown</td>
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<td>Jackie White</td>
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<td></td>
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<td>Apologies: Marilyn McDonald</td>
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</table>
Agenda:

The workshops started with Phil leading a general discussion about what team leaders wanted from the workshops and what sort of barriers exist to leading recovery focussed services. Paul, Jackie and Kate then presented their version of “A Day in the Life of a Team Leader” which illustrated their views of the pressures faced by team leaders and the reasons why we should aim to be recovery orientated leaders. Peter gave a presentation about managing change, and Becky led a discussion on how to lead in a recovery orientated way.

The emerging themes were as follows:

People were asking for clarification about recovery focussed practice. It was evident that people had different levels of understanding of what recovery means, but that everyone was on board with the general principles.

The strongest theme to emerge was that team leaders unanimously feel under stress and disempowered, largely as a result of the conflicting pressures they face. They feel that they are left out of decision making processes and that there are too many imposed changes by non-clinicians. Team leaders have ideas on how things should be done differently, but often feel their hands are tied or that there is little energy left for feeling able to influence change. Team leaders described having to take on increasing workloads and a significant administrative role, particularly around Human Resources. The perception is many systems (for example, Sepia caseload exception reports) make people feel they are failing, the culture of the Trust focuses on what is not being done not celebrating what is being achieved. This is in conflict with the principles of recovery. As one team leader phrased it, “We need an organisation that facilitates recovery, not requires it”.

On a positive note, team leaders were keen to explore how recovery principles apply to managing staff, and how this would look in day-to-day practice. A desire was expressed to reignite passion for working with people, allowing creativity and empowering staff to make changes. It was recognised that the move towards recovery focussed services requires large scale culture change, and people want to know how to be able to influence this.

Again, very positively, team leaders want to explore how they can market and create opportunities for recovery focussed practice, and also how they can measure achievements.

It was acknowledged that in the current economic climate recovery could be hijacked to serve the political agenda solely as a cost-cutting exercise. Team leaders were adamant that they need to stay true to the real meaning of recovery, clearly remaining passionate about providing the best service for individuals in very unsettling and uncertain times.

The team leaders wanted to articulate the strengths of their role:

- Team leaders understand the difficulties and challenges faced daily by front-line staff. They act as buffers between front-line workers and senior management, protecting front-line workers and enabling them to get on with their roles, while having a good understanding of the bigger picture.

- They are credible leaders, recognised for having huge amounts of clinical experience and still engaged in clinical practice.
• They are naturally concerned, not only for the wellbeing of our service users, but also for their staff. If recovery is the right way to go with service users, this must also apply to staff. They know that in order to engage with staff they need to identify their strengths and resources, be interested in them as people, inspire a sense of self-belief, give them the information they need, and respect and value them. These are recovery principles, and they are also the principles of transformational leadership, which is the only truly effective way of influencing culture change.

• They have the potential to be an influential network. As a strong, experienced body of people, with service users needs their paramount concern, they propose that they should become more vociferous about asking for what they need, and doing less of what hinders them.

• Team leaders retain a strong sense of vocation. Recovery enables them to reconnect with the values that led them to come into the job in the first place, re-energising that sense of vocation.

• Team leaders have high standards, and are often highly self-critical. This is what leads to uncomfortable feelings of having failed, of not achieving anything. Being recovery orientated leaders means they can be open about their strengths and limitations, and gives them permission to seek help when needed. Team leaders should feel able to pay attention to their own well-being without feeling that they are failing. They realise they do not celebrate success enough.

Recommendations:

For the Operational Management Group:

• Team Leaders would like to communicate the messages arising from these workshops to the Operational Management Group and would also like for the Operational Managers to have the opportunity to participate in Recovery leadership workshops. It is felt that if these pressures can be recognised and team leaders feel like they have greater involvement and ownership of service developments that this would enable them to take increased ownership of new initiatives and approach problems with creativity. This would include further opportunities to engage with commissioners and for increase modelling of recovery leadership behaviours by operational managers.

• Establish formal and informal networks. Everyone in a leadership position should have an informal network via which they can seek peer support. The more formal Team Leads Network should become an autonomous network, with the agenda set by team leaders. The purpose of this would be to create reflective space, influence service development, and celebrate success. It is important that team leaders unite to identify how processes and systems can inhibit recovery ways of working and address them. We would recommend that the Operational Management Group supports the development of these networks.
• There needs to be a demonstrable organisational acceptance of positive risk taking and team leaders should be supported in leading positive risk taking practice.

• Team Leaders need a Recovery Orientated Management Toolkit. All team leaders should benefit from receiving training in transformational leadership skills i.e. how to communicate a vision, how to empower others, recognising others’ strengths, providing individual attention and inspirational motivation. At present, management training is focused on processes, policies and systems, rather than on how to lead in a recovery orientated way.

• Team Leaders and their staff need training in coaching skills as we move from a culture of caring to one of coaching.

• There needs to be a system for recording and monitoring unmet needs as team leaders try with limited resources to provide a recovery focussed service.

For Team Leaders

• Team Leaders to discuss with their teams what they feel they need to support recovery-orientated practice and feedback to Phil and Becky. As each recovery journey is unique and it is important that is owned at team each team needs to identify its own development goals.

• Team Leaders need to create space within their teams for “recovery headspace” i.e. creating time for recovery orientated reflection, celebrating successes, for example in team meetings and reflective practice groups. This needs to be supported by Operational Management Group

For the Wellbeing and Recovery Partnership

• The WaRP will present the findings and recommendations of this report to the Operational Management Group through the practice and quality business meeting.

• The WaRP will provide written guidance materials to support teams and team leaders by the end of January 2011 to support recovery

• The WaRP will develop a handbook to support staff and managers by the end of April 2011

• The WaRP are committed to meet any requests from teams or team leaders to provide on-going support

Completed by: Kate Antell, Jackie White, Paul Maxwell-Baum
Supported by: Phil Morgan and Becky Aldridge
Wellbeing and Recovery Partnership
Recovery Leadership Workshop: Operational Management Group
18th April 2011  2:30pm-4:30pm

Attendees: Brian Goodrum, Roger Bishop, Andy Vickers, Ally Howard, Claire Onions, Peter Thorne, Sarah Lomax, Deborah Howard, Julia Deadman-Spall, Genevieve Gallagher, Mark Humphries

Facilitators: Becky Aldridge, Phil Morgan, Jackie Lawson

Presenters: Kate Antell, Jackie White, Paul Maxwell-Bown

Introduction
The workshop’s aims were to identify: what recovery leadership is; why it is important; how it can be done; and how will we know it is being done. We felt that the participants engaged extremely well in the workshop and had a fantastic grasp of the recovery principles and a real willingness to embrace them.

The workshop strongly identified why recovery leadership was important, the characteristics and behaviour of a recovery leader. There was some initial work looking at how we would actually make these changes.

This report aims to accurately reflect the discussions held at the workshop. All the words from the flip charts produced by the attendees are included in the write-up. These are in italics.

The next step in developing this work will be translating these changes into tangible and measurable actions and outcomes. This will need to be discussed at the next Practice and Quality Group.

We also anticipate that some of the participants will start to change their behaviour following on from the workshop in terms of developing their awareness of the importance of recovery orientated leadership.

Format and Content of the Workshop
All the attendees were asked to bring a photo or picture that inspired them and that they were willing to talk about. These were collected from the attendees and tea and coffee orders were taken. They were then given a 10-minute presentation on “The Day in the Life of a Team Leader” from the presenters. This was the same presentation given to the team leaders at their recovery leadership workshops. The presentation is relatively tongue in cheek whilst at the same time hard hitting as regards the conflicting demands they have.

There followed a brief Q and A session. The Operational Managers shared that they felt subject to the same sorts of pressures and were keen to highlight that they do attempt to protect their team leaders from “top-down” pressure, but that some is unavoidable. The purpose of this presentation was to cue operational leaders into thinking about how they felt in their own roles and how they worked with others.
Following this presentation the group went downstairs to the “Recovery Leadership Café.” The rooms downstairs were prepared as if they were a café. Tea, coffee and cakes were served, music was playing and there were tablecloths. The overall aim was to create an informal atmosphere in which operational managers could feel relaxed but creative. Also on the table were four sheets of flipchart paper and pens. There were three tables. Each of the pictures collected from the attendees was put in one of the places on one of the tables. The attendees then had to find their place and introduce themselves by talking about why the picture they had chosen inspired them and what qualities they admired about the person. (This was to start to get people to think about the qualities they aspired to in relation to their own leadership style.)

The whole group then had an hour and a quarter to answer four questions:

- Why would/do you want to be a recovery leader?
- What does a recovery leader look like? What behaviours do they exhibit?
- How are you going to become a recovery leader? What will you do?
- How will you know if you are being a recovery leader? What are the barriers and how will you overcome them?

The groups changed tables after each question, with one person remaining behind to feed back what had been discussed on the table previously. This person also changed at each question so that by the end everyone knew what was being discussed on each table. At the very end of the session each of the three tables fed back their discussions. It was agreed that the facilitators would then write up the notes into this report.

The session ended with each participant writing a postcard to themselves, making a comment or commitment to themselves in relation to recovery leadership. These were done privately and put in sealed envelopes and will be posted back to the participants in three months’ time as a reminder of that commitment.

Reflections and Feedback from the Facilitators

We were exceptionally pleased with how well the event went and huge credit has to go to the participants who embraced the tasks and the approach with enthusiasm and passion. It was a real pleasure for us to be facilitators.

We would also like to thank Victoria Suter-Alexander for introducing us to the idea of the World Café approach.

Feedback on the Questions:

Why would/do you want to be a recovery leader?

The reasons for wanting to develop recovery leadership approaches were very much values driven which would lead to improving the quality of life for staff, ourselves, and people who access the service and their supporters. That in turn would lead to an opportunity for all to work towards a shared common goal.

One group described it as fighting back and re-engaging with fundamental values, a journey of discovery and rediscovery. Two groups talked about it being a way of getting “back to basics” and the core of what matters. It was described as a focus, something to hang on to and a key way to make a difference to peoples’ lives. We interpreted the comment about something to hang onto as
relating to the current changes and cost pressures within the NHS and Social Services, providing an alternative focus and a way of doing things differently – a catalyst for change.

The recovery approach was described as central in challenging stigma around mental health and developing services that see beyond a diagnosis. Recovery is about shared humanity and suffering is acknowledged as universal, not self-defining. Recovery leaders offer a positive and optimistic view of the future. It is a hopeful and fun approach which focuses on positive and dream. It is this hopeful approach which we believe creates the opportunities for things to be different.

A recovery leader enables people to build on what they have, and not what they don’t have. This allows greater opportunities to enable people to realise their ambitions (valuing people’s strengths and being aware of who they are and who they want to become). Recovery approaches build on strengths and accept we all have vulnerabilities. This reflexive stance and ability to focus on strengths and vulnerabilities is described as a healthy approach to leadership.

Through using recovery leadership approaches the participants felt that it could be liberating and could promote creativity; that it could unlock the potential of staff. The reasons for this were that each individual is valued and the focus is on people (not models) and relationships that are central to successful recovery leadership. Other qualities that aided this were described as being non-judgemental, loving, developing others, open, honest, offering increased choices and being supportive.

Another key element that recovery leadership offers, and thereby offers the opportunity to do things differently, is the shift in power (this likened to the broader political culture from state [and professional] to individual citizens). Through creating a supportive culture, which is fully inclusive and not hierarchical, people are able to be in charge of their own destiny. In order to be able to do this it is essential to respect one another and challenge with support.

One group put it simply: it is hard to argue against recovery.

What does a recovery leader look like? What behaviours do they exhibit?

A recovery leader:

- Has a vision and understands what they are leading on.
- Models healthy behaviours, such as taking a break, and sets a positive example to others.
- Is proactive and empowering.
- Is a teacher and facilitator, receptive, supportive and helpful.
- Is able to listen, to really listen to the person.
- Is interested in the person and responds to peoples’ different individual needs and develops structures to allow this to happen. They seek to understand what it is like to be in another person’s shoes and try to understand and respond to all roles and people.
- Is Reflexive and finds time for their own “head space” and creates time for others.
- Is able to tolerate uncertainty and not knowing.
- Is able to energise others.
- Is creative, able to explore different options and their effectiveness and creates opportunities to be a change agent.
- Is focused on positive outcomes and is able to identify strengths.
- Is able to take a balanced view.
• Is respectful to others but able to be challenging.
• Creates a culture of learning (failures or difficulties understood as learning opportunities) and trusts others (colleagues and clients) to act.
• Works with legitimate authority, acting with awareness of power imbalances (vis-à-vis ourselves colleagues and clients).
• Empowers people and trusts them. Respects differences and treats people with dignity and acts from principles of compassion and fairness.
• Is able to celebrate successes and promotes ambition.

How are you going to be a recovery leader? What will you do?

One group suggested that they should just do it! The participants strongly identified the need to model recovery behaviours. Recovery leaders need to challenge behaviours and words that are alien to recovery and have the courage of their convictions. They need to model looking after oneself, demonstrating “healthy” behaviours or not being seen as tough or superhuman. To take care of yourself so you have capacity to care for others; peer support was identified as an important way of doing this.

The definitions of recovery leadership are values led and are as much about attitudes and qualities rather than new systems or approaches. One group described this as being person-centred rather than process driven. Recovery leaders need to be honest to themselves and respectful to themselves.

Participants identified they will have to prioritise and manage their time to create space for themselves and others. A key part of this is allowing people to learn from mistakes, including their own. The participants reported that it was important to be able to trust and believe in people, responding to colleagues in a way that is validating, respectful and enabling and act in a way which modelled empowering others.

A key part of being a recovery leader is attempting to foster joint ownership of projects and the service as a whole (through sharing the purpose, evidence and meaning around why we are doing things and what we are doing with staff, people who access the service, their families and friends).

They will need to offer a supportive response when things go wrong and establish a reflective, listening culture, which understands and values complaints and compliments. Regular feedback slots will be developed. This will include feedback from clients, staff, team leaders and other managers. This will include a celebration of successes and what goes well with people who access the services, their supporters and staff. Mechanisms and processes will need to be developed in order to recognise the good job people do. Recovery leaders also need to be effective at communicating consequences when people do not subscribe to and act within the values of the service.

Receiving feedback was also seen as a key part of being a recovery leader, for example, asking for 360 degree feedback and to be open to learning themselves.

The recovery leader also has a responsibility to work “upwards” to support the organisational cultural shift required to sustain the implementation of recovery and change the demands made on them.
How will you know if you are being a recovery leader? What are the barriers and how will you overcome them?

In looking at the above question we were keen to highlight that in principle it is relatively straightforward to aspire to the behavioural change required. However, when services are squeezed and people start feeling under pressure it is more difficult to maintain recovery orientated behaviours. In answering this question we looked at how we could build in protective factors and accountability. The facilitators would suggest that it is this section that forms the basis for our action planning regarding the development of recovery leadership. The following suggestions were made:

1) The development of strengths focused approaches. It was identified that we should be routinely sharing and celebrating our success. However, in order to do this is we need to define what success is. (It was suggested that celebrating success could become a key component of some meetings, such as Practice and Quality meetings).
2) Establish feedback on recovery orientated leadership. One suggestion was 360 degree feedback.
3) We ourselves also need to be reflective and use the cycle of reflection.
4) Review and redesign our meetings so that there is a recovery focus to them. (The ingredients suggested included them encouraging participation, being respectful, nurturing and compassionate.) It was suggested a template could be designed.
5) Establishing effective team culture and culture change was identified. It was suggested that if the change in culture could be driven from the “bottom-up” it would be less restrictive and people in front line services may have the best ideas. This should also be supported by partnership working at all levels.
6) We discussed the current feedback and activity reporting (compliments, complaints, discharges) and balanced scorecard (attendance, incidents, sickness, recruitment) as a way to measure the changes. Happy staff was suggested as an outcome, although we would need to look at how we were measuring suggested happiness.
7) We need to be aware that this is a continuous journey. We need to continue to regularly reflect and review our practice and management approaches. We may need to develop an approach to ensure that happens.
8) In order to make this successful it is essential that all the aims are realistic and have a real world basis. We are committed to making real change and therefore it has to be tangible.
9) We could develop recovery instruments. These could be tools for managers, templates for meeting structures, self-evaluation tools, supervision and appraisal tools.

Conclusion and Recommendations

We view this report as containing all the raw ingredients required to create a clear definition of recovery leadership and some definite next actions in terms of developing how we are going to aspire to that definition. As regards the next steps we recommend:

- For the Operational Management Group to read and agree the report.
- To develop a concise (perhaps 10 point) definition of a recovery leader and cross reference it with the principles of recovery (see Appendix)
- To identify a number of specific projects as regards developing recovery leadership based on the nine areas outlined above.
Appendix

The Principles of Recovery

- Recovery is about building a meaningful and satisfying life, as defined by the person themselves, whether or not there are ongoing or recurring symptoms or problems.
- Recovery represents a movement away from pathology, illness and symptoms to health, strengths and wellness.
- Hope is central to recovery and can be enhanced by each person seeing how they can have more active control over their lives (‘agency’) and by seeing how others have found a way forward.
- Self-management is encouraged and facilitated. The processes of self-management are similar, but what works may be very different for each individual. No ‘one size fits all’.
- The helping relationship between clinicians and patients moves away from being expert / patient to being ‘coaches’ or ‘partners’ on a journey of discovery. Clinicians are there to be “on tap, not on top”.
- People do not recover in isolation. Recovery is closely associated with social inclusion and being able to take on meaningful and satisfying social roles within local communities, rather than in segregated services.
- Recovery is about discovering – or re-discovering – a sense of personal identity, separate from illness or disability.
- The language used and the stories and meanings that are constructed have great significance as mediators of the recovery process. These shared meanings either support a sense of hope and possibility, or invite pessimism and chronicity.
- The development of recovery-based services emphasises the personal qualities of staff as much as their formal qualifications. It seeks to cultivate their capacity for hope, creativity, care, compassion, realism and resilience.
- Family and other supporters are often crucial to recovery and they should be included as partners wherever possible. However, peer support is central for many people in their recovery.

Adapted from Recovery – Concepts and Application by Laurie Davidson, the Devon Recovery Group.
APPENDIX 10
PORTLAND YOI UPDATE REPORT
Dorset Wellbeing and Recovery Partnership

Promoting Emotional Health and Wellbeing in Portland Young Offenders Institute

**Wellbeing Toolkit Programme**

a) **Aim of the Programme:**

- To increase emotional resilience within the young offenders at Portland YOI.

b) **Objectives:** To encourage the young offenders to:

- Have an increased ability to “self-manage” their emotions
- Understand the links between their emotions and their behaviour
- Have an increased sense of emotional wellbeing
- Have an increased sense of purpose and identity

c) **Target Group:** Those Young Offenders who are situated on Benbow and Beaufort Wings. These wings were chosen because of their links with healthcare and the nature of the emotional needs of the inmates on the wings. Those who are referred to primary care mental health services but who do not meet the threshold for intervention but have clearly identifiable needs in regard to promoting their emotional resilience; ii) those identified by Wing staff who have clearly identifiable needs in regard to promoting their emotional resilience but may not require a referral to primary care mental health services.

d) **Background:** This project is being funded by the South West Development Centre as part of the local Access to Psychological Therapies services for 2010/11 developing Emotional Health and Wellbeing Services.

The Wellbeing and Recovery Partnership is a partnership between NHS Dorset: Community Health Services, Dorset Mental Health Forum and Dorset Healthcare University NHS Foundation Trust. The Dorset Mental Health Forum is an independent charity run and led by people who have experienced mental health problems and mental health services. The partnerships’ focus is changing the culture of mental health services and approaches to emotional wellbeing through promoting the principles of wellbeing and recovery, the expertise of lived experience and developing people’s ability to self-manage. For the purpose of this project the partnership is between Dorset PCT and the Dorset Mental Health Forum.

The WaRP has written agreement from Andy Tanner, head of residence, that the YOI support the development of this programme.
The YOI mental health team within the establishment offers mental health services for tier one to three mental health needs. Tier one mental health services are located within the prison within health care and accept referrals from any service in the prison and self referrals. The service offers assessment, support and treatment to prisoners suffering from a tier one mental health issue. Tier two of the service operates equivalent to a community mental health team model and offers assessment and treatment of serious mental health issues, ICPA management, access to specialist services and referral onto community provision. Tier two of the service receives referrals from tier one.

e) The Wellbeing Toolkit:

Bob Shaw (Peer Specialist for the Dorset Mental Health Forum) has developed the Wellbeing toolkit for the general population on behalf of the Wellbeing and Recovery Partnership. Bob is someone with lived experience of mental health problems and has used his own (and others) experience of recovery and self-management to develop the toolkit. This toolkit is also being piloted in secondary care mental health services.

The development of the toolkit was based on the principles of the Wellness Tool Box part of the Wellness Recovery Action Plan (Mary Ellen Copeland) or personal recovery plan, as well as those described in NIACE (National Institute of Adult Continuing Education) “The Really Useful Book of Learning and Earning” (2008). However, it was felt that these tools lacked a focus on a person’s own values, identity and narrative. This toolkit has focused on these areas as well, as more traditional aspects such as healthy daily routines and crisis planning.

The purpose of the toolkit is to be “a self help book you write for yourself,” within it you can put anything you like including pictures, inspirational quotes, techniques that you have found useful to regulate your emotions or mood, things that help when facing difficulties. The idea is the toolkit frames all the different areas of learning a person may take about themselves and put them into one single document. Each toolkit is intensely personal and will be different for each person.

So for example: for one of the young offenders it may be about them using the toolkit to help them understand how listening to music or going to the gym affects their mood and how this can also affect their behaviour, it could be used to help them understand and remind them how and why to use the techniques they have learnt through psychology sessions. It could also help the young offenders to think where they want to be in their lives in the future and make the links between what they are doing in the young offenders institute in relation to education and/or vocation and their futures. It can also be used to support people to identify how they ask for help and cope when they facing difficulties. The purpose of the toolkit is to create a single document which gives a person an overview of their lives and allows them to pull together all of the different learning that they are undertaking within the YOI and their previous learning.
Examples of sections of the toolkit:

- The following description is how I see myself as a person. It is a description of all the things that make me unique.
- This is what is important to me.
- This is what makes me happy.
- My hopes and ambitions are.
- What I want eventually is.
- These are the things that keep me well.
- When I am becoming unwell the following things may happen.
- The people I trust to be around me and advise me are.
- I have received advice from people around me. I may not take it but this is a list of the good things that were said.
- These are the things that have happened to me that make me proud of myself.
- As part of a healthy lifestyle I recognise that a healthy work/life balance is essential, this includes social activities, regular rest and good quality sleep. To achieve this I intend to do the following.
- This section I will write all the things that have helped me cope with difficulties that I have come across in my life.

One of the strengths of the toolkit is people only need to complete the sections that they feel are relevant to them. It is also something that people can keep coming back to and adding new learning and reflecting on.

The key to the development of the toolkit within the YOI is to ensure the programme is accessible to those who may have limited literacy or language barriers to their participation. There will also need to be some pre-engagement work to encourage the young offenders to identify the benefits of such an approach. We will also need to be aware of the support structures within the YOI and the limitations of them, ensuring the young offenders are not “unpacking” too much of their emotional life without having the tools to cope with the feelings that are released. Also we will need to be aware that although the toolkit is personal that within an individuals’ cell there is little private space and the potential for bullying if someone with got hold of their toolkit so consideration will have to be given to how this is managed.

The plan initially is set up a consultation group with some of the young offenders in developing the programme. We will then run a pilot group to test the materials, with a view to them running the full programme. Overtime and depending on the evaluation we will look to roll the programme out across the YOI and look for the opportunities to offer people the choices of attending the group, individual sessions and being able to complete it independently. In the longer term, there maybe some opportunities for some of the young
offenders who have been involved in the programme to support their peers in working with the toolkits.

f) Programme Outline:

The programme will run on a 6 week cycle, it will be offered to 8-10 young offenders at a time. It will consist of:

- A four week group
- Two follow up individual sessions

**Group Sessions**

The group will focus on engaging the young offenders using a range of creative and psychosocial activities encouraging them to start exploring the links between their emotions and their behaviour and to start exploring their identity in regards to who they are and who they would like to become. Exercises could include: designing posters, collage work, desert island discs. The group will slowly introduce the ideas of the tool kit and by the end of the fourth week each group member will have an outline of the first part of the toolkit, which focuses on who am I? and what makes me happy?

The group sessions may include some involvement from peer specialist staff, this would be training and the use of personal narratives (recovery stories) rather than individual coaching. This will need to be considered in the development of the toolkit and dependent on the YOI security department giving clearances.

**Individual Sessions**

These sessions will be followed up by two individual sessions which will focus on a person building up a picture of the skills and strengths they have to cope at present and things that they can do to increase that resilience and also identify the areas that they can work on to develop in order to set or start to work towards their broader life goals. The young offender will be encouraged to complete any relevant sections of the tool kit. The final session will also involve a brief meeting with the young offenders named Wing Officer so the young offender can share any learning with them and continue to build on the work once the programme has finished.

Due to the involvement of the Wing Staff training regarding the toolkit will need to be co-ordinated as part of this project.
Course Materials

The experience of the staff in the YOI is that the young offenders appreciate certificates and quality materials and that this significantly aids engagement and participation. Part of the funds will be focused on developing these quality materials.

g) Programme Delivery:

The programme will be predominately delivered by Healthcare staff, who will be linking closely with Wing Staff in feeding back and utilizing the training programme.

Dave Walker, prison mental health lead has identified Tracey Hendy, health care support worker and Louise Myatt, senior prison officer to deliver the programme. Louise is supporting the programme from the perspective of the wing staff. Dave is ensuring that Tracey and Louise can deliver this within their existing roles and views this as an opportunity to undertake preventative work which, improve cost-effectiveness.

Bob Shaw (Peer Specialist for the Dorset Mental Health Forum) has developed the Wellbeing tool kit for the general population. He is working as a consultant to the project supporting the YOI staff to adapt the toolkit. He may also directly input into training programme for staff and the young offenders. Bob is someone with lived experience of mental health problems and has used his own experience of recovery and self-management to develop the toolkit. This toolkit is also being piloted in secondary care mental health services.

Becky Aldridge (General Manager Dorset Mental Health Forum) will be coordinating other members of staff from the Forum to support Bob in consulting with the YOI staff and manage the evaluation of the project.

h) Programme development

The programme development and evaluation will be overseen by the Emotional Wellbeing Steering Group. This will include Phil Morgan (DCHS Lead for Recovery), Dave Walker, Bob Shaw, Tracey Hendy, Louise Myatt, Vladimiro Rocas (Community Development Worker) and Catherine Powell Deputy Lead Nurse and Mental Health Lead YOI. Vladimiro’s role will be supporting the development of the toolkit ensuring it meets the needs of people from Black and Minority Ethnic groups and people with other issues which may impede their fair access to services. The National Mental Health Development Unit (2010) have developed a Mental Well-Being Checklist to guide service developments in this area and this group will use this framework to support this proposal.

Dave Walker will also feedback the progress regarding the toolkit to the Health promotion action group and use this as an opportunity to link the programme with wider developments in the YOI and potentially the programme will be presented to staff and the young
offenders as a “road show.” There will also be links with the Education and Resettlement departments these are yet to be established.

i) Programme evaluation

The South West Development Centre suggested the *Warwick and Edinburgh Wellbeing Scale (WaEWS)*. Whilst the group see the benefits of using this scale, it is also felt that it will need to be adapted for the prison environment as a number of the areas (for example *I’ve been feeling loved*) may not be suitable, also there needs to be recognition of the limitations to an individuals’ life choices and happiness when in prison.

The group are keen not to use clinical measures as we are not aiming for clinical outcomes but rather focus on recovery outcomes (hope, identity, self-efficacy). In order to do this we plan to use the recovery star, which is a well established recovery outcome measure and we as we feel that the domains on the recovery star fit prison the environment better than other recovery measures and quality of life, wellbeing measures. The domains on the recovery star are Managing Mental Health, Self Care, Living Skills, Social Networks, Work, Relationships, Addictive Behaviours, Responsibilities, Identity and Self-Esteem, Trust and Hope.

- We plan to take a baseline measure using the recovery star and the adapted WaEWS prior to people joining the programme
- Another at the end of the programme.
- Then two follow up measures 6 and 12 months if we are still able to contact the young offenders.

We will also collect data on numbers participating in the programme and numbers completing the programme.

j) Time Scales

- We have commenced meeting as a development group
- We are currently developing materials to begin a consultation with some of the young offenders
- We plan to have the pilot established by May 2011
- We plan to commence the regular programme by September 2011
- We plan to review the programme in March 2012 and undertake initial evaluation and write up findings and develop a new project plan following early indicators. By March would aim to have had 40 young offenders undertake the programme.
k) Development of Pilot

There is currently an initial consultation being taken

l) Costings

Peer Specialist consultation:
Development of course handbook and training materials:
Development of the toolkit and printing costs:
Staff hours to co-ordinate and undertake evaluation:
APPENDIX 11
DORSET COMMUNITY HEALTH SERVICES
SUMMARY RISK STATEMENT
Wellbeing and Recovery Partnership: Risk Assessment, Management and Safety Planning Position Statement

In order to deliver effective recovery orientated practice the Wellbeing and Recovery Partnership (WaRP) feel that it is important to make a statement on our approach to risk assessment and management. This is in line with the findings of the Gonzalez Enquiry (2009) and the recommendations from the Sainsbury Centre for Mental Health for Implementing Recovery (2009). We need to re-evaluate our approach to risk assessment and management to ensure recovery principles are embedded. Following the principles of recovery does not mean that people are able to do as they please, rather they are encouraged to take responsibility and enter into shared agreements.

The key elements of this are engagement, collaboration, transparency and the promotion of an individual’s sense of control, sense of hope, and opportunities for the future (SCMH, 2009). A broad understanding of risk needs to form part of this with an awareness of not just physical harm to self or others but also emotional harm, this including an understanding of the emotional harm that limiting a person’s opportunities can have.

We believe the key to effective risk assessment and management is achieved through effective engagement strategies and the development of relationships. The recovery principles give us a way to engage more effectively with people. We should be looking to connect with a person’s story and engage on an adult to adult basis to develop effective safety plans.

The assessment and management of risk should be, where possible, a collaborative undertaking and a sharing of responsibility around the management of risk between the person, any supportive relationships that they have and the staff team and any other people or agencies involved with them. It is important that the views of the person and their supporters regarding risk are acknowledged, and that there is effective information sharing.

There will be times that services may deem that a person is not able to make informed decisions around their own risk management. It is important that in these situations that any advanced decisions are taken into consideration. People should be encouraged to develop advanced decisions when they are not in crisis that outline how an individual would wish to be happen when they are in crisis. As a person becomes more able to make effective decisions about their risk management, that responsibility is shared. Even when people are unable or unwilling to make decisions about protecting their own safety or the safety of others it is important that services maintain engagement and proactively aim to maintain and develop relationships and offer relevant choices, where possible, and uphold the guiding principles of the Mental Health Act 2007 and Mental Capacity Act 2005.

It is important to acknowledge that as part of the risk assessment and management process that conflict and disagreement may arise. When this occurs it is important to still maintain engagement and that our approaches are underpinned by the values of recovery. It is also important to be transparent as far as possible and that disagreements are noted and solutions, where possible, are worked towards. It is
central that the staff are skilled in using conflict resolution techniques and motivational approach to support the more effective management and self-management of risk.

The Department of Health (2007) acknowledges “the possibility of risk is an inevitable consequence of empowered people taking decisions about their own lives.” It is important the organisation and organisational structures (such as documentation) recognise and support the importance of positive risk taking.
APPENDIX 12
ENHANCED RECOVERY STRATEGY
Enhanced Recovery Strategy

VISION

To create acute care services that promote recovery, where all people are empowered to make choices about their lives, to pursue their personal goals, and to do so with dignity and the respect of others.

MISSION

To accomplish this, services, support and guidance must be delivered in the least restrictive, non-stigmatising, easily accessible manner, informed, where possible, by predetermined client choice. This should be within a coordinated system of community and self care, together with a safe, sensitive and supportive environment for those who require hospitalisation. This should be respectful of a person’s family and loved ones, language, culture, ethnicity, gender and sexual identity.

INTRODUCTION

The purpose of this strategy is to address the challenge of transforming the acute services in Dorset Community Health Services (DCHS), in line with QIPP agenda and putting recovery at the forefront of all interactions. In order to achieve these changes it will require both a reallocation of resources and a shift in culture in reducing a model of dependency to one that enhances self-efficacy. This brings two significant challenges which DCHS is in the process of addressing:

The first is to move away from hospital based acute services to high quality and comprehensive community services. Studies have repeatedly found that while clients sometimes state hospitalisation is necessary, they often report negative experiences. Their preference is for increased support and choice in the community, which significantly minimises disruption to other aspects of their lives. The predominate way to achieve this will be through the continued development of Crisis Resolution and Home Treatment services (CRHT). However, to date, Trusts who have already been through this transition, i.e. moving resources from inpatient settings to the community, have reported varying degrees of success. Those who have reported greatest success have demonstrated a significant reduction in the cost of inpatient beds with an efficient around the clock mental health service available in the community.

The second challenge is to implement a recovery approach which requires a fundamental shift of the dynamics of power. This shift will involve working toward an individual maximising their life opportunities through, or despite, periods of intense emotional distress. This is in contrast to the historical predominant model in mental health which is a diagnostically driven illness approach.
It is essential that these two points are addressed simultaneously. A successfully reallocation of resources can only be achieved effectively with a dramatic shift in the culture of delivery of mental health services. This will be achieved with partnership working between staff, individuals who use service and their supporters.

The purpose of this document is to outline the vision which will underpin the strategy for change of culture and identify the key projects which will drive these changes.

GOAL

People in emotional distress or mental health crisis experience a service which is reflective, empathic, promotes hope, enhances strengths and self-efficacy, while providing the opportunity to learn about their experiences. Any learning should be shared among significant individuals and services involved, thus maximising a person opportunity to develop as part of their recovery journey.

AIMS

In order to achieve the goal outlined above, the following aims have been identified:

1) **Mental health services promote environments and opportunities that support recovery.**

   The development of crisis resolution and home treatment services will be an important aspect to this. In addition, effecting change in the therapeutic environment of inpatient units will take place primarily through implementing Star Wards and developing the Tidal Model.

2) **Mental health services demonstrate a reflective and empathic approach**

   Attention will be given to quality training and development of essential interview skills, through Motivational Interviewing, clinical supervision and reflective practice. The role of peer specialists will be developed.

3) **Mental health services promote hope for individuals, recognise strengths and enhance self-efficacy**

   The focus will be on empowering individuals to take control of their own lives while accommodating mental health difficulties. Systems and approaches will be established that maximise clients’ opportunities to utilise their strengths and to be involved in decisions over all aspects of their care, including medication.

4) **Mental health services facilitate a safe space for individuals to learn about themselves, their vulnerabilities, and how to be actively involved all aspects of their recovery**
Clients will be encouraged to engage in producing a Personal Testimony of their experiences in mental health services. They will also be assisted in developing an awareness of relapse signatures and potential life stressors which led to this contact.

5) *Mental health services provide opportunities for individuals to integrate their experiences and regain control over all aspects of their lives*

Robust and systematic communication between acute services and community teams will be promoted to enhance the opportunities for individuals to aid their self-management. Client-centred approaches to crisis planning and clearly stated advanced decisions will be encouraged to enhance any future contact with acute services.

**OBJECTIVES**

The above aims will be achieved by implementation of specified objectives and addressed through a transition project in which staff are supported in transferring their skills from primarily working in inpatient settings to the community.

In order to achieve aim one, *Mental health services promote environments and opportunities that support recovery*, the follows areas will be addressed:

- Gate keeping is effective so that people are treated in the most appropriate and least restrictive environment
- Inpatients units apply and work towards the Star Wards programme
- Inpatient units continue to work to and develop the Tidal Model
- Attention is given to the factors that have influenced the aspiration of Zero Restraint *(REF)*
- To develop alternatives to hospitalisation, such as crisis house or respite houses
- To continue to develop and expand Crisis Resolution and Home Treatment services (CRHT)
- Wherever possible to offer individuals choices as to how they wish to be supported and how that support is offered when in crisis
- Robust systems are in place regarding communications such as advances decisions, crisis plans etc. All staff should be aware of how to access such information.
- Mental health services to engage with an individual’s supporters or carers in a way in which they can enhance a person’s recovery
- For people to have the opportunities to explore their personal experience and understanding of what is happening for them (spirituality)
- To increase the amount and the quality of 1:1 time
- To develop mechanisms of receiving feedback in order to understand how best to create a recovery enhancing environment (e.g. Personal Testimony and feedback forms, formal questionnaires etc.)
• To ensure people are able to participate in a range of meaningful activities

In order to achieve aim two, *Mental health services demonstrate a reflective and empathic approach*, the follows areas will be addressed

• All staff participate in clinical supervision and reflective practice
• All staff are trained in Motivational Interviewing (which is underpinned by person-centred counselling skills)
• Staff be encouraged and time allocated to regularly attend education/development slots
• The needs and requests of individual clients are taken into consideration when organising and participating in clinical reviews, ward rounds, CPAs etc
• To constantly be aware of the potential for staff to adopt pejorative attitudes in regards to people using mental health service.
• Driven by the *Zero Restraint* Initiative, to develop de-escalation and conflict resolution training
• To employ peer specialists to facilitate an empathic and reflective response from the service
• For staff and people who use the service to participate in group activities which facilitate reflection and understanding.
• To develop mechanisms for feedback on the experience of people who use the service and build feedback into staff and team supervision (patient testimony)

In order to achieve aim three, *Mental health services promote hope for individuals, recognise strengths and enhance self-efficacy*, the follows areas will be addressed

• To build staff belief in how well people can become by having meetings with individuals who have previously been in hospital once they are “well”
• To develop the acute OT services through the OT recovery pathway approach
• Ensure all meetings (ward round, CPAs etc), assessments and reports identify strengths and these are fed back to the person
• All handover meetings to also focus on strengths and promote hope, as well as discussing problems and symptoms
• As soon as viable, collaborative risk taking happens and people are encouraged to build up their own abilities to keep themselves and others safe
• People are introduced to recovery-focused self-management tools (e.g. Wellbeing toolkit, WRAP, crisis plans) (ALSO IN AIM 4)
• Wherever possible, when offered medication, individuals have a fully informed discussion on the purpose, side effects and choices
• Individuals are offered group and individual psycho-education regarding their diagnosis or experiences.
• Increase awareness?
In order to achieve aim four, *Mental health services facilitate a safe space for individuals to learn about themselves, their vulnerabilities, and how to be actively involved all aspects of their recovery*, the following areas will be addressed:

- Regular scheduled Individual time with dedicated worker to focus on solutions to specific difficulties
- Identify personal relapse signatures
- Identify personal goals
- WRAPs will be a key self-management tool, to inform service input, e.g. they include advance decisions and relapse signatures
- Focus on identifying and facilitating vocational pursuits
- Encourage individuals to produce a Personal Testimony of their admission and staff to reflect upon these
- Aspects of the Personal Testimony are drawn upon to contribute toward the development of an Advance Decision document

In order to achieve aim five, *Mental health services provide opportunities for individuals to integrate their experiences and regain control over all aspects of their lives*, the following areas will be addressed:

- To increase the interface between acute services and the community (Recovery Teams, CRHT etc) and/or other services such as rehabilitation
- With permission, mental health services forge relationships with employers
- Increase input from CPA, CCO into acute episodes
- CPA CCOs to support the learning from a period of crisis by working with the person on crisis plans and advanced decisions. It is essential that this information is easily accessible to all staff in mental health services, if required
- CPA CCOs or community OTs to follow up goals identified on the recovery pathway
- Psychological therapies to be available for individuals to follow up any identified needs whilst in acute services

Phil Morgan and Kim Jolliffe
Enhanced Recovery Strategy Steering Group
September 2010
Welcome to the Wellbeing and Recovery Partnership (WaRP) newsletter specifically for supporters of people with mental health problems.

The Partnership’s aim is to embed the principles of Wellbeing and Recovery across all services within Dorset. Recovery in this sense does not mean “getting better” but having the opportunity to build a meaningful life with or without the symptoms of mental illness.

This involves moving away from traditional styles of service delivery to a more person-centred, strengths based approach, engaging with people who access services as partners on their individual journeys of discovery. We believe that developing partnership working with people’s supporters is an essential part of this process too. Hope is also a crucial ingredient. It is key in all aspects ... for the person experiencing the mental health problem, for their supporters and also for professionals. We want to put this at the heart of service design and delivery. This requires a culture change within existing services.

Recovery orientated communication is characterised by “clinicians having relevant expertise, but not positioning themselves as the experts; an expectation of knowledge being shared rather than exclusive and a lack of jargon.” (Slade, 2009)

With this newsletter, we would like to begin a discussion about recovery in relation to carers or supporters. We think that there are three key strands to be considered. Firstly, that supporters have a key role in an individual’s recovery journey. Secondly that the principles of recovery also apply to supporters of people with mental health problems, who are on their own recovery journey. Lastly, but very importantly, being able to share experiences of supporting someone with mental health problems with other peers is invaluable.

We would love to hear from you. Please let us know your views and ideas. Our contact details are printed overleaf. If you would like more information on the Wellbeing and Recovery Partnership (WaRP) and / or you may like to get involved with our work, please let us know.

Phil Morgan, Becky Aldridge and Jackie Lawson

Helpful Definition of Recovery

“Probably the most useful way of understanding recovery is linking it to our own experience because it is something that is common to all of us; it is not specific to mental health problems. Any of us, who have been through a divorce, being made unemployed, a major illness or bereavement, know that that changes us; there is no way to going back to how we were before that event. We have to incorporate that into our way of living and we learn from that and move on with that, which is exactly what we are talking about in terms of recovery from mental health problems. Very importantly, recovery is about taking back control over your own life and your own problems, about not seeing your problems as being uncontrollable, or that their control is just the province of experts. It is about understanding yourself what is possible and what you can do to help yourself.”

Dr Julie Repper, 2009
“What does Recovery mean for us?”
A supporter’s perspective

Murray Rose, chair of the Bridport Carers Forum, describes the opportunities the recovery approach creates for carers:

“Behind almost everyone with mental health problems are those that care, usually relatives, often friends: known collectively as ‘carers’. The name creates a wrong impression, because the term ‘carer’ is generally used for a person who cares for the elderly, helping them cope with their infirmities, often living together to look after their every need. In the world of Mental Health the ‘carers’ role is very different. The need is for those experiencing mental health problems to be as independent as possible. The carer is there for companionship, advice, discussion and moral support. Support is the word, not care in the sense of being looked after.

With the revolution in attitude to treatment being brought about by the Well-being and Recovery Partnership, the contribution from the support person becomes very significant. He or she often best knows the person, knows what his or her interests and aspirations were and are, and can help in guiding recovery along the lines that would fit best with the interests of the person.

Hopefully, gone are the days when the professionals regarded carers as untrained, over-protective and part of the problem. The Well-being and Recovery Approach should give carers an equal role to the professionals, because of their knowledge of the individual, their concern and their ability to recognise early deterioration in health. Through their day-to-day contact, carers are able to encourage the person to get the most out of their life. The carer should be accepted as important by the professionals.

Carers or supporters also have a responsibility to develop this role. Here are some suggestions:

- Firstly, people need to understand the objectives of the new recovery philosophy, so that they can see how the services are aiming to create opportunities for the person to build a meaningful life for themselves.

- Secondly, they can learn how to help a person on their recovery journey. For example, Carers who belong to carers groups will hear from guest speakers, and will be able to discuss and develop ideas amongst themselves. Carers not in groups could attend one-day seminars where some training and much discussion can take place.

- Thirdly through strengthening communications, a possibility is a regular newsletter, such as this. This would enable most carers to be contacted, but a newsletter alone will lose the opportunity of interacting with other carers, which can be a great help when trying to cope with mental health problems.

- Finally, there also needs to be a change in the approach from services and how they involve carers. The CPA (Care Plan Approach) where all interested parties get together to plan a future does not function well for them. The meetings are often held without the carer attending because the carer cannot make the meeting, or because the person does not feel the need for a ‘carer’ to be looking after him or her. The carers often feel they are left out of information sharing unnecessarily on the grounds of ‘confidentiality’. Confidentiality becomes a very serious matter when the person rejects the carer, because even then, the carer does not stop being the carer.

We carers are not keepers, the name is wrong. Our role is support, concern, interest and advocacy. We should have a better name. We have a total interest in our loved ones, and want to celebrate their recovery to a meaningful life, helping in any way we can.”

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Peer Specialist Update Report

1. Purpose of the Report

1.1 The purpose of this report is to update the Workforce Development Group on the progress with regard to implementing the development of peer specialist roles within Dorset Community Health Services (DCHS). Following the Workforce Development Group supporting, in principle, the development of these roles a Peer Specialist Development meeting was set up to co-ordinate and fact-find around this innovative area of mental health practice. The Peer Specialist Development Group consisted of mental health staff, members of the Dorset Mental Health Forum (DMHF), Practice Development and Learning Centre, Human Resources and Clinical Governance. This report outlines the finding of this group and a future direction for peer specialist roles. In summary:

- Following initial positive feedback from service users and DCHS staff we are proposing an extension to this programme and to formalise the development of peer special roles across mental services.

- The group is asked to NOTE the recommendations contained within this report and to agree to the progress of the planned implementation of peer specialist roles across the organisation.

2. Background

2.1 The Wellbeing and Recovery Partnership (WaRP) between NHS Dorset: Community Health Services (DCHS), Dorset County Council (DCC) and Dorset Mental Health Forum (DMHF) is tasked with influencing the delivery of mental health services by “putting recovery at the heart of what we do.”

2.2 Peer specialists are staff who have lived experience of mental health problems, who use this experience to coach others to take control over their own lives and mental health problems. They also act as a bridge between professional staff and people who access the service. Peer specialists seek to role model recovery and are pivotal in organisational culture change, offering “a beacon of hope and a living demonstration that people with mental health problems can make a direct contribution to their own and others’ recovery by using their experience in paid staff positions” (SCMH, 2007, p11).

2.3 DCHS in partnership with Dorset Healthcare University Foundation NHS Trust (DHUFT) and DMHF have been awarded the status of Demonstration Site by the Centre for Mental Health (CMH, formerly Sainsbury’s Centre for Mental Health [SCMH]), due to their commitment to embedding recovery principles in their organisational framework. Central to this is the commitment to developing a Recovery Education Centre and peer specialist roles.

2.4 The Centre for Mental Health describe the vision of the changes to service delivery: “Professionals will remain important, but they will have to recognise that their contribution needs to be made in a different way, acknowledging service users’ self-defined priorities. By contrast, we expect to see a greatly expanded role for ‘peer professionals’ in the mental health service workforce of the future. We recommend that organisations should consider a radical transformation of the workforce, aiming for perhaps 50% of care delivery by appropriately trained and supported ‘peer professionals’ (using the proposed local Recovery Education Centre to train and support these new staff)” (2009 p2).
2.5 In progressing peer specialist role development within DCHS, a qualitative review of the initial pilot phase has been undertaken and the results reviewed within the context of how the post has been perceived by service users and the wider workforce, through case vignettes and experience of the ‘peer specialist’.

3. Update on Peer Specialists within DCHS

3.1 The pilot posts where we were exploring and examining the efficacy and impact of peer specialist roles were in two key areas:

- North Dorset Community Resource Team (CRT)
- Dorchester and Bridport Community Resource Team (D&B CRT)

3.2 Both peer specialists were employed by DMHF and placed within integrated NHS/Local Authorities (LA) services. Although peer specialists form a broad range of roles, which include consultancy and training, with regards to this report the peer specialists referred to are those who work directly with service users within NHS teams, delivering recovery coaching.

3.3 The peer specialist in the North Dorset CRT was based in the employment service having a specific remit to work with those service users who had identified vocational activity as a goal. The role in D&B CRT was much more general, looking at scoping out the potential of the role; undertaking individual recovery coaching with identified service users; and supporting the team to develop recovery orientated practice.

3.4 The evidence of the efficacy of the roles was collected through service user testimony and feedback from staff. The overall feedback has been that the peer specialists have delivered a useful and unique contribution. People who access the service have been able to meet vocational goals and goals relating to social inclusion due to the interventions of the peer specialist. The experience for staff in both areas has been that their eyes have been opened to different practices through asking different questions and using different approaches.

3.5 On the whole the peer specialists and people who access the service report a close rapport, which stems from having had similar experiences. The very nature of people with lived experience being employed by statutory services gives people who access the service a sense of hope, that their life can be different.

“**Inspirational and motivating**”  “**I have found (peer specialist) very helpful and a big motivator**”

“I personally did not realise people like (peer specialist) were working for these type of agencies … this has been a positive eye opener”

“If you can do it I can do it and that’s good for the hope thing”

“I can’t think of anyone better qualified for this type of service”

3.6 This initial positive feedback indicates that the development of peer specialists is worthy of further investigation. We are proposing to expand the number of peer specialists and formalise the evaluation process. Despite the positive indications there are a number of significant issues and problem areas that need to be addressed as regards to the further development of the roles. As these roles are new to the UK Health & Social Care arena there is limited information and guidance on how these roles should be developed; therefore the pilot roles have been developed within a loose framework. In order to scale up the number of peer
specialists and the evaluation, further development in policy and guidance documents is required.

3.7 We see the role of DMHF as integral in the development of peer specialist roles. In examining models for employing the peer specialists we would favour them being employed by DMHF and then being placed within the integrated NHS/LA services. We believe this to be important as DMHF is a recovery orientated organisation led by people with lived experience and are therefore able to provide the type and level of support essential to the positive development of peer specialist roles. This is particularly important when the NHS and Social Care is under a period of significant upheaval and is in the process of becoming (yet to become) recovery orientated organisations. It also allows DMHF to be in the position of “critical friend” ensuring that the development of peer specialists is supported by the organisational change required.

4. Areas for Further Development

4.1 Organisational Change and Team Culture

4.1.1 Central to the development of peer specialist roles is the organisation change which supports the development. The WaRP project plan is looking to address this on a global level. However, at a local level it is important that the team culture supports and promotes recovery. In one of the teams this was not an issue. However, within another service there were some barriers in relation to staff feeling uncomfortable about having someone who has accessed the service working alongside them, with the peer specialist being aware of this discomfort and this impacting on his/her integration into the service and thus increasing his/her levels of work-related stress. This was not necessarily the team within which the peer specialist was placed, but the wider Community Mental Health Service (CMHS). Due to this, for the second part of the placement, the peer specialist was primarily based within the DMHF office rather than the CMHS base. There also appeared to be a rather limited understanding of recovery within that service despite there being presentations and information about recovery available.

4.1.2 The Scottish Recovery Network argues that peer specialists should not be introduced to implement recovery, particularly if they are the only peer specialist in the team. With a view to future placement of peer specialists, it is essential some assessment is undertaken in assessing the “recovery readiness” of the team to ensure the peer specialist will be utilised to their full potential; but also when peer specialists experience prejudice and stigma from within the service it can impact negatively on their own wellbeing.

4.1.3 The WaRP is developing Recovery Skills Training which will be rolled out across the whole of DCHS; this will include references to peer specialists and their roles. The process of developing Recovery Leadership Workshops has commenced and this in the future will include supporting peer specialists.

4.2 Promoting the Peer Specialist Roles and Consultation

4.2.1 Although staff have been given regular presentations and information regarding recovery there was still some confusion around the peer specialist roles. Where the role was more specific within the North Dorset locality this was less of an issue.

4.2.2 There were some difficulties regarding the introduction of the peer specialist within the Central locality. It became evident that there needed to be effective
communication to all staff and an official message from the locality and team leaders including administrative staff, in order to manage issues around staff’s anxieties, and particularly about confidentiality.

4.2.3 In order to take the peer specialists to the next stage it is important to develop some targeted communications for all staff. It will also be important to involve the Union and staff side representation in developing any consultations about future peer specialist roles. Phil Morgan (Lead for Recovery) has already had some initial discussions with Paul Turner (staff side) and he is in the process of identifying a representative to sit on the peer specialist Development Group.

4.2.4 It is important to note that peer specialist roles relate specifically to those who use their experience intentionally to coach others to support their recovery journey and is not the same as employing people with experience of mental health problems into existing posts.

4.3 Human Resources and Occupational Health

4.3.1 Through liaising with the Scottish Recovery Network who has made some significant progress on developing peer specialist roles. They state that special provision should not be given to peer specialists rather the organisation should be able to support its staff effectively whether they have mental health problems or not.

4.3.2 The WaRP is working closely with Occupational Health in developing guidelines to improve the efficacy of how we support existing NHS staff who experience mental health problems. DCHS is also developing a *Hidden Talents* programme which supports challenging stigma within the NHS for staff who have lived experience and also utilising their expertise by experience in practice. The WaRP and Occupational Health (Jessica Foster and Diane Fowler) have developed a joint paper *Occupational Health and Wellbeing and Recovery Partnership: Staff Wellbeing Proposal* which makes a number of recommendations in relation to changes to current practice in order to effectively support all staff (see Appendix 1 for recommendations). Julia Wiffen (Account Executive for DCHS within Human Resources), is aware of this report and it is due to be presented to the Dorset Healthcare University Foundation Trust (DHUFT) WaRP Steering Group on which Colin Hague (DHUFT lead for Human Resources) sits.

4.3.3 In the discussions we have had with Occupational Health they have indicated they would be willing to support peer specialists employed by DMHF placed within the NHS. As part of the development work we need to identify the mechanisms for this.

4.3.4 Peer specialists should have a line manager within the integrated NHS/LA services and recovery supervision through DMHF. As part of the recovery supervision staff are encouraged to complete advanced decisions and explore their self-management skills.

4.3.5 DMHF have developed a generic job description for peer specialists (see Appendix 2).

4.3.6 When looking at staff development more broadly, we need to ensure that lived experience of mental health problems is valued in all roles and that understanding of recovery principles is an essential criterion. We look to Human Resources for guidance around updating job descriptions. We would also
welcome support around developing recruitment strategies that focus on attitude as well as skills and knowledge.

4.4 Confidentiality, Clinical Governance and Practice Development

4.4.1 A key concern for staff when working with peer specialists has related to confidentiality and information sharing. DMHF has its own policies and procedures which include confidentiality. Joyce Green has delivered a talk on Information Governance to DMHF including the peer specialists. There is also a draft agreement, through the General Protocol for Information Sharing between Dorset Community Health Services and Dorset Mental Health Forum. In order to make this more robust we need further clarification from Information Governance on the best way to take this forward.

4.4.2 Following a discussion with Debbie Streeter (Clinical Governance Lead) we established that peer specialist roles were not clinical roles, therefore at this stage did not need access to SEPIA nor to input directly onto SEPIA. Any relevant data was inputted by clinical staff. However, with the expansion of these roles this position may need to be revised.

4.4.3 DMHF recruitment procedures are quality checks through the integrated contract arrangements. In order to bolster this Helen Harris is looking to establish a secondment agreement between DCHS and DMHF.

4.5 Training and Development of Peer Specialists

4.5.1 Although peer specialists have the DMHF induction it is essential that they also access the DCHS induction, including breakaway. In addition, peer specialists are able to access DCHS training.

4.5.2 A training strategy is under development as are plans for the Recovery Education Centre and has been ingrained into the Terms of Reference of Joint Mental Health Training Group. A primary part of the Centre for Mental Health Methodology for Organisational Change is the development of a Recovery Education Centre. A Recovery Education Centre is defined as follows:

4.5.3 “This is staffed and run by ‘[service] user trainers’ and delivers support and training for service users to train staff in recovery principles for teams and wards. (It may or may not be delivered by an external, independent sector [service] user/trainer organisation.) The Centre also runs programmes to train service users as ‘peer professionals’ to work alongside traditional mental health professionals as direct care staff. Arrangements for the management, supervision and support of these staff are co-ordinated by the Centre staff. The Centre offers courses to service users, their families and carers on recovery and the possibilities of self-management. There are a range of links to general educational classes in the community and pathways to courses and other learning opportunities” (SCMH, 2010, p10).

4.5.4 With our training strategy we are in the process of developing this work and would seek endorsement of this through the Workforce Development Group. Our current developments are as follows: DMHF has developed an in-house peer support training which they are currently piloting; a Recovery Skills training programme is under development and planned to be launched in April for all NHS staff; in the future there are plans to develop accredited peer specialist training. All these training courses will be delivered by those with lived experience and where appropriate in partnership with statutory staff.
4.5.5 Current peer specialists are receiving individual mentoring and are being recruited specifically for their existing skills and abilities in relation to being able to self-manage to a certain level, to model recovery and be able to coach recovery.

4.6 Peer Specialists Accessing Mental Health Services

4.6.1 In the evaluation undertaken by the Scottish Recovery Network it was identified that peer specialists may become mentally ill during the course of their work. Interestingly the feedback also stated that people felt that through their role as peer specialist they were able to learn how to self-manage more effectively and these episodes of illness actually enhanced their practice (The Scottish Development Centre, 2009).

4.6.2 It is essential that there are effective support structures. In addition to those outlined in the Human Resources and Occupational Health section of this report, where a peer specialist needs to access services it has been agreed that the peer specialist will access the services in the same way as existing integrated NHS/LA services staff and be subject to the same levels of confidentiality.

5. Future Developments

5.1.1 There are a number of opportunities to develop peer specialist roles, some of which have already begun to take place. These are as follows:

- IAPT – 4 employment support co-ordinators (ESCs)
  - 1 psycho educational course assistant (currently undertaking IAPT low intensity training)

- North Dorset – 1 in CRT employment team
  Further posts under development

- Weymouth and Portland CRT – small scale pilot with 3 posts forming a team

- Bridport CRT – small scale pilot (as above)
  - 1 peer specialist linking with primary care team in GP surgery

- Acute Care – 2 peer specialists working within Stewart Lodge

- YOI Portland – post under development for Wellbeing Toolkit

- Dorset County Council Supporting People Housing (Weymouth) – 2 peer specialists within the team (under development)

5.1.2 It is proposed that peer specialist posts are developed as positions become vacant and through applying for external funding. It is important that the existing peer specialist posts have their funding agreed for the following year. Joanna Neilson (DCHS Service Development Manager) is putting together a business case as regards the development of peer specialist roles to this effect.

6. Conclusion

6.1.1 This is an extremely challenging and exciting time within mental health services and the development of peer specialist roles gives us the opportunity to be at the cutting edge of mental health service delivery. We would like to thank all the staff who have been involved in establishing these pilot positions and commend them for their vision and forward thinking.
6.1.2 The vision of the WaRP is that peer specialists are employed in a range of areas across primary and secondary mental health services and within communities. These areas would include: Acute Care, Community Services, social networking activities, peer support, delivering Recovery training, as well as consultation and representation of people who use services and participation in the planning and design of services. This would be supported by the development of a Recovery Education Centre. It is anticipated that these developments would be supported by our existing structures with guidance from the Centre for Mental Health through our Demonstration Site status.

6.1.3 DCHS is due to become part of Dorset Healthcare University NHS Foundation Trust (DHUFT). This does not impact negatively on the future development of peer specialist roles as DHUFT is fully signed up in principle to the WaRP and its strategic plans. A steering group is being convened in February which Becky Aldridge (General Manager DMHF) will co-chair and on which Phil Morgan (Recovery Lead for DCHS) will sit. It is anticipated that the learning experience of DCHS with regard to developing peer specialist roles will have a significant influence in the development of peer specialist roles for DHUFT.

6.1.4 We feel that the indications are strong that peer specialists have a significant and unique contribution to the delivery of mental health care which will offer a cost-effective approach to providing a service more in line with the requirements of the people who access the service. The Scottish Recovery Network (2006) identified the key areas of potential benefit as follows:

- Increased understanding of service user perspective / service user involvement culture
- Engaging hard to reach groups
- Increasing choice within existing mental health system
- Reducing workload for statutory services
- Cost-effectiveness

6.1.5 It is suggested therefore that these areas are the ones used to evaluate the second stage of the pilot programme and that, through working with Joanna Neilson in the development of the business case, outcome measures are identified in relation to the above. They will also collect data on staffing regarding attendance and performance.

7. Recommendations

- For the Workforce Development Group to endorse the expansion of the peer specialist pilot and the communication of this information across the organisation and to maintain the level of funding currently in existence for peer specialist posts over the coming year.

- For the Workforce Development Group to consider the proposed business case around the development of peer specialist roles, proposed outcome measures and associated consultation with staff side representation.

- For the Workforce Development Group to endorse the development of a Peer Specialist Policy informed by the learning outlined in this report, the guidance of the Centre for Mental Health, and shared learning from other Trusts (for example Cambridge and Peterborough NHS Foundation Trust) who have employed significant numbers of peer specialists.
For the Workforce Development Group to continue to endorse and support the wider organisational changes which will assist the development of the workforce in line with the principles of wellbeing and recovery. This includes the establishment of a Recovery Education Centre and the continuation of building on the changes to the approaches of Human Resources and Occupational Health outlined in this report and the Staff Wellbeing Proposal (see Appendix 1).

Phil Morgan
Lead for Recovery
DCHS

Becky Aldridge
General Manager
DMHF

Peer Specialist Development Group – January 2011

References:

Department of Health (2009) *New Horizons*

Sainsbury Centre for Mental Health (2010): *Implementing Recovery: A Methodology for Organisational Change*

Sainsbury Centre for Mental Health (2008): *Making Recovery a Reality*


Scottish Development Centre for Mental Health (2009) *Evaluation of the Delivering for Mental Health Peer Support Pilot Scheme*

Appendix 1

Recommendations from Occupational Health and Wellbeing and Recovery Partnership: Staff Wellbeing Proposal

- Essential to any cultural change is leaders modelling the behavioural change required. A specific piece of work needs to be developed to look at what this would mean for leaders and what support they would require.

- We need to change the experience and expectation of staff. Building on the work that has already been undertaken we need to emphasise that effective support needs to be available. The NHS offers excellent terms and conditions but there is a clear need for staff to take personal responsibility to manage their own health.

- The experience of how people are communicated with is central to changing people’s experience; this is not solely a training need but rather a shift in organisational culture. It should be a priority to treat everyone with exemplary courtesy, dignity and respect. There is a clear need to drive up expectations and standards around behaviour and interaction.

- As an organisation we need to scrutinise our strategies to motivate and engage our staff and managers in their work. How do we celebrate and share their successes routinely?

- We should develop and provide self-management tools which support individuals and teams’ wellbeing at work, and Wellness at Work Plans.

- We should incorporate emotional health checks into the NHS health checks.

- We need to build on the Hidden Talents project to ensure that individuals with existing mental health problems experience effective line management – with a joined up approach from OH, HR and their manager – so that people are offered a range of options to support their wellbeing.

- To develop strategies so that OH and managers can intervene earlier to support people’s wellbeing.

- We should be developing guidance that promote emotional wellbeing at work, and behavioural and environmental aspects that support healthy teams.

- We will be working more closely with Mental Health Services to develop smoother and clearer pathways for staff who need to access specialist mental health support.

- Develop outcome measures for Occupational Health to utilise, which capture recovery based outcomes in order to collate effective feedback on the service.

- Pay specific attention to the emotional wellbeing of staff around traumatic incidents, ensuring effective debriefing is available and that staff are routinely offered emotional support for incidents such as attending coroner’s courts etc.

- Supervision and reflective practice should routinely take into account staff’s emotional wellbeing at work and this should be built into all training and policies.
Appendix 2
DORSET MENTAL HEALTH FORUM
Job Description

Peer Specialist
‘Expert by Experience’

Hours Per Week:

Salary: £8.32 per hour

Based at: Forum Office, 29 - 29A Durngate Street, Dorchester

Responsible to: To be agreed

Purpose of the Post:
To improve the lives of people with mental health issues and their carers by:

- Promoting Wellbeing and Recovery to peers, staff and the general public, from a lived experience perspective.
- Modelling Recovery to other people with lived experience of mental health problems and to staff in mental health services.
- Supporting the Forum’s Peer Representatives in their roles.
- Collecting and representing the views of people with lived experience.
- Assisting the Forum in achieving the outcomes and milestones which form the basis of the Forum’s agreement with the Big Lottery Fund.
- Promoting the Forum’s philosophy and practice of involvement of people with lived experience.

Possible Areas of Work for Peer Specialist:

(This is not an exhaustive list but is intended to give some examples of possible areas of work):

- Liaising and consulting with Peer Representatives and other people with lived experience, who may or may not access services in local areas.
• Representing the views of people with lived experience at local meetings.
• Representing the Forum and the views of people with lived experience in a variety of settings in local areas.
• Assisting in the development of peer led groups in the community.
• Raising awareness of mental health issues in a variety of settings.
• Assisting in the recruitment and training of mental health staff in the statutory and voluntary sectors.
• Establishing good working relationships with Peer Representatives and mental health staff in local areas.
• Representing the Forum at relevant conferences and local and regional events.
• Assisting in delivering Psycho-Educational Courses with primary care mental health staff.
• Working within statutory mental health services (e.g. Community Resource Teams) to promote and model the Recovery approach to people accessing the service and to staff members. Acting as culture carriers.

General:

• You will be required to fulfil your role by fully implementing and supporting the Dorset Mental Health Forum Policy and Procedures.
• Be aware of and act in accordance with the provisions of the Data Protection Act 1998.
• Undertake Induction and Training as required and later as identified in role.
DORSET MENTAL HEALTH FORUM
Person Specification

Peer Specialist
‘Expert by Experience’

Essential Criteria for Peer Specialist:

• Direct personal experience (“lived experience”) of mental health problems.
• Awareness of mental health issues and mental health services.
• A clear understanding of the day-to-day issues affecting people with lived experience of mental health problems.
• An understanding and awareness of Wellbeing and Recovery principles and how to manage and support your own mental health.
• Willingness to take part in Recovery and Self-Management training within the Forum, for oneself and with an aim of then training and supporting Peer Representatives and other people with lived experience.
• Good communication / interpersonal skills.

Desirable Criteria for Peer Specialist:

Please note that although experience in these areas would be an advantage, training will be provided and available through the Forum.

• Some information technology skills.
• Knowledge of the infrastructure of mental health commissioners and mental health service providers in the local area.
• Ability to prepare and present reports.
• Full driving licence and own transport.
• Ability to work alone with access to day-to-day supervision.
• Ability to organise own work schedule.
• Some knowledge of regional and national organisations involved in mental health.
• Ability to read and summarise detailed information in preparation for meetings and in order to disseminate to others if required.
• Some experience in delivering training to a variety of people and settings.
• Knowledge of Mental health legislation.
• Knowledge of Government policies that relate to mental health service delivery.

Dorset Mental Health Forum wishes to encourage applications from people with disabilities. Where the Person Specification calls for particular qualifications or experience, we will consider waiving these requirements if an applicant who could not achieve them because of a disability can demonstrate he/she would be capable of performing well in the job and fulfils the criteria in other respects.
APPENDIX 15

DORSET MENTAL HEALTH FORUM
PEER SPECIALISTS
Dorset Mental Health Forum

Forum Peer Specialists in Dorset

The Forum is an independent local third sector charity which is led and run by people with lived experience of mental health problems, promoting wellbeing and recovery. Through partnership working they are both strategic and operational partners in the delivery of mental health services in Dorset. Integral to this work is the Dorset Wellbeing and Recovery Partnership (WaRP). The partnership enables the local expertise and experience of people who access services to be at the heart of the development of mental health provision across the county, with the following objectives:

- Partnership working and implementation of the WaRP’s aims, objectives and plans.
- Promoting the principles of wellbeing and the recovery philosophy and the lived experience perspective throughout all aspects of service – commissioning, provision, monitoring, delivery and workforce development across Dorset, including with other partner agencies.
- Enabling independent, effective and meaningful lived experience representation and partnership working at all levels of mental health service planning and provision in Dorset, acting as a critical friend to current service provision and effecting culture change, as well as developing peer led projects and initiatives.

Areas of work for Forum peer specialists are varied and many across mental health services, as well as in different areas of Dorset. Some pieces of work are pilots and projects currently being developed, others are more established and longer term. They include:

<table>
<thead>
<tr>
<th>Areas of Service</th>
<th>Peer Specialists and Peer Representatives</th>
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<tr>
<td>Primary Care Mental Health Services (PCMHS)</td>
<td>4 x Employment Support Coordinators (ESC’s)</td>
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<tr>
<td></td>
<td>5 x Psycho educational course assistants</td>
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<td></td>
<td>(one currently undertaking PWP training)</td>
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<td></td>
<td>Peer Support groups facilitated in Weymouth</td>
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<td></td>
<td>1 x peer linking with GP surgery in Bridport</td>
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<tr>
<td>NHS / DCC Community Resource Teams</td>
<td>North Dorset – 1 x peer in Employment Team</td>
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<tr>
<td></td>
<td>Weymouth &amp; Portland – 3 x peers within team</td>
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<tr>
<td></td>
<td>SLAP – Forum peer led community project (West)</td>
</tr>
<tr>
<td>Operational and Strategic</td>
<td>9 x peers working within WaRP activities in East Dorset to promote principles and work of WaRP.</td>
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<td></td>
<td>8 x peers working in West Dorset developing teams, training and recovery implementation.</td>
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<td></td>
<td>3 x peers involved with statutory staff recruitment</td>
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<td></td>
<td>3 x peers across Acute Care Forums (1 as Chair)</td>
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<td></td>
<td>2 x peers involved with developing Personalisation</td>
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<td></td>
<td>1 x peer in DCHS Operational Management Group</td>
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<td></td>
<td>1 x peer in PCMHS / IAPT management team</td>
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<td></td>
<td>2 x peers (Chair) Commissioning Reference Group Peer designed packages – Wellness Workshops, Wellbeing Toolkit, Recovery Skills training</td>
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<tr>
<td>Young Offenders Institute (YOI), Portland</td>
<td>1 x peer developing YOI wellbeing toolkit / delivery</td>
</tr>
<tr>
<td>DCC Supporting People</td>
<td>2 x peers developing evaluation of housing services</td>
</tr>
</tbody>
</table>

SLAP – Sports and Leisure Activity Programme
DCHS – Dorset Community Health Services
IAPT – Improving Access to Psychological Therapies
PWP – Psychological Wellbeing Practitioner
Get in touch with us...

Welcome to the
Dorset Mental Health Forum

How can we involve you?

If you would like to get involved with the Forum’s work, please complete and return this slip to the Forum’s Head Office address:

Name ____________________________________________
Address ____________________________________________
Postcode ____________________________________________
E-mail ____________________________________________
Telephone ____________________________________________

How would you like to be involved?

☐ Level 1 - Forum Membership
☐ Level 2 - Consultation
☐ Level 3 - Recovery Network
☐ Level 4 - Peer Representatives
☐ Level 5 - Peer Specialists

Please tick.

Areas of interest ____________________________________________

Forum Peer Representatives and Forum Peer Specialists will be interviewed and then go through our usual recruitment, selection, training and induction processes.

The information you provide will be completely confidential at all times and will be subject to the 1998 Data Protection Act.
What is the Forum?

The Dorset Mental Health Forum is a local peer led charity, which exists to improve the lives of everyone affected by mental illness by promoting wellbeing and recovery, influencing local service provision and providing a range of specialist peer led services.

Our values and beliefs

We believe that people with lived experience of mental health problems have a wealth of specialist knowledge and valuable expertise.

We believe in the effectiveness of partnership working in the design and provision of mental health services.

We believe that everyone has an equal right to enjoy all of the opportunities that life can provide.

We promote the principle that hope, mental health and wellbeing are essential to every person.

“Recovery is not about ‘getting rid’ of problems. It is about seeing people beyond their problems – their abilities, possibilities, interests and dreams – and recovering the social roles and relationships that give life value and meaning.”


What does the Forum do?

The Forum undertakes a range of services and activities across Dorset:

**Consultation and Representation**

Of lived experience of mental health problems and local mental health services.

**Wellbeing and Recovery Partnership (WaRP)**

Peer representatives and specialists work in partnership with statutory colleagues and mental health professionals, to change the culture of mental health services and transform experience.

**Dorset Mental Health Advocacy**

Assistance with a range of rights matters.

**Independent Mental Health Advocacy**

for people subject to the Mental Health Act.

**WorkWise**

Employment support coordination, helping people with and towards employment.

**Sports and Leisure Activity Programme (SLAP)**

Peer led community activities for everyone’s mental and physical wellbeing.

**Peer Support Groups**

Mutual support and shared experience.

**Positive Approach Shop, Blandford**

Support and advice to local peer led groups

For further information about activities, visit: [www.dorsetmentalhealthforum.org.uk](http://www.dorsetmentalhealthforum.org.uk)

Getting involved...

There are a number of ways people can get involved with the Forum’s consultation, representation and partnership work throughout Dorset.

We believe in creating opportunities for people to reframe their experiences in an empowering and meaningful way.

**Level 1 - Forum Membership**

Receive free membership card, Reflections magazine and information about events.

**Level 2 - Consultation**

We will contact you periodically to ask about your experiences and for your views about local mental health services. These views are incorporated in our work completely anonymously.

**Level 3 - Recovery Network**

Take part in our learning from lived experience focus groups, which help to inform the work of the WaRP.

**Level 4 - Peer Representatives**

Represent lived experience views in a variety of settings, including training, staff recruitment, staff induction and meetings.

**Level 5 - Peer Specialists**

Represent lived experience views, model recovery, provide recovery coaching to staff and people who access services and also lead on range of specific projects and activities.
APPENDIX 16
HIDDEN TALENTS
MINUTES OF MEETINGS
Hidden Talents meeting 5.10.10

The “hidden talents” project is a new initiative within Dorset Community Health Services looking at celebrating, utilising the expertise of, and supporting those staff who have lived experience of mental health issues. This project is seen as central to the wider cultural change in the organisation that is essential in order for the organisation to embed the principles of wellbeing and recovery.

Approximately 20 staff expressed an interest in this project and 10 people attended the meeting. The staff involved are from a range of grades and backgrounds including admin, clinical and managerial staff from both physical and mental health services. In addition to this other staff, who perhaps would not identify themselves as having lived experience, have raised the importance of the organisation valuing and supporting all staff’s wellbeing. This project should not be seen as exclusive but rather the beginnings of a wider project addressing the relationship between DCHS and its staff.

Prior to the meeting it had been suggested that some of the central themes may be:

- Addressing Stigma
- Sharing Expertise around self-management
- Managing disclosure and its clinical application
- Peer Support
- Guidelines for managers and Human resources and occupational health in supporting staff with mental health problems.

In the meeting we had wide ranging discussions.

It was acknowledged that working in the health service is inherently stressful. That people are not just concerned about their own stress but the stress of the people they supervise, their colleagues and their managers. It was also stated that as a mental health organisation DCHS should aspire to be a model organisation with regards to supporting its staff’s mental wellbeing. In addition, the organisation is subject to frequent change which contributes to people feeling uncertain, vulnerable and stressed.

It was also discussed that there was an expectation of coping and the difficulty of being compassionate towards staff without being perceived as a weak manager.

The emotional environments of teams were discussed and how prevailing moods could be infectious both on a positive and negative level. For example, if there is a culture of high expressed emotion and anxiety that this can be contagious as can low mood and apathy and conversely so can an atmosphere of support and encouragement.

For the organisation to move towards being recovery orientated, staff need to feel that they have control, influence, and are involved in the decisions that affect them.
There was a discussion about how difficult it was for health professionals to admit both to themselves and their colleagues about their experiences of mental health problems.

Staff described having “cover stories” so that they would not need to share their situation with others and the need to be discreet and watch what you say. People talked about fear and the risks of being open and how even when people know you’ve been off sick due to mental ill health, that no one talks about it.

Staff also described feeling guilty for not being able to sort out their own problems and then be expected to be able to work with others. People also talked about feeling like a failure. It was acknowledged that the opportunity to voice these experiences with others was beneficial and people recognised the importance of peer support.

People felt that through disclosure they could possibly more effectively assist recovery and support their colleagues. However, there was fear about doing this and that somehow this would be frowned on by colleagues, the organisation and professional bodies.

People also discussed the positive aspects of their experiences, there was a consensus that through having or a having had mental health issues that people felt that this had improved their practice. For some this had been the reason that they had come into the work, for others they talked about the time before they were ill and after, and how after that they had gained new insights which had improved their practice.

The group felt keen that these discussions should be shared more widely and engage with a wider audience. Central to this was that there needed to be great attention paid to the organisational culture and how responds to the emotional needs of all of its staff. In being able to do this it is important that the issues around the fear of disclosing and living with mental health issues is addressed.

A key discussion was the development of an expert staff programme where staff could utilise their experiences in a way that they could work more effectively with staff and the people who use services.

We plan to have a further meeting in December to build upon these initial discussions. It was decided that this meeting should take place within work time to demonstrate the organisational commitment to this project.
Hidden Talents meeting 10.12.10

The Hidden Talents project is a new initiative within Dorset Community Health Services looking at celebrating, utilising the expertise of, and supporting those staff who have lived experience of mental health issues. This project is seen as central to the wider cultural change in the organisation that is essential in order for the organisation to embed the principles of wellbeing and recovery.

Approximately 30 staff have now expressed an interest in this project and we held a second meeting on 10 December 2010. The staff involved are from a range of grades and backgrounds including admin, clinical and managerial staff from both physical and mental health services.

We reviewed the notes from the first meeting and highlighted the key themes, for the benefit of those who were in the group for the first time. There was then an open discussion, which gave everyone the opportunity to share experiences. As at the first meeting, people talked about stigma, the benefits of disclosure, professional boundaries, feelings of guilt, combined pressures of work and home life, the process of people becoming experts on themselves, and the importance of being able to be offered choices when engaged with Human Resources and/or Occupational Health.

The second part of the meeting focused on developing a more structured plan for moving the project forward. As part of this process, the group gave comments on the draft Staff Wellbeing Proposal which is being jointly developed between the Wellbeing and Recovery Partnership (WaRP) and Occupational Health, and which will be discussed at senior level with Human Resources. The group will feed back to Occupational Health some suggestions about how they can ask staff about their emotional health.

There was general agreement that the Hidden Talents work plan should focus on the following eight areas:

1. Reviewing and developing guidelines to support staff to use self-disclosure positively in their work. Further work is required to explore and define what this would mean and how this would be done.
2. An anti-stigma campaigning element which would focus on the telling and celebrating of recovery stories. Initial discussions took place about developing a recovery stories book by NHS staff. The group felt strongly that people who wished to contribute stories should identify themselves, but that there was no obligation for people to have to tell their story.
3. For the organisation to recognise that working in the health service, whether in physical or mental health services, is stress-inducing, and there needs to be more emphasis on building a healthy workplace and changing organisational culture.
4. Close working with Occupational Health and Human Resources, to enable staff with mental health problems to have a greater sense of control and support to self-manage – “to recognise that people can be experts on themselves”. There was a discussion about the need not
just for the organisation to support people better, but also for individuals to be empowered to take personal responsibility for their own wellbeing.

5. To develop guidelines and policies to support point 4; part of this could be the development of Wellbeing at Work plans or staff and team Wellness Recovery Action Plans.

6. In the context of recognising the expertise and experience of staff currently modelling recovery and self-management, to explore what an “Expert Staff Programme” would look like, both as an informal network and a more structured project. One idea relating to this could be developing peer support groups.

7. To develop guidelines and leadership training to enable managers to effectively utilise the full potential of their staff who have lived experience of mental health problems.

8. The aspiration of the Hidden Talents project to become more inclusive by also involving the supporters (carers) of people with lived experience, and eventually to focus on the wellbeing of all staff. However, as the group is in its infancy, it is felt important for the project to establish itself before broadening out.

Next Meeting: Wednesday 2 March 2pm–4pm at Dorset Mental Health Forum, 29-9A Durnsgate Street, Dorchester, DT1 1JP
Notes from Hidden Talents meeting held 2 March 2011

15 people attended the meeting in the Gallery at DMHF. The group consisted of new members and people who had come to the previous meeting. The group commented on how it was daunting to attend the first meeting as people did not know what to expect. The meeting followed its usual format of informal discussion and peer support for the first half, followed by action planning in the second half. The group feedback that they like this format and the meeting went well. Jackie Lawson, the Recovery lead from DHUFT attended, and there is interest in the future the Hidden Talents becoming a pan-Dorset project.

The meeting started with a discussion about Occupational Health (OH); people reported mostly positive experiences, more recently. The group discussed the value of being able to self-refer to OH, which is no longer an option. It was agreed to invite an OH representative to the next meeting so we could share positive feedback, and discuss how we could work together in the future. Phil reported that OH are very excited about the Hidden Talents project and they want to have more options to offer people and to be more proactive. They want advice on how to talk to people about emotional & mental health and wellbeing. It was agreed by the group that the Warwick-Edinburgh Wellbeing scale could be a good way of engaging with staff about their emotional wellbeing and also provide an outcome measure.

Some people gave feedback from the recent Team Leaders Network day and the feedback from the Team Leaders Recovery Workshop. One of the recommendations that came out of it is to build a toolkit to support managers, and part of the toolkit will include guidance for managers on how to support staff experiencing mental health problems. The Hidden Talents group can act as an Expert Reference Group for this piece of work. This will also link with the work around occupational health.

A discussion was held around the use of disclosure of mental health problems by statutory staff in the course of their practice and around the development of Peer Specialist roles and. This discussion highlighted the need to review the Professional Boundaries policies of both DCHS and DHUFT, and to develop guidelines and policies that enable staff with lived experience to be transparent about how model recovery. It was agreed that there is a need to review and critique the guidance and policies of both organisations, flag up inconsistencies between them, and get the permission to inform them and develop guidance.

Those present discussed the development of the Hidden Talents project and how to raise its profile, and in doing so, to challenge stigma. Ideas include staff talking about their lived experience in team meetings, writing recovery stories, publishing them in Reflections and on the Recovery SW website or even develop a specific Hidden Talents book, and holding a Hidden Talents staff recovery stories workshop as part of World Mental Health week events in October. If people are interested in participating, Phil will circulate the Recovery SW recovery narratives guidelines to the group. Subsequent to the meeting, some HT members agreed that it would be useful to develop branding and an identifiable logo for the project to help raise its profile. If people would be interested in setting up a working group around this could they please let us know.
We agreed to look at the approach taken by SW London & St George’s NHS Trust who employ significant numbers of members of staff who have lived experience. Sue Forber will get hold of the DVD they have produced which has some of their staff talking about their lived experience and we will show it at the next meeting. It was felt that we could learn from SW London and St Georges and that our organisations should highlight the Hidden Talents project in staff recruitment materials.

One of the key areas of discussion was around peer support. It was agreed that some HT members would like to set up a peer support group, which could include recovery stories as part of it. Two members are in the process of planning a peer support group, to be supported by Sue and Phil, and possibly use the Gallery as a venue. This would fall under the banner of HT but be a voluntary / outside working hours venture.

The next meeting will be held on Tuesday 24 May 2-4pm in the Dorset Mental Health Forum meeting room (upstairs).
Notes from Hidden Talents meeting held 24th May 2011

8 people attended the meeting and again the group consisted of new members and people who had come to the previous meetings. Also present at the second part of the meeting were Diane Fowler and Kerry Pounds from Occupational Health who are keen to promote and support the project.

We discussed how despite there being fewer people at the meeting today interest in Hidden Talents is growing as is its profile. The Hidden Talents project has been recognised nationally by the Centre for Mental Health, NHS Confederation and National Mental Health Development Unit as a groundbreaking project in Implementing Recovery for Organisational Change.

Kate Antell presented the Hidden Talents Project and talked about her personal experiences of mental health problems at the Dorset Community Health Services Best Practice Event. This was particularly well received and endorsed by Tim Archer Chief Operating Officer. There were also lots of offers from group members to present, which really indicates the passion and commitment people have to this project.

[Following this the Hidden Talents project was presented by Phil Morgan, Kate Antell, and Jackie Lawson at the First Annual Conference of the University Department of Mental Health at Bournemouth University on 10 June. Again this was positively received and viewed as an important step forward in services embracing recovery principles]

The group had wide ranging discussions about how the Hidden Talents group could move the discussions and projects on to the next stage.

The areas discussed were:

- Update on the Recovery Work going on pan-Dorset including a poster and postcard campaign about what recovery means to individuals (being led by DHUFT) and the Recovery Leadership work (in DCHS)

- The importance of all staff modelling recovery behaviours (this includes defining what recovery behaviours are) The recovery leadership work is focusing on Operational Managers and Team Leaders, the group felt the Hidden Talents group could have a key role for defining what that may mean for frontline staff. The key questions to be addressed are “How do we want to be treated?” and “How do we want to behave?”

- How Hidden Talents and recovery orientated behaviours should be promoted at all stages of staff engagement (pre-reg. training, recruitment, induction, supervision and appraisal.)

- We talked to the Occupational Health Nurses about the importance of self-referral. They said that they would take that back to their team.

- The group discussed how do we promote wellbeing across the organisation. The occupational health staff talked about the 6 key factors identified in work related stress. We discussed Advanced Directives for Staff as described by Richard Peacock who works for the Dorset Mental Health Forum. We also discussed wellbeing at work
plans and how in supervision you can discuss an emotional component and look at work/life balance. We also discussed the importance of having different approaches and valuing difference and diversity. We also talked about the work the Centre for Mental Health and Rethink have done around supporting people with lived experience in the workplace.

- How to shared and celebrate recovery stories
- Identifying resilience, sharing Self-Management Strategies and “leading by example”
- How we can move forward in developing the peer support group
- We discussed the DCHS professional boundaries policy and it was evident within this policy there is scope for Staff to use disclosure in their work but it is important that there are clear guidelines that support it.
- In looking at how the organisation supports the emotional wellbeing of staff it was discussed that Ally Howard has been developing a policy around offering staff support following traumatic incidents and stressful events such as attending coroners court.

We talked about how we could get the right balance with the *Hidden Talents* meeting between sharing experiences and developing projects particularly as there are now so many ideas for projects. In order to get on top of the project work, the group are proposing that we set aside a day in September with a view to compiling a magazine or booklet which is a combination of:

- Defining recovery orientated behaviours
- Recovery stories
- Self-management Strategies
- Tips for Managers and ideas for maintaining wellbeing at work
- The framework for a peer support group
- Guidelines for using disclosure

This booklet can then be used to launch the Hidden Talents project more broadly both within DCHS but also starting the process of launching the project in DHUFT. The next stage will be to seek permission from Brian Goodrum and Tim Archer for the group members to be able to take a day out of their day-to-day roles to develop this booklet.

**Next Meeting: Tbc September 2011**
Introduction

The Wellbeing and Recovery Partnership was formed 18 months ago between Dorset Community Health Services (DCHS) and Dorset Mental Health Forum (DMHF), and since the beginning of October with Dorset Healthcare University NHS Foundation Trust (DHFT). Through exploring our work around recovery and embedding recovery principles (see Appendix) we are becoming increasingly aware of the importance of organisations to support their staff and for staff to be able to maintain their wellbeing. This is central to the “cultural change” required in order to fully embed recovery. If leaders and staff can “model” recovery behaviours we can then work effectively in a recovery orientated way with the people who access our services. Health services should be exemplars in looking after the health and wellbeing of their staff.

Following the “Working for a Healthier Tomorrow” review (2008) and the Boorman review of NHS staff (2009) the Occupational Health Service within DCHS is in the process of becoming an Occupational Health and Wellbeing service. Occupational Health (OH) is now moving towards being accredited and is increasingly working towards the Public Health agenda.

With the developments around peer specialists it has become increasingly evident that services should be responsive to the mental health needs of their staff. The Scottish Recovery Network (2010) advise that rather than having special conditions for peer specialists, services should ensure that they are able to effectively meet the mental health needs of all their staff.

DCHS is taking some exciting steps by embarking on the Hidden Talents programme. This programme is exploring the experience of existing staff who have mental health problems and is looking at the cultural and procedural changes required to increase the support available and challenge the stigma that they experience.

In order to achieve the cultural change needed and to transform the experience of staff in unlocking their potential, further steps are required to shift the focus of Occupational Health and Human Resources. The shift in focus needs to be: a greater emphasis on wellbeing; a focus on early intervention and promoting healthy workplace environments and cultures within teams. Through this shift in focus it is anticipated that there will be increased job satisfaction and reduced levels of staff sickness. This report outlines the areas that we believe need further attention – moving Occupational Health from being a reactive service to a proactive one. We perceive Occupational Health will become central in creating the culture of promoting the health and wellbeing of all.

Increasing Factors for Health and Wellbeing

In order to work in a recovery orientated way it is important to be strengths focused and to look at the factors that promote wellbeing and health in the workplace. It is important to recognise that each person and/or team is individual, unique and has their own journey; but that there are common themes that keep people well.

On an individual basis: sleep, diet, exercise, relationships and meaningful activity.

Within the work environment: work/life balance, job satisfaction, supportive colleagues and managers, feeling in control (and understanding the limits of that control).
What is required is for Occupational Health and Human Resources to work in partnership with staff and managers and for all to become experts in enhancing the work environment: supporting staff, whilst recognising that working in the health service is inherently stressful.

Mental ill health is an increasing cause of sickness absence and reduced work performance. Additionally, work is increasingly causing stress and anxiety, particularly in an uncertain financial climate, with fears of cuts and an increased workload. There is ample evidence that early intervention and effective management of individuals with pre-existing and emerging mental health problems can help reduce sickness absence and presenteeism in the workplace. Bullying and harassment also has a significant impact on the wellbeing of staff and this can take place in subtle ways.

It is recognised that much is already underway in promoting wellbeing in the workplace such as stress management training for line managers, the provision of right care services for all employees and the positive mental health strategies that have come out of the staff survey. The Wellbeing and Recovery Partnership would like to complement this work further by looking in more depth at aspects such as team dynamics and how this affects stress, exploring the potential of peer support in the workplace through the Hidden Talents process, looking into how the organisation could use the skills within itself to promote recovery and most importantly to look at ways of guiding all staff as to how to stay mentally well through the changes and demands facing the NHS at this time.

The organisation needs to move towards creating an environment that facilitates the recovery of its staff – and the people who access the service – by promoting self-management and responsibility in order for them to feel in control of their lives. For those people who are unwilling or unable to take responsibility, strategies need to be developed for them to increase their ability to do so. In the case of staff, effective management approaches need to be implemented.

This is a subtle shift in emphasis and the best course of action is not clear at this stage. We have some opportunities to make links with other Trusts such as South West and St. George’s NHS Trust that has been undertaking some of this work for some time. We have a number of ideas over a range of projects that could be developed in partnership with OH, HR, managers and staff. In order to drive these projects it is essential that there is an organisational commitment and Board level sign up. Once this commitment has been established we would like to develop a strategy and joint project plan (between OH, HR, managers and staff) to drive forward this process of change. We view this as an ideal opportunity for change with the hosting arrangements of DHFT and existing changes being made to the structure of OH and HR.

**Key areas and proposals for development**

- Essential to any cultural change is leaders modelling the behavioural change required. A specific piece of work needs to be developed to look at what this would mean for leaders and what support they would require.

- We need to change the experience and expectation of staff. Building on the work that has already been undertaken we need to emphasise that effective support needs to be available. The NHS offers excellent terms and conditions but there is a clear responsibility for individuals to manage their own health.
• The experience of how people are communicated with is central to changing people’s experience; this is not solely a training need but rather a shift in organisational culture. It should be a priority to treat everyone with exemplary courtesy, dignity and respect. There is a clear need to drive up expectations and standards around behaviour and interaction.

• As an organisation we need to scrutinise our strategies to motivate and engage our staff and managers in their work. How do we celebrate and share their successes routinely?

• We should develop and provide self-management tools which support individuals and teams’ wellbeing at work, and Wellness at Work Plans.

• We should incorporate emotional health checks into the NHS health checks.

• We need to build on the Hidden Talents project to ensure that individuals with existing mental health problems experience effective line management — with a joined up approach from OH, HR and their manager — so that people are offered a range of options to support their wellbeing.

• To develop strategies so that OH and managers can intervene earlier to support people’s wellbeing.

• We should be developing guidance that promote emotional wellbeing at work, and behavioural and environmental aspects that support healthy teams.

• We will be working more closely with Mental Health Services to develop smoother and clearer pathways for staff who need to access specialist mental health support.

• Develop outcome measures for Occupational Health to utilise, which capture recovery based outcomes in order to collate effective feedback on the service.

• Pay specific attention to the emotional wellbeing of staff around traumatic incidents, ensuring effective debriefing is available and that staff are routinely offered emotional support for incidents such as attending coroner’s courts etc.

• Supervision and reflective practice should routinely take into account staff’s emotional wellbeing at work and this should be built into all training and policies.

Completed by Jessica Foster, Diane Fowler and Phil Morgan 25th November 2010
Appendix: Recovery Principles

- Recovery is about building a meaningful and satisfying life, as defined by the person themselves, whether or not there are ongoing or recurring symptoms or problems.
- Recovery represents a movement away from pathology, illness and symptoms to health, strengths and wellness.
- Hope is central to recovery and can be enhanced by each person seeing how they can have more active control over their lives (‘agency’) and by seeing how others have found a way forward.
- Self-management is encouraged and facilitated. The processes of self-management are similar, but what works may be very different for each individual. No ‘one size fits all’.
- The helping relationship between clinicians and patients moves away from being expert / patient to being ‘coaches’ or ‘partners’ on a journey of discovery. Clinicians are there to be ‘on tap, not on top’.
- People do not recover in isolation. Recovery is closely associated with social inclusion and being able to take on meaningful and satisfying social roles within local communities, rather than in segregated services.
- Recovery is about discovering – or re-discovering – a sense of personal identity, separate from illness or disability.
- The language used and the stories and meanings that are constructed have great significance as mediators of the recovery process. These shared meanings either support a sense of hope and possibility, or invite pessimism and chronicity.
- The development of recovery-based services emphasises the personal qualities of staff as much as their formal qualifications. It seeks to cultivate their capacity for hope, creativity, care, compassion, realism and resilience.
- Family and other supporters are often crucial to recovery and they should be included as partners wherever possible. However, peer support is central for many people in their recovery.

Adapted from Recovery – Concepts and Application by Laurie Davidson, the Devon Recovery Group.
Wellbeing and Recovery Partnership

The Dorset Wellbeing and Recovery Partnership is putting the expertise of people with lived experience at the centre of the transformation of mental health provision across the county. The Partnership’s aim is to embed the principles of Wellbeing and Recovery across all services within Dorset and to address the health and wellbeing needs of local communities.

Recovery involves moving away from traditional styles of service delivery to a more person-centred, strengths based approach, engaging with people who use services as partners on their individual journey of discovery.

10 October 2010 is World Mental Health Day. In order to celebrate this, the Wellbeing and Recovery Partnership is putting on a week-long series of free events promoting wellbeing and recovery. Everyone is welcome to attend any of the events, but in order to know approximate numbers, please could you advise the relevant contact person.

This Rethink walk comes BEFORE World Mental Health Day

Rethink Walkers would like to invite you to come and celebrate World Mental Health Day on the highest point of the south coast

Walk: Stonebarrow Hill to Golden Cap (approx 2½-3 hrs)
Gorse-covered hills, a hidden medieval hamlet, and the dazzling summit of Golden Cap

Start: Stonebarrow Hill car park (near Charmouth)
Tuesday 5th October 10.30 a.m.

For more information contact Deborah or Teresa on 01308 459762

Registered in England Number 1227970 Registered Charity Number 271828

The Wellbeing and Recovery Partnership

A week of events promoting wellbeing and celebrating recovery
11–16 October 2010

Look inside – see what’s around – and come along!!
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| Monday 11 October | 16.00 – 18.30 | Launch of **World Mental Health Week**  
**True Stories: Recovery is Real!** | The Gallery, Dorset Mental Health Forum, 29–29a Durngate Street. Dorchester DT1 1JP             | By invitation                      |
| Tuesday 12 October| 10.30 – 12.30 | **Watercolour Workshop** organised by Portland Tout Quarry Art Group; come along and take part! | The Drill Hall, Easton Lane, Portland DT5 1BW                                                      | Amanda Paull                      |
|                   |               |                                                                 |                                                                                                    | Weymouth CRT 01305 766237        |
| Tuesday 12 October| 14.00 – 15.30 | **Movement, Creative Expression and Dance** – come as part of Mental Health Week on this day for free; please book a place with Lisa | Horton Village Hall, Horton, Nr Wimborne BH21 3JA                                                  | Lisa Bridge                      |
|                   |               |                                                                 |                                                                                                    | 01258 841088                      |
|                   |               |                                                                 |                                                                                                    | dancingtherainbow@live.co.uk     |
| Wednesday 13 October | 10.00 – 15.00 | **Hope2Bake** – come and buy a cake!  
**Hope2Cycle** – why not come, drop your bike off for a service or repair, or buy a bike?  
**True Stories** – come and view our recovery stories folder | Unit 5, Plot 25C, Longmead Industrial Estate, Shaftesbury SP7 8PL                                   | Gary Cure                        |
|                   |               |                                                                 |                                                                                                    | Weymouth CRT 07717 516773        |
| Wednesday 13 October | 12.00 – 12.30 | **Mindfulness Walking** – join Sarah on an experiential walk around the borough gardens using different types of mindfulness techniques | Rethink Refreshment Kiosk, Borough Gardens, Dorchester                                               | Sarah Chubb                      |
|                   |               |                                                                 |                                                                                                    | 01305 367000 or Whitfields Rural Activities Ctr 01305 250863 |
| Thursday 14 October | 12.30 – 16.30 | **Recovery Stories Workshop** – come along and hear people recounting their own remarkable recovery stories | Weymouth Adult Learning Centre, 45 Dorchester Road, Weymouth DT4 7JT                                 | Heather Stacey                    |
|                   |               |                                                                 |                                                                                                    | Weymouth CRT 01305 766237        |
| Thursday 14 October | 14.00 – 16.00 | **Creative Art Workshop** – if you would like to attend, please register your booking with Erica or Amy | The Gallery, Dorset Mental Health Forum, 29–29a Durngate Street. Dorchester DT1 1JP                 | Erica or Amy                     |
|                   |               |                                                                 |                                                                                                    | Dorset Mental Health Forum       |
|                   |               |                                                                 |                                                                                                    | 01305 257172                     |
| Friday 15 October | 09.00 – 16.00 | **How to look after your wellbeing** – find out more at the Primary Care Mental Health Services drop-in | Bridport Medical Centre, West Allington, Bridport DT6 5BN                                            | Ellie Madden-Crosby              |
|                   |               |                                                                 |                                                                                                    | 07979 707521                     |
| Friday 15 October | 15.30 – 17.30 | **Recovery Stories Workshop** – come and hear people recounting their own remarkable recovery stories | The Gallery, Dorset Mental Health Forum, 29–29a Durngate Street. Dorchester DT1 1JP                 | Erica or Amy                     |
|                   |               |                                                                 |                                                                                                    | Dorset Mental Health Forum       |
|                   |               |                                                                 |                                                                                                    | 01305 257172                     |
| Saturday 16 October | 13.00 – 14.00 | **Football: The ‘Time to Change Trophy’ 2010** – come for coaching session followed by the Trophy Match | Thomas Hardy Leisure Centre  
Coburg Road  
Dorchester DT1 2HT | Todd Govan          |
|                   |               |                                                                 |                                                                                                    | 01202 688281 or 07943 810606     |
|                   |               |                                                                 |                                                                                                    | todd.govan@dorsetfa.com          |

Further information can be obtained from Phil Morgan: philip.morgan@dorset-pct.nhs.uk  01305 361371 or Becky Aldridge: beckyaldrige@dorsetmentalhealthforum.org.uk  01305 257172