Dorset Mental Health Forum
promoting wellbeing & recovery

NHS Dorset HealthCare University NHS Foundation Trust

Dorset Community Health Services

Dorset Wellbeing and Recovery Partnership

Transforming Experience … Unlocking Potential

Annual Report 2010/11

Completed by Phil Morgan, Becky Aldridge and Jackie Lawson

Foreword

I first met the Dorset Wellbeing and Recovery Partnership when they applied to be a Pilot Site in the national 'Implementing Recovery – Organisational Change' programme[1]. I was immediately impressed by the passion for recovery and commitment to developing genuinely recovery focused services that extended throughout the organisation: from senior managers and the executive team, to people using services and their supporters, and clinicians from all professions.

This passion and commitment, and the creativity it has generated, are reflected throughout the pages of this report. From celebration of the expertise of lived experience among staff in the 'Hidden Talents' programme to the introduction of Peer Specialists in a variety of roles. From the development of peer-led and co-produced training, recovery Leadership Workshops, and promotion of messages of recovery across the organisation, to the introduction of mentors with lived experience for psychiatrists, and much, much more.

Most of all I was impressed by the genuine commitment to partnership working that is so central to recovery focused practice. This partnership is embodied in the Wellness and Recovery Partnership itself: in the coming together of statutory services and the non-statutory Dorset Mental Health Forum that is led and run by people with lived experience. But it is also reflected throughout all the initiatives described in the report. As the authors rightly say recovery is contagious: *"when people 'get recovery' it really breaks down barriers and creates opportunities for genuine partnership working and the spread of the message*."

Because of the progress made and the way in which recovery principles are embedded at all levels, the Dorset Wellbeing and Recovery Partnership were invited to become not a Pilot Site but a national Demonstration Site for the 'Implementing Recovery – Organisational Change Programme'. These are difficult and changing times – both in Dorset and nationally – but, by using these challenges as an opportunity for transforming services, the Partnership has an example that can inspire and inform other services across the country.

Recovery, and the development of services that support people in their recovery journey, are continuing journeys of discovery. This report describes the journey on which the Dorset Wellbeing and Recovery Partnership have embarked. There is much to be celebrated, but as Partnership are the first to recognise, there is still much to be done. The plans for continuing development described are ambitious, but I am confident that, with all the

[1] Commissioned by the Department of Health and delivered through a partnership between the NHS Confederation and Centre for Mental Health the 'Implementing Recovery – Organisational Change' (ImROC) programme is designed to help organisations and their partners to become more recovery-oriented within the framework of ten key organisational changes described in Shepherd, G., Boardman, J. & Burns, M. (2010) *Implementing recovery. A methodology for organisational change*, Sainsbury Centre for Mental Health. ImROC forms one of the seven national work streams supporting the implementation of the national mental health strategy *No Health Without Mental Health* (2011).

talent and resourcefulness that abound in the Dorset Wellbeing and Recovery Partnership, they can be realised.

Well done and bon voyage!

Rachel E. Perkins BA, MPhil (Clinical Psychology), PhD, OBE
Member of Implementing Recovery - Organisational Change Project Team
Chair of Equality 2025 UK Cross Government Advisory Group on Disability Issues
Mind Champion of the Year 2010

Definition of Recovery

"[Recovery is] *a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and roles. It is a way of living a satisfying, hopeful and contributing life, even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness..."*[1]

What Recovery Means to Me

"To me recovery means I try to stay in the driver's seat of my life. I don't let my illness run me. Over the years I have worked hard to become an expert in my own self-care. Being in recovery means I don't just take medications... Rather I use medications as part of my recovery process… Over the years I have learned different ways of helping myself. Sometimes I use medications, therapy, self-help and mutual support groups, friends, my relationship with God, work, exercise, spending time in nature – all these measures help me remain whole and healthy, even though I have a disability."[2]

[1] Anthony B (1993) From the Sainsbury Centre [2008]: *Making Recovery a Reality.*
[2] Degan P E (1993) Recovering our sense of value after being labeled mentally ill, p. 10.

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* Available from Denise Bilton ☎ 01305 361371 or denise.bilton@dhuft.nhs.uk

Executive Summary

Transforming Experience ... Unlocking Potential

What is 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."[1]

Dorset Wellbeing and Recovery Partnership

Welcome to the executive summary of the Dorset Wellbeing and Recovery Partnership's (WaRP) second annual report. This has been an extremely exciting year for the WaRP, above all because the WaRP is now operating across the whole of Dorset i.e. Dorset, Bournemouth and Poole.

Our aim is to change the culture of mental health services and people's attitudes to mental health and wellbeing in Dorset. We plan to do this through promoting the principles of wellbeing and the philosophy of recovery. Central to this is the sharing of expertise and partnership between people with lived experience, their supporters, and mental health professionals.

We are entering a period of rapid change within health and social care services. This, whilst creating some challenges, gives us opportunities to be innovative and do things differently. We see the WaRP as having a key role to play, both now and in the future, towards the development and delivery of mental health services which will allow us to transform services and enable meaningful changes to people's lives.

In September 2010 Dorset Healthcare University NHS Foundation Trust (DHUFT) formally joined the existing partnership between Dorset Mental Health Forum (DMHF) and NHS Dorset: Community Health Services (DCHS), so bringing into being a pan-Dorset Partnership. From 1 July 2011 DCHS became part of DHUFT and is now operating as one organisation.

[1] Dr J Repper (2009) from *An independent investigation into the care and treatment of Daniel Gonzales*, 124-5.

Please refer to our Annual Report 2010/11 and Strategy 2011/12 for full details of our work to date and plans for the coming year.

We have been recognised nationally for our approach to implementing recovery by the Centre for Mental Health, NHS Confederation and Department of Health's Implementing Recovery for Organisational Change (ImROC) programme. We take great pride in having been awarded the status of being a Demonstration Site. However, we also believe this comes with great responsibility. We feel that it is our potential which has been recognised and that we are only at the beginning of our journey. We have a long way to go before our services are truly recovery orientated

Key Achievements

The remit of the WaRP has expanded to cover the whole of Dorset.

The work of the WaRP has been recognised nationally by ImROC and they identified the following key areas of strength:

- **Partnership working:** We have increased the scope and levels of sophistication of our partnership working between people with lived experience and professional staff. There is an increasing understanding of the importance of expertise by experience.
- **Hidden Talents:** A project for statutory staff who have lived experience, which was started in DCHS and is shortly to become pan-Dorset, is working at challenging stigma and looking at how people can use their experiences within their work.
- **Lived experience mentors for psychiatrists:** We have a pilot project where people who have accessed the service are coaching psychiatrists on how to work in more recovery orientated ways.
- **Peer specialists:** We are continuing to develop our peer specialist posts (people with lived experience working in NHS teams modelling recovery) and the initial pilot project gave positive results.

Future Directions

The WaRP Strategy 2011/12 has been launched and it details how we are planning to build on our achievements. The Strategy includes:

- Establishing a **Recovery Education Centre** to co-ordinate and develop training packages for people who access the service, their supporters and staff.
- Running a number of **pilot projects** together with mental health teams **to promote recovery orientated practice** and partnership working with those with lived experience.
- **Engaging with commissioners and GPs** to promote the work of the WaRP.
- Expanding our **Recovery Leadership Programme**.
- Further developing **peer specialist posts** and accredited training.
- Developing the **Hidden Talents** project.

- Developing the **Lived Experience Mentoring for psychiatrists**.
- Developing stronger **partnership working with supporters (carers)** of those with lived experience.
- Transforming acute services through the **aspiration toward Zero Restraint**.
- Developing a pan-Dorset **social inclusion and vocational strategy**.

The progress so far has been achieved by the hard work, support and willingness to take positive risks by a range of people. We are extremely grateful for the commitment and inspiration of the people who have helped us over the past two years. These include people with lived experience, their supporters, clinical staff, managers, administrative staff, commissioners and members of the public. We look forward to the continuation of this project, transforming experience and unlocking potential of all those involved in mental health services in Dorset.

Introduction

This is the second annual report of the Dorset Wellbeing and Recovery Partnership (WaRP). The WaRP was established in April 2009, a partnership initially between Dorset Mental Health Forum (DMHF) and NHS Dorset: Community Health Services (DCHS). Dorset Healthcare University NHS Foundation Trust (DHUFT) formally joined the partnership in September 2010. Dorset Mental Health Forum is a local third sector organisation which is led and run by people with lived experience of mental health problems and access to services. The WaRP also links with a broader informal network of other organisations including local authority and third sector agencies, who share the same commitment to recovery.

The Partnership's aim continues to be to embed the principles of wellbeing and recovery across all services within Dorset. In order for services to put "recovery at the heart of everything they do" there remains a need for whole systems change, through casting a critical eye over current mental health service provision. Use of the expertise of people with lived experience, their supporters and mental health staff will enable required change to occur. Recovery is an internationally recognised conceptual framework which underpins developments in mental health. In England, Recovery features predominantly in the policy documents *New Horizons* (Department of Health, 2009), replaced by *No health without mental health* (Department of Health 2011).

We are fortunate to be able to welcome Jackie Lawson (Recovery Lead for Dorset Healthcare University NHS Foundation Trust) to the team. She has joined Becky Aldridge (General Manager Dorset Mental Health Forum) and Phil Morgan (Recovery Lead for Dorset Community Health Services) in leading the pan-Dorset implementation of recovery. Jackie, Becky and Phil work across both NHS organisations.

In addition, we have an increasing number of people who have lived experience and staff (and a smaller number of supporters) who are passionate about recovery and who are developing and supporting our work.

Through partnership working the WaRP is aiming to transform the experience of people who access mental health services, their supporters and staff.

The health white paper[1] and Department of Health Mental Health Strategy[2] have been published and numerous changes are taking place within health and social care at present. This includes DHUFT hosting DCHS and Bournemouth and Poole Primary Care Trusts. This coming together of organisations will take place over the summer. Within mental health services the role of the WaRP is seen as central to developing a shared philosophy and approach across the new organisation. We are also looking at how recovery principles can support the development of all healthcare services, not just mental health.

Prior to September 2010 the majority of the WaRP work undertaken had been focused in the west of the county. In the east there are some excellent pockets of recovery orientated practice and a strong commitment to organisational change. We are keen to use the learning we have undertaken in the west to accelerate the change in the east with a view to starting to dovetail the work towards the autumn. This report outlines the progress we have made over the past year and the strategy for taking the work of the WaRP forward. In addition it describes our experiences and how we have developed our approaches, ideas and philosophy.

The ImROC project, delivered by a partnership between the Centre for Mental Health, The NHS Confederation and Department of Health, gave their recognition earlier this year to our approach to implementing Recovery by awarding us national Demonstration Site status. We are very proud to have been given this status and we would like to thank everyone who has supported us along the way so far.

[1] DoH (2010) *Healthy Lives, Healthy People: Our strategy for public health in England*. White Paper.
[2] DoH (2011) *No health without mental health: a cross-government mental health outcomes strategy for people of all ages*.

Future Directions

The main aim for the year ahead is for the work of the WaRP to be unified across Dorset. We see the WaRP as having a key role in developing the underpinning philosophy, influencing strategy and supporting the delivery of mental health services. In last year's annual report we described moving from a development phase to an implementation phase, and whilst we have made more steps towards implementation we have also needed a period of consolidation as DHUFT has joined the partnership.

We have found a key strength of the partnership is the shared philosophy of recovery and the principles of wellbeing across organisations which has enabled people with lived experience to be at the heart of service delivery and design. It is by using this as our guiding principle that our integrity and focus is maintained in a time of significant change.

- In order to plan for the future and have opportunity to influence service design and philosophy, a central part of the work of the WaRP will be continuing to build close relationships with commissioners and GPs.

- Implementing recovery pilot projects. There are a number of areas in the county, in both adult and older adults community mental health teams, who are piloting our approaches to working in recovery orientated ways. This is supported by the development of initiatives such as the Recovery and Skills Training, the peer-led Wellness Workshops, and Personal Recovery Workshops based on the Wellbeing Toolkit, the Lived Experience mentoring for psychiatrists and others. We plan to expand the number of pilots this year and start to undertake formal evaluations.

- One of our key discoveries last year was the central importance of staff recovery journeys alongside those who access the service. So a key focus for next year will be the development of the Hidden Talents project and the recovery journeys of staff.

- We have also increased our understanding of the importance of "modelling recovery" behaviours and have run a number of Recovery Leadership workshops. We are planning to build on this work and develop a pathway around Recovery Leadership, following the success of this work in West Dorset.

- An area we have not developed as much as we would have liked is working with carers and supporters, so over the coming year we will be developing opportunities to engage with supporters.

- One of the most significant developments has been the role of peer specialists. We plan to continue to build on this work with a revised and advanced training package, the creation of new positions and pilots.

- A work stream the current peer specialists have been involved in is “life beyond illness”: people participating in their communities and finding work. We see this as a key area for the WaRP to influence, particularly with the DHUFT and DCHS coming together; there is the need for a unified strategy and action plan.

- As a demonstration site for the ImROC project we have 10 days of expert consultation and we have identified two areas we would like to work on with their support.

    - The first is developing an aspiration toward Zero Restraint in our acute services based on the work of Recovery Innovations Inc. of Arizona (see under Section 6, page 40). We see this project as a way of completely transforming our approaches to acute care and crisis work. The project will not just focus on reducing restraint and seclusion but also on how staff can be proactive in engaging with people and providing environments and opportunities that are life enhancing.
    - The second area is the development of a Recovery Education Centre (REC). This will join together recovery journeys of people who access the service, staff, supporters, and provide a way to develop pathways for recovery leadership and peer specialists.

In developing our strategy document for this year we have realigned our 2011/12 strategy with the “10 key organisational challenges”[1] rather than the key priorities we identified in the previous annual report. The progress against last year’s objectives is contained in the narrative under each of the 10 organisational challenges (see Appendix 1 to see how they overlap).

[1] From Shepherd G, Boardman J & Burns M (2010) *Implementing Recovery: A methodology for organisational change*.

Dorset Wellbeing and Recovery Strategy 2011/12

Organisational Challenge	Our Aim	Action
Changing the nature of day-to-day interactions and the quality of experience	When people access mental health services, they, their supporters and staff will experience a greater sense of hope, opportunity, and control over their own lives. People's experience of services will be transformed.	• Continue to undertake and develop the team based recovery implementation pilot projects across Dorset. • Continue to develop the lived experience mentoring of psychiatrists. • Develop a working group exploring the co-production of the CPA process, including assessment and evaluation. • Develop role of recovery narratives. • Develop our approaches to improving day-to-day interactions for carers and supporters.
Delivering comprehensive, user-led education and training programmes	There will be available a range of training packages designed and delivered by people with lived experience and supporters in partnership with professional staff. Initial pilots of these packages have been very successful.	• Continue to develop peer-led and partnership training packages. • Develop tailor-made recovery and skills training for people across Dorset. • Roll out personal recovery workshops and wellness workshops for people who access the service.
Establishing a "Recovery Education Centre" to drive the programmes forward	There is a framework of courses or workshops which people with lived experience, their supporters and staff can attend which will support their personal growth and recovery orientated practice. These are provided in a non-clinical education focused approach.	• Build on existing partnership working. Develop the vision, a project plan and training pathways for the Recovery Education Centre (REC). • The REC will underpin all the work of the WaRP.
Ensuring organisational commitment, creating "the culture". The importance of leadership	People throughout the organisation will have an understanding of recovery and how this should shape their behaviour to one another and the people they serve. It is particularly important for people in leadership roles to "model recovery behaviours".	• WaRP to run Recovery Leadership workshops in East Dorset. • Develop Recovery Leadership Toolkit. • Continue to develop recovery network meetings to facilitate learning from lived experience. • WaRP to participate in all levels of service design and development. • For the WaRP team to engage with commissioners and GPs to promote the principles of wellbeing and recovery in future service design and delivery.
Increasing "personalisation" and choice	People have the opportunity to plan and develop their own recovery journeys and pathways, with services providing a facilitative role. People are supported in developing the skills to take control of their own lives, self-manage and to access direct payments and personal budgets where possible, making informed choices. People's spiritual needs are taken into consideration and they have the space to explore how they perceive the world and find meaning.	• Continue with roll out and evaluation of the Wellbeing Toolkit and recovery narratives, including YOI pilot. • Development of client-led CPA. • Develop the use of advanced decisions, directives, and crisis planning, in aspiring towards zero restraint. • Develop a spirituality project plan. • WaRP to support Personalisation agenda in Dorset.

Organisational Challenge	Our Aim	Action
Changing the way we approach risk assessment and management	Risk assessment and management and personal safety planning is undertaken as a collaborative task with a sharing of responsibility. Staff are provided with training and support which provide the opportunities for positive risk taking. New approaches are developed with regard to managing the people who are experiencing significant distress which may lead to aggression to themselves or others. These approaches will seek to reduce the distress experienced by the person, their supporters and also staff.	• Develop a DHUFT risk statement. • Develop recovery orientated guidelines for risk assessment and safety planning. • Promote dialogue around positive risk taking, and support its concept. • Develop ways to consider crisis as a learning opportunity. • Develop a project plan for aspiring towards zero restraint.
Redefining user involvement	Involvement becomes partnership. The expertise of lived experience is seen on the same level as professional expertise. Partnership working is the aspiration for every interaction with people with lived experience, whether they are accessing the service, volunteering or a paid worker.	• Build on existing partnership working with people with lived experience throughout Dorset. • Increase partnership working opportunities with supporters and carers.
Transforming the workforce	There will be increasing numbers of peer specialists who will be supporting statutory staff in the delivery of services. Peer specialists are integral to carrying the culture of recovery within the services.	• Continue to develop peer specialist roles, creating a stronger relationship with the REC and more training and development opportunities for individuals, staff, supporters, leaders and others. • Develop accreditation links with local education providers.
Supporting staff in their recovery journey	Consideration to be given to the emotional needs of staff. Staff are aware of their own recovery journeys whether they have experienced mental illness or not. Staff who have lived experience of mental health problems should be encouraged to share their expertise by experience. Human Resources (HR) and Occupational Health (OH) will develop to support this ethos.	• Develop Hidden Talents to become a pan-Dorset project. • Challenge stigma and discrimination at every opportunity. • Celebrate lived experience and the modelling of recovery. • Continue work with HR and OH in developing recovery orientated approaches towards staff.
Increasing opportunities for building a life “beyond illness”	Services have a strong focus of enabling people to be able to engage in their own communities, build relationships and friends, and find work opportunities. People in all parts of the service should be encouraged and facilitated to build an identity separate from their illness, engaged in their local community and leading a life that has self defined quality.	• Develop a pan-Dorset social and vocational strategy and project plan. • Promote opportunities to influence local employers and communities. • Continue to engage in anti-stigma and discrimination campaigns. • Promote the importance of everyone from all sections of the community paying attention to their emotional wellbeing.

Our Recovery Journey

The Development of our Approach to Organisational Change

Over the past two years we have learnt great deal. We feel that we have ensured that there is good material available locally which states what recovery is and which gives examples of good recovery orientated practice. However, what is lacking in the literature, and what we feel we have been learning, is what the actual steps are to embed recovery and also what recovery actually looks like in practice and what it means for services. This section outlines our learning over the last two years.

In last year's annual report we outlined a number of people and papers that had influenced and continue to influence our thinking and we are grateful to them. Hopefully we have been able to translate their work to fit our local context.[1] As stated last year, the most significant contribution to our thinking comes from those people in Dorset with lived experience, their supporters and people who are passionate about recovery. These are the people who are committed to the change of mental health services and live recovery every day.

Our Understanding of Wellbeing and Recovery

The problems and limitations of the word 'recovery' are well documented.[2] We feel that linking the concepts of wellbeing and recovery has been helpful in trying to overcome some of these issues. We view wellbeing and recovery as two sides of the same coin. Through talking about wellbeing we have been able to engage with people much more broadly around recovery and communicate its relevance to everyone.

We believe that the universalisation of concepts behind recovery is not only crucial in challenging the stigma associated with mental illness, but it also creates a model for all health care, not just mental health services. This is why we find the Repper (2009) quote so helpful when presenting to people about 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.

[1] If you would like a copy of last year's annual report you can download it from DMHF's web site: (www.dorsetmentalhealthforum.org.uk/recovery.html) or you can contact Denise Bilton (01305 361371; denise.bilton@dhuft.nhs.uk).

[2] Slade M (2009) *Personal recovery and mental illness*, Cambridge: Cambridge University Press.

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."[1]

Fundamentally we believe that recovery can be described as the universal activity of a "search for meaning" and how we understand the challenges and difficulties we face in our lives.

Defining the Role for Services

During this past year we have realised how to articulate the role of services in relation to Wellbeing and Recovery. Central to this has been the quote from Repper and Perkins:

"Any services, or treatments, or interventions, or supports must be judged in these terms – how much do they allow us to lead the lives we wish to lead?"[1]

We translate this into:

Services moving from being places where people receive care and treatment to becoming places that give people the tools to manage themselves and build the lives they wish to live.

We view this as the move from client-centred practice to client-led practice.

We would argue that with client-centred practice the professional still holds significant elements of power in the relationship and potentially unwittingly defines what that person wants rather than the person themselves defining it.

The focus of services needs to become: either being led by those who are able to lead their own recovery journey; or focusing on giving the person the skills to be able to take control and lead their own recovery journey.

The Importance of Recovery Principles

We have found the Recovery Principles (see box below) essential in trying to underpin everything we do. Therefore we have continued to try to be strengths-focused, hopeful and optimistic in all we have been doing, attempting to model recovery orientated behaviour. We believe that it is vital that these principles underpin every interaction and organisational process. Whenever we have become stuck or had a difficulty we have referred back to the principles to ensure we are approaching what we are doing in a recovery orientated way. In addition we strive to continually model recovery with our own behaviour and encourage others to do the same.

[1] By Dr J Repper (2009) from *An independent investigation into the care and treatment of Daniel Gonzales*, 124-5.

We see that this is the key to generating the change we are seeking. This has been underpinned by a fundamental belief that "you cannot do recovery to people".

The Principles of Recovery[1]

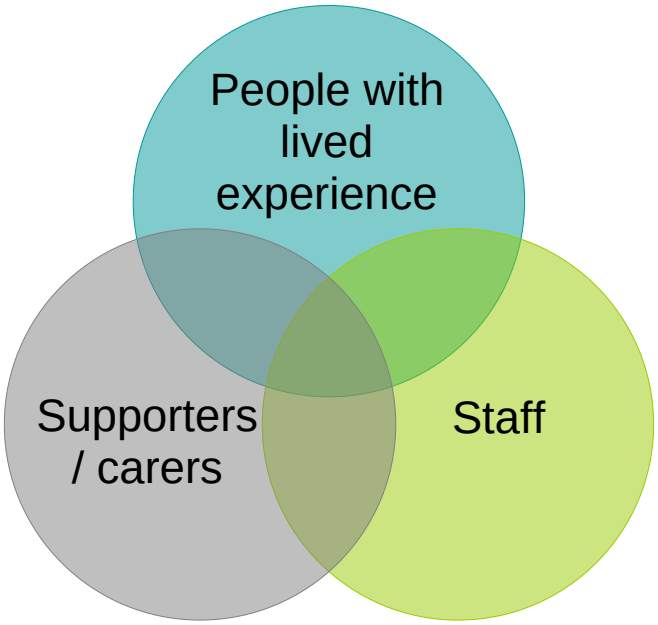
- Recovery is about building a meaningful and satisfying life, as defined by the person themselves, whether or not there are ongoing or recurring symptoms or problems.
- Recovery represents a movement away from pathology, illness and symptoms to health, strengths and wellness.
- Hope is central to recovery 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.

We have also been exploring the parallel processes of working in a recovery orientated way between staff and people who access the service and with teams themselves (see flowcharts in Challenge 1 of the 10 Key Organisational Challenges, pp 21-3.)

[1] Adapted from *Recovery – Concepts and application* by Laurie Davidson, Recovery Devon Group.

Partnership Working

Integral to all parts of this work is the notion of partnership between people with lived experience (and their supporters) and staff. Key to our approach is the understanding of that shared expertise. Whenever we present to teams or services or attend meetings we try to make sure that there is a member of staff and a person with lived experience representing the WaRP. We at all times need to model that partnership working. This has gone a long way to address the power imbalances between members of staff and those with lived experience and to building the credibility of the voice of lived experience. We feel it also challenges stigma and discrimination throughout, thus affecting changes in attitude and culture.



Recovery is Everybody's Business

Another key principle is that where possible we do not have separate activities that focus on recovery; rather, every element of the service has recovery principles imprinted on them. The fact that everyone has a responsibility to model recovery behaviours and that every meeting should reflect recovery principles is central to our approach.

Gathering Momentum and Motivational Approaches

We believe strongly in the importance of "creating a demand" for recovery. People need to want it and feel inspired. That is why initially our message was focused on the philosophy of recovery and the importance of partnership working, learning from lived experience. Understanding the expertise of lived experience and the concept of a shared humanity and wellbeing has been integral to this process.

We feel that this approach is beginning to pay dividends in DCHS as people are starting to ask how they can become more recovery orientated in their practice, rather than asking what recovery is or why it is important. In DHUFT

we are still very much focused on describing the philosophy and the culture in order to create the demand.

We have aimed to respond to every request for support or information about the WaRP and build a “critical mass” of people passionate about recovery. We have tried to focus on people and the areas that are receptive to change.

Our approach has been to try to filter the principles of recovery throughout every aspect of the service rather than focusing on large scale projects: to make small steps in many different areas simultaneously, rather like sowing seeds. Recovery is not something that can be rushed; it is a slow, ongoing process which requires continual reflection and revision and learning. We are therefore talking about a 5–10 year project.

Hearing Simon Bradstreet from the Scottish Recovery Network speaking at the *Refocus on Recovery Conference 2010* helped us clarify our understanding of our approach. There were two important elements. One was the concept of recovery as a *contagion* – this really made sense to us in relation to our attempts to create a tipping point (which is also something that Eugene Johnson from Recovery Innovations of Arizona [RIAZ] talks about)[1]. Moreover, it makes sense to us in relation to how well the message has been received, because when people “get recovery” it really breaks down barriers and creates opportunities for genuine partnership working and the spread of the message.

The other key point that was helpful was the understanding of Kotter’s Change Model[2] (see Appendix 2) and how unwittingly we had used a number of those steps, including creating a vision for change and a sense of urgency. Each stage acknowledges a key principle identified by Kotter relating to people's response and approach to change, and in which people see, feel and then change. John Kotter suggests that at least 75% of people wanting change creates a critical mass. With our work in DHUFT we are now consciously using this framework and principles to guide our implementation of organisational change (see Appendix 3).

We have used combinations of the cycle of change and stages of recovery model to help us understand the role of motivation in influencing change:

[1] http://www.recoveryinnovations.org.
[2] Kotter J P (2010) *Kotter Principles: 8 Steps for leading change*.

Stages of Recovery/ Cycle of Change

The Five Stages of Recovery[1]	Cycle of Change
Crisis* or Moratorium – A time of withdrawal characterised by a profound sense of loss and hopelessness.	Precontemplation
Awareness – Realisation that all is not lost and that a fulfilling life is possible.	Contemplation
Preparation – Taking stock of strengths and weaknesses regarding recovery and starting to work on developing recovery skills.	Decision
Rebuilding – Actively working towards a positive identity, setting meaningful goals and taking control of one's life.	Action
Growth – Living a meaningful life, characterised by self-management of the illness, resilience and a positive sense of self.	Maintenance

***Crisis is our addition following discussion with Dorset Mental Health Forum. We feel it fits better than Moratorium alone in representing people's experience of mental illness**

We recognise each person or team is individual and we try to meet them where they are in terms of their commitment to or understanding of recovery. This is why we have not focused on rolling out large-scale recovery skills training as we want people to be committed to the principle to want to develop their skills in that way. Over the past two years the majority of our presentations have focused on moving people from precontemplative or completive (awareness) to decision (preparation) and action (rebuilding). This highlights the importance of the slow approach in order to bring people along with us.

Maintaining our own Emotional Wellbeing

It is crucial to acknowledge the emotional effort required to lead and participate in organisational change. Our relationships with each other and our colleagues have been essential in this process. We are continually supporting each other and sharing our challenges, debriefing following meetings, planning our approaches, anticipating problems and developing strategies to deal with them.

We have great self-belief and confidence in what we are doing. However, the other side of the coin is that at times we have been plagued with anxiety and self-doubt about what we are trying to do, the enormity of the task, and how we are trying to approach it. This has required us to "hold our nerve" and draw upon the passion and belief that we know what we are doing and we are going in the right direction. Our team work (not just our immediate team but

[1] From Andresen R, Caputi P & Oades L (2006) Stages of recovery instrument: development of a measure of recovery from serious mental illness and Andresen R, Oades L & Caputi P (2003) The experience of recovery from schizophrenia: towards an empirically-validated stage model.

all who are involved in the whole project) has been essential in looking after one another. Different team members hold different “parts” of the emotional impact at different times. What is crucial is that this moves around the group rather than being located with the same person or people and we pay a lot of attention to this within our relationships. We believe it is essential for us to practice and model recovery at all times – walking the walk.

Within all this, we have had to learn the importance of compassion and acceptance, in ourselves, for each other and in our dealings with others.

Celebrating Success and Identifying Markers of Change

In light of the emotional demands of the work it is essential that we celebrate successes. There are some obvious identifiable successes which can be celebrated (for example the ImROC national Demonstration Site and the subsequent encouragement and endorsement of the ImROC team), however we have found that it has been really important to look at very small markers of change. We believe that the experiences of staff and people who access services are gradually transforming. Similar to motivational interviewing we look at statements that people are making and how they are changing or how receptive people are to peer specialists and working with people with lived experience. We are also looking at the sorts of questions people ask us and how they change over time. It is through identifying these and celebrating them that we are enabled to maintain our positive approach. (This is important as a parallel process when supporting someone on their personal recovery journey.)

The 10 Key Organisational Challenges

This section addresses each of the 10 Key Organisational Challenges as described by the Centre for Mental Health, taking each one in turn and reviewing our progress over the past year and outlining our plans for the future. We have included the self rating that we gave ourselves for the ImROC application; we have also reviewed those scores and have updated them. (To see our application form and the notes we used for the ImROC visit see Appendix 4.)

1. Changing the nature of day-to-day interactions and the quality of experience

Self Report for ImROC	Stage 1: Engagement
Description of Self Report	There is a recognition that recovery principles and values are important, but few systematic attempts have been made to implement them by changing staff behaviour. Staff (and people who access the service and supporters) are familiar with the general principles, but unclear about their implications for practice. People who access the service are not generally consulted regarding the quality of services delivered and staff performance.
Current Status	Stage 2: Development
Description of Current Status	There is clear evidence of a recognition that every significant encounter by every member of staff should reflect recovery principles and promote recovery values – aiming to increase self-control ('agency'), increase opportunities for life "beyond illness", and validate hope. Some attempts have been made to ensure that these principles are reflected in practice (e.g. pilots to involve people who access the service and staff selection and/or evaluation), but these are not reflected in routine staff supervision. Some involvement of people who access the service in staff selection, but not routine. In parts of the service, people with lived experience are regularly consulted around the quality of the service.

We feel that this is the most significant and challenging area, and will be our biggest marker in relation to achieving culture change. We are aiming for every interaction to be characterised by recovery orientated behaviour. Although we have increased our self-rating from engagement to development we still feel that we have a long way to go in transforming the experience of people who access the service and their supporters. We have just begun (particularly in DCHS) to move from talking about what recovery is, to how to put it into practice and have started a number of pilot projects.

Promoting the Message of Recovery

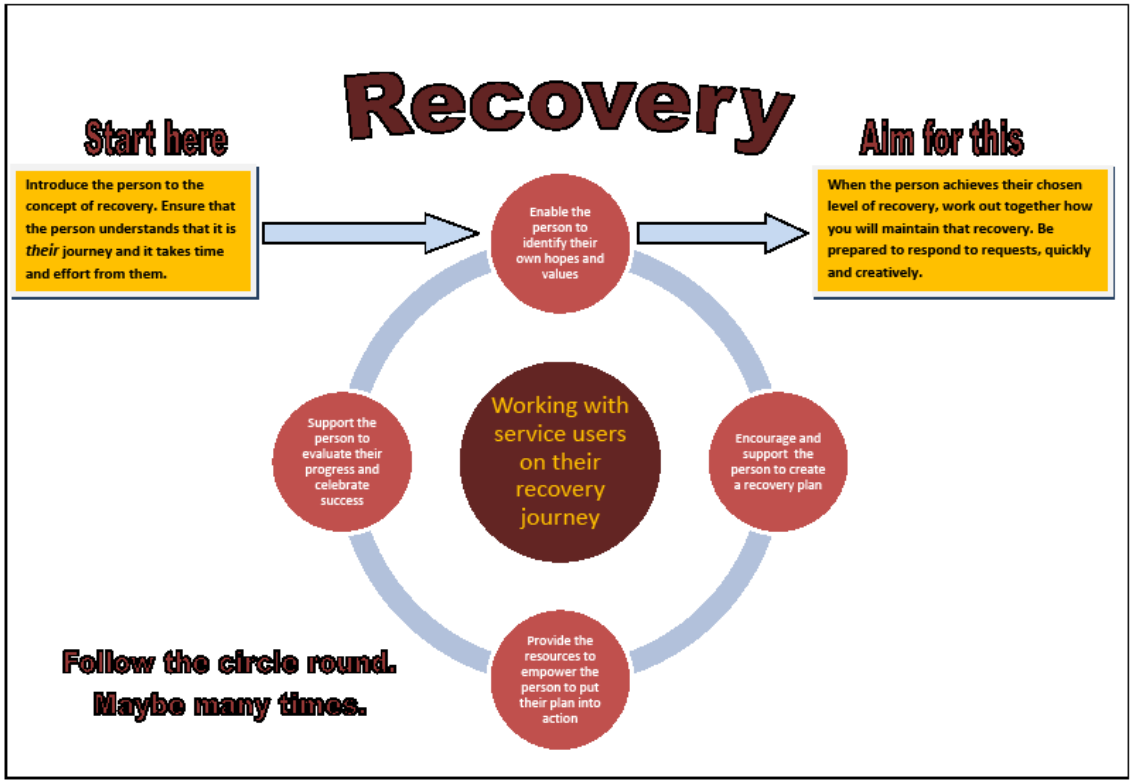
We have continued to promote the messages about recovery through doing large numbers of presentations. In the past year we undertook over fifty presentations, the majority of which were one person with lived experience or peer specialist and one staff member (and where appropriate and possible, a supporter representative). These also included presentations to Self Care Conference, Occupational Health and Bournemouth University. This has been the foundation of our approach in promoting the message around recovery.

We have continued to produce the WaRP newsletters. These are circulated to every member of staff and are available to the general public (see Appendix 5). This has included a specific newsletter aimed at carers and supporters. DMHF also produce *Reflections* which has a focus on recovery and recovery narratives (see Appendix 6). This is available to people with lived experience, their supporters and the general public. We are currently in the process of developing a large publicity campaign aimed at people with lived experience, their supporters, the general public, staff of all levels and all grades based on *What recovery means to me is…*

Last year we launched the Annual Report and Executive Summary and sent leaflets and posters to every GP surgery and Mental Health Services in West Dorset. We have decided against a specific WaRP webpage as the Dorset Mental Health Forum site is extremely comprehensive and there are links from the NHS sites to it.[1] It is also currently the first hit that comes up when Wellbeing and Recovery Partnership are put into Google.

Pilot Projects

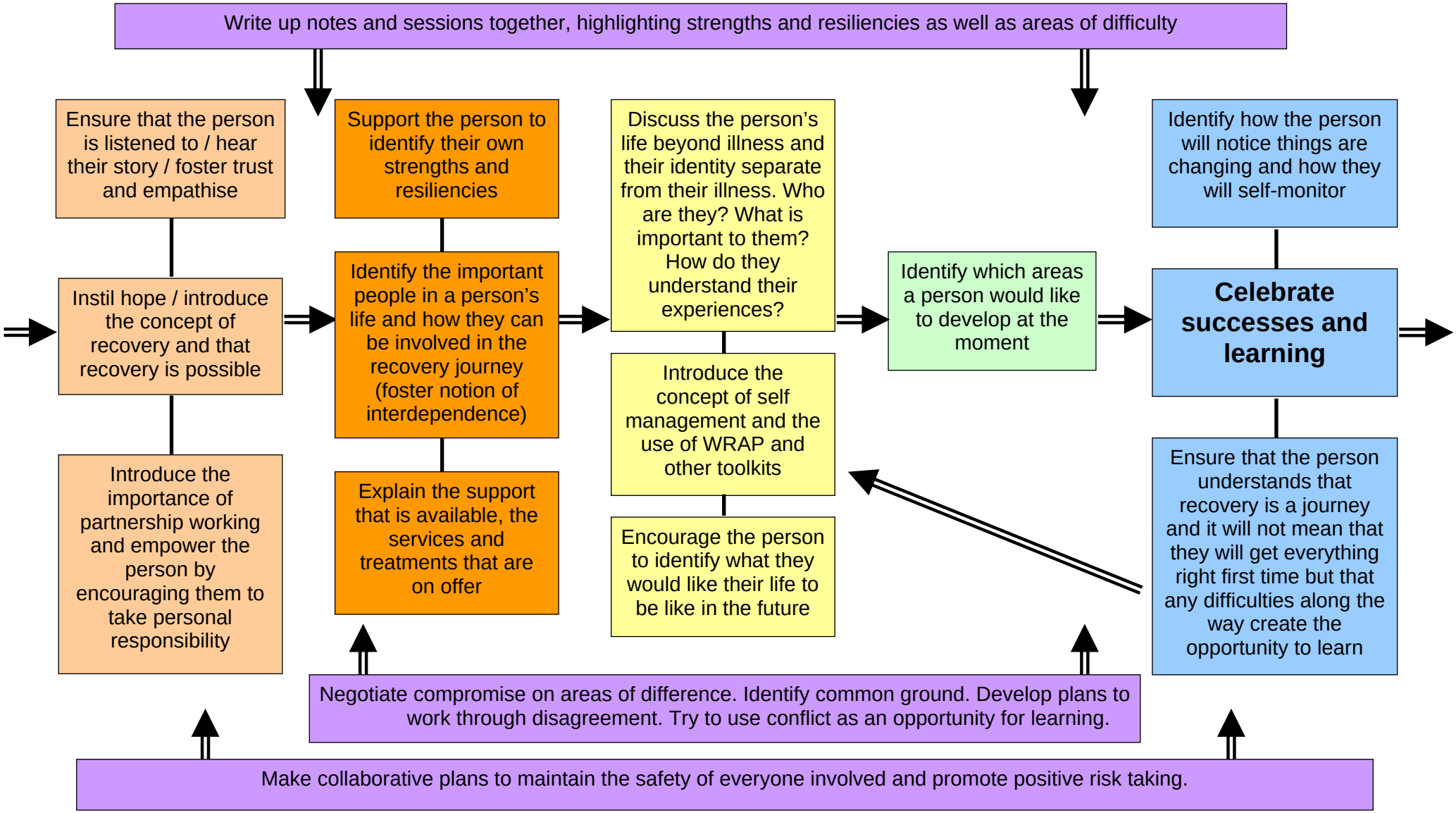
In order to develop our approach to implementing recovery we have developed two flowcharts which we are using as the basis for our work with teams and individuals. One (below) is an overview of the process of recovery developed by one of our peer specialists Bob Shaw and is aimed at people with lived experience, supporters and staff. The other (next page) is a more



[1] www.dorsetmentalhealthforum.org.uk/recovery.html

Guidelines for Facilitating the Process of Recovery

This flowchart is designed to be a guide to support staff in enabling a person to facilitate their own recovery. It outlines the steps which may support this process. Not everyone will go through each step of the process nor will they go through the process in the same order.



detailed flowchart designed to be a supervision tool for staff (both on an individual basis and team basis). There is also a table which maps out the parallel process for teams and their recovery journey (see Appendix 7).

We have commenced a number of pilots across Dorset looking at the implementation of these flowcharts. These initially have been with:

- Weymouth and Portland Recovery Team
- Blandford Older Person's Community Mental Health Team

Through working through the flowcharts and discussing recovery orientated practice the teams have identified their own initial projects. In Weymouth they have decided to review their purpose as a team and ensure it is in line with recovery principles and redesign their leaflets and waiting room with this in mind, thereby changing the expectation for people who access the service. We have also been focusing on the parallel process of the team's recovery journey and the recovery journey of an individual. The Blandford team have chosen to look at their initial assessment process and have designed a new initial assessment called "About me" which includes a greater focus on strengths and resiliencies, what a person finds important in their life, their key relationships and what they mean, and a focus on community participation and social inclusion. Over this year we are planning to expand our pilot sites to include Dorchester and Bridport and a number of sites in East Dorset.

The work in the Blandford team evolved out of their team leader's request to develop some measure of recovery orientated practice. A member of this team met with the WaRP team and together we developed the Seven Standards for Recovery Plans based on the Ten Top Tips for Recovery Orientated Practice.[1] We are using this to measure change within the Blandford team.

Seven Standards for Care Plan Audit
Evidence of client led personal recovery goals For the individual to be given assistance to empower them to identify their own goals. Goals should not be professional led, they should be client led to aid recovery/well-being.
Evidence of focus on client's strengths and resources To support the individual to utilise their current strengths and resources when working towards their goals.
Evidence of goals that focus on quality of life and social inclusion For goals not to be so linked in with Mental Health Services. Instead for the individual to access community resources such as voluntary work to enable social inclusion and for them to be contributing to society. To utilise friends, clubs and organisations that are relative to the goals that have been set.

[1] From Shepherd G, Boardman J & Slade M. (2008) *Making Recovery a Reality*. London: Sainsbury Centre for Mental Health.

Seven Standards for Care Plan Audit
Evidence of focus on the development of self management techniques To support the individual to self manage their mental health problems by encouraging the use of existing coping strategies and developing new ones etc.
Evidence of client having been offered choices and client's wishes and advanced decisions recorded The individual needs to inform the clinician of what they want with regard to therapeutic intervention e.g. which pharmalogical treatment they would like when they become unwell, what they would like to happen when they experience a crisis, alternative therapies, psychological therapies, for the individual's wishes to be adhered to as much as possible.
Evidence of positive risk taking and shared safety planning Realisation that there will be problems along the way and setbacks will occur. Clinician to continue to provide support so that hope is maintained and that the goals the individual has set are continued to be worked towards. Positive risk taking should be encouraged and the clinician must assist the individual with this.
Evidence of proactive engagement with carers and supporters With the individual's consent their family members, friends, or supporters should be consulted in the care plan. This enables the relatives etc to assist where possible but to not be put upon with expectations that are unrealistic.

We are also using these standards to evaluate another pilot project which is using people with lived experience to coach consultant psychiatrists. We commenced this project in March 2010. The aims of the pilot are to:

- Explore the impact and tensions of implementing a recovery orientated approach
- Identify the strengths of the psychiatrist
- Evaluate the experience of the psychiatrist through increasing the levels of recovery orientated reflection in practice
- Evaluate the impact on care planning and the experience of people who access the service

In addition, we have a number of peer-led initiatives. Nick Plumbridge and Terry Bowyer run the Wellness Workshops which developed out of the crisis service in Hahnemann House in Bournemouth. These are designed to engender hope, promote recovery and help people find the next steps to take in their recovery journey. Another peer-led initiative is the Wellbeing Toolkit developed by Bob Shaw. (This will be described in Section 5 regarding Personalisation and choice.)

We are currently examining how we are going to undertake a formal evaluation of all of these pilot projects and are exploring opportunities for research. We are also planning that these pilot projects, alongside other ongoing work with all the organisations, will form the basis of reviewing our approaches to assessment, CPA care planning and evaluation, with a view to developing genuine co-production of service delivery giving people the control they want over their own recovery journey. Alongside the WaRP there are a number of projects looking at evaluation and patient experience (for example,

instant electronic feedback and patient identified goals) and we plan for these to help inform our developments around CPA, assessment and evaluation.

Another key area we need to develop in order for it to be achievable is our engagement with carers and supporters and their involvement in people's and their own recovery journeys.

Action Points:

To continue to undertake and develop the team based pilot projects
To continue to develop the lived experience mentoring of psychiatrists
To develop a working group exploring the co-production of the CPA process, including assessment and evaluation
To develop the role of recovery narratives
To develop our approaches to improving day-to-day interactions for carers and supporters

2. Delivering comprehensive, user led education and training programmes

Self Report for ImROC	Stage 1: Engagement
Definition of Self Report	There is a commitment to increasing the coverage of teaching lead by people who access the service and training on recovery, but it remains patchy. Some training has taken place, but less than 25% of staff have been involved. There have been few attempts to embed learning from recovery stories into practice.
Current Status	Stage 2: Development
Definition	Action is being taken, with some evidence of significant changes in practice, policy and culture. A range of evidence confirms the increased profile of training by people who access the service (or by their supporters) on recovery, aided by an agreed strategy and policy. Approximately 50% of staff have received training in recovery principles formulated and led by people who access the service (and supporters). There is some evaluation of the effects of training, but this is not done systematically. The further development of training led by people who access the service (and supporters) has Board approval and funding is being sought.

One of the guiding principles of the WaRP is partnership working and valuing the expertise of lived experience. Therefore, all recovery focused training and presentations have been delivered or led by a person with lived experience. In some ways our approach to training has been *ad hoc* (providing it where the demand is created). Our focus during the coming year will be to articulate and formalise this process whilst allowing the continued flexible approach. We aim to do this through the establishment of the Recovery Education Centre (REC).

Nearly every staff member across Adult and Older Person's mental health services in DCHS has now received a detailed presentation on recovery and the expertise of lived experience. All these presentations are done in partnership between a staff member of the WaRP team and a person with lived experience. Recovery stories and personal experience are a key element of these presentations. We have also held three specific recovery stories events across Dorset.

Since September 2010 we have been offering these presentations to the adult and older person's mental health teams in DHUFT in the east. We have also presented to all the team leaders at a "Challenges Ahead" meeting and discussed recovery with the majority of senior managers and a number of

teams. People who access the service and supporters are now routinely involved in staff inductions and frequently involved in recruitment.

We have initially shied away from rolling out formal training packages because unless teams and individuals are “signed up” to recovery, we feel that formal training is limited in its effectiveness in impacting on practice. So the focus of our training has been presentations followed by discussions directly with teams. These discussions have included recovery stories which we have found to be powerful tools in engaging staff with the recovery principles and the need for change.

Over the past year we have been developing our Recovery and Skills Training. In last year’s annual report we had planned to roll it out before now but we wanted to make sure we got it right. We have been continually making revisions as our thinking has developed. We are now in a position to pilot this training with the Recovery Team in Weymouth. We will then be planning to roll this training out pan-Dorset. We are also piloting a Personal Recovery Course based on the Wellbeing Toolkit, aimed at people who access the service. These are both peer-led initiatives. In addition, we have begun training staff in the use of the Wellbeing Toolkit (see Section 5 on personalisation and choice for more information on the Wellbeing Toolkit). Furthermore, we are looking to increase the number of Wellness Workshops (see Section 1 on changing day-to-day interactions) and develop regular Recovery Stories Workshops aimed at people who access the service. We are also keen to involve and develop further training for supporters.

Peer trainers are also involved in delivering other training to a range of organisations and people, including Mental Health Awareness, Hearing Voices, and Relapse Prevention.

Over the next year we have funding in place to develop these programmes and through the establishment of the REC to formalise their developments and create a consistent menu of options pan-Dorset. We will also need to ensure we have consistent methods of evaluation for all of the training.

Action Points:

To continue to develop peer-led and partnership training packages
To develop tailor-made recovery and skills training for people across Dorset
To roll out personal recovery workshops and wellness workshops for people who access the service

3. Establishing a "Recovery Education Centre" to drive the programmes forward

Self Report for ImROC	Stage 2: Development
Definition of Self Report	There is recognition that current attempts to involve and support people who access the service to deliver training on recovery have been conducted on an *ad hoc* basis and needs a more strategic approach, but little progress has been made in developing one or considering how it will be delivered "on the ground". There have been discussions about centralising training and working in partnership with training groups led by people who access the service, but these have not been finalised.
Current Status	Stage 2: Development
Definition	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.

The Centre for Mental Health defines the REC as follows:

This ['Recovery Education Centre'] is staffed and run by "user trainers" and delivers support and training for service users to train staff in recovery principles for teams and on wards. (It may or may not be delivered by an external, independent sector 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.[1]

The key for us over the last year has been getting to grips with understanding what a Recovery Education Centre (REC) actually looks like and reflecting on our approaches to the recovery journeys of all involved. We have the organisational commitment to develop a Recovery Education Centre, for example, and the commitment is built into the terms of reference for the mental health training within DCHS. This year the aim is to develop a project plan and to start formalising the development of the REC. This is one of the two areas where we are looking for some support from the ImROC team.

[1] Shepherd G, Boardman J & Burns M (2010) *Implementing Recovery: A methodology for organisational change*.

We are planning to base our project plan around a number of pathways with the idea being that the pathways are loosely based on the Stages of Recovery outlined by Andresen, Oades and Caputi.[1] The focus for our REC will be personal growth, or team or organisational development through recovery orientated approaches. Currently we have six pathways under development.

These are for:

- People with lived experience of mental illness
- People with lived experience of organic mental illness
- Supporters
- Staff
- Leaders
- Peer specialists

We are keen to look at the development of educational approaches to mental health service delivery and hope to offer a range of courses which people are able to enrol on as students. These may provide a range of psycho-educational and practical skill based courses as well as the recovery specific training. It is also an aspiration that the REC is open to the general public and offers a pathway to members of the wider community. A number of organisations nationally and internationally have developed "recovery colleges" which is something we will be exploring, although we have some reservations of having a building within which recovery is located as we are keen to ensure recovery is "everybody's business".

We are developing our formal peer training packages as part of the REC and are discussing the possibility of having these accredited. We have had some very early discussions with Bournemouth University and Sue Clarke from the University Mental Health Department sits on the recovery steering group for DHUFT.

Furthermore, we are looking at the REC in partnership with Bournemouth University as a way of co-ordinating and developing research. We also have a number of training places to develop research skills for people with lived experience.

Action Points:

To build on existing partnership working. To develop the vision, a project plan and training pathways for the REC
The REC will underpin all the work of the WaRP

[1] Andresen R, Oades L & Caputi P (2003) The experience of recovery from schizophrenia: towards an empirically-validated stage model and Andresen R, Caputi P & Oades L (2006) The Stages of Recovery Instrument: Development of a measure of recovery from serious mental illness.

4. Ensuring organisational commitment creating the culture. The importance of leadership

Self Report for ImROC	Stage 2: Development
Definition of Self Report	There is recognition throughout the organisations that its culture needs to change from a "problem-based" approach (focus on illness and symptoms) to a "strengths-based" approach. Plans are in place to review internal "pathways" (referral systems, assessments, CPA, discharge planning, etc.) to make them more recovery-oriented, but little progress has been made so far. There are committed individuals leading the implementation of recovery principles, but they are isolated and only operating at a team level, or at senior level, but not both.
Current Status	Stage 2: Development
Definition	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.

There is full sign-up to the 10 key organisational challenges[1] from DHUFT chairman, Chief Executive and Board and DCHS committee. Dorset County Council has also recognised the work of the WaRP. In addition, there is interest in how the principles of wellbeing and recovery could influence the development of physical services and long term conditions. The WaRP recognises the importance of partnership working with commissioners and with the future changes to commissioning it is important to retain this focus.

There is routine involvement by those with lived experience and supporters in service development initiatives, for example, the DCHS enhanced recovery project (the transformation of the acute services, with the further development of Crisis Resolution Home Treatment Services and Crisis Housing) and the pan-Dorset QIPP pathways events (building care pathways on lean principles but underpinned by the recovery approach).

In DHUFT the WaRP steering group meeting is a partnership between people with lived experience and staff. In the development of the WaRP within DHUFT a comprehensive scoping exercise was undertaken giving a "warts and all" account of the current state of play within the organisation and an outline of a potential project plan based on Kotter's stages for organisational

[1] Outlined in Shepherd G, Boardman J & Burns M (2010) *Implementing Recovery: A methodology for organisational change*.

change[1] (see Appendix 2 for Summary). These findings were presented to the Board, governors, executive management group, and team leaders. There was also a celebration event in December 2010 promoting existing excellent recovery orientated practice within DHUFT. The findings of the report outlined two key challenges:

- Implementing recovery orientated practice within the context of a need to collate information
- Supporting the Recovery Journeys of Staff

The DCHS steering group has been disbanded as recovery is now embedded routinely in most senior meetings. Becky Aldridge sits on the Practice and Quality meeting for Mental Health, which is the meeting of the operational managers for DCHS.

Both organisations have a *Recovery Network* (also known as Recovery Reference Group or Recovery Advisory Network). These are focused on the implementation of recovery and are open to staff, supporters and people with lived experience. Last year we outlined our plans for *Learning from Lived Experience Groups*; these networks have supplanted the need for those groups. The aims of the networks are:

- 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

These groups both act to implement recovery, but also to critique and inform the work of the steering group or the WaRP as a whole (see Appendix 8 for Terms of Reference). For further information on how we are developing our care pathways and CPA process see Section 1 on changing the nature of day-to-day interactions.

We have also started to undertake some work around recovery and leadership and within DCHS have run a number of Recovery Leadership workshops for both Team Leaders and Operational Managers. After each workshop we have written up a report. These workshops have focused on the following questions:

- Why would you want to be a recovery leader?
- What is a recovery leader?
- How are you going become a recovery leader?
- How will you know if you are becoming a recovery leader? What are the barriers and how would you overcome them?

A key part of these workshops is how we build recovery principles (such as strengths focused, developing people's wellbeing) into all everyday practice –

[1] Kotter J P (2010) *Kotter Principles: 8 Steps for leading change*.

meetings, supervision, appraisal. We are also interested in how managers and staff hold themselves to account to each other about their behaviour. Over the next year we plan to create a Recovery Leadership Toolkit and roll out the leadership workshops pan-Dorset. See Appendix 9 for Recovery Leadership reports.

We are gradually changing policies but we see that in some ways practice needs to drive the policies rather than vice-versa so we are updating them as and when required. With DHUFT and DCHS coming together there is the opportunity to review working practices and policies and the WaRP is seen as a key player in influencing these.

Action Points:

To run Recovery Leadership Workshops in East Dorset
To develop Recovery Leadership Toolkit
To continue to develop recovery network meetings to facilitate learning from lived experience
For WaRP to participate in all levels of service design and development
For the WaRP team to engage with commissioners and GPs to promote the principles of wellbeing and recovery in future service design and delivery

5. Increasing personalisation and choice

Self Report for ImROC	Stage 1: Engagement
Definition of Self Report	There is recognition of the need to develop partnership working with people who access the service 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 the priorities of people who access the service 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.
Current Status	Stage 2: Development
Definition	There is a growing move towards greater personalisation and choice in terms of treatment and management options. New policies reflect a revised approach to shared decision making and joint planning. There is evidence that more than 50% of people who access the service feel actively involved in directing their CPA process and determining the content of their care plan. The organisation has produced a range of information and interventions to support self-management approaches. There has been a substantial increase in the uptake of direct payments and the use of personal budgets. There has also been a significant expansion in the use of jointly agreed "advance directives" (e.g. joint crisis plans). Attempts are being made to incorporate WRAP objectives into care plans. The North Dorset locality and DMHF are involved in a national research project examining personalisation led by Rethink, University of Birmingham and the King's Fund.

The focus for the WaRP has been the promotion of self-management. In the QIPP pathway events self-management has been proposed as the central tenet. The WaRP has also been promoting the idea of services moving away from being "client-centred" to being "client-led" and for those not yet at a stage to lead their own care, that the services should focus on enabling them to develop these skills.

The Wellbeing Toolkit

As stated in last year's annual report, when exploring self-management tools the WaRP reviewed all the current tools available and chose to develop a tool locally. Bob Shaw developed the Wellbeing Toolkit on behalf of the WaRP. This toolkit has a much stronger focus on values and identity alongside the typical focus on "the things that keep me well". It can be applied flexibly and

people can use pictures and music as well as writing. We planned for this to be launched towards the end of last summer including an online resource, however, the transition from development to implementation has taken longer than expected. The best way to develop the online resource is still under discussion.

The Wellbeing Toolkit has been piloted on an individual basis, with support from Bob Shaw, by staff and people with lived experience and the initial feedback is positive. The toolkit has also been presented to both Recovery Networks. A pilot group for people who access the service commenced in June 2011. A number of awareness sessions have been rolled out for NHS and DMHF staff as well. We are also developing a Wellbeing pilot in the Young Offender Institute on Portland and this is due to take place (see Appendix 10 for report). The Wellbeing Toolkit was presented at a local Self-Care Conference and has attracted interest from people working within physical services and long term conditions.

As stated in last year's annual report staff should encourage all people who access the service to complete a Wellbeing Toolkit but these plans should be owned by the person themselves. We propose to complement the implementation of the Wellbeing Toolkit, through the development of the REC, by offering people support by peer specialists on an individual basis or by their attending a Personal Recovery Workshop.

The Wellbeing Toolkits should guide and form the basis of the CPA care planning process. If a person has another form of plan e.g. personal recovery plan or WRAP plan, this could be used instead. The crucial factor is that people have ownership of their own plans and that staff are skilled in facilitating people to be able to complete them. At times there may be disagreements regarding the plans of individuals and statutory responsibilities and these should be acknowledged and documented as part of the CPA care planning process. Both the Personal Recovery Workshops and awareness sessions for staff aim to describe how to negotiate care planning using the Wellbeing Toolkit. A number of the trigger questions in the Wellbeing Toolkit are also being developed as coaching questions for the Recovery and Skills Training.

Alongside the work of the WaRP there is ongoing use of WRAP plans. WRAP plans can sit comfortably within the Wellbeing Toolkit as a separate section. The important element is that people are given the opportunity to take control of their own lives and choose which tool works best for them. A Bournemouth CMHT has developed an innovative approach which incorporates WRAP, crisis planning and individual goal-setting. Laurence Mynors-Wallis (Medical Director, DHUFT) has also developed Patient Identified Goals which allow the person to choose their own goals and rate their own progress on them.

A key area for future development is the routine use of advanced decisions, advanced directives, and crisis plans. We are planning that this will be project planned through the aspiration toward Zero Restraint (see Section 6 on changing the way we approach risk assessment and management).

Personalisation and Direct Payments

Alongside the developments led directly by the WaRP in Dorset there are strong links with the personalisation agenda. Self Directed Support (SDS) for Adult Mental Health Services was rolled out on 1 November 2010. It is "early days" as regards using the new forms and processes and a series of training workshops have been arranged to support staff. Prior to the roll out of SDS, Mental Health Services have assessed the social care needs of individuals and have a strong reputation regarding the offer and take up of direct payments, over traditional care managed services. There are currently over 175 people in Adult Mental Health Services in receipt of direct payments.

The North Dorset locality team is involved in a RETHINK research project examining the implementation of personalisation. DMHF is also involved with this research project within the People's Study.

Spirituality

Recovery can be interpreted as "a search for meaning" and it is vital that spirituality is integral to the concept of recovery in the opportunities services create for people to understand their experiences. This is an area we hope to develop further. The Wellbeing Toolkit does give people a way of framing their experiences within their own belief system. However, we are keen to develop this further and plan to develop a project plan to increase spiritual involvement with key partners.

Action Points:

To continue with the roll out and evaluation of the Wellbeing Toolkit and recovery narratives, including the YOI pilot
The development of client-led CPA
To develop the use of advanced decisions, directives, and crisis planning, in aspiring towards zero restraint
To develop a spirituality project plan
WaRP to support the Personalisation agenda in Dorset

6. Changing the way we approach risk assessment and management

Self Report for ImROC	Stage 1: Engagement
Definition of Self Report	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 people who access the service 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.
Current Status	Stage 1: Engagement
Definition	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.

Risk and Safety Planning

In last year's annual report we outlined that in DCHS we had developed a statement that described the links between safety planning, risk and recovery (see Appendix 11 for Summary Risk Statement). This statement has been endorsed by DCHS' operational management group. Within the Risk and Safety Team Leads Network, we have been developing guidelines for staff to work with people in a recovery orientated way including managing their own safety. This work has been done in partnership with people with lived experience. We have completed a first draft of guidelines which has outlined the principles and has a number of tips on how to put these principles into practice. We are now working on a second draft which includes focusing on positive risk taking, proactive engagement strategies and looking at the person's whole life in the context of safety planning and risk management. These approaches are already being incorporated in the Trust training around risk, which is also delivered in partnership with people with lived experience.

We discussed the risk statement in the DHUFT steering group and although there was agreement and support for it, it was decided that in order for people to have ownership and "buy in" it was important for DHUFT to develop its own statement which would then be agreed at Board level. We are currently establishing a working group in order to take forward this piece of work. We will then look to integrate the two statements and practice guidelines.

Transforming Acute Services: Zero Restraint, Zero Seclusion

The other key area we are seeking to develop in our risk assessment and management is working with the ImROC team towards the aspiration of Zero

Restraint within all acute services across Dorset. The "Zero Restraint" initiative comes from the work of Eugene Johnson (CEO of Recovery Innovations of Arizona [RIAZ]) and his team.[1] In reviewing their crisis service they asked the following questions:

- Did people leave with a renewed sense of hope and self-determination that could add meaning and purpose to their lives?
- Did they learn how to better manage their life circumstances so they could avoid this experience in the future?
- Did staff learn anything that could increase their skill in serving people?

They then reviewed their whole service in line with these principles and Eugene stated:

I was enthusiastic and excited about the possibilities of our new recovery mission. I wanted the people we served to really have the opportunity to recover. Stopping the violence of takedowns and restraints in our Crisis Centres seemed like the place to start. That could begin to shift our beliefs and attitudes and jumpstart the transformation of our culture. I made a public declaration for "zero restraint". That got us busy. We educated ourselves, developed new policies, redesigned our training, and measured our progress. Now, whenever there is something to do that is really hard, we remember that we have already done the impossible. "Zero Restraint" has become our metaphor for transformation.[2]

Recovery Innovations developed a coherent and structured approach in order to achieve this and we are aiming to learn from their experience, with the support of the ImROC team. Our aim this year is to develop a project plan to use this as a springboard for the transformation of our acute services.

Initial steps have been made to change the culture within acute care through the introduction of the Tidal Model and Star Wards. However, in order to move things forward, a draft acute care strategy has been developed based on Recovery Innovations' work. There is a need to move toward incorporating an educational approach to understanding acute care including the need for people to build meaningful lives and be reintegrated into their communities (see Appendix 12 for this strategy).

Action Points:

To develop a DHUFT risk statement
To develop recovery orientated guidelines for risk assessment and safety planning
To promote dialogue around positive risk taking, and support its concept
To develop ways to consider crisis as a learning opportunity
To develop a project plan for aspiring towards zero restraint

[1] http://www.recoveryinnovations.org.

[2] Quoted from Ashcraft L & Anthony W (2008) Abstract: Eliminating Seclusion and Restraint in Recovery-Oriented Crisis Services, p. 8.

7. Redefining user Involvement

Self Report for ImROC	Stage 2: Development
Definition of Self Report	The organisation has accepted that people who access the service (and supporters) 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 people who access the service and supporters as partners in care; but their knowledge and expertise is still seen as secondary, rather than primary. The principles of "user involvement" (or as we prefer to say, "involvement by people who access the service") are accepted, but this is not reflected in true "partnership working".
Current Status	Stage 2: Development
Definition	Through our relationship with DMHF 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.

We feel that this is the area in which we have made the most significant progress in the past year. We believe that we have a broad commitment to move away from involvement by people who access the service and focus on partnership working. We have tried to model this at every level, so for every activity of the WaRP there is a representative with lived experience and a professional staff member both promoting the Wellbeing and Recovery agenda. This modelling is central in underpinning the culture change. The voice of lived experience has real credibility and there is the opportunity for significant developments with regard to the sharing of power.

Across both organisations there are clear partnerships and involvements, for example in the Operational Management Group, Clinical Governance, Quality Task Force, Acute Care Forum (DHUFT Acute Care Forum is chaired by a person with lived experience), the enhanced recovery development work and wider QIPP agenda. What is noticeable concerning the changes to interactions is the level and sophistication of this partnership working. DHUFT has a strong Service User and Carer Involvement programme which is key to creating opportunities for participation. In DCHS there are very few areas of the service that are not engaging with people with lived experience in planning, developing or evaluating their service. We are starting to see the knock-on effect, particularly in DCHS, of this filtering down to frontline services and we are seeing staff discussing their approaches to working with people. We have reflected this partnership working in our *Recovery and Skills training* which we are in the process of rolling out across both organisations, emphasising coaching and partnership working.

We still have a long way to go in working with carers and supporters with regard to having a broad group of supporters who are passionate about recovery. That is not to say we do not have a number of key individuals who have been involved in partnership working, but this year we are looking to develop this further and this will be outlined in the development of the REC. We sent out a newsletter last year specifically aimed at trying to engage with carers and supporters and we have recently sent it out again across the whole of Dorset and we are looking to develop a group of carers and supporters who are passionate about recovery (see Appendix 13 for Newsletter).

Action Points:

To build on existing partnership working with people with lived experience throughout Dorset

To increase partnership working opportunities with supporters and carers

8. Transforming the workforce

Self Report for ImROC	Stage 2: Development
Definition of Self Report	The Board and senior managers have recognised that transforming the workforce may require a change in the skill mix and balance of 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, and there is little managerial support or supervision. Human Resources and Occupational Health have not been reformed and no thought has been given to issues of "career progression" for peer staff.
Current Status	Stage 2: Development
Definition	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 OH involvement and the development of a career structure. At present there are a number of pilot peer specialist positions. However, employment of people with lived experience is generally in support work and STR worker roles.

There is clear support across both NHS organisations around the employment of peer specialists and plans are in place for future development of these roles. Dorset County Council is also involved in developing new roles. The WaRP has taken a slightly different approach to developing peer specialist roles and, rather than employing them as part of the NHS they are employed by Dorset Mental Health Forum and then hosted within the statutory service teams. We see peer specialists as being essential to the development of recovery orientated services and key to our learning is understanding that they are as much a peer to the staff as they are to the person who accesses the service. For more information about how employing peers transforms the workforce, please see *Making Recovery a Reality*.[1]

The benefits of employing people external to statutory services and then co-locating them is that people are better supported. They are employed within an organisation which is already recovery orientated, they have access to peer support, peer mentoring and there is greater flexibility in terms of their work and how they operate. They can focus on "recovery orientated practice" and not get caught up in the generic functions of other team members or administration processes. They are also able to access supervision within the NHS and because of the strong partnerships at senior levels between the NHS and DMHF we are able to manage any tensions that arise. We have concerns about putting peer specialists into teams that do not already have a

[1] Available at http://www.centreformentalhealth.org.uk/pdfs/Making_recovery_a_reality_policy_paper.pdf

strong recovery culture but we recognise that peer specialists are key to changing that culture. Peer specialists can be seen as “culture carriers”. Through a flexible approach we are able to manage some tension by involving people incrementally. The other advantage of peer specialists being employed by an external organisation is that they can retain their identity as “critical friends” which can mitigate against some of the institutionalising effects of working within statutory services. This is important for staff, particularly for those with their own lived experience.

For further information see the report into our peer specialist pilots (see Appendix 14). We also believe that until there is a great shift in terms of how Human Resources (HR) and Occupational Health (OH) are able to support staff with lived experience that it is unwise to employ peer specialists within statutory services. The work we are doing with HR and OH is outlined in Section 9 regarding supporting staff on their recovery journey.

As mentioned previously, we are developing our formal peer training packages as part of the REC and are discussing the possibility of having these accredited with local education providers. The WaRP has also taken a broader view of peer specialists so it is not just in the typical peer support work role or delivering training but in addition, consultation on service design and delivery and input into strategic decision making. DMHF has a number of levels of involvement which allows a broad range of people with lived experience to get involved in different activities, within and outside statutory services. (For a full list of different peer specialist roles and DMHF levels of involvement see Appendix 15.)

Action Points:

To continue to develop peer specialist roles, creating a stronger relationship with the REC and more training and development opportunities for individuals, staff, supporters, leaders and others

To develop accreditation links with local education providers.

9. Supporting staff in their recovery journey

Self Report for ImROC	Stage 1: Engagement
Definition of Self Report	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 developing different ways of delivering their expertise.
Current Status	Stage 2: Development
Definition	The organisation recognises the need to support staff in the disclosure of their own lived experience of mental health problems and this is included as an optional part of recovery training. The organisation acknowledges the need to ensure that there are opportunities within individual supervision to address these issues. It is recognised that those with individual recovery stories have a unique and valuable contribution to make to the development and day to day delivery of services. The organisation is developing a shared approach with staff to deliver its vision regarding recovery. Staff generally report feeling included in this process and can see a clear way forward.

There is a clear understanding from both NHS organisations of the importance of staff recovery journeys as well as those from people who access the service and their supporters. There is support from the director of Human Resources (HR) from DHUFT and both Occupational Health (OH) departments for developing new approaches to working with staff.

Hidden Talents

The Hidden Talents project was launched last year in DCHS, with the first meeting being held in November 2010. The following email from Brian Goodrum (Director of Mental Health) and endorsed by Tim Archer Chief Operating Officer was sent to all staff describing the Hidden Talents project. It "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". The email then went on to state "staff having lived experience of mental health problems is viewed as an asset".

The Hidden Talents project is open to all staff who would identify themselves as having lived experience of mental health problems. The focus of the project is:

- Addressing stigma
- Sharing expertise around self-management
- Managing disclosure and its clinical application
- Peer support
- Guidelines for managers, HR and OH in supporting staff with mental health problems

Just over 30 staff are members of the Hidden Talents project with an average of 12 people attending each meeting. The meetings are for two hours and the first hour is an informal discussion where people share experiences. The second half focuses on developing a strategic plan to work on the areas identified.

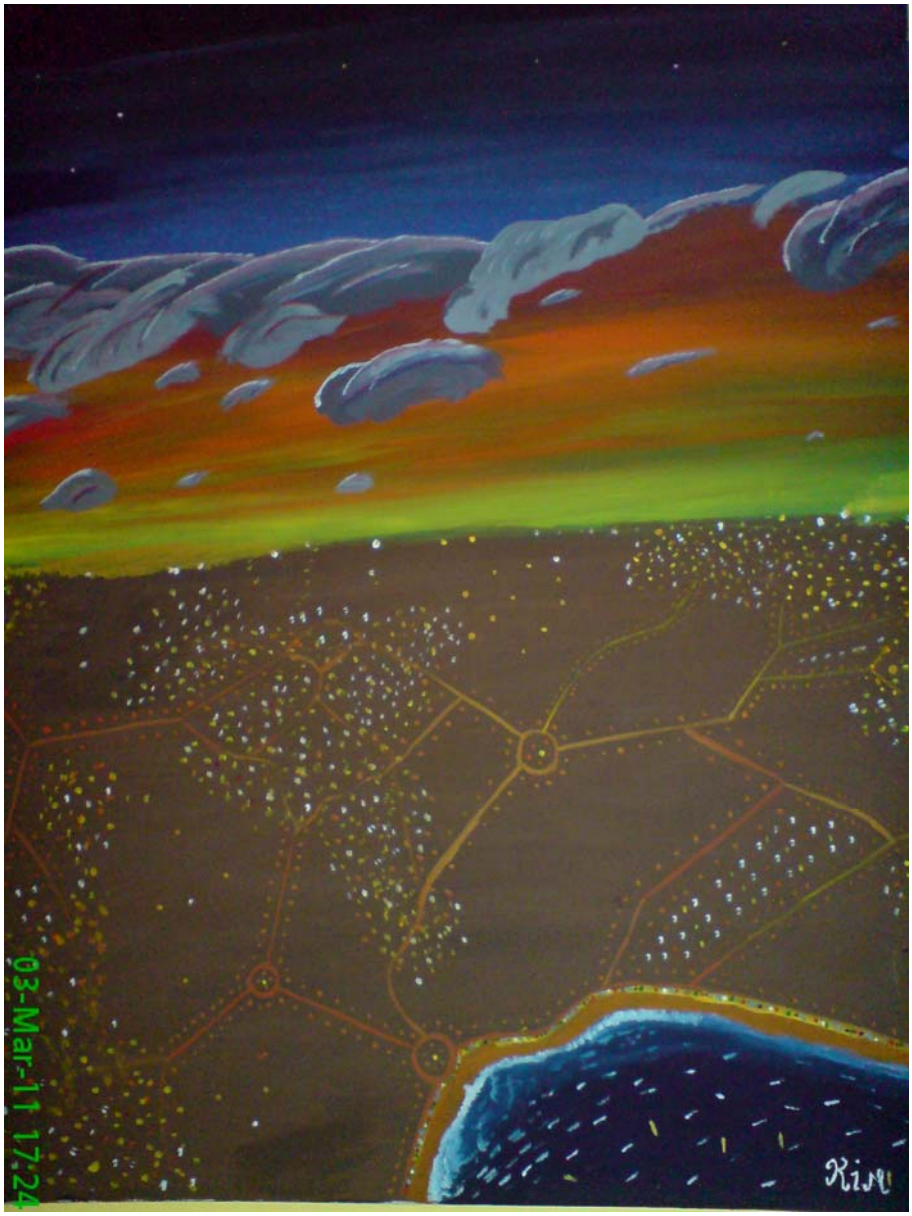
The group has already begun to develop links with OH to act as an expert reference group and has critiqued and commented on the Staff Wellbeing Proposal (see below). The group is keen to develop an anti-stigma campaign based around recovery stories and we are looking at the next World Mental Health Day as a target date for the launch of that. Kate Antell (team leader at Linden Unit) representing the Hidden Talents project told her recovery story at the best practice event for DCHS. Kim Dennick (PA to Deputy Director of Performance and Information and Associate Director of Commissioning – Contracts) has kindly given us permission to use her paintings in articulating her recovery story.

The Seasons in a Year painting is one I did for my nieces' bedroom wall and painted when I was fine and is more typical of the type of painting I enjoy.

Saturn was painted after I saw it through my husband's telescope, again when I was well.

Black Hole; Confusion and Respect were all done when I was ill and were the only ones to survive that period. They survived because my husband stole them away before I could destroy them (something that I seem to do to my art when I am unwell).

From the Air was painted when I was recovering, space and the stars clearly seen but with clouds in the way that still needed to be addressed.



As I said before I am no Picasso but the paintings did help me to explain what my brain felt like when I was unwell and unable to string a coherent sentence together.

The group is also looking at what it means to be a "recovery orientated staff member" in terms of how to model self-management and recovery. The group is also involved in critiquing and influencing the development of policies. For further information, see Minutes from the meetings (Appendix 16).

The Hidden Talents project has yet to be launched in DHUFT. There is plenty of interest in the project and the WaRP has spoken to the staff Disability Forum and currently discussions are taking place about when would be the best time to launch the project. The initial feeling is that the Hidden Talents project in DCHS was launched after a year of wider development work around

recovery and it is the associated culture changes that have enabled its development. DHUFT has formally been part of the WaRP since September 2010 so it may be beneficial to allow some of the broader work around recovery to be embedded first. However, as with all project planning with the WaRP, we will try to be responsive and launch it once we have "created significant demand". This will be a marker of change.

Hidden Talents also presented at the University Department of Mental Health Conference in Bournemouth in June 2011.

Staff Wellbeing Proposal

A Staff Wellbeing Proposal report (see Appendix 17) that was completed jointly by the WaRP and the DCHS OH department has also been adopted by the DHUFT HR and OH department. This report has the following recommendations:

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. Whilst 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 managers – 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 promotes 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.
- To develop outcome measures for OH to utilise, which capture recovery-based outcomes in order to collate effective feedback on the service.
- We should pay specific attention to the emotional wellbeing of staff around traumatic incidents, ensuring that effective debriefing is available and that staff are routinely offered emotional support for incidents such as attending coroners 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.

These recommendations form the basis of a range of projects, for example Hidden Talents and Recovery Leadership. We are also starting a number of joint initiatives with OH. For example, co-facilitating stress risk assessment workshops for team leaders to identify strengths and resiliencies of teams and individuals.

Action Points:

To develop Hidden Talents to become a pan-Dorset project
To challenge stigma and discrimination at every opportunity
To celebrate lived experience and the modelling of recovery
To continue to work with HR and OH in developing recovery orientated approaches towards staff

10. Increasing opportunities for building a life "beyond illness"

Self Report for ImROC	Stage 1: Engagement
Definition of Self Report	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 people who access the service and their supporters 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.
Current Status	Stage 1: Engagement
Definition	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.

Social Inclusion and Vocation

There is recognition of the importance of "building a life beyond illness" with some effective community partnerships and some examples of excellent practice, both within vocational services (including Individual Placement Support) and promoting social inclusion. There are partnerships with the third sector (Rethink, DMHF) and social enterprise. However, there still needs to be stronger links between the community mental health teams, acute and rehabilitation services and a focus on development of social inclusion and vocational outcomes. There also needs to be a consistent approach Dorset-wide and this should be the primary focus for all parts of the service.

There are a number of peer specialist posts in place and under development, supporting building a life beyond illness across Dorset. These include a team of peer specialists in the Weymouth and Portland Community Resource Team and one in the North Dorset Community Resource Team. There are also future plans for peer specialists in Dorchester and Bridport to support this work. Within primary care there is a pan-Dorset team of peer specialist employment support co-ordinators. A peer specialist housing team is under development to look at housing experience and pathways in West and South East Dorset. For further examples of peer specialist work please see Appendix 15.

Despite all these pockets of good practice, particularly with the two organisations coming together, there is however a need for an overarching

strategy looking at vocation and social inclusion which is underpinned by the WaRP vision.

Engaging with the Wider Community

There is a strong Time for Change campaign in Dorset and a number of people in the WaRP steering group and various other staff members are involved in this campaign. Also DMHF and DHUFT are contributing to the Recovery South West Recovery Stories Book and Hannah Walker (Chair of Dorset Mental Health Forum) has co-edited a recent book on recovery stories entitled *Our Encounters with Madness*.[1]

The WaRP has had a number of articles in local newspapers and local radio. Last October the WaRP put on a week's worth of events open to the general public which included the telling of recovery stories (see Appendix 18 for leaflet). We plan to promote another series of events this year.

Action Points:

To develop a pan-Dorset social and vocational strategy and project plan.
To promote opportunities to influence local employers and communities
To continue to engage in anti-stigma campaigns discrimination campaigns
To promote the importance of everyone from all sections of the community paying attention to their emotional wellbeing

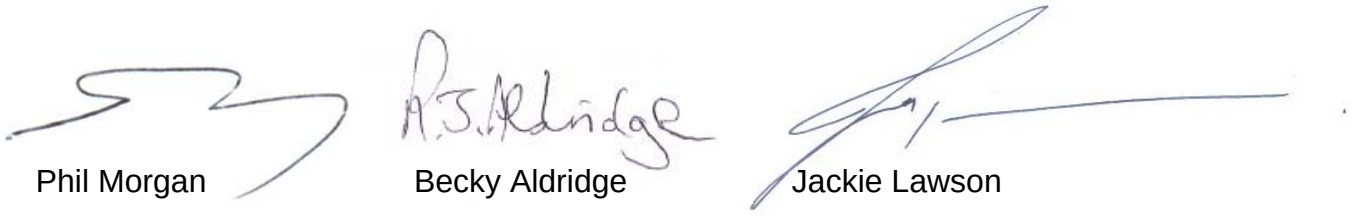
[1] Alec Grant, Fran Biley and Hannah Walker, eds (2011) *Our Encounters with Madness*. ISBN 978 1 906254 38 4.

Conclusion

This has been a tremendous year for the WaRP. We are really excited in taking this work forward over the next 12 months. We have a great opportunity in Dorset to do things differently and make a meaningful change to people's lives. This is not without its challenges, particularly as we enter a period of rapid change within health and social care services. However, there are also some real opportunities to do things differently.

We relish the challenge, as we often say "if it is not difficult we are probably getting it wrong", because the culture change we are looking for is a huge shift. Recovery is a struggle: both for the individual and for the organisation. We are passionate and confident that we will be able to create the culture change we are all aspiring to. The reason for this confidence is the sheer number of people who are committed and passionate about recovery and the WaRP. There are too many people to name here but they are people with lived experience, their supporters, clinical staff, managers, administrative staff, commissioners and members of the public. We are hugely grateful for their support, commitment, passion and inspiration, which has helped immensely us over the past two years. We have also been buoyed by the support of the ImROC team which has helped us recognise the strengths we all have as a partnership.

This annual report has outlined our progress to date and our plans for the coming year. Developing recovery orientated services is a long and slow process but we anticipate making significant progress in the next year in continuing to transform experience and unlock potential.



Phil Morgan Becky Aldridge Jackie Lawson

August 2011

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