Dorset Wellbeing and Recovery Partnership
Transforming Experience … Unlocking Potential

Annual Report
2011/12

Completed by Becky Aldridge, Phil Morgan, Jackie Lawson and Sarah Rose
Foreword

It seems such a short time ago that this ambitious Wellbeing and Recovery programme was launched in West Dorset. But here we are, writing the third Annual Report, and, from the dreams and hopes of a dedicated small group of individuals has risen a programme – so ambitious – that it is already redefining Dorset’s whole approach to Mental Health.

For each year the targets – as well as your belief in what you can achieve – increase. This Annual Report sets out in exciting detail the enormous accomplishments that have been realised over the last twelve months. At the heart of all these programmes is the unshakeable belief in the power of partnership, a partnership of equals that recognises the enormous contribution – and guiding principles – set out by those who have lived experience of mental illness, and who believe that a commitment to recovery is the bedrock to true life fulfilment.

It is their leadership – and their belief in themselves – that creates the roadmap for the Wellbeing and Recovery Partnership. It is their drive that pushes the WaRP to achieve even more; that refuses to accept that there are limitations as to what can be achieved. Their excitement and their vision is contagious and humbling, and the fruits of their endeavour are set out here for all to see. Chief amongst these must be the Recovery and Education Centre which is setting new standards across the country as to the difference that a commitment to the Recovery principles can make.

And yes, we can all acknowledge, that despite the enormous progress, there is still much more to do. As with so much in life, the ability to fulfil our potential is a continuous, and ever-evolving journey. There will be frustrations along the way, I’m sure. But with strong partnership, and by striving towards united and clearly defined goals, there is no doubt that the passion and commitment evident so far will propel us towards ever greater achievements.

Good luck to one and all!

Jonathan Walsh
Chairman
Dorset HealthCare
Definitions of Recovery

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

“Full mental health is not the absence of neurosis but the fulfilment of our potential.”

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Executive Summary

Key achievements
Creating a demand for and valuing expertise by experience
Establishment of the Recovery Education Centre
Launch of Hidden Talents Project pan-Dorset and production of booklet
“What Recovery Means to Me …” Communication Campaign
Person Focused Recovery CPA Guidance
Lived Experience Mentoring for Psychiatrists Guidance
Transitions – A Recovery Arts and Narrative Project
Strengthening of partnership working at all levels of Dorset HealthCare
University NHS Foundation Trust

Welcome to the Third Dorset Wellbeing and Recovery Partnership (WaRP) Annual Report. The Partnership, between Dorset HealthCare and Dorset Mental Health Forum, has been nationally recognised as a demonstration site for the Centre for Mental Health, Department of Health and NHS Confederation’s ‘Implementing Recovery for Organisational Change’ (ImROC) project.

As we enter our fourth year, we have learnt many lessons and have made significant progress in promoting the recovery agenda. Underpinning all these achievements are recognition, acceptance and a willingness to work in partnership with those who have lived experience of mental illness. It is this partnership which enables the expertise of lived experience to influence so many areas of service design, review and delivery.

The strength of WaRP’s partnership has above all been embodied in the Recovery Education Centre (REC), where all courses have been co-designed and co-delivered to students (who may be staff, or people who access services or their supporters). The feedback we have received from people attending the REC has been overwhelmingly positive and we see this as a real bedrock to drive forward recovery orientated practice.

We are beginning to see the ‘first shoots’ of culture change. However, these are challenging times socially and economically and we recognise these ‘shoots’ are fragile. Our task for the coming year is to create consistency across Dorset, share the learning from those areas who have really embraced the recovery agenda and truly embed change through imprinting recovery, lived experience expertise and partnership working into the DNA of all activity focused on promoting the emotional wellbeing of people in Dorset.

Our key areas of work for the coming year are:

- For the Recovery Education Centre to grow and develop.
- To develop peer specialist posts and roles and accredited training.
• To continue to engage with GPs, commissioners and other partners to promote the work of Dorset Wellbeing and Recovery Partnership (WaRP).

• To introduce Team Based Recovery Plans developed in partnership with people with lived experience and their supporters, to firmly embed recovery principles across all parts of the service.

• To re-launch the pan-Dorset Recovery Steering Group and networks to fully ingrain recovery principles into the core management and governance frameworks of Dorset HealthCare.

• To develop the partnership supporting the recovery journey of older people with mental health problems.

• To ensure the recovery journeys of staff are supported through recovery leadership and organisational approaches which are congruent with recovery principles.

• To build on and expand existing projects: Hidden Talents, Lived Experience Mentoring for Psychiatrists, Aspiration Towards Zero Restraint.

• To engage with the wider community about emotional health and wellbeing through challenging stigma, with projects such as Tea and Talk and looking at issues related to wellbeing and recovery with people from black and minority communities within Dorset.

• To continue to develop stronger partnership working with supporters and carers.

• To develop people’s opportunities to build a life beyond illness, through developing personalisation, social inclusion and employment project plans (in particular focusing on the development of Individual Placement and Support (IPS) for those seeking paid employment).

• To explore how recovery principles can inform a rights-based framework promoting the emotional wellbeing of all people in Dorset.

• To research and build robust evaluations of all projects and activities, and seek to publish findings and outcomes.

Please refer to our Strategy Plan for 2012/13 and Annual Report for full details of our work to date and plans for the coming year. Over the past year it has been a privilege to work alongside such inspiring and courageous people and whilst there are too many to name here, thank you, you know who you are and we look forward to working with you over the coming years.
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<th>Organisational Challenge</th>
<th>What it Means in Practice</th>
<th>Action</th>
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| 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. | • To continue with the current communication campaign to promote Wellbeing and Recovery and potentially link this to national campaigns such as Time to Change.  
• For every team to have an appointed recovery lead and Team Recovery Implementation Plan to work with people who access their service to inform, monitor and improve changes to practice.  
• To increase the number of mentors and mentees for the lived experience mentoring programme for psychiatrists. |
| Delivering comprehensive, user-led education and training programmes | There are available a range of training packages designed and delivered by people with lived experience and supporters in partnership with professional staff. | • To continue building on the relationship with the Learning and Development (L&D) Department to increase coproduction with people with lived experience and incorporate recovery principles in all training.  
• To offer regular wellness workshops and other peer-led courses within each CMHT and inpatient unit. |
| 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’. | • To realign the WaRP Recovery Steering Group and recovery networks to ensure recovery principles are integral to Dorset HealthCare’s aims.  
• To undertake recovery leadership workshops once the management restructure has taken place.  
• To build the Recovery Leadership Toolkit in conjunction with the L&D Department, Human Resources and Occupational Health.  
• To develop the Older Persons Recovery Partnership.  
• For the WaRP to continue 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, with services providing a facilitatory role. People’s spiritual needs are taken into consideration and they have the space to explore how they perceive the world. They are supported to develop the skills to self-manage and to access direct payments and personal budgets where possible. | • For the WaRP to participate in the Pan-Dorset Personalisation and Mental Health Steering Group.  
• For the WaRP to support the implementation and evaluation of person identified goals and joint recovery planning, including advanced decisions and directives.  
• To develop a Spirituality Project Plan.  
• To collate narratives describing and monitoring the experience of personalisation in practice by people with lived experience. |
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| Changing the way we approach risk assessment and management | Risk assessment and management and 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 as regards 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. | • To co-design, agree and implement risk-shared decision making standards.  
• To complete the Aspiration Towards Zero Restraint focus groups, finalise the action plan and identify pilot wards.  
• To review current Physical Intervention (PI) training and move to co-produced/co-delivered training which focuses on communication and de-escalation as well as safe PI techniques. |
| Redefining user involvement                                | 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 working in a paid capacity.                                                                                           | • Through the Team Recovery Implementation Plans encourage teams to focus on how they redefine their role with the people they serve.  
• To increase partnership working opportunities with supporters and carers and build a lived experience infrastructure of carers who can input at all levels of WaRP work. |
| Transforming the workforce                                 | There will be increasing numbers of Peer Specialists who will be supporting statutory staff in the delivery of services. Changes to be made to Human Resources (HR) and Occupational Health (OH) approaches and process to support the implementation of recovery principles.                                                                                | • To ensure peer worker training is robust and looks towards accreditation.  
• To evaluate the effectiveness of current peer worker roles.  
• To identify pilot ward(s) for team(s) of peer workers.  
• To develop an action plan on workforce development as regards peer workers. |
| Supporting staff in their recovery journey                  | The emotional needs of staff need to be taken into consideration. Staff have an awareness 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. HR and OH will develop to support this philosophy. | • To continue to develop the Hidden Talents project, challenging stigma and self-stigma within the NHS.  
• To produce guidelines around safe disclosure for staff.  
• To develop a joint action plan with HR and OH in developing recovery orientated approaches to staff, informed by lived experience. |
| Increasing opportunities for building a life ‘beyond illness’| People in all parts of the service should be encouraged and facilitated to build an identity separate from their illness as a central part of their recovery. Enabling people to engage in their own communities, build relationships and friends, and find work opportunities if they choose to. | • To continue to develop the paid employment strategy.  
• To work with commissioners to build partnerships with other third sector providers in delivering a comprehensive approach to social inclusion.  
• To challenge stigma and promote awareness through the Tea and Talk project and Time for Change campaign.  
• To develop the Wellbeing project plan for people from black and minority ethnic groups.  
• To start to develop a rights based framework which supports the emotional wellbeing of all in Dorset. |
Acknowledgements

As a demonstration site for the Implementing Recovery for Organisational Change project (ImROC) we have been grateful for the help and support of the ImROC team, in particular Rachel Perkins who has worked closely with the WaRP team in the development of a number of our projects and has aided our discussions around meeting the organisational challenges we are facing as a team. Also to Julie Repper who has co-ordinated our learning set and supported our development through it. We are also grateful to James Barton (Director of Mental Health Services, Dorset HealthCare) who has attended the majority of the ImROC learning sets. His belief, involvement and backing has really enabled us to drive the project forward, and in particular his commitment to changing people’s experience of services through valuing and investing in the expertise of lived experience.

There have also been a number of staff changes and people moving on, who have been pivotal in the development of the WaRP. Brian Goodrum (Director of Operational Services, Dorset HealthCare) retired at the end of May 2012 and Shaun Byatt (Manager of Dorset Mental Health Forum) semi-retires at the end of September (retiring in March 2013). Brian and Shaun, along with Peter Richell (General Manager, Adult Mental Health, who retired at the end of January last year) were responsible for the development of Dorset Mental Health Forum and the origin and initial development of the WaRP. Without the vision of these three, it is unlikely the WaRP would have come into existence. It is their support and backing which has enabled the WaRP to become as effective as it is. Shaun was also made an MBE last year for his services to mental health. They will be missed and we are grateful for their input.

Another key individual who has moved on, who has had a key role in the development of the WaRP, is Bob Shaw. We would like to thank him in particular for his passion for recovery which he is so expertly able to communicate. He has been instrumental in selling the concept to staff and in the development of the Wellbeing Toolkit. We wish him well in his future endeavours.

We would also like to give a massive thank you to Denise Bilton who has provided administrative support, moral support and has been generally amazing in helping co-ordinate and produce the materials, including this report, for the WaRP. She is due to retire in December 2012 and will be hugely missed.

As well as people moving on, we are really happy to welcome many who have joined and supported the project, particularly those with lived experience of mental health problems (whether they use services or not, work in the NHS or the Forum, or elsewhere) who are able to share their expertise and enthusiasm in driving forward the recovery approach. In particular we are pleased to welcome Sarah Rose (Business Development Coordinator, DMHF) to the WaRP team. Sarah is working alongside Becky Aldridge (General
Manager, DMHF) and is now part of the core WaRP management team (see Section 3, page 24 for more information).

Over the past year it has been a privilege to work alongside such inspiring and courageous people and whilst there are too many to name here, you know who you are and we look forward to working with you over the coming years.
Introduction

Welcome to the Third Dorset Wellbeing and Recovery Partnership (WaRP) Annual Report. The Wellbeing and Recovery Partnership, between Dorset HealthCare and Dorset Mental Health Forum, is moving into its fourth year. The partnership has now been operating across the whole of Dorset for two years and has been nationally recognised as a demonstration site for the Implementing Recovery for Organisational Change project.

For those who are new to the WaRP, it is a partnership between Dorset HealthCare University NHS Foundation Trust and Dorset Mental Health Forum (a local third sector peer-led organisation) which, by promoting the principles of Wellbeing and Recovery, seeks to transform the culture of services, challenge stigma and discrimination and peoples’ understanding of mental health through the expertise of lived experience working in partnership with professional expertise. If you would like further information on the development of the partnership and the work to date it is well documented in our two previous Annual Reports which are available on the websites of both organisations:

- Dorset Mental Health Forum [www.dorsetmentalhealthforum.org.uk/recovery.html](http://www.dorsetmentalhealthforum.org.uk/recovery.html).

Over the past year we have moved from ‘creating the demand for recovery’, which has been the focus of previous years, to undertaking broad-based action. This has been underpinned by a growing interest and valuing of the lived experience perspective which has enabled willing clinicians to think in different ways. We have coined Simon Bradstreet’s phrase and have described this as “Recovery Contagion”. This has included being able to launch the following projects which were all co-produced (by professionals and people with lived experience):

- The Recovery Education Centre
- The Hidden Talents booklet
- The “What Recovery Means to Me …” campaign
- The Transitions – A Recovery Arts and Narrative Project
- The Operational Guidance to Recovery Assessment and Planning (refocusing the CPA policy on recovery principles)

These projects are also complemented by the wider work undertaken by the WaRP, all of which are outlined in this Annual Report. As we stated last year we feel that we are only at the beginning of our journey and we have a long way to go before our services are truly recovery orientated. However, despite operating at a time of cut-backs, continual change and organisational challenge, we have made significant strides forward this year.
Probably our most significant development is the establishment of our Recovery Education Centre (REC) and completion of our pilot term. We believe that ours is the fourth REC or recovery college in the country. All courses in the REC are co-delivered and co-produced by people who have lived experience and mental health professionals. The courses are open to people who access services, their carers and supporters and staff. The feedback from the pilot term has been overwhelming with people telling us that the REC has ‘changed their life’.

We have looked at promoting positive messages about recovery and challenging stigma through the “What Recovery Means to Me …” Campaign, the Transitions – A Recovery Arts and Narrative Project and the Hidden Talents project. The Hidden Talents booklet looks at the lived experience of NHS staff and how that can be understood as an asset by the organisation.

We have also continued to be involved at all levels of Dorset HealthCare in ensuring that the voice of lived experience is central in all service design, evaluation and development. We continued to build on the positive relationships with people who access the service, their supporters, staff, commissioners and others in creating multiple conversations about the importance of recovery and building the recovery contagion. We are extremely grateful for all the belief and support people have given us and it is thanks to them that the recovery agenda within Dorset is moving forward.
Our Journey this Year

Over the past three years the WaRP has moved from being a small entity in the West of Dorset to an influential group that operates across the whole of Dorset (and has been for two years now) and, through being a demonstration site in the ImROC project, having some national recognition. However, it has also been our most challenging year. It is a time of significant uncertainty and change for both Dorset HealthCare and Dorset Mental Health Forum.

As stated in last year’s Executive Summary, since 1 July 2011 there has now been only one NHS provider of mental health services working across Dorset: Dorset HealthCare University NHS Foundation Trust. This has meant that all the services previously under Dorset Community Health Services are now part of Dorset HealthCare. This has lead to a major re-organisation and a restructure which is still on-going. In addition the Chief Executive of Dorset Healthcare, Roger Browning, left in February 2012 and his successor, Paul Sly, started the following month. All this has occurred in the context of the demand to make cost savings within the NHS and social services.

Fortunately for the WaRP, the project is still receiving full backing from the Board and Paul Sly was able to attend and offer his support to our Recovery Education Centre, “What Recovery Means to Me …”, and Hidden Talents launch event. In the longer term, now that there is one organisation it will be advantageous for the WaRP as there will be clear lines of communication and a standardisation across the whole of Dorset. This should lead to a reduction in duplicating our work and negotiating the politics of working across two organisations. Within the new structure of the Mental Health Directorate there is a Lead for Recovery and Social Inclusion post (Band 8a) and a Lead for Recovery Education post (Band 7), thus cementing the high level sign up and commitment to recovery.

Dorset Mental Health Forum (DMHF) has also been subject to change and uncertainty through the work of the WaRP. Similarly, the success of some of its other work streams has increased in size both in terms of workforce and work demands. This happened at the same time as a number of the Forum’s contracts were up for review in April. This lead in the early part of the year to an uncertainty about being able to make concrete plans post April. Whilst the expansion is positive, it also brings its challenges, in particular for the Forum to maintain what makes it unique as a recovery-orientated peer-led third sector organisation whilst becoming a larger organisation and working ever closer with statutory services.

Over the past six months the Forum has been going through a capacity building exercise and ensuring its infrastructure is fit for purpose in order to meet the demands put on it, whilst maintaining its independence and its identity as a local peer organisation, able to act as a collective voice for people with lived experience of mental health problems in Dorset.
Part of this development is the creating of the Dorset Mental Health Forum Business Development Coordinator. We are pleased to welcome Sarah Rose to that role and to the WaRP team. Sarah is working alongside Becky Aldridge (General Manager, DMHF) in order for the Forum to meet the demands mentioned above. The core WaRP team now consists of Becky and Sarah from the Forum and Phil Morgan and Jackie Lawson from Dorset HealthCare.

In our previous Annual Report we talked about our approach being based on ‘creating a demand’ for recovery and over the last year we have definitely created that demand. The WaRP is now either involved in or leading on every significant service development within the Mental Health Directorate of Dorset HealthCare.

Another positive factor is that there is no longer a disparity in terms of East and West Dorset regarding an awareness of the WaRP and recovery. There is a patchwork of more or less recovery orientated parts of the service but this is not based around previous organisational boundaries. This is encouraging as it creates greater opportunities for sharing learning and developing consistency.

In attempting to meet the demand and also to expand the Partnership, by working with more teams over a broader area and with more projects, the WaRP has been stretched far more than in previous years. This, along with other factors outside of work, has impacted on the emotional resilience of the team. In the previous Annual Report the WaRP team has prided itself on ‘modelling recovery’, whereas this year at times it has been difficult to model recovery. From time to time it has felt like we have been talking about being recovery orientated to others but not paying enough attention to looking after ourselves. The support of each other within the team has been vital in getting through this period and it is this support which highlights the depth of partnership working in action. Despite these struggles the WaRP team (predominately made up of those with lived experience) has achieved some fantastic work. It indicates what people who have lived experience can achieve even when not at their best. However, it does highlight the importance of the recovery agenda not being held by a few individuals and the need to create a broader ownership and accountability around the recovery agenda. This will be one of the predominant features of the work of the WaRP this coming year.
Moving Forward

The forthcoming year is a crucial one and central to our objectives this year is 'making the changes stick'. The WaRP has been extremely successful in engaging and motivating people in conversations about recovery and implementing pilot projects with individual teams and groups. We need to move on from 'creating the demand' (we see this as the engagement stage in the ImROC organisational challenges) to focused, broad-based project work which will support the service transformations required. As stated before, central to this is integrating and working with lived experience, and working with people who access services and their supporters and carers to ensure the recovery agenda is meeting their demands and expectations.

In our previous Annual Report we referred to the work of Kotter (2010) and to his 8 steps for leading change. It feels that the key step we are currently working on is 'Step Seven: Never Letting Up'.

The key tenants of Step Seven are:

- Use increased credibility to change systems, structures, and policies that don’t fit the vision
- Hire, promote, and develop employees who can implement the vision
- Reinvigorate the process with new projects, themes, and change agents

In order for us to meet these key tenants are the following five priority areas of development over the next year:

1. Continue to strengthen partnership working and learn from the expertise of lived experience
2. Continued development of the Recovery Education Centre
3. Increased development of peer specialist/peer support work roles within NHS services alongside accredited training
4. Building robust systems of accountability, ensuring and evaluating recovery orientated practice across all parts of the service
5. Continuing to build links with clinical commissioning groups to ensure recovery principles are enshrined in all commissioning.

These areas of development will be supported through the key areas of work outlined in the Executive Summary and Strategy Plan. All action plans will be shaped by the Strategy Plan.

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Future Directions for 2012/13

Central to our future directions is mainstreaming the recovery agenda and project planning so that a broader range of individuals and team leaders become responsible for the implementation of recovery on a local level. This implementation will then be monitored and supported by the WaRP team. We had initially shied away from this approach as we felt it was first important to engage people’s passion for recovery rather than mandate it through clinical governance structures. However, we are now at a stage where in order to make the rapid and consistent progress we are looking to do, it is essential that recovery becomes the central clinical governance goal for the Trust.

We are looking to make our Recovery Steering Group and recovery networks more robust and ensure that each team has a recovery action plan. Teams will have an opportunity to report on the implementation of their action plans through the steering groups and networks but will also be held to account around its implementation. The process will enable teams to identify, report on and break down organisational barriers to recovery orientated practice. In order to do this it is essential to continue to build the lived experience infrastructure with people able to input their personal expertise at all levels of Dorset HealthCare. We are also acutely aware of the parallels between the recovery journeys of people who access services and the recovery process for staff and organisations.

The role of Peer Specialists will continue to develop. In Dorset we have an innovative approach to peer workers where people work at all levels of Dorset HealthCare, employed by Dorset Mental Health Forum. This use of peer workers is very different from other parts of the country, as our Peer Specialists are much more involved in service design and evaluation, rather than on service delivery with NHS teams. Whilst we have Peer Specialists who deliver individual and group recovery coaching and support, we have very few who are permanently co-located within NHS teams in both community and inpatient settings. So over the coming years we will be exploring opportunities for this to expand significantly so there are Peer Specialists working in every team.

In order to do this we also need to be clear what we mean by peer support, Peer Specialists and the skills they require. It is a specific term that is often used generically, incorrectly and indiscriminately in mental health circles at present. Everyone in life has peers, those people who share similar experiences and therefore understanding and perspectives about those experiences. Nurses understand the reality of being a nurse; road sweepers understand what it’s like to be a road sweeper; airline pilots will share experiences and be able to identify with each other; cancer sufferers understand the struggles and challenges of being diagnosed with and recovering from cancer, and the same is true within mental health. The support aspect is no more or less than that. It is something that can be gained, achieved, an occurrence, an action, through the process of identifying and communicating with a peer. Bringing the words together is the alchemy of understanding and acceptance.
Peer support can be used as a blanket term and this can be unhelpful. To some extent, we are guilty of doing the same with the term “Peer Specialist”, where what we mean is peer (as in someone with lived experience of mental health problems) and specialist (as in expert by that experience, utilising that expertise). This is carried out in a variety of different ways and through a range of different roles. The Mental Health Foundation has produced a useful guide outlining the differences between befriending, peer mentoring, facilitated peer support and peer led support.

http://www.mentalhealth.org.uk/content/assets/PDF/publications/peer_support_the_basics.pdf?view=Standard

In reality it is probably more helpful to think of peer expertise. However, it is necessary to be clear and talk about peer expertise in a range of different contexts and purposes. For example, the requirements, challenges, skills and experiences of peers working in specific roles within acute settings is and will be very different say from peer expertise being utilised in training and the REC. Over the next year we will be continuing to move from a generic definition of Peer Specialists, who work on specific projects and bring a range of skills, to firming up the definitions of the differing roles and training required for them, whether that is being a peer trainer, a peer support worker, co-ordinating peer support groups, contributing to NHS management meetings, or being involved in research and service evaluation.

The REC will also need to increase its significance – in the recovery journey of the people who access the service and those who support them (as staff or friends and relations) – so that the educational approach takes a lead role in the future delivery of services. In this manner individuals will be empowered to take control over their own lives, but also mental health professionals are freed up to use their technical expertise. This will lead to a change in power dynamics, where people who access services are encouraged (depending on their capacity) to take personal responsibility and are given the tools to build the lives they wish. Alongside this empowerment approach people will need real opportunities through personalisation and person budgets to build ‘the lives they wish to lead’. If employment is the goal that someone desires, they should have access to the most effective support. The WaRP has a key role to play in developing these.

Our ambitions around reducing the use of restraint and seclusion to zero within the acute services remain, and to use this as a spring board to transform the experience of people accessing the acute services within Dorset. We aim to develop co-produced training which has a strong focus on communication and de-escalation alongside the physical intervention techniques. We also plan to undertake work with individual wards on improving the experience of an individual’s journey through the service, so they can leave acute services with a sense of renewed hope and optimism, and they will have learnt something about how to avoid the same situation in the future.

In these changing and turbulent times the recovery journeys of staff are of great importance and it is essential that Human Resources, Occupational Health and the management and leadership style adopted is informed by
recovery principles – not paying lip service, but creating a vision – in order for staff to offer the best service possible in an environment where they have clear roles, feel valued and know that they are doing a good job.

Essential to all of these processes is working closely with commissioners, GPs and the clinical commissioning groups so that jointly a new vision for mental health can be realised. More broadly this work needs to include all other agencies and third sector organisations so that there is a strong direction for Dorset in supporting the emotional health and wellbeing of all. We have began discussions around a rights based framework which supports the emotional wellbeing of the whole community, underpinned by recovery principles, which can sustain service development and transformation within Dorset across all areas of health and social care.

For us as the WaRP management team it is important that the focus on modelling recovery returns to the fore, that a period of consolidation takes place, and that the work of the WaRP becomes even more project focused and structured.
The 10 Key Organisational Challenges – Progress Report

As our Strategy Plan is based around the 10 Key Organisational Challenges described by the Centre for Mental Health, this section takes each challenge in turn, reviews our progress over the past year and outlines our plans for the future. We have included the self rating that we gave ourselves last year.

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<th>Centre for Mental Health: Ten key organisational changes</th>
<th>Last Year’s Self Rating</th>
<th>Current Status</th>
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<td>Stage 2: Development</td>
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<tr>
<td>2. Delivering comprehensive, service user-led education and training programmes</td>
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<td>3. Establishing a “Recovery Education Centre” to drive the programmes forward</td>
<td>Stage 2: Development</td>
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<td>4. Ensuring organisational commitment, creating the “culture”</td>
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<td>5. Increasing “personalisation” and choice</td>
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<td>6. Changing the way we approach risk assessment and management</td>
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<td>8. Transforming the workforce</td>
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<td>9. Supporting staff in their recovery journey</td>
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<td>10. Increasing opportunities for building a life beyond illness</td>
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1. Changing the nature of day-to-day interactions and the quality of experience

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<td><strong>Definition</strong></td>
<td>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.</td>
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<td><strong>Current Status</strong></td>
<td>Stage 2: Development</td>
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**Progress in relation to last year’s Action Points:**

**Promoting the message of Recovery**

We have continued to produce the quarterly WaRP newsletter updating everyone on our progress and key initiatives (see Wellbeing and Recovery Partnership (WaRP)). Dorset Mental Health Forum has also continued to produce their Reflections magazine (see Reflections Magazine). We have also launched a co-designed and co-produced “What Recovery Means to Me ...” postcard and poster campaign (see Appendix 1) which has examples of what recovery means to local people and also gives people the chance to write in about their own recovery definition. Over the next year we plan to expand this project.

**To continue to undertake and develop the team based pilot projects across Dorset**

These pilots have continued in a number of teams, namely: Blandford Older Person’s Community Mental Health Team (CMHT-OP), Weymouth and Portland CMHT, Purbeck CMHT, Poole CMHT, and Bournemouth CMHTs. Each of these pilots has focused on slightly different areas as defined by the team.

The work in Weymouth has looked at how practice can be more recovery focused. Blandford Older Persons’ team has redesigned their initial assessment, set up a group of people who access their service, carers and supporters to aid service development, and have focused on social inclusion opportunities for people.

The work in Purbeck has focused on creating partnerships and involvement of people who access the service. In Bournemouth we are at the initial stages of
reviewing care pathways in line with recovery principles and in Poole the project is focusing on how the recovery principles can support staff wellbeing and how that translates to the people who access their service.

The next step is to formalise the process for teams to have their own Team Recovery Implementation Plan as designed by Nottingham Healthcare Trust. The Blandford Older Person’s team is currently piloting Nottingham’s Team Recovery Implementation Plan for the WaRP. This will be for all teams rather than just those who have self-selected. Reporting on progress will be formalised though the Trust’s Mental Health Directorate clinical governance structures. Each team will have a recovery lead to support their plan alongside their team leader. The plan begins with a self-assessment benchmarking procedure and then encourages teams to set priorities and develop a Team Recovery Implementation Plan. Information will be collected centrally to look at where the barriers to implementing recovery orientated practice are, so that broad-based action can be taken. We propose that in negotiation with commissioners these team implementation plans are linked to the Trust’s CQUIN targets.

**To continue to develop the lived experience mentoring of psychiatrists**

The initial pilot has been completed and evaluated and from this, a mentoring handbook has developed (see Appendix 2). We now have two mentors and currently three more consultant psychiatrists are being mentored by people with lived experience. The plan for the next year is to identify an additional two mentors and to mentor a total of ten psychiatrists over the next year. We are currently working with the University Department of Mental Health at Bournemouth University in exploring how we can research this project. The project was presented as a poster at the Refocus on Recovery conference held in London in March 2012.

**To develop a working group exploring the co-production of the CPA process including assessment and evaluation**

We have completed the revision of the CPA assessment and planning policy with its operational guidance and have co-produced the new documents. We are particularly proud of the operational guidance which was written originally from the staff perspective and we have now written it from the perspective of someone who accesses the service (see Appendix 3). The feedback we have received about these documents has been positive. We are now developing co-produced/co-delivered staff training and REC training (open to staff, people who access the service and their carers and supporters) to support the implementation of the policy and guidance.

**To develop the role of recovery narratives**

A key success for the WaRP last year was the Transitions – A Recovery Arts and Narrative Project, run by a Peer Specialist, a trained artist and an NHS professional. The project aimed at encouraging people to explore their own recovery journeys through the use of art. The associated booklet (see
http://www.dorsetmentalhealthforum.org.uk/pdfs/other/transitions-art-project.pdf) and exhibition have received positive acclaim.

We ran two recovery narratives courses through the Recovery Education Centre (REC) and both had very positive feedback. Also we developed recovery narratives for NHS staff who have lived experience through the Hidden Talents project (see Section 9). DMHF has continued to publish recovery stories through their Reflections magazines (Reflections Magazine).

**To develop our approaches to improving day to day interactions for carers and supporters**

We have been building links with the carers groups across Dorset, holding presentations on recovery and the REC. These have on the whole been met extremely positively and we are planning to build a constituency of carers and supporters who can be involved in the work of the WaRP more regularly, in particular through the REC.

### Key Action Points:

To continue with the current communication campaign to promote Wellbeing and Recovery and potentially link this to national campaigns such as Time to Change.

For every team to have an appointed recovery lead and Team Recovery Implementation Plan to work with people who access their service to inform, monitor and improve changes to practice.

To increase the number of mentors and mentees for the lived experience mentoring programme for psychiatrists.

### Next Stage: Stage 3: Transformation

*Significant change is fully achieved; major service redesign; radically different*

Every significant encounter by every member of staff aims to reflect recovery principles and promotes recovery values – increasing self-control (‘agency’), increasing opportunities for life ‘beyond illness’, and validating hope. Each interaction acknowledges non-professional expertise and attempts to minimise power differentials. There have been systematic attempts to ensure that these principles are reflected in day-to-day practice (e.g. local audits, use of National Patient Survey data, etc.). The importance of the quality of staff/user interactions has been incorporated into staff supervision and performance ratings. Users are routinely involved in staff selection. Human Resource (HR) policies validate recovery training and link this to opportunities for staff progression.
2. Delivering comprehensive, user led education and training programmes

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<td>Definition</td>
<td>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.</td>
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<td>Current Status</td>
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Progress in relation to last year’s Action Points:

**To continue to develop peer-led and partnership training packages**

All of the training we deliver is co-produced and co-designed. The majority of the development of training packages has taken place within the context of the REC, creating training that is open to staff, people who access the service and their supporters. The WaRP has continued to offer tailor made team training and workshop facilitation.

**To develop tailor-made recovery and skills training for people across Dorset**

With the development of the REC – which includes an Introduction to Recovery course – this training, aimed solely at staff, was put on hold.

There have been specific staff trainings which have focused on recovery. In particular all new starters within the acute service now undertake an Introduction to Recovery course on their first induction day with the Trust.

We are currently working closely with the Learning and Development (L&D) Department around building closer links with the WaRP, the REC and L&D as a whole, thus ensuring that recovery is built into all staff training.

**To roll out personal recovery workshops and wellness workshops for people who access the service**

Both personal recovery workshops and wellness workshops, which are peer led initiatives, have continued to be offered to people who access the service. Both courses became part of the REC. However, in looking ahead it has been agreed that the Wellness Workshop is better placed outside the REC to target
those people who are not well enough or need a greater level of support than those who would choose to attend the REC. The plan is to offer the Wellness Workshop in every team and within every inpatient ward or unit on a regular basis.

**Key Action Points:**

To continue building on the relationship with the Learning and Development Department to increase coproduction with people with lived experience and incorporate recovery principles in all training.
To offer regular wellness workshops and other peer-led courses within each CMHT and inpatient unit.

**Next Stage: Stage 3: Transformation**

*Significant change is fully achieved; major service redesign; radically different*

A cohort of trained service users are in place acting as ‘champions of change’ for recovery within the organisation. Service users are acknowledged as equal partners within a comprehensive range of recovery education and training programmes and a programme of user-led training in recovery has secure funding. Users and carers are contractually engaged in the organisation to deliver training to staff on recovery principles. More than 75% of staff have received training. There is a continuous programme of evaluation and audit to measure the impact of this training and teaching standards. Positive practice changes are routinely implemented as a result of the training.
3. Establishing a ‘Recovery Education Centre’ to drive the programmes forward

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<td><strong>Definition</strong></td>
<td>There are plans to take a more systematic approach to support service users in the delivery of recovery training to staff. Formal contracts are being considered (e.g. with a local independent sector provider) to provide this function and there are plans to build on this model. A review of existing service user-led programmes has been undertaken with a view to refocusing these into a hub for promoting recovery-oriented practice across the organisation.</td>
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<td><strong>Definition</strong></td>
<td>A ‘Recovery Education Centre’ has been established within the organisation. This 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.</td>
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**Progress in relation to last year’s 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*

Probably our most significant achievement of this year is the launch of our Recovery Education Centre Pilot Term. Whilst we have rated ourselves as achieving Stage 3 as regards the development of a Recovery Education Centre we are very much at the early stages of this.

The REC is open to all people who access the service, their supporters, and staff. Its aims are as follows:

- To provide people with the tools and skills to self-manage, through partnership of expertise by experience and professional expertise.
• To enable people to take control of their lives and be able to move beyond mental health services and mental illness.

• To improve service outcomes in relation to both personal recovery and clinical outcomes.

• To enable people to invest in themselves within an educational framework.

• To improve people’s experience of mental health services (including those who work within them and carers and supporters).

• To enable people to make the best use of mental health service.

• To provide a vehicle that reconceptualises mental health services through readdressing the imbalance of power. By promoting an educational model people can learn for themselves and recognise everyone’s potential as an expert.

• To bring people together to realise and inspire individual and collective potential.

We have developed a robust operational policy which outlines how the REC holds no clinical responsibility for people attending courses. (This operational policy is available on request.) Sarah Rose (Business Development Coordinator, Dorset Mental Health Forum) comes from a Further Education background and this has been invaluable in setting up the educational framework of the REC.

We have completed our pilot term which has exceeded our expectations in terms of the feedback we have received. 97.8% of students responded positively about the REC, marking ‘agree’ or ‘strongly agree’ for attending another REC course. Here are a couple of examples of what students wrote on their evaluation forms.

“The course was not what I expected, but was better as it allowed me to develop professionally and personally.”

“I believe what you are offering is vital for someone like me to move forward, and will speed up my recovery process and give me something to focus on (and probably a lot more). I really hope it keeps growing and continues.”

The REC pilot term included the following courses:

• Wellness Workshop
• Introduction to Recovery
• Wellbeing Toolkit
• Early Warning Signs
• Working 2 Work
• Recovery Narratives
The majority of courses ran twice, once in the east of the county and once in the west. In total twelve courses were held. In our second term we aim to run just under twenty different courses and around forty different sessions.

For more detailed information see the REC project plan (Appendix 4), prospectus (Appendix 5), and pilot term outcome report (Appendix 6).

Our next stage is to build the capacity of the REC in terms of administrative infrastructure, number of NHS trainers and peer trainers, and courses offered. This aims to ensure the REC is seen as a central part of all people’s recovery journey when accessing mental health services.

We are currently undertaking some qualitative research into the experience of students and trainers within the pilot term, and are developing a research proposal looking at the cost-effectiveness of the REC. We are doing this in conjunction with the University Department of Mental Health at Bournemouth University. We are also exploring the accreditation of our courses, in particular peer specialist training.

**Key Action Points:**

To continue to develop the Recovery Education Centre (REC), following the REC project plan.
4. Ensuring organisational commitment creating the culture. The importance of leadership

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<td>Definition</td>
<td>The Board has endorsed a Recovery Strategy, including core underpinning principles and values. This is reflected in the wording of external and internal publications. The organisation is active at all levels communicating its recovery approach. There is evidence of Board workshops, staff presentations and training programmes. Recovery forums have been established in partnership with service users. Some internal ‘pathways’ (referral systems, assessments, CPA, discharge planning, etc.) have been reorganised, with user involvement, so as to support recovery processes. Whilst there are a number of recovery initiatives, it is recognised that cultural change has not yet occurred at all levels and in all parts of the organisation. Monitoring recovery practice does not appear in staff supervision.</td>
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Current Status Stage 2: Development

Progress in relation to last year's Action Points:

To run Recovery Leadership workshops across the whole of Dorset

Whilst organisational change has taken place as regards Dorset HealthCare acquiring Dorset Community Health Services with the subsequent management restructure, a lot of the work around recovery leadership has been on hold. What remains is: the commitment from the Chairman of the Board to support the principles of recovery leadership and for there to be a workshop for the Board at a future date; and from the Director of Mental Health for there to be recovery leadership workshops for the newly appointed management team.

Alongside this the Recovery Steering Group in the east and Practice and Quality Group in the west of the county have been either dissolved or put on hold. So there is a need, once the new structure is in place, to reinstate the Recovery Steering Group but with a stronger focus on establishing and monitoring the implementation of recovery orientated practice within teams. It has therefore been suggested that the Director of Mental Health will chair the Recovery Steering Group to ensure that actions are followed up and to create the authority required for organisational change to take place. The Directorate Management Group also needs to have a much stronger focus on recovery as its core business rather than a standing agenda item for updates. All of these meetings need to be informed by the expertise of lived experience.

Outside of the Mental Health Directorate the WaRP team ran some extremely successful leadership workshops with the Connecting Health and Social Care
Operational Managers, which focused on how recovery principles could enhance the change management process within physical services. These workshops are on-going and provide an opportunity to engage with the management within Dorset County Council around recovery leadership.

**To develop the Recovery Leadership Toolkit**

Despite the delays in continuing the recovery leadership workshops within Mental Health Services, in the west of the county within the Team Leads Network, Gary Hawker (Joint Training Coordinator), Kate Antell (Team Leader, Linden Unit), Jackie White (Team Leader, Early Intervention in Psychosis) and Paul Maxwell-Bown (Team Leader, Sherborne CMHT-OP) have all been developing a toolkit for team leaders on how to be more recovery orientated. This work is on-going and we hope to feed it into the work with Human Resources and Occupational Health.

The L&D Department has also expressed interest in working with us to see how to integrate our recovery leadership agenda with their existing leadership training.

**To continue to develop recovery network meetings to facilitate learning from lived experience**

Currently there are two recovery networks: one in West Dorset with a recovery team lead in each team and open to Peer Specialists from DMHF, and one in East Dorset which is open to anyone interested in recovery (staff, people who access the services, supporters and carers). The purpose of these networks is to share information and ideas. As Dorset HealthCare is now one organisation it is important that these networks fulfil the same function. It is proposed that both networks continue for reasons of geography, that both have a recovery lead attend from each team who will then feed back and develop the Team Recovery Implementation Plan. These networks will also be open to Peer Specialists, people who access the service, carers and supporters, and third sector providers.

In addition, we are looking at a specific network which focuses on the recovery journey of older people and has a broader network of third sector agencies, for example, Age UK, Alzheimer’s Society etc. Jackie Lawson has been co-ordinating this and a small network is beginning to grow into a wider partnership.

**For WaRP to participate in all levels of service design and development**

This is happening in the majority of cases, for example, the acute services’ redesign in the west of the county, and the Payment by Results Care Pathway development. In order to cement this it will be useful for the WaRP agenda to be tied to the clinical governance structures of the directorate, as outlined above.
For the WaRP team to engage with commissioners and GPs to promote the principles of wellbeing and recovery in future service design and delivery

The WaRP team have positive relationships with commissioners, who broadly support the recovery agenda. Some initial contacts have been made with GPs; however there is significant work to be done around strengthening the understanding of recovery around GPs and clinical commissioning groups.

Key Action Points:

To realign the WaRP Recovery Steering Group and recovery networks to ensure recovery principles are integral to Dorset HealthCare’s aims.
To undertake recovery leadership workshops once the management restructure has taken place.
To build the Recovery Leadership Toolkit in conjunction with the Learning and Development Department, Human Resources and Occupational Health.
To develop the Older Persons Recovery Partnership.
For the WaRP to continue to engage with commissioners and GPs to promote the principles of wellbeing and recovery in future service design and delivery.

Next Stage: Stage 3: Transformation

*Significant change is fully achieved; major service redesign; radically different*

Recovery concepts are evident at all levels of the organisation. There is strong leadership and action at Board level to ensure that this is reflected through all levels of management and by front line staff. There is recognition of the need to develop partnership working with service users so that professional expertise does not dominate over the wisdom of ‘lived experience’. The service promotes an environment of hope and optimism that recognises the uniqueness and strengths of each individual. Recovery values are embedded in every operational policy, management process including recruitment, supervision, appraisal and audit. All key internal ‘pathways’ (referral systems, assessments, CPA, discharge planning, etc.) have been reorganised, with user collaboration, so as to better support recovery processes.
5. Increasing personalisation and choice

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<tr>
<td>Definition</td>
<td>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.</td>
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<td>Current Status</td>
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Progress in relation to last year's Action Points:

*To continue with the roll out and evaluation of the Wellbeing Toolkit and recovery narratives including the YOI pilot*

The roll out of the Wellbeing Toolkit and recovery narratives has been undertaken within the REC (see Section 3 above). The Wellbeing Toolkit pilot in the Young Offenders Institutes has gone extremely well. The feedback from staff and prisoners alike has been overwhelmingly positive (see Appendix 7 for the report). We have put a bid in with commissioners to extend this project and are awaiting feedback at this time.

*The development of client-led CPA*

As stated previously the CPA assessment and treatment policy and operational guidance have been completed (see Section 1, page 19) and the Wellbeing Toolkit training is now provided under the umbrella of the REC. We see the REC as having a central role in giving people the skills take ownership of their own recovery. Next term we are offering courses on developing your own crisis plans, including advanced decisions etc. With the realigned Recovery Steering Group and Directorate Management Group we anticipate these being vehicles to ensure joint planning becomes central to everyone who accesses Dorset HealthCare Services.

*Person Identified Goals*

Lawrence Mynors Wallace (Medical Director, Dorset HealthCare) has been developing something called Person Identified Goals to ensure that each
person accessing the service has three self-defined goals which shape their journey through services. The WaRP team is in the process of developing guidance to support recovery orientated goal setting.

To develop the use of advances decisions, directives and crisis planning in aspiring towards zero restraint

See Section 6 below for an update on the Aspiration Towards Zero Restraint project.

To develop a Spirituality Project Plan

Some initial meetings have taken place outlining and defining the role of spirituality in recovery. However, these have not come together yet into a tangible project plan. One area we hope to develop is a course on spirituality within the REC.

WaRP to support the personalisation agenda in Dorset

The WaRP has been heavily involved in working closely with the developments in Dorset around mental health and personalisation. Recently the Pan Dorset Personalisation and Mental Health Steering Group has been set up with representatives from the three local authorities, commissioners, mental health providers and the WaRP. Plans are to develop a detailed action plan on personalisation and this will be central to driving the personalisation agenda and individual budgets forward.

Key Action Points:

For the WaRP to participate in the Pan Dorset Personalisation and Mental Health Steering Group.
For the WaRP to support the implementation and evaluation of person identified goals, and joint recovery planning, including advanced decisions and directives.
To develop a Spirituality Project Plan.
To collate narratives describing and monitoring the experience of personalisation in practice by people with lived experience.

Next Stage: Stage 3: Transformation

Significant change is fully achieved; major service redesign; radically different

The planning and delivery of all services is designed to address the unique circumstances, history, needs, expressed preferences and capabilities of each service user. There is a clear emphasis on ‘life goals’ as opposed to symptom treatment goals. Users are routinely supported to control and direct their own care plans, at a level they are comfortable with. More than 75% feel consulted and involved. Organisational policies affirm that service users should direct their own care process. If necessary they are given support to do so (e.g. advocacy). WRAP and joint crisis plans are in routine use. There is continuous evaluation to measure organisational commitment to personalisation and choice.
6. Changing the way we approach risk assessment and management

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<td>Stage 1: Engagement</td>
<td>The organisation is aware of the value of systems and procedures that support open, transparent risk assessment and management policies within a recovery framework. Some staff are conversant with this approach and some attempts are made to involve service users in the process, but it is ‘patchy’ (less than 25% of staff involved). There is ambivalence about the value of ‘positive’ risk taking and this has not been addressed at a Board/general policy level. Staff remain preoccupied with risk as a staff issue alone.</td>
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<td>Stage 2: Development</td>
<td>There is recognition of the need for safety while actively promoting ‘positive’ risk taking. The organisation has introduced formal procedures that support open, transparent risk assessment and management policies within a recovery framework, but these have not been implemented throughout the organisation. These issues have been discussed at Board level, but no clear policies have resulted. Some staff training has been undertaken and around 50% of staff are implementing policies to involve service users in their own risk assessment.</td>
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**Progress in relation to last year’s Action Points:**

*To develop a Dorset HealthCare Risk Statement*

The Trust’s risk policy has an overarching statement about the importance of positive risk taking, and whilst not particularly recovery orientated in terms of developing a risk statement for the Mental Health Directorate of Dorset HealthCare it was felt to be more beneficial to have a statement based on the practical application of a recovery orientated approach to risk management. In discussions with Dr Rachel Perkins (Consultant on the ImROC project team) the role of shared decision making and showing curiosity into the person and their supporters’ perspectives was thought to be central. A statement was developed by Phil Morgan and Dr Ian Rodin (Consultant Clinical Psychologist) in conjunction with Dorset Mental Health Forum outlining the relationship between risk and recovery and its practical application (see Appendix 8). It is currently in draft and needs final agreement by the Directorate Management Group.
To develop recovery orientated guidelines for risk assessment and safety planning and to promote dialogue around positive risk taking and support its concept

In the risk statement described above a model is outlined which looks at promoting engagement and balancing that with the person’s capacity to take personal responsibility. We are looking to set a number of standards which can be measured to ensure there are effective joint risk assessments and management plans. This incorporates positive risk planning as the importance comes with integrating the whole care planning and risk planning process as a shared endeavour.

Standards for engagement in shared planning

To develop ways to consider crisis as a learning opportunity

In the coming term the WaRP has developed a Coping in a Crisis course. As the materials are piloted and develop these will be offered to all services as a way of supporting people in a crisis.

To develop a project plan for aspiring towards zero restraint

The Aspiration Towards Zero Restraint is probably our most ambitious project and has also been our most challenging. Whilst we have broad sign up for the project the challenge has been getting buy-in at team level. We were also over ambitious in trying to implement the approach across all wards and units simultaneously. We have revised our project plan and we plan to set up pilot wards first. These wards will focus on the experience of people accessing the service, their carers and supporters, and staff to try to improve every aspect of the journey and reduce the likelihood of needing to use restraint. This will be coupled with a detailed analysis of when restraint or de-escalation has been used so that the team can develop their learning around the effectiveness of their own de-escalation skills and how restraint could be avoided in the future. It is essential that the person and their carers and supporters are involved in this process. (See the draft project plan for more information in Appendix 9.)
In order to fully inform the project plan we are currently undertaking focus groups with all the ward managers, exploring their hopes and fears around the Aspiration Towards Zero Restraint project. We are working with the University Department of Mental Health at Bournemouth University around this and are looking to write it up.

The other key element around the Zero Restraint project plan is training. The WaRP team has started teaching on the Physical Intervention (PI) course for new staff. The training focuses on hopeful messages around recovery, some of the communication skills required within the acute services, and some of the challenges of working in a recovery orientated way in acute services. As stated before all training is co-produced and co-delivered. We have two Peer Specialists who are due to undertake the training, to complete an evaluation and to inform the development of the PI course.

Currently a review of the PI course is being undertaken and the WaRP is playing a key role in this and is looking at the possibility of co-producing the PI training. We are keen for the course to have a greater emphasis on de-escalation and communication skills. Once this review has taken place we then plan to contribute to the updated course as well as the initial training.

**Key Action Points:**

- To co-design, agree and implement risk-shared decision making standards.
- To complete the Aspiration Toward Zero Restraint focus groups, finalise the action plan and identify pilot wards.
- To review current Physical Intervention (PI) training and move to co-produced/co-delivered training which focuses on communication and de-escalation as well as safe PI techniques.

**Next Stage: Stage 3: Transformation**

*Significant change is fully achieved; major service redesign; radically different*

The organisation has in place systems and procedures that support open, transparent risk assessments and management policies within a recovery framework. The process routinely involves service users and their knowledge of themselves to formulate safe and effective management plans. All staff are fully conversant with this approach to risk assessment and management and are comfortable with it. There is a clear commitment on the part of the organisation as a whole to value ‘positive’ risk taking and a willingness to examine and learn from incidents and support staff, rather than ‘blame’ them if untoward incidents do occur. This has been made explicit to staff by the Board and has been reflected in action. The organisation has successfully reconciled the need to balance its duty of care to provide safe services while promoting a positive approach to risk assessment and management.
7. Redefining user Involvement

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**Definition**

The organisation has accepted the role of service users (and carers) as equal partners in care. A Board-level policy on user involvement at all levels in the organisation from clinical care to strategic planning has been agreed and is being implemented. This acknowledgement of the central contribution of users and carers is reflected in policies and procedures governing the delivery of individual care and the work of teams. Approx. 50% of staff understand how to adapt their role to be ‘educators’ (‘coaches’) and ‘mentors’, rather than traditional ‘therapists’.

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**Progress in relation to last year’s Action Points:**

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

Deciding whether to rate ourselves as having reached Stage Two or Stage Three was difficult. In many ways, particularly on an organisational level, the strength of partnership working within Dorset and the involvement of people with lived experience at every opportunity organisationally, is exceptional and highly valued. The reason we have not rated it to be Stage Three is that we do not feel that on a day-to-day basis staff have necessarily moved comfortably to an ‘equal partners in care basis’, not fully understanding how to deliver their professional expertise in this context. With the development of the REC, the recovery networks and the Team Recovery Implementation Plans we feel that this is how it will filter down more effectively to a practice level and also give us methods to measure them.

*To increase partnership working opportunities with supporters and carers*

As stated previously (in Section 1) we have been building relationships and networks with carers. We strongly feel that the REC will be our primary vehicle for increasingly involving carers in all aspects of our work. Next term, in conjunction with Rethink, we are running a course aimed at supporters, led by peer trainers who themselves have lived experience of being a carer or supporter. We are keen to build a parallel infrastructure of lived experience for supporting someone’s recovery in order to operate and support all levels of the WaRP.
Key Action Points:
Through the Team Recovery Implementation Plans encourage team to focus on how they redefine their role with the people they serve.
To increase partnership working opportunities with supporters and carers and build a lived experience infrastructure of carers who can input at all levels of WaRP work.

Next Stage: Stage 3: Transformation

*Significant change is fully achieved; major service redesign; radically different*

The organisation has clearly accepted the role of service users (and carers) as equal partners in care. It recognises that their knowledge and experience is vital (‘experts by experience’) and that they – and their networks – may have solutions to many of the problems that staff find most difficult. This acknowledgement of the need for partnership is clearly reflected in policy and practice at all levels – individual practitioners, teams and managers. All staff understand how to deliver their expertise in the context of more equal ‘partnerships in care’ and they are comfortable with their new position (‘on tap, not on top’). The organisation is continually reviewing its processes for partnership working with service users and continually ‘raising the bar’ in terms of extending the role of service users in controlling the care process. This not seen as an abnegation of professional responsibilities, nor a downgrading of professional expertise, instead it is seen as a higher form of professional practice.
8. Transforming the workforce

<table>
<thead>
<tr>
<th>Last Year's Rating</th>
<th>Stage 2: Development</th>
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</thead>
<tbody>
<tr>
<td>Definition</td>
<td>The Trust has clear plans in place that will lead to the creation of ‘peer specialist’ roles across the organisation. These plans include clear job descriptions, identification of training resources, supervision and management responsibilities, strategies for placement in teams, timescales for completion, etc. A small number of service users have been appointed into paid positions in the workforce, but on a limited scale (e.g. 5-10 posts scattered through the organisation). Plans are in place for pilots which will provide more intensive input (e.g. at least two service users per team) with appropriate managerial support. Issues regarding career progression for Peer Specialists have been discussed. The trust has begun to address the specific HR and occupational health problems associated with the recruitment of greater numbers of people with direct experience of mental health problems into the workforce.</td>
</tr>
<tr>
<td>Current Status</td>
<td>Stage 2: Development</td>
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Progress in relation to last year's 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*

In Dorset, we have made significant steps around the development of peer workers involved in the REC, and involving them in service development and design. We also have a range of peer workers delivering interventions and support into a range of different services, the majority paid, some voluntary. (However, this is very much on an *ad hoc* basis.) For example, peer-to-peer feedback sessions are offered for people to discuss their inpatient stay, to mentor them, and provide someone to talk to about their recovery and experience in hospital. Other examples are: running group activities, individual recovery coaching, running wellness workshops, and staff training. What is important is that we have a coherent strategy of having peer workers in place in every part of the service.

It will also be important to evaluate the effectiveness of current peer worker roles, where people are co-located, in particular, the Community Resource Teams in Weymouth and North Dorset, but also the volunteers working in Stewart Lodge and Linden inpatient units.

Within DCHS we were at the beginnings of developing a robust strategy around peer specialist roles and looking at the composition of the workforce.
(see last year’s Annual Report). One of the key considerations was how they will be employed, as NHS employees, DMHF employees or joint appointments. There are advantages and disadvantages to all these approaches but the discussions will need to take place to inform the development of an action plan.

Due to the service changes and reorganisation this work has stalled. It is therefore important to revisit this in the coming year. There are two key strands to this: one, that there is sufficiently robust training in place both for peer workers and the team within which they operate; and two, that there is a clear plan on how the development of peer worker roles within the teams will be financed. In order to move this forward the Recovery Steering Group will be drawing up a workforce development action plan. Part of this action plan will involve setting up a pilot of peer workers working on one of the acute wards.

**Key Action Points:**

- To ensure peer worker training is robust and looks towards accreditation.
- To evaluate the effectiveness of current peer worker roles.
- To identify pilot ward(s) for team(s) of peer workers.
- To develop an action plan on workforce development as regards peer workers.

**Next Stage: Stage 3: Transformation**

*Significant change is fully achieved; major service redesign; radically different*

The organisation has fully accepted that people who have direct experience of living with mental illness can, with appropriate training and support, make a significant contribution to the workforce. Most teams have an equal number of peer professionals working alongside other professionals. Peer Specialists are seen as having unique qualifications and experience which is different from, but equal to, those of traditional mental health professionals. They are therefore paid and given status according to their experience and expertise in delivering this role. HR processes and occupational health assessments have been adjusted so as not to provide obstacles to the employment of people with mental health problems (as required by the Disability Discrimination Act (DDA) and the targets under Public Service Agreement (PSA) 16). Clear arrangements for supervision and career progression are in place.
9. Supporting staff in their recovery journey

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<tr>
<th>Last Year's Self Rating</th>
<th>Stage 2: Development</th>
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<tbody>
<tr>
<td>Definition</td>
<td>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.</td>
</tr>
<tr>
<td>Current Status</td>
<td>Stage 2: Development</td>
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Progress in relation to last year's Action Points:

*To develop Hidden Talents to become a pan-Dorset project*

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 and self-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

The project originated in West Dorset and in the past year the group has focused on producing a booklet which highlights the key purpose of the project and providing support and guidance around the emotional wellbeing of all staff (see [http://www.dorsetmentalhealthforum.org.uk/pdfs/other/hidden-talents.pdf](http://www.dorsetmentalhealthforum.org.uk/pdfs/other/hidden-talents.pdf)). Key elements of this are Challenging Stigma and Discrimination and celebrating the modelling of recovery by those with lived experience. We are grateful to Dr Mike Slade (Clinical Psychologist, academic researcher and consultant in mental health services) for agreeing to write the foreword and to Paul Siebenthal who put extensive work into the layout and design of the booklet.

On 24 July 2012 James Barton, Director of Mental Health Services, wrote to and emailed all staff highlighting his commitment to the project and launched it across the whole of the Mental Health Directorate in Dorset HealthCare. Alongside the letter we also developed an anonymous questionnaire looking
at the lived experience of staff and asking whether they felt there was a ‘them and us culture’ and whether, if staff had lived experience of mental health problems, they felt that they had experienced stigma and discrimination from their colleagues. We based this questionnaire on one developed by Glen Roberts and Devon Partnership NHS Trust and we are grateful for their help and support. We are planning to publish the results of this survey in the coming months.

The next step for the Hidden Talents project is to build a consistency across the whole of Dorset and look at specific work streams for the group to participate in. One of them is the safe use of disclosure and the group, with the assistance of Rachel Perkins, plans to run a couple of workshops with the view to developing some guidelines.

**To continue to work with HR and OH in developing recovery orientated approaches towards staff**

The WaRP team has continued to work with HR and OH in developing recovery orientated approaches to staff. Some of this work has stalled due to the reorganisation and its impact on the HR and OH departments.

One key element we have been exploring is Wellbeing at Work tools. In January we purchased the RADAR Striving and Thriving at Work booklets and have had a number of staff piloting them. We also developed an in-house tool: the Wellbeing@work Action Plan which aims to support people through the stress risk assessment process, looking at identifying the specific problem, what strengths and resources people have in place already, and who will take responsibility for which part of the action plan (see Appendix 10). Initial feedback from the tool has been positive but we are eager to pilot more widely.

As stated before we wish to build on the recovery leadership work, but also to look at every stage of the journey of the workforce from recruitment, to supervision, to appraisal, etc., ensuring the recovery principles are fully integrated. We have agreement from HR and strong support from the Director of Human Resources (HR) department for developing new approaches to working with staff and utilising the expertise of lived experience in these developments. In the coming year it will be important that practical steps are taken around this.

**Key Action Points:**

To continue to develop the Hidden Talents project, challenging stigma and self-stigma within the NHS.
To produce guidelines around safe disclosure for staff.
To develop a joint action plan with HR and OH in developing recovery orientated approaches to staff, informed by lived experience.
Next Stage: Stage 3: Transformation

Significant change is fully achieved; major service redesign; radically different

Staff do not fear stigma or prejudice from colleagues in the workplace if they reveal their personal experience of living with mental illness in an appropriate setting. All staff have received appropriate induction and training and have been supported to help them use their personal knowledge and experience to help others and to optimise their own wellbeing. The organisation has in place comprehensive provisions to optimise staff health and to constructively address staff health problems (e.g. augmented occupational health services). The personal qualities and prior experience of staff are valued and included as selection criteria. The organisation formally recognises the commitment and creativity of staff and fully involves them in the implementation of the recovery vision.
10. Increasing opportunities for building a life ‘beyond illness’

<table>
<thead>
<tr>
<th>Last Year's Self Rating</th>
<th>Stage 1: Engagement</th>
</tr>
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<tbody>
<tr>
<td>Definition</td>
<td>The organisation has an inter-agency strategy to promote social inclusion, but little concrete progress has been made. The organisation is reviewing (or has reviewed) with service users and carers what needs to be in place in the community to support recovery. Some effective partnerships do 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 unfocused and too general to have specific impact. Evidence based, supported employment (Individual Placement and Support, IPS) is not widely available.</td>
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<tr>
<th>Current Status</th>
<th>Stage 2: Development</th>
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<tbody>
<tr>
<td>Definition</td>
<td>The organisation has in place a strategy for the development of ‘mainstream’ community support (including housing, employment, leisure and mental health promotion) and good progress has been made regarding implementation. The organisation has effective partnerships in place to provide improved access to paid employment. It has begun to appoint IPS-trained employment specialists to some teams. Operational policies have been revised to promote community integration on discharge from inpatient care. All service users have an agreed plan that they and their carers feel is safe and will sustain their recovery. Work has been done to reduce stigma and discrimination among certain key agencies (e.g. housing, employers, police and neighbourhoods). These projects have been led by suitably trained service users.</td>
</tr>
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</table>

**Progress in relation to last year's Action Points:**

*Develop a pan-Dorset social and vocational strategy and project plan*

We are currently working with commissioners at looking at a paid employment strategy underpinned by the Individual Placement and Support (IPS) model and looking at how socially inclusive alternatives can be available for those not seeking paid employment. We have just drafted a business case for an IPS pilot.

In addition, the DMHF-led initiative Sports and Leisure Activity Programme (SLAP), which is open to anyone and offers a range of sport and leisure activities, for example, cinema, pub, badminton, football, is now operating pan-Dorset and has extended its programme.
There are a number of initiatives promoting social inclusion undertaken by other third sector providers in Dorset, for example, Rethink, and Richmond Fellowship. In order to provide a joined up approach across the whole of Dorset in relation to social inclusion it will be useful to increase the level of partnership working, and involving commissioners.

**To continue to engage in anti-stigma campaigns and to promote the importance of everyone paying attention to their emotional wellbeing and to promote opportunities to influence local employers and communities**

There is a strong Time for Change campaign in Dorset and the WaRP has a close relationship with it. Helen Hutchings, who developed the Tea and Talk project, which is a highly effective way of discussing mental health problems and challenging stigma, has just been awarded a Time for Change grant. Helen is doing this in partnership with DMHF and Dorset HealthCare. The project will primarily be targeting local businesses and community groups to raise awareness of mental health problems.

Through the work of the REC, the WaRP has been contacted by local agencies to provide mental health awareness and recovery training to other organisations, for example, housing providers, further education, the police etc.

The WaRP has continued to receive local media coverage of their work, such as the launch of the REC, Hidden Talents and “What Recovery Means to Me …” (see Appendix 11). DMHF has a strong Twitter following and has been able to promote much of the work of the WaRP through social media. Becky Aldridge was heavily involved in the Mental Health Conference held at Kingston Maurward earlier this year and organised by Councillor Michael Bevan targeting local businesses and building a commitment to support the mental health of all communities within Dorset.

We are also currently developing a project looking at the emotional wellbeing of people from black and minority ethnic groups within Dorset. We are planning to develop a booklet which celebrates the ways that different cultural groups maintain their wellbeing, looking at how stigma and discrimination can harm emotional wellbeing and then giving tips for individuals, families and communities on what they can do to support their emotional wellbeing, and looking at how services can support people from black and minority ethnic backgrounds more effectively. We are working closely with the Trust community development workers around this project. It is being developed within the context at looking more broadly at how the issues relating to equality and diversity interweave with recovery. We describe it as essential that we show tolerance and understanding of ourselves and we promote tolerance and understanding of each other. This underpins the road to recovery and wellness.

We are increasingly looking to develop a rights based document underpinned by recovery principles that outline the components that support emotional
wellbeing and attempting to promote this as a framework for service design and development.

**Key Action Points:**

To continue to develop the paid employment strategy.
To work with commissioners to build partnerships with other third sector providers in delivering a comprehensive approach to social inclusion.
To challenge stigma and promote awareness through the Tea and Talk project and Time for Change campaign.
To develop the Wellbeing project plan for people from black and minority ethnic groups.
To start to develop a rights based framework which supports the emotional wellbeing of all in Dorset.

**Next Stage: Stage 3: Transformation**

*Significant change is fully achieved; major service redesign; radically different*

The organisation recognises that full citizenship and community integration is essential in promoting individual recovery. It has developed a range of effective partnerships with external organisations to support individuals in building a life for themselves independent of formal mental health services. There is a focus on promoting settled accommodation; maintaining and developing relationships; paid employment and training; and full inclusion in ordinary community activities. Peer support networks have been developed to sustain community inclusion. There is a particular emphasis on the importance of paid employment and IPS workers have been established in all teams. Issues for promotion of health and wellbeing across diverse cultures have also been addressed. The organisation supports social inclusion through a comprehensive range of targeted anti-stigma work in the communities that it serves. These projects have been led by suitably trained service users and there is active follow-up.
Conclusion

The coming year is pivotal in the development of recovery orientated practice and the WaRP. It is time now for recovery to move from being an addition to services to being the central focus and basis of service provision. The Recovery Education Centre provides a key opportunity to push the recovery agenda forward.

We undertook the ImROC methodology self assessment with the Directorate Management Group, who rated the scores similar to the WaRP team. But scored lower on “building life beyond illness” and “redefining risk”. When we carried out the same exercise with our recovery networks (which represent people who access services and statutory and non-statutory service providers), they rated all areas, apart from the development of the Recovery Education Centre as lower. We would expect this differentiation as the organisational change agenda filters down. It also demonstrates to us that whilst we have the plans in place and have made some steps forward, we are still a long way away from changing everyone’s “day to day experience”.

On some levels this year progress has been slower than we would have liked. Both Dorset HealthCare and Dorset Mental Health Forum are going through significant restructures and once these are complete it should lead to greater streamlining and opportunities to drive change forward.

We are in increasingly challenging economic times and this is putting greater pressure on individuals and services. It is important for the WaRP to ensure that recovery principles are not hijacked to ration services but that they are maintained as a way to provide the services people want, where people are offered information and are empowered. With the cuts to services, teams are being forced into greater collaboration and to think creatively about innovation and new approaches, and we see this as a real opportunity.

Central to this and fundamental to the WaRP is valuing the expertise of lived experience. This has been our most significant achievement in building the demand for and credibility of lived experience. It is this corner stone which we will continue to build on as we move forward.

Phil Morgan

Jackie Lawson

Becky Aldridge

Sarah Rose

September 2012
Bibliography


APPENDICES
APPENDIX 1
WHAT RECOVERY MEANS TO ME
POSTCARD AND POSTER CAMPAIGN
“Peace of mind, he’ll cope when I’m not around.”
Anna
Carer, Peer Representative Dorset Mental Health Forum, Governor of Dorset Health Care University NHS Foundation Trust.

“I dislike the term ‘recovery’, but to me it is about transforming my experiences and inspiring others.”
Helen
Service User Trainer, fundraiser local bi-polar self-help group.

“A journey of hope and discovery to better days.”
Terry
Peer Specialist Rethink, and Dorset Mental Health Forum

“A road that leads to peace, acceptance and a feeling of contentment and wellbeing.”
Jonathan
Chairman Dorset Health Care University NHS Foundation Trust

“It’s about learning from the past and looking to the future. Realising recovery is within us all.”
Nick
Peer Specialist Dorset Mental Health Forum, Mental Health Act Hospital Manager, Governor Dorset Health Care University Foundation Trust.

“Living with, despite and beyond my illness.”
Jackie
Recovery Lead Dorset Health Care University NHS Foundation Trust

For more information contact:
The Wellbeing and Recovery Partnership
Transforming experience ...unlocking potential

Telephone: 01305 123456 • www.xxxxxxxxxxxx.co.uk
Recovery means to me...

...now tell us what recovery means to YOU!

__________________________________________

__________________________________________

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__________________________________________

Your name ________________________________
The Wellbeing and Recovery Partnership

Transforming experience...unlocking potential
Lived Experience Mentoring Guidelines

July 2012
Lived Experience Mentoring for Psychiatrist Handbook

“The mentoring process has already helped me to think critically about my practice. It was a shock to realise that I could give the details of someone’s symptoms and diagnosis, but have little to say of their personal strengths and hopes. This is often in my mind as I talk to people now. It has also helped me to celebrate small successes and remain optimistic about people’s capacity to change.” Consultant Psychiatrist

This handbook outlines the background, purpose and process of the lived experience mentoring for psychiatrists. It aims to be a guide for mentors and mentees. This mentoring process is a set of 6 meetings held on a monthly basis, which promotes reflection and recovery orientated practice.

Aim of the Project

- For the experience and outcomes of people accessing the service to be improved through psychiatrists focusing on the individual’s recovery journeys

Objectives

- To increase psychiatrists’ understanding of the application of the recovery approach
- To increase psychiatrists’ understanding of their own strengths and resiliencies
- For the mentor and mentee to engage in a recovery orientated partnership

Why Mentoring?

The Oxford English Dictionary defines the term Mentor as “an experienced person in a company or educational institution who trains and counsels new employees or students”. In this case the experience that is being utilised is lived experience of mental health problems by a person who has accessed mental health services, recognising the psychiatrist’s professional expertise but acknowledging that there is an opportunity for him/her to be a student as regards learning from the expertise of lived experience.

This mentor/mentee relationship inverts some of the traditional power dynamics between psychiatrists and people who access services. The relationship should mirror the partnership working that underpins effective recovery orientated practice.
Personal Recovery

Personal recovery is defined as:

“… a deeply personal, unique process of changing one’s attitudes, values, feelings goals, skills, and/or 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.” (Anthony, 1993).

Embracing personal recovery means looking beyond clinical recovery and empowering the individual to take control of their own life. When the focus is too heavily on clinical recovery there can become a disconnection between the professional viewpoint and that of the person who is accessing the service. This disconnection is well illustrated by Mary O’Hagan’s (2010) article Two Accounts of Mental Distress comparing her diary accounts with her clinical record.

Today I wanted to die. Everything was hurting. My body was screaming. I saw the doctor. I wanted to collapse against the wall and cry out and show him how I feel about things but I said nothing. Now I feel terrible. Nothing seems good and nothing seems possible.

I am stuck in this twilight mood where I go down like the setting sun into a lonely black hole where there is room for only one. – Mary’s diary

Flat, lacking motivation, sleep and appetite good. Discussed aetiology. Cont. Li Carb. 250 mg qid. Levels next time. – Medical notes

The purpose of the lived experience of psychiatrists is to overcome the disconnection, as highlighted by the above quotes, using the recovery approach in order to improve the experience and outcomes for all involved.

Shared Decision Making and Evidence Based Practice

Central to bridging the gap between the perception of the individual and psychiatrist is the role of shared decision making and an acknowledgement of different perceptions. Entering into a relationship based on shared decision making does not just help bridge the perception gap but also the gap between the evidence base drawn from population studies and the impact of that treatment on the individual. However, shared decision making requires a redefining of relationships.

“Shared decision making diverges radically from compliance because it assumes two experts – the client and the practitioner – must share respective information and determine collaboratively optimum treatment … It helps to bridge the empirical evidence base, which is established on population averages, with the unique concerns, values and life context of the individual client. From the vantage point of the individual healthcare client, the efficacy of a particular medication is not certain … the question of how the medication will affect the individual becomes an open experiment for two co-experimenters – the client and the practitioner.” (Deegan and Drake, 2006)
Recovery and Psychiatrists

Recovery is for All: Hope, Agency and Opportunity in Psychiatry\(^1\) is an excellent paper which outlines the importance of psychiatrists embracing the recovery approach. They outline the key tenants to recovery as follows:

- **Recovery** is about individualised approaches and, as the definition suggests, it is about having a satisfying and fulfilling life, as defined by each person.
- **Recovery** does not necessarily mean ‘clinical recovery’ (usually defined in terms of symptoms and cure) – it does mean ‘social recovery’ – building a life beyond illness without necessarily achieving the elimination of the symptoms of illness.
- **Recovery** is often described as a journey, with its inevitable ups and downs, and people often describe themselves as being in Recovery rather than Recovered.

Recovery can be seen as a process and can be most helpfully defined by three core concepts:

- **Hope**. Hope is a central aspect of Recovery as Recovery is probably impossible without hope. It is essential to sustaining motivation and supporting expectations of an individually fulfilled life.
- **Agency**. This refers to people gaining a sense of control. Recovery means service users taking control over their own problems, the services they receive, and their lives. It is concerned with self-management, self-determination, choice and responsibility.
- **Opportunity**. This links Recovery with social inclusion and thus peoples’ participation in a wider society. People with mental health problems wish to be part of communities; to be a valued member of and contribute to those communities; and have access to the opportunities that exist within those communities.

Underpinning Principles and Recovery Frameworks

The materials developed for the lived experience mentoring of psychiatrists have been developed from a number of sources, however, they are primarily based upon the 10 Top Tips for Recovery Orientated Practice\(^2\). Boardman et al (2010) have realigned them in under three broad categories:

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TEN TOP TIPS FOR RECOVERY-ORIENTATED PRACTICE

A. Understand Recovery
1. Help the person identify and prioritise their personal goals for Recovery (not the professional's goals).
2. Demonstrate a belief in the person’s existing strengths in relation to the pursuit of these goals.
3. Be able to identify examples from your own lived experience, or that of other service users, which inspires and validates hope.
4. Accept that the future is uncertain and that setbacks will occur, continue to express support for the possibility of achieving these self-defined goals – maintaining hope and positive expectations.

B. Know how to collaborate
5. Encourage self-management of mental health problems (by providing information, reinforcing existing coping strategies etc.).
6. Listen to what the person wants in terms of therapeutic interventions, e.g. psychosocial treatments, alternative therapies, joint crisis planning etc. Show that you have listened.
7. Behave at all times so as to convey an attitude of respect for the person and a desire for an equal partnership in working together.
8. Indicate a willingness to 'go the extra mile' to help the person achieve their goals.

C. Have a broad view
9. Pay particular attention to the importance of goals which take the person out of the traditional sick role and enable them to serve and help others.
10. Identify non-mental health resources – friends, contacts, organisations – relevant to the achievement of these goals.

The Dorset Wellbeing and Recovery Partnership (WaRP) has adapted these top tips into a series of auditable recovery plan standards (see Appendix 1). The main tool for the mentoring discussions is the Process of Recovery Flowchart which has also been developed by the WaRP (see next page). This flowchart outlines the key components in the process of recovery and it is suggested that this flowchart is used as a starting point for conversations. The flow chart can be used thematically e.g. talking about a particular component of recovery or about an individual and how their recovery journey may be enhanced by focusing on these areas.

The recovery flowchart specifically does not focus on diagnosis or medication, and it is important that the mentoring supports the psychiatrist to look more broadly at the individual. This is not to say that discussions around medication or diagnosis and how they can be addressed in a recovery orientated way are not helpful, but rather they should not be the sole focus of the mentoring.

An additional useful resource which may be worth discussing is the SPIKES: A Six-Step Protocol for Breaking Bad News which is in Recovery is for All3, which outlines how to approach sensitive issues with people.

Recovery and Risk Management

Risk and Recovery are not separate concepts. To recover, people need to take risks in order to learn. The extent a person is able to take control of their own recovery is based on the extent they are able to take personal responsibility for their own wellbeing and the wellbeing of others. If people are unable to take considered risks this can lead to emotional harm as they are unable to develop and grow.

Enquiries into the deaths of people who have accessed mental health services frequently focus on the importance of engaging with the individual and how effectively services have been able to build connections with them, their supporters, and/or their communities.

Staff and services need to be skilled at engaging with the person and have curiosity about who they are in terms of their identity, what is important to them, the important people around them and their community. They also need to be skilled at moving with the person, depending on their mental state and capacity, to take personal responsibility. Central to this is the development of shared plans and agreements.

The minimum standard for a recovery orientated risk assessment and management is to acknowledge the person and their supporters’ perspective as regards their own risk assessment and management plans. This does not mean the service needs to agree with these perspectives, but rather they should be acknowledged and form the basis of on-going discussions. The gold standard is the development of a joint plan which is led by the individual who is able to demonstrate their own self-management and determine the response from services (if required) when they become unwell or distressed.
Standards for engagement in shared planning

Minimum Standard:
Staff curious-
Person and
their supporters
views are
listened to
and
described

Good Standard:
Person and their
supporters views are
heard and
represented, shared
plan commenced,
differing views
acknowledged

Gold Standard:
Person takes lead
role in shared plan,
identifying own
needs and service
responses.

Level of Engagement

Ability to take personal responsibility
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.

1. Ensure that the person is listened to / hear their story / foster trust and empathise/ allow the the person to be with their distress
2. Instil hope / introduce the concept of recovery and that recovery is possible
3. Introduce the importance of partnership working and empower the person by encouraging them to take personal responsibility
4. Support the person to identify their own strengths and resiliencies
5. Identify the important people in a person’s life and how they can be involved in the recovery journey (foster notion of interdependence)
6. Explain the support that is available, the services and treatments that are on offer
7. Discuss the person’s life beyond illness and their identity separate from their illness. Who are they? What is important to them? How do they understand their experiences?
8. Introduce the concept of self management and the use of WRAP and other toolkits
9. Encourage the person to identify what they would like their life to be like in the future
10. Develop a shared understanding (Recovery Formulation)
11. Identify which areas a person would like to develop at the moment
12. Negotiate compromise on areas of difference. Identify common ground. Develop plans to work through disagreement. Try to use conflict as an opportunity for learning.
13. Celebrate successes and learning
14. Ensure that the person understands that recovery is a journey and it will not mean that they will get everything right first time but that any difficulties along the way create the opportunity to learn
15. Make collaborative plans to maintain the safety of everyone involved and promote positive risk taking.
16. Write up notes and sessions together, highlighting strengths and resiliencies as well as areas of difficulty
Mentor Competencies:

<table>
<thead>
<tr>
<th>Competency</th>
<th>Evidence</th>
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<tbody>
<tr>
<td>To have lived experience of mental health problems and have accessed secondary mental health services</td>
<td>Able to describe direct experience</td>
</tr>
<tr>
<td>To be a trained Peer Specialist employed by Dorset Mental Health Forum</td>
<td>Application completed and training undertaken</td>
</tr>
<tr>
<td>To have a good understanding of recovery and how to communicate it in a way others can understand and use to facilitate the recovery of others</td>
<td>To have proven track record of working as a peer specialist and being able evidence this through being observed</td>
</tr>
<tr>
<td>To be assertive</td>
<td>To give examples of situations where you were able to be assertive</td>
</tr>
<tr>
<td>To be able to constructively challenge and be critical in a helpful manner</td>
<td>To demonstrate self-awareness and tact in a variety of settings</td>
</tr>
<tr>
<td>To be inquisitive and reflective</td>
<td>To complete a reflective piece prior to undertaking mentoring and be willing to complete two reflective pieces during the mentoring relationship</td>
</tr>
<tr>
<td>To be ready to learn</td>
<td>To be able to recognise and document on learning needs</td>
</tr>
<tr>
<td>To be willing to participate in supervision by Mentor Programme Leader</td>
<td>To attend regular supervision meetings</td>
</tr>
</tbody>
</table>
Mentor/Mentee Responsibilities

In understanding the mentor and mentee responsibilities it may be useful to look at the roles and responsibilities, Rani Bora (2012) outlines in the Rethink booklet *Empowering People: Coaching for Mental Health Recovery*. The mentor should: appreciate, facilitate, nurture, challenge and empower, by providing opportunities for exploration, experimentation and failure. The mentor needs to create a safe space and communicate in a transparent and real way.

The mentor should not: solve or fix, generate results for the person, give the message that they are the expert with all the answers, dominate, or predominately give advice.

The mentee should: be open to new learning; realise that there are no quick fixes; be willing to enter into a shared enquiry with the coach; accept that they will need to take action to achieve whatever they want to achieve from the mentoring; give the coach/mentor feedback on what is working and what is not working.

The mentee does not: become defensive and threatening when challenged; blame the coach/mentor for their slow/lack of progress.

Understanding these roles and responsibilities are important in terms of thinking about the parallels between the psychiatrist’s relationship with their clients and how they can enter into recovery orientated partnerships.

Process

The mentoring process covers six sessions over six months. The sessions last for one hour. The expectation is that the work will take place outside of the sessions in terms of the psychiatrist continuing to reflect on their practice. The expectation is that both mentor and mentee will write two reflective accounts over the six months, one after the first session and one after the final session. Both parties are welcome to write additional reflective accounts should they wish to do so.

The framework for mentoring should not be prescriptive and should be negotiated between the mentor and mentee. This is important as it should mirror a recovery orientated partnership. However, the discussion should incorporate the broad aims of the project, discussions around the recovery flowchart and reflections. It is also essential that ground rules are agreed in the first session.

[4](http://www.recoverydevon.co.uk/download/Empowering_People.pdf)
What is essential is that the discussion focuses on:

- Real people and real situations rather than theoretical discussions on recovery;
- Looking at what has gone well and teasing out the learning from things going well, as well as discussing challenges or problems.

The suggested session outline is as follows:

<table>
<thead>
<tr>
<th>Proposed discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Session 1</strong></td>
</tr>
<tr>
<td>Introduction, agree ground rules, set the scene, talk through recovery flowchart, agree how disagreements will be addressed, talk through focus of the sessions.</td>
</tr>
<tr>
<td>After the session complete reflective account.</td>
</tr>
<tr>
<td><strong>Sessions 2 – 5</strong></td>
</tr>
<tr>
<td>Reflect on previous session and any learning that took place.</td>
</tr>
<tr>
<td>On-going discussion could be based on a particular person or on a particular theme around recovery (e.g. instilling hope, focusing on strengths).</td>
</tr>
<tr>
<td><strong>Session 6</strong></td>
</tr>
<tr>
<td>Reflect together on previous session and then whole mentoring process. Develop plan of action as regards psychiatrist continuing to build on any learning that has taken place.</td>
</tr>
</tbody>
</table>

**Confidentiality**

All mentors are employed by Dorset Mental Health Forum who have a confidentiality agreement with Dorset HealthCare University NHS Foundation Trust, so Forum staff are under the same obligations around confidentiality as NHS staff. As the mentor has no need to know the identity of the clients being discussed their full names do not need to be mentioned. If the mentor recognises the person the psychiatrist is describing they should declare it and move on to discuss someone else. This and any other potential conflict of interest should be clarified and negotiated in the first session before any client discussions take place.
Challenges or Problems

Were there to be difficulties within the mentor/mentee relationship, this should be brought to the attention of the two project leads (one for Dorset HealthCare Trust and one for Dorset Mental Health Forum). There will then be a discussion on the best way to resolve any arising issues.

Reflection

People can undertake their reflection in any media, or any way they wish to. The focus should be on change and how people have experienced the process and any learning that has taken place. It would also be useful to reflect on the aims of the session. They should be willing to share the two accounts. We have included Gibbs’ reflective cycle (Appendix 2) for reference.

Evaluation

There are three proposed modes of evaluation. The qualitative evaluation is using the reflective accounts to see if there has been any change in attitudes or approach; this will be the minimum evaluation for all mentoring relationships. In addition is an audit of recovery plans using the 7 standards for recovery planning (see Appendix 1), and finally is the INSPIRE questionnaire on a pre- and post-mentoring group of clients.

Conclusion

This project is still in the pilot stage and these guidelines are aimed to outline the process. This is a living document so will be refined and developed as the lived experience mentoring programme continues; therefore we would always welcome any feedback on this project.

Phil Morgan – Co lead, Wellbeing and Recovery Partnership

Hannah Walker – Chair, Dorset Mental Health Forum

Jonathan Godfrey – Consultant Psychiatrist
Bibliography


Appendix 1

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 professionally 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.

- **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 clients wishes and advanced decisions recorded**
  The individual needs to inform the clinician of what they want with regard to therapeutic intervention e.g. which pharmacological 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 individuals 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 individuals consent their family members, friends, or carers 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.
Appendix 2:

Gibbs’ model of reflection (1988)

- **Description**: What happened?
- **Evaluation**: What was good and bad about the experience?
- **Conclusion**: What else could you have done?
- **Action Plan**: If it arose again what would you do?
- **Feelings**: What were you thinking and feeling?
- **Analysis**: What sense can you make of the situation?
- **Evaluation**: What was good and bad about the experience?
APPENDIX 3

POLICY FOR RECOVERY ASSESSMENT AND CARE PLANNING INCLUDING CARE PLAN APPROACH
Policy for Recovery Assessment and Care Planning including the Care Programme Approach

Your Guidance for Recovery Assessment and Care Planning

Summary Operational Guidance for CPA and Standard Care
1. Purpose

- The purpose of this document is twofold: To set out the expectations for people who access community mental health services.
- To provide clear guidelines to staff about how to follow the operational procedures for people who are accessing community mental health services.

2. Introduction

The key principles of modern mental health services are to promote your recovery, focusing on personalised care, which addresses the concerns of your supporters and carers and ensures consistency of provision through a streamlined approach. This document sets out the processes of the community mental health team (CMHT) and outlines how recovery principles act as an overarching approach within which the frameworks of Care Programme Approach (CPA) and Standard Care sit.

“[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...” (Anthony, 1993)

The aim of our service is to promote your recovery by:

- Instilling hope, so that you can believe your life can be different
- Supporting opportunities, so that you can build a life distinct from or despite your mental illness
- Enabling you to take control, so when you feel able to, you are able to manage your own life.

We aim to do this by providing you with the tools (e.g. coping skills, psychosocial interventions, medication, recovery skills) for you to build the life you wish to live. Recovery is not a passive process, you will need to be actively involved.

If you have a wide range of needs from a number of services, or if there are concerns about your ability to keep yourself safe or maintain the safety of others you should receive a higher level of co-ordinated support. This is called the Care Programme Approach (CPA). Otherwise you will receive your support through a process called Standard Care.

The team are here to support and be alongside you on your journey. This document will outline the referral, assessment and care or recovery planning process. This document also describes what you should expect from your worker. It outlines what is expected of you in order for you to fully engage in your own recovery.

3. Expectations

You can expect staff to:

- Listen to what you have to say
- Remain hopeful about your recovery
- Find out what is important for you in your recovery
- Treat you as an individual
- Work in partnership with you
- Explain things clearly to you
- Keep in touch with other people helping you
- Support you to make decisions and coordinate/facilitate your care
- Provide you with information relating to your care and treatment
- Help you review how things are working for you

There is an expectation that the staff will have conversations with you that should focus on your:
Personal recovery goals which are led by you

You should be given assistance to empower you to identify your own goals. Goals should not be led by your worker; they should be led by you to aid your recovery/well-being.

Strengths and resources

You should be encouraged to identify and utilise your current strengths and resources when working towards your goals.

Quality of life and social inclusion

Your goals should not solely be linked with Mental Health Services. Instead, you should be encouraged to access community resources such as paid or voluntary work to enable social inclusion and to utilise friends, clubs and organisations that are relative to the goals that have been set.

Development of self management techniques

Your goals should identify how you are going to self manage your mental health problems by encouraging the use of existing coping strategies and developing new ones.

Offering choices and client’s wishes

You should be offered choices by your worker with regard to therapeutic intervention. This would include advanced decisions, which would state your preferences for treatment when you are in crisis or become unwell and are unable to make informed decisions about your care.

Positive risk taking and shared safety planning

It is recognised that there will be problems along the way and setbacks may occur. Your worker will continue to provide support so that hope is maintained and the goals you have set are continued to be worked towards. Positive risk taking should be encouraged and your worker will assist you with this.

Proactive engagement with carers and supporters

With your consent your family members, friends, or carers should be consulted in agreeing your recovery plan. This enables them to assist where possible but to not be put upon with expectations that are unrealistic.

Partnership

We want staff to work in partnership with you, which requires effort from both parties.

4. Making Sense of your Experiences

It is important for us that you are able to make sense of what has happened or is happening to you. Traditionally mental health services may have focused on a medical approach, looking at diagnosis, and whilst that is still important we also would like to know how you perceive your diagnosis and how you explain your experiences or how you understand your place in the world.

For some people spirituality is an important part of their recovery. We would like to create the opportunity for you to talk about your spirituality, if that is important to you. This does not have to mean a religious sense of spirituality but more about the beliefs you hold about the world which you find meaningful and help you make sense of your place in it. If this is important to you your worker will be happy to discuss this with you.

Peer Specialists

Peer specialists can “act as a beacon of hope”. We also recognise that sometimes it can be really helpful to speak to someone who has been through a similar situation to you or who has the same
We work in partnership with Dorset Mental Health Forum which is a charitable organisation that employs people with mental health problems. They have staff who work alongside NHS teams, called peer specialists, and they use their own experience of having mental health problems and using mental health services to support individuals and staff to maximise their opportunities for recovery.

**Working with you where you are:**

We will try to match our support and interventions to where you are on your recovery journey. We sometimes use the stages of recovery model to help with this (see below). It would be helpful for you to think about where you are in this process. (Sometimes this may change rapidly.)

As you are able to move through your recovery journey we would like you to increasingly be able to take control of your own care and treatment; we call this being client-led. If you do not feel able to do this we will support you in the areas you do feel able to control and will try where possible to offer you choices.

**The five stages of recovery**
(from Andresen, Caputi & Oades, 2006)

1. **Crisis** - A time or chaos and difficulty in coping or staying in touch with reality or a time of withdrawal characterised by a profound sense of loss and hopelessness;
2. **Awareness** - Realisation that all is not lost and that a fulfilling life is possible;
3. **Preparation** - Taking stock of strengths and weaknesses regarding recovery and starting to work on developing recovery skills;
4. **Rebuilding** - Actively working towards a positive identity, setting meaningful goals and taking control of one's life;
5. **Growth** - Living a meaningful life, characterised by self-management of the illness, resilience and a positive sense of self.

### 5. The Processes: Referral, Registration, Screening & Assessment

Your referrals will be screened by a member of the Mental Health Team on the day of receipt. The worker will record their decision on the Integrated Electronic Service User Record (IESUR) using the Referral Outcome Decision Screen. IESURs are the electronic (computer) databases which the team members use to hold information about all people they provide a service to.

When the team receive your referral, they will first decide a service that is of benefit for you. If they can you will be allocated to a team member (who is a mental health professional) for assessment. They will (possibly with a colleague or colleagues) offer you an assessment within the following timescales:

- **EMERGENCY** (seen that day unless it is agreed with the referrer that it can wait)
- **URGENT** (seen within 5 working days)
- **ROUTINE** (seen within 4 weeks)

If your referral is not thought to be eligible it will be discussed at the next CMHT meeting. If the outcome of the discussion at the team meeting remains that the service would not be of benefit to you at this time, you (and the referrer) will be written to and be given information and advice and, where applicable signposted to relevant services. This will be recorded on the IESUR using the Referral Outcome Decision Screen.

### 6. Assessment

At your first point of contact with the service, for assessment, you (and where appropriate your carer) should be informed about:

- Who you are seeing (name and profession of mental health worker)
The agency represented
Where relevant, the team represented

Your first appointment with health care staff will be within 4 weeks of receipt of the referral. If you are having a social care assessment, social care staff are responsible for ensuring that this is undertaken within 48 hours of receipt of the referral and completed within 28 days.

The initial assessment will help you and us identify what your current difficulties or needs are, but also look to understand what is important to you as a person, what your aspirations, preferences and strengths are. We will also discuss your longer term aspirations around employment, occupation, education and training.

Whether this is your first assessment or whether you have been seen in the service before (and this is a re-assessment) it is essential that a full assessment is completed. This will include a re-evaluation of past information and risk assessment in line with your current presenting concerns.

The most important thing is that you feel that you have been listened to. Whilst we need to ask specific questions and record information on forms due to the regulation of health and social care services, we also want to take time to listen to you. It will be really helpful if you are able to give your views on all areas that you discuss and these will be recorded in your assessment by the professional involved.

You may find it helpful to look at the assessment with your worker to agree it is an accurate record of both of your views.

The Core Assessment will be used to record the assessment. To see an example of the assessment forms, please speak to the person undertaking your assessment. These show you the sort of questions you can expect to be asked. If you are 65 or over you may have a slightly different assessment procedure called the Single Assessment Process (SAP).

We will then discuss with you whether the CMHT is the best place to meet your current needs. The assessment will be used as an essential and ongoing element of your care, informing the level of multi-agency involvement and determining whether your support is provided under CPA or Standard Care.

You will also be given the Service User Assessment and Care Planning Information Booklet which forms part of the initial mental health assessment. We have to provide this booklet to you as it enables us to collect important information which forms part of the assessment. This will be either be sent to you along with the first appointment letter, or provided at your first appointment. Our administrative staff will ensure this happens.

The booklet will have your Care Coordinator's/Lead Professional's name, contact details, and team details as outlined on the inside front cover.

This booklet contains a range of important information that you need to be aware of such as:

- Confidentiality
- Sharing information with service users
- Who to contact if you have a mental health crisis
- The Care Programme Approach and Standard Care
- Text messaging
- Service user contact with children
- Ethnicity monitoring
- Vocational questionnaire
- Driving and disability
- Choices
- Links to other support organisations

A risk assessment will also be completed as part of your initial mental health assessment. This is a statutory requirement, but we are also aware that when you experience emotional distress you may have thoughts of harming yourself and in rare circumstances harming other people. We want to be able to work with you around this and involve you in decisions around safety planning.
We also would like to know about any important people in your life and how they can support you on your recovery journey. If there is anyone who has an unpaid role who provides you with regular support they may be entitled to an assessment of their own needs. This is known as a carer’s assessment.

We are keen to support people with any parenting responsibilities and recognise that being a parent is both challenging but also a key role in supporting your own recovery. We will ask about your parenting, if applicable, and provide the support you or your family (including identifying any young carers) may require or want.

In rare situations people with mental health problems have directly or indirectly harmed their children; therefore we have a legal obligation to identify any child or children for whom you have a regular caring responsibility. For each child the mental health professional will need to record the full name of each child, their date of birth, their address, their school, GP and the relationship between you and the child.

Please try not to be intimidated by the process as this is something we have to do with all clients and does not mean we are questioning your ability to parent.

However, if we do have concerns around any issues relating to abuse or neglect of children we will contact or seek advice from the Trust’s named nurse/doctor for safeguarding children and make a referral to social services child care team. This may be done as a precautionary measure if there is any uncertainty around neglect or abuse.

7. Level of Support Offered

If the CMHT is to provide you with support following your assessment, it will be discussed with you and within the CMHT as to what level of support you will need. This will either be Standard Care or Care Programme Approach.

Standard Care is aimed at people who:

- Are able to self-manage their mental health problem to the degree that they do not need intensive ongoing support
- Have an active informal support network
- Pose little danger to themselves or others
- Maintain contact appropriately and are proactive with their contact with services
- Are only in contact with one statutory agency

Care Programme Approach is aimed at people who:

- Have a number of complex problems that they are having difficulty managing (for example substance misuse)
- Have a current or potential risk which could lead to them harming themselves or others
- Have a limited ability to self manage their mental health problem
- Find it difficult to maintaining positive contact with mental health services
- Have difficulty looking after themselves and neglect their own needs
- Have contact with a number of other agencies.

CPA must apply when service users are subject to Supervised Community Treatment (SCT) or subject to Guardianship under the MH Act (section 7).
8. Recovery Planning

Once we have completed the initial assessment process we will start what is called recovery planning.

This is to enable you to set goals for yourself and identify what you will do to try to achieve them and what the service will do to support you. These goals should be based on what you have identified as being important to your recovery. In writing up your goals it is important to draw up your strengths and resources to support you. Some people find it helpful to write their recovery plan in their own words.

Example of recovery plan:

<table>
<thead>
<tr>
<th>What are we trying to achieve?</th>
<th>How are we going to do it?</th>
<th>Who is going to do it?</th>
</tr>
</thead>
<tbody>
<tr>
<td>I will be able to go to the shops by myself.</td>
<td>I will learn how to keep a log of when I feel anxious, by recording my anxiety rating, what thoughts I’m having and more realistic thoughts.</td>
<td>Client</td>
</tr>
<tr>
<td>I will agree with my care co-ordinator at each visit the next task to practice to help me get used to being out.</td>
<td>My care co-ordinator will review this log with me when she visits me at home, fortnightly.</td>
<td>Care Co-ordinator</td>
</tr>
</tbody>
</table>

The care plan will reflect the assessment detail, including risk, and has the following functions:

- It is a description of the process of care planning
- It summarises identified needs and how they are to be met
- It is a formal record setting out what is going to be done, why, when and by whom
- It provides you and your carers with information to enable you to contact the service at any time
- It includes clear indicators of relapse, contingency and crisis plans if you are on CPA

If you are on Standard Care, your recovery plan may be in the form of a letter.

Sometimes when you have experienced mental illness it can be hard to know what you want. Staff can use tools to help you identify goals, for example they may support you to use the Recovery Star and talk to you about different areas of your life such as relationships, housing, managing your mental health etc. Staff are requested to offer you the opportunity to complete a Recovery Star.

They may use the questions from INSPIRE which will ask you about what is important to you for your recovery and whether you would like to work on it with your worker.

If it is still difficult to decide what you want to work on, you may want to make your recovery plan based around trying to identify what is important to you.

The recovery plan will include the goals you have identified and you will be asked if you wish to score them out of 10. These are called Person Rated Outcome Measures or PROMs. This is because at later reviews, you can talk again about these goals and rescoring them will help you see whether the support and treatment have got you closer to what you want to achieve. The Recovery Star can also be used in the same way.
Your recovery plan will be documented on the IESUR. You and your carer or supporters (if appropriate), your general practitioner and other people involved in your treatment and care as appropriate should receive a copy of your recovery plan. Sharing this information with any other people involved in your care will be discussed with you.

You should be provided with information about your choice to receive copies of clinical correspondence. This will be done as per the Sharing Information with Service Users and Carers Policy.

9. Recovery Plan Review

Your recovery plan should reflect the changes that are happening in your life and the lives of your supporters and your needs. Therefore you should regularly review your recovery plan with your worker. It would be helpful if you agree an agenda with your worker before the meeting and make sure you are able to talk about what is important to you. You may want a peer specialist to support you with this.

We are required to review your recovery plan annually, but it is good practice for it to be reviewed regularly, particularly if your circumstances have changed.

Key times when your recovery plan is to be reviewed:

• At your request, and if appropriate at the request of your carer
• Prior to discharge from an inpatient unit to the community
• If there is a significant change in how you are presenting or how you appear clinically or your social circumstances change
• Prior to discharge from the service
• Prior to discharge from medical treatment at a general/community hospital or equivalent
• If you do not attend appointments or refuse treatment
• On permanent transfer of Care Coordinator/Lead Professional
• When extended leave, Section 17 or Supervised Community Discharge SCT under the Mental Health Act 1983 (as amended 2007) is granted for a period of more than five working days.

When you review your recovery plan and you are on CPA it is called a CPA review. This could be a single meeting or several discussions. You should be able to choose how you would like it run. A CPA meeting will involve the people who are supporting you on your recovery journey. This may be health professionals, people from other agencies (e.g. housing) and your supporters and carers. However, you can choose who you want to be present at your review. Your Care Coordinator can then contact other people that they will need to involve outside of your meeting.

If you choose not to have a meeting, your worker can complete the review with yourself and then collect other people’s contributions separately. They will let you know how they are doing this and what other people have said.

As your need for support changes, we will move with you. Self-directed support will be the natural progression and the need for intensive care coordination support and CPA will end. The need to remain on CPA should be discussed at the end of every meeting and this should be recorded on your recovery plan, as should the date of the next review meeting.

You, your carer or any member of your care team can request a review or review meeting at anytime.

If you are on Standard Care you will not need to have a formal review but your support should be reviewed at each meeting with your Lead Professional.
10. Moving On: Discharge From The Care Programme Approach And Standard Care (Leaving The Service)

Following a discussion with you, it is likely there will come a point where you and/or the service feel that you no longer need to be within the CMHT, therefore you no longer need to be on CPA or Standard Care.

This will be considered with you and your carers or supporters (where appropriate), how you are progressing on your recovery journey, to what extent your mental health problems are causing difficulty or disruption to your life. There will also be a significant consideration given to your safety and any risk concerns. It may also be due to you refusing further treatment or support.

On discharge from the service or CPA, appropriate information should be shared with you and your carers/supporters, including plans for support, Adult Protection Plan (where applicable), follow-up, and a clear statement about the action to take in the event of a relapse. You should also be informed in writing how to re-access services should the need arise. Your GP will be notified in writing.

If CPA/Standard Care is no longer needed, this will not remove your entitlement to any services for which you continue to be eligible.

Discharge from CPA/Standard Care must be fully recorded on your IESUR.

Where you are subject to Section 117, the Section 117 policy should be followed.

For some people they may not need to come back to mental health services. For others it may be part of their recovery journey that they have periods in the service and periods out of it. It is important people have the opportunity to learn from their experiences and shape their support accordingly. An important part of a person’s recovery journey is to be able to learn from their experiences and grow and develop through this.

11. Transfer Of Care Coordinator/Lead Professional Responsibilities And Joint Working Arrangements Within And Between Teams

Sometimes there may be a need for you to change worker or team. This may be because you have moved location or your needs have changed.

Staff will write to the new service (or record it in your IESUR if it is a transfer within the existing service) that you will be going to. This will include an up to date care plan, summary of clinical history and reasons for transfer. It is the responsibility of your Care Coordinator/Lead Professional to ensure that your reviews are co-ordinated and documented, including Section 117 meetings and reviews.

There should also be documented and written confirmation by the new Care Coordinator/Lead Professional acknowledging acceptance of Care Coordinator/Lead Professional responsibility.

You and your carers and others involved in your care should be notified by the your current Care Coordinator/Lead Professional of the transfer of Care Coordinator/Lead Professional responsibility. Notification should be in writing and recorded in your notes.

We recognise that changes to workers or teams that you have an established relationship with can be a difficult time and can leave people feeling unsettled. If you or your worker have any concerns about any potential risk factors or issues relating to safety, these should be discussed and should form part of the transfer of care/care plan.
12. If You Do Not Attend Appointments

When you receive a service from us, we have a duty of care to you. This means that if we do not hear from you or see you and we have concerns we will have to take the following actions.

**ACTION – ROUTINE**

- If you do not attend for appointments, we will notify your general practitioner (GP) and follow-up action will be agreed and recorded. This will be proportionate to our understanding of your situation and any risk considerations.
- Your Care Coordinator/Lead Professional will make all reasonable effort (including a home visit, if appropriate and safe) to try to get in touch with you and try to find out your views on your care. This will continue until a review of your treatment/care leads to you being discharged from the service, or the treatment/care plan being revised.
- Your Care Coordinator/Lead Professional should undertake a review within ten working days.
- The Consultant Psychiatrist/Line Manager and multi disciplinary team (as appropriate) will be kept informed and all interventions planned/agreed will be undertaken and recorded.

**ACTION – ROUTINE**

Actions that will be taken where immediate risk is identified:

- Your Care Coordinator/Lead Professional should review the case immediately, informing and consulting with people and agencies involved in your care.
- The Consultant Psychiatrist, Line Manager and, where appropriate, Duty Officer will be informed.
- An adverse incident report should be filed in line with local policy.
- All interventions planned/agreed and actions taken should be recorded in your IESUR.

- Written details of your risk information and any action to be taken will be passed to your general practitioner within one working day.

If you have moved area and your whereabouts are known/suspected:

- Written details of the history of your contact with services and risk indicators will be passed to the receiving services (secondary mental health services, children’s services if relevant, and current general practitioner where known) within one working day.
- All information forwarded to the receiving services and general practitioner will be detailed and documented in your case notes.
Contacts
Dorset HealthCare University NHS Foundation Trust
11 Shelley Road, Boscombe, Bournemouth, Dorset  BH1 4JQ
Tel: 01202 303400  Fax: 01202 301798

The information in this leaflet is available in additional languages and alternative formats. Please contact the Trust for further details.

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www.dorsethealthcare.nhs.uk
Dorset Wellbeing and Recovery Partnership (WaRP)
Recovery Education Centre
Project Plan

Defining the Recovery Education Centre:

The Dorset Healthcare University NHS Foundation Trust (DHUFT) has been given Demonstration Site status within the Centre for Mental Health’s Implementing Recovery Organisational Change (ImROC) project. Within their methodology for organisational change the Centre for Mental Health cite the need to “Establish a Recovery Education Unit to drive programmes forward” (Shepherd et al 2010). As active participants within the ImROC programme, the Trust is planning to set up a Recovery Education Centre (REC). Given the geography of Dorset, the centre will operate as a number of virtual centres utilising a range of venues within the community.

A REC will provide the opportunity to meet the needs of a large number of people, professional expertise will be backed up by the expertise of lived experience as every course is co-designed and delivered. The courses will also be able to provide greater contact with supporters and carers. The REC will also provide a framework for the training of staff, who will be able to learn alongside supporters and carers and people who access the service in how support someone’s recovery. It will also allow staff an opportunity to pay attention to their own personal development and growth.

Vision:

To provide a learning experience that is accessible to all. Recognising people and communities hold their own solutions. Through working together in partnership, everyone can realise their own unique potential.

Mission:

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?” (Repper & Perkins, 2003).

The Dorset Wellbeing and Recovery Partnership will achieve this by providing a learning environment to give people the tools to live the lives they wish to live and build their own recovery. An educational framework will empower people to find hope, see and embrace opportunity through building skills and gain control by putting these skills into practice in their lives. The Recovery Education Centre will enable people to learn alongside one another to facilitate personal growth and the development of others.
Purpose:

- To provide people with the tools and skills to self-manage, through partnership of expertise by experience and professional expertise.
- To enable people to take control of their lives and be able to move beyond mental health services and mental illness.
- To improve service outcomes in relation to both personal recovery and clinical outcomes.
- To enable people to invest in themselves within an educational framework.
- To improve people’s experience of mental health services (including those who work within them and carers and supporters).
- To enable people to make the best use of mental health service.
- To provide a vehicle that reconsititutes mental health services through readdressing the imbalance of power. By promoting an educational model people can learn for themselves and recognise everyone’s potential as an expert.
- To bring people together to realise and inspire individual and collective potential.

Rationale:

The Recovery Education Centre (REC) will be a key vehicle in transforming people’s experiences of mental health services, this will be delivered through the proven partnership of Dorset Mental Health Forum (DMHF) and Dorset Healthcare University NHS Foundation Trust (DHUFT.)

There is evidence from the USA and emerging evidence from within the UK that through providing educational approach alongside clinical approaches improve service outcomes, the experience of people who access the service and a reduction in Community Mental Health Service contact time (Slade, 2009; Wybourn and Rinaldi, 2010; 2011). The WaRP has piloted a number of courses which anecdotally have similar results.

The purpose of the REC is to provide education and training for people who access the service, carers and supporters and staff. This shared learning will lead to a breaking down of ‘them and us’ culture which will in turn enhance the quality of experience of mental health services for all.

The focus is for individuals to recognise and develop the skills they need to live the lives they wish to live, allowing clinicians to focus upon delivering the technical expertise. The REC will do this initially and primarily by giving people a framework within which they can understand their experiences and how they manage their own recovery.

The REC will empower people to effectively utilise mental health services by; delivering courses which provide them with an understanding of what they can do for themselves, to make informed choices about their treatment and make best use of the service. The REC will not replace the need for care co-
ordination, care management, risk assessment and risk management and therapeutic intervention. Courses provided within the REC will delivered within a quality framework.

**Project Plan:**

The Dorset Wellbeing and Recovery Partnership recognise establishing a Recovery Education Centre will be an evolving process that will take a number of years to develop. We therefore envisage 4 phases of development with the first phase being completed in September 2012. This project plan aims to demonstrate the 4 phases with an in-depth plan of steps required to complete the initial first phase of the project.

**4 Phases of Recovery Education Centre Development:**

<table>
<thead>
<tr>
<th>April 2012</th>
<th>September 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Phase 1:</strong>&lt;br&gt;Secondary Care Mental Health Service&lt;br&gt;Summer Term&lt;br&gt;<strong>Completion September 2012</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Phase 2:</strong>&lt;br&gt;Broaden Menu of courses: Including carer specific courses&lt;br&gt;Link with IAPT&lt;br&gt;Identify funding streams, personalisation, CPA&lt;br&gt;Recovery Leadership</td>
<td></td>
</tr>
<tr>
<td><strong>Phase 3:</strong>&lt;br&gt;Consolidate REC group&lt;br&gt;Build partnership with additional community organisations.&lt;br&gt;Recovery College Funding Streams</td>
<td></td>
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<tr>
<td><strong>Phase 4:</strong>&lt;br&gt;Open Access College for the community</td>
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</table>
## Phase 1: Stepped Development Plan

<table>
<thead>
<tr>
<th>Project Area</th>
<th>Action</th>
<th>Next Steps</th>
<th>Who</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Project Development</strong></td>
<td>Identify project leads</td>
<td>Complete</td>
<td>SR, JL</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Set up project group</td>
<td>Complete</td>
<td>SR, JL, SA, PS, BA, PM (project group)</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td>Set out REC Mission and Vision Statement</td>
<td>Finish statement and get JB approval</td>
<td>Project Group</td>
<td>10/2/12</td>
</tr>
<tr>
<td></td>
<td>Describe phased development plan</td>
<td>Complete plan</td>
<td>JL and SR</td>
<td>10/2/12</td>
</tr>
<tr>
<td><strong>Course Development</strong></td>
<td>Get CMHT group audit feedback</td>
<td>Meet with LD</td>
<td>JL and SA</td>
<td>10/2/12</td>
</tr>
<tr>
<td></td>
<td>Identify courses for first term</td>
<td>Seven courses identified</td>
<td>Project group</td>
<td>Complete</td>
</tr>
<tr>
<td>(These are current titles of courses as run at present but are subject to change)</td>
<td>Intro to recovery</td>
<td></td>
<td>GH BS</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Develop lesson plan format</td>
<td>Develop template for Lesson plan</td>
<td>SR</td>
<td>15/2/12</td>
</tr>
<tr>
<td></td>
<td>Develop Lesson plans for identified courses</td>
<td>To complete during course development fortnight</td>
<td>Development group</td>
<td>24/3/12</td>
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<tr>
<td>Systems and Processes</td>
<td>Formalise process of enrolment</td>
<td>JL and SA</td>
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<tr>
<td></td>
<td>Develop information collection system for college data</td>
<td>JL and SA</td>
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<tr>
<td></td>
<td>Develop clinical record keeping system</td>
<td>JL and SA</td>
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<tr>
<td></td>
<td>Develop Operating Procedure</td>
<td>JL and SA</td>
<td></td>
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<tr>
<td>ILP planning</td>
<td>SR outline &amp; SA</td>
<td></td>
<td></td>
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<tr>
<td>Identify administrative support</td>
<td>Project Group</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Practicalities</td>
<td>Identify venues for courses</td>
<td>SA</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Link with tutors and identify</td>
<td></td>
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<tr>
<td></td>
<td>Identify budget for venues</td>
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<td></td>
<td>Agree any payments</td>
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<tr>
<td>Trainer Development</td>
<td>Identify trainers for courses</td>
<td>Project Group</td>
<td>15/2/12</td>
<td></td>
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<tr>
<td></td>
<td>Develop in-house train the trainer (PTLLS)</td>
<td>SR</td>
<td>9/3/12</td>
<td></td>
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<tr>
<td></td>
<td>Train the trainers</td>
<td>SR and identified trainers</td>
<td>13/3/12</td>
<td></td>
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<tr>
<td>Information and Marketing</td>
<td>Course information leaflets</td>
<td>SR</td>
<td></td>
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<tr>
<td></td>
<td>Course trainers to develop</td>
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<td></td>
<td>Develop Prospectus</td>
<td>Identify who will design</td>
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<tr>
<td></td>
<td>Market courses to all teams and through forum</td>
<td>Develop Marketing strategy</td>
<td>SA</td>
<td>13/3/12</td>
</tr>
<tr>
<td>Evaluation and Quality</td>
<td>Develop methods of</td>
<td>Project group</td>
<td>Draft 13/3</td>
<td></td>
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<tr>
<td>Assurance</td>
<td>evaluation from students</td>
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<tr>
<td>Develop methods of evaluation for staff</td>
<td>Project group</td>
<td>Draft 13/3</td>
<td></td>
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<tr>
<td>Develop quality assurance framework</td>
<td>Project group</td>
<td></td>
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<tr>
<td>Develop costings and tariffs for courses</td>
<td>Project Group</td>
<td></td>
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<tr>
<td>Set up evaluation and development fortnight</td>
<td>Project Group</td>
<td>End of Summer Term</td>
<td></td>
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<tr>
<td>Commence Courses</td>
<td>REC launch event</td>
<td>Project Group</td>
<td>4/2012</td>
<td></td>
</tr>
<tr>
<td>Start course programme</td>
<td></td>
<td></td>
<td>End 4/2012</td>
<td></td>
</tr>
</tbody>
</table>

Project Plan Compiled by: Becky Aldridge, Sarah Rose, Paul Siebenthal, Phil Morgan, Jackie Lawson and Sam Adkins
References:


Rinaldi M. and Wybourn S. 2011. The Recovery College pilot in Merton and Sutton: Longer term individual and service level outcomes. London:
The Recovery Education Centre

PROSPECTUS 2012

Dorset Mental Health Forum
promoting wellbeing & recovery

Dorset HealthCare University
NHS Foundation Trust NHS
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Welcome to the Recovery Education Centre Summer – Term 2012

Everyone has a right to wellbeing, to feeling positive about today and feeling hopeful for tomorrow. At times life can feel uncontrollable, and empty of opportunity, and most of us experience this at some point. At the Recovery Education Centre, you will find courses that help to empower you to find hope, to see and embrace opportunity through building skills and gain control by putting these skills into practice in your life.

We can all benefit from learning how to be kinder to ourselves and how to cope with negative events that happen in our lives.

The Dorset Recovery Education Centre is being delivered to you by the local NHS provider Dorset HealthCare University NHS Foundation Trust and the Dorset Mental Health Forum (a peer-led charity). This partnership between the two organisations forms the Wellbeing and Recovery Partnership (WaRP). The aim of the WaRP is to change the culture of mental health services and people’s attitudes to mental health and wellbeing in Dorset. Providing education to people who access services, their supporters and staff who work within these services is a key vehicle in ‘transforming people’s experiences and unlocking their potential.’

Regardless of who you are or what your relationship is with mental health services we hope you benefit from the courses that we have to offer. They have all been co-designed, and are co-delivered by a Peer Specialist, who has lived experience of a mental health condition, and a Healthcare Worker. By combining the expertise of lived experience with the professional understanding of mental health, we are modelling true partnership working and recognise the collective learning and teaching potential for all.
Wellness Workshop

The Wellness Workshop is an introductory, interactive session on the principles of personal recovery delivered by Peer Specialists with lived experience of mental health problems assisted by Trust staff.

It gives a snap shot of the many things involved in achieving wellness and the challenges faced. The trainers draw on their considerable lived experience to support the principles on offer and this provides direct access to people who have learnt to live with their problems and regained quality of life. In the session we talk about defining wellness, the ‘journey’ of recovery, acceptance & denial, and the importance of learning.

We very much believe in the power of sharing our experiences to aid others and to provide vital hope that better days can lie ahead. This is the workshop’s main purpose. By learning to live with a mental health condition you can decide your own destiny and can get back into the world, but when you are unwell this is hard to see or believe. But it is possible and the workshops are one way of demonstrating this.

The Wellness Workshop is delivered in a single session.

**Dates:** 10th May  
**Venue:** Seaview Day Centre, Croft Rd, Poole, BH12 3LD  
**Times:** 6pm to 8pm.  
**Refreshments:** Tea and Coffee is provided.

**Dates:** 30th May  
**Venue:** The Sherborne Centre for Well Being, 1 Abbey Rd, Sherborne, Dorset, DT9 3LE  
**Times:** 2.30pm to 4.30pm.  
**Refreshments:** All refreshments can be purchased from the cafeteria.
Recovery Narratives

Recovery Narratives are stories of recovery. The stories, like the people they belong to, are deeply personal and individual. These are not stories of woe or stories that support the notion of people with mental illness being victims. These are however, stories that contain hardship, illness and pain. They are also stories of great hope and immense courage, often illustrating the universal search for meaning that is innate in all of us.

Narratives show the movement towards understanding and acceptance, as we progress towards mental wellness, a wellness shaped by the notion of recovery. Recovery being a framework of hope, acceptance and control over our lives. Not about being recovered, as in, without symptoms but rather living a full, meaningful and satisfying life whether we’re a carer, staff member or a person with lived experience.

The Recovery Narratives course is delivered across three sessions, held every three weeks.

| Dates: | 9/05, 29/05, 21/06 |
| Venue: | 843 Christchurch Rd, Pokesdown, BH7 6AR. |
| Times: | Each of the three sessions run between 2pm to 4pm. |
| Refreshments: | Tea and Coffee is provided. |

| Dates: | 17/05, 7/06, 28/06 |
| Venue: | The Gallery, 29-29a Durgate St, Dorchester, DT1 1JP |
| Times: | Each of the three sessions run between 2pm to 4pm. |
| Refreshments: | Tea and Coffee is provided. |
Wellbeing Toolkit

The Wellbeing Toolkit is a self management tool. It consists of 40 statements which challenge a person to assume personal responsibility for their own recovery and wellbeing.

Completing a toolkit has been shown to be a positive and uplifting experience. It is not a therapy in itself but a framework on which all other therapy can be hung, a skeleton on which the flesh of hope and recovery can be applied.

The kit is wholly owned and personalised by the person completing it. They define how it will look and how it will be used. They decide if they are going to complete all 40 statements or just those that are relevant. The kit is intended to be a personal self help manual written by a person about a person. It may include inspirational quotes, music, uplifting pictures, encouraging ideas, therapies and anything else that has been shown to work for that person.

The course takes place over three sessions. One full day followed by two half days at one week and three week intervals. All course materials are supplied.

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<table>
<thead>
<tr>
<th>Dates:</th>
<th>21/05, 28/05, 11/06</th>
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<tbody>
<tr>
<td>Venue:</td>
<td>Leon Centre, 13 Fernhill Avenue, Weymouth, DT4 7QU</td>
</tr>
<tr>
<td>Times:</td>
<td>The first day runs from 10am to 3pm. The following two sessions run between 1pm and 3pm.</td>
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<tr>
<td>Refreshments:</td>
<td>Tea and Coffee is provided. Please bring your own lunch.</td>
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<thead>
<tr>
<th>Dates:</th>
<th>18/06, 25/06, 09/07</th>
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<tbody>
<tr>
<td>Venue:</td>
<td>Room B304, Bournemouth House, Lansdowne Campus of Bournemouth University, Christchurch Rd, Bournemouth BH1 3LH</td>
</tr>
<tr>
<td>Times:</td>
<td>The first day runs from 10am to 3pm. The following two sessions run between 1pm and 3pm.</td>
</tr>
<tr>
<td>Refreshments:</td>
<td>All refreshments can be purchased from the cafeteria in the main reception.</td>
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</tbody>
</table>
Early Warning Signs

The course Early Warning Signs provides people with an opportunity to develop their own early warning signs ‘signature’, and to think about what happens when they start to become unwell.

Recognising your Early Warning Signs can be a really powerful way in helping you self-manage and highlight to others what support you require should you begin to become unwell. In this course, the trainers work with you to formulate an advanced plan which you can take with you and share with those who you feel would find it beneficial. For example, part of your advanced plan might be that when you feel more anxious than usual it is helpful to phone a friend and organise to do something together. Or perhaps it involves you sharing your plan with your care co-ordinator so that if you become unwell, you have formulated your own package of care that could then be taken forward.

Recovery is about regaining control, control of your life, control of your opportunities and control of your wellbeing. This course is designed to reaffirm your feelings of control and discuss ways in which you can remain in control and make your own choices.

The Early Warning Signs course is delivered in a single session.

<table>
<thead>
<tr>
<th>Dates:</th>
<th>7th June</th>
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<tbody>
<tr>
<td>Venue:</td>
<td>Leon Centre, 13 Fernhill Avenue, Weymouth, DT4 7QU</td>
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<tr>
<td>Times:</td>
<td>10am to 4pm.</td>
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<tr>
<td>Refreshments:</td>
<td>Tea and coffee is provided. Please bring your own lunch.</td>
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<table>
<thead>
<tr>
<th>Dates:</th>
<th>4th July</th>
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<tbody>
<tr>
<td>Venue:</td>
<td>Room B304, Bournemouth House, Lansdowne Campus of Bournemouth University, Christchurch Rd, Bournemouth BH1 3LH</td>
</tr>
<tr>
<td>Times:</td>
<td>10am to 4pm.</td>
</tr>
<tr>
<td>Refreshments:</td>
<td>All refreshments can be purchased from the cafeteria in the main reception.</td>
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</table>
**Introducing Recovery**

Introducing Recovery explores both the concept and the practicalities of achieving recovery in mental health. This is a dynamic and interactive course which provides people with an opportunity to examine their own attitudes and beliefs about recovery and which may lead to a change in perspective or outlook. The course celebrates how recovery may differ from one person to another, and provides a framework in which individual difference and strengths can be identified and promoted.

This course a unique opportunity to benefit from exploring current thinking around recovery in mental health by focusing on the importance of being person-centred, optimistic and instilling hope.

The Introducing Recovery course is delivered in a single session.

<table>
<thead>
<tr>
<th>Dates:</th>
<th>2nd May</th>
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<tbody>
<tr>
<td>Venue:</td>
<td>Wareham Library, South Street, Wareham, BH20 4LR</td>
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<tr>
<td>Times:</td>
<td>10am to 4pm.</td>
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<tr>
<td>Refreshments:</td>
<td>Tea and coffee is provided. Please bring your own lunch.</td>
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<tr>
<th>Dates:</th>
<th>8th May</th>
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<tbody>
<tr>
<td>Venue:</td>
<td>Seminar Room, Bridport Community Hospital, Hospital Lane, North Allington, Bridport, Dorset, DT6 5DR</td>
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<tr>
<td>Times:</td>
<td>10am to 4pm.</td>
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<tr>
<td>Refreshments:</td>
<td>Please bring your own refreshments.</td>
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<table>
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<tr>
<th>Dates:</th>
<th>23rd May</th>
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<tr>
<td>Venue:</td>
<td>MacMillan Centre, Christchurch Community Hospital, Fairmile Road, Christchurch, BH23 2JX</td>
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<tr>
<td>Times:</td>
<td>10am to 4pm.</td>
</tr>
<tr>
<td>Refreshments:</td>
<td>Please bring your own refreshments.</td>
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Working 2 Work

Work is good for both physical and mental health and well-being. Everyone can work if they are in the right job and if required, had the right support.

Working 2 Work is for those who want to believe they can work, for those who want to find a way into or back to work, and for those who feel their mental health history may be a barrier to work.

This course will give you the opportunity build on your existing skills and strengths and gain confidence to make concrete steps towards work. You will gain information about services available to help you towards work, gain support to help you identify what you want to do and the next steps in achieving employment, as well as finding ways to overcome the obstacles that you may face.

Everyone will have the opportunity to develop of Curriculum Vitae.

The Working 2 Work course is delivered in a six weekly sessions.

<table>
<thead>
<tr>
<th>Dates</th>
<th>11/06, 18/06, 25/06, 2/07, 9/07, 16/07</th>
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<tbody>
<tr>
<td>Venue</td>
<td>IT suite in the Buckland Centre,</td>
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<tr>
<td></td>
<td>11 Shelley Road, Boscombe, BH1 4JQ</td>
</tr>
<tr>
<td>Times</td>
<td>10.00am to 12.30pm.</td>
</tr>
<tr>
<td>Refreshments</td>
<td>Tea and coffee is provided.</td>
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</table>
Enrolling and registering with the REC

If you are interested in attending courses offered by the Recovery Education Centre, please contact the centre’s co-ordinator on:

Telephone: **07789 983863**

Email: **recovery.educationcentre@dhufft.nhs.uk**

The next step is to register with the Recovery Education Centre. The registration form can be downloaded from the internet:

**www.dorsethealthcare.nhs.uk/recovery** - we can also post it or email onto you, and then you can email it back!

We also hold registration events. These will be arranged throughout the term, so please contact us for further information about your nearest one.

Once you are registered with the Centre, we will contact you to arrange enrolment onto the courses that you wish to attend.

At enrolment, we ask that you bring with you a photographic form of identification, such as your driving license or passport. If you don’t have any photographic identification please contact the REC co-ordinator who will be able to help.

One part of enrolment is the completion of an Individual Learning Plan which formulate your learning aspirations, longer term wishes and can be used to help you map progress made towards these goals.
Learning suited to your needs

Traditional education settings, sitting in a classroom and hurriedly taking notes, are not suited to everyone nor are they especially enjoyable to attend. Consequently we have designed courses that move away from this model of teaching, we provide opportunities for discussion, promote independent learning, and offer an environment which is open to all opinions, questions and thoughts.

All of the courses offered vary in length; from a single hour session, to a series of workshops over several weeks. The classes, seminars, and workshops don’t rely on you having fantastic reading and writing abilities, the only thing that we ask is that you want to attend the course.

Is it learning for learning’s sake?
No, is the short answer! The aim of the Recovery Education Centre is to help students to achieve their personal goals. This is why, alongside you, we help you to develop your own individualised ‘Individual Learning Plan’. The plan will ask you to identify both short term and long term goals; it is the responsibility of the Recovery Education Centre to support you in both, setting these goals and in supporting you to achieve these goals.

The idea of setting goals might be a little daunting but there really is nothing to worry about. The purpose is to ask you to think about what it is that you might want to do, or what skills you might like to gain, which will then help you in your everyday life.

Do I need books, or other equipment for the classes?
It might be helpful for you to bring along a notebook and pen. Any other materials that you might need will be provided by the course trainer. We have a selection of books in our library that you might find interesting also.

What if I can’t attend?
We understand that sometimes things happen and they get in the way of our initial plans, whether it’s because the bus was late, or you’re not feeling well. It is helpful if we know that you’re unable to attend. If you would like to withdraw your place on the whole course, if you could let us know then your place can be offered to someone else. It is also possible to defer your place on a course in the next term.

What if I don’t like the course?
Well, that’s ok! We review the content of each course regularly, and so your feedback (both positive and negative) can help us to design and offer courses that meet the needs of our students. If you would like to swap onto another course just speak with our REC co-ordinator who will be able to help you.
Beyond the Recovery Education Centre

...Making the Future

The Recovery Education Centre brings you and other people together to help realise and inspire individual and collective potential. The courses offered build confidence and provide support to help you access opportunities. We believe that it is not merely what you know, but what you can do with your knowledge and acquired skills.

As well as learning opportunities offered by the Recovery Education Centre you can join other colleges in Dorset, or enrol onto programmes which enable you to learn from home. If you would like further information about this please speak with our Recovery Education Centre co-ordinator who will be able to help in the first instance.

Education can also be a pathway to vocational opportunities. With greater insight, and progression with personal discovery challenges in the workplace might interest you. If you would like to meet with a member of the team to discuss vocational opportunities, in the community, please get in touch with us!
FAQ

**If someone is a peer specialist, what does it mean?**

Peer Specialists represent lived experience of mental health illness. Importantly they model recovery, and through this are able to instil hope for the future. They provide recovery coaching to staff and people who access services and also lead on range of specific projects and activities which take place in the community and within organisations.

**How is the content of the course designed?**

All of the courses delivered by the Recovery Education Centre are co-designed and co-delivered by both a Peer Specialist Trainer and an NHS member of staff. We believe that course design in this way brings together different perspectives and expertise which can then be utilised in an educational framework.

**Can I get help in making sure I choose the right course?**

Of course! Before you are able to attend a course offered by the Recovery Education Centre it is important that you attend an enrolment appointment with the REC co-ordinator and a Peer Specialist. At this appointment we will discuss the courses that you might like to attend, and offer any support in choosing courses if you feel that you might like some guidance.

**What if I find that I need support with my learning once the course has started?**

Please contact the REC co-ordinator, as we will be able to work with you in order to put a plan in place ensuring that your learning needs are met.

**How will I know when I need to apply?**

The Recovery Education Centre runs Registration and Enrolment days throughout the term at different venues in Dorset. To find out when your nearest one is being held, please contact the REC co-ordinator.

**What if I need support with my mental wellbeing whilst attending the Recovery Education Centre?**

The Recovery Education Centre operates in a similar way to a Further Education establishment (such as a college). Therefore we do not provide clinical interventions, as we expect you to be able to access support outside of the centre. If you are feeling distressed whilst attending a course it is important to speak with your trainer. Your trainer will have access to your ‘Personal Support Plan’ which is formulated at the point of enrolment.

**Where can I get more information from?**

More information about the Recovery Education Centre can be found on our website at: www.dorsethealthcare.nhs.uk/recovery or www.dorsetmentalhealthforum.org.uk

You can also contact the REC co-ordinator on: 07789 983863 or send us an email: recovery.educationcentre@dhuft.nhs.uk

**Does the Recovery Education Centre monitor my learning?**

Your Individual Learning Plan will help you monitor your learning, as at the point of review we will look at your progress towards attaining the goals that you set.

**How can I get involved with the Recovery Education Centre?**

The REC co-ordinator will be able to help, and sign post you on to other 3rd party organisations.

**What if I want to bring a family member or friend with me?**

Everyone is welcome at the Recovery Education Centre; all we ask is that your family member, friend or supporter also enrols onto the same course. They will also gain a lot from the course!

**Is food and drink provided?**

Most of the venues offer tea and coffee, although sometimes this may need to be purchased (depending on the venue’s facilities). We are not able to provide lunch, and it is advisable that you bring something with you if the course lasts all day – just in case the shops are a distance away from the venue.
Contact Us

We love hearing what you have to say, and we welcome all enquiries. If the courses that we offer don’t meet your needs please let us know, as we are always looking to develop the programme of courses that we have.

The Recovery Education Centre operates in the virtual sense. We have two main premises, one in Pokesdown and one in Dorchester. The courses offered are mainly held out of venues in the community, so that hopefully students don’t have to travel too far to attend one of the courses offered.

If you would like to come and chat about the courses offered or the Recovery Education Centre in general please get in contact with us.

Email: 
recovery.educationcentre@dhufft.nhs.uk

Telephone: 
07789 983863

Post:
Recovery Education Centre,
c/o 843 Christchurch Rd, Pokesdown,
Bournemouth, BH7 6AR
The
Recovery
Education
Centre

Dorset Mental Health Forum
promoting wellbeing & recovery

Dorset HealthCare University NHS Foundation Trust

The Dorset Wellbeing and Recovery Partnership
Recovery Education Centre Pilot Term Report July 2012

"I believe what you are offering is vital for someone like me to move forward, and will speed up my recovery process and give me something to focus on (and probably a lot more). I really hope it keeps growing and continues.” Dorset REC student feedback, June 2012

1.0 Introduction

1.1. The Wellbeing and Recovery Partnership has completed their pilot term. The term ran between 2 May and 16 July (inclusive). Students were able to register with the REC from 4 April. This report outlines the feedback received from the students who attended the courses run by the Recovery Education Centre (REC). This report also describes the continuing evaluation and development of the REC.

1.2. The REC is not an actual centre, but a series of courses that are offered in various locations across Dorset.

1.3. The REC is based on a Further Education (FE) model; all the people who access the REC do so as students. Students first need to register with the college, they then undertake an individual learning plan (ILP) with the REC coordinator to identify which course they would like to attend and which courses would best aid them to meet their goals. For students who are planning to attend a number of courses IPLs are reviewed once a term.

1.4. All courses are co-produced and co-delivered by qualified NHS clinicians and people with lived experience of mental health problems.

1.5. All courses are open to people who access mental health services, their carers and supporters, and staff. The exclusion and inclusion criteria are similar to that of an FE college.

1.6. The REC holds no clinical responsibility for people attending courses (see REC Operational Policy for more information).

1.7. The aims of the REC are as follows:

- To provide people with the tools and skills to self-manage, through partnership of expertise by experience and professional expertise.
- To enable people to take control of their lives and be able to move beyond mental health services and mental illness.
- To improve service outcomes in relation to both personal recovery and clinical outcomes.
- To enable people to invest in themselves within an educational framework.
- To improve people’s experience of mental health services (including those who work within them and carers and supporters).
- To enable people to make the best use of mental health service.
- To provide a vehicle that reconceptualises mental health services through readdressing the imbalance of power. By promoting an educational model people can learn for themselves and recognise everyone’s potential as an expert.
- To bring people together to realise and inspire individual and collective potential.
1.8. The REC pilot term included the following courses:

- Wellness Workshop
- Introduction to Recovery
- Wellbeing Toolkit
- Early Warning Signs
- Working 2 Work
- Recovery Narratives

1.9. The majority of courses ran twice, once in the east of the county and once in the west. In total twelve courses ran. Initially it was planned to run thirteen courses, however, one of the Introduction to Recovery courses was cancelled as we were unable to market it quickly enough between the launch of the prospectus and the start of the course. This has therefore not been included in the evaluation.

2.0 Feedback and Evaluation

2.1. Registration:

2.1.1. 78 students registered an interest in attending a course offered by the REC. 66% were female and 34% male. Students registered had an average age of 44 years (range 48 years, minimum age 23 years maximum 71 years). Two students over the age of 65 years registered and attended courses provided by the REC. For the purpose of this report, students who have registered after 16 July have not been included.

2.1.2. Students were asked to select the capacity in which they were accessing the REC: User of Service, Staff Member, Carer/ Supporter/Family/Friend/. Students were able to choose more than one option. 21% of students’ selected more than one option; indicating the importance of recognising that people may hold ‘multiple identities.’

2.1.3. The most represented target student population was ‘User of Service’ with 41% of student’s selecting that option. 23% of students selected ‘Carer / Supporter / Family / Friend’ which was the second most commonly chosen (see Figure 1).

*Figure 1 includes students who selected ‘multiple identities’. Each identity selected was considered independently.
Other organisations accessing the REC included staff working for Richmond Fellowship and Dorset County Council.

2.1.4. The majority of people who identified themselves as accessing a service are doing so in the community. Only 12% of students stating they access a service were currently an inpatient (either at St Ann’s or Nightingale House). None of these 12% attended a course offered by the REC, although they were all offered a place. Reasons for this included:

- Not all staff working with the individual were aware of their registration and plans to attend courses (uploading the letter of confirmation to RiO was not sufficient); neither REC staff nor staff working with the individual followed this up with them.
- Staff and the individual remain unclear about what the REC is, and how it operates.

2.1.5. The majority of students registered with the REC live in Bournemouth and Poole, although this is unsurprising given the geography of Dorset. 43% of Dorset’s population live in Bournemouth and Poole, and 22% in West Dorset (incl. Weymouth, Portland and Dorchester). More courses were offered in the more urban areas. It is worth noting that other commonly cited locations were those where courses were offered, for example Sherborne and Christchurch (see Figure 2).

Figure 2: Number of students registered with the REC categorised by locality

* Several NHS staff recorded their contact details as being their place of work.

** Students with a contact address outside Dorset were NHS staff members.

2.2. Enrolment and Attendance:

2.2.1. In total 132 places were available to students with 75% being filled. In total 49 different students attended a course offered by the REC. On average students attended just one course offered by the REC.
2.2.2. The percentage of course places filled could have been higher if we had allowed more time to market the courses. (In the first three weeks we would have needed to register 60 students to fill the first three courses.) As the term progressed courses were fully booked and we are now running waiting lists for all of the courses for the Autumn term.

2.2.3. The self-selected identities of students were almost the same as registrants: 42% people who access services, 25% carer or supporter, 14% NHS staff, 14% Dorset Mental Health Forum Staff, 5% other.

2.2.4. 80% of students with a confirmed place attended at least one session and of these 69% completed the course. The biggest attrition rate was seen for courses spanning 3 sessions or longer.

2.2.5. 4% of places were deferred by students due to a decline in health and extenuating circumstances.

2.3. Feedback Forms:

2.3.1. 80% of the students who attended the courses completed feedback forms. The feedback form had a place for comments and a rating scale. See Figure 3. The quotes taken from the feedback forms were extremely positive.

“It was great. I got far more out of it than I could imagine”

“Thoroughly enjoyable! Even though I don’t have an illness myself I feel I have got a lot from the course.”

“Being able to talk openly and honestly with no embarrassment or anxiety demonstrated how far I’ve come.”

“Attending the course … makes me feel part of something, not alone or out of the ordinary, which I do the majority of the time … I feel I have already benefited from it.”

Figure 3: Graphical representation of course feedback – pooled data across courses and locations. Total number of feedback forms included: 55.
2.3.2. Of the 55 feedback forms completed all but one rated the majority of areas for evaluation as 'strongly agreed' or 'agreed', particularly in relation to the aims and objectives of the course being explained, met, and people wanting to do further REC courses. One person rated all areas as strongly disagree but this may have been an error as the written qualitative comments on the form were positive.

2.3.3. 97.8% of students responded positively about the REC, marking 'agree' or 'strongly agree' for attending another REC course.

2.3.4. There is some learning for the REC regarding people having knowledge and awareness of the course content to ensure it is what they expected. Verbal feedback has shown that people had not experienced anything like the REC before in terms of joint learning, and their comments were meant in a positive sense. “The course was not what I expected, but was better as it allowed me to develop professionally and personally.”

2.3.5. There have also been issues relating to certain venues which need exploring. Interestingly NHS venues did not appear to impact on people’s ability to engage as a student and it was clear that what was important was that the room was able to be set up as a classroom or learning environment.

2.3.6. We also held evaluation meetings for each of the courses, examining what went well and what could be changed. A number of the courses have now been made more ‘educational’ whereas in the pilot term their emphasis leant heavily towards peer support or had too much of a clinical focus.

2.3.7. Also discussed was the need to have sessions aimed at people who were too unwell or had difficulty engaging, which did not necessarily sit within the REC, but could signpost people towards the REC. It was therefore decided the Wellness Workshop would sit outside the REC, but be delivered in every locality and inpatient unit to meet that need.

3.0 Marketing:

3.1. The initial marketing of the REC included discussions with senior staff members about the development of the programme, e.g. the Directorate Management Group, and the Practice and Quality Meeting.

3.2. Where possible both an NHS member of staff working within the REC and a Peer Trainer attended both inpatient and community team meetings across Dorset. This joint approach was not possible for each visit made. We were unable to visit all teams within the time constraints.

3.3. Presenting to carers groups helped spread the word, and although the registration events were not well attended, they did provide a useful number of students for the REC.

3.4. Staff working within teams were encouraged to consider the benefits of attending a course for their own development (personal and professional) and so be familiar enough with the programme offered to enable them to signpost others to the education centre.

3.5. From the data obtained it is evident that most students registered an interest in the REC through having had a discussion with someone about the project, rather than through electronic means of communication or advertising. Students did not cite the 'internet' as a source of information about the REC. See Figure 4 for an overview.
Figure 4: Graphical display of how students heard about the REC

![Graphical display of how students heard about the REC](image)

3.6. If we look specifically at the data based on locality for people who access mental health services we can see which areas our marketing was most effective. Poole and the Purbeck areas were most notable in limited numbers of people who access services. For the next term we will need to adjust our marketing strategy.

Figure 5: Service Accessed Grouped by Locality

![Service Accessed Grouped by Locality](image)

4.0 Research and Development:

4.1. We are working closely with the University Department of Mental Health at Bournemouth University to develop a number of research proposals. We are currently undertaking a study looking at the experience of students and trainers within the pilot term. We are also in the process of planning a research project looking at the cost-effectiveness of the REC in relation to Quality of Life Adjusted Years Outcomes.
5.0 Key Learning Points:

- To improve marketing (making it more specific and targeted informed by the above data), and to start the marketing process earlier, particularly in rural areas.

- To give the information about the REC to people in a clear and succinct way, particularly those on inpatient wards, and to work closely with staff to facilitate inpatient attendance.

- To offer the REC courses in more diverse locations across the county, particularly in the rural areas.

- To review our evaluation forms so that we obtain feedback which will better inform REC development, particularly around ensuring good retention on the courses and increased compliance in completion to 90%.

- To explore how to improve attendance rate from a place being offered to actually attending the course.

- To ensure that all venues are comfortable and provide a positive learning experience.

- When people complete their ILPs, to ensure that the course content is explained to them and they both signposted to the correct course and also on to other opportunities outside of the REC.

- To offer peer-led initiatives that engage people outside the REC (particularly those who may be too unwell to attend) but that can signpost into the REC, for example Wellness Workshop.

- To expand to meet demand, offer a broader range of courses, and conduct more robust evaluation. We are planning to offer approximately 20 different courses next term, on 40 different occasions.

- To engage with teams and individuals to identify NHS trainers to deliver on courses, and ensure these trainers are released by their managers.

- To move towards an accredited training for trainers course for all REC trainers.

- To look at income generation opportunities around REC courses (Dorset Mental Health Forum have already been approached by a number of organisations around providing training in response to the REC). To ensure REC staffing infrastructure is able to meet this demand.

- To ensure the REC is developed in line with potential funding streams, e.g. PBR, IAPT in order to build sustainability.

- Future consideration is also required regarding the possibility of premises which could hold the library and information centre for the REC.

- To feed back progress to the Directorate Management Group and James Barton in order to take the REC forward.
6.0 Conclusion:

6.1. The initial feedback from the Recovery Education Centre has been extremely positive and it has huge potential. It is important that the REC now increases in scale, incorporating the above learning points, so that we can measure its impact more broadly.

Phil Morgan  Sarah Rose  Jackie Lawson
Recovery Co-Lead  Business Co-Ordinator  Recovery Co-Lead
Dorset HealthCare  Dorset Mental Health Forum  Dorset HealthCare

Phil Morgan and Jackie Lawson
Recovery Co-Leads
Dorset HealthCare University NHS Foundation Trust

Sarah Rose
Business Co-Ordinator
Dorset Mental Health Forum
Promoting Emotional Health and Wellbeing in Portland Young Offenders Institute

PILOT Outcome Report: Wellbeing Toolkit Programme

Summary

The Wellbeing Toolkit has been piloted in the Young Offenders Institute (YOI) on Portland. The aim of the toolkit is for participants to be able to better manage their emotions and develop a positive focus for the future. The early indications from these pilots are that there is evidence that the Wellbeing Toolkit, on completion of the course, has a positive impact on the emotional wellbeing of most of the participants.

Our recommendations are

- to continue to run the Wellbeing Toolkit within the YOI
- to run a pilot course in an Adult prison within Dorset
- to explore the possibility of developing a mentoring programme to run within the prison for graduates of the toolkit.

Introduction

The Wellbeing Toolkit is a self-management tool that has been developed and designed by Bob Shaw on behalf of the Wellbeing and Recovery Partnership. Bob Shaw is a peer specialist consultant and has applied his own experience of mental health problems and using mental health services to design this Toolkit. The Wellbeing Toolkit differs from other self-management tools as there is a great focus on a person’s values. This toolkit has been adapted for use within the YOI on Portland.

The purpose of these programmes is to support the young offenders to increase their emotional resilience, through having an increased: sense of purpose and identity; ability to “self-manage” their emotions; and understanding the links between their emotions and their behaviour.

The toolkit also creates the opportunity for the young offenders to have an overview of their life both within the prison and outside, to see how they can integrate what they have learnt in the prison into their lives outside.

This project is being funded by the South West Development Centre as part of the local Improving Access to Psychological Therapies services for 2010/11 towards developing Emotional Health and Wellbeing Services. The project is being delivered by the Wellbeing and Recovery Partnership, which is a partnership between NHS Dorset: Community Health Services, Dorset Mental Health Forum and Dorset HealthCare.
University NHS Foundation Trust. For the purpose of this project the partnership is also between Dorset PCT and Dorset Mental Health Forum.

Outline of the Sessions

Format for the sessions are:

- One group session introduction to the toolkit by Bob Shaw giving an overview of its use and purpose.
- 6 individual sessions with Healthcare Support Workers, working through each section of the toolkit.

Participants

There have been three courses with a total of 16 participants. The participants have been selected from referrals from Benbow and Beaufort Wings. These wings were chosen because of their links with healthcare and the vulnerable nature of the inmates on these wings.

The idea was to target those who are referred to primary care mental health or identified by wing staff but who do not meet the threshold for intervention although they have clearly identifiable needs in regard to promoting their emotional resilience. This could be understood to be step one in the stepped care model for primary care. People who exceeded this threshold were not excluded. A number of participants met the threshold for secondary care services.

All but one participant completed the course.

Outcomes

This pilot project is being evaluated through the use of the Recovery Star and reflective accounts from the participants and facilitators. In the project development it was suggested that the Warwick Edinburgh Wellbeing Scale could be used. It was agreed that prior to the pilot it would be adapted locally to reflect more accurately the needs of the prison population. However, following further discussions it was agreed that only the Recovery Star would be used. The young offenders self-rated using the Recovery Star.

The majority of participants scored the same or showed improvement in at least one domain. Only three participants rated no change. The two domains that saw the most significant change were:

- Managing Mental Health: 10 out of 13 people rated an improvement in managing their mental health
- Trust and Hope: 8 out of 13 rated an increased sense of Trust and Hope.

The biggest mean increases in scores pre and post the programme were in Managing Mental Health, Trust and Hope, Identity and Self Esteem and Relationships.
Following further discussions with Commissioners it was agreed that in addition clinical measures would be used. The GAD-7 (measuring anxiety) and PHQ-9 (measuring depression) assessments were completed for the last group. Unfortunately the data for this group is incomplete due to one of the staff members going on long-term sick. The plan is for this measure to be used with future groups. Of the two participants for which we have complete data, both saw a reduction in their PHQ-9 score (from 9 to 6 and 17 to 9). One reduced their GAD-7 (from 9 to 6) and the other stayed the same.

In addition, we asked the young offenders to write a reflective account of their experience. Some people identified that it had strengthened ties to their families; some people used it to manage their emotions within the prison environment; others described it as being useful in planning the future. As part of the reflective process one of the participants met with Commissioners and the project team on 27th January 2012 to talk about the benefits of the toolkit. He spoke passionately about the toolkit and how it had helped him identify what he wanted to do in life and how the toolkit enabled him to do this. He stated his aim was to “make his mother proud”. He was able to articulate how the toolkit could both help him maintain his mental health and reduce his chance of reoffending. He also made suggestions that the toolkit could be enhanced by having peer mentors – offenders who had been through the course supporting others.

The toolkit also enabled the service to pick up unidentified needs and two clients were picked up by the Prison Mental Health Inreach Team as additional support needs were identified. It also facilitated two men being discharged from the Prison Mental Health Inreach Team and one from the Primary Care Mental Health Team.

### YOI Pilot Outcomes

<table>
<thead>
<tr>
<th></th>
<th>Before</th>
<th>After</th>
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<tbody>
<tr>
<td>Trust and Hope</td>
<td>4.7</td>
<td>6.5</td>
</tr>
<tr>
<td>Identity and Self Esteem</td>
<td>4.8</td>
<td>6.7</td>
</tr>
<tr>
<td>Responsibilities</td>
<td>6.1</td>
<td>6.8</td>
</tr>
<tr>
<td>Addictive Behaviour</td>
<td>5.9</td>
<td>6.6</td>
</tr>
<tr>
<td>Relationships</td>
<td>5.6</td>
<td>7.2</td>
</tr>
<tr>
<td>Work</td>
<td>6.8</td>
<td>7.2</td>
</tr>
<tr>
<td>Social Networks</td>
<td>7.0</td>
<td>8.1</td>
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<tr>
<td>Living Skills</td>
<td>7.6</td>
<td>8.0</td>
</tr>
<tr>
<td>Self Care</td>
<td>5.9</td>
<td>8.6</td>
</tr>
<tr>
<td>Managing Mental Health</td>
<td>5.9</td>
<td>8.8</td>
</tr>
</tbody>
</table>

3
Conclusion

From the outcome data from the Recovery Star and the Wellbeing Toolkit there appear to be benefits for the young offenders, particularly in relation to managing their mental health, which is the main aim of the toolkit. Some of the young offenders were also able to use the toolkit to manage their emotions and frustration. In addition, it enabled them to take stock of their lives in a safe supportive manner. It would appear the toolkit may have some benefits for a broad range of prisoners.

There is potential that links between the Wing and Healthcare can be strengthened through this approach and also the relationship between prison staff and the young offenders.

The toolkit enabled staff to identify needs and goals which had not been previously picked up. This could have a significant impact on individuals’ health and likelihood of reoffending.

Recommendations

We are pleased with the initial outcomes from the three pilot sessions and we are due to run a two more courses before April 2012. We will continue to collect data on the outcomes of these courses, including the clinical outcome measures.

This course offers the prison a unique opportunity for the young offenders and prisoners to take stock and recognise their own skills and resources, build coping skills, build relationships, identify goals for the future and integrate all the different forms of learning they experience in prison. It also creates an opportunity for greater integration between the Wings and Healthcare (and potentially education, resettlement and all other areas of the prison).

We would recommend the following:

- The commissioning of the toolkit course within the YOI for the next year for further evaluation.

- The commissioning of a pilot within an adult prison within Dorset.

- The commissioning of a project developing peer mentors within the prison to promote the use of the toolkit and support prisoners to complete their toolkits.
# APPENDIX 1

<table>
<thead>
<tr>
<th>Reason for Referral</th>
<th>Other information</th>
<th>Descriptive Outcome</th>
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</thead>
<tbody>
<tr>
<td><strong>First Workshop: July 2011</strong></td>
<td></td>
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</tr>
<tr>
<td>A</td>
<td><strong>Self-harming behaviours, low self-esteem and behaviours on the wing. Having difficulty getting off basic.</strong></td>
<td><strong>Prior to workshop on Primary Care Mental Health Team (PCMHT) caseload.</strong></td>
</tr>
<tr>
<td>B</td>
<td><strong>Unable to manage daily needs and the prison regime independently.</strong></td>
<td><strong>Learning disabilities.</strong></td>
</tr>
<tr>
<td>C</td>
<td><strong>Following self-harm incident.</strong></td>
<td><strong>Did not meet threshold for PCMHT but was deemed to benefit from needing some further support.</strong></td>
</tr>
<tr>
<td>Reason for Referral</td>
<td>Other information</td>
<td>Descriptive Outcome</td>
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<tr>
<td>D</td>
<td>Increase ability to manage his behaviours.</td>
<td>with Prison Mental Health Team.</td>
</tr>
<tr>
<td></td>
<td>Psychosis, currently under care of Prison Mental Health In-Reach Team. Currently declining any prescribed medication.</td>
<td>D read toolkit when feeling angry and stopped acting out. It “made me look at my life and want to change it”. “There’s more to life than drugs.”</td>
</tr>
<tr>
<td>E</td>
<td>Raise self-esteem and build confidence.</td>
<td>“It has helped me realize how certain things calm me down. If something arises and I get angry the toolkit is something that helps me keep calm.”</td>
</tr>
<tr>
<td></td>
<td>Previously discharged from PCMHT in November 2011 following period of suffering from anxiety.</td>
<td>E identified the toolkit to be a helpful coping mechanism and completed a food diary and sleep diary over the period of a week.</td>
</tr>
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<td></td>
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<tr>
<td><strong>Second Workshop- September 2011</strong></td>
<td></td>
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</tr>
<tr>
<td>F</td>
<td>Setting goals for future and within custody.</td>
<td>Stated the toolkit has “enabled me to think about the future” and the “people who are important to me”. Discharged from Prison Mental Health Inreach Team.</td>
</tr>
<tr>
<td></td>
<td>Psychosis, NOS Depressive Disorder, under care of Prison Mental Health Inreach Team with support from PCMHT.</td>
<td></td>
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<tr>
<td>G</td>
<td>Difficulty managing emotions.</td>
<td>Discharged from PCMHT.</td>
</tr>
<tr>
<td></td>
<td>Depressive Disorder. Under care of PCMHT.</td>
<td></td>
</tr>
<tr>
<td>H</td>
<td>Difficulty connecting with his emotions.</td>
<td>Identified links between his emotions and offending behaviour. Is servicing a long sentence and identified little hope for the future. Referred on for psychology.</td>
</tr>
<tr>
<td></td>
<td>ADHD, care of Prison Mental Health Inreach Team.</td>
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<tr>
<td>I</td>
<td>Difficulty managing his behaviour and sustain employment</td>
<td>“I didn’t think it would help me to start with but now I’ve started it’s helped me a lot as</td>
</tr>
<tr>
<td>Reason for Referral</td>
<td>Other information</td>
<td>Descriptive Outcome</td>
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<tr>
<td>J</td>
<td>Holistic emotional wellbeing.</td>
<td>“The more I do the more it will help me.” “Made me evaluate my life.” Showed to his father and could see benefits for his father to do a similar course.</td>
</tr>
<tr>
<td>K</td>
<td>Build links between DSH and emotions. Emotionally unstable and depression.</td>
<td>Discharged from Prison Mental Health Inreach Team back to primary care. “I have realized how certain things help me in life.”</td>
</tr>
<tr>
<td>L</td>
<td>Manage emotions more effectively. Low mood, anger and history of self-harm.</td>
<td>Using Toolkit as a thought diary and incorporating other work such as a suicide prevention plan with his support worker in the community. Plans to use toolkit when back in the community when he is struggling. Has also shared toolkit with his father and kept his father informed of his progress.</td>
</tr>
<tr>
<td>M</td>
<td>Poor engagement with mental health services. History of mental illness and non-compliance.</td>
<td>M attended 4 sessions. Did not complete course. Referred to GP due to low mood.</td>
</tr>
<tr>
<td>N</td>
<td>Lacking in confidence. Increased anxiety trigger by being in prison environment.</td>
<td>Previously undiagnosed OCD which was severely impacting on his ability to function. Referred to secondary services. In written reflection identified</td>
</tr>
<tr>
<td>Reason for Referral</td>
<td>Other information</td>
<td>Descriptive Outcome</td>
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<td></td>
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<td>the toolkit as an important first step in working out a plan for the future.</td>
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<tr>
<td><strong>O</strong> Expressing interest to change his offending lifestyle.</td>
<td>Referred to PCMHT. Long history of heroin use and low mood.</td>
<td>Identified toolkit has helped him manage his emotions.</td>
</tr>
<tr>
<td><strong>P</strong> Unable to identify positives for the future.</td>
<td>Referred to PCMHT due to low mood.</td>
<td>Stated to staff in offender management units that the course helped him recognize why he does not trust people and why he blocks feelings out and why this impacts on his empathy for others. No identifies needs to do further work around understanding his emotions.</td>
</tr>
</tbody>
</table>
APPENDIX 2 Recovery Star Outcomes

<table>
<thead>
<tr>
<th></th>
<th>Managing Mental Health</th>
<th>Self Care</th>
<th>Living Skills</th>
<th>Social Networks</th>
<th>Work</th>
<th>Relationship</th>
<th>Addictive Behaviour</th>
<th>Responsibilities</th>
<th>Identity and Self Esteem</th>
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</table>

Numbers in green indicate an improved score

*data not available.
APPENDIX 8
RECOVERY AND RISK ASSESSMENT AND MANAGEMENT
Recovery and Risk Assessment and Management

Risk and Recovery are not separate concepts. To recover people need to take risks in order to learn. The extent a person is able to take control of their own recovery is based on the extent they are able to take personal responsibility for their own wellbeing and the wellbeing of others. If people are unable to take considered risks this can lead to emotional harm as they are unable to develop and grow.

Enquiries into the deaths of people who have accessed mental health services frequently focus on the importance of engaging with the individual and how effectively services have been able to build connections with them, their supporters, and/or their communities.

Staff and services need to be skilled at engaging with the person, and have curiosity about who they are in terms of their identity, what is important to them, the important people around them and their community. Staff also need to be skilled at moving with the person depending on their mental state and capacity to take personal responsibility.

The minimum standard for a recovery orientated Risk Assessment and Management is to acknowledge the person and their supporters perspective in regards to their own risk assessment and management plans. This does not mean the service needs to agree with these perspectives, but rather they should be acknowledged and form the basis of on-going discussions.

The gold standard is the development of a joint plan which is led by the individual who is able demonstrate their own self-management and determine the response from services (if required) when they become unwell or distressed.

In order to develop skills around recovery orientated risk plans, our focus is on the development of joint crisis plans and therefore it is proposed that we develop a training video focused on building engagement and working towards joint crisis planning. We also need to create an organisational culture which supports staff being able to show curiosity, engage effectively and feel supported around making risk decisions.
Aspiration Towards Zero Restraint Project Plan

**Aim:** To explore how the experience of people accessing acute services can be transformed using recovery principles.

**Objectives:**

We want people to leave our acute service feeling:
- a renewed sense of hope and self-determination that could add meaning and purpose to their lives
- that they learned how to better manage their life circumstances so they could avoid this experience in the future

and for staff to feel that they had:
- The opportunity to learn to increase their skill in working with and caring for people

(Ashcroft and Anthony, 2012)

There are a number of key considerations in order to make Acute Services more recovery orientated:

- To improve the experience of all involved staff in acute care, people who are accessing the service, and their carers and supporters.
- How Peer Specialists can be used to work on wards to model recovery, instill hope in people when they are unwell and act as a bridge between staff and people who access the service.
- To analyse and understand the current use of Physical Intervention and identify opportunities to reduce it.
- To analyse and understand the current use of de-escalation and engagement and identify opportunities to increase it.

*Recovery Innovations* in Arizona decided that the use of restraint and seclusion was incompatible with a vision for recovery orientated service. They undertook a project within two of their crisis services that led to the use of restraint and seclusion reduced to almost zero. This project is testing the hypotheses to see if this is achievable within a UK context.

There are also current drivers encouraging services to eliminate “the use of face down take downs” (MIND, 2011), and to provide quality assurance around patient experience and that restraint is “used as a last resort with minimum force” and to focus on the development of de-escalation skills (NICE, 2011).

Through the Aspiration towards Zero Restraint we seek to review and refocus every aspect of a person’s journey through acute services in order to optimise their (and their carers and supporters) experience of the service and their develop of skills to help them manage through a crisis. In order to achieve this it is essential that we pay attention to the experience of staff, to build on their strengths and ensure that they receive the support required to engage fully in this service transformation.

This project plan is a revised plan, taking into consideration and learning from the initial project planning which looked to launch the project across the whole of the acute service
simultaneously. This revised project plan focuses on the development of pilot wards and a much slower approach to development.

<table>
<thead>
<tr>
<th>Project Area</th>
<th>Action</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Get high level sign up and agreement</td>
<td>Discussion with JJ, AH, JB on project brief</td>
<td>Jun 2011</td>
</tr>
<tr>
<td></td>
<td>Get Board Level Sign up</td>
<td>Sept 2011</td>
</tr>
<tr>
<td>Initial discussion and scoping exercise</td>
<td>Formal and Informal Discussions with team leaders, people who access the service, risk department key stake holders. Identify and address initial reservations or hopes about the project</td>
<td>April 2012</td>
</tr>
<tr>
<td></td>
<td>Undertake scoping exercise involving UDMH to ascertain peoples hopes and fears for the project.</td>
<td>August 2012</td>
</tr>
<tr>
<td>Physical Intervention Training</td>
<td>Design Training, that promotes recovery and puts the individual’s perspective at the heart of the PI training</td>
<td>March 2012</td>
</tr>
<tr>
<td></td>
<td>Commence Delivery of Training on monthly 5 day course</td>
<td>April 2012</td>
</tr>
<tr>
<td></td>
<td>Begin feedback session at end of 5 day course</td>
<td>June 2012</td>
</tr>
<tr>
<td></td>
<td>Develop video training for the refresher PI course</td>
<td>September 2012</td>
</tr>
<tr>
<td>Initial Pilot Phase</td>
<td>Identify Pilot Ward 1</td>
<td>September 2012</td>
</tr>
<tr>
<td></td>
<td>Initial discussions with ward manager and ward team. Identify key individuals to take the project forward from NHS.</td>
<td>September 2012</td>
</tr>
<tr>
<td></td>
<td>Deliver Recovery Training to pilot ward</td>
<td>September 2012</td>
</tr>
<tr>
<td>Task</td>
<td>Completion Date</td>
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<td>----------------------------------------------------------------------</td>
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<tr>
<td>Scoping exercise with ward staff undertaken by UDMH</td>
<td>October 2012</td>
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<tr>
<td>Formal Launch of project on Pilot Ward JB, JJ.</td>
<td>October 2012</td>
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<tr>
<td>Identify ward de-escalation champions, monitor and evaluate every de-escalation include learning points to develop ward managing difficult situations manual</td>
<td>October 2012</td>
<td></td>
</tr>
<tr>
<td>Undertake RCA for every PI situation, include learning point on how this could be avoided in the future, add to ward manual.</td>
<td>October 2012</td>
<td></td>
</tr>
<tr>
<td>Analyse PI data identify flashpoints for use of PI or any patterns</td>
<td>December 2012</td>
<td></td>
</tr>
<tr>
<td>Commence patient, and carer experience mapping exercise</td>
<td>October 2012</td>
<td></td>
</tr>
<tr>
<td>Commence staff experience mapping exercise (focus on freeing up staff to interact with clients, look at opportunities to celebrate success)</td>
<td>October 2012</td>
<td></td>
</tr>
<tr>
<td>Complete experience mapping exercise and develop experience pathways with standards</td>
<td>February 2012</td>
<td></td>
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<tr>
<td>Pilot Phase 2</td>
<td></td>
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<tr>
<td>Identify second pilot ward and develop action plan based on above actions and any learning that has taken place.</td>
<td>March 2012</td>
<td></td>
</tr>
<tr>
<td>Data Collection</td>
<td></td>
<td></td>
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<tr>
<td>Ensure data collected is as accurate as possible, discuss with JJ and acute care forum</td>
<td>September 2012</td>
<td></td>
</tr>
<tr>
<td>Identify outcome measures around hope, opportunity and control</td>
<td>October 2012</td>
<td></td>
</tr>
<tr>
<td>Section</td>
<td>Description</td>
<td>Date</td>
</tr>
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</tr>
<tr>
<td>Teams monitor</td>
<td>Teams monitor and review own data, celebrate success.</td>
<td>October 2012</td>
</tr>
<tr>
<td>Links with</td>
<td>Identify those individuals who often require PI when admitted to hospital and work with community teams and the person and their carers to look how the use of PI could be reduced when they are admitted. – Find lead for this part of the project</td>
<td>February 2012</td>
</tr>
<tr>
<td>Community Teams</td>
<td>Link into broader project looking at the development of joint crisis plans</td>
<td>February 2012</td>
</tr>
<tr>
<td></td>
<td>Encourage people to have expressed wishes, advanced directives and information for staff which tells them about who they are a person and what is important to them.- Find Project lead for this part.</td>
<td>February 2012</td>
</tr>
<tr>
<td>Section 136</td>
<td>Gather evidence of number of PI situations around S136</td>
<td>March 2012</td>
</tr>
<tr>
<td></td>
<td>From information gathered consider specific project looking at S136 process</td>
<td>March 2012</td>
</tr>
<tr>
<td>Evaluate Project</td>
<td>Review project plan and progress to date, develop plan going forward</td>
<td>September 2013</td>
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</tbody>
</table>
APPENDIX 10
WELLBEING@WORK ACTION PLAN
Managing stress at work: Wellbeing@Work Action Plan

This document aims to give an overview of how to effectively support staff to manage stress within the workplace. This document gives a step by step guideline of how best to do this.

(a) The biggest impact on reducing sickness is “Making Work a Great Place to Be”. But you work for the NHS, how can this be? The things we know that improve working environments and promote wellbeing within teams are:

- Positive relationships within teams
- People having clear roles and responsibilities
- People having a control and say over their working life
- A supportive environment
- Acknowledging change can be a difficult process and trying to manage it more effectively
- Setting priorities for people that enable them to effectively manage the demands of their role

These are also the same areas identified for stress risk assessment (under HSE guidance). When these are not present it is more likely for people to experience ill health associated with stress at work. Issues relating to stress are rarely clear cut and are often a mixture of home and work stressors.

As a manager if you are aware of these areas you can try to promote these conditions.

(b) It is important as managers that we are available and create opportunities for informal discussion with individuals about wellbeing at work and offer encouragement, support and thanks. This also allows emerging issues to be “nipped in the bud.”

(c) In managing the wellbeing of your workforce, management supervision is an excellent opportunity to follow up any informal discussion or create a space for people to discuss how they are coping at work. It is a fine balance between being supportive and rescuing and solving someone else’s problems. Your role is not to rescue or solve the person’s problems but to support the person and what they need to do within the context of the team.

In order to discover the root of the problem or difficulty, it is important to ask open questions (in dealing with difficult situations it can be helpful to have some rehearsed questions or statements) such as, tell me about? How are you? I’ve noticed that…? Think about asking people about their work life balance.

Once a person has had the opportunity to express how they are experiencing their work it is important that any difficulties are backed up by facts or clear observed. For instance sickness absence and attendance reports are helpful in identifying patterns.

You may want to consider proactively completing a Wellbeing@Work Action Plan which is a supportive tool for staff and their managers to work through a stress risk assessment process in partnership.

(d) Once a problem is identified we can then look at what actions need to be taken and who can support you. Examples of common problems or stressors are: changing work arrangements; relationship pressures; potential job loss arising from financial pressures; work volume control; change of work base; accommodation changes; changing job requirements; grievance issues raised. If you are struggling for ideas on how to offer someone the most effective support it may be helpful to seek support from your peers and be mentored by someone more experienced. You can also phone HR (443120) or OH (443066) for an informal chat.

(e) Trigger points are identified in the Health, Wellbeing and Attendance Policy; however you can refer a member of staff at any time if you have concerns. When referring a member of staff please be clear as to why you want OH to see them and include any relevant background information. Ask yourself what questions you need answered and then include them on the referral form (for example: is the person able to undertake all the responsibilities required of them for their job? Is the person able to take part in physical interventions? Would this person benefit from a phased return to work? What are reasonable adjustments to make?)

People are also able to access counselling either through a staff counsellor (former B&P and Dorset HealthCare staff) or RightCore Care (former Dorset Community Health Services) is available to staff.

(f) It is as important as the initial identification of any problem to offer ongoing support and identify whether the person is putting any steps or suggested measures into practice and whether they are working or need to be refined.

Useful forms/reports to use to support someone at work:

- Wellbeing@work action plan document – draft overleaf.
- Stress risk assessment and action (see back of Stress policy)
- Sickness absence reports
- Department attendance sheet
This could be used to form a stress risk assessment

**What is going well, what strengths and resources do you have?**

**What is the difficulty/problem?**

**What is the impact on you and on the team and on the service?**

**What been done already (what’s worked and what hasn’t)?**

<table>
<thead>
<tr>
<th>Further action (who is going to do what)</th>
<th>By when</th>
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<tbody>
<tr>
<td>What are you going to do?</td>
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<td>What is the Service going to do?</td>
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</table>

**Comments**

**Signed:** Manager Signed:

**Date:** Date:
APPENDIX 11
LOCAL MEDIA COVERAGE
Help for those with mental illness

Help for those with mental illness

They are also offering an opportunity for individuals to hand over their own stories of mental illness for others to learn from.

In addition to the communication campaign, they are utilising the services of the Recovery Centre. The project aims to utilise the experience of staff to challenge negative attitudes towards mental illness and promote change.

The Recovery Education Centre provides people with education and tools to self-manage, promote choice, personal responsibility and ultimately control of their own wellbeing. The courses offered are available to people with personal experiences of mental ill health, their carers, friends and family, and also for staff members who work alongside people suffering with mental ill health.

All of the courses have been developed and are delivered by expert practitioners with a mental health doctor and a healthcare worker from Dorset HealthCare University and Foundation Trust.
Help for those with mental illness

THE Dorset Wellbeing and Recovery Partnership (between Dorset HealthCare University NHS Foundation Trust and Dorset Mental Health Forum) held a celebration event to launch three projects challenging stigma surrounding mental illness and promoting the principles of recovery.

The first project ‘What Recovery Means to Me...’ communication campaign illustrates the individual nature of people’s experience of recovery. For example, Terry states: “for me recovery is a journey of hope and discovery to better days ahead.”

They are also offering an opportunity for individuals to send in or tweet at dorsetmhforum - their own idea of what recovery means for them.

In addition to the communication campaign, they are celebrating the success of Hidden Talents. The project seeks to utilise the experience of NHS staff to challenge negative attitudes towards mental illness and promote change.

The Recovery Education Centre provides people with education and tools to self-manage, promote choice, personal responsibility and ultimately control of their own wellbeing. The courses offered are available to people with personal experience of mental distress, those who access mental health services, their carers, friends and family, and also for staff members who work alongside people suffering ill health.

All of the courses have been co-produced and are co-delivered by a peer specialist from the Dorset Mental Health Forum and a health care worker from Dorset HealthCare University NHS Foundation Trust.
Partnership celebrates projects tackling mental health stigmas

The Dorset Wellbeing and Recovery Partnership is celebrating after launching three projects to challenge the stigma surrounding mental illness.

Working together, Dorset HealthCare University NHS Foundation Trust and Dorset Mental Health Forum, launched three projects with the first being What Recovery Means to Me, which is a communication campaign which highlights the individual nature of people's experience of recovery.

The second project, called Hidden Talents, seeks to utilise the experiences of NHS staff to challenge negative attitudes towards mental illness and promote organisational change, thus supporting mental wellbeing.

Finally, they launched the Recovery Education Centre, which gives people the education and tools to self-manage and promote choice, personal responsibility and ultimately control their own wellbeing.

All of the courses have been produced and are delivered by a peer specialist from the Dorset Mental Health Forum and a health care worker from Dorset HealthCare University NHS Foundation Trust.
A positive take on mental health

The Dorset Wellbeing and Recovery Partnership are celebrating after launching three projects to challenge the stigma surrounding mental illness.

Working together, Dorset HealthCare University NHS Foundation Trust and Dorset Mental Health Forum launched three projects with the first being What Recovery Means to Me, which is a communication campaign highlighting the individual nature of people's experiences.

The second project, called Hidden Talents, seeks to utilise the experiences of NHS staff to challenge negative attitudes towards mental illness and promote organisational change. Finally, they launched the Recovery Education Centre, which gives people the education and tools to self-manage.

All of the courses have been co-produced and are co-delivered by a peer specialist from the Dorset Mental Health Forum, and a healthcare worker from Dorset HealthCare University NHS Foundation Trust.