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Scottish Association  
for Mental Health  
(SAMH)  
Evaluation of  
Recovery Approach

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Report  
August 2007

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# 1. Executive Summary

With financial backing from the Scottish Recovery Network, the Scottish Association for Mental Health (SAMH) commissioned an independent evaluation of its adoption of a strategic recovery approach into the organisation.

The evaluation was carried out from August 2006 –July 2007 by devlinbeattie partnership ltd.

The concept of recovery has its genus in user involvement in North America and has been increasingly adopted in the field of mental health since the late 1980s. Some mental health service providers have begun to realise that the traditional approach to treating service users as though their mental health problems will inevitably be life-long and debilitating can be detrimental to recovery.

The adoption of a recovery approach represents a fairly radical change in the way services seek to engage with service users. Service provision should no longer involve a passive maintenance of peoples' illness but should actively promote strategies for self directed recovery.

SAMH initially adopted a working definition of recovery which is adapted from the Mental Health Commission of New Zealand. It is;

***'Recovery is happening when people can live well in the presence or absence of mental health problems and the many losses that come in their wake, such as isolation, poverty, unemployment and discrimination. Recovery does not always mean that people will return to full health or retrieve all their losses, but it does mean that people can live well in spite of them.'***

SAMH has since developed its own definition of recovery, in consultation with staff, service users and representatives from other organisations:

“Recovery is a belief that people can live a fulfilling life, regardless of the problems and difficulties they may be facing.”

SAMH began to consider implementing a recovery approach some 4 years ago following staff attending a conference in London and reflecting on how the organisation could use the

approach to improve services. This started a period of reflection and examination of systems, processes, structures and assumptions about service delivery that were prevalent. Subsequently a conference to discuss recovery was organised with senior managers and heads of departments. The conference commissioned an external organisation, 'Working to Recovery' which used personal testimony viewed as a powerful method of delivery, to set the tone and start to build momentum in the organisation.

SAMH subsequently decided to implement a recovery approach throughout the organisation. It was decided to establish a recovery team for a two year period as the key implementation driver.

The recovery team's objectives are to;

1. Increase and raise awareness of the recovery agenda and ethos within SAMH
2. Ensure systems, policies, strategies and departments are recovery friendly
3. Produce clear and accessible information for all stakeholders
4. Utilise and promote an effective evaluation process into the agenda of recovery
5. Establish, maintain and develop effective and efficient working relationships with external bodies and stakeholders

The evaluation objectives were to;

- Evaluate the process of implementation of SAMH's recovery approach
- Explore staff and service users' understanding of recovery and assess the extent to which there is consistency of understanding across the organisation
- Assess the extent to which recovery-oriented approaches are embedded in policies, procedures and practices
- Assess the impact on service users
- Assess the extent to which the recovery team has realised its aims and to identify barriers and enabling factors involved in this
- Make recommendations on how SAMH should further develop its approach to recovery
- Inform the wider community of mental health service providers through the Scottish Recovery Network and other means

To deliver the evaluation aims and objectives the following methods were used;

1. Desk research
2. Front end workshop with key staff
3. Staff survey
4. Semi-structured interviews with staff and other stakeholders

5. Case study
6. Regional staff workshops
7. Group discussion with service users
8. Group discussion with locality managers
9. Attendance at SAMH's Internal Policy Development Group

Interim findings were presented to SAMH's Corporate Plan Delivery Group in December 2006.

The findings identified the following emerging issues;

- Recovery is a buzzword/current 'big thing'
- SAMH organisational culture
- Some staff felt devalued, deskilled and disillusioned (about how recovery has been introduced, the organisational process/style rather than the approach)
- Perception that recovery is separate from operational practice
- Good clear understanding of a recovery approach
- 2 tiers of staff emerging
- Recovery co-ordinator held in high esteem
- Training and information
- Role of locality managers

The Corporate Plan Delivery Group acknowledged the issues and agreed that positive action was needed which focussed on;

- Integrating the theory into practice and service delivery
- Managers taking a lead
- Encouraging ownership
- Driving the agenda
- Sustaining the approach

Since the interim report a number of actions have been progressed;

- Workshop with the Corporate Plan Delivery Group and 3 practice development managers
- Session with locality managers
- Session with depute service managers in North region
- Regional action plans
- Service re-design

The final stages of the evaluation found significant positive change in how the organisation was implementing a recovery approach.

The recovery team has successfully met its objectives although its focus has mainly had an internal with less of an external role than originally anticipated.

At the conclusion of the evaluation there are several areas that merit highlighting. These are;

- Measuring the impact
- Knowledge and understanding of recovery approach
- Staff confidence and attitude
- Focus on recovery while mainstreaming the approach
- Sharing practice
- Service re-design
- Effective leadership

## 2. Introduction

With financial support from the Scottish Recovery Network, the Scottish Association for Mental Health (SAMH) commissioned an independent evaluation of its adoption of a strategic recovery approach into the organisation, its ethos, services and partnerships. The evaluation took place from August 2006 - July 2007 with an interim report in December 2006.

SAMH is recognised as the largest charitable organisation in Scotland in mental health services providing accommodation, support, information, training, employment, and day services. The organisation has expanded its services to work with those experiencing substance misuse and homelessness.

The evaluation assesses how the formation of the recovery team has impacted on SAMH changing to a recovery focussed organisation.

Success requires evidence that recovery is embedded in the culture and ethos, service design, development and delivery, assessment and care/action plans of service users.

Success also includes the impact on partners, their practice and service delivery. In seeking to underpin its work with a recovery approach, SAMH recognises that individuals are more than an illness or health problem but are holistic beings with wishes, desires, skills, potential and abilities which can enable them to live life well.

SAMH's Organisational Purpose, Vision, Values and Mission are set out in the draft corporate plan for 2007-10 as;

### **Purpose**

SAMH is dedicated to mental health and well-being for all.

### **Vision**

SAMH vision is a society where people are able to live their lives fully regardless of present or past circumstances.

### **Values**

Values underpin everything SAMH does. It believes everyone has the right to be treated with dignity, respect and equality. SAMH believes everyone is entitled to hope and choice and to achieve personal fulfilment.

## **Mission**

SAMH will lead by example. SAMH will be innovative, purposeful and challenging in all that it does. SAMH will campaign for rights and rights-based services, challenge stigma and discrimination and promote inclusion. SAMH will work to raise the aspirations and expectations of people who use services, people who deliver services and society as a whole.

SAMH will promote mental health and well-being within community and corporate life.

Four explicit aims are set out within the corporate plan;

1. Ensuring we continually improve to enable us to be the leading mental health organisation within a competitive environment
2. Developing board and staff to ensure we deliver the mission of the organisation
3. Operating an efficient and effective organisation to achieve best value
4. Achieving change in culture, attitudes and behaviour towards mental health to improve quality of life for everyone

SAMH has a Corporate Plan Delivery Group (CPDG) comprising the Executive Team and senior managers that leads on the delivery of the aims and associated objectives of the organisation.

During the period of implementing a recovery approach, SAMH has undergone a large reorganisation and expansion with changes to structure, creation of new posts and grades, and some longstanding staff leaving the organisation and new personnel in senior posts.



### 3. Context

There has been recent significant policy and legislative development within mental health and other related areas which impact on SAMH's organisational priorities and service planning and delivery.

This includes;

- National Programme for Improving Mental Health and Well-Being
- Improving Health in Scotland: The Challenge, Scottish Executive 2003
- Partnership for Care: Scotland's Health White Paper, Scottish Executive 2003
- Local Government (Scotland) Act 2003
- Mental Health (Care and Treatment) (Scotland) Act 2003
- The Regulation of Care (Scotland) Act and National Care Standards

The concept of recovery has its genesis in user involvement in North America and has been increasingly adopted in the field of mental health since the late 1980s. Some mental health service providers have realised that the traditional approach to treating service users as though their mental health problems will inevitably be life-long and debilitating can be detrimental to recovery.

The adoption of a recovery approach represents a fairly radical change in the way services seek to engage with service users. Service provision should no longer involve a passive maintenance of peoples' illness but should actively promote and seek strategies for self directed recovery.

In 2000 the Mental Health Foundation published a report suggesting that mental health services needed to adopt a more holistic approach to mental health that recognised the expertise of service users based on their personal experiences.

The essence of a recovery approach is that service users are proactively encouraged to acquire the skills and knowledge to take more control over, and management of, their own mental health and lives in general.

One of the four core aims of the National Programme for Improving Mental Health and Well-Being (set up by the Scottish Executive in 2001) is 'promoting and supporting recovery from mental health problems'.

The National Programme funds the Scottish Recovery Network to;

- Raise awareness of recovery from long-term and serious mental health problems
- Develop a better understanding of what helps people recover and stay well
- Build capacity for recovery by contributing to the development of the values, conditions, environments and relationships that support recovery and well-being

SAMH had initially adopted a working definition of recovery which is adapted from the Mental Health Commission of New Zealand. The definition is;

***‘Recovery is happening when people can live well in the presence or absence of mental health problems and the many losses that come in their wake, such as isolation, poverty, unemployment and discrimination. Recovery does not always mean that people will return to full health or retrieve all their losses, but it does mean that people can live well in spite of them.’***

SAMH has since developed its own definition of recovery, in consultation with staff, service users and representatives from other organisations:

“Recovery is a belief that people can live a fulfilling life, regardless of the problems and difficulties they may be facing.”

SAMH started to consider implementing a recovery approach some four years ago following staff attending a conference in London and reflecting on how the organisation could use the approach to improve services. This started a period of reflection and examination of systems, process, structures and assumptions about service delivery that were prevalent.

Subsequently a conference to discuss recovery was organised with senior managers and heads of departments in Glasgow. The conference commissioned an external organisation, *Working to Recovery*, which used personal testimony, viewed as a powerful method of delivery to set the tone and start to build momentum in the organisation.

A further four sessions were organised with a mix of staff including support workers. There were 100 staff at each session. The same external agency, *Working to Recovery* were involved using personal testimony which was variously viewed as ‘powerful’, ‘motivating’, ‘de-motivating’, ‘challenging’, ‘confrontational’, ‘patronising’ and ‘offensive’. (This is expanded more fully in the section on interim report findings).

It is against this background that SAMH decided to implement a recovery approach throughout the organisation and establish a recovery team for a two year period to drive the agenda.

## 4. Methods

The aim of this evaluation is to analyse the extent to which the recovery ethos has been incorporated into the values, policies and practice of SAMH.

The evaluation objectives are to;

- Evaluate the process of implementation of SAMH's recovery approach
- Explore staff and service users' understanding of recovery and assess the extent to which there is consistency of understanding across the organisation
- Assess the extent to which recovery-oriented approaches are embedded in policies, procedures and practices
- Assess the impact on service users
- Assess the extent to which the recovery team has realised its aims and to identify barriers and enabling factors involved in this
- Make recommendations on how SAMH should further develop its approach to recovery
- Inform the wider community of mental health service providers through the Scottish Recovery Network and other means

To deliver the evaluation aims and objectives the following methods were used;

1. Desk research
2. Front end workshop with key staff
3. Staff survey
4. Semi-structured interviews with staff and other stakeholders
5. Case study
6. Regional staff workshops
7. Group discussion with service users
8. Group discussion with locality managers
9. Attendance at SAMH's Internal Policy Development Group

### **Desk research**

A range of SAMH's policies, procedures and corporate plan was examined with a view to evidencing the implementation of a recovery approach.

The recovery team provided action plans, pilot recovery paperwork, review findings of the use of the pilot paperwork, draft recovery indicators and training materials.

Regional recovery action plans have also been provided and examined.

### **Front End workshop with key staff**

This workshop was designed to bring together key staff in the organisation (including the Executive team) considered to be the critical drivers of organisational change. Unfortunately on the day of the workshop due to other urgent business, none of the Executive was able to attend, with the majority of those present being locality managers. However they participated in the evaluation in other ways.

The session;

- Comprised a SWOT analysis
- Established a baseline of practice
- Established clarification of vision and purpose
- Considered proposed outcomes
- Considered strategies for embedding the approach into practice and overcoming resistance
- Identified priorities for action

### **Staff survey**

Questionnaires were distributed to all staff via SAMH's Extranet (in-house intranet). Initially only a sample of staff was to be surveyed however by using the Extranet all staff were able to participate.

There were two surveys; the first survey was conducted from 10 October to 10 November 2006 (it had been hoped to run it at the beginning of the evaluation however SAMH was carrying out a staff survey and did not want two surveys running concurrently). The final survey was conducted from 10 May to 7 June 2007.

The intention was to use the survey as one of the tools to assess 'journey travelled' by staff.

78 (8.5%) members of staff responded to the first survey and 171, approximately 19% of staff, responded to the final survey.

## **Semi-structured interviews with staff and other stakeholders**

23 people were interviewed and included a range of support workers, depute and service managers, locality managers, other SAMH senior managers, members of SAMH's Executive Team and external stakeholders in health, social care and the Care Commission.

The interviews took place at the beginning and towards the end of the evaluation process and focused on views of changes in practice, impact, outcomes, experience of training, understanding of approach, staff confidence and perceptions of competence. They also explored perceptions of success factors and lessons learned.

## **Case Study**

The case study is intended as an illustration of one service's experience of implementing a recovery approach. It also provided an opportunity for service users' views to be sought and heard.

## **Regional workshops**

The evaluation team was conscious that although its headquarters are in Glasgow, SAMH is a national organisation and so the evaluation team travelled to regional areas to involve staff, canvass their views and take account of unique circumstances in different areas. Workshops took place in each of the three regions; North (Aberdeen), Central, South and East (Musselburgh) and West (Glasgow), at the beginning and towards the end of the evaluation.

The sessions explored;

- Knowledge and confidence about the approach
- Barriers and supports to change
- Practice development and support
- What the learning has been
- What's different
- Evidence
- Outcomes
- Impact for service users
- Progress made
- Opportunities there have been to feed into the organisation

### **Group discussion with service users**

The evaluation team had significant discussion with SAMH about how best to involve service users in the evaluation process. It was agreed that the most appropriate method was via the case study and by attending a meeting of the National User Involvement Group.

Discussion was unable to take place with the National User Involvement Group due to their very full work programme.

However, another user involvement group based in Dundee, *The Link*, was willing to participate and share their views.

The discussion considered;

- What do you think about recovery?
- What makes a good service?
- What is good about SAMH's services?
- What could be improved?
- What is wanted from a service?
- What has changed?

### **Group discussion with locality managers**

This group discussion took place near the end of the evaluation process in recognition of the locality manager's pivotal role to progress a recovery approach in the organisation.

Areas explored were; what has changed, how is the approach being implemented, what evidence is being gathered, what does it mean for service users, critical success factors and any barriers to successful implementation.

(A list of all evaluation participants is attached as Appendix 1.)

## 5. Findings

This section details the findings of the evaluation and includes the following sections;

- a. The Recovery Team
- b. Interim Findings
- c. Taking Stock/Making the Adjustments
- d. Case Study
- e. Final Staff Survey
- f. Internal Policy Development Group
- g. SAMH Staff
- h. Service Users
- i. External stakeholders

### a. The Recovery Team

The recovery team was formed in 2005 as the key agent for change within the organisation. The team is made up of a recovery co-ordinator and 2 recovery impact workers. The team is based in the Research, Influence and Change section of the organisation with the co-ordinator reporting directly to the Chief Executive. This arrangement reflects the serious approach and level of importance given to the approach by those at the highest level in SAMH.

The team was established on a temporary basis for 2 years with an anticipated end date of October 2007. Throughout its life the team has had significant periods when it has not been fully staffed. From the end of February 2006 to the end of August 2006 one of the recovery impact workers was on maternity leave and although temporary cover was arranged, this did not happen in practice, due to sick leave. For the period January 2007 to the anticipated end date the team has functioned with the co-ordinator and a part-time impact worker.

The objectives of the recovery team are to;

1. Increase and raise awareness of the recovery agenda and ethos within SAMH
2. Ensure systems, policies, strategies and departments are recovery friendly
3. Produce clear and accessible information for all stakeholders
4. Utilise and promote an effective evaluation process into the agenda of recovery
5. Establish, maintain and develop effective and efficient working relationships with external bodies and stakeholders

## Meeting the objectives

### 1. Increase and raise awareness of the recovery agenda and ethos within SAMH

The team has taken on the role of catalyst and champion within the organisation. Much of fulfilling this objective has been about being visible, accessible and responsive to colleagues at all levels in the organisation.

There has been significant feedback from staff at all levels of the organisation that the recovery team has been the major factor in developing and implementing the approach and that in the majority of instances contact with the team has been very positive and constructive.

The team has carried out visits to all 86 SAMH's services.

Training has been significant in progressing this objective, with the team leading and delivering a number of training sessions across the organisation. This included a variety of different courses in addition to specific recovery approach training.

Training has been extended to those not traditionally involved in training eg those working in business development, human resources, finance and administration, in an effort to ensure understanding across all those working in the organisation. (Table 1 shows a breakdown of training provided.)

Table 1

Course	Number of participants	Who
Self harm	54	3 regions
Hearing voices	49	National
Recovery	44	3 regions
Recovery	353	West 10 sessions Central, South & East 9 Sessions North 6 sessions
Mental health awareness	125	Central, South & East 2 sessions West 1 session National 1 session
Psychological perspective of recovery	12	3 regions
Working with survivors of sexual abuse (front line staff)	13	3 regions
Working with survivors of sexual abuse (line managers)	15	3 regions



## 2. Ensure systems, policies, strategies and departments are recovery friendly

The placing of the recovery team in the Research, Influence and Change section of the organisation sets the tone for this objective. The team was responsible for the review of the organisation's policies to ensure they were recovery focussed. This work has now been assumed by the internal policy development group. The recovery co-ordinator attends this group.

A sample of policies has been scrutinised during the evaluation and make explicit reference to recovery. In particular, the '*Boundaries Paper*' (which outlines boundaries in practice and gives scenarios to help staff consider a recovery approach) has been a significant document in the recovery process, prompting significant discussion and setting out a number of case study/scenarios for discussion and exploration of issues. The Boundaries Paper will be reviewed annually.

Throughout the evaluation the issue of effective induction has been raised as critical in 'setting out SAMH's stall' in terms of culture, values, expectations and aspirations for new staff. There has been a significant period when no organisational induction programme has been in place. More recently the induction programme has been re-designed with a recovery approach as an integral component – the programme is now in place.

Recovery is now also a feature of the recruitment process with adverts and job descriptions explicitly outlining SAMH's commitment to the approach. Recent members of staff have outlined that recovery was a feature of the interview process.

Paperwork to assist the implementation of the approach was developed and piloted in three services. The recovery team has reviewed the use of this paperwork with the three services.

The review has come to a number of conclusions about the paperwork and its implementation and future. These include;

- Many of the tools were very useful and assisted with implementing a recovery approach
- Many staff involved felt they wanted more training and workshop sessions to develop their skills and confidence in using the tools
- Some amendments are required to make the paperwork more user friendly
- Paperwork that focussed particularly on hopes and dreams was especially helpful

### **3. Produce clear and accessible information for all stakeholders**

The team has been instrumental in producing recovery briefings, updates and other written information making particular use of SAMH's Extranet.

Other communication has taken the form of discussions, attending team meetings and delivering training.

### **4. Utilise and promote an effective evaluation process into the agenda of recovery**

Recently the team has worked to develop a set of recovery indicators for the organisation. These indicators have been circulated to managers in the organisation but are not presently being used, nor is it clear what the organisation's plans for implementation are. During this evaluation the issue of measuring and evaluating recovery has been a recurring theme with staff wanting a 'user friendly' tool that evidences what they are doing.

This has been progressed at the same time as the Scottish Executive has developed a set of recovery-oriented practice indicators which are due to be piloted in four NHS areas with a planned full implementation in 2010.

### **5. Establish, maintain and develop effective and efficient working relationships with external bodies and stakeholders**

During the life of the recovery team the majority of, though not all, actions have been internal to the organisation.

Internally most of the work on this objective is carried out in the ways outlined above; training, discussion, support to managers and services.

It is fitting that in many instances the contact with external stakeholders happens at an operational level eg. commissioning and monitoring of services and as part of the inspection process. The recovery team has offered support to colleagues in this regard but local managers have led on this area eg. during the inspection process managers will have had communication with Care Commission staff about service aims and objectives in the pre-visit self assessment and during the inspection itself.

The recovery co-ordinator has been the SAMH representative within the Scottish Recovery Network Management Group with a view to informing and being influential in the national context.

The team has also attended and presented at national and external conferences on their work and SAMH's vision and aspirations for recovery eg. giving a presentation at Community Care Live Scotland Conference 2006 and facilitating a workshop at the Scottish Recovery Network Conference 2007.

## b. Interim Findings

This section outlines the emerging issues that were identified after the first phase of fieldwork and presented in the December 2006 Interim Report to SAMH's Corporate Plan Delivery Group.

A range of issues was identified across the organisation and we outline those that had been expressed by several sources rather than focussing on single/isolated views.

The emerging issues were:

- Recovery is a buzzword/current 'big thing'
- SAMH organisational culture
- Some staff felt devalued, deskilled and disillusioned (about how recovery has been introduced, the organisational process/style rather than the approach)
- Perception that recovery is separate from operational practice
- Good clear understanding of a recovery approach
- 2 tiers of staff emerging
- Recovery co-ordinator held in high esteem
- Training and information
- Role of locality managers

### **Recovery is a buzzword/current 'big thing'**

SAMH has a number of staff who have worked in mental health services, either within or outwith, SAMH for many years. As in other organisations, staff demonstrate a range of capacities and choices about implementing change.

Adopting a recovery approach is perceived by some staff as a totally positive development for SAMH. For others, their perception is that it is 'nothing new'; perhaps an extension to

person-centred approaches or merely a new term to describe practice that has been in place for years, practice that reflects their own.

Staff with this view have expressed frustration at the resources allocated to implementing a recovery approach. There is also a view that a recovery approach is being used as a way of saving resources by moving people out of services.

### **SAMH organisational culture**

SAMH's organisational culture was raised during the evaluation.

The view that challenging or dissenting from messages delivered through training by headquarters staff is not welcomed, was expressed by some staff and that this is an extension of a culture that discourages challenge or dissent. This has left some with unresolved questions/issues about a recovery approach and may have contributed to their lack of motivation to implement the approach.

We are keen to stress that this is restricted to perception; that no evidence has been presented to substantiate perceptions. However, it was discussed openly during the early stages of the evaluation.

### **Some staff felt devalued, deskilled and disillusioned**

Related to the quality of recovery training, some staff expressed feelings and behaviour indicating they felt deskilled, devalued and disillusioned by their experience of a recovery approach. Specifically, this related to how recovery was introduced, the organisational process and style rather than the approach.

Some staff reported feeling patronised during recovery training, feeling their own practice was being undermined by the process and being unclear about the requirements of a recovery approach (concerns about paperwork and a loss of boundaries were the most referred to issues). The issue about losing boundaries related to staff feeling concerned that there would be a blurring of their role as staff members and that they were expected to act in a more informal manner almost as 'friends'. Some staff had concerns about where this approach may lead eg. over familiarity with service users, too high expectations of service users and the loss of boundaries contributing to a reduction in 'safe' practice.

## **Recovery is separate from operational practice**

For a minority of staff, their understanding that recovery is an ethos which will have a fundamental impact on operational practice was yet to be fully understood. Their capacity for implementing change in their own practice may be limited or inhibited by their knowledge/understanding of recovery and their view that recovery is something separate.

## **Good clear understanding of a recovery approach**

Many staff involved in the evaluation expressed a consistent understanding of a recovery approach that reflected information/publicity material produced by SAMH. Many staff welcomed the introduction of recovery, reporting the view that it represents best practice and 'the way forward' for mental health services, including NHS led services. Those staff presented as highly motivated and were clearly making links to practice.

## **2 tiers of staff emerging**

The two points above reflect the emergence of a 2 tier picture of SAMH staff: those 'with the programme' and those not.

Whilst this may be inevitable in a diverse staff group during a process of change, it presents an agenda for the organisation to ensure all staff understand recovery as the principle driver within the organisation, reflected in staff development and appraisal and performance management processes.

## **Recovery co-ordinator held in high esteem**

A key strength in implementing recovery was the status of the recovery co-ordinator amongst staff, particularly amongst those who participated in recovery training. The co-ordinator played a key role in allaying fears and anxieties, being available as a support to staff teams, clarifying processes and procedures including the piloted paperwork and was recognised as demonstrating a high degree of professional capacity in all aspects of recovery implementation.

## Training and information

Training and information focussed on recovery was raised by all levels of staff in the organisation. The quality of training, access to training, follow-up information and the potential for SAMH to deliver training to external agencies have all been raised.

The particular issues were:

- Quality of recovery training, both internal and external – widely differing views amongst participants including concerns raised about the appropriateness of some of the delivery ie. the terms ‘fundamentalist’ and ‘zealot’ were used by some staff to describe the style of recovery training. Whilst obviously this does not totally reflect the training experience, it has raised concerns about the credibility of recovery amongst participants who report a poor training experience
- Controversy, particularly in respect of boundaries, raised, but not resolved, during training – the subsequently issued boundaries paper has gone some way to addressing these issues
- Access to training. There was a perception amongst staff outwith the central belt, that access to training is not equitable. There was also concern that staff are unable to access training due to operational pressures.
- Following the initial recovery workshops accessed by a large percentage of staff who have gone on to implement the approach, there was a demand for ‘next stage’ training, allowing staff to explore their experiences of implementing recovery, barriers and supports and the impact on service users
- There was a common perception that training is delivered on a ‘piecemeal’ basis and that it needs to be part of planned programmes of professional and service development reflected in service and staff plans
- Follow-up practice development to training was inconsistent amongst services, eg. a recovery approach is a standing agenda item in some teams, whilst there has been little discussion in others
- Concern was raised about the lack of a SAMH induction programme. There was a view that such a programme would offer an ideal opportunity for new staff to learn about a recovery approach along with other critical core components of the organisation.

## Role of Locality Managers

Locality managers are the conduit from senior management and the parent organisation to workers delivering services around the country. They are role models for operational staff and are critical in progressing and ensuring the implementation of a recovery approach. This has been recognised by the recovery co-ordinator who meets with them regularly and has requested they each devise a recovery action plan. These action plans are at different stages.

At the interim evaluation stage it was clear that there was significant difference and enthusiasm across this group of staff. The evaluation team was aware that in some areas locality managers were driving the agenda and encouraging ownership by their staff. In areas where this lead was being shown staff we have met were able to reflect on what a recovery approach meant for them and were considering the impact on service delivery and practice.

## c. Taking Stock and Making Adjustments

The interim report highlighted a number of areas that required action in order for the organisation to progress the implementation of the approach successfully.

The Corporate Plan Delivery Group acknowledged the issues and agreed that positive action was needed which focussed on;

- Integrating the theory into practice and service delivery
- Managers taking a lead
- Encouraging ownership
- Driving the agenda
- Sustaining the approach

Since the interim report a number of actions have been progressed;

- Workshop with the Corporate Plan Delivery Group and 2 Practice Development Managers
- Session with locality managers
- Session with depute service managers in North region

- Regional action plans
- Service re-design

### **Workshop with the Corporate Plan Delivery Group and Practice Development Managers**

This first session took place in January 2007. The focus was to ensure that senior managers, key figures in the organisation, experienced the same training as their staff, understood SAMH's vision and aspirations about a recovery approach, could reflect and explore issues and clarify their role.

The practice development managers were invited to this session in recognition of their critical role in supporting learning into operational practice.

### **Session with locality managers**

This session had the issues above acknowledged by the CPDG as its focus. Locality managers have a unique role in the organisation, with their interface with the strategic agenda and headquarters and their operational management responsibilities. They are in a unique position to;

- Influence and model an approach
- Support and encourage debate and discussion
- Hold services accountable

This session explicitly gave locality managers responsibility (and made them accountable) to progress the approach and ensure integration into practice.

### **Session with Depute Service Managers in North region**

In the North region discussion took place with the assistant director, practice development manager and recovery co-ordinator to consider how best to move things on in a positive manner.

There had been significant tension and reluctance to consider the approach. Many staff felt early training had been poor and insulting about their practice and had adopted a position of defending their services and operations (this was not exclusive to the North region).



Depute service managers were identified as being crucial players in this region; many were longstanding members of staff carrying significant credibility with colleagues.

A day was facilitated by the recovery co-ordinator and practice development manager which was hoped would move the situation on and let people 'get past' any negative feelings and consider the approach on its merits.

This session was considered a success. Depute service managers were able to; explore issues, consider implications for their services, think about service change and take ownership of moving the agenda forward.

### **Regional action plans**

As part of encouraging ownership and integrating the approach into service planning and delivery, the three regions were tasked to develop and implement an action plan for their local areas. This was done under the stewardship of the assistant directors with practice development and locality managers as key players. Each region has at least a draft action plan in place.

The local action plans use different formats. It is our view that, to demonstrate consistency, it would have been helpful to have used a common template similar to that used by the recovery team.

There are few timescales identified in the action plans and few associated outcomes to action points which may hinder a focussed approach to achieving outcomes with staff unclear of the reasons to progress some actions.

### **Service re-design**

At the time of setting up the recovery team SAMH recognised that some of their established services did not lend themselves to an easy accommodation of a recovery approach. In order to address this there has been significant service re-design with a focus on moving from the maintenance of service users to a holistic approach based on service users' potential, hopes and wishes.

By changing organisational structures a 'moving on together' feel has been generated which has allowed staff to consider a new approach and culture for new services.

Some of the service re-design has had social inclusion at the core which is reported to have been of assistance in understanding the aims and developing the new services. For example, in Inverclyde, services are now incorporating facilities in the community that service users can use/be included in, rather than, looking for mental health specific services, which, in some instances reinforces a separation of people from their local community.

In Moray some services are moving from a more traditional approach to a 'clubnet' model of service.

## d. Case Study

This short case study is intended to illustrate one service's experience of understanding and implementing a recovery approach.

It is presented in interview format to try to do justice to the discussion that took place between the staff and evaluation teams.

**Abbreviations** - Staff members are referred to as *ST*, the service manager as *M*, service users as *SU* and the evaluator as *db*.

### An interview with a supported accommodation service

*db*: How would you describe your service?

*M*: We are a 24 hour supported accommodation service. We sum up our approach as one that is person-centred, aiming to maximise independence, minimise interference and promote independence.

Residents do their own thing: their shopping and cooking, deciding when and how they want to do things in the house, coming and going as they choose.

A staff member organised residents meetings, but apart from that, our input into the domestic arrangements is limited to any health and safety issues that come up.

*db*: What does the recovery approach mean for your service?

*ST*: It's about residents achieving their own goals; about living well with a condition and seeing the best way forward. It's about seeing the whole person, recognising that a resident,

like all of us, has several roles in their life: brother, parent, daughter, student and so on...

**ST:** It's also about relationship building, where service users 'let you in' and you become part of their recovery.

**ST:** Yes and you need a good team ethos with trust and a recognition of the need for flexibility amongst the team. We're fortunate here: our manager allows for risk and is genuinely developmental in her approach. I would definitely say we are working in a learning environment here where personal learning is modelled by the manager and staff members.

**SU:** The house is cosy and homely. It's our house: we come and go as we please. The residents meetings have changed how the building works and we are able to make it clear to staff that we want the staff to be here for us but we also want our privacy. We get that now and that's very important.

**SU:** Yes, we decide how we want to live here. Staff help us move on and help us in reviews and things like that. We can speak for ourselves but sometimes we need their help.

**db:** How has the recovery approach made a difference to the service?

**ST:** Recovery underpins everything we do now. Although we've also believed in the recovery approach and tried to work to it, we used to be more rigid, more task orientated. Our recording reflected this and really told us nothing. This work is full of people making judgements and judgements block recovery. Now recording is about the process a resident is involved in with us and about positive changes they experience.

**db:** Can you give some examples of how things have changed: practice, the work done by staff, the experience for service users?

**M:** It's been a gradual transformation so sometimes it's difficult to remember how and when a decision to change was made but these are a few specific examples:

- We didn't use to challenge assessments of psychiatrists even if we didn't agree with them. We maybe felt they were more 'professional' than us and so deferred to them but our knowledge and understanding as well as our confidence in the recovery approach, means we can contribute positively to reviews and other processes that they generally lead. As a team we are clear we can support service users using an approach that is consistent with their experience in the house.
  
- The way the house ran was more to suit the staff than residents. For instance, staff used to get residents up by 10.00 every morning no matter what. It's been a gradual

change but these kinds of things don't happen any more and everyone here, staff and residents, knows this is residents' home and should be treated as such. You or I would never expect someone to be able to make us get out of bed at a certain time of day. It's the same here.

- As a staff group, we used to encourage residents to go out, participate in local community activity and make plans to move on to their own tenancy. Residents may want to participate in groups or classes. If they do that's great: we'll support them to do this. But if they don't want to and prefer to spend the time on their own or in the house, that's up to them. We see our role as facilitating moving on when residents identify for themselves they're ready. This might happen quickly, slowly or somewhere in the middle. We now go at the pace of the resident.

**ST:** For some years there was an arrangement that residents didn't use the kitchen after 10pm. This was because of a health and safety concern about one resident's use of the gas cooker. Then we asked ourselves 'Can we use the kitchens in our home after 10pm and if we can, then people living here should have that choice too'. So we changed to an electric cooker, removing the risk and giving back all residents opportunity for recovery; something quite simple, but made an enormous difference to people living here.

**ST:** We question ourselves and each other all the time. Recovery is about parking our own expectations and judgements about what constitutes quality of life for someone and often about throwing your assessments out of the window. That can be both risky and scary at first so we need to rely on each other and our manager to allow this to happen and to change the pace from ours to service users'.

**ST:** We also need to accept that recovery applies to staff too. How can we promote a culture that we can't relate to ourselves? That's about personal learning and reflecting that in your work. We see the need to learn from each other's experience: good and bad.

**db:** What are some of the challenges you've faced in implementing the recovery culture you talk about?

**M:** While we feel confident as a staff team and think service users understand our approach, we have a long way to go as a whole organisation and in promoting our approach to other agencies. Our big challenge is with psychiatric services and others in the NHS. While we try to make an impact locally and we've made progress in sharing our perspectives with social workers, that's something SAMH needs to co-ordinate nationally. It's a huge task but one that needs to happen if we're serious about making a lasting difference to service users.

**ST:** We were 'fired up' by some of the things Ron Coleman had to say at the initial recovery

conference and we were already trying to work like that but we were conscious that old boundaries and ideas about duty of care would need to shift and this has continued to stretch us. We've not got it right every time but, with a strong team, we've got through it and learnt that being busy and task – focussed has nothing to do with recovery.

**db:** How are you being supported to understand and implement the recovery approach?

**ST:** We support and learn from each other! The initial conference and some training have been good and the recovery team has spent time with us here which was really useful but building a culture in a team needs ownership of those in it and we've done those ourselves.

**M:** SAMH has a locality manager so we're part of that structure. As an organisation, we need to develop a culture of recovery throughout. It'll not happen overnight but we're moving in the right direction.

## e. Final Staff Survey

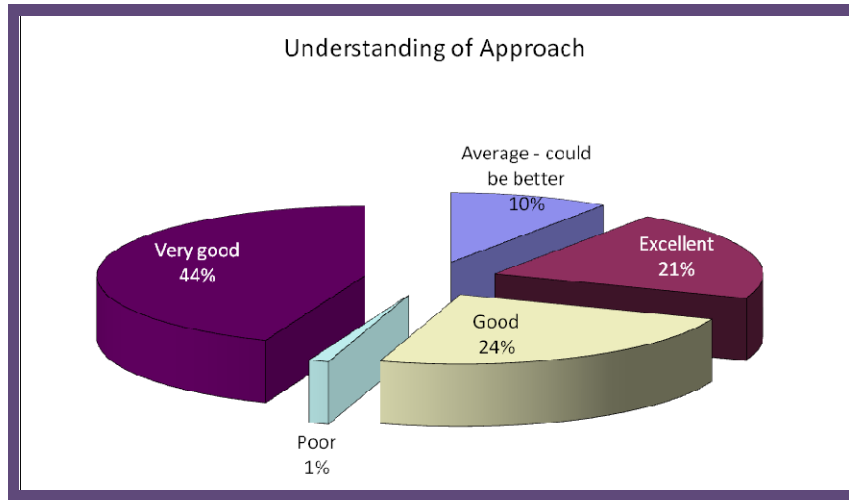
The final staff survey was posted on the Extranet from 10 May to 7 June 2007 available to all staff. (The final survey is attached as Appendix 2.)

It was hoped that survey would give a picture of the journey travelled by staff during the process. The results are as follows.

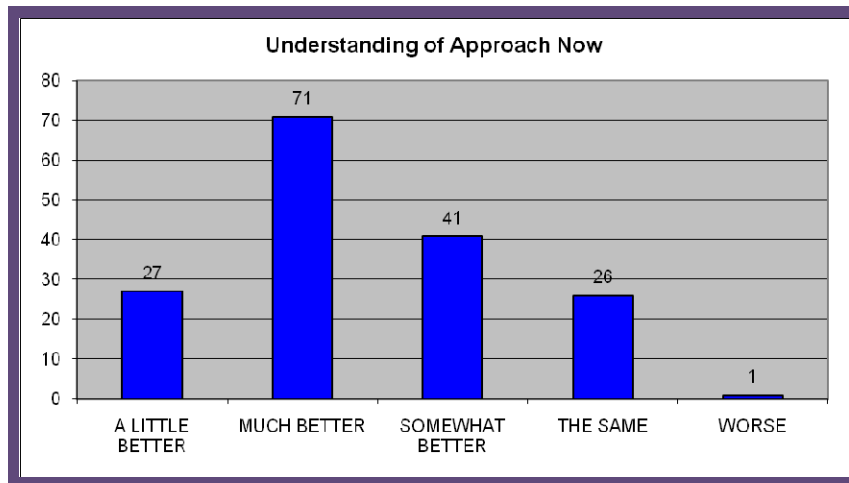
171 staff responded to the survey, approximately 19% of the organisation.

Of those who responded to the survey, 59% had been in post longer than two years and 42% (72) of respondents were support workers.

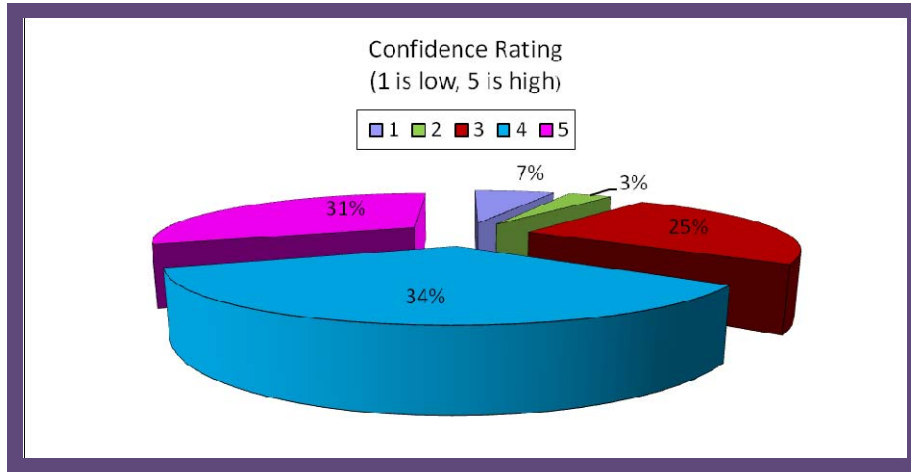
Respondents were asked to rate their understanding of the recovery approach by choosing one of five descriptors. 89% rated themselves as having a good, very good or excellent understanding.



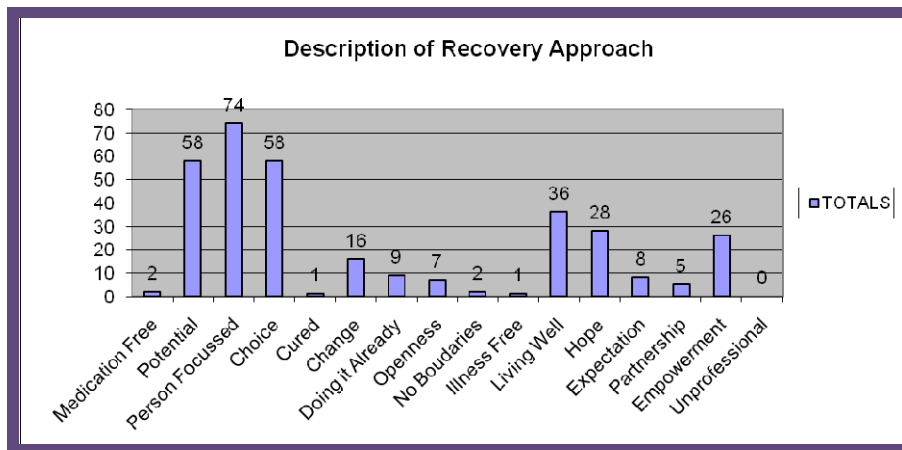
Respondents were also asked how their understanding of the approach was now compared to 12 months ago. Over 81% of respondents judged their understanding to be better. 59 support workers responded positively.



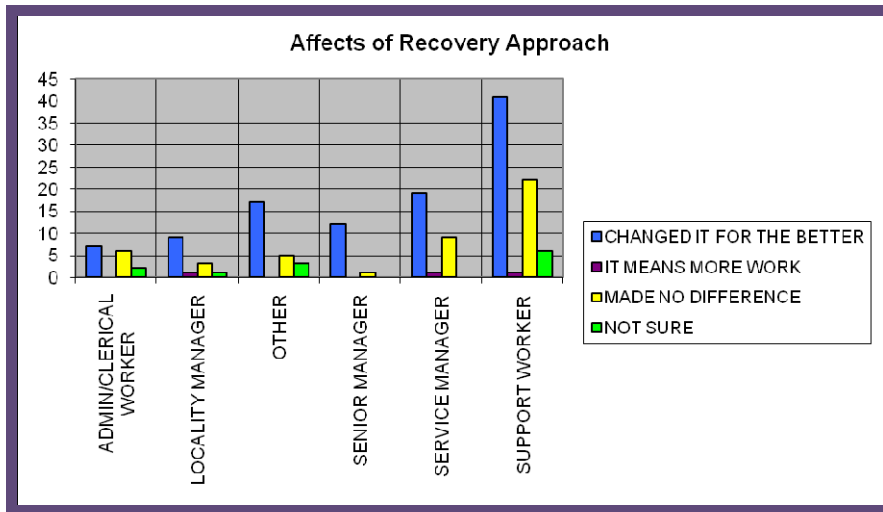
Respondents were asked to rate how confident they felt about a recovery approach with 1 being low and 5 high. 90% rated themselves as a 3 or above.



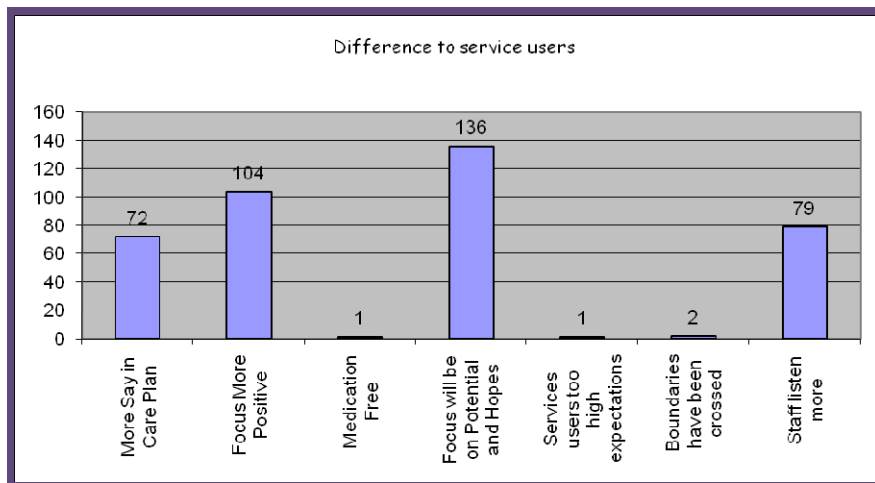
To illustrate their level of confidence and knowledge staff were asked to choose three words/phrases from a selection that best described a recovery approach. The main descriptors were; potential, person focused, choice, living well, hope and empowerment.



On being asked ‘How has adopting a recovery approach affected your practice?’ the majority of staff (across all roles) stated ‘it had changed it for the better’ (3 people thought it meant more work and 13 were unsure).



Staff were asked ‘what difference has adopting a recovery approach meant to service users?’





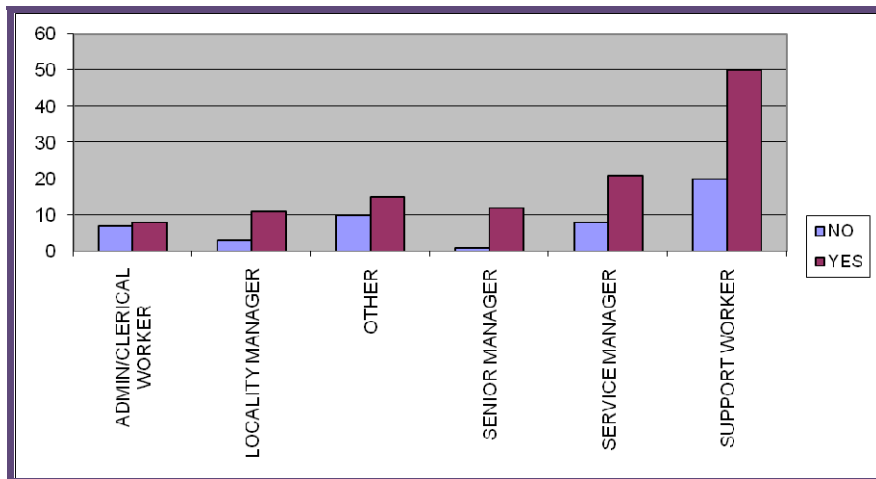
Respondents were asked ‘*what have you done in last 12 months that has helped you understand a recovery approach?*’

This was an opportunity for staff to expand and say what helped them personally. The majority of staff responded and the responses can be grouped into several different themes;

- Not much – already confident in approach
- Contact and discussion with the recovery team
- Training, workshops and conferences
- Discussions with external colleagues
- Literature; internet, national and international research, personal study
- Joining SAMH (new staff)
- Reflection on practice and pillars of recovery
- Developed local action plan
- Using recovery paperwork

Respondents were asked if using a recovery approach had changed any of their practice, 70% said ‘Yes’.

For many of those who said there was ‘no change’ they explained that they were already working in a recovery focused way. The breakdown by job is shown in the table below.



The final question asked staff to give an example of how their practice had changed using a recovery approach. Not everyone completed this question but responses can be grouped in the following themes;

- Practice hasn't changed – don't deliver services
- Practice hasn't changed always working in a person- centred and recovery focused manner
- Staff engaging more actively with service users
- Staff changing their attitudes about service users
- Focus on potential, hopes and dreams
- 'Can do' not 'can't do' attitude and approach
- More openness between staff and service users

The following are examples of what staff said;

*'It focuses on what our service users can do rather than what they can't. It has given hope back to services users and empowered them to aid themselves in their own recovery'*

*'Made me question much more what we are doing and why. Consider all areas of practice and for whose benefit we are doing it, even areas which on the surface appear to be in the best interests of the service user'*

*'We no longer put the emphasis on what we think is important but look to what our service users think is important'*

*'My practice hasn't changed. My approach has always been recovery focused.'*

*'I am more aware that recovery is not all about being free from symptoms, which has impacted the way I approach people.'*

*'Reminded myself of the importance of genuine active listening to service users' rights, needs and wishes. Rekindled passion back into the job.'*

*'Supporting a client in trying to achieve his dream of producing a CD'*

*'As an admin worker a greater awareness and understanding of recovery has improved my job satisfaction and better understanding to aspects of my role, the work I carry out and the importance of this to service users and the team.'*

*'Service users now complete their own support plan ie. unique plans giving them "ownership" of their support package.'*

*'I have become more understanding – listened to what people say rather than ask questions. Seeing how good a person feels when they are given the right of choice.'*

## f. Internal Policy Development Group

The evaluation team participated in one meeting of the Internal Policy Development Group, led by the Director of Research, Influence and Change, established to monitor organisational policy development and change in the context of service re-design.

Several policy developments were presented to the meeting, all of which made clear and specific reference to a recovery approach. Discussion amongst group participants was full and frank with all understanding the importance placed on ensuring organisational policy reflected SAMH's vision and aims.

## g. SAMH Staff

Several methods were used to obtain the views of a range of staff across the organisation.

The early findings are outlined in the section Interim Report. This section outlines the findings from the final stages of the evaluation.

Irrespective of the format participated in staff were asked to consider the following areas;

1. What has changed/ what progress has been made? (over the last few months)
2. How is a recovery approach changing outcomes/making a difference?
3. Give an example of how the principles of recovery are used in your service?
4. What is helping you implement recovery?
5. What are the barriers to implementing recovery?
6. What would help you most to implement recovery approaches?
7. What does recovery mean to service users?

### **What has changed/what progress has been made?**

There was an overwhelming view that things had changed. Staff reported feeling more confident and receptive to a recovery approach. Some individuals reflected that previously they had been resistant or 'closed' to a recovery approach, linked to feeling undervalued when the approach was introduced and for some a belief that they were already implementing a recovery approach. Many participants realised that, as they gained more information and knowledge about a recovery approach, that they had not been using the principles of recovery.

Some participants had been involved in service re-design and this has been a vehicle for increasing understanding of how the approach could and should be used in practice. Staff were able to reflect that some 'traditional' services did not easily lend themselves to implementing the approach.

Many staff were clear that their attitude and how they worked with service users had changed. This had been described by several participants as moving away from doing things for clients to really listening and encouraging service users to explore and express their wishes, hopes and dreams with the staff member working alongside the service user.

Staff have felt more confident about discussing the approach in their workplaces and many talked about being more open to exploring what recovery means to them and their services.

Many participants believed that the evaluation process has played a part in the progress by allowing staff to express their frustration and be heard by the organisation. Participation in the evaluation has proved to be cathartic for some people.

### **How is a recovery approach changing outcomes/making a difference?**

The majority of staff were able to give individual examples of how outcomes have changed and service re-design was also viewed as a major factor in making a difference. Some staff felt it was early days for service users to experience changed outcomes.

Staff reported they had no agreed system for evidencing outcomes and thought it was important that SAMH adopted a system for all services to use. Some managers were aware of SAMH's recovery indicators but were clear they were not in use at present.

### **Give an example of how the principles of recovery are used in your service?**

The majority of staff were able to give an example of how recovery is being used in their service. This ranged from services being re-designed to some services making sure that service users complete their own individual plans rather than the staff member.

Team meetings and discussions were reported to play a key role in this process with staff spending time talking about practice and service delivery, changes and implications.

An example was given by a staff member of a service user who previously had, as part of his care plan, that staff would encourage and assist him with ironing clothes. This was an ongoing bone of contention between staff and the service user who did not want to iron his clothes and would at times get staff to do his ironing. A fresh look was taken at this issue and the service user decided he wanted someone else to do his ironing. The service user approached a neighbour in his block of flats. The result - the service user pays the neighbour for ironing services, his clothes are well ironed and his time with the support worker is used to focus on reaching his aspirations and hopes.

Other examples include;

In one service one man had for years had his money managed by staff due to concerns he would 'blow' the lot early in the week leaving him nothing for the rest of the week. For some time the man had said he wanted to manage his own money. This was resisted by staff who were concerned about his ability to cope with financial responsibility. As part of implementing a recovery approach staff agreed that the man should get control of his money. The agreement was he would get his money, pay his rent and have financial control. The implications of spending all his money at once were outlined. The first week the man paid his rent, bought some food and 'blew' the rest. It was a long week where he had to borrow from other service users for cigarettes and other sundries. However, this is an

experience that many of us go through - spending too much at once and living with the consequences. The man has continued to manage his finances successfully and enjoys the responsibility of being treated and behaving like an adult rather than receiving 'pocket money' every day.

### **What is helping you implement recovery?**

Almost all staff reported a change in attitude, feeling more open and relaxed about a recovery approach. Staff had been able to let 'their guard down', reflect and think about the approach without being defensive.

One of the most important features of assisting the implementation of the approach is discussion at team meetings with colleagues and with managers. This has given staff a forum to discuss issues, implications, ideas and reservations in a safe setting. The presence of the recovery team members in these discussions have been described as helpful and as identifying a link to people with specialist knowledge.

Some staff identified using the recovery paperwork as part of the pilot as helpful. The areas for discussions and questions in the paperwork, in particular the focus on hopes and dreams ensured that staff covered these areas moving on from more traditional discussion areas.

The re-design of some services was again raised in this context.

Participation in training has been an important part of the journey for many staff assisting in the understanding of the approach using an experiential format.

Contact and discussion with locality managers has been important and given an ownership to local services. Where locality and service managers have been seen to be enthusiastic in promoting the approach, staff have been 'allowed' to embrace the approach.

One locality manager gave a very honest and reflective example of this; the manager outlined that he/she had felt very negative after attending the first tranche of training and had returned to 'base' with a defensive and almost hostile attitude - 'we're not doing that here'.

Although the manager did not say this directly to staff, it is accepted that this/her attitude would have been self-evident. This meant that staff took a lead from the manager and the approach was resisted or ignored. However, this attitude changed over a period of time following the interim report and meetings with other locality managers, the recovery co-

ordinator and the practice development manager. With the locality manager starting to reflect on practice in local services, take ownership and set a positive tone, staff took their lead.

The presence and accessibility of the recovery team has provided colleagues with a central point of contact for information, advice, training, discussion and debate. Some staff have been concerned about the recovery team coming to an end and losing this point of contact before the approach is firmly embedded in practice throughout the organisation. In the short term it remains important for some staff to have an identified point of contact. Local managers are providing this contact for other staff.

There are recovery fora set up in several areas, some of which have had a connection to the recovery team, others less so. These fora have provided important opportunities for staff at different levels of the organisation to come together and discuss and debate recovery in practice. It will be important these fora continue. It is recommended that these fora communicate widely with staff in their area as staff who do not attend don't always receive information.

### **What are the barriers to implementing recovery?**

Some staff have felt that the design of their service (the more 'traditional' services) has been a barrier to full implementation. Staff have tried to implement the approach but feel the design and make-up of the service is a barrier in itself and recognise that for full implementation and integration of the approach, service re-design is necessary.

Likewise, staff report finding the existing paperwork limiting. This was voiced as a genuine frustration. Many staff are keen to use the recovery paperwork which has explicit questions which focus on the principles and language of recovery.

Some staff have stated the change process is not happening quickly enough; they believe that colleagues have been wary about the approach (because of the factors previously outlined) and so have been defensive and resistant to implementation slowing the process.

Staff have also reported that a lack of understanding of the approach from external colleagues has been a barrier although this has been changing positively over the last few months.

One example of this is in the North region: a new referral was made to a joint community addiction team (NHS and SAMH) for a man who was on a methadone programme with a view to reduction and becoming drug free.

On meeting the SAMH support worker and formulating his individual action plan the man said what he really wanted was a job but due to the nature of prescribing and supervising his methadone he believed 'there was no way he could get a job'. The worker encouraged him to look for a job and agreed they would investigate how his methadone could be managed to accommodate his employment.

The man found a building job, an agreement was reached with the NHS and pharmacist to allow the man to get his prescription a day in advance. This meant he could start his work at the time of 7.30/8.00am and make a commitment to employment. Within six weeks his methadone had reduced by 20mls. He was enjoying his job, his physical health was much improved, his self-esteem was raised and his relationship with his partner had improved.

For the first time in years the man had a reason to get up, a focus in life – he was enjoying life and looking forward to being drug free.

### **What would help you most to implement recovery approaches?**

Staff are keen that managers in SAMH lead discussions with counterparts in other agencies to outline what the organisation is trying to do in respect of a recovery approach to promote all agencies working together with the service user to attain the same goals.

Staff have also suggested that multi-agency training would be helpful to ensure that all those involved with a service user have a shared understanding of the approach.

A central point of contact for staff would be helpful until the approach is embedded in practice in all parts of the organisation.

Staff reported that it would be helpful to continue to have discussions in teams and localities about recovery with a particular focus on practice and service delivery.

It was also suggested that good practice examples of recovery in action should be widely circulated across the organisation to allow a sharing and exchange of information. This is linked to the need to celebrate success within the organisation which would recognise good practice and also act as a motivator for staff.



## **What does recovery mean to service users?**

This has been an area of significant movement for many staff since the interim report. There was a significant number of staff early in the evaluation process who viewed the implementation of a recovery approach as something that would impact negatively on service users. There was concern that the approach was a means of resource management with people being 'pushed through and out of' services before they were ready.

There is now a clear understanding of the approach and what it means for service users. This includes stopping support that encourages dependence such as, 'ferrying' service users around in cars and staff accepting, actively encouraging and supporting service users who say they want a job, rather than reducing their options and suggesting volunteering as a 'safer' alternative.

Staff were able to talk about how service users are becoming more confident and demanding of services and their local community. Staff are seeing service users responding positively to being believed in and being encouraged to pursue their aspirations.

## **h. Service Users**

The Link User Involvement Group in Dundee agreed to have a group discussion as part of the evaluation. This section summarises the discussion. The discussion covered the following areas;

- What do you think about recovery?
- What makes a good service?
- What is good about SAMH's services?
- What could be improved?
- What is wanted from a service?
- What has changed?

All the participants had seen the leaflet circulated by SAMH 'Recovery Works'. The leaflet was viewed as having some good points there was some debate that the use of the term recovery could be misleading in terms of it might mean being cured or not taking any

medication. Others thought this was not the case and that the leaflet explained the approach well.

Everyone liked that the leaflet had been produced and wanted it circulated widely. They felt that the leaflet set out that there is hope for people experiencing mental health difficulties and that life is far from over.

Some participants reported that services had made some changes eg. people completing their own unique plans rather than support workers doing it, they reported being asked what they wanted to do rather than being told what they could or couldn't do.

One service user said that for much of his life services had 'done their best to take things away from me' eg driving, job, where he could live and with whom. He stated that SAMH didn't do this; it focused on what he could do, and then tried to support him to do that successfully. He stated that he could for the first time in many years see a future where he was described not as a mental illness but as an individual living successfully in the community with his partner, enjoying life with minimal support. He thought there might be a time where he could live in the community without support.

The basis of a good service was described as one where;

- People are respected and valued
- People are really listened to
- They are treated as individuals with different needs and wishes
- Staff are constant and can be relied on
- There are good relationships with support workers

The group did express that they felt quite far from SAMH headquarters (planning and decision-making and geography) in spite of a couple of members being on the National User Involvement Group. They were of the opinion that more people might get involved from outwith Glasgow if the group's meetings were held, on occasion, in different areas.

There was concern that some of the organisational arrangements of the national group hindered full participation.

This included;

- Not receiving minutes of meetings until a few days prior to the next meeting
- Not being able to volunteer for many sub or task groups as it would mean travelling to Glasgow

- The previous 'job description' to participate was very long and off-putting and should be streamlined.

There was concern that the agenda spent too long considering things that had happened previously, leaving little time to look to the future and share what is happening in different areas. It was also felt that the recruitment to the national group had been problematic and rushed – people needed time to consider their situation, preparation and to be supported to participate in the process.

In spite of the above, the opportunity to participate in user involvement fora was welcomed. For some people it gave them opportunity to 'do something with my life instead of sitting in my house doing absolutely zero'. Others said it gave an opportunity to network, share information and gain knowledge and gain power. The format of being in a group was considered to be positive as there was more confidence and more authority than as an individual.

There was desire for this group to have more opportunities to influence services. There had previously been a suggestion that service users and staff would meet regularly to talk about services, improvements, future plans and areas of concern. It was subsequently decided this wouldn't happen.

Communication with staff has improved over the last couple of years but the group felt this could be improved on a service planning and delivery basis (individual communication was described as good). Service users were keen to get access to SAMH's Extranet site, seeing this as a vehicle to share information and raise issues.

All of the group were positive about their individual experiences receiving services from SAMH and appreciated the campaigning work done nationally by the organisation. There was a significant appetite to get involved and contribute to the future of the organisation.

## i. External Stakeholders

A small number of external stakeholders were contacted to determine their views of how SAMH was implementing and communicating a recovery approach. The external stakeholders were representative of service commissioners and the Care Commission.

Areas covered in the discussions were;

- SAMH is implementing a recovery approach throughout its organisation and services – are you aware of this/how were you made aware of this?
- What are the implications from your perspective of implementing this approach on service planning and delivery?
- Have you any concerns about this approach in terms of services meeting statutory requirements and or care standards?
- Have you had any feedback from staff, service users or service users' families during inspection/service visits/reviews about a change of approach/culture within services?

All the external stakeholders contacted were aware that SAMH was implementing the approach and knew this from ongoing frequent contact with staff and managers.

The new approach was said to be particularly evident during service re-design process and when setting up new services. There was some concern that some of the more 'traditional' type services do not lend themselves to being fully recovery focussed eg there was a concern about some service users becoming 'stuck' and over dependent on staff in supported accommodation services.

None of the external stakeholders had concerns about SAMH using a recovery approach. There were no concerns that taking a recovery approach would impact on the organisation's ability to meet statutory and policy requirements.

There was an acceptance that there approach was being used in a person focussed manner with the appropriate strategies for risk management in place.

The Care Commission has been carrying out focussed inspections which considered the outcomes and individual's experience of their care and staff practice. A recent service inspection found that the organisation offered an individualised and consultative person centred service that service users were positive about. This resulted in positive comments about the quality of service provided.

Commissioners believe that the use of a recovery approach is likely to mean a 'throughput' in terms of service use with more emphasis on outcomes, employability and peer support approaches. Agreement on qualitative outcomes will be an important part of partnership working moving away from outputs and numbers of hours of support received by a service user thus creating a flexible responsive service tailored to the individual.

## 6. Conclusion

SAMH has planned and implemented a process of culture and organisational change during the last three years.

In addition to a restructuring of the organisation it has set out to implement a recovery approach requiring a significant change in culture, service design and delivery.

Throughout the evaluation staff were open, honest and reflective with a range of staff enabled to participate without instruction to reflect 'the party line'.

At the interim report stage there were a number of issues identified requiring action in order for SAMH to progress successfully. These issues were neither insignificant nor immediately resolvable and given that significant resource had been utilised to implement the approach, were disappointing to senior managers.

The Corporate Plan delivery Group under the stewardship of the Chief Executive accepted the interim findings and set out to tackle them in a constructive and forthright manner. This included a training session for the most senior officers in the organisation. This session was to ensure that those key staff fully understood the vision and approach and experienced the same training as their staff. It also explicitly gave both ownership and accountability for the approach's successful implementation to key players. This approach was subsequently cascaded through the organisation with a particular focus on locality managers, service and depute service managers.

Throughout the time of the evaluation a strong vision and leadership has been apparent from senior managers particularly from the Chief Executive who has been unwavering that a recovery approach and pillars of recovery are what should be driving service design, planning and delivery to ensure services that deliver improved outcomes for service users.

There are several areas which merit highlighting at the conclusion of the evaluation;

- Measuring the impact
- Staff confidence and attitude
- Knowledge and understanding of recovery approach
- Focus on recovery while mainstreaming the approach
- Service re-design
- Sharing practice
- Effective leadership

## **Measuring the impact**

This is an area that requires attention. Many staff were able to describe how things were different because of a recovery approach and were frustrated that they could not evidence outcomes. (There was some confusion in distinguishing outputs and outcomes but a strong feeling that staff didn't want to only 'count hours of service and tick boxes').

The recovery team has developed a set of indicators although these are not currently in use. Likewise the Scottish Recovery Network and the Scottish Executive has developed a set of recovery-oriented practice indicators (the Scottish Recovery Indicator), due to be piloted in four NHS Board areas with a planned national implementation in 2010.

Consideration should be given to how best to introduce and use them while considering future 'fit' with the national indicators.

SAMH should also use other tools to measure the impact of recovery approach on services including service user feedback and reviewing and evaluating regional action plans.

## **Staff confidence and attitude**

Many staff have been positive throughout the evaluation. However, there was a significant number who, as a result of their initial experiences and perceptions of the approach and SAMH's motivation, were negative and, in some cases resistant to exploring and using the approach. This is no longer apparent.

Many staff present as much more confident and assured about recovery and some have been able to reflect on their early feelings. Several workshop participants in each of the three regions expressed that they felt differently about the approach and what it meant both for them and service users. They had previously felt stressed and anxious but now those feelings had gone, understanding was increased and they were able to move forward in a more confident, positive manner.

Many staff reflected that they had previously thought they were using the approach but as their understanding grew they realised they had not been recovery focussed.

The change in staff attitude was evident in the way staff positively engaged, the open and thoughtful consideration that went into discussion and the way they could look back and examine how their attitude and behaviour had 'blocked' implementation of the approach.

## **Knowledge and understanding of recovery approach**

Participants in the evaluation have shown a marked increase in this area. Everyone involved had heard of and could describe the approach without difficulty. Staff were able to discuss what recovery meant for them and how their practice and services had changed in light of using a recovery approach. The implementation of the approach was overwhelmingly considered to be positive for the organisation and more importantly for service users.

## **Focus on recovery while mainstreaming the approach**

It is clear that the approach is being mainstreamed into operational practice and service delivery. This is evidenced by new policies, procedures and plans incorporating practice, service re-design and changes in engagement and intervention with service users. Whilst there has been a significant change throughout the evaluation there is no place for SAMH to 'take the foot off the accelerator', particularly as the recovery team's conclusion is close. There will be a need to keep an explicit focus on recovery, with identified points of contact for staff members to seek information and advice.

## **Service re-design**

SAMH has recognised that some of its more 'traditional' services do not easily lend themselves to full adoption of a recovery approach. It is engaged in a programme of service re-design across the country ensuring that services are holistic, person centred and encourage service users' participation, their hopes and dreams.

Many staff report that being involved in service re-design has helped them understand the approach, its principles and improved outcomes for service users.

Staff have reported understanding that importance of 'how they are with clients' ie. their attitude (how engaging and encouraging they are and what expectations they have of service users), engagement and behaviour can impact either negatively or positively on service users.

## **Sharing practice**

For many staff the sharing of practice examples has been significant in helping understand the approach and show how it can be used in different types of setting.

Staff have suggested that there is continued opportunity to share experiences with colleagues perhaps via local fora, Extranet and other bulletins/newsletters. The appetite for sharing and exploring is present and bodes well for a culture of learning and reflection within the organisation.

There are recovery fora in some areas continuation which should be encouraged with some guidance given to ensure effective communication with those who don't attend.

## **Effective leadership**

In any organisation the performance of leaders is critical to success. SAMH has shown a commitment to the approach at the most senior level of the organisation. This was not always present in other individuals considered to be in a leadership role. This has changed.

Following the findings of the interim report detailing the importance of ownership by managers, including those in localities with direct responsibility for services, remedial work was carried out with a range of managers from senior management through to depute service managers. This work made explicit managers' responsibility and accountability for implementing the approach and 'allowed' and encouraged these staff to own how the approach was implemented rather than seeing it as the preserve of the recovery team and others at headquarters.

SAMH's reorganisation with subsequent staff movement and new managers in post undoubtedly had a bearing on the issues identified in the interim report.

The recovery team has met its objectives successfully although has had less external contact and influence than initially planned. This was to ensure a focus on internal impact and in recognition of the team not being fully staffed for significant periods of time.

At the early stages of the evaluation many staff presented as defensive, resistant and closed to the approach and its implementation. They felt that by bringing in a 'new' approach, their practice was considered as outdated or 'poor'. Involvement in the evaluation process allowed many staff to discuss their thoughts and feelings and have this fed back to senior management. The evaluation process has for some staff been both cathartic and an opportunity for learning.



## And finally.....

Towards the end of the evaluation it was evident that many staff had travelled a significant distance in adopting and implementing the approach. Many staff were able to discuss their earlier feelings and accept their attitudes made implementation of the approach difficult.

Staff presented as much more relaxed and confident; able to discuss what the approach meant to them and how they were applying it in their services. Some were able to laugh at how resistant they had been and were able to examine why their former practice was not recovery focussed.

At the end of the evaluation some staff felt that the pace of change was not quick enough, whereas, in the early stages many felt there was no need for change.

All the evaluation participants believed a recovery approach should be implemented throughout the organisation and that it would have positive effects on service users.

**‘The tension has gone now. We understand it (recovery) now and see it as a good thing. We’ve heard what other people are doing - I can’t believe I was so stressed about it.’ – support worker**

# Appendix 1

## List of participants

The Link User Involvement Group, Dundee  
Whins of Milton Service

78 participants in the initial survey  
171 staff in the final survey

The following participants in workshops and interviews;

Sam	Anderson	Peter	Inglis
Isabel	Armstrong	John	Irving
Jill	Arshad	Douglas	Johnston
Mary	Ballantyne	Julie	Karp
Michelle	Blair	Kate	Kay
David	Bovaird	Claire	Keenan
Joan	Brown	Holly	Key
Tracey	Brown	Irene	Kidd
Greg	Burgess	Jacqui	Lamont
Jan	Cameron	Roseann	Logan
Murdo	Campbell	Eilidh	MacDonald
Tommy	Carlin	John	Mackie
Sean	Carlisle	Lesley	Mania
Susan	Castle	Carolyn	Martin
Karen	Conn	Paula	Mason
John	Crawford	Noreen	McBride
Catherine	Crossley	Alison	McClymont
Bronwen	Davies	Gordon	McCrae
Alana	Dearden	Sharon	McCrae
Lyn	Docherty	Teresa	McIntyre
Kelly	Dougan	Charlie	McMillan
Kath	Duncan	Les	McNeil
William	Ellis	Ronnie	Menzies
Lesley	Forbes	Carol	Montgomery
Susan	Forrest	Terry	Morris
John	Gallagher	Christina	Naismith
Irene	Gill	Shona	Neil
Tracy	Grant	Lorraine	Nesbitt
Carol	Heron	Terry	O'Neill
Mark	Hall	Alan	Ostler
Don	Halley	Alison	Park
John	Harper	Charlie	Parker
Hugh	Hill	Susan	Paterson

John Ramsay  
Liz Reid  
Audrey Rennie  
Debbi Riddell  
Lori Ritchie  
Chris Robb  
Kim Robertson  
Bill Russell  
Martha Simpson  
Debbie Smith  
Sarah Smith

Angela Spencer  
Keith Staples  
Caroline Steadman  
Robert Thomson  
Cliff Watt  
Chris Weir  
Janice White  
Kate Winstanley

# Appendix 2

## Final SAMH Staff Survey - Recovery Approach

Please place an x to indicate your response

### 1. How long have you worked with SAMH?

0-6 months	
6-12 months	
2 -24 months	
over 2 years	

### 2. How would you describe your job?

senior manager	
locality manager	
service manager	
support worker	
admin/clerical worker	
other (please state what)	

### 3. How would you rate your understanding of the recovery approach?

Excellent	
Very good	
Good	
Average Could be Better	
Poor	

**4. How would you rate your understanding of the recovery approach now compared to 12 months ago?**

Much better	
Somewhat better	
A little better	
The same	
worse	

**5. Have you heard of the recovery team?**

yes	
no	

**6. What information have you had about the recovery approach?**

none	
discussion at team/staff meeting	
training course	
information as part of induction to job	
written information (leaflets etc)	

**7. Rate how confident you feel about the recovery approach (1 is low 5 is high)**

1	
2	
3	
4	
5	

**8. Tick 3 words/phrases that you think best describe a recovery approach**

medication free	
potential	
person focussed	
choice	
cured	
change	
doing it already	
openness	
no boundaries	
illness free	
living well	
hope	
expectation	
partnership	
empowerment	
unprofessional	

**9. How has adopting a recovery approach affected your work?**

Changed it for the better	
It means more work	
Made no difference	
Changed it for the worse	
Not sure	

**10. What difference has adopting a recovery approach meant to service users? (Mark all that apply with an X)**

They have more say in their care plan	
The focus is more positive	
They work towards being medication free	
The focus will be on their potential and hopes	
Service users have too high expectations	
Boundaries with staff have been crossed	
Staff listen to service users more	

**11. What have you done in the last 12 months that has helped you understand the recovery approach?**

.....  
 .....  
 .....

**12. Has using the recovery approach changed any of your practice?**

<b>Yes</b>	
<b>No</b>	

**13. Please give one example of how your practice has changed using the recovery approach.**

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