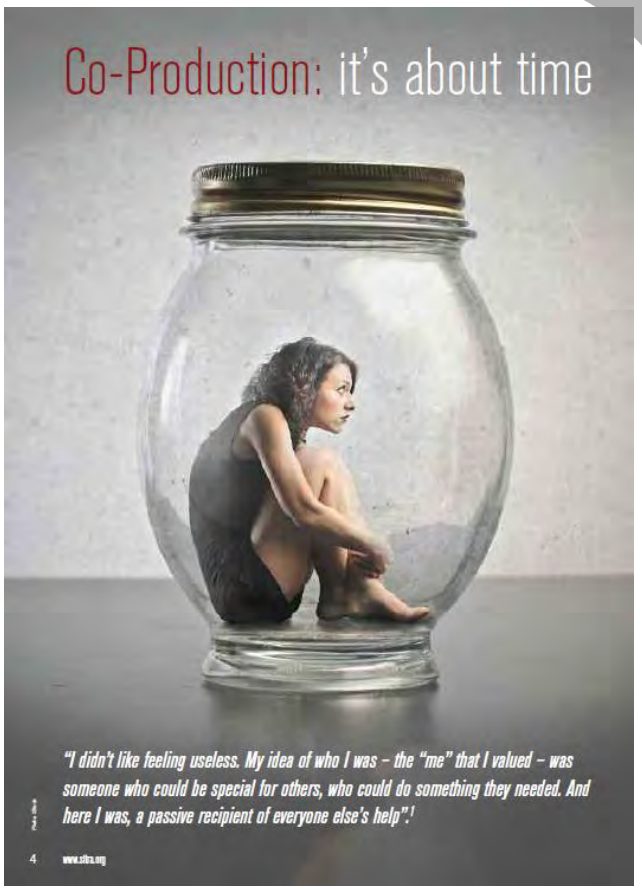
Engaging in Co-production and Developing Team Recovery Implementation Plans



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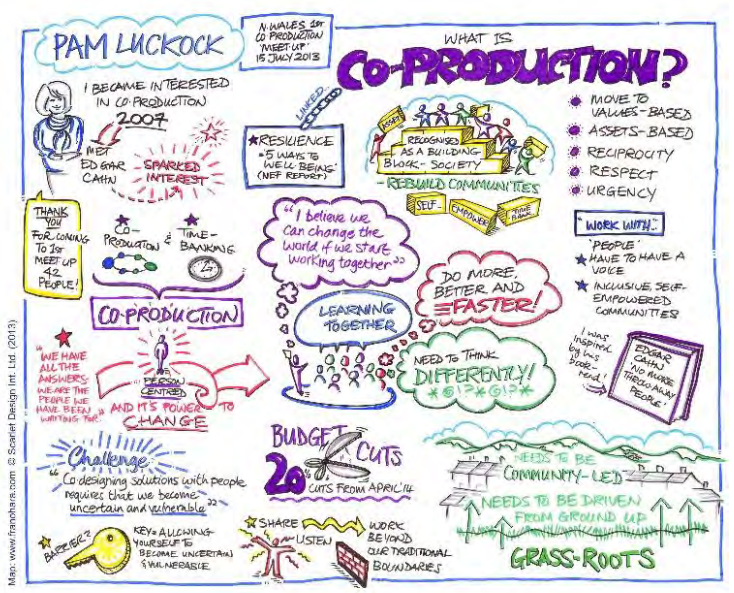
Part 1
Co-production, shared decision making and NDIS



A view from 4 perspectives

- Over 30 years working in UK NHS mental health services ... from clinical psychologist to director …
- Over 20 years in various UK government advisory committees/roles
- 4 years as founder member and senior consultant with UK ‘Implementing Recovery through Organisational Change’
- Over 25 years being on the receiving end of mental health services (inpatient and outpatient)

Everyone diagnosed with a mental health condition faces the challenge of recovering a satisfying, hopeful and contributing life

- finding meaning in what has happened
- finding a new sense of self and purpose
- discovering and using your own resources and resourcefulness
- growing within and beyond what has happened to you
- pursuing your aspirations and dreams

"Recovery is *"a way of living a satisfying, hopeful and contributing life even within the limitations caused by illness. ... a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and roles. 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)

‘Recovering a life’ not ‘recovering from an illness’

- **Recovery is not the same as ‘cure’**

  Rebuilding your life is not about ‘becoming normal’ - does not mean that all problems have disappeared but you have worked out ways of living with them

- **Recovery is not a professional treatment or intervention**

  Recovery is a personal journey. Mental health services cannot ‘make people recover. They may be able to help you ...but they cannot rebuild your life for you.

“Recovery is not fixing what’s broken It’s finding wholeness, meaning, and purpose”

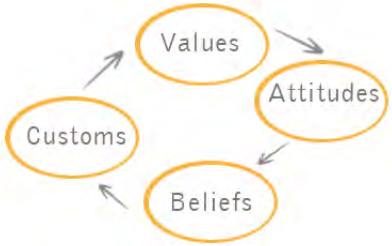
Duane Sherry

“ Recovery in mental health is not about waiting for the storm to be over. It is about learning to dance in the rain.”

Peer Recovery Trainer, CNWL London Recovery College

Recovery is a personal journey, but it is not a journey travelled alone

It is a journey travelled in the context of a family, a social network, a community , a culture, a place …



- The **meaning of mental health challenges** has to be understood in the context of the person's social network and community

- The **resources and possibilities for rebuilding a meaningful, valued and satisfying life** must be understood in the context of the person's social network and community

- **People close to the person also face the challenge of recovery.** It is not only the person who grows within and beyond what has happened – this challenge also faces relatives and friends. Relatives and friends face two challenges of recovery: helping the person they love in their journey and recovering and rebuilding their own lives.

Everyone's recovery journey is different, but three things seem to be particularly important

Hope
Believing that a decent life is possible

Control and self-determination
Control over your life and destiny, the challenges you face and the help you receive

Opportunity and citizenship
The opportunity to do the things you value and participate as an equal citizen

(See for example, Anthony, 1993; Repper and Perkins, 2003; Shepherd et al, 2007; Perkins and Slade 2012; Perkins and Repper 2012)

Personalisation and personal budgets in England and NDIS in Australia can be an important tool in promoting recovery

Giving people greater control over the resources and supports they need to do the things they value and pursue their own aspirations and ambitions

Personalisation and personal budgets in England

- **A personal budget is an allocation of social care or NHS resources** (or an integrated allocation of both) **that is controlled by an individual and can be used to meet identified goals**

- It can be
  - **notional budget** managed by statutory services
  - a **third party can manage the budget** (an independent voluntary organisation or an individual - friend or relative)
  - a **direct payment**: the money is transferred to the person and they buy goods and services themselves. An independent direct payment support agency (e.g. Independent Living Centre) may help the person to manage their direct payment

Personalisation and personal budgets are the basis of a different conversation between the person and professionals by putting the person in the driving seat

"We stopped talking about my 'needs' and started talking about how I wanted to live my life."

- They **recognise that each person is the expert** about what matters to them **-** what they want to do in life **-** and the sort of support they find helpful
- **Resources are then allocated and a support plan is developed based on the person's preferences and wishes –** there is no fixed menu …

Choice and control with money attached!

Personalisation/NDIS and recovery: two ideas, one shared vision

"At their core, both recovery and personalisation are rooted in self-determination and reclaiming the rights of full citizenship for people with lived experience of mental health problems."

(Alakeson and Perkins, 2012)

- Rooted in **lived experience** and **self-determination**
- Goal of **equal citizenship** for all people with mental health conditions
- Focus on helping people **to pursue their aspirations** rather than getting rid of problems
- Focus on **strengths and possibilities** rather than deficits, dysfunctions and problems
- Challenge the mental health system to **see 'patients' and 'service users' as people**
- **Move beyond 'service land'** specialist mental health services do not hold all the answers
- **Challenge predominance of professional and clinical knowledge over the expertise of lived experience**

Involve a different relationship - a change in the balance of power - between mental health workers/services and those whom they serve

- **Traditional services recognise one set of experts**
  - The mental health workers and the patients/clients/consumers: ‘them’ and ‘us’
  - Assumed that mental health workers are the experts
  - Therefore it is mental health workers’ job tell ‘them’ what is wrong with them and what they need to put things right
- **Recovery–focused services and personalisation/NDIS: two sets of experts**
  - Experts by profession, qualification and degrees – expertise based on professional research and theories
  - Experts by lived experience – expertise based on personal experience and personal narratives
- **Creating recovery-focused services requires that we**
  - Use our professional expertise differently
  - Recognise, value and use the expertise of lived experience
  - Recognise that each person is the expert in their own recovery

A different kind of relationship
changing the balance of power

- **Mental health professionals ‘on tap’ not ‘on top’**

  Putting our knowledge and expertise at the disposal of those who may find it helpful rather than telling people what to do

- **Shared decision making at an individual level**

- **Co-production in service design, delivery and development**

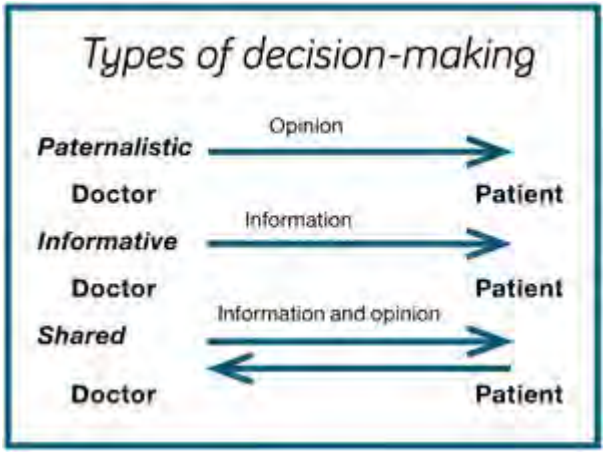
Central features of shared decision making and co-production

- the people who use services are **experts in determining their own requirements**
- people who use services **play an active role in meeting their own needs**, rather than being passive dependents/recipients of services
- **mutual aid between people who use services**, promoting new mechanisms of **peer support**
- **broader community (including families) are active in the production of support**, offering a collective model of co-production
- involves a **redefinition of what constitutes an 'outcome'** in public services, focusing on those things that are important to people who use services (often less tangible issues like relationships and quality of life)

Shared decision making and co-productive approaches **can be used with different people who use services** (people with mental health conditions, physical impairments, dementia ...)

Needham, C (2009) *SCIE Research briefing 31: Co-production: an emerging evidence base for adult social care transformation*

Shared decision making at an individual level



Shared decision making assumes that there are two sets of experts:

- **The mental health workers/social workers** bring an **understanding of the problems**, **possible supports and interventions** and **their potential benefits** from their professional training and experience and from research

- **The consumer** brings an understanding of their own **values, aspirations and preferences**, their **lived experience of what has been helpful** and what has not, and **their own skills, networks and resources**
- **People who are important to the person (friends, relatives)** may also bring their experience of what has been helpful

And that the two sets of experts share their expertise:

- Come up with solutions for support and help that are **in line with the person's values, aspirations and preferences**, assist them to **achieve their aspirations** and **use their own skills and resources**

Research shows that shared decision making leads to greater engagement, higher satisfaction with services and better quality decision making

(e.g. Kreyenbuhl et al, 2009).

Making a reality of shared decision making can be challenging

Helping people to decide what they want and what is important to them and what support might be available

It can be difficult for anyone to decide what is important to them, what they want to do in life and what help they might value

For many people in mental health services, the problems are magnified. They may:

- have **given up on their aspirations and ambitions** because they have
  - been told that they are 'unrealistic'
  - faced many barriers in trying to pursue their ambitions (discouragement, lack of support, prejudice, discrimination)
- have **little confidence in their own abilities and judgements** because they have been told these are flawed
- be **used to being told what is best for them** and what they should do so they have given up making decisions for themselves
- have **little idea about all the options available** to them
- have **little idea about the different possible sources of support**

In addition, too often, staff in mental health services

- **are very good at 'verbal persuasion'** (aka bullying) persuading the person that the staff view is the correct one
- have very **low expectations** of the people whom they serve:
  - do not know what people who experience mental health challenges can achieve,
  - believe that because of their mental health condition they cannot make decisions for themselves and need to be 'looked after'
- are often **unaware of all the possibilities and supports available within communities** and across different service providers

Things that can be helpful

- **Images of possibility -** seeing what others who have faced similar challenges have achieved
- **Time to explore possibilities** and reach decisions
- **Someone independent to act as a coach**: help you to think through what is important to you, evaluate different possibilities etc.
- **Independent help with support planning and brokerage:** someone outside provider services
- **Access to full information about different sources of support - within and outside 'service land' -** in an accessible format … including 'going to see for yourself'
- **Decision aids** (courses, leaflets, fact sheets, videos, DVDs, websites, interactive web sites e.g. 'common ground' developed by Pat Deegan https://www.patdeegan.com/commonground/uses)

- **Access to the expertise of lived experience**: people who are managing their own budget, receiving different sorts of support etc. so you can find out what it is really like!
- **Examples of what sorts of support others have received**
- **Support groups where people can share experience**
- **Courses/workshops in shared decision making** (for people using services and for staff e.g. Health Foundation Co-creating Health Programme)

http://www.health.org.uk/public/cms/75/76/313/551/Co-creating%20health%20briefing%20paper.pdf?realName=vK5jXO.pdf

The importance of peer support and consumer-led organisations in providing help with support planning and brokerage in relation to personal budgets

UK support planning and brokerage demonstration project (2011)

Compared support planning and brokerage provided by consumer organisations and by statutory organisations (Local Authorities)

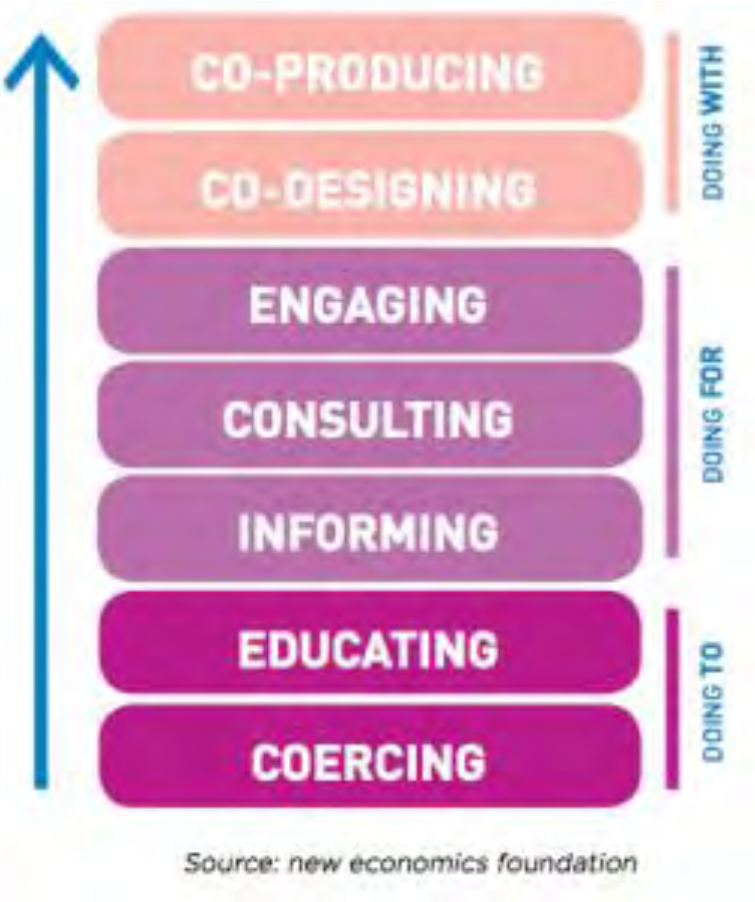
Support planning from consumer organisations:

- Perceived as more 'human', less bureaucratic, offering greater continuity of support
- People more likely to opt for a personal budget and take it as a direct payment
- Particularly valued the peer support element

http://www.ndti.org.uk/uploads/files/support-planning-and-brokerage-project-report.pdf

e.g. Kent Peer Support Brokers http://peersupportbrokers.co.uk/

Co-production at a service level



Traditional 'consumer involvement'
Involving 'them' in 'our' services:

- **Consultation:** asking for 'consumer' opinions on plans or proposals developed by mental health workers … or offered 'choice' between a couple of options determined by mental health workers
- **A customer service approach:** asking consumers 'what do you want?' … with mental health workers/services expected to deliver what consumers want ... or often explaining why they can't deliver it 'yes, but ...'

Often:

- One or two service consumers on 'our' committees, interview panels etc. (no control over agenda, job descriptions, always in a minority ...)
- 'Consumers' seen as undifferentiated - defined only by consumer status not other skills and attributes they may have
- Outcomes defined by service providers (reduced bed days, throughput, medication compliance ...)

Alison Cameron, London, describes her experience of 'user involvement'

"I found the experience of being a passive recipient of care dehumanising, disempowering and disenfranchising. I felt patronised and invalid."

then

"Somewhere … I managed by chance to make contact with others who were successfully managing their alcohol problems and mental health issues and experienced the tiniest glimmer of hope …

"I started to claw myself back with the help of my peers. I started to take power back… I started to become a participant in my own recovery … I started to notice what was going on around me and note that things needed to be improved."

"I trained as a mental health advocate, began to speak at conferences, write articles, campaign, rattle cages … In fact I was almost the poster child for 'service user involvement'."

but

"I became increasingly disillusioned that I was simply being wheeled out to create the illusion of commitment to … 'involvement', 'empowerment' etc. but I could see that my involvement was to a great degree tokenistic and that professionals often had a profound fear of competent, forthright service users who were often at least as well-informed as they were."

Co-production

"Co-production ...is not the same as consultation or the types of tokenistic participation of people who use services and their carers which do not result in meaningful power-sharing or change."

Needham, C (2009) *SCIE Research briefing 31: Co-production: an emerging evidence base for adult social care transformation*

"Co-production goes well beyond user* [consumer] *involvement ... It promotes equal partnership between service workers and those intended to benefit from their services – pooling different kinds of knowledge and skill, and working together."

"Co-production means designing and delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours. Where activities are co-produced in this way, both services and neighbourhoods become far more effective agents of change."

New Economics Foundation (2011) *In This Together. Building knowledge about co-production*

NESTA (2009)The Challenge of Co-production

NESTA (2012) People Powered Health Co-Production Catalogue

Co-production

- Challenges the conventional model of public services …

'Product' delivered to a 'customer' from on high	→	Devolvement of power, choice & control to people using services, communities and frontline staff

- Requires a shift in mind-set …

People using services being seen as 'burdens on an overstretched system'	→	People using services as assets: the 'real wealth' too often untapped & wasted resources

Consumer and professional roles in the design and delivery of services

(Adapted from Carneige Trust (2006) 'Commission for rural community development. Beyond Engagement and participation, user and community co-production of services)

		Responsibility for the planning and design of services		
		Professionals as sole service planner	**Professionals and consumers/ communities as co-planners**	No professional input into service planning
Responsibility for delivery of services	Professionals as sole service deliverers	Traditional professional service provision	**Professional service provision but consumers involved in design**	Professionals as sole service deliverers of consumer designed services
	Professionals and consumers/ communities as co-deliverers	**Consumer co-delivery of professionally designed services**	**Full co-production**	**Consumer co-delivery of consumer designed services**
	Consumers/ communities as sole deliverers	Consumer delivery of professionally designed services	**Consumer delivery of co-designed services**	Self-organised, consumer run provision

There is no one 'correct' way of doing co-production … but there are 6 key principles

(see Boyle et al, 2010; New Economics Foundation 2011; Alakeson, 2013)

1. Recognising people as assets (rather than problems)

Transforming people who use services from passive recipients of services and burdens on the system into equal partners in designing and delivering services.

2. Building on people's capabilities (rather than just focusing on their needs)

Altering the delivery model of public services from a deficit approach to one that provides opportunities to recognise and grow people's capabilities and actively support them to put these to use with individuals and communities.

- Lived experience of mental health conditions and the expertise people have gained as a result is valued
- People who use services have many 'hidden talents' other than their experience of mental health challenges and using services (qualifications, skills, knowledge, expertise, personal qualities …)
- Moving from a focus on 'getting rid of problems' to enabling people to have opportunities to use and grow their talents and capabilities and put these to use with other people and in their communities

3. Mutuality and reciprocity (rather than passive consumption of public services)

Offering a range of incentives to enable people to work in reciprocal relationships with professionals and with each other, where there are mutual responsibilities and expectations.

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4. Shared roles: blurring distinctions between producers and consumers (with consumers being actively involved in producing outcomes)

Dissolving distinctions between professionals and recipients, and between producers and consumers of services, by reconfiguring the way services are developed and delivered.

- Staff and consumers working together
- Moving beyond ‘them’ and ‘us’ to ‘we’
- Moving beyond consumers saying what they want and staff being expected to deliver it
- Sharing responsibility for delivery as well as deciding what should be delivered

4. Peer and community networks (that complement bilateral relationships between professionals and consumers)

Engaging peer and personal networks alongside professionals as the best way of building knowledge and supporting change.

6. Facilitating rather than just delivering services

Enabling public service agencies to become catalysts and facilitators of change rather than sole providers of services themselves.

- Widening the resource base
- Shifting from 'delivering services' to supporting things to happen
- Services cannot fix people but they can support people in their journey of rebuilding their life … recognising and using their own resources and resourcefulness and the resources available to them in their networks and communities
- Catalysts to development of networks and supports ...
- (e.g. Creative Minds in South Yorkshire http://www.southwestyorkshire.nhs.uk/quality-innovation/creative-minds/ and Prosper in South West London http://www.prospernetwork.co.uk/)

Co-production and shared decision making mean doing things differently at both an individual and a service level

- From **token representation/involvement to equal partnership**
- **From consulting – to working together** to understand constraints and define possibilities at individual and service levels
- **From asking consumers' opinions opinion on support plans or service development proposals to working together to develop the proposals in the first place** – starting from a blank sheet of paper
- **From professionals taking responsibility for providing what service consumers want to shared responsibility for design and delivery** of individual support, services and risk
- From **service defined outcomes to consumer defined outcomes**
- From **'consumers' as an undifferentiated mass to recognition of range of assets, talents and resources** - the untapped wealth in our services

From 'them' and 'us' to 'we'

From 'yes, but ...' to 'yes, how ...'

Breaking down boundaries between ‘us’ and ‘them’ means developing a different kind of relationship: relationships that demonstrate our common humanity

How can we help people to see themselves as ‘human beings’ if we do not relate to them as human beings? How can people regain their self-respect, if we do not demonstrate our respect for them?

If our services are to recognise and value both of these types of expertise we must also recognise both those types of expertise in staff

Staff bring two types of expertise

- Our professional qualifications and experience
- Our lived experience:
  - Our experience of life - skills talents, interests, beliefs, culture...
  - Our experience of trauma and recovery from trauma

Rules about ‘professional boundaries’ often stop us using our experience of life and our experience of trauma and recovery

We have spent a lot of time thinking about how to use our professional expertise – we must now start valuing, and thinking about how we use, our lived experience

For example, 'knowing each other'
(part of the UK Safer Wards initiative)
http://www.safewards.net/interventions/know-each-other

Safewards

Know Each Other Template- Staff

You do not need to answer every question on this form, but please tell us something about yourself! This will be typed up, laminated and put in a folder which will be kept in the communal areas of the ward, to help people to get to know each other.

Name:

Job title:

Years of experience working in mental health:

Likes:

Dislikes:

Hobbies/interests:

Previous Jobs:

Favourite TV programme:

Film :

Book:

Music:

Please try and give some explanations for your answers (e.g. 'because it makes me laugh…)

Favourite quote:

Top life tip:

Anything else???

Things to consider when sharing more personal information about lived experience of trauma and mental health challenges

Dorset Wellbeing and Recovery Partnership (2013)
Dorset Healthcare NHS Foundation Trust and Dorset Mental Health Forum

- **WHAT** you are prepared to share, and be aware of this before you get into the position of sharing any information.
- **WHY?** What is the purpose of sharing information, are you clear what the potential benefit to the person will be?
- **HOW?** What is the best way to share experience, how is it best approached?
- **WHEN?** Each situation and each person is different and careful thought needs to be given to each one.

Co-production and shared decision making are not easy …

For staff and service users it means major changes: moving from the ‘trenches’ of ‘them’ and ‘us’ to the ‘no man’s land’ in between

- Mental health workers have to accept that ‘the experts don’t always know best’
- Consumers have to accept responsibility not only for saying what should be done but also for doing it
- Moving beyond criticism of each other to recognising each other’s strengths and contribution
- Moving beyond ‘service land’ to embracing the assets in networks and communities

Working out new relationships takes time and effort!

But they can transform lives as well as services
Sue Williams' experience of co-production(2012)

From burden to asset

"A report written about me in 2010 started with the words 'Ms Williams is a very vulnerable woman with many complex needs' … but as a result of co-production I have been transformed from a burden to an asset! …This transformation has been amazing - not only do others now have radically altered perceptions of me, my own self-perception has changed radically from difficult, dependent patient to contributing, highly valued colleague. This transformation feels almost magical … How did that happen?

Well an important way was being asked to … use my lived experience - and other skills - to co-develop policy, provision and training. I am on a steering committee and I co-produce and co-facilitate training at the Recovery College, as well as working as a peer support worker in a ward. In all these settings I have moved from being a passive and unhappy recipient and survivor of services to a thriving and valued colleague."

Engaging peer and personal networks

"As recently as 2010 the only adults I had contact with were within 'services". The long list of 'helping' professionals included psychiatrists, psychiatric nurses, therapists, social workers, family workers and lawyers. My diary was full of appointments with them all.

More recently, through co-production my social network has changed dramatically … I got involved with all sorts of people in different capacities through peer support training and groups, in policy and provision meetings and at the recovery college. I addressed the debts that were dragging me down with help from the CAB, I have become a parent Governor at my children's school – an important achievement considering that throughout 2010 I was in the family court every fortnight where my ability to be a good enough mother to my children was being scrutinised. I no longer have a social worker, or a CPN – I have sole care of my children, I have friends and colleagues and an active role in my community."

Shared roles: blurring **distinctions between producers and consumers**

"I moved from only having contact with professionals as a patient in their services to working alongside those same staff who once treated me . Initially I thought this might be a difficult position for both myself and those who have worked with me and was worried about how they might respond. What I experienced was a delighted response from staff who without exception all said how great it was to have me as part of their team. Some commented that it was rare and rewarding for them to see users of their service when they were well and this gave them a more positive view of the reality of recovery.

There is no sense of 'them and us' and I feel that the unique perspective that I brought having been a patient on the ward … was genuinely appreciated. I saw how perceptions and stereotypes relating to mental health could be transformed by having someone that used to be a patient on the ward working there. More than one member of staff and a number of patients have said "I can't believe that you were ever on the ward." Many said in different ways that they were personally inspired having seen it was possible. I know where they are coming from because two years ago I could not have even imagined it was possible!"

Back to NDIS …

Evaluations of personal budgets in England show that personal budgets are effective and cost effective

- Led to significant improvements in **quality of life, choice and control and psychological well-being**
- **Greatest gains for people with mental health conditions**
- People who took the budget as **a direct payment reported more positive outcomes**
- Reduced the cost of support for individuals

… **but only if it is done properly**

Evaluation of Individual Budgets Pilot Programme (IBSEN, 2008); *National Personal Budget Survey* (TLAP, 2001); *Evaluation of the Personal Health Budget Pilot Programme* (DH/PSSRU 2012)

The way it is implemented affects the results … where shared decision making and co-production were poor, outcomes were less good

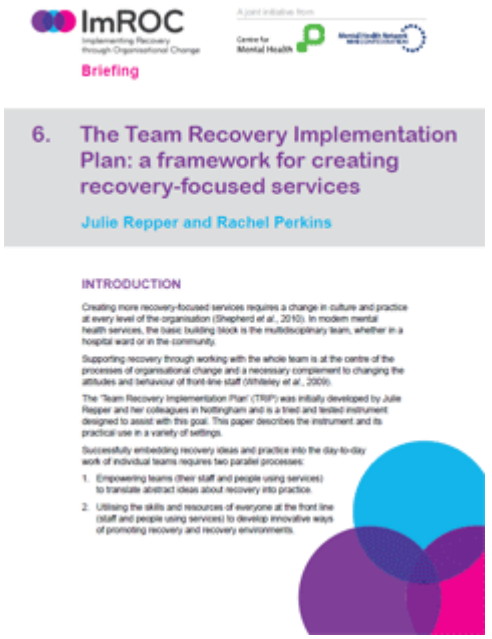
Problems in some areas

- **Lack of information** many people do not know the possibilities a personal budget affords and how it can be used
- **Processes are very slow and bureaucratic** up to 40 pages of assessment is not unknown and it can take many months to set up a budget
- **Lack of flexibility, extensive rules about what budget can be used for** and beliefs that some people (especially those with mental health challenges and learning disabilities) could not manage personal budget
- **Not enough/poor quality help in developing support plans**
  - helping people to think about what is important to them
  - helping people to think through the different sources of help and support available - 'thinking outside the box' of traditional service provision

Discussion: Co-production, shared decision making and preparing for NDIS …

What are we already doing?
What else can we do?
How might we do it?

Part 2
Developing Team Recovery Implementation Plans



ImROC
Implementing Recovery through Organisational Change

A joint initiative from Centre for Mental Health and Mental Health Network NHS Confederation

Briefing

6. The Team Recovery Implementation Plan: a framework for creating recovery-focused services

Julie Repper and Rachel Perkins

INTRODUCTION

Creating more recovery-focused services requires a change in culture and practice at every level of the organisation (Shepherd *et al.*, 2010). In modern mental health services, the basic building block is the multidisciplinary team, whether in a hospital ward or in the community.

Supporting recovery through working with the whole team is at the centre of the processes of organisational change and a necessary complement to changing the attitudes and behaviour of front-line staff (Whitley *et al.*, 2009).

The "Team Recovery Implementation Plan" (TRIP) was initially developed by Julie Repper and her colleagues in Nottingham and is a tried and tested instrument designed to assist with this goal. This paper describes the instrument and its practical use in a variety of settings.

Successfully embedding recovery ideas and practice into the day-to-day work of individual teams requires two parallel processes:

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

Everyone who is diagnosed with mental health problems faces the challenge of recovering a meaningful, valued and satisfying life

- **Recovery is not an end point or a destination it is an ongoing journey of discovery** - a way of approaching each day's challenges
- **There is no formula for recovery** - each person's journey is unique and deeply personal

The challenge for services is how to better assist lots of different individuals in their journey of recovery

- **Creating services that better support people in their recovery journey is not an end point or destination it is an ongoing journey** - a way of approaching everything that we do
- **There is no formula for the development of recovery-focused services …**

The process of creating services that better support people in their journey of recovery is much more like ‘cultivating a garden’ than ‘following a blueprint’

Just like the journey of recovery, it requires that we

- understand and develop your strengths and resources - celebrate what we have achieved
- use these strengths and resources to continue to grow, move forward, build on what you have achieved

If we are going to be successful, we need to use all the assets and expertise available to us - the expertise of lived experience and professional expertise - and bring these together in a genuine partnership of equals

The Team Recovery Implementation Plan offers us a way of doing this

Team Recovery Implementation Plans (TRIP) are a way of facilitating co-production within teams and services

We cannot make services more recovery-focused by top down prescriptions

- this alienates and disempowers both staff and service users
- It means we fail to use the expertise, creativity and ingenuity of those at the front line

If we are going to continue improving our ability to promote the recovery of the people who use services we need to

- **embed recovery focused thinking and practice at the grass roots of organisations** – within individual teams
- **harness all the resources in those teams** - especially the creativity and ingenuity of all of front-line staff and the people they serve – **together we can make a difference!**

Initially developed in Nottingham – used in a range of different teams and services in the UK and beyond

- in statutory and voluntary sector services … including Richmond Fellowship in England
- in residential, inpatient, floating support, community, employment, day services …

- **NOT a 'one off' exercise but an on going process** of co-producing, co-delivering and co-reviewing what we are doing
- **NOT a 'tick box' exercise –** another form to be filled in - **but a way of supporting recovery-oriented ways of working in teams and promoting collaborative service development**

Experience suggests that it is the **process of using TRIP** – working together in a different way to create change, changing relationships and day to day interactions – that is important rather than the content of action plans themselves

Founded on co-production:

an equal partnership between front line workers and those who use the services

- **Recognising people as assets and building on the strengths within the team** (among staff and people using the service)
- **Mutuality and reciprocity: breaking down barriers, blurring roles** (staff and service users sharing responsibility for both design and delivery**)**
- **Extending the resource base** (by extending peer, personal and professional networks)
- **Teams/service as catalysts for change rather than creators of change** (enabling people to lead their own recovery and empowering people to develop a range of resources in peer networks and communities to support them in their journeys)

The components of TRIP:

1. Identifying assets

an overview of the resources that exist within the team among staff and people using the service

Not just experience of working in/using mental health services, also

- **'hidden talents'** e.g. skills and interests in IT, music, sport, gardening, languages, lived experience of trauma ….
- **contacts** with a range of communities and organisations and access to the resources within them

Anything that might be useful in supporting people in their recovery journey and in creating a more recovery-focused team

Moving beyond problems and needs – identifying skills and assets and using these within the service - can be really important in building confidence, seeing yourself as 'more than a mental patient', rebuilding your life

Components of TRIP 2: Benchmarking progress in recovery-focused practice

Good practice statements drawn from *Recovery Self Assessment – Provider Version* (O'Connell et al, 2005) and *10 Key Organisational Challenges* (SCMH, 2010)

Rating progress on a 5 point scale BUT this is not a simple 'tick box' exercise: **the discussion and details of progress made are the important bit** … the rating just enables the team to identify priorities and recognise progress made over time

A collaborative process of discussion among staff and people using services:

- celebrating what has already been achieved
- identifying areas that might need to be addressed
- ideas about things that could be done
- deciding on priorities

TRIP benchmarking asks people to think about things like

- Understanding of opportunities in communities and promoting community participation
- Helping organisations/facilities in the community to understand and accommodate people with mental health challenges (generally or in relation to an individual)
- Involvement of people who are important to the person like family and friends
- Personal recovery plans, health and well-being at work plans etc.
- Collaborative support planning and shared/self-held progress notes
- Choice, helping people to decide what they want (even if this is not what we think is best)
- Positive risk taking (helping people to try new things) and collaborative safety plans
- Peer support, recovery stories
- Self-defined recovery goals and celebrating progress to towards these
- Access to recovery education … with expertise from people who have moved on
- Signposting/helping people to access different interventions and supports
- Involvement of people using services in recruitment
- Recovery focused supervision and appraisal for staff
- Supporting staff well-being

Components of TRIP 3: Identifying priorities and developing action plans

- These don't have to be the 'worst' areas – often a combination works best:
  - quick wins and longer projects
  - building on something we are already doing and embarking on something new

Targets for action need to be SMART Specific, Measurable, Achievable, Realistic, Timed: identify what can be achieved by when and how you will know it has been achieved

At least one member of staff and one person using services jointly responsible for implementation … assisted by a 'working group' as necessary

TRIP benchmarking, identifying priorities and action planning can be done in many ways, for example

- meetings with both staff and service users present,
- separate staff and service user forums then bringing the two together,
- by individuals and then collated …

But people need to come together to agree benchmarking, identify priorities and agree action plans … and how the skills and resources available to the team might be used to achieve these

For example, whole team recovery away-days (staff and service users/representatives)

Components of TRIP 4: Keeping the plans alive - review and re-setting of goals

To keep the whole process alive teams need to establish **forums for reviewing progress, problem solving, refining and building on work plans** … supporting joint leads in their work and holding them accountable for their actions

Can set up new meeting, but may be preferable to use an existing meeting (e.g. ward community meeting or team business meeting – but must include people using services) so TRIP is core part of the work of the team

Annual review to complete the cycle and develop new action plans

- Celebrate achievements
- Review assets, re-do benchmarking, agree new priorities, establish new action plans …

Embedding TRIP as ‘business as usual’ within services

- Process taken seriously by Board and senior managers: requiring completion, celebrating progress
- Relationship to business planning and quality assurance processes: not a separate initiative but unifying forum for all quality improvements
- Supporting the process: ongoing learning sets for team leaders to enable sharing of ideas and good practice and problem solving

Working in Groups:

Look through the TRIP benchmarking:

What are you already doing to promote the recovery of those whom you serve?

What ideas have you got about ways in which you might be able to develop and build on what you have already done?

Comments, issues etc. on the benchmarking

Working in Groups:

How might you be able to set about developing your own Team Recovery Implementation Plan

Identifying assets

Benchmarking

Identifying priorities and developing action plans

Keeping the plans alive - review and re-setting of goals