ImROC

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14. Recovery: the Business case

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EXECUTIVE SUMMARY

This paper makes the Business Case for supporting recovery. We believe that this should be informed by three types of data: evaluative research (such as randomised controlled trials); the perceived benefits for service users – what might be termed 'customer satisfaction'; and best evidence about value for money.

Some of the ImROC 10 key challenges have a very strong research base. For example, there is substantially more randomised controlled trial evidence supporting the value of peer support workers (challenge 8) than exists for any other mental health professional group, or service model.

Similarly, the scientific evidence for supporting self-management (challenge 1) is compelling. Other challenges have a strong evidence base indicating that they improve people's experience of services. The positive experiences of students at Recovery Colleges (challenge 3) and the beneficial impact on experience of more involvement in safety planning (challenge 6) are clear.

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Finally, the economic evidence is strong for some challenges. There is for example an established financial benefit from workplace mental health programmes (challenge 9), and a very strong value-for-money argument supporting the importance of access to decent housing, education and employment opportunities (challenge 10).

Of course, the Business Case is only one reason services should be attempting to support recovery. Some people would argue that it is a 'rights' issue. Those who use services simply deserve – by right - to be provided with the services that they appear to find most helpful. A third reason is political – mental health policy in many countries including the UK is clear that tax-payer funded services should focus on supporting recovery. A fourth reason is the pressure on Trusts to meet efficiency savings; a clear focus on supporting recovery can inform evidence-based resource allocation decisions. A final reason stems from the impact of political and economic pressures on the work of managers and practitioners in mental health. In countries throughout the developed world the demand for mental health services far exceeds the political will to dedicate adequate resources to it. This means that we may all have to think again about the nature of mental health services themselves – what should their priorities be? And, how should they be provided? Supporting recovery has some of the answers to these difficult questions. We believe there is now sufficient evidence to justify a focus on recovery as the 'core business' of the mental health and social care system.

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INTRODUCTION

This Briefing Paper presents the business case for offering recovery-focused services in health, social care, housing and other relevant sectors. It builds on existing work on investing in recovery which attempted to review some of the economic and social benefits of enabling people to achieve their own life goals, supporting them to manage their own condition, get a job, make friends, and maintain safe and secure housing of their choice [1]. The paper is aimed at senior managers, chief executives and commissioners in health and social care and other related sectors, policy makers, clinicians, people who use services, their families and carers. In this Briefing Paper we use 'mental health services' as a shorthand for the full range of services across all sectors which support people's recovery.

The concept of 'recovery' has become a dominant theme in mental health system policy internationally in the 21st century [2]. Thus, the World Health Organization Mental Health Action Plan 2013-2020 identifies the need for 'a recovery-based approach that puts the emphasis on supporting individuals with mental disorders and psychosocial disabilities to achieve their own aspirations and goals' [3]. The challenge for mental health services in each country is therefore not 'whether to support recovery?', but 'how?'.

To do this, we must be clear what we are talking about when we use the word 'recovery'. It is still a contested term and there remains considerable variation in how it is used by different commentators. In the ImROC programme we have consistently used it to describe the efforts of people with mental health problems to live meaningful and satisfying lives [4]. This is often referred to as 'Personal Recovery' to distinguish it from a process of symptom reduction ('Clinical Recovery') [5]. ImROC has also leant heavily on the early work by Repper and Perkins which highlighted the importance of 'hope', 'control' and 'opportunity' as key processes underlying these individual journeys [6]. Hope Control Opportunity

These ideas have been confirmed in a systematic review of the literature which added two other key processes: 'connectedness' and 'meaning'. This produces the 'CHIME Framework' [7] which consists of Connectedness (social support/ integration), Hope (optimism for the future), Identity (beyond that of a 'patient'), having Meaning (in one's life), and the importance of Empowerment (achieving some control over one's mental state and adjustment). CHIME Connectedness Hope Identity Meaning Empowerment This framework has been widely used to identify the processes of personal recovery which need to be supported in mental health services.

Overall, recovery is consistent with an emerging new paradigm about the delivery of services, which places far greater emphasis on people's strengths and possibilities than on their problems and deficits.

Supporting recovery therefore involves working differently. An international analysis of best practice in recovery support identified the need for transformation at four different levels [8], shown in Box 1.

"The challenge for mental health services in each country is therefore not 'whether to support recovery?', but 'how?'."

"CHIME: Connectedness Hope Identity Meaning Empowerment"

Box 1: Best practice in supporting recovery

1. ***Supporting recovery*** – providing treatments and other supports as a resource for the person to use in their recovery journey, rather than doing things to the person
2. ***Working relationships*** – 'how' you work with the person matters, i.e. the relationship is more than the vehicle to provide treatment, it is the 'treatment' – which has implications for e.g. relationships in a care co-ordination context
3. ***Organisational commitment*** – the culture within services directly impacts on how our services work, e.g. a disempowering management culture creates a disempowering (and disempowered) work-force.
4. ***Promoting citizenship*** – recovery happens in 'real life', as individuals find a safe home to live in, make friends, engage in meaningful occupation, etc. – these are the things we all need for wellbeing.

So, supporting recovery involves using clinical expertise as a resource, engaging with people as partners in care, not simply recipients, ensuring top-to-bottom alignment with recovery values in our organisations, and focussing efforts beyond health and social care systems to create pathways to citizenship. The ImROC programme identified '10 Key Organisational Challenges' to support these levels of transformation [9], shown in Box 2.

Box 2: 10 key organisational challenges as published in 2010

1. Changing the nature of day-to-day interactions and the quality of experience
2. Delivering comprehensive, user-led education and training programmes
3. Establishing a 'Recovery Education Unit' to drive the programmes forward
4. Ensuring organisational commitment, creating the 'culture'. The importance of leadership
5. Increasing 'personalisation' and choice
6. Changing the way we approach risk assessment and management
7. Redefining user involvement
8. Transforming the workforce
9. Supporting staff in their recovery journey
10. Increasing opportunities for building a life 'beyond illness'

"Hope Control Opportunity"

Some of these key challenges have been updated in the light of experience, as will be discussed later. We also note that the journey of understanding about recovery is not finished, and anticipate the need to focus more in the future on for example experiences of family [10], physical health (drawing on studies such as SHINE [11] and IMPARTS [12]), ethnicity [13] and community partnerships.

In this paper, these 10 key challenges are used to organise the information for the business case. For each organisational challenge, three important types of evidence of effectiveness will be summarised:

a) evaluative evidence from formal **research studies**. We now have credible scientific evidence for a number of effective approaches to supporting recovery, which we will describe later in this document.

b) evidence from narrative accounts and **experience of individuals** regarding the impact of these 'recovery-supporting services' on them, their families and on workers in the services (organisational/ cultural changes). People using services have also talked about the transformative potential of recovery:

Being supported in my recovery, rather than just having my symptoms of mental illness treated, meant that I got my life back, albeit a different one... I'd ended up with no hope, believing I was 'untreatable' and inadequate, but now I am back in the 'driving seat' of my life. I have friends, a job and an active role in my community because I was lucky enough to come into contact with people who could see the person behind the label and focus on me and my life, rather than just my symptoms.

c) **economic evidence** where available on the cost and efficiency of these new services. We will argue that investing in effective actions to support recovery also makes economic sense; something that is vital when health and other public services are under enormous pressure. Recovery is associated with a lower need to make use of specialist health services, increased participation in paid and voluntary work, as well as in social activities, more stable accommodation, and positive impacts for family units.

These three forms of evidence (research, personal experience and economic) constitute the Business Case justifying a move towards more recovery-oriented services. This paper, like all ImROC Briefing Papers, is co-written between people with a range of professional and lived experience.

"Recovery is consistent with an emerging new paradigm about the delivery of services"

Key organisational challenge 1: Changing the nature of day-to-day interactions and the quality of experience

Key concepts: Narratives; Strengths-based; Coaching; Shared decision-making; Self-management; Joint crisis planning; Open Dialogue

Research studies

The first challenge – and the most fundamental one – is to change the nature of day-to-day interactions between staff and people who use mental health services so that they are continually perceived to be supporting personal recovery and improving the quality of care experienced. This is an ambitious aim, but it must be the ultimate objective of all the organisational changes to be discussed later. It is also needed –only 31% of people nationally report having a very good experience of care based on their contact with mental health services [14].

Supporting personal recovery, whether inside or outside formal mental health services, is dependent on access to trusted and enduring relationships – what have been called **recovery promoting relationships** [15]. They are based on establishing shared values, demonstrating empathy, warmth, and respect for the individual, combined with a willingness to go the 'extra mile' [16]. These qualities form the bedrock for all forms of mental health care [17] and the evidence for the importance and effectiveness of these relationship skills is now well-established [18 19]. All professions make some effort to include them in their basic training, but the extent to which they are central to accreditation varies across professional groups.

There is also now evidence regarding *unhelpful* characteristics of staff working with people with severe mental health problems. A systematic review of the literature concluded that conversations which are pessimistic, uncaring, paternalistic or disrespectful hindered the development of helpful relationships and contributed to instilling hopelessness and inhibiting personal growth [20]. These detrimental effects were particularly damaging in the context of services characterised by discontinuity, coercion or insufficient time.

However, there are approaches which reflect recovery-supporting values, involve pro-recovery working practices and have an emerging evidence base. These include:

Use of narrative accounts

In terms of recovery-oriented practices, the best starting point is listening to the persons own account of what has happened to them. Everyone has a story to tell and the process of telling your own version of your story in your own words is almost always experienced as positive and validating. Such narratives help people to make sense of their experiences, they provide a basis for formulating personal goals and monitoring progress. They also provide a source of information and explanation which is complementary to a conventional, 'evidence-

"It [inpatient care] was a frightening and bewildering time for me. I felt completely lost and did not know what was happening to me or what the future might hold…(then) I met a nurse who proved, literally, to be my life-saver…She was a great inspiration. She told me that I would not always be in this state, although a lot of that would be up to me. With her support, I started to learn about myself…This wonderful woman gave me the strength to carry on, and not end my life as I had planned."
Service user

"My experience of using services was mainly that the focus was always on what was wrong with me….. I was always on the receiving end of other people's decisions about me, and I was not asked for my opinion. This just increased my own feelings of having nothing of any value to anyone...then one time my care co-ordinator asked what I thought about a decision … I remember feeling really surprised that he was asking me, but it actually started me thinking for the first time in a long time, about my own situation and what I could do about it."
Service user

based medicine' approach [21]. Approaches like Photovoice [22] are emerging as ways of enabling people to find ways of presenting their own perspectives, experiences and feelings using different media.

Building on strengths

A second important practice is the consistent use of a 'strengths' approach [23]. This seeks to identify the person's qualities, assets and competencies and their environmental resources (friends, neighbours, local opportunities) which might be used firstly as a basis for relationship building, secondly to confirm their personal value and achievements which they often struggle to identify, and thirdly as the foundations for building up skills and strategies to further their personal life goals [24]. A review of strengths-based interventions for people with severe mental illness identified benefits in relation to hospitalisation rates, employment/educational attainment, and intrapersonal outcomes such as self-efficacy and sense of hope [23].

Coaching

Another recovery-supporting practice, which has been developed in the last few years, is the 'coaching' model [25]. This uses many of the same techniques as the strengths approach, e.g. an emphasis on the service user taking the lead, the importance of identifying personally-relevant goals [26], and a focus on strengths and natural supports. However, there is greater emphasis on the importance of staff behaviour as a 'coach', or learning partner ('on tap, not on top') and on the service user's responsibilities to make a commitment to action. There is now emerging evidence for the effectiveness of coaching in relation to supporting recovery, both in [27] and beyond [28] the mental health system.

Shared decision-making

Systematic review evidence indicates that collaborative relationships which help individuals increase their sense of control over their lives are the best approach to supporting hope [29]. This can be achieved by establishing a greater focus on shared decision-making [30], particularly in relation to medication management [31]. NICE Guidelines state that shared decision-making should be used with all people using mental health services (Quality Statement 3), including specifically those detained under the Mental Health Act (Quality Statement 11) [32].

Joint crisis planning

This is an important application of shared decision-making in the context of discharge planning following inpatient admissions. The 'Joint Crisis Plan' (JCP) is formulated by the service user, together with peer support if available, and the key mental health staff involved in their care, including the treating psychiatrist. In an initial randomised controlled trial, people who were discharged with a JCP were shown to have significantly fewer compulsory admissions compared with controls over a 15 month follow-up period [33]. Qualitative data also suggested that the JCP group felt more 'in control' of their mental health problems [34]. A second study produced less impressive results, due to practical difficulties in ensuring that the joint planning meetings always occurred and were effectively facilitated [35]. Implementation of JCPs also depends on successfully engaging clinicians and overcoming their prejudices regarding the validity of service users' views and the feasibility of meeting them [36].

"The challenge for modern, recovery-oriented, mental health services is not just doing more of the same thing"

Self-management

Closely allied to shared-decision-making is the support of 'self-management'. A comprehensive review of the evidence by the Health Foundation (550 systematic reviews, randomised controlled trials and large observational studies) concluded that *"the totality of evidence suggests that supporting self-management can have benefits for people's attitudes and behaviours, quality of life, clinical symptoms and use of healthcare resources"* (p. v) [37]. The review found robust evidence that effective self-management support leads to higher self-efficacy and subjective well-being. Lower-quality evidence linked more effective self-management with improved clinical outcomes and the potential to reduce visits to health services by as much 80%. Specifically, in relation to mental health, peer-led self-management programmes improve primary care contact and physical health-related quality of life [38]. Approaches which include the full and active involvement of the person, rather than simply the passive provision of information, are most likely to be effective. Thus, the Health Foundation recommends, *"a fundamental transformation of the patient-caregiver relationship into a collaborative partnership"* (p.vi).

> *"I have noticed a gradual shift in the way the [memory service] team relate to people living with dementia since the peer support workers have been in post. They focus more on the existing skills and strengths of each person and how these can be built upon"*
> ***Project lead***

Open Dialogue

A final approach which brings together a number of recovery- supporting practices is 'Open Dialogue' [39]. This was developed in a small rural community in western Lapland, but is now beginning to attract international attention. It places the service user and their immediate carers at the centre of a shared decision-making process and assumes that their key role is to listen and try to make sense together of the personal meaning of psychosis. Implementation of the approach is based on rigorous training and implies significant organisational change but much is currently being claimed for its effectiveness in helping people achieve long-term valued outcomes, particularly in relation to reducing dependence on medications. At the moment, the evaluative research requires replication in larger, more heterogeneous and urban populations.

To summarise, the challenge for modern, recovery-oriented, mental health services is not just doing more of the same thing - more staff, greater professional expertise, more 'evidence-based' treatments, etc. We need to change the fundamental characteristics of the interactions between those tasked with delivering the services and those receiving them. We need to provide high quality, basic human relationships which develop trust, based on a respect for individuality and personal experiences of developing resilience in managing their experiences (of 'illness'). This will involve developing services which build on people's strengths and resources to help them use professional expertise to move towards personally valued social goals (housing, integration, employment), not simply the reduction of symptoms.

Economic evidence

If better long term social functioning is achieved as a result of reshaping the nature of the relationship between staff and people who use mental health services then positive economic outcomes will be achieved. For instance we know that participation in employment is both empowering, associated with better health (and thus lower need for health care services) and reduces the need for social welfare benefit support. Specific economic evidence on the different approaches that we have described are however limited.

Evidence on the economic benefits of shared decision making (for any health condition) is mixed, but studies appear to focus solely on short term outcomes rather than longer term benefits of better social functioning [40]. Separately there is also a literature on the value of peer support for decision making which is discussed later. Studies on shared decision making suggest that despite initial increase in staff contact time required for collaborative discussions, there are positive long term impacts on health service use. For instance several studies show that health coaching (particularly telephone coaching) for long term conditions can be cost effective. Analysis in the US of almost 10,000 people who received health coaching for conditions including depression and schizophrenia revealed consistent cost savings due to lower inpatient and outpatient contacts [41]. There is also some evidence in England that investing in coaching in community mental health teams, can be done without any immediate (one-year) significant impact on costs to the health system [27]. A German study looking at telephone coaching for different patient groups including people with mental health needs also did not identify any significant impact on health outcomes or costs[42]. Another small English case study which looked at costs and benefits of providing training in health coaching for a wide range of health conditions, reported substantial cost savings due to reduced time needed to treat people which would more than cover the costs of training. It did however acknowledge the need for large scale quantitative evaluation of coaching to formally determine costs and benefits [43].

The economic evidence on approaches to self-management tends to focus on physical rather than mental health needs[44 45]. This often suggests actions are cost effective. However little is known specifically about the economic case for self management in people with chronic mental health problems such as depression or anxiety disorders, although some economic analysis is underway [46].

There is evidence on the economic case for the joint crisis planning trials that we have discussed. The first of these studies found that there was almost an 80% probability of crisis planning being at least cost effective and often cost saving per additional 1% of hospital admissions averted compared to a standard information service, when taking into account use of health, social care and criminal justice system services over the subsequent 15 months [47]. The second study reported a similar likelihood of being cost effective from a health system perspective; in addition crisis planning had a 44% chance of being cost saving, although there was no significant difference in costs compared to routine support, when the broader impacts of criminal activity and time out of employment were taken into account [48]. A trial of joint crisis planning in the Netherlands found that it reduced future compulsory hospital admissions over the following 18 months, but there were no other significant impacts on health service use [49].

Key organisational challenge 2: Delivering comprehensive, co-produced learning opportunities

This key challenge has been updated in the light of experience.

Key organisational challenge 2: Coproduced Recovery focused learning and development opportunities are available for all staff working in services

Key concepts: Adult education; Self-directed learning; Problem-centred learning

Research studies

Adult learning is inextricably intertwined with recovery [50]. In general terms, adult learning in younger adults has been empirically shown to be an effective approach to reducing health inequalities [51-53]. There is also evidence from across the age range that participating in learning events can have positive effects on life satisfaction, health and wellbeing[54] [55]. For mental health service users, adult learning can also enhance resilience and help build social capital [56]; it can also reduce symptomatology and enhance wellbeing[57]. Overall, adult learning is therefore likely to impact beneficially on health and well-being and may increase community participation[58].

Specifically in relation to supporting recovery, adult learning is at the heart of developments like Recovery Colleges (key challenge 3) and peer support (key challenge 8) and it is through staff learning that changes in attitudes occur - especially among those in senior positions – and these lead to changes in organisational culture (key challenges 4 and 9). However, how these educational processes are organised is critically important.

Learning is not the same as being taught. Both teaching and learning are important. Some individuals prefer one method to another and some topics lend themselves more easily to one approach over the other. Nevertheless, *'perhaps the most critical shift in education in the past 20 years has been a move away from a conception of "learner as sponge" toward an image of "learner as active constructor of meaning" '* [59]. The key differences between 'teaching' and 'learning' (adapted from Wilson and Peterson [59]) are summarised in Box 3.

"Achieving authenticity and integrity…that's the challenge! I think genuine transformational leadership can be achieved by creating increased opportunities for dialogue between service users, carers and practitioners which is unfettered by the institutional restraints of the organisation. This is not "a quick fix" but a complex, slow process which requires a lot of hard work. If this process is endorsed corporately, it enables an on-going conversation at all levels of the organisation which facilitates the development of common values, aims and more open, genuine co-productive relationships between all the participants."
Recovery Programme Lead

"I think a recovery focused leader needs all the usual qualities of transformational leadership but they also need to really 'get recovery' and to be able to communicate it in a way that inspires others. They don't give up and they keep going even when the odds are stacked against them. They are prepared to take a leap of faith and although they know the direction of travel, they don't think they have all the answers."
Clinical Director

Box 3: Difference between teaching and learning

Moving from…'teaching'	*Moving towards…'learning'*
Passive absorption of information	*Active engagement with information*
Individual activity	*Both individual activity and collective work*
Individual differences among students seen as problems	*Individual differences among students seen as resources*
Facts and procedures of a discipline	*Central ideas, concepts, facts, processes of inquiry, and argument of a discipline*
Simple, straightforward work	*Complex, intellectual work*
Teachers in information-deliverer role	*Varied teacher roles, from information deliverer to architect of educative experiences*
Teachers do most of the work	*Teachers structure classrooms for individual and shared work*
Lessons contain low-level content, concepts mentioned; lessons not coherently organized	*Lessons focus on high-level and basic content, concepts developed and elaborated; lessons coherently organized*
Teachers as founts of knowledge	*Teachers know a lot, but are inclined to improve their practice continually*

An approach to learning that ImROC uses with whole teams (including staff from all professions and people using the service) is the **Team Recovery Implementation Planning Process (TRIP)** [60]. This process is a collaborative learning experience founded on co-production, in which the service becomes a catalyst for change rather than a creator of change by (a) enabling people to lead their own recovery and (b) supporting the development of recovery-oriented services and empowering people to develop resources in peer networks and communities. Early evaluation of the impact of TRIP is promising [61].

To summarise, changing staff (and thus organisations) to become more supportive of recovery involves using modern educational ideas which assume that people come to training with an active interest in learning, but also with their own pre-existing beliefs. Learning is about providing opportunities where these beliefs can be made explicit and can be discussed and, if appropriate, challenged. This is often best done in a group setting where everyone – not just the teacher – is encouraged to contribute. Approaches such as Schwartz Rounds [62] and engaging leadership [63] address the dynamic, relational and distributed nature of leadership.

"In order for staff to be able to work effectively within the recovery approach, they must feel empowered by their managers. Giving recovery targets or instructions to deliver recovery just won't work. Recovery focused leadership looks for the strengths of individual staff members and teams and brings them out, by giving support and encouragement. This does not mean that managers overlook problems or ignore bad practice, but looking for problems is not their starting point."
Service Director

Economic evidence

It is important to assess the economic impacts on staff of co-produced learning and development opportunities, as well as understand whether there are any financial and/or organisational barriers to participation in such learning opportunities. However much of the existing literature on co-production does not appear to devote much attention to outcomes and impacts on staff, other than changes in attitudes, as seen in the REFOCUS study. Improved understanding and insights for staff as a result of this type of learning, may be beneficial in terms of their own mental and physical health and perhaps also in terms of staff turnover – something that has been seen with the implementation of co-produced approaches to safety planning that are discussed in key challenge 6. This however needs to be assessed in future studies that look more at the impacts on the workforce and not just at changes in attitudes or knowledge.

Key organisational challenge 3: Establishing a 'Recovery Education Unit' to drive the programmes forward

This key challenge has been updated in the light of experience.

Key organisational challenge 3: Coproduced, Recovery focused learning opportunities are available for everyone using the service where people with mental health conditions, the staff and families who support them and others in local communities can share expertise and learn together

Key concepts: Recovery Colleges, Educational Approach, Co-production, Adult learning

"The recovery and social inclusion course felt amazing for me …. I have owned and worn a coat of stigma for most of my life. It was made to measure. Nowadays though, whenever I feel its weight upon my shoulders, I take it off and hang it on the nearest hook. It has become outworn, unnecessary and for the first time in my life, I feel confident enough to say that my own business with it is finished."

Coming to the college was an important first step in regaining confidence and motivation to do more with my life."

Research studies

Recovery Colleges are one of the key developments for promoting co-produced learning [64] and are probably the most visible change in mental health services which are attempting to engage with the recovery agenda. Currently there are nearly 70 Recovery Colleges in England [65] and they are being developed in several different European countries, and in Australia, Japan and Hong Kong [66]. The theoretical foundations for Recovery Colleges include: shared decision-making and self-management (key challenge 1), adult learning (key challenge 2), co-production (key challenge 7) and community participation (key challenge 10). They therefore embody a number of the central principles for supporting recovery. However, while the theoretical foundations are strong, the empirical evaluations are still weak.

Overall the available empirical evidence is consistently positive. Recovery Colleges are popular with service users, they engage people who often find traditional day services unattractive and attendance rates are consistently high [65]. There is also some evidence that they are associated with improved outcomes, both subjectively (higher hopefulness, more goal-directed behaviour) and reduced use of community mental health services, particularly among those who attend at the majority of scheduled sessions. Care co-ordinators with clients who attend RCs are also more likely to value and support self-management [67].

There is also evidence of benefits for the organisation as a whole in terms of improved staff expectations and attitudes [68]. There is patchy evidence that they can help with restarting education, voluntary work or employment [69] with one study finding 70% of students going on to be mainstream students or to paid or volunteer work [70]. This led an independent think-tank report to state that Recovery Colleges have '*significant potential for impact on improving employment outcomes'* [71].

However, the methodologies used to investigate these outcomes consist primarily of single case, prospective, follow-up studies using cross-sectional interviews or observational approaches [72 73 69 74 75]. There is little agreement on standardised outcome measures [76]. There is also a need to conduct further research to clarify the key elements of the 'independent variable' (i.e. attendance at the college). At the moment it is not known exactly what characteristics are critical [77]. These issues are being addressed in a NIHR-funded study called RECOLLECT (www.researchintorecovery.com/recollect).

"The 'telling your story' course gave me a different perspective on what I was feeling. I realised I still had some work to do, but was helped to see how to do it. Meeting other people who told their stories in different ways helped too."

"I have found the course to be a source of inspiration – I feel it breathed new life into my practise. It gave me a new approach to my patients, not seeing his/her problems, but their strength"

"Recovery Colleges are one of the key developments for promoting co-produced learning"

"It was helpful hearing people describe problems similar to those of my son."

Economic evidence

There is positive albeit limited evidence on the economic impact of recovery colleges. In England in-house evaluations of recovery colleges do suggest that there is a justified business case. The most methodologically robust evaluation compared the use of mental health services by students in the 18 months prior to and post enrolment in a recovery college. Overall there was a reduction in inpatient stays, admissions under the Mental Health Act and in community contacts while mental health outcomes also improved. Reductions were greater for students who completed a course compared with a retrospectively identified population that did not. It was estimated that overall there was a significant reduction in NHS Trust resource demands of £1,200 per student per year, even after taking into account the additional costs of delivering the Recovery College [78]. Costs averted increased to £1,760 for students who successfully completed a course.

An in-house evaluation of another Recovery College also identified a significant reduction in the use of health services by students (costs averted of more than £845 per year for those the completed a course) twelve months after attending courses [79], but students may have not have been comparable to those who did not use the college [78]. Overall, the evidence is encouraging, and potentially conservative. Some of the other benefits of using Recovery Colleges that may be realised, such as more confidence in seeking employment, will likely make the economic case more powerful. They also need to take account of the value of volunteer / co produced time and discretionary unpaid additional inputs from staff [80]. Going forward it will be important to compare investment in Recovery Colleges with appropriate alternative options to support recovery, using methods including controlled trials.

Key organisational challenge 4: Ensuring organisational commitment, creating the 'culture'. The importance of leadership at every level

This key challenge has been updated in the light of experience.

Key organisational challenge 4: Recovery focused leadership at every level and a culture of Recovery

Key concepts: Organisational commitment; Recovery as a priority; Empowering management; REFOCUS; Illness Management and Recovery (IMR); Team Recovery Implementation Plan (TRIP)

"We must think beyond simply 'training' staff to behave in different ways."

Research studies

Helping mental health services better support recovery means addressing some of the organisational changes necessary to establish a unique and distinctive culture. Of course, the quality of support for individuals will ultimately depend on the quality of care provided by individual staff in their everyday interactions (key challenge 1) but, in order for this to happen consistently across the organisation, we must think beyond simply 'training' staff to behave in different ways. This is illustrated in a study examining the implementation of 'Illness Management and Recovery Programmes' across 12 community settings in the USA [81]. Training was found to be important, but it only had a lasting effect if issues of supervision and leadership were also addressed. A 'culture of innovation' was also found to be important, i.e. organisations being open to considering changes in existing practices. This aspect of organisational readiness has also been found important in England [82]. If all these factors were present then they acted synergistically, but no one element was sufficient on its own. So, how can we ensure that the shared values of recovery permeate the whole culture of the organisation and are reinforced by leaders at all levels?

This is particularly difficult at a time when there are *'unclear goals, overlapping priorities that distract attention, and compliance-oriented bureaucratised management'* [83]. These directly impact on how the organisation performs and, across the NHS at the moment, staff and managers feel overloaded, disempowered and are failing to deliver the high quality care that they seek to achieve. These three elements of organisational culture – goal clarity, clear priorities and an empowering management style – all therefore need to be addressed.

1. *Goal clarity* - Implementation of the REFOCUS intervention [15] in England was directly related to staff perceptions about organisational commitment [82], i.e. did the Trust really want to change? The commitment of the organisation was judged by staff on the basis of resource allocation (e.g. what training is compulsory and back-filled?) and the choice of Key Performance Indicators and outcome measures currently used by the Trust. Put simply, the dimensions an organisation chooses to notice (and then either celebrate or punish) send a powerful message about its core business – what it is really here to do. If these don't reflect recovery concepts and values [76] then staff will not think that the organisation is really committed to delivering a more recovery-oriented service. One approach is to collect and publish recovery-related outcome data [76], such as the proportion of people on the caseload meeting normal citizenship expectations (e.g. meaningful occupation, decent housing, at least one close relationship, enough money to live on) and personally valued life goals [84].

2. *Clear and recovery-focused priorities* - A grounded theory study (n=97) across England showed that staff experience conflicting organisational demands and priorities [85]. This was confirmed in a systematic review which found that organisational priorities influenced staff understanding of recovery support [86]. However, simply having a clear priority does not guarantee that recovery is being supported, especially when there are multiple meanings of the word. Thus, there is currently a rather cynical conceptualisation of 'recovery' which sees it as simply subservient to the financial needs of the organisation, using success indicators such as cost reduction, throughput, discharge, and setting limits on service provision. Although this co-opting of the word 'recovery' to meet organisational goals has been criticised by both the people who work in services [2] and those who use them [87], nevertheless it persists. It highlights the need not just to set recovery-oriented priorities but to be clear about what this means. This involves addressing questions such as how the Trust Board will know that people recover, and from a wider sociopolitical perspective how Trust activities relate to the public health agenda, support community resilience, address health inequalities and improve overall population health.

"My experience of recovery focused management is having a manager who can have a conversation with you that leaves you feeling supported and like they are getting to know you as a person. Someone who has got to know your particular skills, interests and expertise, and has the confidence in you to take responsibility in those areas for the benefit of the team as well as for me as an individual."
Physical health and wellbeing lead

3. *Empowering management style* – There is a close link between empowerment and wellbeing in the workplace [88] and there is also good evidence that improving staff wellbeing improves the experience of care [89]. We should therefore be thinking about ways to increase feelings of empowerment among frontline staff (and users). One way that we have found very useful in achieving this in the ImROC programme has been the use of a team-based, practice development instrument, the Team Recovery Implementation Plan (TRIP) as described in Challenge 2 [60]. The TRIP operates at the first level of leadership in the organisation (frontline staff and people who use services) but, of course, leadership is to be found at all levels and in all disciplines. Furthermore, organisations don't change from the 'top down', or the 'bottom up': they change when leadership at all levels of the organisation are giving consistent messages. *'The most important determinant of the development and maintenance of an organisation's culture is current and future leadership'* [90]. This is why any attempt to help services become more recovery-oriented in their practice must grapple with the organisational context (for example by engaging in compassionate leadership [91]), not simply the behaviour of individual staff members or groups. Addressing organisational inhibitors (e.g. bureaucracy, paperwork, caseload size, Serious Untoward Incident processes, safety policies, risk averse cultures) has been one of the most important lessons of ImROC.

Economic evidence

There is little economic evidence specifically on the notion of recovery focused leadership and a culture of recovery, but this Briefing Paper has highlighted the value of other aspects of meeting the key challenges of recovery. Effective recovery focused leadership potentially should improve the working environment. A management style that empowers frontline workers and service users to make co-produced decisions is consistent with the principles of a healthy workplace environment. Following the implementation of TRIP in one ward in a London Trust the level of staff sickness absence and assaults on staff over the following year decreased, but a comparative evaluation is required in order to determine whether this reduction is due to TRIP [60]. More broadly the economic benefits of a healthy workplace environment that may arise in part due to a recovery-focused orientation, such as improved productivity, innovation and creativity, as well as reduced absenteeism and staff turnover are set out in response to key challenge 9. The economic benefits of a co-produced and recovery focused approach to safety management are set out in key challenge 6.

Key organisational challenge 5: Increasing personalisation and choice

Key concepts: Personal budgets; WRAP; Advocacy

This relates to both personal budgets (addressed in key challenge 10) and approaches to supporting self-management and personal control (addressed in key challenge 1). The focus here is on the translation of these challenges through care planning and advocacy processes.

"For me my Health and Wellbeing plan is a way I can manage my life. It constantly changes but it makes me reflect on the things I can do for myself and what I need to do to keep balanced. This has helped me inform my careplan, but that is always something I have felt more imposed on me. It's my Drs opinion of what they need to do, it never really helped me know myself. As you know. It gave me a context to hang the strategies I already had and used, I just hadn't seen them that way before."
Peer trainer

Research studies

As different people's recovery journeys are different, a central task for mental health services is to ensure that individual care is genuinely personalised and maximises involvement and choice. This is not easy. Despite repeated exhortations, in various Department of Health policy documents over many years, a cross-sectional study of care planning in England and Wales found that care planning remains very bureaucratic, often with little evidence of user involvement or shared decision-making, and lacking in clarity regarding support for personal recovery [92].

One way around this is for services to use specific tools aimed at documenting personal recovery plans. The Wellness Recovery Action Planning (WRAP) provides such a framework and covers developing a personal plan, coping with distressing symptoms, managing crises, and staying 'well'. It was designed by a service user for service users and has been widely used around the world [93]. WRAP guides the individual or group to reflect on what has assisted them to stay well in the past and to examine strategies that have assisted others with their recovery. The focus is on approach motivation (defining wellness and supporting goal striving) rather than avoidance motivation (e.g. symptomatic relief), in line with the insight from positive psychology that positive ('approach') goals are more likely to be sustainably attained than negative ('avoidance') goals [94]. The process also relies on peer facilitation to activate the hope-inducing benefits of authentic role models [95]. A large randomised controlled trial involving people using community mental health services in the USA showed positive results for WRAP in terms of reduced symptomatology, increased hope and quality of life compared with standard care [96].

Whatever their derivation, Personal Recovery Plans should contain an identification of the person's internal and external resources and a plan for how they can use these to achieve their chosen goals. It is also desirable that they are clear and as short as possible. The person should not necessarily have to share their recovery plan with staff: it belongs to them. This creates new expectations about role expectations and the balance of power. So recovery plans are not the same as care plans, although there should be as much overlap as possible between the two. Learning from maternity services in which the mother owns her plan may be relevant.

"Recovery plans are not the same as care plans"

> *"It [Health & Wellbeing Plan] makes me more reassured and less stressed to know that we have a way to communicate easily and effectively with others involved in his [my son's] life."*
> ***Carer***

Economic evidence

There is limited evidence on the resource impacts of individual care planning. Some approaches in England to care planning have been criticised for excessive paperwork and bureaucracy, whilst reforms in the way in which mental health services are paid for may act as a disincentive towards genuinely individualised care plans [92]. The business case needs to be strengthened for mechanisms to promote increased personalisation and choice. WRAP has been the subject of some economic assessment. A randomised trial in the US found that compared to individuals who received non-peer delivered nutrition or wellness education, individuals who received WRAP subsequently made use of fewer mental health services over an eight month follow up period, which implies a reduction in health care costs. Their perceived need for services also reduced, while both groups had positive recovery-related outcomes [97]. In a small qualitative study in Ireland some service users cited how WRAP had helped them avoid hospitalisation [98].

> *"I meet with people and we try to identify what they would like to do and how best they can achieve their goals supporting them on their road to recovery…..I support people to complete the Self Directed Support (SDS) questionnaire….For me the most important part of this is encouraging and enabling the individual to rediscover passions and hobbies that they may have forgotten about/or think is no longer possible because of their mental health and I also encourage and support them to try something new."*
> ***Peer support worker***

Key organisational challenge 6: Changing the way we approach risk assessment and management

This key challenge has been updated in the light of experience.

Key organisational challenge 6: Reducing restrictive practice; changing conceptions of risk as something to be avoided towards working together to improve safety

Key concepts: Safety planning; Seclusion and restraint, No Force First

"Professionals and people using services need to work together to agree the right balance of risk and choice."

Research studies

Accurately predicting the risk of violence or self-harm in a given individual is extremely difficult [99]. However, notwithstanding the lack of evidence that it is possible, mental health services have become increasingly preoccupied with procedures for the assessment and management of risk and this has sometimes become a barrier to personal recovery [100]. Many staff have become so risk averse that they are no longer prepared to engage in what might have previously been seen as positive risk-taking, i.e. working with the service user to help them manage those risks which are necessary for them to pursue reasonable and realistic life goals [101]. This has happened despite clear government and professional guidance to the contrary [102]. A 2016 article in the British Journal of Psychiatry concluded that risk prediction is not only *'futile'*, it is *'potentially harmful, confusing clinical thinking'* [103]. Instead the authors argued *'for a shift in focus towards real engagement with the individual patient, their specific problems and circumstances'* (p.271) .

Real engagement with the individual in the context of risk management is exemplified in the work done on safety planning [104]. Safety planning is not casual or reckless, but it promotes a way of working with risk that enables practitioners to support people in taking risks as a route to positive outcomes.

The change in language from 'risk' to 'safety' also recognises that risk is an inevitable part of life and should be an integral part of informed (and shared) decision-making regarding a person's life goals. Professionals and people using services need to work together to agree the right balance of risk and choice. For people using services, it is important to be an active participant in conversations and subsequent decisions about keeping themselves safe. This way they contribute to, and see the relevance of certain decisions, and are more likely to feel able to take responsibility for letting staff know what can be done to help them feel safe; what their 'triggers' are; what can be done to avoid or minimise these situations. Thus they are able to take more responsibility for their actions and to learn how to increase their confidence in managing their own risk. This process of 'co-producing' (see key challenge 7) their safety and wellbeing plans at every stage in the process has not been empirically investigated.

One area where the management of risk is based on much greater involvement of service users is regarding the reduction of serious and violent incidents in hospital, particularly those which result in the use of physical restraints, seclusion or forcible medication. Research in the U.S. identified '6 core strategies' for reducing seclusion and restraint in hospital [105] [106]. These are shown in Box 4.

Box 4: Core strategies for reducing seclusion and restraint

1. Ensuring leadership to support organizational change, involving the senior management team
2. Developing the workforce (training in de-escalation techniques, 'trauma induced care, modifying the environment, etc.)
3. Planning ahead to prevent incidents occurring
4. Developing the roles of service users as staff trainers, advocates and peer workers
5. Using debriefing techniques to promote learning
6. Using data to inform practice

"It goes without saying that it can at times be quite emotive seeing people suffer from their mental illness or from the effects of being sectioned, particularly having been there myself and being able to identify with their pain and frustrations. It was initially quite hard to see the use of physical interventions but going on the training helped to ease my discomfort and gave me an opportunity to provide valuable feedback so that the training can be developed to be more recovery focused."
Peer support worker on acute inpatient ward involved in co-producing de-escalation training

A training curriculum based on these strategies has been developed and evaluated across 43 facilities in 7 States over a four-year period [107] [108]. Two-thirds (n=28) were able to achieve stable implementation, and on these sites 54% were able to reduce restraint hours by an average of 55% and the percentage of people restrained by an average of 30%. Reductions in seclusion and restraint were less impressive where full implementation was not achieved. There were also increases in both user and staff satisfaction, significant reductions in staff turnover and related costs. These results have also been replicated in Canada and a similar study is currently being conducted in England by Professor Joy Duxbury.

A second example of reducing seclusion and restraint which is based directly on the implementation of recovery principles has been reported by Ashcraft and colleagues [109]. They called their approach *No Force First*, and used similar strategies to the six described above with an emphasis on leadership, staff training, consumer debriefing and regular feedback. However, they placed the contribution of service users as trainers, alongside staff, at the centre of the initiative. With constant support they were able to eliminate seclusions and restraints in two crisis centres over a period of two-and-a- half years. Later revisits found no replacement with chemical restraints. The *No Force First* approach has been replicated in this country, particularly by Mersey Care NHS Foundation Trust. It explicitly uses a process of co-production, with professionals and service users working together to design, implement and evaluate the programme. Early data from two pilot wards assessed over two years indicated 60% reduction in physical and medication-led restraint, 46% reduction in staff assaults, staff sickness reduced by 25%, improved staff morale and satisfaction, and a positive improvement in service user experience [110] [111]. As a result, the Care Quality Commission positively acknowledged No Force First as a restraint-reduction strategy. More generally, there is evidence that co-produced approaches to reducing violence on wards are effective, from trials in Finland [112] and Spain [113].

Economic evidence

There are substantial costs associated with seclusion and restraint, some of which may be averted through the adoption of a co-produced approach to safety management. A number of studies have highlighted costs for service users and staff related to adverse health impacts, such as injuries, falls and deaths [114]. Agitation and distress, which can be inevitable consequences of restraint, have themselves in a review been associated with longer inpatient stays [115]. Analysis in Spain also suggests that the costs of managing agitation in service users using seclusion and restraint are roughly three times the costs of verbal or psychological actions alone [116].

There are substantial costs associated with the intensive levels of staff time that are needed for the management and implementation of traditional seclusion and restraint policies. One costing study in England estimated the costs of managing conflict and the use of restraint on adult inpatient psychiatric wards in 2005 [117]. It estimated that around 50% of all nursing resources were taken up in the management of conflict and use of containment strategies. Costs of manual restraint per year per ward were reported to be £14,084 while costs of seclusion were a further £5,007.

There will also be legal and other costs associated with adverse events arising from the use of restraints. Although not well studied, violence and injuries are likely to have an adverse impact on workplace staff sickness rates and staff turnover, implying further costs to mental health care systems [118]. The mean costs per violent incident were estimated to be £3,212 in six inpatient wards in East London, of which 54% was for staff sickness absence, and replacement staff costs, with the remainder attributed to response team costs, legal costs and medication [119].

Few studies outside of the US have evaluated the economic impacts of introducing measures to reduce the use of restraints [118]. For instance one US study looked at the impact of a policy to reduce the use if restraints at one inpatient facility for young people aged 13-18 [120]. The costs of staff time and medication related to restraint reduced by 91% in the year following the introduction of the policy – 3,991 restraint events fell to 373 events. Costs for managing restraint were then just 8% of what they had been prior to the policy change.

More potential benefits can also be seen in a randomised trial in Finland of a co-produced approach, which found that staff time for seclusion and restraint could be significantly reduced without any increase in violence, although impacts on staff sick leave were equivocal [121]; it did not however report actual changes in costs. The No Force First pilot study in Merseyside did realise estimated savings of £0.25 million per annum in secure awards alone due to reduced staff sickness and absence related to assaults and injuries, according to an independent assessment [110]. This assessment also concluded that scaling up implementation to all wards potentially might avoid costs of £1.2 million per annum.

"Another area where peer support has helped, I believe, is in the use of physical interventions. I think those who have been there have an awareness of how apparently trivial issues, like not being allowed to go out for a cigarette for example, can become magnified when you're an in-patient, and how quickly such situations can escalate and result in physical restraint. Working on a very busy in-patient ward, I think my particular focus has been on trying to identify and respond quickly to the day to day individual issues that arise for service users in a way that prevents any escalation. I've found it be very helpful just talking quietly to the person, acknowledging (with the benefit of lived experience) just how difficult and frustrating their current situation is, and trying to figure out solutions together."
Peer support worker

"I completed my health & wellbeing plan and asked for the advanced statement part of it to be scanned onto my notes. Many months later, I experienced a 'blip' and ended up in A&E. The doctor got a copy of my plan and reminded me of what I had said would be helpful in a crisis. Just being able to share this information in this way made a massive difference and I was in a position to return home much sooner than had ever happened before."
Peer trainer

Key organisational challenge 7: Redefining user involvement

This key challenge has been updated in the light of experience.

Key organisational challenge 7: User involvement is replaced by fully resourced coproduction so that the views, experiences and aspirations of people using services and their family members are accorded the same value as the views of staff in the organisation

Key concepts: Co-production; Power

Research studies

The importance of user and carer involvement in mental health services has been emphasised for many years. However, making it a reality is difficult and time-consuming, and many services are still essentially staff-led, with users and carers being consulted at the end of the process when most of the important decisions have already been taken. For this reason when we have been promoting services to support recovery through ImROC we have continually come back to the concept of co-production.

Co-production represents a new way of thinking about the delivery of health services. The ideas came from an analysis of the difficulties faced by public bodies in delivering effective and relevant services in times of economic austerity. They have been popularised in England through the work of independent think-tanks such as the New Economics Foundation (nef) and Nesta. In a seminal publication they defined co-production as, *'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 effective agents of change'* (p.11) [122].

According to the New Economics Foundation, Nesta and the Innovation Unit [123] the main features of co-production are shown in Box 5.

"It [co-production] feels democratic and about mutual respect, rather than pity. It's about everyone learning together. It feels exciting. It just feels so much better."
Mental health worker

Box 5: Key features of co-production

a) *Recognising people as assets* - transforming the perceptions of people as passive recipients of care and 'burdens' on the system, to equal partners in designing and delivering services.

b) *Building on people's existing capabilities* - actively supporting people to recognise and use their strengths, rather than conforming to a deficit model.

c) *Reciprocity and mutuality:* - offering people who use services opportunities to develop reciprocal relationships with professionals (and with each other) and enter into mutual responsibilities and expectations.

d) *Peer support networks* - enhancing knowledge generation and transfer through engaging personal and peer networks alongside those of professionals.

e) *Breaking down barriers* - blurring the distinctions between professionals and producers and consumers of services. Reconfiguring the power relations and the way services are developed and provided.

f) *Facilitating rather than delivering* - enabling professional staff to become catalysts of change, instead of sole providers of services.

"Co-production represents a new way of thinking."

Co-production is about doing things ***with*** people, rather than ***for*** or ***to*** them. It assumes that the people who use mental health services and their carers have specific knowledge and expertise that traditional professionals don't have (or at least not in the depth that service users and carers have it). It further assumes that *both* professional expertise and personal experience are important, so the most effective services arise from both parties being fully involved in their design, delivery and evaluation.

Co-production is not the same as the 'big society'. It is not simply using service users and carers to do the traditional things that professionals do without training or paying them appropriately. Co-production is about service users and carers working together with professionals in different ways, bringing their experience and expertise to produce different solutions, and then integrating these – wherever possible - with professional approaches, e.g. in Recovery Colleges (key challenge 3) or Peer Support (key challenge 8). Co-production is therefore explicitly about a change in the power relationship between professionals and people who use services [124]. This is probably the most controversial and challenging implication of trying to work in this way.

Nevertheless, the value of co-production for public services is now widely acknowledged. It underpins policy initiatives in England (e.g. *People Powered Health* programme [123], Co-creating Health [125 126]), Wales [127] and Scotland [128]. For **people using services** it means improved outcomes and quality of life and better, more realistic and sustainable, public services. For **frontline staff** it means shared responsibility and increased job satisfaction from working with more satisfied service users. For **managers** it means more positive ways of limiting demands on services, making them more efficient. For **all citizens** it means increasing social capital, social cohesion, and reassurance about the availability and quality of services in the future. True co-production must therefore lie at the heart of mental health services which aim to support recovery [129].

"I know first-hand, just how transformative being involved in co-production can be. I have moved from feeling I was just a burden on services to now being full involved in helping to develop them... At one time the only adults in my life were mental health professionals, now I have work colleagues and a network of friends!"
Peer trainer

Economic evidence

In many cases evaluations that have looked at co-production have not put an economic value on the benefits of this approach. In order to calculate the return on investment it is important to know about the financial costs of supporting co-production. Little information has been published on these costs, but it is likely that value of the time and other inputs of people with lived experience into co-production will more than outweigh additional formal resources that are required. Co-production in effect should provide net additional resources and capacity to mental health services. This hypothesis needs though to be formally tested.

It is also important to know what the economic consequences of co-production are. A review of evidence on co-production in mental health identified a number of studies (both small scale evaluations and trials) that reported an association with reduced health care costs, e.g. for medications and specialist mental health services. The review also identified benefits from improved social functioning outcome, e.g. employment and reduced dependency on public services [124].

Recently a significant trend in reduced costs in contacts with health and social care services six months and nine months after beginning to participate in peer support groups was observed in England. This uncontrolled analysis combined the experiences from people involved in one or more peer support activities, including on-line peer support. Overall, including impacts on employment, education and volunteering, costs were 28% lower than baseline at 6 months and 53% lower at nine month follow up [130].

This finding reinforces an earlier review which suggested that *"an approach which may also in time offer the biggest scope for cost savings in mental health care is to promote and expand co-production, drawing on the resources of people who are currently using mental health services, for example in peer support roles"* [1] (p.6).

"Co-production is about doing things with people, rather than for or to them."

"As a service-user, I've been asked a quite a lot about my opinions on the professional's ideas in mental health services, but now through co-production, I am able to also share my ideas and hear the professional's opinions on these. That is really empowering!"
Service user

Key organisational challenge 8: Transforming the workforce

Key concepts: Peer support workers; Peer trainers; Stigma; Staff attitudes

"Working as a Senior Peer Support Worker is an opportunity that is beyond any expectations that I had when I was unwell. During my time in hospital I thought a lot about wanting to use my experience as a way of supporting others in future, in order to help them feel understood and less alone. At the time I never thought this role would exist and I feel privileged to be part of an initiative that I believe has and will continue to have an invaluable impact on mental health services. Doing this work gives me a sense of purpose, and has given meaning to the difficulties that I went through in the past. I believe that my role keeps me motivated to keep well and look after myself, in order to support others in doing the same and this responsibility has added huge value to my daily life and future aspirations."
Peer support worker

Research studies

In addition to Recovery Colleges, the other most visible sign of services moving explicitly towards supporting recovery is the inclusion of peer workers. These are individuals with mental illness who use their lived experience to support others to recover [131]. The value of peer support has long been recognised in mental health services [132] but only recently have peer workers begun to be taken seriously as an effective addition to the workforce. A Cochrane review conducted in 2013 identified eleven randomised trials involving 2,796 people, showing equivalent outcomes from peer support workers compared with professionals employed in similar roles [133]. Wider reviews using a greater range of studies have shown more positive effects [134 135 136]. These are summarised below.

- In no study has the employment of peer support workers been found to result in worse health outcomes compared with those not receiving the service. Most commonly the inclusion of peers in the workforce produces the same or better results across a range of outcomes.
- The inclusion of peer support workers tends to produce specific improvements in service users' feelings of empowerment, self-esteem and confidence. This is usually associated with increased service satisfaction.
- In both cross-sectional and longitudinal studies, patients receiving peer support have shown improvements in community integration and social functioning. In some studies they also bring about improvements in self-reported quality of life measures, although here the findings are mixed.
- In a number of studies when patients are in frequent contact with peer support workers, their stability in employment, education and training has also been shown to increase.

Some of these findings are not replicated across all studies depending on the methods used and the quality of the evidence (which is quite variable). Nevertheless, the overall evidence shows that having contact with a peer support worker leads to an increased sense of empowerment and positive benefits in terms of social inclusion. The next frontier is therefore implementation, and both ImROC [137 138] and others [139 140] have developed guidance to assist in this process.

"One of the main benefits to working with a peer support worker is that of positivity; seeing someone who has experienced mental health problems but has moved forward and is now working. I believe the PSW is good at validating service users' experiences whilst also seeing the potential in people and being able to identify people's strengths rather than looking at all the negatives."
Mental health worker

If individuals are to be supported in their personal recovery by traditional staff or peers then staff have to believe that it is possible. There is evidence that some mental health professionals still hold stigmatising views about people using services [141]. This 'othering' behaviour – emphasising differences rather than commonalities - can foster low expectations and negative attitudes to the possibility of change hindering the development of 'non-patient' identities and getting in the way of recovery. This needs to change and we therefore need to think about how to change staff attitudes so as to make them more generally supportive of recovery.

The most effective approaches to reducing stigma in the general population are those that include direct contact between persons from the stigmatised group and those that hold the stigmatising attitudes [142]. If managed correctly, this contact should allow both groups to identify and share their common humanity, which then breaks down stereotyped attitudes. An early peer support service in assertive outreach found that peer workers *"created a more positive attitude toward persons with mental illness"* [143]. A comprehensive review concluded that anti-mental health stigma programmes aimed at staff should contain personal testimony from a trained and enthusiastic speaker who has lived experience and who shows that recovery is both real and possible, demonstrating by their example competence and a successful way of living [144]. This is what peers do, and so the inclusion of peer workers in the workforce should be a powerful way of addressing negative staff attitudes. Where peer workers are well-established there is good anecdotal evidence that this is indeed the case. Thus, the inclusion of peer workers not only has direct benefits for people receiving this service (and for those delivering it) it also contributes to changing the organisational culture so as to make support for recovery more generally acceptable.

"Having contact with a peer support worker leads to an increased sense of empowerment and positive benefits in terms of social inclusion."

Economic evidence

It can be difficult to distinguish between studies focused on the economic benefits of peer worker interventions and other types of peer support interventions. Evidence on the broader benefits of peer support interventions was discussed in challenge 7. Here we focus on the economic case for peers who are salaried members of the workforce, though studies on volunteer peer workers have also been conducted.

One review looked at the impact of paid peer workers on the use of psychiatric hospital beds, where peer workers provided additional services such as befriending, mentoring or advocacy in community mental health teams or in the community [145]. Six studies (one from Australia and five from the US) were identified, four of which generated a positive return on investment, with a weighted average return on investment of almost 5:1. While this is a limited evidence base, the economic benefits may be understated as the analysis does not take account of any positive impact on quality of life and other outcomes.

Findings from one of the US studies in this review were used to help model potential cost savings to the mental health system in England through peer mentoring, although

the precise value of mental health specific savings was not reported [146]. This analysis may be limited by its assumption that changes in the future use of psychiatric services in one hospital in Connecticut through the use of peer mentoring would apply to the English context [147].

A pilot randomised trial in the UK looked at 4 weeks support provided by peer support workers to people who had recently been discharged from inpatient mental health care [148]. The study was too small to identify any statistical differences in costs or outcomes, but did suggest that a larger study might be able to confirm the observed good probability of being cost effective. Another US study looking at the use of peer mentors in homeless veterans found no difference in the costs or use of health services [149].

"There is no sense of 'us and them' in our team, and I feel that the unique perspective that I have brought having been a service user on the ward, who understood first-hand how it can feel, 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 colleague and a number of service users have said things along the lines of "I can't believe you were ever on the ward!" Many said in different ways, that they were inspired by seeing such a thing was possible – I know because two years ago I'd have agreed with them!"
Peer support worker

"I would like to think that my practice very much embraces the concept of recovery, yet (the peer support worker) has arrived and made me pause and rethink, not in a critical way but in a gentle questioning way."
Consultant psychiatrist

Key organisational challenge 9: Supporting staff in their recovery journey

This key challenge has been updated in the light of experience.

Key organisational challenge 9: Supporting staff to cope effectively with the stressors that are inevitable in working in mental health services

Key concepts: Lived experience in the workforce; Reducing absenteeism and presenteeism; Expertise in wellbeing

"Supporting staff makes sense every way you look at it."

Research studies

Supporting staff makes sense every way you look at it. Stressed, demotivated and demoralised staff either go off sick or are vulnerable to 'presenteeism' (consistently under-performing at work) – both of which reduce organisational effectiveness. However, there are further recovery-specific reasons to attend to staff wellbeing.

First, to harness the un-tapped resource of lived experience in the non-peer workforce. A national survey found approximately 2 in 5 of the NHS mental health workforce have personal experience of mental ill-health, and over three-quarters have supported a family member or friend with mental health problems [150]. However, less than half had fully disclosed their lived experience to colleagues. Initiatives around *'valuing the life, lived and professional skills and experiences of staff'* [151] will involve organisational leadership with engaged support from human resources.

Second, there is evidence that staff hold different views about sources of wellbeing for themselves compared with people using their services. Mental health staff in England hold a more deficit-based perspective on wellbeing for service users and a more strengths-based view for themselves (i.e. 'they' need fixing but 'we' need a meaningful and enjoyable life) [152]. Developing expertise in sources of resilience and wellbeing as a core part of professional experience has the potential to positively impact on this anti-recovery attitude.

Third, developing expertise about wellbeing makes ideas about recovery easier to understand. For example, the CHIME framework aligns very closely with the Foresight work on mental capital [153], summarised by the New Economics Foundation as five-a-day for wellbeing: Connect, Be active, Take notice, Keep learning, Give [154]. Supporting the development of worker expertise in wellbeing will increase their skills in support recovery, because in many senses wellbeing *is* recovery [155].

Finally, as noted in key challenge 4, improving staff wellbeing is a pathway to improve the experience of using services: *'Individual staff wellbeing is best seen as an antecedent rather than as a consequence of patient care performance; seeking systematically to enhance staff wellbeing is not only important in its own right but also for the quality of patient experience'* [89].

Specifically in relation to wellbeing in the workforce, evidence-informed strategies are now possible. A systematic review of workplace interventions for common mental disorders such as depression or anxiety synthesised 140 reviews including 20 of moderate or high quality, incorporating findings from 481 studies [156]. The review identified empirically-supported approaches to primary prevention to reduce onset (enhancing employee control, promoting physical activity), secondary prevention to mitigate effects (cognitive-behavioural therapy-based stress management), and tertiary prevention to support symptom reduction and return to work (exposure therapy, CBT-based and problem-focused return-to-work programmes).

"He (the nurse) just seem really tired and stressed and like he just did not have the energy to bother with me at all, let alone care about me."
Experience of being treated by stressed, demotivated and demoralised staff

"She (the doctor) looked at me, but there was no eye contact and she rushed me away. It made me wonder what she'd been on. She seemed in a worse place than me."
Experience of being treated by stressed, demotivated and demoralised staff

"A long time ago, I saw a doctor after I'd attempted to take my own life. I remember that he asked me what it proved? I replied 'a lot.' I never saw him again and I heard that he took his own life. I've often wondered if my comment had an effect on him."
Experience of being treated by stressed, demotivated and demoralised staff

Economic evidence

It has been argued that an extension of the recovery based approach to the health and wellbeing of staff working in mental health services may help the NHS to have a healthier workforce and reduce levels of absenteeism [151]. In fact many of these principles, e.g. empowering staff to have more control over the way that they work, focusing on workplace environmental factors that can be conducive to occupational stress and poor mental health, flexible working arrangements, increasing the value that line managers place on their staff and the importance of maintaining contact with staff when they are on sick leave are entirely consistent with what are now regarded as key approaches to promoting mental health and wellbeing in the workplace [157-159].

Moreover there is a strong business case for adopting these principles for workplace mental health promotion programmes. While most of the evidence tends to focus on specific interventions, such as the introduction of workplace wellbeing programmes or brief psychological support for staff experiencing stress, there is also a recognition that broader workplace measures such as training for line managers to recognise stress and workplace environmental assessments, including measures to establish a healthy working culture, can generate positive returns on investment to workplaces, including health services [160]. Positive benefits include a reduction in sickness absence, presenteeism, staff turnover and early retirement. There is a very broad literature on the level of return on investment from these types of workplace health promotion activities. While caution must be exercised on how the results of these studies are interpreted as many different methodologies are used in different country contexts, in broad terms there tends to be at least a 2:1 return on investment to the workplace of evidence-based actions to address common mental disorders and an even greater level of return on investment for some workplace (mental and physical) health promotion actions [160].

Key organisational challenge 10: Increasing opportunities for building a life 'beyond illness'

This key challenge has been updated in the light of experience.

Key organisational challenge 10: Prioritisation of life goals (full citizenship and community integration) in all care planning processes

Key concepts: Housing First; Personal budgets; Individual Placement and Support (IPS); Community participation

"Leaving home at 16 was the start of a long personal journey into homelessness, and a 20 year battle with complex mental and physical health difficulties. After several intensive hospital admissions, time spent sofa surfing, in hostels, and insecurely housed, I became what is often termed a 'revolving door patient', with little hope of finding the way out. I now have a place that I can call home, a place that feels safe and warm and where I have the choice to stay for as long as it suits me.. .. I have skills and strengths that health care and social workers helped me to find and to build upon…The things that helped me to find a way to stop the door revolving, to find a door to a home, were being seen and respected as an individual, not being defined by my problems or my label of 'damaged' or 'vulnerable' or 'homeless' ...Respect, compassion, empathy, being seen and heard and valued… Life being homeless is hard. People usually don't end up homeless because they have had easy lives up to that point. Having no security, no stability, no support system, alongside the demoralising and damaging effect that homelessness can have on mental and physical health, where just surviving feels like a battle"
Peer researcher working with people experiencing homelessness

Research studies

If supporting recovery is about one thing, it is about placing the achievement of personal life goals (full citizenship and community integration) alongside symptom reduction as the major objective of mental health services [8]. This is reflected in a focus on housing, money, employment and social integration. There is now a robust evidence base for the effectiveness of a range of approaches to achieving these objectives and these now need to be (re)incorporated into service design.

Housing

Good housing is more than just shelter [161]: it is the bedrock of successful community living. Notwithstanding this simple fact, the topic of housing has received little attention over the years from mental health professionals. An exception to this rule is the Housing First initiative. This was developed in the U.S.A. to meet the needs of homeless people with complex mental health and substance misuse problems. It prioritises the identification of suitable housing, based on personal preference, and then delivers other supportive services to the person once they are housed, without a pre-requisite that their substance misuse must cease first. The use of permanent housing options and the commitment to floating support means that the resident does not have to make continual moves between different types of accommodation as their support needs change.

A definitive randomised controlled trial across Canada showed that homeless people living with mental illness (n=1,198) who received the Housing First intervention had increased housing stability over 24 months compared to those not receiving the intervention [162]. A qualitative study with a sub-group of participants (n=60) also found positive impacts on hope and recovery goals [163]. In this study, despite there being no requirement for the Housing First group to abstain from substance misuse, there was actually no significant difference between the two groups regarding their levels of drug and alcohol use. The annual per capita costs of the Housing First programme were also around half those of 'treatment first' programme. This approach has been tried in England [164] but is not widespread.

Employment

The Individual Placement and Support (IPS) approach is now the best researched approach to supporting people with mental health problems to access and retain mainstream employment. It has a number of similarities with the Housing First approach in that it is also based on placing the person in a work position of their choice as quickly as possible and then providing them and with an integrated package of vocational and clinical support *in situ*. A 2013 Cochrane review (14 trials, 2,265 people) concluded that IPS *'is effective in improving a number of vocational outcomes relevant to people with*

severe mental illness' [165]. IPS consistently achieves employment rates 2-3 times better than traditional alternatives such as pre-vocational training and sheltered workshops. This holds true in high and low income settings, across different countries, irrespective of the underlying employment rate. Longer term follow-up studies of people placed through IPS suggest that the higher rates of employment are maintained and have positive impact on non-vocational outcomes such as improved confidence and wellbeing, and reduced sense of stigma. The one study where IPS failed to produce such impressive results was where it was not implemented with good fidelity to the research model [166] [167]. A more recent review and meta-analysis of 19 international studies also found that IPS was more than twice as likely to lead to competitive employment compared to vocational support even where economic growth was low [168].

In contrast to supported employment, much less attention has been focused on assessing the cost effectiveness of supported education services to help young people remain in and complete their education, which in turn will increase career opportunities and earning potential. There is emerging evidence on adapting IPS to deliver supported education, for instance in Australia [169].

Money

For people with serious mental health problems - as for the rest of the community - not having enough money clearly reduces both the meaning and enjoyment of life [170]. Since people with serious mental health problems are more likely than the rest of the community to experience poverty, it is specially important to ensure that they have access to financial advice in various forms [1]. The topic of material support is only recently receiving attention from mental health professions [171] [172].

An approach which aims to give the person direct control over a substantial proportion of their financial support is known as Personal budgets (or self-directed care). This has been tried both in the U.S.A. [173] and in England [174], and aims to provide the person with the resources that would otherwise be spent on services to allow them to spend them on whatever they think will be most helpful. This sounds like it must be a good idea, but there are considerable practical problems in its implementation, both bureaucratic and in ensuring that resources are effectively targeted on those in greatest need. The effectiveness of personal budgets also depends very much on the quality and continuity of the supportive relationships [175]. It therefore remains to be seen whether it will be possible to get personal budgets to work effectively and if they can be rolled out on a large scale in statutory services. (The best examples of effective use of personal budgets are currently still in the voluntary sector). If these problems of implementation could be successfully addressed then personal budgets could undoubtedly make a significant contribution to supporting community integration and social inclusion.

Social integration

Personal networks are important for recovery at an individual and a group level. Each one of us, whether living with mental health problems or not, can probably name a few key individuals who have helped us keep on going when times are tough. Close, personal, social supports help reassure, they shape identity, provide meaning to life, give a sense of belonging and access to new resources [176]. There is specific evidence that positive relationships can be the tipping point that starts a person's recovery journey [177] [178]. Similarly, feeling a part of the community, not just physically located within it, is a fundamental human need. However, despite the obvious importance of social support, interventions to support social network development have not been much researched in the mental health literature. Approaches like wellbeing networks and asset mapping [179] therefore need to be given more attention and evaluated in terms of their practical value.

"People with serious mental health problems are more likely than the rest of the community to experience poverty."

"I know only too well the barriers to getting (and using) treatment that come with the label of 'homeless'. Not having support or the hope that things can be different… Lacking the confidence and understanding of unfamiliar health systems…Feeling undeserving, worthless… These things can make it impossible to even identify the help you so desperately need, never mind where to get it."
CNWL Recovery Stories, 2014

"Positive relationships can be the tipping point that starts a person's recovery journey."

Economic evidence

There is a strong evidence base on the benefits of facilitating recovery and preventing relapse through actions that support education, housing and employment, and other aspects of social functioning[1]. In this Briefing Paper we can only provide a brief flavour of this evidence base. A key challenge though is to work effectively not only within the health sectors, but across sectors, such as with the private sector, financial services and banking sectors to reduce the risks of unmanageable debt, with employers, and not least with the non-government sector such as housing associations to both fund and implement evidence based actions.

It is vital to measure and highlight the personal, social and economic outcomes such impacts on the rate of employment, the completion of education and training, and securing stable housing, in addition to more narrow mental health specific measures of recovery. Achieving secure employment will benefit society through a reduced need for welfare support while better educational outcomes increase the likelihood of securing good employment. Employment in turn can promote independence. A lack of access to secure housing and employment, as well as unmanageable debt and poverty are also associated with an increased risk of future poor physical and mental health.

Housing

As well as being a key component of a recovery strategy, there are substantial economic opportunities along the care pathway to improve outcomes and reduce costs for mental health service providers through use of appropriate housing services, rather than more expensive mental health services. These housing options are heavily dependent on the level of housing stock available in any local area; clearly this is challenging in England.

Recovery may be aided by better access to long term (albeit still transitional) housing support as well as long term independent housing. Housing associations can play a very important role. For instance the 'One Housing Group' and an NHS Trust in London have developed a Care Support Plus model which initially provided 15 high quality self contained supported housing units, helping service users prepare for the transition to other forms of accommodation. The service has reduced hospital stays and costs to the health services by more than £440,000 per annum with a reduction in hospital admissions from a total of 408 weeks in the two years prior to the scheme compared with 57.7 in the subsequent two years, with a further 12 flats built [180].

Looking at longer term support, a review of economic studies on Housing First in Canada, the US and Australia suggests that they *'can lead to significant cost offsets. When considering improvements in housing stability, health, and quality of life, Housing First may be a very cost-effective intervention for chronically homeless populations'* [181]. However the follow up time periods for most of these studies are quite short so less is known on long term impacts. Furthermore Housing First has had to operate in a climate with a severe shortage of social housing and affordable private-market housing in many Canadian communities. This can impact on the potential benefits of the programme.

"Around two-thirds of all of the costs of poor mental health are due to lost opportunities to participate in employment."

The City of Toronto's 2007 examination of the Streets to Homes programme found that the low supply of affordable housing resulted in a reliance on shared accommodation, which was less desirable to participants and generally led to worse outcomes, when compared to individuals housed in private apartments[182]. This is pertinent given the housing shortage in England.

An observational study of the Housing First approach in England reported decreased repeated homelessness for people who on average had previously experienced 14 years of homelessness. Potential cost-savings were estimated to be £15,246 per person per year, assuming potential savings between £4,873 and £3,098 per person in support costs, as well as from reductions in A&E visits and fewer contacts with the criminal justice system. While promising, sustainable funding will be an important factor for the continued success in the provision of this type of open-ended support [183]. This may also be dependent on rules governing entitlements in respect of housing benefit.

A national survey of 619 people from 22 residential care, 35 supported housing and 30 floating outreach services across England also looked at the costs of mental health supported accommodation services. It estimated mean costs of £371,445 for supported housing compared to £474,339 for residential care [184]. After adjusting for differences in need, quality of life was similar in supported housing to residential care, but with greater levels of social inclusion and a higher risk of experiencing crime. Floating support was much less expensive but associated with poorer quality of life outcomes and higher risk of crime.

Employment

Around two-thirds of all of the costs of poor mental health are due to lost opportunities to participate in employment. Most evaluations suggest that IPS is more effective than vocational rehabilitation in helping people return to competitive employment [168]. There is evidence particularly from the US on long term sustainability of benefits, although these have been hampered by funding structures [185].

In Europe evidence from Switzerland indicates that higher rates of competitive employment can be sustained over at least five years: 43% employed for at least 130 weeks versus 11% in the vocational rehabilitation groups. In this analysis there were no significant differences in overall costs of the two programmes – the higher costs of the supported employment programme were offset by reduced in patient admissions and lengths of stay. However mean incomes from employment in the supported employment group in the study were also almost double those in the vocational rehabilitation group [186].

A review of economic studies drew the conclusion that in the English context IPS would pay for itself within a year – with then annual costs per individual of £2,700 being offset by reductions in the use of mental health services of more than £3,000 per annum [187]. In an earlier multi-country trial, including supported employed in London, IPS was found to be less costly than vocational rehabilitation, with an overall mean net benefit to society, taking account of additional productivity through employment, of £22,615 per client compared to vocational rehabilitation services [188].

"So it's the day after my release...I'm on my way to sort out my script and prevent myself from going in to withdrawals and using. The first key worker I saw there was brilliant! Not only did she ensure my script...she also spoke about actually where to go from here....the ambition I had from before drugs was slowly coming back but I didn't honestly know how to get back into society and work etc."
CNWL Recovery Stories, 2014

"Good housing is more than just shelter."

These findings can be replicated even in very different country contexts: a recent evaluation of IPS plus psychological therapy was compared with traditional vocational support in Japan. At one year follow up while there were no overall differences in costs between the two groups, rates of employment were higher and clinical outcomes better in the supported employment group [189]. In contrast to employment, insufficient attention has been given to the assessing the economic case for comparable supported education services; a gap in the evidence that should be addressed

Money

Evidence on the cost effectiveness of personal budgets is modest, in part because evaluations have tended to focus on different client groups rather than people with mental health needs. A systematic review on personal budgets for people with mental health problems only identified cost effectiveness evidence in two of 15 studies assessed [190]. The more recent of these English studies concluded that the additional cost of delivering personal budgets was a cost effective use of resources given the improvements in quality of life and neutral impact on costs [191].

However, there remain many logistical and administrative challenges in expanding the use of personal budgets; the flip side of more individual choice is that the sustainability of existing services and supports is also weakened. Some of these issues may be explored further in ongoing evaluation of the relatively new Integrated Personal Commissioning areas that are being rolled out in England. These IPCs can include personal budgets as one element of an approach that in theory should be co-produced with service users [192].

People with some mental health needs may also be particularly vulnerable to falling into debt. Financial difficulties reduce the likelihood that people will recover from mental health difficulties. Investing in services that provide specialist welfare advice to people with mental health needs is likely to be a cost saving intervention even if only a small number of clients then have a reduced risk of using inpatient mental health services [193]. A recent economic modelling analysis suggests that the provision of face to face debt advice would aid recovery rates from depression, with costs of service provision being more than outweighed by a small reduction in costs to the NHS and a much greater impact on the wider economy by decreasing barriers to work [194]. Other new modelling work also suggests that there is a return on investment to face to face debt advice services of almost £3 for every £1 invested due to the avoidance in the general population of depression and anxiety problems associated with problematic debt [195].

"There is a strong evidence base on the benefits of facilitating recovery and preventing relapse through actions that support education, housing and employment."

CONCLUSION

We have considered a broad sweep of evidence and across a wide range of subject areas. That is inevitable with a topic like supporting recovery since it is as much about a set of underlying ideas, principles and values which can be applied to almost any intervention, as it is about the effectiveness of specific approaches. However, we believe it may be helpful for commissioners, health and social care leaders, and other stake-holders to be aware that there is a defensible and growing business case for the ten key organisational challenges.

Where the business case can be made specific, the traditional outcome evidence is – unsurprisingly – patchy. The scientific evidence supporting self-management (Challenge 1) is compelling and the emphasis on 'learning' – particularly joint learning ('coproduction') is highly consistent with modern educational thinking (Challenges 2 & 7). The evidence regarding the effectiveness of Recovery Colleges is promising (Challenge 3), but, at present, it is methodologically weak. A recovery-oriented approach to leadership and management (Challenge 4) is also very much supported by a substantial literature on organisational change, and a highly individualised approach to the planning and delivering of care (Challenge 5) is globally accepted as the bedrock of good practice in mental health services. Staff are also commonly overworked and undervalued, so the evidence that practising in a way that supports recovery is helpful to their morale and well-being (Challenge 9) is therefore potentially very important. There is good randomised controlled trial evidence supporting the value of peer support workers (Challenge 8), and the evidence in favour of the benefits of helping people pursue common personal recovery goals – stable housing, employment, financial support, social integration (Challenge 10) – is well established. Thus, the overall picture is of general support for a recovery-oriented approach, with more evaluative evidence needed, but strong evidence for high service user satisfaction and promising evidence for cost-effectiveness in certain key areas. It is this general picture which led the World Health Organisation to make supporting recovery one of its central organising principles for mental health services across the globe [3].

In terms of the strength of the evaluative evidence it is not surprising that randomised controlled trials are relatively rare. This is generally a new approach and it will take time for researchers (and funders) to catch up with the promising nature of these new developments and give it rigorous attention. However, this is balanced by the very strong evidence for increased satisfaction from people who use recovery-supporting services. In our view it is unusual for service developments to have generated such consistently high support from the people who use them – and from most of the people who deliver them. This leads us to believe that supporting recovery is a process which taps into some of the basic reasons why people approach mental health services for help and the essential motivation of staff to try to help them. This has to be a powerful combination.

Finally, we believe that supporting recovery may be a part of the solution to the global crisis of apparently almost limitless demand for care in the face of increasingly constricted resources. If these two pressures are to be reconciled we believe it will require a fundamental rethink of not only what is delivered by mental health services, but also *how* it is delivered. As part of this re-evaluation we believe that governments, managers and practitioners will have to redefine their goals and re-examine their workforce. Our speculation is that this transformation will involve changes in skills (such as a far greater emphasis on coaching to support self-management), structures (e.g. more partnerships with, and working through, community resources) and workforce, with the involvement of many more peer workers alongside traditional professionals. This transformation is perhaps the most daunting – but exciting – challenge.

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ImROC's Vision

For systems, services and cultures to support Recovery and wellbeing for all locally, nationally and internationally.

ImROC's Mission

ImROC works in partnership with communities to develop systems, services and cultures that support recovery and wellbeing for all. ImROC has been leading the way in recovery-oriented service and practice improvement since 2011.

Originally established on behalf of the Department of Health to champion its 'Supporting Recovery' initiative, through a collaboration between the Centre for Mental Health and the NHS Confederation's Mental Health Network, ImROC is now hosted through Nottinghamshire Healthcare NHS Foundation Trust. This innovative new partnership allows us to cement our close working relationship with frontline providers of care, ensuring that our work remains relevant and useful to practitioners, managers, system leaders, local communities and ultimately, the people who access services.

Our role is about enabling people (who use services, work in services and live in communities) to unlock and pool the strengths and talents they take for granted, explore new ways to make use of them, share knowledge and learning, and facilitate recovery-oriented improvement in the outcomes and experience of health and social care. We rely on and embrace the expertise, experience and collective wisdom of everyone we work with, and encourage communities to develop as a result. Our job is about using our expert knowledge to inspire others to believe that change is possible; pursue their dreams, and most importantly to act: changing attitudes and behaviours. This ethos of working in co-production is at the heart of our organisational work, and role models what we seek to achieve at a practice level too.

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