ImROC

Issue 3
Winter Edition 2017

Winter Newsletter

Working in partnership with communities to develop systems, services & cultures that support Recovery & wellbeing

Editorial

Dear All,

Over the last few months ImROC has been leading system wide developments in both the UK and in Asia, drawing on our experience of coproduction and peer support. The *Lets Live Well in Rushcliffe* project is truly inspiring, demonstrating the power and potential of whole communities working together to support people with long term conditions, including mental health problems. Through fortnightly coproduction meetings, many different stakeholders in local communities have both contributed to the central project and benefitted from their involvement by increasing the reach of their own service, adjusting their offer, or finding a meaningful role in their local area. For example, a local church is developing 'cafes' in new locations, providing a safe and supportive place to be, to meet people, do things together and learn about self-management; Nottingham Citizens is extending its dementia friendly training to local communities; libraries are increasing their courses on wellbeing and self-management; housing associations are working in partnership with us to invest in local communities …. We have

now recruited and trained 3 Health Coaches to work in GP practices across Rushcliffe and 12 Link Workers who will support people to identify their own goals and engage in local communities to achieve them. All the employees bring their own lived experience and are building on their own areas of interest (knitting, sport, beauty, music, meditation, education…) to develop their contribution to the project.

In Singapore, we are embarking on a three year project to support 12 mental health providers, mainly NGOs, to employ peer workers. This involves careful exploration of their current organisation using the ImROC ten Challenges to assess their 'readiness' for peer support; developing Recovery Champions and Recovery Implementation Plans at team level, as well as negotiating the role of peer workers in different settings.

In our fourth visit to Hong Kong last month, we were working with New Life, the largest NGO working with people who have mental health conditions, to coproduce more Recovery focused ways of working at every level of the service, and to discuss the further development of their peer workforce.

We have also been developing new ImROC products. The long awaited *Business Case* for Recovery has been launched alongside our *Coproduction* paper. Both are important additions to existing understandings of Recovery and as usual with ImROC publications, are focused on what this all means for practice. Further briefing papers will be published very soon: Recovery Colleges ten years on, and Recovery and Open dialogue are next in line, both drawing together existing evidence and exploring what this means for practice. What is becoming ever clearer, is the potential that Recovery orientated services have to increase self-management; reduce unplanned and compulsory admissions and improve achievement of life goals – all of which reduce costs to services. Since these outcomes are absolutely aligned with the goals of the new Accountable Care systems, the challenge does not lie in convincing them why they need to focus on Recovery but how best they can achieve this.

Editorial Continued.

As we continue to use our accumulating experience and expertise, we are launching a whole new package of peer worker training and support that can be tailored to different organisational requirements leading to them being licensed as an ImROC peer support service, and accredited to provide ImROC peer support training. Do get in touch if you would like to know more.

As another winter brings its own challenges to add to existing pressures it will be important for everyone to reflect on what they personally can do to make a difference. Once again, Recovery provides some answers. Personal stories of Recovery remind us how much every conversation matters. Whether we are working with colleagues, people using services, managers or family members, a Recovery orientated approach is all about recognising qualities, skills, assets and strengths; using every opportunity to appreciate others' achievements; valuing and believing in people. This is at the heart of creating a Recovery focused culture for services that we all find more comfortable and rewarding.

With very best wishes for 2018,

Julie M Repper

Director, ImROC

Recovery College Audit

Written by Alessia Anfossi, ImROC Research Intern

It is a great pleasure to share with you the results of the work lead by our intern Alessia in the last few months. The aim of the survey was to explore the current state of Recovery Colleges in the UK and the different ways that Recovery Colleges have incorporated and applied the Recovery Principles.

The final report comprises the relevant findings that emerged by the survey and also an appendix with the latest updated list of all Recovery Colleges identified.

One of ImROC goals is to share knowledge and to develop evidence based practice around Recovery. We can consider this survey as a pilot, and we hope that this work will progress in the future, including even more Recovery Colleges and producing useful results so that improvements can be made both in research and in managing the Recovery Colleges.
We hope that everyone can take the most from this and we would like to express special thanks to all the participants who took part to the survey, with patience and commitment.

A copy of the final report can be found at:

https://imroc.org/current-state-recovery-colleges-uk-final-report/

What would it take to make peer support available to all?

Q Improvement Lab – what would it take to make peer support available to all?

Written by Jenna Collins, Marketing and Communications Manager – Q, The Health Foundation

Many working in mental health and wellbeing – including most people reading this newsletter – will know of the transformational impact that peer support can have on people's lives.
However, the availability and take-up of peer support is not widespread, particularly in physical health services. This is why, since April 2017, the Q Improvement Lab has been exploring what it would take to make peer support available to all.

Funded by the Health Foundation and NHS Improvement, the Q Lab was created to bring people together to work on complex challenges. We are testing whether by combining methods from a range of disciplines (such as design and behavioural science) and collaboratively developing and testing ideas we can discover new ways of approaching and solving complex challenges in health and care. In our pilot year, our first Lab challenge is on peer support.
The starting point was surfacing and understanding the current challenges facing peer support across the system. To do this we used desk research, ethnographic interviews and had conversations with many of the people that came forward to collaborate with us (including at a 2-day co-design workshop).
Together we designed three pieces of work to take forward.

The first piece of work is on improving access to peer support. Specifically looking at what influences people's decision to (or not) refer, recommend or access peer support. We're running a survey this month which should provide us with some valuable insights on people's motivations. We hope the findings can then be used to shape the information and support needed to improve uptake of peer support services.

The second is on evidence, and how we can better capture the holistic impact that peer support can have on people's lives. We're working with those involved in the Lab and a small group of national charities to think about how an online space could help us collect and share evidence. We are also looking at how different organisations and sectors effectively use storytelling to capture lived experience and how this can be done most impactfully for peer support.

Finally, we are working closely with all Lab participants (a diverse group of around 150 people) to connect with each other and share examples of what does and does not work in peer support. One of the outcomes that the Lab is trying to achieve this year is encourage new relationships and collaborations, and it's exciting to see examples of that happening.

When it comes to peer support, the wider health and care system could learn a lot from mental health and wellbeing services and it is part of the Lab's remit to help shed a light on that, so we would welcome you to get involved and share your expertise.

If you have peer support evaluations, examples of how storytelling is being used, or would like to connect with others involved in peer support we'd love to hear from you. Contact us at QLab@health.org.uk or visit our website https://q.health.org.uk/q-improvement-lab/ for updates.

LEARNING EVENTS

Recovery Demonstration Day

On the 21th September 2017, ImROC held a Recovery Demonstration Day hosted by Nottinghamshire Healthcare NHS Foundation Trust, after the successful Refocus on Recovery Conference. We were delighted to host this seminar and would like to thank all the participants from UK and internationally who actively took part to the day.

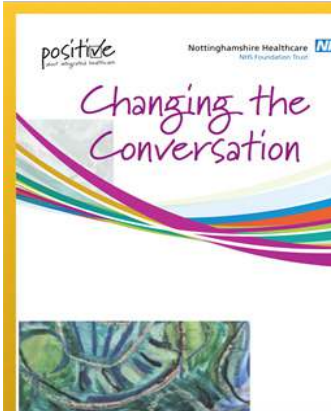
Development Days showcase the recovery-orientated practice from across a host organisation. Nottinghamshire Healthcare NHS Foundation Trust shared the challenges and possibilities of Recovery-focused services in action. With close to 50 delegates from eight different countries we jointly heard examples of innovation and strategic commitment to Recovery. As a group we pondered and discussed the benefits and challenges of working similarly in our home settings.

Dr Dave Manley, Clinical Director, Specialist Services and Chair of Local Partnerships Recovery Steering Group, Nottinghamshire Healthcare NHS Foundation Trust described recovery-focused leadership reminding us that Recovery is a very personal approach that needs to be coproduced and adapted for each situation. Notts Healthcare has a recovery governance structure although criticisms of recovery becoming over professionalised are acknowledged within the organisation.

Titling the strategy Changing the Conversation highlights the importance of having different conversations. So what are the hurdles for a strategy that sits well within the organisational values and had the tenacious leadership of the Board to make this happen? The concept that recovery 'is done', the box is ticked and there is other work that now needs to be the priority. In fact the Recovery journey is ongoing. Coproduction takes many forms. It is a paradigm we can adapt across care settings and directorates. A culture of openness is crucial. Dave finished by championing optimistic leadership, building a community of interest and presenting the evidence case in the context of real lives.

"The work of helping people in distress to realise possibilities of action so that at some future time, they and those they love, will feel it is not unworthy of what has happened to them" ***Gilles Deleuze***

Julie Repper, Recovery Lead for Nottinghamshire Healthcare NHS Foundation Trust, presented on the background to developing the strategy. Whilst Recovery may have different meanings to different people, the conversation is and will always be the most important whether at an individual, organisational or community level. Overall, the strategy enables staff to work in a positive, supportive non-restrictive way and the evidence tells us staff have greater job satisfaction and lower sickness. *Changing the Conversations* is core business and aligned to both the business strategy and values.



LEARNING EVENTS

After an overview about co-production from Liz Walker including an adapted version of Sherry Arnstein's 'Ladder of Participation' and its application in practice, one of the core-principles of Recovery, Tracey Taylor, Director of Nottingham Recovery College, described the work of the college over the last six years since it opened. The college has a large number of venues and campuses including primary care and wellbeing pilot, a strong person-centred approach and holds centrally the benefit of developing an Individual Learning Plan (ILP) with each student. A discussion was held on how elements of the Nottingham Recovery College are distinct from a traditional ImROC recovery college, such as being open for staff to attend courses.

Thanks to Emma Watson, Peer Support Development Lead, we talked about Peer Support and about the importance of peer roles in different settings and the path to becoming a peer worker. Particular attention was given to the training and support of peers, highlighting also the actual challenges, such as the career progression and the evaluation of the Peer Workers impact.

After the lunch break Liz Walker joined us once more with John Kemp, Health Development Officer at Principia to present on the new ImROC project *Living Well in Rushcliffe*. The introduction from John described the importance of self-care and the health coaching. *Living well in Rushcliffe* is a health and wellbeing project that brings together individuals and organisations within the community to strengthen relationships, share expertise and develop new ways of supporting local people. Some of the aims of the social prescribing project are employing link workers and health coaches in GP practices to support local residents live the lives they want to lead and build confidence.

We look forward to hosting the next event! Get in touch to register your interest imroc@nottshc.nhs.uk

THE BUSINESS CASE FOR RECOVERY

The challenge in co-writing the briefing paper on 'The Business Case for Recovery'

Written by Sue Williams, Senior Peer Trainer & ENRICH Peer Coordinator CNWL Recovery & Wellbeing College

The challenge in co-writing the briefing paper on 'The Business Case for Recovery' was for me, not whether to do it, but how to do it. This very much mirrored one of the key challenges discussed in the briefing paper, that of not whether to support recovery, but how. I was not sure how we were going to pull together a single briefing paper given there are so many different ideas about recovery, let alone needing to review and present the evidence. Initially, the task felt daunting, but working with people who have published a great deal was an invaluable experience because I was able to learn how to develop a structure to organise the information. Using the ten ImROC organisational challenges as the framework, it was then possible to review and present three types of evidence for each challenge. Evaluative evidence from formal research studies, providing credible scientific data for a number of effective approaches to supporting recovery, evidence from narrative accounts and experiences of individuals and economic evidence (where available) on the cost and efficiency of these new services. It was refreshing to see that the evidence from personal experience and the valuable insights from people using services were valued equally to other types of evidence. I found the whole experience of co-writing the paper, a great example of genuine co-production in action.

In looking at the evidence relating to **Challenge 1: 'Changing the nature of interactions'**, it was concluded that we need to change the fundamental characteristics of the interactions between those tasked with delivering the services and those receiving them. Rather than continuing to do more of the same thing, we need to focus more on what's strong and less on what's wrong. We want to build on people's strengths to help them use professional expertise, allowing them to move towards personally valued social goals (housing, integration, employment), and not simply the reduction of symptoms.

Challenge 2: 'Delivering comprehensive, co-produced learning opportunities' was updated, in the light of experience, to 'Co-produced recovery focused learning and development opportunities are available for all staff working in services.'

A main point made here was that 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 their own learning, but also with their own pre-existing beliefs.

Challenge 3: 'Establishing a Recovery Education Unit to drive the programmes forward.' This challenge was also updated to become **'Co-produced, 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 the local communities can share expertise together.'** Evidence reviewed here emphasised the essential role of recovery colleges in promoting co-produced learning.

We looked at the data relating to **Challenge 4: 'Ensuring organisational commitment, creating the culture'**. This challenge was updated to become. **'Recovery focused leadership at every level and a culture of recovery.'** An important recommendation was that we must think beyond simply 'training' staff to behave in different ways. Evidence from research studies found that training was found to be important, but it only had a lasting effect if issues of supervision and leadership were also addressed.

THE BUSINESS CASE FOR RECOVERY

We looked at the evidence relating to **Challenge 5: 'Increasing personalisation and choice'.** A central task for mental health services is to ensure that individual care is genuinely personalised and maximises involvement and choice. The evidence reviewed, however, suggests that care planning remains very bureaucratic, often with little evidence of user involvement or shared decision-making. A key recommendation was to promote the use of specific health & wellbeing tools with a focus on defining wellness and supporting personal recovery.

We considered the evidence relating to **Challenge 6: 'Changing the way we approach risk assessment and management'** and updated the challenge to **'Changing conceptions of risk as something to be avoided towards working together to improve safety.'** A key recommendation was that professionals and people using services need to work together to agree the right balance of risk and choice.

Challenge 7: 'Refining 'user involvement' to encourage 'co-production'. Evidence reviewed in the briefing paper highlighted the value of co-production for public services. For people using services, it means improved outcomes, quality of life and 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.

Challenge 8: 'Transforming the workforce'
Having examined the evidence base for introducing peer support workers, the general findings were of an increased sense of empowerment and positive benefits in terms of social inclusion. It was concluded that the next frontier is therefore implementation, and both ImROC and others have developed guidance to assist in this process.

Challenge 9: 'Supporting staff to cope effectively with the stressors that are inevitable in working in mental health services.' It was clear from every perspective that supporting staff makes sense. 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.

Challenge 10: Increasing opportunities for building a life 'beyond illness', was revised to become **'Prioritisation of life goals (full citizenship and community integration) in all care planning processes.'**

Having reviewed the available research, there is a strong evidence base on the benefits of facilitating recovery and preventing relapse through actions that support education, housing and employment.

Finally, As Mike Slade comments " 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 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."
The briefing paper can be found at: https://imroc.org/resources/14-recovery-business-case/

Recovery in Mind

Written by Angela Ryan

I started Recovery in Mind last June having been a student myself with the Southern Health Recovery College the previous year. Inspired by meeting Poppy Repper (Real Lives) at the ImRoc Conference last January I decided to set up my recovery college as a social enterprise. We are based in Newbury in West Berkshire.

It's been a busy year to say the least! Within a year we have worked with around 100 students, have had 3 wonderful MH professionals seconded to Recovery in Mind by our local CMHT (2 OT's and a CPN), had the support of Alex Luke, head of West Berks CMHT, fundraised (talks etc), managed to get some grant funding, moved into our office with training room, wrote the courses and co-facilitated the courses and filled in more grant applications than I care to remember. I am also mum to 3 year old Flo and 17 year old Storm. My lovely neighbour does all our admin and bookings and I have a multitude of supporters (many of whom were around to support and care for me when I was unwell with psychotic depression and PTSD in 2014 and 2015 – so they 'get' mental health) who help to run courses, like my photographer friend Alex or Jess who is a volunteer who supports one of my students who is visually impaired. My friends Anna and Tim ran a fundraising ball when finances were difficult (they still are but I just carry on regardless and have faith in those around me) – you get the picture. So it really is a community effort.

However, the most important are our students. Our courses are free of charge to anyone living in West Berkshire who has a mental health challenge – not just those who are supported by CMHT but also those who are supported by their GP or in the case of a handful of our students, who haven't even felt able to go to their GP for help for whatever reason and are not 'with' anyone. I wanted to help prevent people perhaps becoming more unwell or struggling with crisis. I'll never be sure if that's the case but I feel it's a more open community that way. Students come from town and many of the rural villages spread across the patch.

So our courses. Well we decided to develop a 3 step system, after our second term, so that our students get the most from the courses and we have the best possible 'turn-up' and retention rate that we can achieve.

STEP ONE – our 1.5 hour taster session – Is Recovery in Mind/Recovery College for you?

STEP TWO – Welcome to Recovery Course six weekly sessions aimed at understanding the concept of recovery, what your recovery may look like and setting the goals for yourself (there's loads more but I think you get the idea) then final session is a day is at an organic farm conference centre high up on the Berkshire Downs. A time to review the course, enjoy a home cooked organic lunch together, tour the farm by tractor and trailer and celebrate the end of the course and the beginning of own recovery journey. Many students haven't left town for a while or even their own homes. I personally find this day very inspiring – to have met those students a few months before and to have watched them to get to where they are is worth every moment of those grant application forms and late nights.

I digress….

STEP THREE – students can choose any of our other course – 5 week Five Ways to Wellbeing Course – very out and about, WRAP course, Recovery St (capturing your recovery story through the use of photography), Healthy cookery workshops, Self-compassion, Wellbeing in the Wild days and more.
So how do I grow the college…..obviously by using Peer Trainers. So that's when I started working with Waldo. We worked together for about 3 months to think through the needs of our particular training. So it was decided that I would lead our Induction Day and that Waldo would come to West Berkshire to lead the 2 day 'train the trainer' and follow this up with a 'micro-teach' day 8 days later. As is always a challenge for everyone we had potential peer trainers drop out – home life, caring roles, work and the wobbles led to us only starting the part with Waldo with 5 peer trainers. When the micro-teach we were down to 3. The course was a success thanks to Waldo's knowledge, passion for recovery and sharing that all-important 'lived-experience' which I think is absolutely vital to get right. I can't thank Waldo enough for supporting me and to ImRoc too.

Recovery in Mind

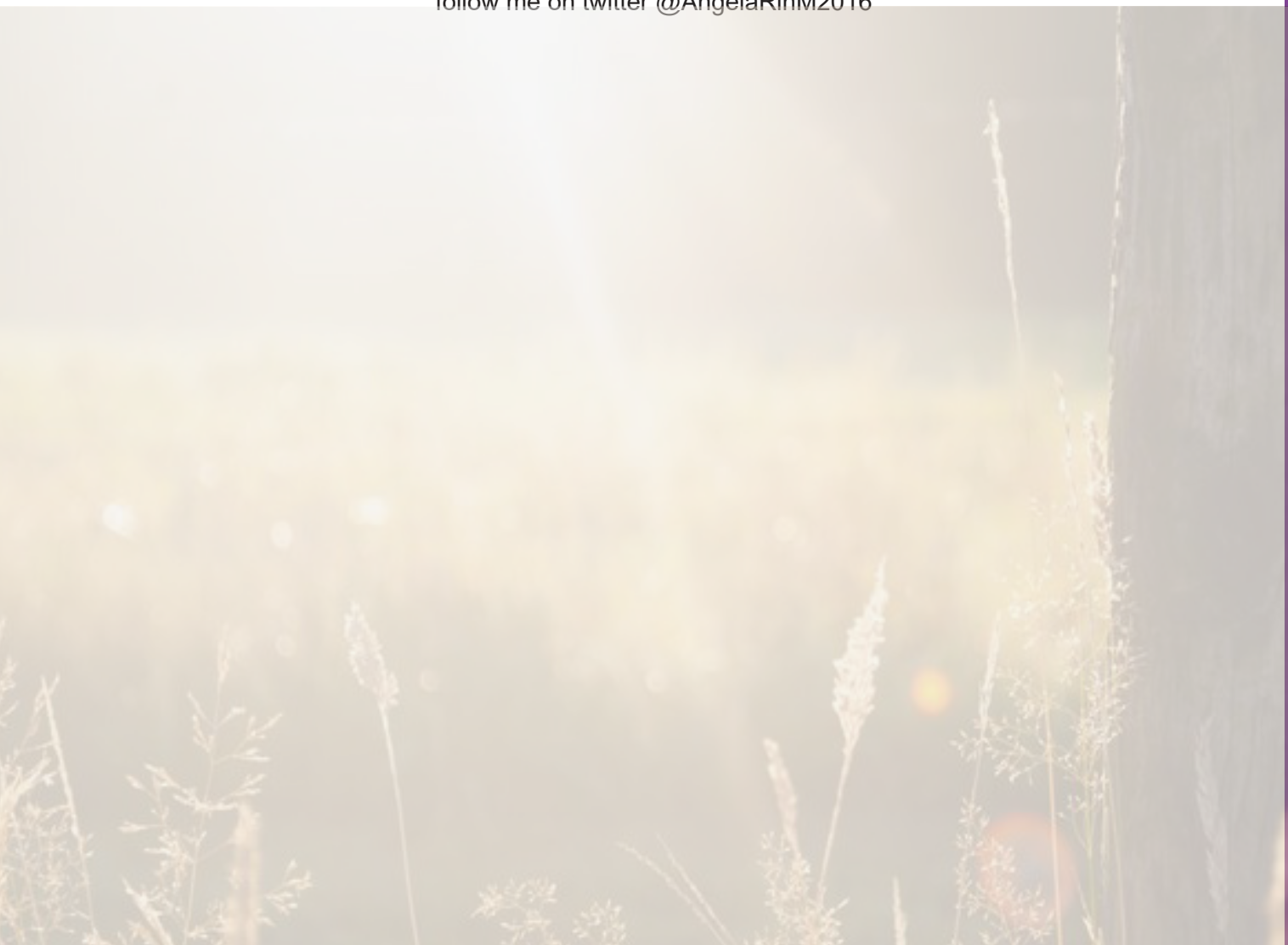
So exciting times ahead and we hope Waldo will visit us more often……. for those of you who don't know, Waldo, aspired to be a cowboy in his childhood so when he stayed with friends of mine in our village for the course he was near the horse field where the village kids keep their ponies (including my 3 year old daughters Shetland pony) – next time he comes I will be arranging for him to be riding and practicing his lasso tricks!

So what next…. Well I plan to scale up the number of courses and student places. The funding is my biggest challenge. This really is 'frugal innovation' – I ran the whole of Recovery in Mind for less than £30,000 last year. I never set out to be rich (good job!) as the social enterprise model dictates that all your profits go back into your social purpose not the pay packets of directors or generously paid staff. So to help us raise funds we are now running 'Wellbeing Days' open to the public including pilates, yoga, creativity and mindful walking as well as a talk about my own journey and why I set up Recovery in Mind. They are run in Newbury at a beautiful private home called Treetops (email me if you would like to know more or make a booking!) We are also able to offer corporate Wellbeing Days so spread the word.

As you can probably tell I love my work. I set out to start a recovery college and not to becomea leader but I have had to take that on as well. For me I feel that finally my illness was not 'lost time' but has led me on to pastures new…. Part of my own personal recovery really – but I don't think I would encourage others to do the same only two years post hospital. Its tested my own mental wellbeing once too often and I really did think I was becoming ill again on several occasions so I have learnt to practice what I preach and show myself a bit of self-compassion (yes new course coming in January!). My own family are a great support and I have them to thank too.

www.recoveryinmind.org.uk

follow me on twitter @AngelaRinM2016



Out In The Field - International

Recovery College International Community of Practice

Written by Sara Meddings, Psychology and Psychological Therapies Consultant Lead for Recovery and Wellbeing

The Recovery College International Community of Practice met for its second meeting on 9-11 August 2017. The event was chaired by Dianne Hardy from Australia and hosted by Marianne Farkas and Boston Recovery Centre. Participants included people from Canada, Australia, USA, Israel, Italy, France and the UK. Sara Meddings represented ImROC and Sussex Partnership.

What defines us

The group discussed what defines a recovery college. Recovery Colleges are situated in a range of contexts including within mental health services, non-governmental organisations, education settings and are often partnerships of these. Recovery Colleges' defining features were first outlined by ImROC as co-production; inclusion and open to all; based on education principles; recovery focused, strengths based and person centred; community facing and progressive. These are essential characteristics of a recovery college but other approaches may also include some of them. Recovery education centres may be broader and not all are recovery colleges. For example in some colleges co-production and inclusion of staff and family members are not core features.

Why might recovery colleges work

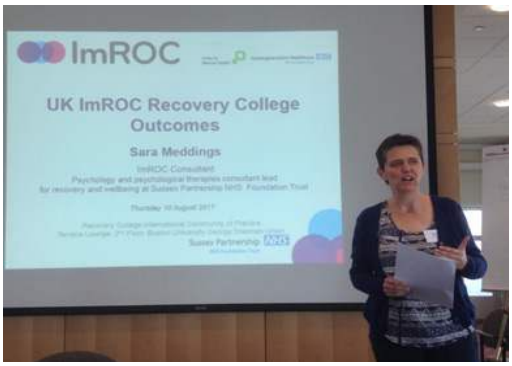
A range of possible mechanisms of action for why recovery colleges might work were discussed. These include: changing how people see themselves and others; new relationships, social connections and peer groups, reducing self-stigma, increasing hope, increasing confidence and control. One of the next steps for research is to look into this further.

What would it be helpful to know when starting out
We shared ideas about what it would be helpful to know about when first developing a recovery college. These include:

- Amount of admin staff required to run a college
- What to collect from students to evaluate the college without burdening students and how much resources it takes to research or evaluate
- Value of visual representations to show a recovery college works
- Start with a pilot and start small
- The importance of communication including with different professional disciplines
- How to recruit a team.
- How to support peers in their roles and manage performance.
- The importance of working with occupational health, Human Resources and employee assistance programmes.
- How to pay for or fund recovery colleges
- The value of partners and consideration of who is the lead partner

Outcomes

Sara Meddings summarised the range of outcomes from ImROC Recovery Colleges in the UK. Evaluations show students achieve personal goals and learning outcomes and make progress towards recovery, quality of life and socially valued goals. Students also use services less. Evaluations from recovery colleges in Australia showed similar results.



Out In The Field - International

Future Research

The time is ripe for further research building on the evaluations in the UK and elsewhere. Sara Meddings outlined some of the key research questions. We need to explore further what is a recovery college (defining features); what makes them work (mechanisms of action) and who uses and benefits from Recovery Colleges and who doesn't. She explored the desirability and feasibility of an RCT and the value of realistic evaluation to gain a deeper understanding first.

Lots of research is just starting. Mary Leamy from Kings College is planning a realistic evaluation of recovery colleges. Mike Slade is leading a current research project, RECOLLECT, examining the defining features, possible mechanisms of action and a census of who is using them. ImROC are carrying out a national survey of 71 UK recovery colleges to explore how they relate to the defining features and to create a national database (see Alessia Anfossi's report). Holly Thomson is asking students one year on about their experience of recovery college and how it helped their recovery. In Canada, Vicky Stergiopoulos is looking at how recovery colleges can help recovery and homelessness; Myra Piat and Catherine Briand have funding to develop a new recovery college in Quebec with a waitlist control study. Mike Slade and Claire Henderson are planning RECOLLECT-2 which may include an RCT.

The International Community of Practice

People value the community of practice for its international perspective; learning from recovery colleges at different stages of development; sharing research and evaluation and building an international evidence base.

The group would like to create a website and database of recovery colleges. Sub-groups may meet of colleges at similar stages of development or people with special interests addressing similar questions. The group aims to develop common projects eg to map all recovery colleges in the world; write papers together or create a special edition of a journal about recovery colleges.

The majority of attendees were from Western English speaking or European countries. Colleagues from Uganda, Sri Lanka and Japan were not able to attend. We need consider how to make the group inclusive and to reflect the diversity of countries and cultures with recovery colleges.

Reflections

ImROC and the UK have been at the forefront of the development of Recovery Colleges. This has built on but is fundamentally different from pre-existing Recovery Education Centres. This diversity is helpful at the moment when we are still exploring which key dimensions make them work. As Recovery Colleges develop around the world there is much we can learn from one another, both from the new questions people ask and the developments they initiate. Different contexts and cultures bring different questions to the foreground and opportunities to find new innovations. For example, parts of Canada and Australia are so rural that they may be at the forefront of thinking how we can reach people in isolated rural areas. Other countries may help us consider inclusion and diversity in new ways. We can continue to learn from the way Boston Recovery Education centre is part of the university with accredited courses and its students being students of Boston University. New Recovery Colleges are able to carry out robust research as they start out, building on the work already done.

The International Community of Practice affords the opportunity not only to learn from one another but to build an evidence base and narrative together about Recovery Colleges and how they work. It appears that Recovery Colleges are effective across a whole range of cultures and countries. By working together we can strengthen the discourse and maintain robustness whilst Recovery Colleges become more established in terms of policy and research and until they become a core or integral part of mental health provision.

Out In The Field - International

ImROC hosted visit for Kwai Chung Hospital and Mental Health Association of Hong Kong

On Monday 9th October 2017, 21 professionals from Hong Kong took part to a three-day visit to Nottinghamshire Healthcare NHS Foundation Trust, facilitated by ImROC. The aims of the visit were to gain ideas, inspiration and learning about enablers of recovery; to consider the role of a peer workforce in creating a recovery-focused culture; to explore approaches to change staff attitudes and behaviour; to recognise the importance of community resources and partnerships. In particular, the participants expressed interest in exploring in depth the concept of co-production and Recovery Colleges, reflecting on the shift of identity to become students who attend college from service users, , considering the staff and cultural change in terms of how to integrate the concept of recovery in the team, discussing recovery in different settings (e.g. NGOs and hospital settings, specifically in acute services), learning about Peer Support and how to implement it in the services, promoting recovery to the public, and hearing about organisational collaborations. The core objective of the visit was to enhance recovery-oriented practice taking into consideration attendees own job role in their organisation .

On Monday Julie Repper, ImROC Director & Recovery Lead at Nottinghamshire Healthcare NHS Foundation Trust, gave an overview of the Trust's Recovery Strategy, with reference to the national transformation program and to the collaborative process that led to informing the organisational strategy. The Team Recovery Implementation Plans, known as TRIPs, and the Recovery Action Learning Sets were introduced to understand in practice how to support a whole team in becoming more recovery-focused.

Tuesday morning was dedicated to review the development of a peer workforce across third sector organisations. Turning Point represented one of the best examples in this context, having developed a strong and consolidated network in Nottingham. The group was escorted to Beacon Lodge, a transitional service that offers person-centred tailored support for people who have been discharged from acute mental health wards. Afterwards, they heard Haven House, Alfred Minto House and Carlyon House presentations, exploring the differences between these services, in terms of referrals, accessibility, staff, guests etc. The highlight was the support they give to the people who access their services and the promotion of an individual's journey of recovery, as leading thread running through all services provided by Turning Point. Evidence of the progress made by Turning Point was also supported by the direct experience of several guests and peer support workers, who shared their personal reflections, their roles and their personal journeys through the services, inspiring the group and giving practical demonstrations of the recovery-approach success.

In the afternoon the visitors moved to the Institute of Mental Health, where Professor Mike Slade introduced the Refocus Model, explaining the effectiveness of the intervention and how to implement it in the services, for example developing a Refocus Coaching for Recovery training.

Wednesday, the final day, was entirely dedicated to Peer Support in Nottinghamshire Healthcare NHS Foundation Trust. Liz Walker, Workforce Recovery Lead, facilitated the discussion around establishing and developing a peer workforce and showcasing peer support training, supervision, team preparation and employment support, with the support of two Peer Support Workers who shared their experience covering this role.

We would like to thank all the participants from Hong Kong, wishing them good luck in implementing and sharing Recovery strategies in their services and teams. Therefore, we would like to thank all the external partners that shared their knowledge with passion and made the visit interesting and inspiring!

Out In The Field - International

A new path?
Implementing supported employment in sheltered employment – The Award Winning Integrative Unit Model at Shekulo Tov Group, Israel.

Shekulo Tov is a non-profit organization who was founded in 2005 and a service supplier for more than 3,000 service users. Shekulo Tov provides person-oriented community based vocational recovery, supported employment and leisure and recreational services to people with psychiatric and other disabilities.

Our vision is that anyone, including people who were diagnosed and 'non suitable to work', should have the opportunity to have a safe place for employability and training alongside with a meaningful opportunity to find job in the open market, when they are ready for it. With that spirit Shekulo Tovs' recovery professionals, along with The Israeli Ministry of Health' support, developed the Integrative Model and implemented it in all Shekulo Tov's training units. Shekulo Tov's integrative model represents an essential change of perception vis-à-vis sheltered and supported employment. It is a formative shift from the two sequential approaches of "train, then place" or "place then train" to a simultaneous approach of "train and place". The model's continued development led to the formation of Shekulo Tov Group training units which all embedded the "integrative units" model.

The Integrative Model encourages interactions between society at large and individuals coping with psychological disabilities. These individuals, who are our service users, benefit through reinforced self-confidence and gain recovery tools and practices that significantly improve their chances of placement in the open market. Along ongoing support, service users are offered skills and career development, training programs and are provided with necessary preparation and support to measure their vocational progress.

Supported employment services are not detached from the earlier stages of the vocational recovery process. From the start of the inclusive employment procedure, service users meet employment support specialist and together they explore relevant occupations. Throughout the process, emphasis is placed on honing the skills needed for the desired open labor market job. When a service user indicates interest in filling an open labor market position, the employment-support specialist, who is already familiar with that individual, assists with job seeking and continues providing the service user with support as needed once he/she has taken up the job. Service users who leave or are dismissed from a job in the free market, are invited to rejoin the training program and receive intensive support by the same staff until they feel ready to reapply for an open labor market job. This process gives service users a security net and a recovery sequence along training and mentoring and diminishes any feeling of failure.

Furthermore, integrative units operate as productive work environments that enable the service users to acquire vocational skills. In addition, the units function as recovery accelerators. Integrative units involved in the Shekulo Tov program manufacture chocolate, candles, soap, paper products, used books (the largest Israeli brand for second hand books and the third largest Israeli book chain) and provide a wide variety of training tracks both within and outside of the unit. These products are unique brands of Shekulo Tov and have an additional value for the consumer. Furthermore, the Integrative units

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operate as additional lines of business actualize the concept of maximizing interactions between our service users and the general public. Another unique and successful unit is Good Dog, which offers dog walking by a regular, trustworthy and professional dog walker, with psychiatric disability. This service has a meaningful impact on changing society's perception of people with psychiatric disability.

Even Though Shekulo Tov Group started from providing sheltered occupation, we developed a holistic approach which comprises from a joint dialog with employers from the open market who share our vision. Our open market employers are from a variety of fields, such as: Customer service & sales (e.g.: RENUAR, ZEBRA, IKEA, Yes Planet, The Israeli Museum in Jerusalem), restaurant businesses (e.g.: Aroma, McDonald's, Burger King) and Computers (e.g. IBM).

In the past three years alone, our unique integrative model has successfully led to long-term open labor market work inclusion of more than 800 (25%) people with psychiatric disabilities who were referred to us by the government as 'unsuitable for the open market'. All are currently earning minimum wage or more and hold jobs in various occupational settings such as: customer service, sales, education, manufacturing, retailing and more. Furthermore, the Model has reduced service users' preparative vocational training for open labour market placement from 4 years to 20 months. Shekulo Tov's Integrative model was awarded the "Project Zero" prize for impactful social enterprises in early 2017, categorized under Innovative Practice 2017 on Employment, Work and Vocational Education and Training. For more information on Shekulo Tov Group, visit us in: https://s-tov.org/

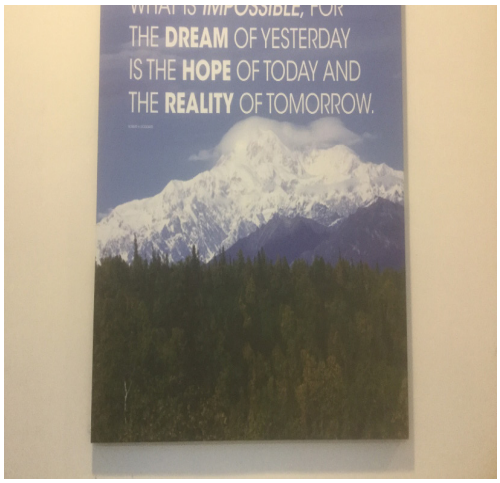
Out In The Field - International

Singapore

In November, we began our work commissioned by National Council of Social Services (NCSS) to support mental health services in Singapore develop and integrate a peer workforce within recovery-orientated organisations. This programme reminds us of the importance of embedding recovery through every level of an organisation to maximise the impact and value of lived experience.

We spent one fascinating week meeting managers and teams across four organisations who are transforming the culture of their organisations with national support from NCSS. Together we reviewed organisational readiness for peer support at both an organisational level using the 10 key challenges as well as a team level to provide baseline information. By identifying priority areas of work to build on the foundations of positive practice and recovery-focused leadership already firmly in place, we have developed plans for action including training, guidance materials and workstrands coproduced and codelivered by newly forming working groups.

When we return in the Spring, we will put these plans in to action. As with all our work we share our learning and experiences but importantly consider the principles and practice within the context and culture of each team or organisation. One area of work we will delve in to with member sites is the challenge of having recovery-focused difficult conversations. We will find the best way to remain honest and true to our values when giving feedback and finding the right path for developing peer roles within organisations.



ImROC - Meet our newest member of the Team!

My name is Sandra Hutton, I am currently Head of Patient and Carer Engagement with Northumberland Tyne and Wear NHS Foundation Trust .I am delighted and excited to become involved as an ImROC Consultant. My involvement with ImROC began in 2013 when my Trust signed up to become a member. This was a very timely opportunity for us. As an organisation we were going through a massive transformation and organisational change within our community mental health and learning disability services. Working and embedding the principles and values of ImROC, whilst they complimented and aligned themselves to the values underpinning our transformation work within NTW, it also us presented with a number of challenges in helping us to helping us explore and move forward to become more recovery focussed in our day to day practice/ intervention and delivery of our services.

I am a mental health clinician by background, having worked in the NHS mental health field for over 34 years now. My passion and drive is working collaboratively in partnership with service users, carers and staff to ensure that the voices of people who come into contact with mental health services are heard. I strongly advocate for people taking personal responsibility for their own well-being and believe and recognise the importance of everyone being a leader in their recovery/discovery journey.

Peer Support, Recovery Colleges and working within a 'Think Family' framework are all important and crucial areas that I am very passionate and committed to developing further. I hope that by drawing on my own lived experiences of having used mental health services, will empower others to improve the quality of people's lives and help create opportunities for service users and carers that were once simply not available.

I am looking forward to working as an ImROC Consultant and feel very lucky to be part of a very passionate, committed and inspirational team.

Obituary - Jane McGregor

Written by Julie Repper, ImROC Director

It is with great sadness that we remember Jane Mcgregor, who passed away on the 22nd November 2017 following a long period of ill health. Jane was a good friend to ImROC and to me personally. Memorably, I met her on the shore of Lake Garda in Italy where Geoff and I were working. It was a beautiful sunny evening and Jane and I started talking about our respective careers. She started by saying that she had been a teacher but that her Phd investigated the notion of space in education. As she described what this meant with characteristic wit and enthusiasm, I began to draw parallels between what she was saying and the Recovery Colleges that we were beginning to develop through ImROC. This was the beginning of a conversation that lasted over the three days and led to Jane contributing to the development of Recovery colleges locally, nationally and internationally.

Jane immediately saw the potential of Recovery Colleges, and much more than that she was able to articulate what we were trying to do (as well as we could from a health service perspective) in educational theory and language. She gave us much greater confidence in the value of what we were trying to do and she influenced and informed us so that we really could achieve our ambitions and describe our achievements in credible educational terms.

Working with Jane was an absolute pleasure because she was approached every project with determination and intelligence, but she was also so generous in her support. Rather than grasping the limelight she attended to detail, ensured that everyone understood, answered questions in detail and followed up inquiries, provided additional reading to those interested, noticed anyone struggling, and was assiduous in adhering to core values and principles.

Jane's unfailing encouragement, enthusiasm, her humour, personal interest in people, integral values and in-depth knowledge of education – particularly Student Voice and democratic learning approaches - enabled her to genuinely work alongside people developing Recovery colleges, whether through a learning set, through skype support to Australia, in one to one sessions or in group work. She made it easy and it felt as though it was all our own idea! She did not take sufficient credit for her contribution, but she has published important papers that will go on having an influence and I know that within our world of Recovery her very special constellation of gifts will not be forgotten.

That is Jane at a personal level. What I have not spoken about yet is the enormous contribution that Jane has made to the development of Recovery colleges, not just in England but all over the world.

Jane McGregor

Written by Sara Meddings, ImROC Consultant & Psychology and Psychological Therapies Consultant Lead for Recovery and Wellbeing

Jane McGregor, who died on 22 November 2017 aged 62, was passionate about equality and making a difference in education. Most recently she made a significant contribution to the development of Recovery Colleges in the UK and around the world.

Prior to joining ImROC Jane led a career in the field of education as a geography teacher and then as an educational researcher. Her PhD on how different kinds of space affect the interactions between teachers is seen as seminal. She was a key person at the National College for School Leadership's Networked Learning Communities, bringing together research and the practical experience of professionals and students. She was a champion of 'student voice' and the way students and teachers could learn from one another. She is well published and edited the left-wing educational journal 'Forum'. She brought this experience and expertise to her work with ImROC.

Jane formally started working as an ImROC consultant in early 2012. However, I recall conversations during the preceding years between Geoff, Julie and Rachel about how Jane's approach to education and her educational expertise had been contributing to the development of ImROC and of Recovery Colleges in particular. Jane formally started working as an ImROC consultant in early 2012. However, I recall conversations during the preceding years between Geoff, Julie and Rachel about how Jane's approach to education and her educational expertise had been contributing to the development of ImROC and of Recovery Colleges in particular. Jane influenced ImROC's early decision to use a learning set model in the first phase of the ImROC programme. She helped us to understand the difference between teaching and learning and the value of professionals and people using services bringing their different expertise and co-creating new knowledge together.

Jane has supported over 20 Recovery Colleges through individual consultations and co-facilitation of the Recovery College Learning Network. She supported the development of SE Sydney Recovery college in Australia and hosted international visits from Tokyo and elsewhere. She was good at connecting people and networking - she was the person to ask about what Recovery Colleges were out there and kept a record of all as they emerged. Jane's work on the defining characteristics of Recovery Colleges has been a key to us learning how they work.

Jane was passionate about equality and co-production – all her work was imbued with this. She spoke at the spring 2014 conference on co-production. She nurtured people, helping them find solutions and grow their confidence and expertise, letting other people shine whilst she supported in the background. She brought a commitment to including student voices in the development of Recovery Colleges. Her insistence on co-production and co-learning was genuine and visible in the way she worked as well as words she said. Jane brought a wealth of expertise and wisdom around education to the RCLN, both in teaching about adult education principles and in showing how to step away from a lesson plan to follow the needs and interests of participants.

Outside of work Jane was a great friend. She was there for people with a listening ear when they were going through hard times. She was a keen gardener, traveller and art lover.