Recovery-Related Brief Interventions for Psychosis

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9.1 Introduction

Mental health services in most countries are facing fundamental challenges in terms of their capacity to meet ever-increasing demands with limited resources and limited powers to increase the availability of funding. Mental health conditions represent the single, largest source of disability (World Health Organization 2008), and the mismatch between demand and supply has been so great that we may have to rethink our traditional assumptions about the content and "style" of service provisions – both "what" is delivered and "who" delivers it.

This chapter will examine these themes in relation to psychosis and some of the new ideas which focus on the importance of supporting "recovery." It has long been established that for people with psychosis, their symptomatic course and their social outcomes can be heterogeneous and often not closely correlated with one another (Strauss and Carpenter 1977; Harding et al. 1987). It is also the case that while antipsychotic medications are effective in controlling symptoms in the acute phase for most people, they are not effective in a substantial minority of cases (about one in five, according to the Royal College of Psychiatrists 2014). On the other hand, effective psychosocial interventions have been relatively neglected in research and service delivery (see Chap. 1). Doubts have also been raised recently regarding the long-term use of antipsychotics since there is preliminary evidence that maintenance medication may lead to worse social outcomes in young people with remitted psychosis, despite a more benign symptomatic course (Wunderinck et al. 2013). In either case, one cannot assume that the most effective way to improve long-term outcomes for people with psychosis is simply through the administration of

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symptom-oriented treatments – medical or psychological. Instead, one needs to look at how to combine traditional treatments with more social models of care in order to improve outcomes.

9.2 Supporting Recovery

One of the most well-known social models in mental health services derives from ideas about the importance of supporting "recovery" (Slade 2009). This underpins national policies across the developed world. But what does "recovery" mean in this context? What are the key practices? What is the evidence for their effectiveness – and cost-effectiveness? And what are the organizational implications of adopting such an approach?

The term "recovery" is contested, and there are different definitions used by different authors. However, most people use the term to refer to the process of building a meaningful and satisfying life, as defined by the person himself/herself, whether or not there are ongoing or recurring symptoms. This definition stems from the work of one of the intellectual founders of the recovery movement, Bill Anthony, who defined recovery as "*a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and roles. It is a way of living a satisfying, hopeful and contributing life, even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness*" (Anthony 1993).

This definition emphasizes "personal recovery" (i.e., the achievement of individually chosen life goals) and may be contrasted with the more common understanding of "clinical recovery" where the emphasis is on symptom treatment and management (Slade 2009). Of course, symptom relief is desirable whenever this can be achieved, but for many people with psychosis, the key question is not simply how can we eradicate their symptoms? It is how can we help them live meaningful and inclusive lives in the presence of residual symptomatology? Repper and Perkins (2003) used their study of the narrative accounts of people with mental health problems to suggest that the process of recovery contains three essential components: "hope," "control," and "opportunity." "Hope" consists of maintaining a belief that it *is* possible to pursue one's personal goals despite the difficulties of intractable symptoms and negative social reactions (stigma). Achieving some sense of control over symptoms and life choices is then a prerequisite for maintaining hope and taking "opportunities" to build a life "beyond illness" and participating in the community in the same ways that everybody else does. This formulation of recovery has been supported by a systematic literature review conducted by Slade and his colleagues (Leamy et al. 2011) which confirmed the importance of hope, control, and opportunity and added two additional themes – "connectedness" and "meaning."

In this chapter, an argument will be presented that one of the central tasks of staff is to support personal recovery in the sense defined above. This means supporting the development of key interventions, based on sharing knowledge, power, and responsibility with service users and their families. It does not involve an increase in workload, rather the opposite. It also does not mean that we shouldn't offer evidence-based treatments like medication and CBT. However, it may mean sometimes we have to carry hope for the person when he/she has lost it himself/herself. It certainly means a change in attitudes, with staff looking all the time to help people function in key social roles – e.g., in safe and secure housing of their choice, in meaningful occupation, in supportive relationships, and in feeling a part of the community in which they live. This is what the therapeutic "work" does. Staff thus have to prioritize supporting the person in pursuit of these goals. This does not take extra time. Staff may also have to be prepared to work together with service users and carers to "coproduce" new services.

9.3 Coproduction

The term "coproduction" was originally introduced by a political economist (and later Nobel Prize winner), Elinor Ostrom, in the 1970s. She had been asked by the Chicago Police Department to investigate why crime rates had apparently increased when the city's police officers changed their operations from being mainly on the "beat" to being mainly in cars. Ostrom (1973) concluded that the key reason for this was that by moving into cars, the police became detached from the communities they were supposed to be serving. As a result they lost access to the wide range of knowledge, experience, assets, and skills of members of the community – including some of the criminals themselves – who also had an interest in controlling crime. Edgar Cahn, a human rights lawyer, then took this idea and coined the notion of the "core economy" to describe the networks of formal and informal relationships that make up local communities (Cahn 2001). The core economy – as distinct from the market economy – is the platform upon which "specialist programs" in society (e.g., public services) are actually built. This gives us a new way of defining "capacity" in public services which takes us beyond the services themselves.

In England, the New Economics Foundation and NESTA, two radical, independent "think tanks," have applied these ideas to thinking about the organization and delivery of public services in a time of austerity (Boyle and Harris 2009). They identified coproduction as an alternative model of engagement to the dominant model where "professionals design and deliver services for needy users" and brought together a number of examples from across the health and social care field (see Nesta/Innovation Unit/*nef* 2012). These included projects from across the age range (children, teenagers, adults, and older people) and with various special populations (offenders, homeless, people with acquired brain damage, learning disabilities, HIV). These programs demonstrated the value of a range of coproduced interventions including information and advice services, mutual support and self-help, personalization, pooled budgets, Time Banks, and life coaching.

Boyle and Harris were careful to clarify that coproduction was not the same as what is sometimes called "task shifting" where staff with lower levels of education and training take on the delivery of interventions previously the province of more highly paid professionals, i.e., attempting to solve the capacity problem by simply having the same services delivered more cheaply. By contrast, coproduction calls for new partnerships between professionals and service users (and carers) to deliver different kinds of services to local communities which better meet their needs as defined by the people on the receiving end of services.

At the heart of this new perspective is the recognition that people who are receiving services are not simply passive recipients of care – problems for services to "fix." They are also part of the solution of what to do and how to do it. But to release this capacity, they must be made equal partners in the process: equal but different. If this perspective is adopted then it opens up a vast pool of talent and resources which are more than adequate to meet the capacity problem. However, this is not easy. There is often a fear of what may be lost, as well as what may be gained, by rebalancing the power relationships in mental health services. This fear is perhaps most acutely felt by those who currently have the greatest power and status in the system.

With these ideas in mind, the reader can now turn to the questions of how to make supporting recovery a reality in mental health services (Shepherd et al. 2008). This will begin by considering what this means in practice by looking at supporting recovery under two headings: (a) at the level of individual care practices and (b) in relation to the organizational context.

9.4 Supporting Recovery at an "Individual" Level

At an individual level, Slade and his colleagues have made a helpful distinction between "recovery-promoting relationships" and "pro-recovery working practices" (Bird et al. 2011). The former relates to the general quality of the therapeutic relationship and applies to all relationship-based interventions; the latter refers to specific, pro-recovery working practices relating to the support of recovery. In addition, a number of approaches can be added which, although not necessarily derived directly from recovery ideas, are nevertheless highly consistent with supporting recovery for individuals. These three sets of individual-level practices are summarized in Box 9.1.

Box 9.1: Effective Individual-Level Recovery Practices (From Shepherd et al. 2014)
Staff should aim to:

Facilitate recovery-promoting relationships
- Establish shared values
- Demonstrate good, basic relationships skills (empathy, warmth, respect)
- Support personal hopes and aspirations
- Promote a sense of control ("agency")

Use "pro-recovery working" *practices*

- Narrative accounts (recovery stories)
- A "strengths" approach
- "Coaching" methods
- Personal recovery plans (WRAP, STAR)
- Self-management
- Illness Management and Recovery (IMR)
- Shared decision-making
- Person-centered "safety planning"

Use specific approaches which support the achievement of common recovery goals

- Joint Crisis Plans (JCP)
- "Housing First"
- Individual Placement and Support (IPS)
- Use of "personal budgets" (social and health)

9.4.1 Recovery-Promoting Relationships

Relationships are at the heart of recovery. The creation of supportive relationships depends upon establishing shared values and demonstrating empathy, warmth, respect, and a willingness to go the "extra mile" (Borg and Kristiansen 2004). These qualities form the bedrock for all forms of care (National Institute for Health and Care Excellence 2014). Some would argue that they have been undermined in recent years with the increasing fragmentation of service structures and disruptions to continuity of care. There has also been an increasing emphasis on "treatment as technology," associated with the "marketization" of healthcare and service models based on "transactions," rather than the relationships within which these transactions take place. It has been argued that models of care which neglect the importance of these basic human qualities are at much greater risk of neglecting the needs of individuals and even of abuse. Recent examples in England of the neglect of older people in hospitals underline these dangers and highlight the responsibility of managers and policy makers, as well as frontline staff, to ensure that these conditions do not arise (Francis 2013).

9.4.2 Pro-recovery Working Practices

In terms of recovery-oriented practices, the best starting point for most people is to encourage them to tell their story. Narrative accounts are the oldest, and probably the most powerful, ways in which we make sense of the world and build relationships. Everyone has a story to tell, and the process of storytelling is almost always experienced as positive and validating. Narratives are inherently meaningful and are expressed in a form and language that is accessible and relevant (Greenhalgh and Hurwitz 1999). They also provide a source of information and explanation which is complementary to a conventional "evidence-based medicine" approach (Roberts 2000). Narratives should therefore be the beginning of any supportive relationship, and most practitioners will naturally start by inviting the person to "*Tell me a bit about yourself…*" These stories can then be shaped over time until there is a version that both the person and their key worker can agree upon as a basis for moving forward (similar to CAT formulations in brief analytic therapy, Ryle and Kerr 2002). Such documents can sit alongside more formal assessments and are particularly useful in terms of helping people formulate personally relevant goals and in monitoring outcomes (see below). The use of narratives is therefore a quick and easy way of ensuring that a therapeutic contract is couched in a way that is meaningful and engaging for the person. Because of their direct relevance, they are often more suitable for routine outcome measurement than standardized questionnaires (see below) and can be enhanced with some form of quantification (e.g., Goal Attainment Scaling, Kirusek and Sherman 1968).

A second important practice is the consistent use of a "strengths" approach (Rapp 1998). This is a way of recording information that seeks to identify the person's competencies and their environmental resources (friends, neighbors, local opportunities) which might be used to further their personal life goals. They provide a useful alternative to simply listing their problems. A strengths assessment often develops from encouraging the person to tell his/her story as this can provide important clues to activities and interests that were pursued in the past and might be used again in the future.

Another recovery-supporting practice which has been developed in the last few years is known as the "coaching" model (Bora et al. 2010). 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, and a focus on strengths and natural supports. However, there is greater emphasis on the importance of staff behavior as a "coach," or learning partner, and on the service user's responsibilities to make a commitment to action. Although there is good evidence for the effectiveness of coaching in relation to the management of long-term health conditions (O'Connor et al. 2008), there is little evidence as yet regarding its specific effectiveness in relation to supporting recovery in mental health services.

The use of narratives, building on strengths, and a coaching approach can then form the basis for developing a personal "recovery plan." This may use formal tools such as the "Wellness Recovery Action Plan" (WRAP), (Copeland 2015) or the Recovery STAR (McKeith and Burns 2010), or simply be developed through informal discussions (e.g., narratives). WRAP is a framework which is aimed at helping the person develop a plan to cope with distressing symptoms, prevent relapse, manage crises, and stay "well." It was designed by a service user for service users and has been used widely in many countries. The Recovery STAR has also been developed to provide a structure for personal recovery planning. It contains ten recovery "domains" and the service user and staff member work together to rate each domain area on a 10-point scale. The results are then presented visually on a star diagram. It is an attractive, easy-to-understand format and most service users seem to find the ten domains helpful for identifying personal goals, although some report that it needs to be more personalized.

Both WRAP and the STAR are useful methods for engaging people, assisting with personal recovery planning, and monitoring individual progress. However, both have limitations which arise from their standardized format and therefore limited acceptability to some individuals. Neither is psychometrically very sophisticated, and they are not recommended for use as outcome measures (Killaspy et al. 2012). Whatever their derivation, personal recovery plans should contain an identification of the person's internal and external resources and a plan for how he/she can use these to take control of his/her life and achieve his/her chosen goals (Perkins and Rinaldi 2007). The person should not necessarily have to share their recovery plan with staff: they belong to the individual and are not the same as "care plans" (although it is clearly desirable that there is as much overlap as possible between the two).

As indicated earlier, an important theme in most people's recovery is the struggle to achieve a greater sense of control over their symptoms and their life in general. One needs therefore to consider attempts to improve the person's capacity for "self-management." There is strong evidence, mainly from studies in the physical healthcare field, that supporting self-management can be extremely helpful in terms of ameliorating symptoms, improving quality of life, and reducing dependency on formal healthcare interventions (Foster et al. 2007; De Silva 2011). Self-management can refer to a wide variety of methods from simply handing out leaflets to personal support through telephone monitoring, goal setting, coaching, and structured education. However, approaches which include the full and active involvement of the person, rather than the passive provision of information, are most likely to be effective.

Mueser and his colleagues (2002) have developed a comprehensive educational and self-management package designed to provide people with severe mental illness with the information and skills necessary to manage their symptoms more effectively and work toward achieving personal recovery. The "Illness Management and Recovery Program" (IMR) consists of five components: (i) "psychoeducation" regarding severe mental illness; (ii) the provision of information on medication and side effects, using a "motivational interviewing" approach; (iii) a relapse prevention program; (iv) training in coping skills and problem solving; and (v) a cognitive-behavioral approach to symptom management. The program is delivered using an educational format, but with professionals taking the lead role having determined the majority of the content. Preliminary findings have been published regarding its implementation in the USA and Australia (Mueser et al. 2006; Salyers et al. 2009) and a randomized controlled trial found that service users appeared to have increased their knowledge of illness, coping skills, personal goal identification, and attainment (Hasson-Ohayon et al. 2007). There was weaker evidence of improvements regarding hope and no significant gains regarding social support or help from others. Systematized programs like IMR provide a good summary of basic information and give general tips on self-management, but they do not really reflect "*a fundamental* *transformation of the patient-caregiver relationship into a collaborative partnership*" (De Silva 2011, p. vi). They therefore cannot be said to fully represent coproduction

Alongside self-management and educational approaches, there has also been increasing interest in "shared decision-making" to support recovery. This brings together two sources of expertise – the knowledge, skills, and experience of health and social care professionals and the individual's knowledge and expertise of his/her own condition. Both forms of expertise are key to making good decisions. Used together they enable the person to make choices regarding treatment and management options that are most consistent with research evidence and with his/her own preferences and priorities. "Shared decision-making" is therefore the basis of truly informed consent. Again, there are already a number of examples of the value of this approach in the physical healthcare field (e.g., Simon et al. 2009), and they are now beginning to be applied in mental health, particularly in relation to medication management (Deegan and Drake 2006; Drake et al. 2010; Torrey and Drake 2009; SAMSHA 2011). A recent article coproduced by service users, carers, and professionals places shared decision-making in relation to medication management clearly within the framework of recovery-oriented practice (Baker et al. 2013).

The assessment and management of risk are central concerns of mental health services (and the public), but in recent years, *staff preoccupation with risk has sometimes become a barrier to personal recovery*. Many services have become highly "risk averse" and are often reluctant to engage in what might have been seen previously as "positive" risk taking, i.e. working with service user to help him/her manage those risks which are necessary in order to support the person in pursuing reasonable and realistic life goals. This has happened despite clear government and professional guidance to the contrary (e.g., Department of Health 2007). To compensate for this, recovery-oriented professionals have developed new approaches to managing risk which are based on involving service users fully in the development of a plan to support the pursuit of their life goals in ways that are safe for them and for those around them. This is known as person-centered "safety planning" (Boardman and Roberts 2014). Again, at its heart is an assumption that *the best – and most effective – methods for risk assessment and management will be those that fully involve the person in the process*. Managing risk is an inherent part of all our lives and surely those whose risk "problems" have caused them the most difficulties have the greatest interest in managing their risk effectively. Of course, not everyone will seek to manage their own risk responsibly, but maybe it is time that we began with this as the default assumption, rather than that everyone with a mental health problem (and/or some contact with forensic services) simply wishes to pursue their own goals with no regard for the consequences to themselves or others.

All these approaches to supporting recovery at an individual level do not require much in the way of additional staff time. Indeed, if incorporated into routine practice, most involve less time because they are more efficient in focusing on what is important to the service user and they are therefore likely to save time in the long run. They do this by using a language and a sense of priority that service users can easily understand. Most also do not involve doing "new" things: they involve doing "old things" differently, with a different set of attitudes and expectations. Of course, this is not to say that they are necessarily easy for professionals who are used to being "in charge" and to determining the priorities (and the language) themselves. Nevertheless, it is a significant challenge for many professionals to be able to make a contribution which is genuinely responsive to the needs of service user, accepting their priorities, and working out exactly what skills and knowledge they have that may be useful. That doesn't require a lot of time, but is does require intelligence, sensitivity, and, perhaps, a little humility.

9.4.3 Specific Approaches Which Support the Achievement of Common Recovery Goals

It is difficult to pursue your recovery goals if you are in a hospital, and most people with psychosis would wish to avoid unnecessary admissions to hospital, particularly if these are compulsory under Mental Health legislation. The "Joint Crisis Plan" (JCP) is an intervention which has been specifically developed to achieve these aims and is based on a process of coproduction (Henderson et al. 2004). The JCP is formulated by the service user, together with peer support if available and the key mental health staff involved, including the treating psychiatrist. It is therefore similar to an "advance statement" (or the kind of crisis plan contained in WRAP) but with the explicit inclusion of the clinical staff and the treating psychiatrist in the discussion. In an initial randomized controlled trial, people who were discharged with a Joint Crisis Plan were shown to have significantly fewer compulsory admissions compared with controls over a 15-month follow-up period (Henderson et al. 2004). Qualitative data also suggested that the JCP group felt more "in control" of their mental health problems (Henderson et al. 2008). A second study produced less impressive results, but the authors acknowledge that this was mainly due to practical difficulties in ensuring that the joint planning meetings always occurred and were effectively facilitated (Thornicroft et al. 2013).

Once in the community, finding somewhere safe and practical to live which is consistent with personal preferences is at the center of most peoples' recovery (Shepherd and Macpherson 2011). There is a dearth of evidence regarding the effectiveness of sheltered housing programs, but *an exception is the "Housing First" initiative* which was developed in the USA to meet the needs of homeless people with complex mental health and substance misuse problems. It prioritizes the identification of suitable housing, based on personal preference, and then delivers other supportive services to the person once he/she is housed, without a prerequisite that their substance misuse must cease first. The use of permanent housing options and the commitment to floating support mean that the resident does not have to make continual moves between different types of accommodation as their support needs change. There is now good evidence for its effectiveness and prospective trials comparing the "Housing First" model with traditional "treatment first" approaches have found that almost twice the number of people manage to maintain stable housing after 2 years (Padgett et al. 2006). 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 program were also around half of the "treatment first" program. Similar results have been reported more recently by Stergiopoulos et al. (2015), although they comment on the difficulties with implementation and remaining faithful to the fidelity of the model in different settings. This approach has been tried in England (Shelter 2008) but is not widespread.

For most people, meaningful occupation is next on the list of personal recovery goals, and here the evidence for effective intervention is much stronger. The "Individual Placement and Support" (IPS) model (Becker et al. 1994) has consistently been shown to be the most effective approach for helping people with severe mental health problems gain and retain paid employment . There is now very strong evidence, both nationally and internationally, that IPS consistently achieves employment rates two to three times better than traditional alternatives such as prevocational training and sheltered workshops (Burns et al. 2007; Bond et al. 2008; Sainsbury Centre for Mental Health 2009). Longer term follow-up studies of people placed through IPS also suggest that the higher rates of employment are maintained and have positive impact on non-vocational outcomes, e.g., improved confidence and well-being and reduced sense of stigma (for further details, see Chap. 20 in this book by Bell). IPS has a number of similarities with the Housing First approach. Thus, it is also based on placing the person in a work position of his/her choice as quickly as possible and then providing him/her with an integrated package of vocational and clinical support *in situ* rather than wasting a lot of time on preplacement assessment and training efforts which generally don't predict behavior across settings or produce generalized improvements. The one study where IPS failed to produce such impressive results was where it was not implemented with good fidelity to the research model (Howard et al. 2010; Latimer 2010).

Finally, one needs to consider the most basic form of support for recovery – financial subsistence. It almost goes without saying that adequate financial support is important in the recovery of individuals with psychosis, but the Benefits Systems in most countries are often complex and difficult to negotiate. People – especially those with mental health problems – therefore require specific advice and advocacy, and this is seldom available, even 'though there is evidence to suggest that it would be extremely cost-effective (Parsonage 2013). 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 USA and in England (Cook et al. 2008; Alakeson and Perkins 2012) and aims to provide the person with the resources that would otherwise be spent on services for them to spend on whatever they think will be most helpful. This sounds like it must be a good idea, but there are considerable practical problems around its implementation. These include the processes to calculate the amount of money made available, monitoring of what it is used for, ensuring that resources are effectively targeted on those in greatest need, and coping with the inevitable bureaucracy involved. It therefore remains to be seen whether a practical system to get personal budgets to work effectively can be devised and rolled out on a large scale. If it could, then this would undoubtedly be a very important development.

9.5 Supporting Recovery at an "Organizational" Level

It has been mentioned earlier that to support an individual's recovery effectively requires not just the efforts of individual practitioners but also of the organizations concerned. They need to be committed to making this a reality (Shepherd et al. 2010). Of course, for the individual, their judgment of quality of service will be mostly determined by their experiences with individual staff, but what can the organization do to ensure that this is of a high quality and remains so? Effective staff training is part of the answer, but is not sufficient in itself. This is well illustrated in a study by Whitley and his colleagues (2009) who examined the implementation of Mueser's "Illness Management and Recovery Programs" across 12 community settings. They found that while training was important, it only had a lasting effect if issues of supervision and leadership were also addressed. They also noted the importance of a "culture of innovation" within the organization which was open to changes in existing practices. If all these factors were present, then they acted synergistically, but no one element was sufficient on its own. The *ImROC program* (*Im*plementing *R*ecovery through *O*rganizational *C*hange) began with this as its starting point. It assumed that training staff on its own would not be sufficient to consistently support recovery and that it would be necessary to facilitate a range of organizational changes to support and sustain change "on the ground."

9.5.1 The ImROC Program

The ImROC program was launched by the Secretary of State for Health in England in April 2010. Its aim was to assist public mental health services (NHS Trusts), their local authority partners in Social Service departments, and local independent sector organizations, particularly user and carer groups, to improve their capacity to support the recovery of people using these services, their family, friends, and carers. The program has been delivered through a partnership between two non-government organizations (charities): the Centre for Mental Health and the Mental Health Network of the NHS Confederation (NHS Confederation/Centre for Mental Health 2012).

It began by developing a simple audit tool consisting of "10 key organizational challenges." These were drawn from workshop discussions with a number of services who had already made some progress in changing their organizations to support recovery and were prepared to share their experiences. (More than 300 health and social care staff together with 60 users and carers contributed to these discussions which were held in different parts of the country during the period 2008–2010.) The challenges were designed to assist local organizations – public and independent – to work together to review current services and then set locally agreed priorities for change (Shepherd et al. 2010). They are set out in Box 9.2.

Box 9.2: "10 Key Organizational Challenges" for Organizations Wishing to Support Recovery (From Shepherd et al. 2010)

1. Changing the nature of day-to-day interactions and the quality of experience
2. Delivering comprehensive, user-led education and training programs
3. Establishing a local "Recovery Education College" to drive the programs forward
4. Ensuring organizational commitment, creating the "culture," leadership at all levels
5. Increasing "personalization" 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'

The "10 key challenge framework" was not designed as a psychometric instrument, and its test-retest or inter-rater reliability have never been systematically explored. However, it has now been widely used to support the development of more recovery-oriented services by a range of different groups – staff, service users and carers, clinicians, and managers – and has proved a useful heuristic. It also appears to have good content validity when compared with the areas identified by Le Boutillier et al. (2011) in their international review of recovery-oriented practice.

9.5.2 The ImROC Methodology: Evidence-Based Organizational Change

The ImROC methodology has been based on a set of elements which are most likely to be effective in producing organizational change. These emphasize knowledge dissemination (guidelines), the importance of choice and local ownership, clear and realistic goal setting, and continual feedback on progress. At their heart is a process of closed audit loops (goal setting, action, review) deployed in repeated "Plan-Do-Study-Act" cycles. This is recommended by leading experts as the most effective way of producing organizational change (Iles and Sutherland 2001; Berwick 2008; Health Foundation 2013). It is similar to an "Action Research" model where the results and learning from the initial intervention are used to inform future goals and future change processes.

At each stage, there is an attempt to involve staff at senior levels in the organization, particularly team leaders and managers. They are included in the training and project planning and encouraged to begin to supervise staff according to the service developments being worked on (e.g., using recovery-supporting language and behavior, spending time coproducing a course for the Recovery College with a service user, etc.). There are also usually special sessions for the most senior managers (Board) to ensure that they are familiar with what is going on and that it reflects the overall goals of the organization. They are encouraged to think how they can support the desired changes in the attitudes and behavior of the staff. The process is described in detail by Shepherd et al. (2010).

In order to sustain the service developments, sites were also offered membership of an “Action Learning Set” (Revans 1998). This consisted of groups of clinicians, managers, service users, and carers who met on a regular basis to provide opportunities for mutual learning and support. These were extremely effective in maintaining the momentum for change with staff and service users working together to solve common problems on an equal footing. The Learning Sets also sparked off inter-site visits by teams of staff and service users between the workshops, creating a learning network in which ideas and experiences could be honestly shared in a non-critical (and, largely, noncompetitive) environment.

As indicated, the program aimed to establish new coproduced services to support recovery, and it was therefore important that the process of organizational change itself demonstrated coproduction. Thus, wherever possible, the external consultants consisted of experienced mental health professionals working together with people with “lived experience” who were coached (and paid) for their contribution. Many of these service user consultants were also peer workers recruited from local services.

9.5.3 What Has ImROC Achieved?

The program has worked with more than two-thirds ($n = 35$) of the NHS mental health Trusts in England and their local partners. It has supported a number of new service developments.

- The establishment of *500+ Peer Support workers* – Trained, placed, and supported to work alongside mental health professionals in a variety of positions. This has involved the development of training materials, guidance on employing Peer Support workers, and evaluation of impact.
- The opening of *30+ Recovery Colleges* – These are local facilities, modeled on educational lines, where people with lived experience, professionals, carers, and others can learn together to construct and cope better with mental health difficulties and become better integrated into their local communities.
- *New ways of thinking about the assessment and management of risk* – Staff have been helped to use recovery-focused principles to move from *a* preoccupation with “risk” and “risk management” to a process of working directly with the service user to work out strategies they can use to pursue their own life goals in ways that are safe for them and safe for the people around them.
- *A significant reduction in the use of physical restraint and forcible medication on acute wards* – This builds on previous work by Recovery Innovations in Phoenix,

Arizona, who developed an approach known as “No Force First” (Ashcraft et al. 2012) which involves coproduced training for staff and exploration of alternatives to physical methods of intervention. This initiative has been pioneered by Mersey Care NHS Trust in Liverpool (UK) and has received national recognition (King et al. 2013).

9.6 Effectiveness of Service Developments to Support Recovery

What is the evidence for the effectiveness of these service developments in supporting recovery? At this stage, no one has tried to evaluate the effects of a “whole system” change; this would be very difficult (and costly) and would pose a host of methodological and design problems. However, it is possible to look at the evidence for “specific” service developments, and there are two where there is a growing body of evidence: (a) Recovery Colleges and (b) Peer Support workers.

9.6.1 Recovery Colleges

As indicated above, the concept of the “Recovery Colleges” is based on an “educational” model and uses coproduction to develop and deliver courses to students who are a mixture of service users and staff (co-learning). “Recovery Colleges” (also known as “Recovery Education Centers”) are a relatively new development in the UK, although they have been present in a similar form in the USA for several years. The first example appeared more than 20 years ago at the Centre for Psychiatric Rehabilitation in Boston (http://cpr.bu.edu/living-well/services) and the concept was then developed by “Recovery Innovations” in Phoenix, Arizona (Ashcraft and Anthony 2005). It was imported into England in 2010 and has become a central theme in the ImROC program (Perkins et al. 2012). The first UK “Recovery College” was established in South West London and St. George’s Mental Health NHS Trust and officially opened in September 2011. A second was quickly established in Nottingham, and there are now almost 40 in operation, mainly in England, but also in Scotland, Ireland, Italy, Australia, and Japan.

Recovery Colleges are new, and there is little evidence for their effectiveness as yet from randomized controlled trials. Work is currently underway to identify a set of “key defining features” which might, in time, form the basis for fidelity criteria which would allow replicable interventions in a control group design; *see* McGregor et al. 2014. Nevertheless, there is an emerging and consistent set of findings from prospective, uncontrolled, cohort studies, mainly conducted in England, but with some support from other countries (notably Australia, Italy, and Japan) which suggests very positive findings associated with attendance at the Colleges. These are summarized by Shepherd et al. (in press). They suggest that Recovery Colleges are very popular among users, with over 90 % reporting that the course they attended was “good” or “excellent” and that they would recommend it to others (Rennison et al. 2014; Meddings et al. 2014). Students also feel that the College helps them progress toward their personal life goals and to feel more hopeful about the future (Rinaldi and Wybourn 2011). In this study of the 74 students who responded to a questionnaire (83 % of the total surveyed), almost 70 % had become mainstream students, gained employment, or started volunteering. There is also evidence in two of the prospective studies that students' quality of life and well-being were significantly improved after attending the Recovery Colleges (Meddings et al. 2015; North Essex Research Network 2014). Learning with others with similar problems and with professionals who are genuinely open to challenge also means that Recovery Colleges can often engage people who find traditional services unacceptable. Attendance rates are generally high (around 60–70 %) which is similar to mainstream adult education. Lastly, Recovery Colleges are a resource for training and developing staff skills to support recovery more effectively. As one member of staff said "*attending a recovery college course is the very best introduction to working with people with psychosis*" (Sussex Recovery College Student, quoted by Shepherd et al. in press). They therefore also have the potential to raise staff expectations and thereby change the culture of the organization in which they are located.

9.6.2 Peer Support Workers

Peer support is based on people who have direct experience themselves of mental health issues and can use this to help others in similar circumstances. It may be defined as "*offering and receiving help*, *based on shared understanding*, *respect and mutual empowerment between people in similar situations*" (Mead et al. 2001) and has a long history in mental health services, beginning with the moral treatment era in the early part of the nineteenth century (Davidson et al. 2012). The use of peer support in hospitals declined in the later part of the nineteenth century as the mental health professionals – medical, nursing, psychology, and social work – established themselves, but it made a reappearance in the 1960s and 1970s in the Therapeutic Community movement. They are now popular again, with more than half of the US states making peer support billable under Medicaid and trained peer workers being employed in many countries all over the world (Repper 2013a). Peers may be employed either in addition to traditional professional staff or instead of them in certain specific roles, e.g., as peer trainers in Recovery Colleges, support workers in community teams or on inpatient wards, as case managers, etc.

In terms of evidence for their effectiveness, like the Recovery Colleges, there have been few, well-designed, randomized controlled trials (Pitt et al. 2013; Lloyd-Evans et al. 2014). However, other reviewers have considered non-RCT evidence (Warner 2009) and taken a more inclusive approach, including "gray" as well as published literature (Repper and Carter 2011). Not surprisingly, because of the variable quality of the evidence and the use of different samples, different reviewers come to slightly different conclusions. Nevertheless, a number of consistent findings do seem to emerge.

- In no study has the employment of Peer Support workers been found to result in worse health outcomes for those receiving the service.

- Most commonly the inclusion of peers in the workforce produces the same or better results in a range of outcomes when compared with services without peer staff.
- Peer Support workers tend to produce specific improvements in patients' feelings of empowerment, self-esteem, and confidence.
- In some studies, the presence of peer workers in teams also seems to be associated with improvements in self-reported physical and emotional health and in clinician-assessed global functioning.
- In some studies, they also bring about improvements in satisfaction with services and quality of life, although with regard to the latter the findings are mixed.
- In both cross-sectional and longitudinal studies, patients receiving peer support have shown improvements in community integration and social functioning.
- The introduction of Peer Support workers has been associated with a reduction of alcohol and drug use among patients with co-occurring substance abuse problems.
- In some studies, when patients are in frequent contact with Peer Support workers, their stability in employment, education, and training has been shown to increase.

As indicated above, some of these findings are not replicated across all studies, and there is also significant variability in the nature of the intervention evaluated (e.g., the amount of training peers receive prior to placement, the nature and frequency of the interactions between peers and service users, and the degree of integration of peers into the professional teams). This makes some inconsistency in the findings not surprising and, as with Recovery Colleges, highlights the need for further work before replicable interventions can be evaluated in control group designs. Nevertheless, Repper (2013b) has described some of the key features necessary to "standardize" the peer worker interventions. These include open recruitment, with clear job descriptions and "person specifications"; high-quality training; careful preparation of teams before placement; good supervision and support for peers once placed; and clear job roles, with appropriate payment, on recognized pay scales, and terms and conditions like other workers. Most of all Repper stresses the importance of organizational commitment to support their introduction and ensure that their integrity is maintained.

Again, as with Recovery Colleges, in addition to the direct benefits for those receiving the service, there is also evidence of benefits for the peer workers themselves. They feel more empowered in their own recovery journey, have greater confidence and self-esteem, feel more valued and less stigmatized, and have a more positive sense of identity (Repper and Carter 2011). Just as peer workers provide hope and inspiration for service users, so they can challenge negative attitudes of staff and provide an inspiration for all members of the team. Their example demonstrates to everyone that people with mental health problems can make a valued contribution to their own and others' recovery if they are given the opportunity. In our experience, this observation of cultural change is common in services where peer workers have become established, but to our knowledge it has not been formally investigated.

9.6.3 Cost-Effectiveness

In relation to Recovery Colleges, in the review by Shepherd et al. (in press), they noted that attendance at Recovery Colleges can reduce the use of hospital and/or community services leading to significant cost savings (Rinaldi and Wybourn 2011; Mid-Essex Recovery College 2014).[1] For example, in the case of South West London and St. George's for students attending more than 70 % of their chosen courses, this amounted to approximately £800 per student per year. For a College with a thousand students on the books (not uncommon), this amounts to a substantial saving. Similarly, in relation to Peer Support workers, Trachtenberg et al. (2013) examined a small sample of outcome studies ($n=6$) which aimed to evaluate whether the introduction of Peer Support workers into community crisis teams or acute inpatient wards reduced the use of hospital beds (either by preventing or delaying admissions to hospital or by shortening the length of inpatient stays). Across the studies, the average benefit to cost ratio (taking into account sample size) was more than 4:1. Thus, the estimated value of the reduction in hospital bed use achieved by introducing peer workers far exceeded the cost of employing them. There are methodological limitations with this study due to the small sample size, but the results provide preliminary support for the proposition that adding Peer Support workers to existing mental health teams may result in significant cost savings in terms of inpatient bed days. This conclusion is echoed in a recent review commissioned by the UK charity Rethink (2014) from the Personal Social Services Research Unit, led by Professor Martin Knapp, at the London School of Economics. They suggest, "*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*" (p. 6).

These studies therefore support the case for the cost-effectiveness of developments like Recovery Colleges and Peer Workers. There are also other potential savings which have not yet been factored into these calculations. For example, both of these developments depend on the employment of peer workers, and we know from the IPS literature that, in the long term, there are considerable cost savings for people who enter the employment market as they make less use of mental health services and become less dependent on public subsistence (Sainsbury Centre for Mental Health 2009). In addition, there is anecdotal evidence that adopting more recovery-oriented ways of working can have dramatic effects on reducing staff sickness and absence.[2] Since it is estimated that mental health problems account for more than a third of sickness absence in the NHS workforce (Health Service Journal

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[1] There is also anecdotal evidence that a minority of students (around 20–25 %) actually i*ncrease* service use in the first few months of attending, probably due to increased awareness of support options (Barton, Southwest Yorkshire Foundation Trust, *personal communication*, 2014).

[2] For example, in the study cited above on reducing levels of physical restraint and forcible medication on acute wards, the 50 % reduction in these incidents was accompanied by a more than 90 % reduction in staff sickness and absence (King et al. 2014).

2013) costing about £500 million, there is also huge potential for additional cost savings through this route.

To summarize, there is evidence that *both Recovery Colleges and Peer Workers* may not only deliver a wide range of benefits, but can also be highly cost-effective. Specifically in relation to peer workers – whether in Recovery Colleges or working alongside staff in teams – *adding* them to the existing workforce seems likely to reduce, rather than increase, costs, particularly if they are targeted on those people at highest risk of repeated admissions to hospital (e.g., many people with psychosis). On the other hand, if Peer Support workers are *substituted* for a proportion of traditional mental health workers, then, assuming broadly similar rates of pay, any benefits in health or quality of life for service users is sufficient to justify their use as it is, in effect, a costless improvement.

Conclusions

To conclude, there is good evidence that attempts to provide support for "recovery" – in the sense of helping people with psychotic conditions pursue their chosen life goals – can be delivered *both effectively and cost-effectively*. To do so, it requires the implementation of a set of approaches and interventions at the level of individual care, supported by key organizational (service) developments which will maintain these changes over time. *These changes do not require huge increases in staff time, but they may require fundamental changes in staff attitudes*. Staff need to believe in the capacity of people to find and construct – sometimes with some help – new meanings to their experiences and new solutions to their problems. This means sharing power and respecting each other's expertise. If this is combined with practical help in the area of key social goals like housing, occupation, and financial stability, then it maximizes the opportunities for service users to live the kinds of "ordinary lives" that everyone else aspires to whether or not they have continue to experience residual symptoms. Simply existing in these valued roles will go a long way to minimizing symptoms and maintaining progress. Genuine collaboration and real partnerships, between consumers and professionals, also mean that burdens are lifted on both sides and services will be both more valued *and* more cost-effective.

Of course, there is still much to do before this can be achieved. We need to know more about exactly *which* individual-level interventions are most effective. Similarly, we need to know more about the effectiveness of key service developments (Recovery Colleges, Peer Workers) where it is clear that, currently, developments in practice seem a long way ahead of service evaluation. This may mean making greater user of quasi-experimental designs, in addition to randomized controlled trials. This would be facilitated if there was clearer agreement on routine outcome and "input" measurements ("who" was getting "what"?). We could then begin to summate findings across studies. We also need to know more about the process of care, what are the mechanisms underlying change in these new interventions? What do these changes in feelings of "hope" and "empowerment" tell us about what is happening in the psychology of the individuals concerned? Can the interventions be fine-tuned to particularly focus on achieving these kinds of changes? Finally, we still need to know much more about how to help organizations change so as to most effectively support these changes in practice. How do we get professionally led, health-oriented organizations to focus on non-health (social) goals and make these as much a priority as the alleviation of symptoms? How do we get health and non-health organizations to work more effectively together, respecting each other's unique contribution, while recognizing the need to collaborate? These are the big questions that we need to address if we are to get the maximum value out of investment in mental health and social care services and solve some of the pressing capacity problems raised at the outset.

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