

Steps towards “putting recovery at the heart of all we do”: workforce development and the contribution of “lived experience”

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Abstract

Purpose – *This paper aims to describe a review and overview of the issue of developing guidance on implementing recovery and supporting organisational change, focused specifically on seeking to clarify the many different contributions that “lived experience” could make to training and workforce development.*

Design/methodology/approach – *The particular focus of our workshop was to clarify the key issues in workforce development, training for a recovery-focused service and the contribution of “lived experience”. A particular outcome was to emphasise the benefits of collaborative co-working between people who use services and practitioners at all levels.*

Findings – *A key element of our learning has been in valuing collaborative co-working and the synergism of personal experience, professional training, research and evaluation.*

Originality/value – *The paper draws out what lessons have been learned already and sketches guidance for future practice and service development.*

Keywords *Rehabilitation, Training, Employee development, Organizational change, Post experience learning*

Paper type *Research paper*

Introduction

On June 5 2008 Devon Partnership NHS Trust (DPT) hosted the third in the Sainsbury Centre for Mental Health’s (SCMH) series of exploratory workshops with the aim of drawing on our local experience in the service of shaping emerging national guidance (SCMH, 2010). A broad constituency of 60 or so people gathered in the attic rooms of a faith community overlooking the river Exe for a day which was both energising and exhausting. This paper revisits the learning from that day and brings it up to date.

The Devon story began with and has been sustained by people with a passion. Our local experience pivots around the founding of Recovery Devon (RD) in 2003, the “Vision Statement” of the Local Implementation Team (LIT, 2005) and of the commitment of the network of health and social care services in Devon to “Put recovery at the heart of all we do” (DPT, 2008a). These broad manifestos for change have led to development of specific guidance in Devon on recovery outcome measures and standards (DPT, 2008b, 2009c), Recovery Coordination as the core framework for clinical care (DPT, 2009b) and an overarching Workforce Strategy (DPT, 2010a). Our activity and achievements have been favourably cited in national publications (RCPsych, 2008; Slade, 2009; MIND, 2008) and many of our local reviews and guidance papers have been published in national journals. But we would not want to overstate our progress and feel an overriding need to “keep it real” and recognise that we’ve only just begun an ambitious programme of system transformation (Good, 2010).

The particular focus of our workshop was to clarify the key issues in workforce development, training for a recovery-focused service and the contribution of “lived experience”. A particular outcome was to emphasise the benefits of collaborative co-working between people who use services and practitioners at all levels.

Over the last ten years there has been a gathering interest and sharpening focus on recovery as the guiding purpose of mental health and social care services (Repper and Perkins, 2003; CSIP *et al.*, 2007; Roberts and Hollins, 2007). There is increasing recognition that what has become the dominant approach of traditional services – focusing on *getting better from* symptoms, problems, difficulties and disorders, i.e. clinical recovery, does not necessarily enable people to get forwards into a valued pattern of life and living with or without ongoing problems, i.e. personal recovery (Slade, 2009). Hence alongside the continuing production of on evidence-based treatment guides there has been a growing emphasis on the importance of choice, opportunity, hope, self-determination, social inclusion and personalisation as overarching mediators of wellbeing (RCPsych, 2009; National Mental Health Development Unit, 2010). Many of these factors are prominent in individual stories of personal recovery and thematic analysis of anthologies of such stories have provided the foundation of the international recovery movement (for example in the USA, Ralph, 2005; New Zealand, Mental Health Commission, 2007; Scotland, Scottish Recovery Network, www.scottishrecovery.net).

Although there is a growing and collaborative commitment anyone teaching or learning about recovery will necessarily engage with some of the conceptual, political, and cultural complexities that surround it. There is much to be gained by engaging with these differences and at times dissonance (Davidson *et al.*, 2006; Roberts and Hollins, 2007; MIND, 2008).

Some have worried that talking about personal recovery for people with long term (“chronic”) conditions is an unacceptable distortion of ordinary language that usually associates “recovery” with “cure” (Oyebode, 2004). Some have disputed professional and organisational interest in adopting the recovery approach, seeing it as an attempted takeover or “colonisation” of something that belongs to the service user movement (Social Perspectives Network, 2007; MIND, 2008). To a degree this has been answered by recognition that recovery fundamentally “belongs” to the person themselves, that services cannot “recover” anyone, and to agree that there is an ongoing need to stay true to the civil rights roots of recovery which can be traced back more than 200 years through deep currents of values-oriented activism and emancipatory humanism (Davidson *et al.*, 2010). Some have worried quite appropriately that organisations, teams and services will see merit in superficially relabeling themselves as “recovery focused” without engaging with the fundamental challenges that are needed for it to be meaningful, as described in the SCMH (2010) policy guide.

There is also value in recognising that although the current emphasis on recovery substantially arose from the activism and personal testimony of people who had used psychiatric services (Colman, 1999; Leibrich, 1999) there is significant resonance between the guiding values of the recovery approach and those of core mental health professions, notably mental health social work (CSIP *et al.*, 2007) and occupation therapy (College of Occupational Therapy, 2006). There is also commitment being made to values-led approaches in other professional groups including nursing (DH, 2006), and many of the professional leads for recovery-focused practice have come from rehabilitation psychology and psychiatry (Roberts *et al.*, 2006; Slade, 2009).

The convergence of these different strands of testimony, advocacy, innovation and re-evaluation of core values has led to an emphasis on recovery being positively embraced in current guidance and policy initiatives, each of which cites the others and which collectively add up to a remarkable consensus (Shepherd *et al.*, 2008; SCMH, 2009, 2010; Future Vision Coalition, 2009; DH, 2010). Their joint pitch for a new vision, horizon and foundation for mental health and social care services is not simply further tinkering with structures or a matter of weaving in some new techniques or technologies but at its most ambitious is expressed as “transformation” and takes in fundamental considerations of what it means to be a mental health practitioner or a person using services.

The same guidance identifies the central importance of training and workforce development as a means of achieving these changes and borrowing from international examples of progressive services the SCMH (2010) has suggested that each NHS Trust develop a "Recovery Education Unit" that would steer and oversee this process. However, it falls short of offering specific guidance on the content of that education and there is not yet anywhere in the UK that offers a comprehensive demonstration of how this may work in practice.

At present there are inevitable tensions between prioritising training for recovery-focused initiatives and the substantial agenda of mandatory and essential training that NHS Trusts and other professional bodies require their workers to complete, and for which there is then accountability to external regulatory bodies. This agenda has a strong tilt towards risk and safety issues which, as identified in the guiding vision of New Horizons (DH, 2010, p. 7), still need to be balanced with "quality", e.g. choice, personalisation and recovery.

This paper will describe some of our experience of engaging with workforce development and training in a large NHS Trust, which is seeking to interweave a recovery emphasis into other required training processes, but with acknowledgement that the tension of competing priorities remains.

What is the workforce of an NHS Trust?

The DPT is the main provider of mental health and social care in Devon. It has an annual turnover of £110 m per annum, covers approximately 2,500 square miles, receives 18,000 referrals each year and employs over 2,000 people (Table I).

Workforce development

Reorienting services around a focus on personal recovery implies a shift of power and authority towards enabling people to make informed choices and take control of their own lives. This has profound implications not only for the content of future training and development but the whole process involved in equipping workers to support such outcomes.

However, as can be seen (Table I), trying to do anything with the whole workforce is a considerable challenge. It is a project so wide in its scope and ambition that it can seem

Table I Staff employed in Devon partnership NHS Trust at 1 March 2010

<i>Staff group</i>	<i>WTE</i>	<i>Headcount</i>
Psychologists/psychotherapists	77	112
Social workers	20	22
Assistant psychologists	7	7
Healthcare assistants	471	543
Technical instructors	16	21
Admin and clerical (including managers)	353	424
Dietician	1	1
Drama/art/music therapists	8	12
Occupational Therapists	93	122
Physiotherapist	3	5
Consultants	58	67
Other senior medical staff	23	34
Junior medical staff	31	32
Nurses	646	722
Pharmacists	5	6
Pharmacy technicians	3	3
Other	100	2,252
Total	1,915	

Source: Clinical Cabinet Papers DPT (available at: glenn.roberts@nhs.net)

a daunting knowing where to start. There are also key framing issues around working out who has authority, mandate or responsibility to initiate such changes?

In some ways we have benefitted in Devon from not having an overarching plan or strategy until very recently, so much as progressive engagement and commitment in response to a broad range of people and projects. We believe that “recovery” is not an agenda that can be easily parachuted in or successfully imposed. It needs anchor points, champions, enthusiasts and leaders who “get it”. It needs both grass roots support and executive mandate. As with personal recovery, although hope can be borrowed for a time, it needs to take root locally and be cultivated personally to bear fruit. Over time the goal, hope and ambition for systems transformation have become increasingly clear. But our simple observation is that you can only start from where you are and you will inevitably start with those who have a spark of interest and enthusiasm.

Steps and stages in developing a recovery-focused workforce

Adopting a recovery-focused approach to practice, practitioners and services challenges the point and purpose of an NHS Trust and the goals and practices of the people who are employed in it (see the “10 key challenges” in SCMH (2010)). Although there is a broad inclusive ambition to establish a recovery culture that involves the whole workforce there are also different implications for different workers depending on their responsibilities. From early experiments with “recovery awareness courses” for willing applicants we have come to think of different levels of training that progressively engage in developing:

- awareness;
- understanding;
- skills; and
- qualities and the person of the practitioner.

And that there are different points of contact for training and development that take in the whole developmental pathway of people working in the organisation:

- advertisement;
- job descriptions;
- interview;
- appointment;
- induction;
- support and supervision;
- ongoing audit of practice;
- developmental reviews;
- wellbeing in the workforce;
- sickness and absence policy;
- continuing professional development;
- mentoring;
- appraisal;
- job planning;
- disciplinary and capability procedures; and
- leadership and governance.

Many of these processes are underpinned by national guidance, legislation and professional standards but all can be interpreted in the light of recovery values and principles. For example:

Job descriptions

We now include the following in job descriptions for all posts in the Trust:

It is a requirement of all employees to have an understanding of the broad principles of the recovery approach and to incorporate them into every aspect of their work [. . .].

Support, supervision and ongoing audit of practice

The practice of teams is regularly reviewed with a “practice quality audit” tool (DPT, 2010a), an evaluative and reflective inventory which aims to support and report on developing recovery oriented practice. Additionally, we are aiming to provide “recovery support partners” as coaches to teams and clinical team leaders across all services (DPT, 2010a).

Continuing professional development

Most professional groups within the Trust have sought inputs on recovery to their qualifying courses, team or service review days. Additionally, there have been a wide range of topic specific projects that have been convened around developing guidance on specific aspects of recovery oriented practice which has then provided the foundations for staff and practice development. This includes:

- recovery outcome measures (Dinness *et al.*, 2007; DPT, 2008a, 2009c);
- choice and detention (Roberts *et al.*, 2009);
- report and letter writing (Roberts and Thekkepalakkal, 2009);
- medication and prescribing (DPT, 2010b);
- recovery coaching (Bora *et al.*, n.d.);
- Wellness Recovery Action Plan(WRAP) and self management (Hill *et al.*, n.d.b); and
- dementia care (Hill *et al.*, n.d.a).

New work – new workers?

In addition to developing training and workforce initiatives for the existing staff there is evidence that the international move towards recovery oriented practice is stimulating thinking about new roles and responsibilities (Slade, 2009). We have some experience of developing trainers in support of the WRAP and self management and peer support workers, largely through third sector providers and only on a small scale (Hill *et al.*, n.d.b; Ley, 2009; Ley *et al.*, 2010). Devon has been a national lead in setting up training for support time and recovery workers (Hill *et al.*, n.d.a) but this has so far had far more impact on third sector and independent providers than within the Trust (see STaR section on www.recoverydevon.co.uk).

Transforming the composition and profile of the workforce (SCMH, 2009) may become one of the most significant considerations in implementing recovery. Suggestions such as, “aiming for perhaps 50% of care delivered by appropriately trained and supported “peer professionals” has huge implications in relation to the present workforce which also touches on how current workers can be supported to use their personal experience as expertise (below).

Seeing ourselves as others see us: the value of visitors and fellow travellers

Over recent years recovery leads in Devon have been widely invited to present our work in other settings which has engaged us in reflective and sometimes challenging conversations that have seasoned our local understanding (MIND, 2008). We have also benefitted greatly from a succession of visiting experts, guides and fellow travellers.

The contributions of Mary Ellen Copeland and Shery Mead to RD conferences in 2003/2006 ignited our engagement with WRAP and Intentional Peer Support and the reflective reviews of O’Hagan (2008, 2009) and Mike Slade (2008) led to reports and commentaries that contributed to planning for the future.

Our commissioners asked RD to review all these impressions and reports and suggest the top 3 priorities for development. These have recently been clarified as, alternatives to acute hospital admission and the provision of “sanctuary”, support for personal recovery planning, and development of peer support.

Teaching and training

Recovery teaching and training has a focus on “recovery” as an area of content but, more importantly is itself concerned to be recovery focused, and an embodiment of recovery values in action.

This raises interesting and complex questions concerning how to determine the goals, method and message of any training experience and who should teach, with what knowledge, experience and authority? It is probably universally accepted now that good teachers are life-long learners and this has never been truer than in the context of recovery.

Redefinition of what it means to be an expert doesn't mean there is no such thing as knowledge, skill and expertise, but that it is relative, plural and dependent on context. There are therefore people who have variously gained their expertise through training, by personal experience or research and some highly valued people have learned through two if not all three routes.

Teachers, trainers and coaches

An interesting problem arose from trainers who are experts by personal experience, organising themselves into a Recovery Trainers Group (RTG) and developing a governance framework to provide commissioners and other purchasers of their services with quality assurance (DPT, 2008c). This identified for the first time that whereas the members of the RTG had sought qualification as trainers this was not the case for the practitioners they were teaching with. They understandably raised the question of how practitioners could assure others that they were competent to teach, which we've yet to answer.

We have sought to develop guidance, teaching and training through broadly constituted workgroups that include different and even dissonant viewpoints. For example, medication is often a significant part of the intervention that is offered to people who use mental health services. However, there has been little discussion of the role and value of medication as a support for personal recovery. This may reflect the negative experiences and associations that many people who use services have had in relation to using medication, in particular feeling that they have had little choice or control over whether and how to use it. In seeking to put “recovery at the heart of all we do”, it was felt to be essential to develop and implement guidance for mental health workers on putting recovery principles into practice in relation to prescribing and medicines management.

A project group was formed with representation from key professions and people with personal experience. The group reviewed the existing literature, discussed how the locally endorsed recovery principles could be operationalised in relation to prescribing and medicines management and carried out a wider consultation, interviewing people who take medication and carers about their experiences of using medication to support personal recovery. The resulting guidance (DPT, 2010b) recommended that medication be seen as a tool that individuals can choose to use in different ways at different times to achieve their personal recovery goals and provided specific guidance for prescribers in adopting a collaborative approach. The project group is now working on dissemination and training initiatives to support engagement with the guidance as a contribution to cultural change.

In addition to these publications and topic based training initiatives there has been a growing commitment in Devon to offering broader training in the recovery approach, initially as “awareness courses” and more recently as an annual 20 place modular course run in partnership between University of Plymouth and DPT. The course organisers have themselves benefited from extended study of recovery and commissioning of the course has been supported by recognition of the need to create a body of people within the Trust with the

necessary knowledge to sustain the development of recovery-orientated practice without diluting the recovery movement's status as a civil rights movement. They thereby seek to reconcile the apparent contradiction in professional practitioners seeking to support people in self management and self determination. Students are encouraged to read recovery literature produced by people with experience of using services as well as policy documents associated with recovery. In their role as culture carriers, students are asked to consider how to change their practice and that of their team, particularly in relation to power dynamics and issues around ownership of the recovery journey. Taught lectures on the course are open to anyone in the Trust and have been very well attended, generating broad interest and engagement.

The wider perspective: recovery education and training in society

If we feel a bit daunted by the size of the task involved in “transforming the workforce” we may be more so when it comes to consider the agenda for the whole of society and the suggestion that a key role for mental health professionals of the future will be as social activists (Slade, 2010). Personal recovery centres on recovering a life and pattern of living that a person values, it is about having a place in society and gaining or regaining the rights and responsibilities common to all citizens. Recovery is a philosophy and system of values with significant roots in other civil rights movements that uphold respect for diversity and acceptance of disability (Davidson *et al.*, 2010). Stories of personal recovery (DPT, 2009a) often pivot around people finding a way back to a valued and contributing place in non-segregated social settings – and services and staff can do much to help or hinder this process.

Our own recovery standards (2008a) include, “All services are able to engage with, and effectively respond to, issues of prejudice, stigma and discrimination”, but how? One response has been to join the national time to change campaign and offer information, discussion and provocation well beyond our familiar services boundaries. For example:

Flashmob. World Mental Health Day in October, 2009 saw 400 people gathered in Exeter city centre frozen in silence for two minutes drawing attention to the campaign. This led to press and social media responses which widening impact and awareness. The event was filmed and has so far had more than 1,300 hits on YouTube.

Tea and talk. A series of informal workshops have been organised in business and agency settings across Devon. This was aimed at increasing awareness of mental health over tea and cakes. It has been enthusiastically accessed by 19 companies and organisations in the local economy and has a lengthy list of further requests. Evaluation of the project (Ley, 2010) found that people gained greater awareness and new knowledge. People particularly enjoyed the discussions with other members of their group and found the quiz very thought provoking, expressing surprise and shock at some of the statistics on prevalence and suicide.

The value of “lived experience” in training and workforce development

There is a considerable need for care and thoughtfulness when engaging with the “lived experience” agenda from the point of view of an NHS Trust and there are many reports of it being done badly. On the one hand, it should simply be a given that people with direct and personal experience of mental health problems and services are involved in all steps and stages of workforce development, teaching and training. But there are many stories of how this doesn't work out as people hope. Considerable care is needed to ensure involvement; partnerships and collaborations are effective and successful.

In a simple sense it comes back to putting recovery values into action but this is complex in practice and there are a variety of interrelationships between personal experience, training and workforce development.

Training by people with lived experience

The contribution of people with lived experience can be illustrative, touching, challenging, inspirational, confrontational and supportive. This personal contribution can powerfully

shape attitude and understanding. It can also be valuable to people in recovery to have this opportunity to use their “mental wealth”. As an experienced trainer one of the present authors (JW) emphasises that working in partnership is especially important for staff whose majority of contact is with people who may be in the acute phase of their condition. Recovery training from people with lived experience brings with it a realism that cannot be acquired from text books or formal training from those who haven’t “walked the walk”.

A further step is in valuing the contribution of people with personal experience as part of the workforce. We have experience in Devon of setting up an “Intentional Peer Support” training course but also that, without dovetailing the training opportunity into jobs and ongoing support and supervision; it is easy for the learning to be lost (Ley *et al.*, 2010).

There are additional challenges for those who may offer to be trainers:

- accusations from fellow “service users” of complicity with the system;
- engaging with staff who feel accused by “user activists”;
- muddled or inconsistent arrangements for paying people with “lived experience” for their contributions;
- being misunderstood or unappreciated;
- confusion in how to preserve an independent viewpoint when “joining the staff”;
- being praised and valued and put on a pedestal which can be “othering”;
- the stress, challenge and sometimes isolation of the expert role.

Our aim is for all recovery education in Devon to be organised with and delivered collaboratively by people with personal and professional experience working together as colleagues.

“Training” for people with lived experience

Progress in personal recovery is not dependant on getting a perfect service. Many of the founders of the recovery movement described very poor experience of services and their determination to recover despite them. It is a salutary and humbling realisation for practitioners that services cannot “recover” anyone, but can provide the supports, stimulus and preconditions of recovery that make it more likely that people can successfully embark on their own recovery. The practitioners’ contribution is only half the picture – the other is dependent on how people engage with their own recovery and how they use the helps and supports around them.

The desired outcome is not of becoming “empowered service users” but people who are able and hopeful about getting on with their lives on their own terms with or without mental health services. Our attention in Devon was drawn to the possibility of peer education in recovery for people who use services by O’Hagan (2008, 2009) during her consultative visit but beyond issuing a guide for people who use services (Davidson *et al.*, 2010, p. 1) we have hardly yet begun.

“Lived experience” within the workforce

Historically psychiatric services have been characterised by segregation and a pervasive “them and us” mentality. Staff and patients have had very different roles marked out by rituals, rules, uniforms, control and privileges. But of course staff are people too and personal and family experience of mental health difficulties may have provided the empathy, insight and motivation that drew people into this work in the first place (Rippere and Williams, 1985). But, if unexamined and unsupported, this empathic sensitivity may also constitute a vulnerability that leads to occupational stress and burnout (Roberts, 1997). The health and wellbeing of staff has recently been reemphasised as having a critical influence on the quality of patient care but remains ill considered. As Boorman (2009) concluded “It is ironic that the NHS is trying to focus on the public health agenda yet not making it available to its own staff, because staff should be exemplars”.

Our local Devon Recovery Standards (Devon, 2008a) include mention of the need to support the health and wellbeing of staff which is consistent with the SCMH (2009) emphasis on, “Supporting staff in their recovery journey”, but there is a question of where and how to begin.

The DPT staff survey of “lived experience”

All staff working in DPT were invited to participate in a survey of their personal experience of mental health problems and services and 560 replied (23 per cent). Forty three percent of respondents reported personal experience of mental health problems and over half of those also had personal experience of services or treatments. Sixty one percent of respondents had experience of supporting someone close to them with mental health problems and the majority included contact with mental health services or treatments. Although two thirds of respondents said they were able to be open with their managers and colleagues one third did not and 138 people gave reasons for this – the majority of which was fear of stigma, misunderstanding or rejection (DPT, 2009d).

Subsequent discussion in the Trust expressed both a concern for the wellbeing of the workforce but was also able to regard this as potentially a “wealth of experience” and agree with the conclusions of the Boorman (2009) review that there is a sound political, business, ethical and service rationale to work on improving the health and wellbeing of the mental health workforce. There is an additional opportunity to value the “lived experience” of the staff as a potential resource in recovery oriented practice. Actions from this survey include:

- dissemination and publication of findings;
- a new conversation around staff health and wellbeing;
- further development of links with mindful employer;
- developing DPT job adverts to value personal experience;
- support for staff to turn their personal experience into expertise, through training, support and supervision;
- bid for further support for time to change; and
- DPT healthy workforce strategy.

Putting it all together – a strategic approach

One of the elegant observations about the integrity of recovery oriented approaches is in how the same values and processes work at personal, practice, team, service and organisational levels. But there is a significant problem in thinking how to teach or train the whole workforce of an NHS Trust (Table 1) and making values-based learning compulsory is at risk of breaching its own values. But training outcomes will be very limited if opportunities are only taken up only by those who are already interested.

Our approach has been to do both. We have gained endorsement for general and widespread standards and commitments to practice improvements whilst offering more intense learning opportunities to some and recruiting those with skills and interests to coach and support others. The whole approach has recently been gathered in a workforce development strategy (DPT, 2010a) which sketches out action and activity at every level. It describes costs and commissioning options for training from various providers to achieve this goal. It is supported by a commitment to embed recovery outcome evaluation in routine practice (DPT, 2008b, 2009c) and implementation has begun.

Conclusion

The DPT was invited to participate in the SCMH recovery project on the basis of what has been achieved to date. In describing this in the present paper we are aware that we are largely documenting a naturalistic process with numerous contributions that have only recently resulted in more systematic and strategic plans. At this stage of our development

we can reflect on what have we achieved, what have we learned and where are we going. The “we” in this equation reaches far beyond the present authors and takes in a wide and diverse community of people in Devon with a shared commitment to supporting developments in recovery who are in an early but active process of seeking to work together for a common purpose.

It is not easy to draw out clear lessons for others who are commissioning and delivering education and training elsewhere. It is also difficult to know what we have achieved whilst sitting in the middle of a whirlwind of interacting processes. It may be easier to judge in a few years time but we are confident that we have a secure foundation and are pointing in the right direction.

We take some comfort in international observations (Slade, 2009) “service transformation” often emerges in response to crisis and takes a decade or more to achieve. This paper describes our strand of input into the SCMH guide for Trusts and commissioners which clearly identifies the key challenges to be addressed but also allows for customisation and prioritisation on the basis of local circumstances (SCMH, 2010).

Our story can and should prompt the reader to reflect on theirs and, as with personal recovery, there is much that can be learned from hearing stories of others’ experience but that is no substitute for giving careful thought to what I/we can do here and now and in simply taking the next available steps and opportunities. It has been hugely inspiring to see people moving forwards in recovery – be that people using services, practitioners or teams and very rewarding to be in a range of mutually supportive relationships with others pursuing regional and nationally developments. A key lesson is to find at least a few like minded people to work with on this together.

Five years on from commitment to the LIT Vision we have confidence that we’ve made a good start – but if the goal is transformation – we have a long way to go before our practice and services are in a mature form. We are aware that “the map is not the land” and how wide can sometimes be the gap between good papers and good practice. We also believe and can demonstrate that with persistence, commitment and collaboration the gap can be progressively narrowed and bridged. A key element of our learning has been in valuing collaborative co-working and the synergism of personal experience, professional training, research and evaluation. Our latest project has been to set up a Recovery Research and Innovation Group within the R&D department of the Trust which aims to host an inclusive group from all these backgrounds to support the Trust’s strategic aims which include developing services that are personalised, and recovery focused.

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Further reading

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