

Evaluation of the Scottish Recovery Network

EVALUATION OF THE SCOTTISH RECOVERY NETWORK

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TABLE OF CONTENTS

EXECUTIVE SUMMARY	1
1 INTRODUCTION	6
Background and national policy context	6
The Scottish Recovery Network (SRN)	6
Aims and research questions	7
Structure of this report	7
2 METHODS	8
Getting the perspectives of stakeholders	8
Review of literature, monitoring data and statistical information	9
Case studies	10
Analysis	10
3 WHAT IS THE SCOTTISH RECOVERY NETWORK?	11
Creation of the Scottish Recovery Network	11
Vision, aims and objectives	11
Target groups	12
SRN's activities and outcomes	13
Staffing	14
Funding	14
4 OBJECTIVE 1: RAISE AWARENESS OF RECOVERY	16
How the has SRN raised awareness of recovery	16
Reach	17
Effectiveness	20
Impact	21
5 OBJECTIVE 2: DEVELOP AN EVIDENCE BASE FOR RECOVERY IN SCOTLAND	22
How the SRN has developed an evidence base for recovery	22
Effectiveness and impact	23
6 OBJECTIVE 3: BUILD CAPACITY IN COMMUNITIES	24
Wellness Recovery Action Planning (WRAP)	24
Peer support worker schemes	26
Local recovery networks	29
7 OBJECTIVE 4: SUPPORT PRACTICE DEVELOPMENT	34
Scottish Recovery Indicator	34
Developing learning materials for professionals	35

8	INFLUENCE ON POLICY AND PRACTICE	38
	Influence on national mental health policy	38
	Influence on practice	40
	Barriers and levers to influence	43
	The SRN's influence on practice: The perspective of service users	43
9	IS THE SRN GOOD VALUE FOR MONEY?	44
	Governance and management	44
	How costs and benefits are weighed up in making decisions	45
	How performance and outcomes are measured and reported	46
	Whether outcomes (or objectives) have been achieved within budget	46
	Views from evaluation participants	47
10	THE FUTURE OF RECOVERY AND THE FUTURE OF THE SRN: KEY MESSAGES AND CONCLUSIONS	48
	How has the SRN planned and implemented its work?	48
	To what extent has the SRN delivered on its aims and objectives?	49
	The SRN's influence on policy	50
	The SRN's influence on practice	50
	Reach, effectiveness and impact	51
	Value for money	53
	The future for recovery and the future for the SRN	53
	Recommendations	55
	REFERENCES	57
	ANNEX A: WHAT IS "RECOVERY"?	59
	ANNEX B: BACKGROUND TO THE CREATION OF THE SRN	60
	ANNEX C: SRN OUTCOME MODEL, 2008	62
	ANNEX D: SRN WEBSITE STATISTICS AND ATTENDANCE AT EVENTS	63
	ANNEX E: CASE STUDY SUMMARY REPORTS	69
	Case study area 1	69
	Case study area 2	71
	Case study area 3	73
	Case study area 4	74

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A note about terminology

Throughout this document, the following terminology will be used:

The Network – with a capital ‘N’, is a short-hand for the Scottish Recovery Network or the SRN.

Service users – in the context of this report, refers to people with long-term mental health problems, who use secondary mental health services. However, it is acknowledged that the distinction between “service user” and “service provider” can be blurred. Some service users who are in recovery may make very little use of services, and service providers may themselves be service users or former service users.

EXECUTIVE SUMMARY

Introduction (chapters 1 and 2)

1. An evaluation of the Scottish Recovery Network (SRN) was commissioned by the Scottish Government and ran from October 2009 – September 2010. The aims of the evaluation were to assess the effectiveness and impact of the SRN (at a national policy level; at a local level; and at the level of service users), and the extent to which the SRN is providing value for money.
2. The evaluation involved the collection of data from a range of sources. Interviews and / or focus groups were carried out with key stakeholders including SRN staff. In addition, a review was undertaken of the SRN-related evaluation literature and an analysis carried out of the SRN's data on resource distribution, events attendance and website visits. Finally, four local case studies (involving both service users and service providers) were undertaken.

About the SRN (chapter 3)

3. The SRN was established in 2004 as an initiative under the former National Programme for Improving Mental Health and Wellbeing. It has three main aims:
 - To raise awareness of recovery from mental health problems, and in particular, long-term mental health problems
 - To develop an understanding of recovery within a Scottish context, and to share that learning with others
 - To share ideas and encourage and support action nationally and locally for the promotion of recovery.
4. These aims have been translated into four main objectives: (i) to raise awareness; (ii) to promote understanding; (iii) to build capacity in communities; and (iv) to support practice development.
5. The Network is funded entirely by the Scottish Government. Funding has increased from £200k per year in 2004-05 to the current £475k per year in 2010-11. The SRN's staff team has also grown from the initial 2.5 to 6.5 at present.

Objective 1: Raise awareness of recovery (chapter 4)

6. In its early years, a major focus for the SRN was on raising awareness of recovery and making connections — with service users and mental health professionals. Awareness-raising activities included: organising conferences, workshops and other events; attending / speaking at non-SRN events; producing and distributing publications and other resources; and developing and maintaining a website and mailing lists. To a lesser extent, the Network has also attempted to raise awareness of recovery among the general public.
7. As of June 2010, there were 5,700 individuals on the SRN mailing list. In an 18-month period between April 2008 – October 2009, the SRN distributed tens of thousands of publications or other resources (posters, postcards, etc.). On average, the SRN website receives about 3,000 visits per month.

8. Participants in this evaluation believed that the SRN had made an enormous contribution to raising awareness of recovery in Scotland. However, there was also evidence to suggest that further work was still needed to reach people who are not yet engaged with the Network.

Objective 2: Develop an evidence base for recovery in Scotland (chapter 5)

9. A major focus for the SRN has been on creating an evidence base to promote and support recovery-oriented practice in Scotland. It did this partly by looking to and learning from what others had done internationally, but also by developing Scotland's own evidence base — through its Narrative Research project.
10. The Narrative Research Project (begun in 2005) involved gathering qualitative evidence (i.e., stories of people's personal experiences) from 64 people with mental health problems across Scotland, who had experience of recovery. The aim was to find out about and disseminate insights regarding the factors that helped and hindered recovery from a Scottish perspective.
11. The Narrative Research was widely cited by evaluation participants as one of the SRN's biggest successes. The SRN has used its findings for pamphlets, podcasts, awareness-raising materials and training materials.
12. The SRN has not undertaken any further in-house research, but has continued to support research and evaluation in a significant way. Nearly all of the SRN's other major initiatives have been evaluated (eight evaluations in total).

Objective 3: Build capacity in communities (chapter 6)

13. The SRN has sought to build capacity in communities through: (i) supporting Wellness Recovery Action Planning (WRAP); (ii) developing and supporting peer worker schemes and (iii) supporting the development of local recovery networks.

WRAP

14. WRAP provides a structured method for helping people with mental health problems to maintain wellness and make advance plans for the eventuality of a crisis. The process of developing a personal WRAP begins by attending WRAP training. The SRN has funded the delivery of training for WRAP facilitators (a five-day training course), so as to create a group of individuals in Scotland who are able to deliver WRAP training to others. In addition, the SRN is developing a quality assurance scheme for WRAP facilitators, and currently provides facilitators with on-going support through regular "facilitator network" days.
15. At the time of this evaluation, WRAP was being delivered widely to service users around Scotland, although there were also reports of not enough local facilitators to meet demand. A separate evaluation found that WRAP was effective in increasing hope, expectations and self-direction for recovery.

Peer support worker schemes

16. The SRN has promoted the development of peer support worker schemes in mental health services in Scotland. At the same time, national policy commitments provided an impetus for a peer worker pilot scheme to be

implemented in five NHS boards in 2007-08. The SRN was not substantially involved in the implementation of the pilots, but provided support to the pilot sites by convening meetings for the groups involved in implementation and training.

17. There is no complete information available about the number of peer workers employed in Scotland. However, the SRN estimates that there are around 25 in paid roles. In addition, there are also volunteer peer workers in some areas.
18. The SRN is involved in taking forward many of the recommendations of the peer support pilot evaluation. For example, working with the Scottish Qualifications Authority (SQA) to create a new nationally recognised award for peer support worker training, and in developing guidance for employer organisations.

Local recovery networks

19. The SRN views local recovery networks as a way of promoting the sustainability of recovery at a local level. Local networks provide a neutral place for people with mental health problems, carers and families, and service providers to meet to discuss the concept of recovery and how to make it real in their communities.
20. The SRN's initial approach to supporting local recovery networks was largely responsive — i.e., providing advice, information and guidance as requested, and occasionally collaborating or part-funding specific projects. However, in April 2010, a Network Officer was appointed, at least in part, to add capacity for the development of local recovery networks.
21. As of August 2010, there were three well-established and active local recovery networks (LRNs) in Lothian, Lanarkshire and Ayrshire & Arran. There were also networks in Highland and Renfrewshire which were reported to be less active. Two new networks were being established in Borders and Dumfries & Galloway.
22. This evaluation found that LRNs were felt to have achieved changes in attitudes, values and practice, and in those areas, service users reported that they felt more empowered. Factors that supported the success of LRNs included: funding; having a mix of professionals and service users on steering groups; support from strategic managers in the NHS or local council; having an organisation that was prepared to host the network; good communication systems; a focus on meeting local needs; and help from the SRN.

Objective 4: Support practice development (chapter 7)

23. The SRN has supported practice change through the development and roll-out of the Scottish Recovery Indicator (SRI) and training materials for mental health professionals.

Scottish Recovery Indicator

24. The SRI is a mental health service development tool. It involves the assessment of 19 indicators focused on factors known to promote recovery. The SRN has invested considerable effort in supporting the use of the SRI in mental health services in Scotland, to enable services to reflect upon, and where necessary, to make changes to their practice. As of June 2010, there were more than 850

registered users of the tool across every Scottish health board. An evaluation of a pilot implementation of the SRI found that it had good potential for influencing service culture and service change towards more of a recovery approach.

Developing learning materials for professionals

25. The SRN has worked together with NHS Education for Scotland to create a national framework for training mental health workers (particularly nurses) in recovery-based practice. This has led to the development of the *Realising Recovery* learning materials, which builds on an existing training programme called the *10 Essential Shared Capabilities (10 ESCs)*. An evaluation of the impact of the *10 ESCs* and *Realising Recovery* found that the training raised awareness of a range of issues relating to values in mental health practice, and that it helped practitioners to recognise where there was a need to develop / change aspects of their practice.

The SRN's influence on policy and practice (chapter 8)

26. This evaluation found that the SRN has had a significant influence on national mental health policy. They have done this through their success in engaging with a wide range of stakeholders; through the creation of a robust evidence base for recovery in Scotland; and through the perceived value of the tools and training materials they have developed. The SRN is the main implementation body for national policy on recovery, and it is clear that the working relationship between the SRN and the Scottish Government has been successful.
27. The SRN has also had an influence on practice. The greatest influence was reported to be in the area of NHS mental health nursing and community mental health services in general. However, there were also some groups on whom the SRN has had less influence, namely GPs, psychiatrists and psychologists, although there is evidence that the SRN has had a measure of success in engaging with psychiatrists around the issue of recovery.

Value for money (chapter 9)

28. This evaluation found that stakeholders think that the SRN does a good job, meeting its objectives in a high-quality way, and achieving this with little resources when compared to other national mental health initiatives. The SRN also has transparent governance and management arrangements, and there is evidence of the SRN making sensible decisions about the use of its resources. It is suggested, however, that the SRN and Scottish Government should agree indicators for assessing whether the Network is meeting intended outcomes.

The future for recovery and the future for the SRN (chapter 10)

29. Evaluation participants at every level felt that much progress had been made in the area of recovery in Scotland. However, there was also a feeling that recovery was not yet fully embedded into practice and there was more work to be done. There was also a strong view that there was an important role for SRN beyond 2011 (when the Network's current funding ends). At the same time, participants felt that the SRN should not be the *only* player. They saw an important role for government (in continuing to prioritise and support policy in this

area) and for those responsible for the planning and delivery of services at a local level to ensure that recovery-related practices were embedded in services.

Recommendations (selected)

- The work of the SRN should continue beyond 2011.
- The Scottish Government and lead professional bodies should continue to promote and support recovery in Scotland. In particular, the Scottish Government should continue to give priority to recovery through commitments in key policy documents in mental health and other areas.
- The Scottish Government and the SRN should discuss and agree appropriate indicators to measure the SRN's outcomes and how data on these indicators will be collected.
- The SRN should continue to expand the Network, engaging with service users and professionals who have an interest in recovery. However, we would recommend that:
 - New efforts be made to target awareness-raising activities to primary care professionals
 - New efforts be made to identify and establish direct contact with service user and carer groups to ensure that the message of recovery is being heard by as many as possible
 - Continued efforts be made to engage with psychiatrists and psychologists.
- The SRN should continue to support services to develop recovery-oriented practices, and in particular, should continue to support services to use the SRI.

1 INTRODUCTION

1.1 This is the final report of an evaluation of the Scottish Recovery Network (SRN). The evaluation was commissioned by the Scottish Government and ran from October 2009 – September 2010. Its main aims were to assess:

- The effectiveness and impact of the SRN — (a) at a national policy level, (b) at a local level particularly in relation to those who play a role in providing support to mental health service users (i.e., statutory services, voluntary organisations and carers), and (c) at the level of service users
- The extent to which the SRN is providing value for money.

Background and national policy context

1.2 There have been major changes in mental health policy and service delivery in Scotland over the past two decades. These changes have included a shift away from psychiatric in-patient care to community-based care, and the enacting of mental health legislation that puts service users' involvement and rights at the heart of mental health services.¹

1.3 At the same time, there has been an increasing emphasis on the notion of “recovery”, and several major national policy initiatives have sought to improve mental health services, and bring about a more recovery-oriented focus. (See in particular, the review of mental health nursing,² *Delivering for Mental Health*³ and *Towards a Mentally Flourishing Scotland*.⁴) See Annex A for further discussion of the concept of “recovery”.

1.4 The notion of recovery has required a shift in thinking by service providers and service users, to believe that recovery is possible for everyone with a mental illness. And it has required a shift in values and practice, as the role of services therefore has become less to do with “providing care” and more to do with supporting and empowering individuals to achieve their own recovery.

The Scottish Recovery Network (SRN)

1.5 It is within this context that the Scottish Government launched the Scottish Recovery Network (SRN) in December 2004 as an initiative under the National Programme for Improving Mental Health and Wellbeing. The main purpose of the SRN is to promote the concept of recovery at a national and

¹ Office of Public Sector Information (OPSI). *Mental Health (Care and Treatment) (Scotland) Act 2003*. Available at: www.opsi.gov.uk/legislation/scotland/acts2003/asp_20030013_en_1.

² Scottish Government (2006) *Rights, Relationship and Recovery. The report of the national review of mental health nursing in Scotland*. Available at: <http://www.scotland.gov.uk/Resource/Doc/112046/0027278.pdf>.

³ Scottish Government (2006) *Delivering for Mental Health*. Available at: www.scotland.gov.uk/Publications/2006/11/30164829/16.

⁴ Scottish Government (2009) *Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009-2011*. Available at: www.scotland.gov.uk/Resource/Doc/271822/0081031.pdf.

local level, and to support mental health services in Scotland in adopting recovery-oriented practices.

- 1.6 A fuller description of the Network and its activities is given in Chapter 3. The main point to make here is that, although many of the SRN's initiatives have been the subject of evaluation, the Network itself has not previously been evaluated.

Aims and research questions

1.7 This evaluation sought to answer five inter-related questions:

1. How has the SRN planned and implemented its activities and to what extent has it delivered on set aims and objectives?
2. What influence has the SRN had — (a) on national policy, and (b) on engendering recovery values and practices in Scotland — and how has this been achieved?
3. To what extent have the SRN's interventions / projects been successful in reaching their target populations, how effective have they been and what has been their impact?
4. Has the SRN provided good value for money in pursuing its aims, influence, reach and impact?
5. What needs to be done in the future to promote the recovery agenda and what role should the SRN have in this?

Structure of this report

1.8 This report contains 10 chapters:

- Chapter 2 sets out a brief description of the methods used in this evaluation.
- Chapter 3 provides a detailed description of the Scottish Recovery Network — its aims, objectives, activities, staffing and funding.
- Chapters 4, 5, 6 and 7 will look in more detail at the SRN's four objectives: (i) raising awareness of recovery; (ii) developing an understanding of recovery; (iii) building capacity in communities; and (iv) supporting practice development. For each objective, we will:
 - Describe the activities the SRN has undertaken to meet that objective
 - Examine the extent to which those activities have reached their target populations
 - Assess their effectiveness in terms of the outcomes (i.e. changes) achieved, and
 - Describe their impact.
- Chapter 8 focuses on the SRN's influence on policy and practice
- Chapter 9 examines whether the Network is good value for money
- Chapter 10 discusses the main findings of the evaluation, considers the implications for the future and makes recommendations.

2 METHODS

2.1 This section provides a brief summary of the methods used in this evaluation. The research methods were selected to enable the research questions to be fully answered and to obtain a variety of perspectives on each question.

2.2 Data were collected in this evaluation through:

- Interviews with 33 stakeholders, including the Director of the SRN
- Two focus groups with stakeholders involved in the planning and delivery of SRN activities (one with the SRN staff team and one with its Strategy Group)
- A review of the SRN-related evaluation literature (eight evaluation reports)
- An analysis of SRN data on resource distribution, events attendance and website visits
- A review and analysis of a variety of available monitoring reports, action plans and other official documents, including published policy documents
- Four case studies in different NHS Board areas. The case studies involved six interviews and four focus groups, which were attended by a total of 45 people, both service users and service providers.

Getting the perspectives of stakeholders

2.3 Three face-to-face interviews were carried out with the Director of the SRN over the course of the evaluation. Each of these interviews had a slightly different purpose. The first aimed to gather information about the rationale for setting up the SRN, and the Network's aims, objectives, outcomes and target groups. The second interview discussed staffing and the SRN's main activities. The third interview explored the extent to which the Network has provided value for money.

2.4 As one of the key aims of this project was to evaluate SRN's contribution to developing and delivering national mental health policy, we undertook three face-to-face interviews with Scottish Government officials working in the area of mental health policy. We also conducted two interviews (one face-to-face and one by telephone) with individuals who had been involved in mental health policy development in the earlier years of SRN's work.

2.5 We conducted telephone interviews with representatives of national practitioner bodies. The purpose of these interviews was to assess the SRN's role in raising awareness of the recovery agenda within:

- The Royal College of General Practitioners
- The Royal College of Psychiatrists (Scotland)
- VoX (Voices of Experience — National service user group)
- The Association of Directors of Social Work
- The Mental Health Nursing Forum

- 2.6 Telephone interviews were also conducted with four strategic partners of the SRN. Interviewees were purposefully chosen on the basis of their known proximity to the SRN's work: all had a significant level of previous and / or ongoing involvement in planning and / or implementing aspects of the recovery agenda in Scotland.
- 2.7 All SRN staff (apart from the Director) were invited to participate in a focus group. It was attended by four current and one former member of staff. A further staff member was interviewed by telephone.
- 2.8 To get the views of the SRN Strategy group on the effectiveness and impact of the Network, we conducted a focus group discussion using a participative approach, which combined elements of appreciative inquiry with a SWOT⁵ analysis.⁶
- 2.9 Short telephone interviews were carried out with 17 senior managers of mental health services from around Scotland (representing nearly every NHS Board area). The purpose of these interviews was to find out about the influence of the SRN at a local level, so they focused specifically on the managers' awareness of the SRN, the use by their local services of SRN materials and interventions, and their perceptions of the impact of the SRN in their areas.

Review of literature, monitoring data and statistical information

- 2.10 We were aware in undertaking this evaluation that many aspects of the SRN's work had previously been evaluated. We reviewed eight evaluation reports to gather information (where feasible) about the acceptability / usefulness, reach, effectiveness and impact of each intervention evaluated. However, in undertaking this literature review, we found that many of these evaluations were small-scale and formative. They mainly sought to identify learning that would inform wider roll-out of particular initiatives. Therefore information about the effectiveness and impact of those initiatives is limited.
- 2.11 The SRN's reach was assessed through the collation and analysis of the SRN's records of contacts and participants. We focused on the period from April 2008 (as there had been a previous analysis of data up to that point) and, where possible, analysed data up to December 2009. As the means of gathering website statistics changed in November 2009, we analysed website statistics from November 2009 to May 2010.
- 2.12 Sources of data examined were:
- Email contact list
 - Materials distribution spreadsheets

⁵ SWOT = Strengths, Weaknesses, Opportunities, Threats

⁶ A second meeting with the Strategy group took place towards the end of the evaluation to feed back preliminary findings. This second meeting did not involve the collection of any further data.

- Events spreadsheets
- SRI workshops attendance records
- Website statistics
- Number and location of WRAP facilitators

- 2.13 In addition to reviewing evaluations and monitoring data, we also undertook an analysis of SRN strategic documents and monitoring reports. The purpose of this analysis was mainly to gather information about the SRN's history, aims, objectives, activities and outputs. This exercise therefore provided an independent source of data to that collected through interviews.
- 2.14 To assess the influence of the SRN on policy and practice, we also reviewed a number of policy documents, including *Towards a Mentally Flourishing Scotland; Delivering for Mental Health; Rights, Relationships and Recovery* (the review of mental health nursing); and the unpublished proposal to develop a Drugs Recovery Consortium in Scotland.

Case studies

- 2.15 The purpose of the case studies was to explore whether and how the SRN's role in supporting local recovery networks has had an influence and impact on recovery-related activity at a local level.
- 2.16 We studied four geographical areas. Two of these had well-established and active local recovery networks; one area was in the early stages of setting up a network, albeit the process had been going on for some time; and the fourth area did not have a network but was reported to have undertaken a great deal of recovery-focused activity.
- 2.17 In each of the three areas with a recovery network, we held a workshop which was attended by its local members. The purpose of the workshops and interviews was to gather information about the extent of influence of the SRN on local recovery work. We also carried out a telephone interview with each local network co-ordinator, and a review of documents relating to each network's development and action plans.
- 2.18 The purpose of including one non-network area as a case study was to explore how local recovery work was developing without a local network and to identify any challenges in developing one. However, we do not claim that the issues in this area are necessarily generalisable to any other areas.
- 2.19 Within the non-network area we conducted three telephone interviews with senior professionals who had been identified as playing a key role in the development of mental health services in the area. We also conducted a focus group with a service user group attended by six people.

Analysis

- 2.20 Our analysis focused on answering our five key research questions, and drew on the entire range of data gathered through each of our data collection exercises.

3 WHAT IS THE SCOTTISH RECOVERY NETWORK?

- 3.1 This section provides a description of the SRN. It includes information about its aims, staffing and funding. In doing so, it provides an important context for this evaluation.
- 3.2 The data presented in this section comes from our interviews with the Director and other stakeholders at a national level, our documentary analysis and our focus group meeting with the SRN Strategy Group.

Creation of the Scottish Recovery Network

- 3.3 When the National Programme for Improving Mental Health and Wellbeing was launched in October 2001, one of its key aims was “promoting and supporting recovery.” The identification of “recovery” as a priority by the then Scottish Executive reflected, to some extent, what was happening in recovery movements elsewhere in the world — particularly in the United States and New Zealand.
- 3.4 However, at the time, the idea that people could recover from long-term mental illness was a relatively new concept in Scotland, at least insofar as it neither featured prominently or explicitly in national policies, nor did it drive service design.
- 3.5 Over the course of nearly two years, a series of stakeholder events and workshops were held which laid the groundwork for establishing a recovery movement in Scotland, and eventually a group of stakeholders put together a proposal to establish a “Scottish Recovery Network”. The “network” concept was favoured because it was seen to provide a way for people to exchange ideas and experiences with people in other parts of the country.
- 3.6 The Scottish Recovery Network was officially launched in December 2004 as one of the main initiatives under the (former) National Programme and the Scottish Executive gave the Network £200,000 per year for its first two years. Further details about the history of the Network is given in Annex B.

Vision, aims and objectives

- 3.7 The SRN’s vision is that:

People who experience mental health problems and those around them should expect recovery. The values and principles which underpin the recovery experience should form the basis of how, as a society, we approach mental health issues.⁷

- 3.8 The SRN sees its role as “a catalyst for change”.

⁷ Scottish Recovery Network (2008) *Progressing recovery in Scotland 2008/11. Action Plan*. Submitted to the Scottish Government. See page 4.

- 3.9 The Network has three main aims and these have not changed substantially since its inception:
- To raise awareness of recovery from mental health problems, in particular, long-term mental health problems
 - To develop an understanding of recovery within a Scottish context, and the factors which help and hinder it, and to share that learning with others
 - To share ideas and encourage and support action nationally and locally for the promotion of recovery.
- 3.10 These three aims have been translated into four main areas of work (or objectives): (i) awareness-raising; (ii) promoting understanding; (iii) building capacity in communities; and (iv) supporting practice development.
- 3.11 Ultimately the SRN is trying to bring about a shift in attitudes and values — both among people who have mental health problems, and among those who support them. At the same time, it is also trying to change behaviour — by increasing self-directed behaviour among service users, empowering them to make choices and take control and responsibility for their own lives, and by changing practice among service providers so that they are able to support the process of recovery effectively.

Target groups

- 3.12 The SRN has two main target groups: mental health service users and practitioners / providers of secondary mental health services. In addition, it was suggested by some participants in this evaluation, that the SRN is also (perhaps to a lesser extent) targeting the general population with messages that recovery is possible. This was seen to be important because an individual's likelihood of recovering is greatly enhanced if they are surrounded by people (including family, friends and colleagues) who are supportive and optimistic about recovery.
- 3.13 In relation to service users, the SRN Director and members of the Strategy Group reported that the SRN makes no distinction between people with severe or less severe mental health problems. However, in practice, the majority of service users involved with the Network are likely to be those with more long-term mental health problems, primarily because these individuals tend to be better linked into service user groups. It was noted by more than one participant in the evaluation that it has been harder for the SRN to reach individuals who are not linked to services, or service user networks.
- 3.14 In relation to service providers, the Network's messages and activities are intended to be relevant to professionals working across all sectors (NHS, local authority and voluntary), but particularly those supporting people with long-term and acute mental health problems. The Network has prioritised work with NHS secondary mental health services, partly because there was a view that recovery-based values are (traditionally) less prevalent in NHS services, which were perceived to have more of a medical and risk management focus, and partly because of commitments made in policy documents such as the *Review of Mental Health Nursing* and *Delivering for Mental Health*.

SRN's activities and outcomes

3.15 The SRN has taken forward its work through a number of initiatives, and Table 3.1 below shows how these link to the Network's objectives. Each of these activities, and what is known about their reach, effectiveness and impact, will be described in greater detail in the following chapters.

Table 3.1: The SRN's objectives and activities

Objective	Activity
Raise awareness of recovery	<ul style="list-style-type: none"> ▪ Developing, expanding and maintaining the Network (through organisation of events, workshops, roadshows, etc. and through on-going communication / dissemination)
Develop an evidence base for recovery in Scotland	<ul style="list-style-type: none"> ▪ Undertake / commission / manage research
Build capacity in communities	<ul style="list-style-type: none"> ▪ Support delivery of Facilitator training for Wellness Recovery Action Planning (WRAP) ▪ Support development of local recovery networks
Support practice development	<ul style="list-style-type: none"> ▪ Develop learning materials for professionals ▪ Develop and support use of Scottish Recovery Indicator (SRI) ▪ Develop and support the use of peer support worker schemes

3.16 In order to be able to assess the effectiveness of the SRN, it will be necessary to find out whether the Network has achieved its intended outcomes.

3.17 The SRN developed a logic model in 2008 to describe and show how its programme of work is expected to achieve intended outcomes. (The logic model can be seen in Annex C.) In this model, the aims and objectives of the Network are not explicitly stated, but rather what the SRN does (its key activities and outputs) are aligned with the changes it hopes to effect (outcomes). The activities listed in the model largely correspond to the activities listed above.

3.18 In assessing the SRN's effectiveness, our intention is to focus on the medium-term outcomes (for years 3-4) shown in the logic model. These are:

- Increased opportunities for learning about personal recovery in formal education / other settings
- Increased hope, expectations and self-direction for recovery amongst people with experience of mental health problems, families and professionals
- More recovery-focused mental health services and conducive policy environment.

Staffing

- 3.19 The Network began initially in 2004 with 2.5 FTE staff: the Director, a Research Officer and a half-time administrator. When the Network was established, there was an absence of a Scottish evidence base for recovery, and so the initial priority was to establish that evidence base. (This was done through the Narrative Research project, as will be seen in Chapter 5.) Thus, the original staffing team reflected this priority.
- 3.20 The staff team has grown over time and as of September 2010, there were 6.5 staff: the Network Director; the Network Manager; the SRI Project Lead; two Network Officers and two administrators (1.5 FTE). According to the SRN Director, the Network's staff team has expanded mainly in response to policy initiatives, e.g., on the roll-out of the SRI and peer support.
- 3.21 All the SRN's staff are employees of Penumbra and the Network is subject to Penumbra's terms and conditions and policies.

Funding

- 3.22 Funding for the SRN comes entirely from the Scottish Government, and since 2004, the SRN has received £2,317,000 in total (an average of £331k per year). The Network is currently funded until March 2011. Table 3.2 below sets out the SRN's annual income per year over the (nearly) seven years of its life.

Table 3.2: Income per year

Financial year	Income received
2004-05	£200,000
2005-06	£200,000
2006-07	£250,000
2007-08	£342,000*
2008-09	£400,000
2009-10	£450,000
2010-11	£475,000
Total	£2,317,000

* The SRN's award for 2007-08 was £270,000. However, they later received a supplemental award of £72,000 for that year.

- 3.23 Table 3.3 below shows annual budget allocations for a selection of initiatives under the National Programme. The first three years' funding for the SRN is included under the heading "Promoting and supporting recovery".

Table 3.3: Annual budget allocations (2003 – 2007) for selected initiatives under the National Programme for Improving Mental Health and Wellbeing (2003-2007)

	2003 – 2004	2004 – 2005	2005 – 2006	2006 – 2007
Mental health awareness raising / mental health literacy (Scottish Mental Health First-Aid)	350,000	350,000	350,000	350,000
Stigma and discrimination (<i>see me</i>)	650,000	750,000	800,000	810,000
Suicide prevention (national implementation support) (Choose Life)	750,000	850,000	950,000	1,000,000
Local suicide prevention support funding (Choose Life)	3.2 million	3.2 million	3.2 million	3.2 million
Breathing Space telephone advice line	550,000	600,000	650,000	650,000
Promoting and supporting recovery (includes funding for Scottish Recovery Network)	—	250,000	250,000	260,000

Source: NHS Health Scotland (2008) *A review of Scotland's National Programme for Improving Mental Health and Wellbeing: 2003 – 2006*. Available at: www.healthscotland.com/documents/2388.aspx.

4 OBJECTIVE 1: RAISE AWARENESS OF RECOVERY

- 4.1 This chapter describes the work that the SRN has carried out in relation to raising awareness of recovery among service users and service providers (its key target groups) as well as among, carers and the general public.
- 4.2 The evidence presented in this section comes from interviews with the SRN Director, policy officials, SRN partners and representatives of national stakeholder organisations; an analysis of SRN monitoring reports and monitoring data; focus groups with the SRN Strategy Group and staff group; telephone interviews with senior mental health managers from around Scotland; and our review of the literature, and in particular, the evaluation of SRN communications (Gordon *et al*, 2008).⁸

How the has SRN raised awareness of recovery

- 4.3 In the first two years of its life, the focus of much of the SRN's work was on raising awareness of recovery and making connections — with service users and mental health professionals — to expand the Network. We heard from a range of participants in this evaluation that the SRN “*got the dialogue going*”.
- 4.4 One of the main ways it did this was by collecting, distilling and sharing narrative accounts or personal stories from service users on what has helped them to recover. These accounts were then disseminated through a variety of formats (e.g., printed publications, postcards, website, podcasts, etc.) to service users, service providers, families, carers and the general public.
- 4.5 Awareness-raising has also involved activities such as:
- Organising conferences, workshops, road shows and other events around Scotland
 - Attending and speaking at non-SRN events
 - Producing and distributing publications and other resources and disseminating the findings of research
 - Developing and maintaining a website and mailing lists (postal and electronic).
- 4.6 Many of these tasks are largely administrative in nature, but as the SRN Director stated, this is “*a resource-intensive activity which can be easily forgotten in describing the work of the SRN*”.
- 4.7 Through these activities, the SRN has made contacts with people and invited them to “join” the Network. One of the SRN's partners suggested that the SRN adopted an ‘opt-in’ approach, rather than a targeted approach to Network membership. People have joined because of their interest in recovery and the SRN has concentrated much of its efforts on working with those individuals.

⁸ Gordon J, Cohen L, Cassidy J & Blamey A (2008) *Communicating the message of recovery: An independent evaluation of SRN communications*. Scottish Recovery Network. Available at: <http://www.scottishrecovery.net>.

- 4.8 At its most basic level, “joining” the Network involves simply being added to the SRN’s e-newsletter mailing list, which is distributed roughly every 1-2 months. However, beyond this, being a member of the Network has given service users and service providers access to a wide range of publications, resources, information and numerous opportunities through meetings and events to learn more about what recovery might mean to them.
- 4.9 Senior mental health managers from across Scotland reported that SRN publications and leaflets are often made available on wards and in community services to provide information to service users and their families. Resources developed by the SRN are also frequently given out to professionals attending recovery-related training.
- 4.10 The SRN acts as a conduit for information about recovery from around Scotland. For example, the “News” page of the SRN website includes information not only about SRN events and activities but also about other relevant local and national events.

Reach

- 4.11 We heard from a range of sources in this evaluation that *“the recovery message is being heard”* and *“the word ‘recovery’ is being heard and talked about”*. Many individuals gave much of the credit for this to the SRN.
- 4.12 Based on monitoring data gathered from the SRN, it would appear that the Network is reaching large numbers of people. For example:
- As of June 2010, there were 5,700 individuals on the SRN mailing list. It is not possible to identify how many of these are mental health professionals, service users or carers.
 - Over 35,000 copies of *Journeys of Recovery* (related to the Narrative Research project) have been distributed.
 - A total of 560 booking forms were received for the SRN’s annual conference in 2009. Delegates came from every NHS Board in Scotland except Shetland, and included CPNs, service managers, project managers, OTs, development workers, community workers, psychologists and advocacy workers. There was also a small number of attendees who described themselves as service users (n=10), carers (n=12) and volunteers (n=9). The figure for service users likely under-estimates the actual number of service users attending the event since many service users would not have identified themselves in this way when booking. Fifty-two delegates at the conference left the job title / designation field blank. If these 52 are added to the 10 above, this suggests that there may have been as many as 62 service users attending the conference (11% of all conference delegates). These figures do not include people who gave a job title when booking, but who may also have been (or may once have been) users of mental health services.
 - In addition to the annual conference and other events organised by SRN, staff keep a record of other events they attend to give presentations or host

workshops or information stalls. In 2008 there are records of SRN staff being at 58 events across Scotland attended by almost 3,000 people (mainly professionals, but a small number were for service users, general public or students / trainees). In 2009, there was a record of staff being at 40 events across Scotland attended by over 2,000 people. Most of the 2009 events were mixed events for professionals, service users and carers.

- In the six months from December 2009 to May 2010, the SRN website recorded a total of 19,729 visits, of which 12,328 (over 60%) were by unique visitors (i.e., non-repeat visitors) from 91 countries including the UK. The vast majority — over 16,500 — came from within the UK. (It is not possible to distinguish visits originating from Scotland from those in the rest of the UK.) On average, the SRN website receives about 3,000 visits per month.
- In the 18-month period between April 2008 and October 2009, the SRN distributed tens of thousands of publications or other resources. Analysis of requests from one health board area in the 18-month period showed 25% of names requesting materials were repeats (i.e., one individual requesting different, or additional, materials), which would suggest that the materials distributed by the SRN are seen as useful and credible.
- The SRN maintains a spreadsheet containing information about types of materials requested and who has requested them. An analysis of this spreadsheet for the 18-month period April 2008 to October 2009 indicated that requests for materials had come from all Health Board areas in Scotland with the exception of Orkney. In addition, requests had come from other parts of the UK and abroad, including Finland, Australia, Canada, New Zealand, Ireland, the Netherlands and the USA.

4.13 Further data related the SRN's reach is provided in Annex D.

4.14 During the period of this evaluation, the SRN had made a significant effort to raise awareness of recovery in remote / rural areas of Scotland. This was undertaken through a series of road shows — in Thurso, Oban and Stranraer. In total, around 200 individuals attended. Each of the roadshows was preceded by publicity in local newspapers and on the radio, which included the sharing of personal recovery stories in order to reach more than just those who attended the events. Each was followed up afterwards with SRN-arranged meetings to explore the possibility of developing local recovery networks or other recovery supporting activities in those areas.

Awareness-raising among the general public

4.15 Much of the SRN's awareness-raising activity has been directed at mental health professionals, service users and their families / carers. However, the SRN has also, to a lesser extent, sought to raise awareness among the general public through media campaigns and articles placed in national and local newspapers (e.g., a major media campaign to launch the findings of the

Narrative Research Project, articles in local newspapers preceding road show events, and an article in the *Guardian on-line* dated Thursday 10 June 2010⁹).

- 4.16 It was reported by the Director and the Strategy Group among others, that there has been an on-going question about whether and how much the SRN should be engaged directly in raising awareness of recovery among the general public. The SRN feels that there is a need for this and as will be seen below, this view is borne out by national research into public attitudes. However, public awareness-raising is a role which — it could be argued — should be undertaken by *see me* (the mental health anti-stigma campaign in Scotland).¹⁰
- 4.17 An important source of evidence in relation to the reach and effectiveness of SRN's awareness-raising activity is the national Scottish survey of attitudes to mental wellbeing and mental health problems. (The title of the survey is *Well? What do you think?*) This survey began in 2002, and was carried out every two years until 2008. The survey was designed to measure changes over time which might be expected as a result of initiatives undertaken by the former National Programme for Improving Mental Health and Wellbeing.
- 4.18 To inform work in the area of recovery and to measure progress, respondents to the 2004, 2006 and 2008 surveys who had experienced a mental health problem, were asked a series of questions about their own recovery. These findings will be discussed in Chapter 8, in relation to the SRN's influence on practice.
- 4.19 However, in terms of the general public: between 2006 and 2008, the *Well?* survey showed a slight *decrease* in the proportion of respondents within the **general population** who agreed with the statement: *'The majority of people with mental health problems recover'* (from 46% to 42%). In fact, between 2002 and 2008, the proportion of people agreeing with this statement fell from 50% to 42%.
- 4.20 It could be argued that the wording of this statement does not adequately assess awareness among the general public of "recovery", since the statement implies that recovery is only an end-state, rather than an on-going process. Nevertheless, given that there has not been a public campaign by *see me* on recovery, the fact that there has been a steady decline in the proportion of people who agree with the statement would suggest that the SRN's relatively small efforts to reach the public with the message of recovery have so far not been effective. This may highlight a need for a more substantial public awareness campaign specifically on the topic of recovery.

Other groups that have not yet been fully reached

- 4.21 There is also evidence from other sources, including from an evaluation of the SRN's communications, and interviews undertaken as part of this evaluation, to

⁹ See www.guardian.co.uk/commentisfree/2010/jun/10/broaden-discussion-mental-health-issues.

¹⁰ See <http://seemescotland.org.uk>.

suggest that there is still work to be done to reach certain groups with the message of recovery. For example:

- *Psychiatrists:* Some interviewees (including the representative of the Royal College of Psychiatrists (Scotland)), felt that there was still a need to do more to reach psychiatrists and other clinical staff (including psychologists) with the message of recovery. However, it should be noted that the SRN has sought to encourage dialogue with psychiatrists by attending and speaking at conferences organised by the Royal College of Psychiatrists in Scotland. In addition, a representative of the Royal College of Psychiatrists (Scotland) sits on the SRN Strategy Group.
- *General practitioners:* There was widespread acknowledgement that GPs have not engaged fully with the SRN. This view was also expressed by a representative of the Royal College of General Practitioners in Scotland. However, recently, the SRN has tried to address this by targeting material distribution to primary care services. It should be noted that engagement with GPs has also been reported as a difficulty in other evaluations of mental health interventions, including the evaluation of Applied Suicide Intervention Skills Training (ASIST)¹¹ and the evaluation of Choose Life.¹²
- *Service users:* While we found that many service users had clearly understood the notion of recovery and its implications for their own wellbeing, we also found that some were unfamiliar with the term recovery and what it means. Some reported that their initial response to the idea of recovery was to regard it with suspicion (believing that “*recovery was about taking away your benefits*”). The evaluation of SRN communications found that service users who did not consider themselves to be in recovery tended to be less receptive to messages of recovery.
- *General (non-mental health) nurses:* A number of interviewees in the evaluation remarked that mental health nurses from around Scotland have largely “embraced” recovery, but felt there was a need to raise awareness among general nurses working in hospitals and in primary care services.

Effectiveness

4.22 Policy officials largely agreed that the SRN had raised the profile of recovery in Scotland, but they also felt that there were still shades of opinion among service providers and service users about what recovery actually means — i.e., whether recovery is only an end-point or whether it is also a process / journey. At the same time, none of the interviewees were concerned about this, and both policy officials and representatives of the SRN’s partner agencies were all happy that the SRN had tried not to be too prescriptive about what it meant.

¹¹ Griesbach D, Russell P, Dolev R & Lardner C (2008) *The use and impact of Applied Suicide Intervention Skills Training (ASIST) in Scotland: A literature review and evaluation*. Scottish Government. Available at: <http://www.scotland.gov.uk/Publications/2008/05/21112543/0>.

¹² Russell P, Lardner C, Johnston L & Griesbach D (2010) *Evaluation of phase 2 of Choose Life strategy and action plan*. Scottish Government. Available at: <http://www.scotland.gov.uk/Publications/2010/03/30174735/0>.

- 4.23 One of the SRN's partners, in discussing the Network's awareness-raising activities, commented that, before the SRN: "*We weren't talking about recovery as much as we do now*". All interviewees felt that the SRN should be credited with making an enormous contribution to raising awareness of recovery in Scotland. But equally, they felt that it is not possible to attribute *all* of this to the SRN, since the recovery agenda has been promoted and embedded in a wider national policy agenda, only some of which has been directly influenced by the SRN.
- 4.24 At the time the evaluation of the SRN's communications was carried out in 2008, the evaluation found that the Network's large-scale distribution of resources had not translated into high levels of awareness of the SRN. There were greater levels of awareness among people who were members of the Network (i.e., on the SRN's electronic mailing list). However, even in this group, awareness of some of the Network's resources (publications, postcards, etc.) was only around 50%.
- 4.25 Some of the other findings from this evaluation were that:
- While the concept of recovery was understood to mean either a state of full recovery, or a journey or process, there was some confusion about which of these interpretations was intended. The researchers recommended that SRN should be clearer that *both* interpretations are intended.
 - When shown copies of the SRN's resources, service users felt they were optimistic and hopeful and that they validated their own experiences. Carers found the SRN resources informative and reassuring.
 - It was suggested at the time of the evaluation that some of the SRN's current resources may be viewed as less relevant to some individuals, in particular, for people with mild to moderate mental health problems, and (in some cases) for people who are at an early stage in their diagnosis.
- 4.26 It was suggested that the effectiveness of the SRN resources could be improved if they were specifically targeted to particular groups, and if they were accompanied by information or advice on the context, timing or nature of their use. Since the evaluation, the SRN has been addressing these recommendations.

Impact

- 4.27 The evaluation of the SRN's communications identified a number of impacts of the Network's awareness-raising and communications activity. In particular, many of the professionals involved in the evaluation said that the SRN had influenced and reinforced their knowledge and practice and that of the organisations they worked in.

5 OBJECTIVE 2: DEVELOP AN EVIDENCE BASE FOR RECOVERY IN SCOTLAND

- 5.1 This section examines the activities undertaken by the SRN in addressing its second objective — developing an evidence base for recovery in Scotland.
- 5.2 This information comes from: interviews with the Director, policy officials and the Network’s partners; the focus group with the SRN Strategy Group; an analysis of the SRN’s monitoring reports; and a review of SRN-related evaluation reports.

How the SRN has developed an evidence base for recovery

- 5.3 A major focus for the SRN in its early years was in relation to creating an evidence base to support recovery-oriented practice in Scotland. In the first instance, this involved looking to, and learning from what others had done (i.e., in the USA and New Zealand). WRAP and the ROPI (Recovery-Oriented Practices Index — the tool upon which the SRI was based) were both originally developed in the United States. The SRN brought both these tools to Scotland, adapted them for a Scottish context, and then evaluated their implementation.
- 5.4 At the same time, the SRN began to develop Scotland’s own evidence base for recovery, and it did this through what is referred to as the Narrative Research Project.
- 5.5 The Narrative Research Project, begun in 2005, involved gathering qualitative evidence (i.e., stories of personal experience) from 64 people with mental health problems across Scotland who had experience of recovery. The aim was to find out about and disseminate insights regarding the factors that helped and hindered recovery from a Scottish perspective. In 2007, SRN published the findings from this project in a report entitled, *Recovering Mental Health in Scotland*.¹³
- 5.6 SRN describes this research as the “cornerstone” of all its other initiatives. The findings from the study and SRN’s subsequent collection and sharing of further narratives have formed the basis for pamphlets, podcasts, awareness-raising materials and training materials developed by the Network.
- 5.7 Since the Narrative Research was published, the SRN has undertaken no in-house research, but has continued to support research and evaluation in a significant way. Two of the SRN’s major initiatives — the implementation of peer support worker schemes and of the Scottish Recovery Indicator, were rolled out initially as pilots in a small number health board areas and then evaluated to inform wider implementation across other areas of Scotland.

¹³ Brown W and Kandirikirira N. (2007) *Recovering mental health in Scotland. Report on narrative investigation of mental health recovery.* Scottish Recovery Network. Available from: www.scottishrecovery.net/Narrative-Research-Project/narrative-research-project.html.

- 5.8 Nearly all of the SRN's other major initiatives have also been evaluated (comprising eight evaluations in total, not including the current evaluation). The SRN commissioned four of these evaluations, and was involved in the other four either through a presence on the evaluation steering group, development of the research brief, assessment of tenders, or through part financial support.

Effectiveness and impact

- 5.9 The Narrative Research was widely cited by those who participated in this evaluation as one of the Network's biggest successes — in particular, by the SRN Strategy Group and representatives of the Network's partner agencies. One interviewee stated:

[The Narrative Research] gave a structured approach to people reporting their recovery. So instead of being dismissed as anecdotal, the cumulative effect was a powerful source of evidence. [Former member of the SRN strategy group]

The SRN started us thinking about recovery — their initial burst of research and information was what galvanised the staff. [Senior mental health service manager]

The SRN has captured the service user's perspective and made the whole recovery agenda a bit more real.... [Senior mental health service manager]

- 5.10 One of the SRN's purposes in undertaking and commissioning research has been to use that research to inform the development of other aspects of its work. Therefore, in assessing the effectiveness of this activity, it is necessary to ask, have the findings of this body of research informed the SRN's wider work?
- 5.11 There is good evidence from our documentary review to show that the SRN has given careful consideration to the findings of evaluation reports, and in many cases has followed up on recommendations. For example:
- Further development of the SRI has taken place following the initial pilot implementation. This has included redevelopment of the SRI web interface.
 - The SRN has undertaken work to develop peer support implementation guidelines following a recommendation made in the evaluation of the peer support pilot schemes.
 - In addition, the SRN has worked together with the Scottish Qualifications Authority to develop a recognised qualification for peer support worker training.
 - Following evaluation of the SRN's communications, further development was undertaken of the SRN website and a spreadsheet was created to record requests for printed resources (i.e., who has requested them, organisation type, how many, etc.). In addition, they are ensuring that narratives can be searched on-line via the website so that people can find experiences that are relevant to them. They also led a project and produced an associated publication on recovery and informal carers.

6 OBJECTIVE 3: BUILD CAPACITY IN COMMUNITIES

6.1 This section will explore how the SRN has addressed its third objective — to build capacity in communities. In particular, we will look at the SRN's activities in relation to:

- The support of Wellness Recovery Action Planning (WRAP)
- The development and support of peer worker schemes
- Supporting the development of local recovery networks.

6.2 We could also consider here the SRN's extensive work in developing training materials for professionals, since ultimately, the training of professionals should lead to an increased capacity for recovery within services. However, this activity will be discussed in the following section which looks at how the SRN has supported practice development.

Wellness Recovery Action Planning (WRAP)

6.3 WRAP is a 'self-management' tool, originally developed by Mary Ellen Copeland, founder of the Copeland Centre for Wellness and Recovery in the United States.¹⁴ WRAP provides a structured method (essentially, a self-held personal plan) intended to help people maintain wellness and to make advance plans for the eventuality of a crisis. WRAP was developed for use primarily by people with mental health problems, and is designed to help individuals take more control over their own wellbeing and recovery.

6.4 The process of developing a personal WRAP begins by attending WRAP training. WRAP training (that is, Level 1 training) is intended to be delivered in group sessions lasting (in total) between 12-15 hours. The training is carried out by qualified trainers, or Facilitators, who have attended a five-day course (Level 2 training) delivered by an Advanced Level Facilitator accredited by the Copeland Centre. Facilitators, themselves, are meant to be people with lived experience of mental health problems, and so they are assumed to be in a good position to be able to share with their groups their own personal experience of using the WRAP tool.

6.5 At the present time, there is currently only one Advanced Level Facilitator in Scotland, and the SRN has an agreement to work with this individual to deliver Level 2 training. The SRN has funded three deliveries of Level 2 training (that is, the 5-day Facilitator training course) so as to create a group of individuals in Scotland who are able to deliver Level 1 WRAP training to others. Finally, the SRN has also funded some delivery of Level 1 linked to later Facilitator training, although most Level 1 training has been organised and funded locally within local recovery networks or service user groups. There were some anecdotal reports of WRAP being delivered in a one-to-one situation in the context of a therapeutic intervention, but we found no independent evidence to corroborate this. We did, however, hear from some senior mental health managers that

¹⁴ See <http://copelandcenter.com/>.

service users in some areas are positively encouraged by their key workers or community psychiatric nurses to attend WRAP training, and that WRAP is included (or in the process of being included) in local Integrated Care Pathways (ICPs) in some areas. The latter was specifically mentioned in Dumfries & Galloway and Highland.¹⁵

- 6.6 According to monitoring reports submitted to the Scottish Government and the Strategy group in 2010, the SRN is currently working to develop a quality assurance scheme for WRAP facilitators as part of a wider strategic review. In the meantime, the SRN maintains contact with WRAP facilitators and provides them with on-going support through the organisation of regular “Facilitator Network” days.
- 6.7 It is perhaps worth noting that, according to the Director of the SRN, one of the main motivations in bringing WRAP to Scotland was to create more of a balance in the SRN’s activities — many of which were targeted at services and mental health professionals. *“There was a feeling that service providers should not be the sole message-carriers about recovery.”* WRAP gives service users something tangible and practical, which they can use to support and take control of their own recovery.

Reach

- 6.8 As of July 2010, the SRN had funded training for 42 WRAP facilitators in Scotland. In addition, other agencies from around Scotland have separately funded facilitator training for another (approximately) 30 individuals. The facilitators whose training the SRN funded came from eight of the 14 health board areas in Scotland, although the majority were based in Lothian (n=11), Greater Glasgow and Clyde (n=11) and Tayside (n=8).
- 6.9 As mentioned above, there is currently only one Advanced Level Facilitator in Scotland. This was identified by the SRN Director as a potential threat to the future sustainability of WRAP. A few senior managers also mentioned that there were capacity problems in relation to Level 1 training — i.e., not enough local facilitators to meet demand.
- 6.10 In our telephone interviews with senior mental health managers, only two managers (both from the same local authority area) did not know whether WRAP training was being delivered locally — which possibly suggests that it is not. However, all the other senior managers who took part (representing 10 local authority areas) said that WRAP was delivered widely to service users in their areas. WRAP was also being delivered in three of our four case study areas, and there were plans to pilot it in the fourth area where there was reported to be a great deal of interest in the tool. In one case study area, service users in the local recovery network had customised WRAP so as to make the language and images more relevant to people living in the area.

¹⁵ The SRN perspective on these developments is that they are not necessarily positive. The SRN would argue that WRAP should not become prescriptive, or part of a “programme” delivered by services, but rather it should be available outside of services through community and peer groups.

Effectiveness and impact

- 6.11 In our focus group with the SRN Strategy Group, WRAP was identified as one of the Network's biggest successes.
- 6.12 The SRN has commissioned two evaluations of WRAP. The most recent of these sought to assess the relevance, impact and effectiveness of WRAP for individuals attending pre-existing groups, where the possibilities for continued mutual support in the development of WRAPs could be explored.¹⁶
- 6.13 The evaluation found that WRAP was effective in increasing hope, expectations and self-direction for recovery among people with mental health problems. Individuals identified a number of benefits from taking part in WRAP groups. These included being able to identify new strategies for self-management and dealing with difficult situations, being able to identify "triggers" (which lead to negative feelings / behaviour), self-monitoring and taking active steps towards wellness. WRAP was also found to be useful in facilitating communication with family members and professionals particularly in relation to what the individual would like to happen if they become unwell.
- 6.14 There is also some evidence from this evaluation that both facilitators and participants had more positive views of their own recovery and wellbeing following WRAP training (and in the facilitators' case, having trained others). Some of the impacts reported by participants included: feeling they could take ownership over their wellbeing and being able to talk about their experiences for the first time.
- 6.15 The SRN also commissioned an evaluation which looked at the use of WRAP among a group of black and minority ethnic women. One of the main aims of this evaluation was to comment on the cultural relevance and appropriateness of WRAP for this population.¹⁷ This evaluation found that the women valued the training, particularly the opportunities to talk with other participants. However, the evaluation highlighted some areas that might require some consideration in future delivery to South Asian women, e.g., the stigma around mental health problems in the South Asian communities and the cultural appropriateness of key WRAP concepts such as self-advocacy and assertiveness.

Peer support worker schemes

- 6.16 As with WRAP, the concept of peer support was borrowed from the United States and other countries. According to the Director of the SRN, there were several reasons for developing a peer support scheme in Scotland:
- It provides a good example of recovery-focused work — peer workers are able to help model recovery to others, reminding people that it happens.

¹⁶ Scottish Centre for Social Research and Pratt R (2010) *Wellness planning in self-help and mutual support groups*. Final report. Scottish Recovery Network.

¹⁷ Gordon J and Cassidy J (2009) *Wellness Recovery Action Plan (WRAP) training for BME women: An evaluation of process, cultural appropriateness and effectiveness*. Scottish Recovery Network.

- There is a high level of unemployment among people with long-term mental health problems. Employment as a peer worker can enable people to make a positive contribution in an area that they are experts in.
 - Peer support is a way of delivering user-involved services.
 - Peer support schemes can encourage service providers to value people's lived experience of mental health problems.
- 6.17 In 2005, the SRN held a conference to raise awareness of peer support schemes that operate in the United States and to introduce the concept as a possible means of promoting recovery in Scotland. Scotland's first peer support service, Plan2Change (a partnership between Penumbra and NHS Lothian with support from the SRN at the design and development stage), was established in Edinburgh shortly afterwards.¹⁸ This service was evaluated in 2007-08.¹⁹
- 6.18 At the same time, in *Delivering for Mental Health* (2006), the (then) Scottish Executive made a commitment (Commitment 2) to provide a training programme for peer support workers, and to have peer support workers employed in three NHS boards by 2008. By January 2008, pilot peer support schemes were established in five NHS Board areas (Lothian, Grampian, Forth Valley, Greater Glasgow and Tayside), with 15 peer worker posts spread across six different services. These pilots were evaluated in 2009.²⁰
- 6.19 The SRN had no significant involvement in the implementation of the pilots. However, the Network supported the pilot sites by convening meetings for the groups involved in: (a) developing the pilot schemes and (b) training graduates and peer workers. These groups have since been amalgamated and continue to meet to offer networking and learning opportunities.
- 6.20 Following the evaluation of the pilots in 2009, the SRN has subsequently taken on a greater role in helping to create a structure to support further roll-out of peer support schemes in Scotland. For example, training for peer support workers in Scotland has so far been delivered by a US-based agency, Recovery Innovations. However, to engender the sustainability of peer support schemes in the longer term, the SRN has been working together with the Scottish Qualifications Authority (SQA) to create a new nationally recognised award for peer support worker training. Learning materials for this training are also being developed. The SRN is also developing guidance for organisations that are considering employing peer workers, and the Network offers support to

¹⁸ Bradstreet S & Pratt R (2010) Developing peer support worker roles: Reflecting on experiences in Scotland. *Mental Health and Social Inclusion*, 14(3), August 2010.

¹⁹ McLean J, Schinkel M & Stevenson R (2008) Plan2Change: Evaluation final report. Available at: www.penumbra.org.uk/craigmillarpeersupport.htm.

²⁰ McLean J, Biggs H, Whitehead I, Pratt R & Maxwell M (2009) Evaluation of the Delivering for Mental Health Peer Support Worker pilot scheme. Scottish Government. Available at: <http://www.scotland.gov.uk/Publications/2009/11/13112054/28>.

peer workers themselves through regular meetings, access to an on-line forum and telephone support.

Reach

- 6.21 The SRN does not hold complete information about the number of peer workers employed in Scotland since the actual employment of peer workers is undertaken by individual agencies at a local level. As of September 2010, the SRN's best estimate of the number of peer workers in paid roles was around 25. In addition, there are also volunteer peer workers in some areas. However, our interviews with senior managers and findings from our case studies would suggest that peer worker schemes are still not common.
- 6.22 Two of our case study areas participated in the national peer worker scheme pilot. In one of these areas, there are now three peer support projects. However, in the other, peer workers are no longer employed, albeit there was a suggestion that this may change in the future.
- 6.23 In our interviews with senior mental health managers, we asked whether services in their areas were employing, or had considered employing peer workers. Only three managers, two of whom were from the same area, said that peer workers were currently employed in their local services: in this area, a local voluntary sector mental health service was employing the worker and this individual was working alongside the NHS in-patient and community teams. A third manager said their area had taken part in the national peer worker pilot, but that there were no peer workers employed in the area at present.
- 6.24 More than half of the remaining managers said they had considered employing peer workers, and some indicated that extensive discussions (involving staff from the SRN) had taken place locally in relation to this. One manager said that as part of a major redesign of their local mental health services, they were considering employing peer workers in the future.

Effectiveness and impact

- 6.25 As mentioned above, an evaluation of the national peer support worker pilots was published in 2009 (McLean *et al*, 2009). The evaluation found that peer support schemes were able to be implemented in a variety of service settings. However, there were some challenges in implementing the role within the NHS, and it seemed that not all of the NHS sites were well-prepared for incorporating the peer worker role into their teams. One of difficulties was that there was inconsistent job grading and salaries between different areas, despite similar job descriptions.
- 6.26 The evaluation made a large number of recommendations covering a wide range of issues, including training and employment arrangements for peer workers. Chief among these was that peer worker schemes should be used to *enhance*, not *introduce* recovery-focused practice into services.
- 6.27 The evaluation reported that the peer worker scheme had impacts on service users, service providers and the peer workers themselves:

- Among service users, some felt frustrated and even angered by the approach taken by the peer support worker; they wanted the worker to *do* things for them (i.e., make phone calls, etc.), whereas the worker wanted to encourage service users to take responsibility for their own affairs. However, others felt the service had given them hope for their own recovery and aspirations for the future.
- Among service providers, peer workers were seen to make a positive contribution to services by modelling recovery and it was suggested by staff that the peer worker role challenged the ‘them’ and ‘us’ culture that can exist in services. However, there were also some structural barriers to making the role work — i.e., not having a clear definition of the role of the peer worker which led to difficulties in grading posts; some resistance from staff, particularly in cases where the peer worker had him / herself received services from the organisation they were now working in, or where other staff were on the same employment banding as the peer support worker.
- Among the peer support workers, some had to overcome a number of challenges in the role (i.e., in some cases having to adjust to employment after years of not working; developing the role from scratch; learning about their working environment). However, the peer workers felt that being able to overcome these challenges gave them an increased confidence which enhanced their own recovery.

6.28 The SRN was not substantially involved in the implementation of the national peer worker pilots, beyond hosting networking opportunities, but it has subsequently been very involved in taking forward action to address the recommendations of the evaluation, through the development of a training programme and on-going support for peer workers and guidance for potential employers.

Local recovery networks

6.29 SRN has supported the development of local recovery networks as a way of encouraging the sustainability of recovery at a local level.

6.30 Local recovery networks are described on the SRN website as *“a neutral place for people with mental health problems, carers and families, and service providers to come together to discuss the concept of recovery, ways to promote it and how make it real for people in their community”*.

6.31 Until recently, SRN’s approach to encouraging the development of local recovery networks has been largely responsive — i.e., providing advice, information and guidance where requested, and occasionally collaborating on or part-funding specific projects. They have also produced a series of leaflets that provide guidance on setting up and sustaining local networks. However, in April 2010, the SRN appointed a Network Officer partly to add capacity for the development of local recovery networks.

6.32 Our evaluation sought to gather information about the perceived impact of local recovery networks by conducting four case studies. In particular, we wanted to see whether the presence or absence of a local recovery network made a

difference to people's knowledge / awareness of recovery and in whether and how local services had adopted recovery-oriented practices.

- 6.33 Case studies were undertaken in two areas that had relatively long-established local recovery networks, one area that was in the process of setting up a network and one area that did not have a network.

Reach

- 6.34 As of August 2010, there were three well-established and active local recovery networks — in Lothian, Lanarkshire and Ayrshire & Arran. There were also local networks in Highland and Renfrewshire, but these were reported to be less active. A previously active network in Tayside had gone into abeyance, and two new networks were in the process of being established — in the Borders and Dumfries & Galloway — with support from an SRN Network Officer.
- 6.35 Following a road-show in Thurso in Spring 2010, there was some discussion about setting up a local recovery network in that area (separate from the existing network in Highland), but ultimately a decision was made locally not to do so.
- 6.36 We also learned in our non-network case study area that there had been considerable discussion and a meeting with the SRN about setting one up there, but that discussions had faltered. This was partly because of a perception that the network would require additional resources (both funding and time) which were not available.

Summary information on case study areas

- 6.37 The key findings from the three network area case studies are attached as Annex E, and an analysis of the data collected in the case studies is presented below. Table 6.1 sets out some of the features of the three network areas.

Table 6.1: Key features of the three local recovery networks

	Network area 1	Network area 2	Network area 3 (newly established)
Date of launch	2005	2008	2010
Source of funding	NHS Board	Joint funding from local councils and NHS Board	In-kind support only (part-time admin support)
Hosted by/auspice body	NHS Board	Voluntary sector agency	No hosting arrangements at present – user led
Number of members	300	15 member organisations 600 people receive e-bulletin, 150-200 attend events	N.A. – network to be formally launched in November 2010.

- 6.38 There were common themes across the two areas where there were established recovery networks (Network areas 1 and 2). In both areas, the networks comprised a large membership of professionals, service users and carers. Both areas had also received funding and support from statutory

services. In one area, the network was chaired by a senior manager from the local NHS Board and the board also provided paid administrative support. In the other, the network received funding from two local councils and the NHS Board to help with materials and publicity. In this area, the network was hosted by a local service user- and carer-led organisation that aims to influence planning and delivery of mental health services.

- 6.39 In both areas, there was a strong ethos of engendering recovery values within services and across agencies to underpin practice and a commitment to the participation of people with lived experience, for example, in the delivery of values-based recovery training.
- 6.40 The main areas of activity undertaken by these two networks included training, communication, building a local evidence base, promoting the use of tools such as the SRI and WRAP, building partnerships and sharing stories of recovery.
- 6.41 In the new network area (Network area 3) the process of setting up a local network had taken some time and there had been various difficulties. However, in the last year, with support and a small amount of funding from the SRN, there had been a meeting at which agreement was reached to set up a network.
- 6.42 Currently the group is small and predominantly made up of service users. There is an interim management committee and the official launch of the network was planned for the end of 2010. In addition to the SRN support, the network has had support from a clinical psychologist and administrative staff time. This has been channelled via a joint NHS and council multi-agency group. However the group has received no funding from local statutory agencies.
- 6.43 In the non-network area (Case study 4), it was reported that, although there was agreement (from some individuals, at least) that a local recovery network would be a good thing, there was no agreement on how this would be taken forward and by whom. Some service users suggested that the recovery network did not get off the ground because of lack of money and others thought there was a lack of interest by those in senior positions. However, one senior manager who had been involved in discussions about setting up a network, said that there was a feeling that it would not add significantly to what was already taking place in the area and might result in busy people being further stretched by having more meetings to attend.

Effectiveness

- 6.44 There is evidence from the two network areas that the local recovery networks have achieved changes in attitudes, values and practice. Some of the changes include: better terminology used, for example, in care plans; more “ownership” of recovery; and a more person-centred approach by services.
- 6.45 Participants in both areas were positive about progress but identified that there were still challenges. For example, it was felt that certain professionals are still not receptive to recovery and rarely attend the training. In addition, there was a view that there was still a need to raise awareness of recovery.

- 6.46 In the new network area, while there has been progress, some challenges remain. This is a predominantly rural area and there are accessibility and transport issues which hinder attendance at meetings. Venues are also difficult to find. Perhaps more fundamentally, it was suggested by one participant that building a recovery network requires considerable energy and there may not be sufficient capacity for this in rural areas. This raised the question of whether a network is the best model for a rural area.
- 6.47 In the non-network area, a senior mental health professional had been seconded on a two-year contract to raise awareness, deliver training, and undertake other activities to generally promote recovery and ensure it was embedded into practice. In this area, it was also reported (by professionals) that there were already very good mechanisms for service users to provide input into the on-going development of mental health services.

Impact

- 6.48 In both established network areas, participants agreed that the attitudes of both professionals and service users have changed. There was belief that recovery is possible. One of the key factors for professionals has been the participation of people with lived experience in the delivery of training and in the sharing of their stories.
- 6.49 Service users felt that they had been given opportunities to have their voices heard and that they were more accepted and empowered. In both areas examples were given of service users developing new skills and confidence through taking part in training, conferences and other activities. Some have found employment or become volunteers, moving on from feeling isolated, lonely and despairing.
- 6.50 One of the main benefits for service users was that, it was no longer assumed that, *“You have to take medication and that’s it”*. Or that you are *“cursed with this for the rest of my life”*. As one service user said, people *“feel there is light at the end of the tunnel”*.
- 6.51 In the new network area, service users said they felt more empowered as a result of their discussions about recovery and the positive psychology sessions provided by the clinical psychologist.
- 6.52 In the non-network area, the service users were not familiar with the term “recovery” (although two were familiar with WRAP), but service providers were clear that they were supporting it. Service users said they *were* being given hopeful messages, but the term recovery was not generally used. Although the evidence from this area suggests that services were recovery-oriented, it appeared that people did not have a shared understanding of what was happening locally.

Role and influence of SRN

- 6.53 SRN responded to approaches from the two established network areas and worked with them to formulate their ideas about recovery and how to take forward a network. Both areas viewed SRN as very supportive and thought

SRN's work on raising awareness and the publication of the narrative research had helped the local efforts to promote recovery. They saw SRN as an exemplar and a "pump primer" for local work. The local networks "translated" the work of SRN to fit within the local context. In addition, SRN have sometimes contributed resources and collaborated with local networks. They have also contributed staff time and more recently new posts have enabled them to give support on SRI, peer support and gathering stories.

- 6.54 It was interesting that among service users who participated in the case studies, some recognised the role that SRN had played at national level in promoting understanding and belief in recovery and in developing and disseminating research and practice tools.
- 6.55 In the new network area, although progress had been slow, the SRN was seen to have been supportive, particularly in the last 12 months when the Network Officer has played an important role. The SRN has helped to promote understanding of recovery; they have funded travel and venue expenses and a publication. They were seen to be very skilful, supportive and enabling. They have helped to link this area with other networks. The SRN website and publications are also highly regarded.

Learning from case studies

- 6.56 In the well-established network areas, there were some common factors that had helped their success. These were:
- Funding
 - Having a mix of professionals and service users on steering groups
 - Support from strategic managers in Councils and / or the NHS
 - An established organisation to provide hosting or an 'auspice body'
 - Good partnership working with national and local organisations
 - Offering tangible ways to make recovery work – for example, training and WRAP (locally adapted)
 - Good communication and disseminating information and evidence
 - Help from SRN (with tools, training etc)
 - Focusing what they do on meeting local need.
- 6.57 In the new network area, we found that it had struggled because of the rural nature of the area, the lack of a common understanding about recovery and a lack of funding. However, the support from the SRN had helped it to focus efforts on getting a network established.

7 OBJECTIVE 4: SUPPORT PRACTICE DEVELOPMENT

7.1 The SRN's final objective is to support practice development within mental health services. It has done this primarily through the development and wide-scale roll-out of the Scottish Recovery Indicator (SRI) and training materials for mental health professionals.

Scottish Recovery Indicator

- 7.2 The SRI is described on the SRN website as "a mental health service development tool." It is a tool that is intended to help organisations evaluate, for themselves, whether and how they have adopted recovery-oriented practices. It is based on the Recovery Oriented Practices Index (ROPI), which was developed in the United States, and adapted for use in Scotland as a result of a need identified in *Rights, Relationships and Recovery*, and the subsequent commitment made by the (then) Scottish Executive in *Delivering for Mental Health* (Commitment 1).²¹ This commitment was reiterated and extended in *Towards a Mentally Flourishing Scotland* (Commitment 22) which states that the tool should be in use by the majority of mental health services by 2010.
- 7.3 The use of the SRI involves an assessment of 19 indicators which are focused around factors known to promote recovery.²² The assessment involves interviews with staff and service users and an analysis of client case files. SRI documentation recommends that the tool be applied to 10 cases. The main output from administering the tool is an action plan focused on areas where change may be needed to make the service more recovery-focused. The SRN has promoted the SRI as a tool which enables services to reflect on their practice, rather than as an audit tool.
- 7.4 The SRN has developed a web-based interface to the SRI, and through this is able to monitor the use of the tool. The Network has also developed guidance on using the tool and has delivered an extensive programme of workshops to promote the SRI to local services and to deliver training in its use.
- 7.5 The SRI was piloted in five health board areas between September 2007 and April 2008, and the pilots were evaluated.²³ The SRI was subsequently revised in light of the findings of the evaluation, and the SRN is currently working with NHS Education for Scotland to develop regional learning networks and new research to assess the impact of the tool.

Reach

7.6 According to a report to the SRN's strategy group, as of June 2010, there were more than 850 registered users of the SRI. A report to the Scottish

²¹ Scottish Executive (2006) *Delivering for Mental Health*. Available at: <http://www.scotland.gov.uk/Publications/2006/11/30164829/16>.

²² Details of the indicators are available at: www.scottishrecoveryindicator.net/the-parts/the-indicators.

²³ McLean J & Whitehead I (2008) *Evaluation of the Scottish Recovery Indicator Pilot in five health board areas*. Scottish Government. Available at: www.scotland.gov.uk/Publications/2008/10/23104029/10.

Government for the period September 2009 – April 2010 states that there were registered users in every health board in Scotland. In this same six month period, 16 workshops were delivered to 391 participants.

Effectiveness and impact

7.7 The evaluation of the pilot implementation of the SRI found that:

- The SRI had good potential for influencing service culture and service change towards more of a recovery orientation. Furthermore, service providers felt that the level of detail in the tool made it possible to identify good practice and areas for improvement.
- However, during the period of the evaluation, none of the pilot areas had produced a formal action plan for change.
- Some barriers to greater effectiveness of the tool were seen to be that it was quite time-consuming to complete, and that there had been a general lack of involvement and support for the SRI process from psychiatrists in the pilot areas.
- A series of recommendations were made in relation to further development and roll-out of the SRI. Most of these recommendations had the aim of improving the process of administering the SRI, preparing staff in advance of the process and planning for action following administration of the SRI.

7.8 The administration of the tool was reported to have had some positive impacts in each of the pilot sites. These included:

- The development of strengths-based care documentation and procedures
- Finding ways for service users to have greater input to service development
- Addressing the issue of employment for people with mental health needs
- A greater enthusiasm and passion for recovery within teams.

7.9 The administration of the tool was also reported to have created a sense among service users that *they* were at the centre of a service change process — that is, services were changing to help them move forward in their recovery.

Developing learning materials for professionals

7.10 The SRN, together with NHS Education for Scotland (NES), has played a major role in developing a national framework for training in recovery-based practice.

7.11 There are two parts to this activity. The first involved the development of the *Realising Recovery* learning materials for NHS mental health nurses. The *Realising Recovery* materials are intended to build on a set of learning materials previously developed by NES called the *10 Essential Shared Capabilities* (or *10 ESCs*). The second part of this activity involved the development of a two-day training session for workers in the voluntary sector, called *Recovery in Practice*. Both these activities are described here.

10 ESCs and Realising Recovery Learning materials

7.12 In 2007, NHS Education for Scotland (NES) developed the *10 Essential Shared Capabilities for Mental Health Practice learning materials (Scotland)*.²⁴ The materials were based on an existing resource originally developed in England, which NES adapted for a Scottish context following consultation with service users, carers and mental health workers. The *10 ESCs* are described by NES as the foundation upon which good mental health practice is based.

10 Essential Shared Capabilities

- | | |
|---------------------------|--|
| 1. Working in partnership | 6. Identifying people's needs and strengths |
| 2. Respecting diversity | 7. Providing service user centred care |
| 3. Practising ethically | 8. Making a difference |
| 4. Challenging inequality | 9. Promoting safety and positive risk taking |
| 5. Promoting recovery | 10. Personal development |

7.13 The *Realising Recovery* learning materials were developed by NES working together with the SRN. The *Realising Recovery* materials build on the *10 ESCs* learning materials and address in more detail ESC 5 — Promoting Recovery. The materials contain six modules, and incorporate findings and extensive material from the SRN's Narrative Research project. Moreover, the Director of the SRN was a member of the editorial group, and was involved in writing one of the modules — so the SRN was directly involved in the development of these learning materials.

7.14 The aim of the *Realising Recovery* learning materials is:

- To enable mental health professionals to make changes in their practice
- To support change by presenting key topic areas in relation to recovery and practical guidance to help workers develop new roles, relationships and ways of working with service users and wider communities.

7.15 Because the *Realising Recovery* materials build on the *10 ESCs* materials, their use is intended to follow *10 ESCs* training. Both the *10 ESCs* learning materials and the *Realising Recovery* learning materials have been disseminated widely by NES to NHS staff (mainly mental health nurses) through a phased training programme. This has involved training individuals in each NHS Board to deliver the training at a local level.

7.16 Between February 2008 – January 2010, a national longitudinal evaluation, commissioned by NES, was undertaken of the impact of these resources.²⁵

²⁴ See <http://www.nes.scot.nhs.uk/initiatives/mental-health/publications>.

²⁵ Macduff C, Gass J, Laing A, Williams H, Coull M, Addo M & Mackay R (2010) *An evaluation of the impact of the dissemination of educational resources to support values-based and recovery-focused mental health practice*. NHS Education for Scotland (NES). Executive summary available at: <http://www.nes.scot.nhs.uk/media/688260/executive%20summary%20%28mar%2010%29.pdf>.

Reach

7.17 The evaluation found that:

- Sixty-eight individuals (most from a nursing background) were trained as trainers. Attrition of trainers was low during the period of the evaluation.
- By the end of 2009, nearly all NHS Boards had taken forward *10 ESCs* training, but only a few had taken forward *Realising Recovery* training. It was suggested that this may be because of the different status and priority seen to be given to the two forms of training in national policy documents.
- However, across Scotland, less than a quarter of the MH nursing staff (about 2,000 people) had received *10 ESCs* training by autumn 2009.

Effectiveness and impact

7.18 In relation to the effectiveness and impact of the training:

- The training was found to have raised awareness among mental health workers of a range of issues relating to values in mental health practice. Some individuals reported that the training helped them to recognise where there was a need to develop / change aspects of their practice.
- The majority of trainees reported that the training had a positive impact on their individual practice, for example, through improvements in service user involvement; care planning based on users' own perceived needs and strengths; and development of positive risk-taking.
- For some people, the impact of the training was to reaffirm a perception that their practice already incorporated recovery-oriented values. However, these types of positive self-assessment were sometimes questioned by other survey respondents (and by some trainers and service managers).

Recovery in Practice training

7.19 In addition to these training materials, SRN commissioned two voluntary sector agencies (Health in Mind and Penumbra) to develop and deliver a two-day training programme called *Recovery in Practice* for people working in the voluntary sector.

7.20 This was intended as a small pilot, and therefore the question of 'reach' was not relevant to this particular training. An independent evaluation was commissioned to assess the effectiveness of the training.²⁶ This found that the training strengthened recovery values and beliefs in many of its participants. In addition, there was evidence to suggest that in its current form the training was more appropriate to those working directly with people with mental health problems, rather than service managers.

²⁶ Gordon J (2010) *Evaluation of Recovery in Practice training*. Scottish Recovery Network. Available at: www.scottishrecovery.net/Latest-News/evaluating-recovery-in-practice-training.html.

8 INFLUENCE ON POLICY AND PRACTICE

- 8.1 The previous four chapters have examined the SRN's various initiatives, their reach, effectiveness and impact. These initiatives have largely been targeted at secondary mental health services and service users. However, at the same time, the SRN has worked closely with policy makers at a national level to take forward the recovery agenda in Scotland.
- 8.2 In this chapter we set out our findings on: (a) the influence of the SRN on national policy and (b) on engendering recovery values and practices in Scotland — and how has this been achieved.
- 8.3 Our evidence comes from a review of policy documents and a review of the SRN's reports to the Scottish Government; interviews / focus groups with the Network Director, his team and the SRN strategy group; local network case studies; and interviews with strategic partners and national policy leads.

Influence on national mental health policy

- 8.4 The SRN was established in the context of a new mental health and wellbeing policy which, for the first time, highlighted recovery as a priority in Scotland. The National Programme for Improving Mental Health and Wellbeing was launched in October 2001, and the SRN was launched just over three years later in December 2004. Subsequent policy development in this area has been rapid, and recovery has had, and continues to have, a prominent role.
- 8.5 Recent policy documents have reinforced the value and importance of recovery and made commitments to support implementation.^{27, 28, 29, 30} Since the Director of the SRN was involved in developing all of these documents, some interviewees cited this as evidence of SRN's influence on national policy. Others saw it more as a reflection of the SRN's central role in implementing policy commitments, although these individuals also acknowledged the importance of SRN's profile within the Scottish Government.
- 8.6 Members of the SRN Strategy Group described the current political and policy climate in Scotland as one of the factors that has enabled the SRN to pursue and achieve its objectives. One of SRN's partners echoed this view: "*The National Programme provided an environment in which SRN could flourish.*"

²⁷ Scottish Executive (2006) *Rights, Relationships and Recovery: The Report of the National Review of Mental Health Nursing in Scotland: Delivery Action Plan*. Available at: <http://www.scotland.gov.uk/Publications/2006/04/18164814/0>.

²⁸ Scottish Executive (2006) *Delivering for Mental Health*. Available at: <http://www.scotland.gov.uk/Publications/2006/11/30164829/4>.

²⁹ Scottish Government (2009). *Towards a mentally flourishing Scotland. Policy and action plan 2009-2011*. Available at: www.scotland.gov.uk/Publications/2009/05/06154655/5.

³⁰ Scottish Government (2010). *Rights, relationships and recovery: refreshed. The report of the national review of mental health nursing in Scotland. Action Plan for 2010-2011*. Available at: www.scotland.gov.uk/Topics/Health/health/mental-health/RRRmentalhealth/rrractionplan.

- 8.7 Indeed, in considering the influence of the SRN on national policy, it is important to reflect, as some interviewees did, on the context in which they were operating. The National Programme had included recovery as one of its main strands. This was the result of an interest in recovery in Scotland arising from work being done in other parts of the UK and internationally. The recovery approach has been embraced by many professionals and mental health organisations.
- 8.8 Many of the participants in this evaluation felt that it was difficult to assess the influence of SRN in light of this more general interest and activity, in particular to disentangle sources of influence and to assess the level of progress that could be considered to be directly attributable to SRN. Nevertheless, the continued focus on recovery and on pieces of work being led by the SRN clearly show that there has been a positive working relationship between the SRN and the Scottish Government.
- 8.9 When asked *how* the SRN had influenced policy, interviewees (policy officers, the SRN's partners and other stakeholders) felt it had done so through:
- Stimulating and sustaining a dialogue and debate about recovery and what it means for individuals, and by engaging with stakeholders at all levels (policymakers, professional bodies, practitioners and service users). This “inclusive” approach was felt to be the key characteristic of the SRN.
 - Having responded efficiently and effectively in delivering policy commitments (particularly around the SRI, peer support, values-based training, and WRAP).
 - By getting the voices of service users heard and taken into account in policy development (for example, through the Narrative Research project).
- 8.10 Overall, the evidence suggests that the SRN has influenced the continuing focus on recovery in mental health policy. It has achieved this through the strength of its own work, but has also been helped by a good working relationship with Scottish Government and a supportive policy environment.
- 8.11 At the same time, there was evidence to show that the SRN has also been influential in other areas of policy — in particular in the substance misuse field. The work of the SRN, and the perceived “*great success*” of the recovery movement in mental health were specifically cited as one of the influences leading to the promotion of a recovery approach in the *Road to Recovery* (2008)³¹ and the creation of the Scottish Drugs Recovery Consortium. The document, *Mental health in Scotland: Closing the gaps — making a difference* (December 2007) also highlights the role of recovery in the care and support for people with co-occurring substance misuse and mental health problems.³²

³¹ Scottish Government (2008) *The road to recovery. A new approach to tackling Scotland's drug problem*. Available at: <http://www.scotland.gov.uk/Publications/2008/05/22161610/0>.

³² Scottish Government (2007) *Mental health in Scotland. Closing the gaps, making a difference*. Available at: <http://www.scotland.gov.uk/Publications/2007/12/10141643/18>.

- 8.12 Some interviewees suggested that the SRN had also had an influence on policy developments related to other aspects of health, such as chronic illnesses like diabetes. Furthermore, the policy document, *Mental health in Scotland: Improving the physical health and wellbeing of those experiencing mental illness* does not specifically mention the SRN, but one (policy) interviewee considered that this document had been informed by the concept of recovery.³³
- 8.13 Some interviewees commented that the SRN were proactive in looking at new policy developments to ensure that recovery was included where appropriate.

Influence on practice

- 8.14 In addition to examining the extent to which the SRN has influenced mental health (and wider) policy in Scotland, we also sought to assess the extent to which the SRN has had an influence on engendering recovery values in mental health practice in Scotland.
- 8.15 As noted above in relation to influence on policy, some of the changes that have been observed by interviewees may be the product of a general increase in interest in recovery. Most interviewees, however, believed that SRN has played a significant part in effecting change by creating a Network where ideas and information can be developed and exchanged, and by developing an evidence base, training materials, resources and practice tools. One interviewee commented that the SRN has helped with thinking about culture, attitudes, values and behaviour of staff and with practice developments in nursing and social care. As another individual said: *“Recovery is becoming part of practitioners’ vocabulary.”*
- 8.16 Senior managers were asked whether (in the last 2-3 years) the notion of recovery had led to any changes in the approach their services take to supporting people with mental health problems. The majority said that substantial or fundamental changes had taken place in their services during that period. More specifically, managers pointed to:
- A more collaborative way of working with clients
 - More of a focus on strengths, rather than deficits
 - Better integration between hospital and community services, and between NHS and voluntary sector services
 - Services that are more responsive to clients’ needs
 - An emphasis on encouraging people to be independent and take responsibility for their own recovery.
- 8.17 The senior managers who were interviewed in this evaluation indicated that recovery is a main focus of mental health services in their areas. Many gave examples of how their services had adopted recovery-oriented practices, and spoke about changes in thinking among staff. One senior manager said that the local hospital mental health day service had even changed their name to

³³ Scottish Government (2008) *Mental health in Scotland. Improving the physical health and wellbeing of those experiencing mental illness*. Available at: <http://www.scotland.gov.uk/Publications/2008/11/28152218/0>.

“The Recovery Centre”, which they felt better reflected what the service was about.

- 8.18 Senior managers also indicated that the SRN’s publications and resources were being widely disseminated in their services, and SRN interventions (WRAP, the SRI and peer support schemes) appeared to have been adopted by many services.

Areas of greatest influence

8.19 Areas where the SRN was seen to have had the greatest influence were in:

- **Mental health nursing:** The SRN was seen to have had a strong influence on *Rights, Relationships and Recovery*. SRN has also had a significant influence on practice through working with NES to develop the *Realising Recovery* learning materials which are being used extensively in training mental health nurses, and through the roll-out of the SRI.
- **Social work:** One senior social work manager felt that the SRN was having a “*transformational effect on health and social care*”. Another senior manager, representing the Association of Directors of Social Work, also considered that SRN was having an effect on practice on the ground, particularly through the development of tools that translated the values of recovery into a “*workable and sensible form*”. Some interviewees identified a ‘synergy’ between recovery values and the person-centred ethos of social work as a key factor in helping the SRN to influence practice in social work and social care. This view was echoed by senior managers of mental health services who held joint posts in social work and health.
- **Voluntary sector:** VOX, the national organisation which promotes the voice of the services user, supports all the SRN’s work and advertises opportunities to work with recovery networks. Many VOX members are involved in running recovery networks. VOX also shares information about recovery, for example, via its website, and the organisation has members’ meetings 3-4 times a year where recovery is normally one of the topics chosen by members for discussion.
- **Mental health services in general:** The SRN has been involved in working with Quality Improvement Scotland (QIS) in relation to developing standards for Integrated Care Pathways for mental health services.³⁴ The SRN was also part of the reference group for a separate QIS project on developing a best practice guide for adults admitted to mental health inpatient services.³⁵ The latter document makes a number of references to the SRI and to WRAP.

³⁴ Quality Improvement Scotland (2007) *Standards for Integrated Care Pathways for Mental Health*. Available from: http://www.nhshealthquality.org/nhsqis/files/mentalhealth_standardsforICP_DEC07.pdf

³⁵ Quality Improvement Scotland (2009) *Best Practice Statement — March 2009. Admissions to adult mental health inpatient services*. Available from: www.nhshealthquality.org/nhsqis/files/MENTALHEALTHREV_BPS_MAR09.pdf.

Areas where the SRN has had less influence

8.20 There were other groups where recovery was reported to be less well understood or accepted. These were:

- **Primary care:** It was felt that the SRN had made little progress in engaging with primary care. At the same time, primary care has not been one of the main target groups for the SRN. Nevertheless, the SRN acknowledges that it is important to reach primary care providers with the message of recovery, and there have been greater efforts to do so, for example through targeted publication and poster distribution. The difficulty of getting GPs to take part in recovery-related training was highlighted by interviewees and by the local network workshops. However, these issues have been raised in other evaluations of mental health improvement initiatives.³⁶

The Royal College of General Practitioners in Scotland has not taken any specific action to promote recovery to its members, and the view was expressed that, in any case, GPs would see very few people with serious mental health problems, since these individuals would ordinarily be referred to secondary mental health services. There is also an issue of capacity, as GPs are already required to have an in-depth knowledge of several conditions.

However, mental health service users (attending local recovery workshops) commented that people in the first stages of their illness are most likely to be seen in a primary care setting. The view was that it was crucial, even at this stage, to be given a positive and optimistic message of recovery.

- **Psychiatry:** There were mixed views about the extent to which psychiatrists had engaged with the idea of recovery and with the SRN. At a UK level, the Royal College of Psychiatrists (RCPsych UK) supports and promotes the notion of recovery.³⁷ It was reported by a representative of the RCPsych in Scotland that the SRN would be able to have little influence on the RCPsych at a UK level. However, in fact, SRN staff have spoken at three RCPsych UK conferences, and work undertaken by the SRN is specifically cited in a paper jointly published by the RCPsych UK, the Care Services Improvement Partnership and the Social Care Institute for Excellence.³⁸

The representative of the RCPsych in Scotland suggested that the SRN had had some influence on psychiatrists, but there was also a perception of some “anti-psychiatric” feeling among groups promoting recovery which has inhibited greater engagement by psychiatrists in the past. It was not suggested that the SRN had been involved in creating such feeling. Nevertheless, a constructive debate was thought to be the way forward to build on the interest that many psychiatrists do have in recovery.

³⁶ Russell P, Lardner C, Johnston L and Griesbach D (2009) *Evaluation of Phase 2 of Choose Life*. Scottish Government. Available at: <http://www.scotland.gov.uk/Publications/2010/03/30174735/0>.

³⁷ See the statement on recovery and rehabilitation on the RCPsych website: www.rcpsych.ac.uk/campaigns/fairdeal/whatisfairdeal/recovery.aspx

³⁸ Care Services Improvement Partnership (CSIP), Royal College of Psychiatrists (RCPsych) & Social Care Institute of Excellence (SCIE) (2007) *A common purpose. Recovery in future mental health services. Joint positive paper 08*. Available at: www.scie.org.uk/publications/positionpapers/pp08.asp.

Barriers and levers to influence

- 8.21 Interviewees identified a number of barriers to taking forward a recovery approach in practice. These included: constraints on time (particularly for GPs and other clinicians); money and staff shortages; entrenched attitudes; and in some cases, a mistaken belief within certain sectors that having a “person-centred” approach is equivalent to practising recovery. There was also some concern about the short timescales for *Towards a Mentally Flourishing Scotland*, which runs only until March 2011.
- 8.22 On the other hand, national policy drivers have all helped to support the SRN in its efforts to influence mental health practice in Scotland.

The SRN’s influence on practice: The perspective of service users

- 8.23 There are obvious difficulties in attributing changes in service practice solely to the SRN. The SRN may provide excellent support and tools to promote practice change; however, ultimately changes in practice are the responsibility of local service commissioners and providers. *Nevertheless*, one would expect that an increasing adoption of recovery practices within services would be one of the outcomes of the work of the SRN, and indeed the SRN has identified “more recovery focused mental health services” as one of their medium-term outcomes. (See again Annex C.)
- 8.24 It could be argued that the best perspective on whether or not services are increasingly adopting recovery-focused practices is *not* that of the service providers, but *rather* of service users.
- 8.25 In relation to this, it should be noted that there is evidence from the bi-annual *Well?* surveys which shows that people with mental health problems are increasingly receiving positive messages of recovery from the professionals with whom they come in contact.³⁹ Furthermore, there is some evidence that people with mental health problems may increasingly be receiving positive messages of recovery from the people around them (friends, family).⁴⁰
- 8.26 Importantly, results from the *Well?* survey also showed that people with mental health problems who had received a positive message from professionals were more likely than those who had not to have *above average* mental wellbeing. While a survey of this nature can not determine direction of causality, this finding is consistent with findings from the Narrative Research undertaken by the SRN which reported that being given an optimistic message of recovery can lead to positive outcomes for people in their own journeys of recovery.

³⁹ Davidson S, Sewel K, Tse D and O’Connor R (2009) *Well? What do you think? (2008) The fourth national Scottish survey of public attitudes to mental wellbeing and mental health problems*. Scottish Government. Available at: <http://www.scotland.gov.uk/Publications/2009/09/15120147/24>.

⁴⁰ Between 2006 and 2008, there was a statistically significant increase in the proportion of people with experience of a mental health problem who said they had received a positive message of recovery from professionals with whom they had contact: 73% in 2008 compared to 66% in 2006. There was also a slight increase in the proportion who said they had received a positive message of recovery from the people around them, but this change was not statistically significant: 79% in 2008 vs. 76% in 2006.

9 IS THE SRN GOOD VALUE FOR MONEY?

- 9.1 This chapter examines evidence in relation to our fourth research question: *Has the SRN provided good value for money in pursuing its aims, influence, reach and impact?*
- 9.2 It was beyond the scope of this evaluation to undertake a full cost-effectiveness analysis. Rather, we have focused our efforts on answering the question which was of primary interest to the Scottish Government — *Is the SRN good value for money?* To answer this question, we sought to determine whether the SRN had achieved a good balance between quality, outputs and outcomes on the one hand and cost on the other. In particular, we attempted to ascertain:
- Whether the SRN had sound governance and management at strategic, financial and operational levels
 - Whether costs and benefits were weighed up when making decisions
 - How performance and outcomes are measured and reported
 - Whether the Network has achieved the outcomes it set out to achieve, within budget.
- 9.3 Evidence has been drawn from our documentary review; interviews with the SRN Director and strategic partners; and the focus group with SRN staff.
- 9.4 It should perhaps be noted that the Network has never previously been asked by the Scottish Government (outside of the current evaluation) to consider or report on the issue of value for money / cost-effectiveness.

Governance and management

- 9.5 The Scottish Recovery Network is funded on a three-year cycle by the Scottish Government. A budget is agreed and the SRN produces a three year action plan which is refined once the budget is confirmed. The action plan sets out the links between government policy and SRN objectives and provides an outline work plan. In the latest action plan the SRN also set out an outcomes model (as shown in Annex C).
- 9.6 The SRN is directly responsible to the Scottish Government for achieving its objectives, and six-monthly reports are submitted to the Mental Health Division by the SRN Director. These provide detailed information about the Network's activities, expenditure and outputs from the previous six months.
- 9.7 The SRN also meets quarterly with the members of its Strategy Group. This is a stakeholder group that includes service users and representatives of service user organisations, a social worker (representing ADSW), a psychiatrist (representing the Royal College of Psychiatrists), representatives of major voluntary and private sector mental health service providers, a researcher and a Scottish Government policy officer. The group does not have management responsibility for the SRN, *per se*. However, it acts as a sounding board for the Director, and provides input to priority-setting and the SRN's workplan.

- 9.8 The SRN is hosted by Penumbra, a voluntary sector mental health agency, and the SRN Director is line-managed by the CEO of Penumbra. Ultimately, the Board of Penumbra is responsible for the governance of the Scottish Recovery Network. The CEO of Penumbra sits on the SRN's Strategy Group which meets quarterly. Strategic partners felt that the hosting arrangement was appropriate and supportive, and frees the Director to concentrate on the SRN agenda, rather than governance matters.
- 9.9 Most staff are line-managed by the Director of the SRN. Administration staff are managed by the Network Manager. The increased budget of the SRN over the past few years (see again Table 3.2) has enabled it to increase its staffing from 2.5 FTE in 2004-05 to the current 6.5 FTE in 2010-11. Action plans are set and performance reviewed when staff members first start, but after that it was reported to be less regular. There is no formal link between action plans, appraisal / review and feedback into new plans. The view of the Director was that, *"There is a feedback loop but it is not a rigid thing — 'everything you do must fit into the plan'. Flexibility has worked well for us and enabled us to take new opportunities as they come"*.
- 9.10 This was echoed by some evaluation participants who gave numerous examples which showed that the SRN has remained flexible to be able to respond both to policy needs and to requests for support / advice / information from local areas.

How costs and benefits are weighed up in making decisions

- 9.11 Once a three-year budget and action plan are agreed, the criteria for making decisions on how to use resources are based on whether proposed activities would fit within the action plan, and with SRN's overall approach, direction and activities. Ideas are discussed in the staff team and the Strategy Group.
- 9.12 There is evidence in the regular monitoring reports of decisions being taken based on the relative benefits of activities, for example:
- Three additional proposed road-show events were cancelled due to prioritisation of other work
 - Work by an external contractor to develop guidelines was not what was envisaged so the contract was stopped and work was taken in-house
 - Following a tender process it was decided not to appoint a contractor for work on SRI research as it was not clear what new knowledge would be gained
 - A survey of postal update recipients showed that they found the updates useful, so it was decided they should be continued, with some improvements.
- 9.13 However, while there was evidence that the pros and cons of activities and their 'fit' with the SRN's workplan were discussed, we found little evidence that the *explicit costs* of activities were part of the decision making process. To be fair, however, it should be reiterated that the SRN has not, before this evaluation, ever been asked to consider these issues. Nevertheless, it was the view of the Director that this was an important issue to consider in future.

How performance and outcomes are measured and reported

- 9.14 Until recently, there were no outcomes set out for the SRN's work, either by the SRN itself or by the Scottish Government. The SRN has therefore not been required to measure or report on outcomes.
- 9.15 The process for setting objectives for the SRN's work in its early days followed a consultation with stakeholders which was sponsored by the then Scottish Executive.⁴¹ Once a Network Director and staff had been appointed, there was further consultation in relation to the specific nature of the SRN's work. This was informed by a stakeholder survey, the findings of which appear to have been taken into account in setting the SRN's objectives in the first years.⁴²
- 9.16 Stakeholder consultation has also informed the development of WRAP and the SRI in Scotland and, as previously mentioned, the SRN's Strategy Group is a stakeholder group of service user, service provider and policy representatives.
- 9.17 In terms of reporting, as mentioned previously, the SRN reports on a six-monthly basis to the Scottish Government, and on a quarterly basis to the strategy group. Reporting mainly focuses on outputs and activities. The SRN is not currently required by the Scottish Government to set out, or report on, outcomes.
- 9.18 Nevertheless, in 2008, the SRN developed its own logic model and has identified appropriate outcomes. However, there is some difficulty in attributing outcomes specifically to the SRN. The only regular measurement of outcomes takes place through the bi-annual *Well?* survey, which asks about the experience of people with mental health problems in relation to whether they have received a positive recovery message.

Whether outcomes (or objectives) have been achieved within budget

- 9.19 In considering the SRN's short-term and medium-term outcomes, there is some evidence from this evaluation that these outcomes are being met through the SRN's activities — for example, enhancing the evidence base and increasing opportunities for learning in relation to recovery. The SRN has also achieved these within budget in all the years since its inception.
- 9.20 However, many of the outcomes are extremely difficult to measure — for example 'increased hope, expectation and self-direction of recovery among people with experience of mental health problems'.
- 9.21 In addition, it is difficult to attribute some of the outcomes solely to the work of the SRN and separate this from a conducive policy environment overall, for example, in relation to 'an increased understanding and application of values and relationship that promote recovery in key professionals'.

⁴¹ Scottish Development Centre for Mental Health (2002) *Would recovery work in Scotland? Report of a one-day workshop at the West Park Centre Dundee*. Available at: www.scottishrecovery.net/Where-SRN-came-from/where-srn-came-from.html.

⁴² Scottish Recovery Network (2005). *Perceptions of recovery: the role of the Scottish Recovery Network. A survey report*. March.

Views from evaluation participants

- 9.22 To complement our analysis of the evidence on providing value for money, we asked evaluation participants (including the Director and staff, strategic partners and national and policy stakeholders) for their views about whether the SRN provided value for money.
- 9.23 We heard very positive views about the cost-effectiveness / value for money provided by the SRN. Overall, a network was seen to be an effective model and the Director was widely felt to be able and effective. The SRN staff team saw the SRN as “quite cheap” and “punching above its weight”. This latter point was echoed by strategic partners. The way that SRN works synergistically with other agencies was thought to be cost-effective because it “joins things up” and therefore helps to prevent duplication.
- 9.24 Particular pieces of work were seen to have been very cost-effective because they have had a “catalytic effect” and had a number of sustainable outputs. For example, the work on WRAP has led to a pool of trained facilitators and the SRI has been adapted, at little cost, into a tool which is appropriate for Scotland. Although the initial work of the SRN in undertaking and distributing the findings of the Narrative Research project and establishing the network was resource intensive, this work has led to the development of sustainable knowledge resources including training materials, publications and the SRN website.
- 9.25 There was a view expressed at one focus group that perhaps the SRN had tried to do too much and was running into capacity problems. A further point was that it may be better value for money if anti-stigma messages (for example through the *see me* campaign) were more integrated with recovery messages.

Other comments on the SRN’s way of working

- 9.26 Many individuals also commented on the SRN’s *style* of working, which was described variously as: “bridge-building”, “inclusive”, “supportive”, “not prescriptive” and “collaborative”. Others described SRN staff as “approachable”, “willing to listen” and “dedicated to the recovery agenda”. The work of the Network was considered to be “high quality”, “true to recovery values – not tokenistic” and communicated in “every day language”.
- 9.27 National policy representatives described the SRN’s way of working as “slow and steady”, and attributed much of the success of the Network to its Director, who was described as “clever” for taking the time to engage meaningfully with a wide range of people (service users, service providers, carers) across Scotland.
- 9.28 Finally, in the review of the National Programme carried out in 2006-07, the SRN was praised for having taken forward its work “intelligently”, and for having given the service sector “a new sense of direction”.⁴³ The review panel went further to say that the SRN had a key role to play in the future of mental health improvement in Scotland.

⁴³ NHS Health Scotland (2008) *A review of Scotland's national programme for improving mental health and wellbeing 2003-2006*. Available at: www.healthscotland.com/documents/2388.aspx. See page 43.

10 THE FUTURE OF RECOVERY AND THE FUTURE OF THE SRN: KEY MESSAGES AND CONCLUSIONS

- 10.1 This evaluation has sought to answer five questions. In this chapter we now address those questions directly:
1. How has the SRN planned and implemented its activities and to what extent has it delivered on set aims and objectives?
 2. What influence has the SRN had — (a) on national policy, and (b) on engendering recovery values and practices in Scotland — and how has this been achieved?
 3. To what extent have the SRN's interventions / projects been successful in reaching their target populations, how effective have they been and what has been their impact?
 4. Has the SRN provided good value for money in pursuing its aims, influence, reach and impact?
 5. What needs to be done in the future to promote the recovery agenda and what role should the SRN have in this?
- 10.2 We will also draw some conclusions, consider the implications for the promotion of recovery and the future direction and priorities of the SRN, and offer some recommendations.
- 10.3 A significant focus of this evaluation was on the effectiveness and impact of the SRN — on national policy, on practice within secondary mental health services, and on individual service users. The overall message from the evaluation is that SRN can demonstrate considerable achievements in all these areas. However, there is still more to be done to ensure that recovery practices are fully embedded in the range of services that have a role in supporting people with mental health problems in their recovery journeys.

How has the SRN planned and implemented its work?

- 10.4 This question is about *processes*. *How* has the SRN carried out its work? The following major themes arose in relation to this question:
- **Business and planning processes:** We found evidence of forward action planning, a logic model and regular detailed six-monthly reports to the Scottish Government. The SRN have good systems for monitoring their performance on activities and outputs. However, we would suggest that some further work could be done on developing indicators for medium- and long-term outcomes, and that future planning, monitoring and reporting are aligned with these.
 - **Stakeholder engagement, consultation and involvement:** We found evidence that the SRN's planning processes and activities were informed by meaningful consultation and ongoing dialogue with a wide range of stakeholders, including service users, policy makers and secondary mental

health professionals. The SRN also have a stakeholder strategy group to which they report quarterly.

- **Partnership working:** We found evidence of good partnership working — in relation to the development and roll-out of training and practice tools, and in the development and implementation of policy in this area.
- **Credibility:** The Network has achieved a high level of credibility: through its evidence base, particularly the focus on the voice of service users; its development of standardised, accredited training for peer support workers and WRAP facilitators; and its highly-regarded staff team. The Director is a respected and credible spokesman for the recovery movement and was cited by virtually all participants as a key factor to the Network's success.

10.5 Many of the terms used by participants in this evaluation to describe the Network also say something about *how* the Network has carried out its work. It has been described as a “*catalyst*” and “*pump primer*”, a “*bridge-builder*”, “*facilitator*” and “*collaborator*”.

To what extent has the SRN delivered on its aims and objectives?

10.6 The evidence gathered through this evaluation (as discussed in Chapters 4-7) clearly shows that the SRN *has consistently* delivered on its objectives:

- **Awareness-raising:** through organising conferences, workshops, road shows and other events; attending and speaking at national and local non-SRN events; producing and distributing publications and other resources; and developing and maintaining a website and mailing lists.
- **Establishing an evidence base for recovery in Scotland:** initially through the Narrative Research project, but also through the commissioning and support of on-going evaluation. The SRN has been open and committed to evaluating its own initiatives, and has given careful consideration to the findings of that evaluation.
- **Building capacity in communities for recovery:** through support of training for WRAP facilitators and peer workers, and through support of local recovery networks. This is perhaps the most challenging area of the SRN's work, but the evidence clearly shows that the Network has systematically and consistently sought to overcome those challenges. The developments are encouraging, but there are some threats to the longer-term sustainability this work — e.g., only one Advanced Level facilitator for WRAP in Scotland; only a few peer support workers in post; and difficulties in starting and sustaining local recovery networks.
- **Developing practice tools:** in particular, the development of the Scottish Recovery Indicator and the development of training materials for professionals — both of which are currently being rolled-out widely across Scotland.

The SRN's influence on policy

- 10.7 The SRN has operated in the context of a policy commitment to recovery and a growing (and continuing) interest in recovery among professionals. The SRN has capitalised on that favourable environment.
- 10.8 Participants in this evaluation generally agreed that SRN has had an influence on mental health policy in Scotland. Some thought that their influence arose from being the main implementation body for the national policy. However, others felt that their influence was much broader. These individuals cited examples such as:
- Their success in engaging in an ongoing dialogue with a wide range of stakeholders
 - The creation of a robust evidence base for recovery in Scotland, and ensuring that the voices of service users are prominent
 - The perceived value of the practice tools and training materials that the SRN has been involved in developing
 - Their influence on policy in the substance misuse area.
- 10.9 It is clear that SRN has had a “seat at the table” as policy in this area has been developed. The working relationship between the SRN and the Scottish Government has clearly been successful, and is something for which both parties can take credit.

The SRN's influence on practice

- 10.10 There was a consensus that SRN has had an influence on practice but, as noted above, this has been within the context of wider interest in recovery among mental health professionals. The greatest influence was reported to be in the area of mental health nursing, and again, this group was prepared and primed for change through a major policy initiative (the review of mental health nursing). However, we also heard that the SRN had had a major influence on the provision of (multi-agency) community mental health services in general.
- 10.11 The SRN set itself a high aim — culture change within mental health services. We would suggest that, while policy may have been able to influence practitioners' thinking, the Network has gone much further than that, and has influenced the values, attitudes and beliefs of professionals and structures and practices within organisations. It has done this by:
- Developing training materials which are now being disseminated and used widely across Scotland
 - Providing a platform for the collective voices of service users to be heard
 - Facilitating opportunities for service users to work alongside professionals (through peer support schemes and through the delivery of training)
 - Developing, facilitating and supporting the use of practice tools which help people to understand clearly what the practice of recovery looks like.
- 10.12 Participants identified some groups on whom the SRN were thought to have had less, or little influence, namely psychiatrists, psychologists and general

practitioners. However, GPs are often difficult to engage in view of their limited time and the large number of health issues that they are required to address. It also needs to be acknowledged that general practitioners were not one of the SRN's main target groups. We would also suggest that the SRN (as a voluntary sector body) is not necessarily best-placed to influence practice among medical professionals. However, we found that the SRN has, at least, had a measure of success in engaging with psychiatrists (by inviting a psychiatrist onto their Strategy Group and by speaking at events organised by the Royal College of Psychiatrists in Scotland).

- 10.13 We also heard concerns that in some cases people may *think* they're practising recovery, but they may not be. In our view, the wider roll-out of the SRI will eventually address this issue, as it will help practitioners to understand that the practice of recovery is more than simply adopting a "person-centred approach".

Reach, effectiveness and impact

Reach

- 10.14 The SRN has reached large numbers of people through their website, email list, seminars, conferences and road shows and has disseminated large numbers of publications and other types of materials. However, it is less clear how these materials are being used by those who receive them.
- 10.15 The national roll-out of the SRI is proceeding well, but is far from complete. The administration of the tool takes time, and is somewhat challenging. We would anticipate that local services will continue to need support in this area over the next few years.
- 10.16 WRAP is also being used widely across the country, and the delivery of WRAP training is being promoted enthusiastically in many areas. Some areas have taken steps to include WRAP in local Integrated Care Pathways as well.
- 10.17 The roll-out of recovery-related training across Scotland is also proceeding well, but again, far from complete. This is not necessarily an area that the SRN can address directly, as the delivery of this training is being undertaken at a local level. While it is being delivered extensively to mental health nurses, there is a question about whether such training should also be offered routinely to social workers, occupational therapists, psychologists, and other staff groups who regularly work with people with mental health problems.
- 10.18 Peer support schemes have been less successful in being established across Scotland. We sensed some ambivalence — perhaps more so within NHS services — in implementing these schemes. Difficulties have been identified with grading of posts, providing appropriate management and support structures, and delivering training. The SRN is addressing these issues.
- 10.19 The work in establishing local recovery networks has been slow to get off the ground — mainly because, until recently, the SRN simply has not had the capacity to concentrate on this area. Only a few networks exist at the moment,

and some of these are working well. Others have had difficulties getting started, and still others have foundered. A new approach may be needed.

10.20 It is important to note that much of the SRN's communication with service users has been through mental health services and service user groups. Although there is a risk that some individuals with mental health problems may not be reached through these mechanisms, we feel, in general, that this has been a good approach. The difficulty is that the SRN has not yet reached all service user groups, and cannot necessarily rely on services to make those contacts.

Effectiveness

10.21 The evaluations of WRAP, peer support, the SRI, training and communications have been generally positive. However, most of these evaluations were small-scale and formative. They mainly sought to identify learning that might inform a wider roll-out of an initiative.

10.22 Given the current focus on outcomes-based planning, the SRN has developed its own logic model, which lists its expected outcomes in the short-, medium- and long-term. To date, there has been no input from the Scottish Government (nor has there been a requirement to report on outcomes). We would suggest that there should be some discussion between the Government and the SRN and some joint work on developing and agreeing indicators to measure outcomes. And in doing this, it needs to be acknowledged that the SRN cannot be held entirely responsible for service change (or lack of service change) at a local level.

10.23 As stated in Chapter 3, the SRN's medium-term outcomes are:

- Increased opportunities for learning about personal recovery in formal education / other settings
- Increased hope, expectations and self-direction for recovery amongst people with experience of mental health problems, families and professionals
- More recovery-focused mental health services and conducive policy environment.

10.24 The findings of this evaluation indicate that these outcomes are being met, but there is still work to be done to ensure that they are *fully* met in every part of Scotland.

Impact

10.25 When participants in this evaluation, including service users and senior mental health managers, were asked directly what impact they felt the SRN had had in their area, many replied to say that the impact had been transformational. They were also able to give some examples in relation to:

- Hope / optimism / voices being heard / people going on to employment
- People now believe that recovery is possible
- Changes in care planning procedures
- Changes in language used by practitioners

- Day services and community services being renamed to “recovery services”
- Changes in attitudes *and* practices.

10.26 The most recent findings from the *Well?* survey show that mental health service users in Scotland are increasingly being given positive messages from the professionals they have contact with. This is an important impact of the work of the SRN. However, evidence from our case studies suggests that there are still some service users who are unaware of the recovery message or unsure about what it means for them. The SRN may need to review how they manage their contact with this important group and seek to engage more directly.

10.27 Finally, according to service users, to maximise the positive impact of recovery, there is a need for the message of recovery to be heard by the providers of other types of services, such as housing and employment, since these services also have an important role in supporting people with mental health problems.

Value for money

10.28 We found evidence that stakeholders think that SRN does a good job and meets its main objectives in a high quality way. Moreover, they believe that this has been achieved with little resources when compared with other national mental health initiatives. The Network’s initial focus on developing an evidence base for recovery in Scotland was an investment that has proven to be a powerful force for change. Therefore, the SRN was felt to be good value for money.

10.29 The SRN has transparent governance and management arrangements, and overall the Network is achieving what it set out to do, and within budget.

10.30 We also have evidence of the SRN making sensible decisions about the use of its resources, but as mentioned above, there is a need to do more on measuring outcomes, through the development of agreed indicators. The Network should perhaps also consider more regular / formal staff appraisal and making more direct links between staff work plans and overall outcomes.

The future for recovery and the future for the SRN

10.31 There was a strong view among those who took part in this evaluation at every level that much progress had been made in the area of recovery in Scotland. The general feeling, however, was that recovery was not yet fully embedded into practice and there was more work to be done. There was also a strong view that there was an important role for SRN beyond 2011 (when the Network’s current funding ends). At the same time, participants felt that the SRN should not be the *only* player. They also saw an important role for government (in continuing to prioritise and support policy in this area) and for those responsible for the planning and delivery of services at a local level to ensure that recovery-related practices were embedded in services.

10.32 Participants placed a high value on the “network” approach as a way of working with a wide range of stakeholders and, in particular, of keeping the dialogue about recovery dynamic. Overall it appears to be a cost-effective way of creating a great momentum for recovery in Scotland. There appears to be

significant scope for spreading the recovery message through the “critical mass” of supportive people already convinced about the value of the recovery approach. This would imply that the SRN should continue what it is doing, but seek to improve its reach and, wherever possible, find ways to improve the effectiveness and sustainability of its interventions.

- 10.33 We would also suggest, however, that there would be value in targeting some of the SRN’s activities to groups such as psychologists, psychiatrists and GPs, where there has been limited reach for the recovery message. Psychiatrists have an important role in providing care for people with long-standing mental health problems, while GPs tend to see people at an early stage in their experience of mental ill health. In both situations, people with mental health problems could well benefit from receiving a positive, hopeful message. At the same time, we also acknowledge that medical professionals may not be persuaded or challenged by a small organisation in the voluntary sector. To date, the SRN has pursued a low key strategy engaging with the medical profession by being at the “right” tables and influencing guidelines, training and speaking at relevant meetings. This seems like a sensible approach.
- 10.34 There appears to be wide support for the Network largely retaining its current objectives, and continuing with its current activities. However, in our view, the SRN should continue its focus on new developments so that it keeps inspiring people to think afresh. To do this, SRN would need to continue to support / develop research on what helps and hinders recovery.
- 10.35 A question about whether the SRN should have a higher public profile and become more involved in awareness raising among the general public was frequently raised. The findings of the bi-annual *Well?* surveys suggest that a public campaign on recovery may be needed. The recovery message is, at least in part, an anti-stigma message, and large-scale public anti-stigma campaigns have previously been the role of *see me*. At the same time, the SRN clearly has extensive expertise in the area of recovery. In our view, given its limited resources, the knowledge and expertise of the SRN would be better used by working together with *see me* to develop a major public awareness campaign on recovery, rather than the SRN undertaking such a campaign itself. The SRN could continue to do smaller things such as newspaper or magazine articles for different audiences.
- 10.36 For recovery to become fully embedded, more needs to be done at local level. The SRN’s approach to local networks has been responsive and supportive, but there have been problems in setting up networks or maintaining them. We would suggest that the SRN should explore options for different models for these networks to meet the needs of different areas: for example, to address difficulties in rural areas where transport is difficult and people are scattered. The focus of local recovery networks should be on adding value to what is happening locally (rather than duplicating it), and on sustaining recovery in the long-term.
- 10.37 However, the SRN cannot be held entirely responsible for the implementation of recovery-oriented practices at a local level. Ultimately, local commissioners

and service providers are responsible for the delivery of their own services. Some participants argued for a role for “recovery champions” at a local level to ensure that recovery is embedded in services, that training is delivered to staff, and that service users are involved in service development.

- 10.38 SRN should continue to offer support to services. In particular, there may be scope for the SRN to expand their role in supporting services to use the SRI. The SRI is potentially a powerful tool for service change but it is effectively a self-evaluation tool. Service leads may need on-going support and encouragement, and may well value the chance to debrief with an independent “friend” during or after administration of the tool.⁴⁴
- 10.39 We frequently heard concerns expressed about whether the impetus to develop good recovery-oriented practice would suffer in the impending budget cuts. A continuing clear policy direction would help to address these concerns.
- 10.40 Individuals at a local level expressed a desire to have greater exchange with other areas to share (and learn about) good practice. There may be a role for the SRN in facilitating this exchange by acting as a conduit for information through its website or by holding events.

Recommendations

- The work of the SRN should continue beyond 2011. The Network should continue to work in partnership with other bodies to promote an understanding of, and the attitudes and values that are consistent with, the practice of recovery. Much of the SRN’s work in its first few years has focused on generating interest, awareness and enthusiasm for recovery. It has been successful in doing this. The focus now must be on creating sustainable structures to support recovery practices in the longer term. We acknowledge that the Network has already begun to move in this direction in all of its activities, and this work should continue. Practice change has begun, but it is not yet complete.
- The Scottish Government and lead professional bodies should continue to promote and support recovery in Scotland. There needs to continue to be a joined-up, coherent, national policy aimed at creating a sustainable structure to support recovery and make it mainstream. The Scottish Government should continue to give priority to recovery through commitments in key policy documents in mental health and in other related areas, such as housing and employability, as these types of services can affect the lives of service users as much as mental health services.
- The Scottish Government and the SRN should discuss and agree appropriate indicators to measure the SRN’s outcomes, and how data on these indicators will be collected (i.e., through regular national surveys, like the *Well?* survey, or through the SRN’s on-going evaluation of its own initiatives). The SRN’s current logic model is a good starting point, but this

⁴⁴ We note that the SRN has begun to develop regional learning networks. At the time of writing of this report, these include 90 individuals who will be local SRI champions.

model lacks information about who else has a role in ensuring that longer-term outcomes are met.

- The SRN should consider how it can better monitor and record information about how its publications and other printed resources are being used, and by whom.
- The SRN should continue to expand the Network, engaging with service users and professionals who have an interest in recovery, and supporting existing Network members to promote recovery values and practices in their own areas. However, we would recommend that:
 - New efforts be made to target awareness-raising activities to GPs and other primary care professionals (practice nurses) — the SRN should discuss with the Scottish Government what might be the best ways of approaching this task given the known difficulties
 - New efforts be made to identify and establish direct contact with service user and carers groups in Scotland — to ensure that the message of recovery is being heard by as many as possible
 - Continued efforts be made to engage with psychiatrists and psychologists.
- The SRN should review and consider how to adapt the model of local recovery networks for a range of circumstances: for example in rural areas. There may be options for the use of technology or establishing several small networks in a larger geographical area. In doing this, they should liaise with local commissioners, service providers and service users.
- The SRN should continue its role in supporting services to develop recovery-oriented practices, and in particular its role in supporting services to use the SRI. We note the SRN's plans to undertake further research on the impact of the SRI in the future, and we would suggest this research could include a longitudinal analysis of the monitoring data the SRN already holds (i.e., how do services' SRI scores change over time?), an analysis of the action plans that services create after administration of the SRI, and an analysis of whether those action plans are effective in producing service improvements. Such analysis should be anonymised, in order that the SRI does not begin to be perceived by services as an audit tool.

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ANNEX A: WHAT IS “RECOVERY”?

“Recovery” has been defined in different ways, and although definitions may vary, there is general consensus that:

- Recovery is an individual process
- It involves engendering hope and optimism that recovery is possible
- It requires developing — or possibly changing — attitudes, values, goals and skills in order that mental health service users can lead satisfying and hopeful lives
- It requires ‘buy-in’ from mental health service users and those who play a role in supporting them
- Those who support mental health service users (including statutory services) can play a pivotal role in building the capacity of service users to become active partners in their own care.⁴⁵

Recovery can be conceived of as a journey, as well as an end point. It is about supporting people to be active in managing their own healthcare and to carry out everyday activities even with ongoing symptoms. It is about working *alongside* people with mental health problems (i.e., ‘working with,’ rather than ‘doing to’), by offering them tools and techniques that can help them on their journey of recovery.

⁴⁵ Berzins K (2006) *Implementing a recovery approach in policy and practice: A review of the literature*. Scotland’s National Programme for Improving Mental Health and Wellbeing: Small Research Projects Initiative 2005-06. University of Glasgow. Available at: www.scotland.gov.uk/Publications/2006/06/19103019/1.

ANNEX B: BACKGROUND TO THE CREATION OF THE SRN

When the National Programme for Improving Mental Health and Wellbeing was established in 2001, “recovery” was one of its main priorities. However, recovery was then a relatively new concept in Scotland.

To allow the concept to be explored, the (then) Scottish Executive sponsored an “Open Space” event which was held in Dundee in November 2002. The purpose of the event was to discuss the question: “Would recovery work in Scotland?” The event was attended by over a hundred people, including service users, carers and mental health professionals from a range of sectors. A report of the event concluded that there was a great deal of enthusiasm for creating a recovery movement in Scotland, and it was felt that a “network” would be the best mechanism for taking this forward.⁴⁶

The “network” concept was favoured because it was seen to provide a way for people to exchange ideas and experiences with people in other parts of the country. At this point, the Scottish Development Centre for Mental Health began to develop a mailing list (and email list) of people with an interest in recovery in Scotland.

The Open Space event was followed by a Recovery Workshop in Edinburgh in 2003 which explored how recovery could be taken forward in Scotland. A subset of the group involved in this workshop subsequently met to develop a formal proposal to the then Scottish Executive for two-year funding for what began to be referred to as “a Scottish Recovery Network.”⁴⁷ This proposal included a set of aims and objectives for the Network, and an action plan, which included developing a proposal for further funding beyond 2006. It was agreed at this stage that the voluntary sector mental health agency, Penumbra, would act as the host of the network and that any staff hired to carry out Network business would be Penumbra employees.⁴⁸

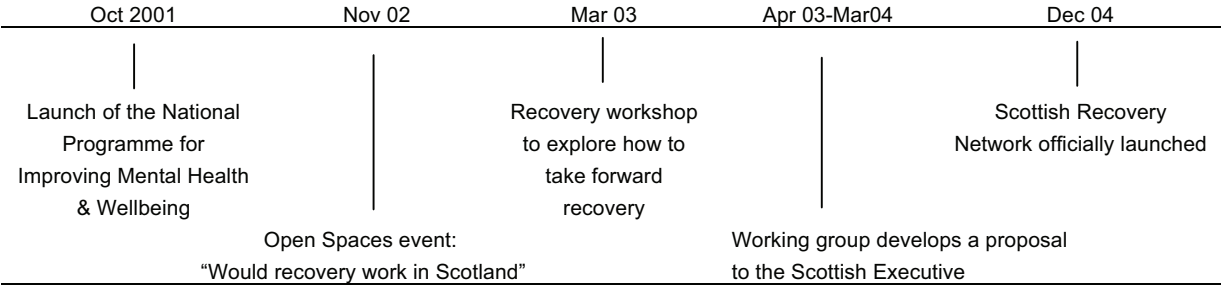
The Scottish Recovery Network was officially launched in December 2004 as one of the main initiatives under the National Programme and the Scottish Executive gave the Network £200,000 / year for its first two years. (See timeline on the following page.)

⁴⁶ Scottish Development Centre for Mental Health (2002) *Would recovery work in Scotland? Report of a one-day workshop at the West Park Centre Dundee*. Available at: www.scottishrecovery.net/Where-SRN-came-from/where-srn-came-from.html.

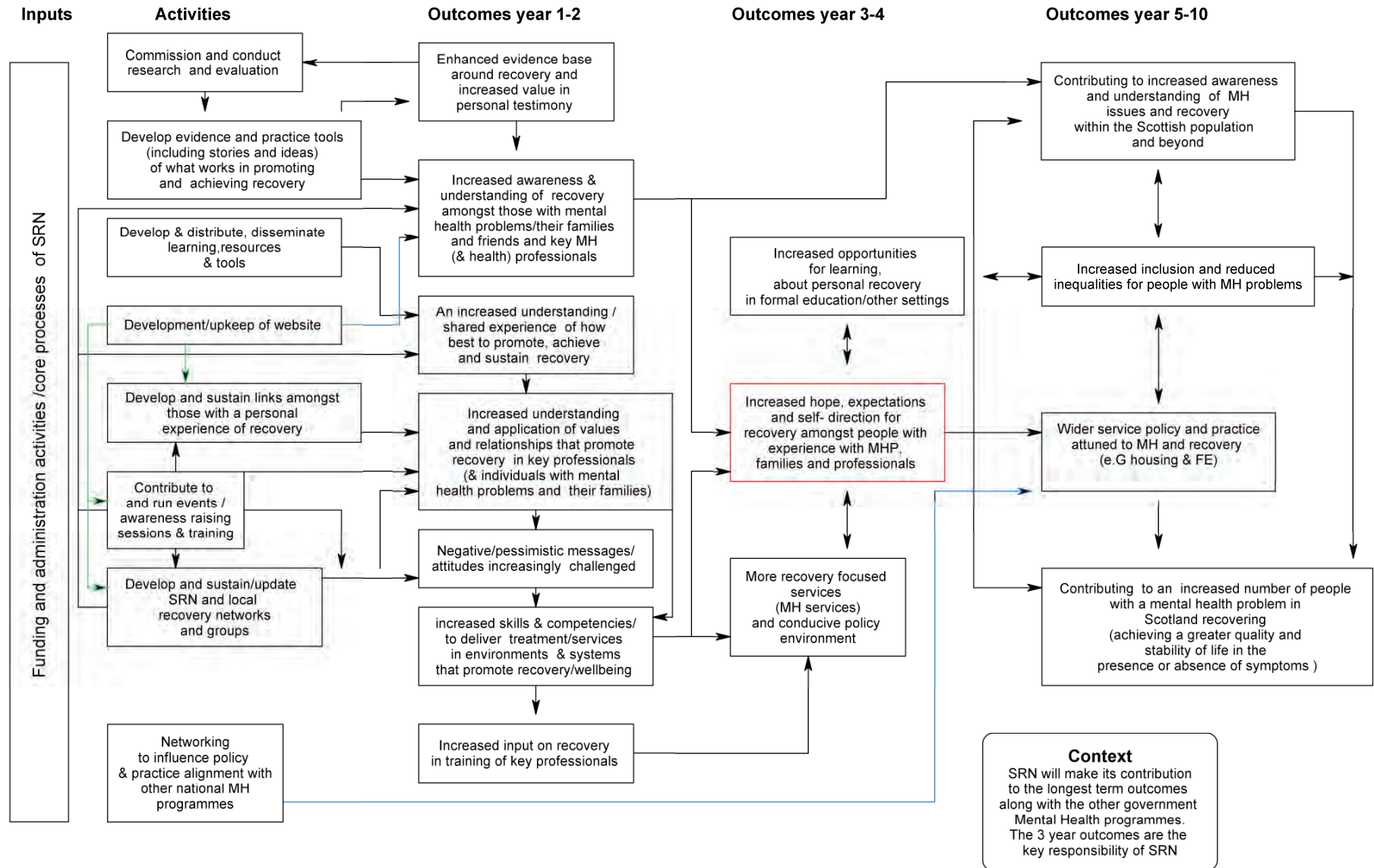
⁴⁷ *Developing a Framework for Recovery in Scotland. A joint proposal to support the development of the Scottish Recovery Network, 2004-2006*. (Undated, unpublished proposal to the Scottish Executive.)

⁴⁸ Of the agencies represented in the working group, the choice of which would host the Network was between Penumbra, SAMH and the Scottish Development Centre for Mental Health (SDC). As SAMH hosted *see me*, it was felt not to be appropriate for SAMH to also host the SRN, and at that time, the SDC said they did not have the capacity to do so.

Key milestones in the period preceding the launch of the SRN



ANNEX C: SRN OUTCOME MODEL, 2008



ANNEX D: SRN WEBSITE STATISTICS AND ATTENDANCE AT EVENTS

Data sources

The sources of data we used in this analysis are described below.

Email contact list

This is a list of the email addresses of all those who have signed up to receive email updates from SRN. It contains only the email address, date added to the list, date modified and date of last mailing. It is not possible to analyse anything useful for this evaluation except the number of addresses on the list. However, the database has improved since the previous analysis was carried out, in that it no longer contains non-functioning email addresses (i.e. those which bounce back), so each entry is a unique and functioning contact. In addition to the email list there is also a postal list containing 171 contacts.

Materials distribution spreadsheets

SRN conducts a targeted distribution of new materials, for example a poster produced during 2008, which was sent to all GPs in Scotland and to 252 hospitals and 543 voluntary organisations/mental health resources across Scotland. Once the targeted distribution is complete, all future requests for materials are recorded on the general material distribution spreadsheet. This records distribution of a wide range of materials such as pens, post-its, document wallets and other publicity materials as well as key resources such as the Journeys of Recovery and Routes to Recovery booklets.

There are three spreadsheets which record general materials distribution from April 2008 onwards - one for the time period April to October 2008, one for October 2008 to September 2009 and one from October 2009 onwards. They contain the name and address of the person requesting the materials and the numbers of each type of material. They also record the number of resources given out by SRN staff at events they attended.

For the purposes of this analysis, we focused on the distribution of five key materials:

- Journeys of Recovery booklet
- Routes to Recovery booklet
- WRAP leaflet
- Recovering Mental Health in Scotland Report
- SRN postcards

Unfortunately, the spreadsheet fields do not include categories for organisation (e.g. Health Board) and these are only sometimes recorded as part of an address, therefore it is not possible to analyse the type of organisation making a request.

Events spreadsheets

Spreadsheet records for three events organised by SRN were included in the analysis. These were the SRN annual conference held in February 2008 and two smaller events to promote recovery held in Thurso in December 2009 and in Stranraer in March 2010.

Names and addresses of those making a booking for the annual conference were recorded. However, delegate details were not recorded in a way which allowed non-manual analysis, for example the name, address and organisation fields are free-text. There is no category for health board area, which means that geographical analysis had to be done by manually matching towns to health board areas.

For those attending the Thurso event, only name and organisation name (if applicable) were recorded and it was not possible to tell what type of organisation it was (e.g. statutory or voluntary). The event was also aimed at service users and carers and it was not clear which category people were in.

At the Stranraer event the reason for people's interest in recovery was recorded, from a choice of: mental health problems, family/friend mental health problems or professional interest.

In addition to the events held by SRN, a spreadsheet record has been kept of events at which SRN staff have given presentations, workshops, talks or have hosted an information stand. These record the title, organising body, date, location, SRN role and input, target audience and number attending.

SRI workshops

There is a separate record kept of the workshops that have been held by SRN to promote the Scottish Recovery Indicator. The data is recorded on an SRI website, so each event record has to be separately searched for the numbers attending.

Website statistics

From November 2009 SRN website statistics have been available via Google analytics, which provides a much improved service since the earlier report. It is now possible to get the number of website visits, repeat and non-repeat visits, length of visits, depth of visits (i.e. number of pages visited), average time on site etc. Website statistics were analysed for the 6 month period between 1 December 2009 and 31 May 2010.

Findings from the analysis

Contact with people and organisations and repeat contacts

The e-mail contact list contained 5,516 contacts as at March 2010. It is not possible to identify the type of contact. The list has grown by 2,200 since May 2008. All contacts listed are unique and valid (i.e., the email address does not bounce back). There are an additional 171 postal contacts, making a total of 5,687 people who have requested, and continue to receive, updates from SRN.

The materials distribution spreadsheets recorded 1,365 names of people requesting materials between April 2008 and October 2009. It is not possible to analyse the type

of post / organisation. Analysis of requests from one health board area in the 18 month period showed 25% of names requesting materials were repeats (maybe for different materials or additional materials).

A total of 560 booking forms were submitted for the annual conference in 2009. In the job title category, 406 gave a job title – these included CPNs, service managers, project managers, OTs, development workers, community workers, psychologists and advocacy workers, to name a few. 12 described themselves as carers, 10 as service users, 9 as volunteers, 4 as students and 119 had no job title entered.

The Thurso event was aimed at service users, professionals and carers and was attended by 33 people. Of these 23 listed an organisation name and 10 did not.

At the Stranraer event, two thirds (63%) of the 52 people who completed an evaluation form were there for professional interest and 38% each were there because of personal or friends/family mental health problems. Presumably the overlap was due to more than one reason, for some people.

In addition to the annual conference and other events organised by SRN, staff keep a record of other events they attend to give presentations or host workshops or information stalls. In 2008 there are records of staff being at 58 events across Scotland attended by almost 3000 people (mainly professionals, but a small number were for service users, general public or students/trainees). In 2009 there was a record of staff being at 40 events across Scotland attended by over 2000 people. Most of the 2009 events were mixed events for professionals, service users and carers.

The SRI website records that 29 SRI workshops have been held, attended by a total of 796 people. Most workshops were attended by service providers (including practitioners, managers or trainees) and two were attended by either service users or mixed service user and provider groups.

The SRN website recorded a total of 19,729 visits in the 6 months from December to May, of which 12,328 were by absolute unique visitors (ie non-repeat visitors). More than two-fifths (43%) of all visits were bounces – i.e. they visited only one page before leaving the website. Almost 60% of visits were new visits. The average time spent on the website across all visits was nearly 4 minutes. Most visitors (52%) came via search engines, over a quarter (28%) was direct traffic and a fifth (20%) came via referring sites.

Distribution of materials

Table D.1 shows the numbers of key resources distributed between April 2008 and October 2009. In this period there were 1,365 requests and tens of thousands of the key resources had been distributed (multiple numbers of these resources were often requested).

Three-quarters of the resources had been distributed on request and one-quarter distributed at events. There is no record kept of how these resources were further distributed after receipt.

Table D.1: Key resources distribution by SRN between April 2008 and October 2009

	Journeys of recovery	Routes to recovery	Report	Postcards	WRAP leaflet*
Distributed at events	1859	4866	1078	5139	2020
Requested	10381	11188	924	21983	3123
Total	12240	16054	2002	27122	5143

* Distributed from October 2008 only

The website statistics show the pages that were most visited. There were over 85,000 page views altogether. The home page had 13,538 views (16% of views), the 'What is recovery' page and 'Resources' page had 5% each; the 'Activities' page had 4% and the 'Publications' page 3%. All other pages were viewed less. There was an average of 4.32 pages viewed per website visit.

Geographical distribution of contacts

Visitors to the SRN **website** came from 91 countries. The vast majority (16,584) came from within the UK. There were 1,009 from Australia and 518 from the USA and fewer than 350 visits each from Canada, New Zealand, Ireland and the Netherlands. The remaining 647 visits were from 84 other countries.

The **postal contact list** includes contacts from all Health Board areas in Scotland, with the exception of the Western Isles and Orkney. The email contact list does not provide geographical addresses.

A manual analysis of the April 2008 to October 2009 **materials spreadsheet** indicates that requests for materials were made from all Health Board areas in Scotland with the exception of Orkney. In addition, requests had come from other parts of the UK and abroad, including Finland, Australia, Canada, New Zealand, Ireland, the Netherlands and the USA.

The **annual conference** booking records show a total of 449 bookings with addresses within Scotland and 26 with addresses outwith Scotland. Those within Scotland were spread across the following health board areas:

Glasgow	97
Tayside	95
Lothian	72
Forth Valley	46
Highland	30
Fife	27
Grampian	26
Lanarkshire	17
Ayrshire & Arran	16
Borders	14

Dumfries and Galloway	5
Western Isles	3
Orkney	1
Shetland	0

Of the 58 **events** SRN staff attended in 2008, 25 were in Glasgow and 14 in Lothian Health Board areas and, of the 40 attended in 2009, 14 were held in Glasgow and 10 in Lothian Health Board areas.

Of the 29 **SRI workshops** and events recorded, 11 were in Glasgow; 4 in Lothian; 3 each in Ayrshire and Arran and Lanarkshire; 2 each in Grampian and Tayside; and 1 in each of the other Health Board areas, with the exception of Borders, Western Isles, Orkney and Shetland, where there had been none.

Contacts, by service provider

The only data that can be analysed to assess the type of organisation people came from is the annual conference bookings data. This shows that the 332 people for whom an organisation type was identifiable were from the following:

NHS	142
Voluntary organisations	127
Councils	29
Partnerships	15
Academic institutions	10
Government organisations	7
Housing associations	2

Conclusions

The limitations of the data mean that it is only possible to draw very general conclusions:

- The website statistics show a high level of interest in the work of the Scottish Recovery Network, with nearly 20,000 visits, of which three-fifths (around 12,000) were not bounce visits. There were 12,000 non-repeat visits and visitors spent an average of four minutes on the site and looked at an average of four pages.
- SRN is directly and regularly in contact with at least 5,500 people who have asked to be kept informed of its work – as evidenced by the size of the email contact list, which has also grown in size in the past year. Other than through website statistics, it is not possible to identify whether it has reached more people than this, as duplicate or repeat contacts cannot be identified across different types of reach (i.e. email contact list, postal requests for materials, attendance at events etc.).
- The indications are, from requests for materials and attendance at events, that the vast majority of SRN contacts are in Scotland.
- The people who have attended events are predominantly service providers. The annual conference was attended by large numbers from the NHS and voluntary sectors.
- Tens of thousands of the key SRN resources have been distributed across Scotland and to nearly all Health Board areas.

- Geographical analysis of events shows that those attended or run by SRN have been predominantly in the central belt, in particular the Glasgow and Lothian Health Board areas.
- SRN has reached across the globe, as evidenced by requests for materials and over 3,000 website visits from people in other countries.

ANNEX E: CASE STUDY SUMMARY REPORTS

Case study area 1

The local recovery network steering group was formed in 2005, following an event organised by a senior NHS mental health manager, in collaboration with the SRN. The network is funded by the local NHS Board. Its aim is to ensure that recovery is embedded within service provision and to connect people who have a common interest in recovery.

The steering group now has 14 members, a 50/50 mix of professionals and service users. It is chaired by an NHS manager, and has a paid administrator. There are 300 members on the network's email list who all receive a newsletter three times a year. A separate newsletter goes to GPs, services user groups, etc.

The LRN has three task groups (again 50/50 representation) :

- *Communication*: responsible for raising awareness through the website, newsletter and events, including an annual conference.
- *Education and Training*: 17 trainers run a training programme around the 6 Realising Recovery modules.
- *Evidence*: includes academics, service users and health services and is developing a recovery-based values framework.

Other activities include:

- Gathering and disseminating information about recovery and recovery practice to challenge existing practice and enable people's voices to be heard
- Developing peer support projects
- Bringing people together to discuss the concept of recovery, e.g. employers, with the aim of creating mutual understanding, encouraging new ideas and improving ways of working.

What changes have taken place as a result of LRN's work?

The major change identified was that both professionals and service users now believe that recovery is possible. Other changes were:

- People with experience of mental health problems have gained hope and confidence from having their voice heard. Professionals benefit from meeting people and hearing their stories. Some people with experience of mental health problems have moved on to develop new skills and confidence through taking part in training and conferences. Some have found new employment or become volunteers.
- There have been both strategic and operational changes to adopt recovery, e.g. in new care plans. Some area teams are now called Community Recovery Teams. In a recent training evaluation nurses said that in future they would take more care with the language they used in case notes.

- Service delivery has improved, for example CPNs were said to be more recovery-focused. However, change was not universal and certain professionals were reportedly not so receptive — for example, doctors rarely attend training.
- The work on recovery has promoted the idea that carers are part of the process of recovery. However, difficulties sometimes arise when young people are transferred to adult mental health services, as carers (family) are not automatically involved with adult services.
- Publicity has helped to strengthen links with the community, e.g. Mental Health Arts Festival, links to Black and Minority Ethnic and Lesbian, Gay, Bisexual and Transgender community.
- Three mental health teams are in the early stages of working with SRI.

One of the main factors for change has been the involvement of people with lived experience in network activities and delivering training. This challenges professional attitudes by embodying recovery and showing that recovery is possible. It gives hope and reduces stigma. It also promotes use of a person-centred approach.

Role of SRN

The SRN have provided advice and shared learning and good practice. They were reported to be *“incredibly supportive”*. The SRN helped by raising awareness of recovery; developing the Narrative Research; acting as a *“pump primer”* with their research and materials; introducing peer support; and starting off WRAP. The SRN has also worked collaboratively with the local network to host recovery Training for Trainer courses and a peer support conference.

Ideas for the future

- The SRN should continue to promote recovery at a national level. Local networks or groups need to be provide support for recovery at a local level. It should be a marriage of national effort and local activities.
- It was felt to be important that SRN was a **network** where there was respect for all points of view. However, there was a suggestion that they should be a bigger presence like Choose Life or See Me although there was also recognition of the value of work that was *“quieter and more grassroots”*.
- It was suggested that recovery could be introduced to people by primary care at an early stage of illness. There should also be training targeted at medical schools.
- There should be efforts to widen awareness of recovery, for example through contacts with psychologists, more publicity in communities and by learning from other parts of the UK. The SRN should invite more politicians along to awareness-raising sessions and should try to engage recovery champions at a policy level.

Factors that could hinder progress were greater conservatism in rural areas where stigma is greater and there are issues of transport and accessibility. Factors that could help were having ongoing support in the community i.e. networks of people with similar issues; involving families and carers and giving them support; and a deepening understanding of what works in recovery.

Case study area 2

The local recovery network was formally launched in June 2008 although work on recovery had already started in 2005/6. The network is funded by two local councils and the NHS to help with the cost of events and producing promotional materials. The network's aim is to raise awareness of recovery, promote better understanding of what recovery actually means and to show that change is possible.

The network is hosted by a local service user- and carer-led organisation that aims to influence planning and delivery of services across the area. The principles of the network are: service users and carers drive their own recovery, services facilitate recovery and the community maintains recovery through positive attitudes. The workshop group said that one of the strengths was that the local network was hosted by a service user- and carer-led organisation.

There are now 15 member organisations including. Network membership is split about 60 / 40 professionals to users and carers. Around 150-200 people attend events and an e-bulletin goes to around 600 people.

The main activities of the network are creation and dissemination of material, organising and participating in events (for example the Mental Health Arts and Film Festival), and delivering presentations. Specific activities are:

- The development and sharing of personal narratives, drawing on the national work of SRN. This material has been used to develop multi-media resources which are used in training professionals and in awareness-raising more widely.
- Working in partnership with organisations, including the local *See Me* partnership (now amalgamated with the network). In addition, the partnership between the councils and NHS helps consistent messages to be spread throughout the area.
- Sharing information through a website maintained by the NHS board.
- Delivery of recovery training, e.g. for NHS and council staff. Joint training (delivered by service users and providers) creates a wider perspective and helps people to understand each others' challenges. Service users gain confidence in their own recovery and can see that recovery is possible.
- Promoting the use of tools: SRI, WRAP (adapted for local use by service users), and providing peer support.
- Linking to national networks and agencies, e.g. Choose Life, VOX, Samaritans.
- Consulting with service users about services.

What changes have taken place as a result of LRN's work?

Members of the network reported the following changes:

- People with mental health problems reported feeling more accepted and more positive. Mental illness is not seen as a life sentence any longer which helps people to progress in their own recovery. However, people need time to understand about recovery – to build their confidence.

- Some of the activities can be springboards to other opportunities. People often progress in their own recovery through their participation, for example some have become volunteers or have gone on to education, training or employment.
- There were reported to be changes in practices within services. For example, a more person-centred approach, changed terminology and changed attitudes.

Factors influencing change were thought to be the use of the SRI, the introduction of WRAP, peer support workers in three acute wards and the delivery of recovery training. Local events and awareness raising were felt to have changed attitudes. However, some thought there were still challenges to achieving practice change.

Role of SRN

The SRN has engaged with the network from the start and was felt to be very supportive. The initial meetings helped the network to clarify their aims and establish a mutual understanding of what recovery means. The national work of the SRN is regarded as an exemplar and a guide for local work. For example, the evaluation of peer support, the leadership programme, and sharing of knowledge and experience as well as resources and evidence. The local network's motto is "Link National, Think Local". They have tried to "translate" the work of SRN to fit within the local context. The SRN were said to understand this and be willing to listen.

More specifically, SRN have contributed matched funding for the development of local multi-media resources, and collaborated on getting it done. They have also provided support and advice on the SRI, peer support and gathering stories from service users.

Ideas for the future

- The SRN should have a higher profile, similar to Choose Life and *See Me*, and possibly a more public campaign, e.g., social marketing. Some felt the SRN should be driving recovery at Government level and should have more resources.
- There needs to be more joined-up national policy aimed at creating a sustainable structure to support recovery and make it mainstream.
- It needs people in services to "walk the talk" and managers to endorse recovery as an absolute priority, e.g., writing it into job descriptions.
- There could be more exchange between areas across Scotland to share good practice.
- Think about promoting recovery at a much earlier stage in a person's illness. This would need evidence about savings, e.g., preventing long-term care, reducing the need for medication, reducing re-admission rates.
- SRN could develop a model for local Recovery Champions.

Factors that hinder progress were felt to be: attitudes, stigma and negative media coverage (seen to be still current).

Factors that could help were: local champions, training a wider range of groups, more open government that involves service users, joined-up working with mutual support and sharing between agencies and consistent messages.

Case study area 3

The local recovery network is due to be formally launched at an event towards the end of 2010. It became a constituted organisation in February 2010, and at that time the interim management committee comprised members who were mental health service users, social workers, voluntary sector mental health service providers and psychiatric nurses. It is expected that a fully-fledged management committee will be elected at the launch meeting.

An embryonic network has been meeting and consulting locally for the past two-and-a-half years. During most of this time it has been supported by a clinical psychologist and her secretary, who has acted as network co-ordinator. This in-kind support has been channelled via a joint NHS and council multi-agency group.

The network has received very little funding. At the time of the case study, it had £500. The SRN has provided some funding to hire venues and pay travel expenses but it has received no funding from either the local council or health board. Once the network elects a new management committee, the plan is to apply for funding. There have also been preliminary discussions with a local service-user led mental health service about it becoming the host for the network.

There have been a number of barriers to the development of the network:

- A fear of what recovery might lead to — some participants were reported to have feared that it was a way of *“getting people off sickness benefits”*
- A lack of consensus about the meaning of recovery
- A lack of funding
- People leaving the network because of a perceived lack of decision-making
- Difficulties finding venues for meetings
- Access and transport to venues which is very difficult in this rural area and can prevent people getting to meetings.

Factors that have helped with development of the network are:

- In-kind support — the input from the clinical psychologist and secretarial support
- Support from the SRN including travel expenses and publicity materials, help with facilitating meetings and events, providing advice, for example, on forming a charitable body. The SRN was described by one participant as being *“skilful, supportive, enabling and providing clarity”* and *“very positive and encouraging”*
- Support from a local voluntary sector mental health service — on procedures, etiquette, overcoming doubts and problems in the decision-making process
- Persistence among the members of the embryonic network
- Telling their stories about their experiences of mental health problems.

Following the launch event, the network plans to raise awareness of recovery through more publicity and events; make the network more secure by finding an affiliate or auspice body and securing funding. Other planned activities include work in schools to tackle stigma; and pilot WRAP training.

However, some critical issues (raised by the clinical psychologist) for a network in a rural area are thought to be:

- To what extent is a local network the best model for promoting recovery — or should it be achieved by, for example, building capacity in an existing local voluntary organisation; adopting recovery in all services; and promoting greater service user involvement in services?
- As a national policy, how should it be funded locally?

Case study area 4

This area did not have a local recovery network, although there had been discussion among local service providers, service user representatives and the SRN about the possibility of establishing one. It was suggested that there had been agreement (from some people, at least) that having a network would be a good thing, but there was no agreement about how this should be taken forward and by whom.

Nevertheless, the (three) professionals who took part in the case study all reported that a lot had been done locally to develop more recovery-focused services. This included service redesign, the training of staff and the use of the SRI tool. All of these individuals felt that recovery approaches were being adopted in the area. Examples included:

- The development of a new model of care within the acute admission wards
- Care plans in all services being done jointly with service users and carers
- The involvement in the national peer support worker pilot
- A focus on individuals' strengths and strengths-based care planning.

In addition, the out-patient service had been renamed the “Recovery Team” to reflect its focus on promoting and supporting recovery.

There are active service user and carer networks in the area, and formal mechanisms for service users and carer representatives to be involved in local service planning groups.

However, in the focus group with service users, it seemed that the *term* recovery is not commonly used by service providers in delivering therapeutic care (e.g., by GPs or mental health professionals), although about half the group, and particularly those who were familiar with WRAP, were aware of the concept.

The view from service users was that recovery was not consistently promoted, but at the same time, service users also acknowledged that they did routinely get positive and optimistic messages from the service professionals they had contact with.

In this area, it would seem that recovery practices may be happening, but that service users don't recognise these as such. There appeared not to be a 'recovery vocabulary' among the service users.

It is important to acknowledge however that the service users involved cannot be assumed to be representative of those in the local area.

Role of SRN

Only half of the service users had heard of the SRN. One individual had attended SRN events and this individual was the only one who knew what the SRN do.

The professionals saw the SRN as a positive resource for support. Examples were given in relation to the availability and accessibility of information, leaflets and other resources. The Director of the SRN had also been to speak to the local Mental Health Development Group, and several people from the area had attended the national conference, as well as seminars and other events organised by the SRN. It was reported that service users and carers have also attended SRN events, and part of their role has been to feed back to others (including clinicians) on these meetings.

The SRN had also provided support locally in relation to the roll-out of the SRI, and as mentioned above, the SRN Director had attended a meeting of local stakeholders to discuss the possibility of developing a local recovery network.

Ideas for the future

Professionals were happy with what the SRN is doing now, and it was suggested that the SRN should continue to keep the profile of recovery high — at least in part because of perceived cultural resistance by (some) staff to have their practice challenged. One individual expressed the view that a recovery network may be established in the area in the future.

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