Recovery-oriented mental health services
An international scoping review

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Background

Northern Ireland's Mental Health Strategy 2021-2031 (Department of Health, 2021) outlines the key priorities for transforming mental health services and highlights the role that a recovery-oriented approach can offer in terms of supporting individuals and families.

Considerable work and progress has already been made in Northern Ireland to develop and deliver recovery-oriented services and reflects the considerable contribution that the community and voluntary sector continue to make in partnership with statutory services.

Understanding the Northern Ireland context is important to facilitate the delivery of a comprehensive approach to recovery given our history of conflict, the practical aspects of an integrated health and social care system and the dominance of the traditional medical model in the management of care (Davidson and Leavey, 2010). The 'You in Mind' Regional Mental Health Care Pathway (Department of Health, 2014) implemented in 2014 and the 'Implementing Recovery through Organisational Change' (ImROC) programme in each of the five Health and Social Care Trusts (HSCTs) recognised the need for a personalised and recovery-oriented service but also urged wider organisational change. Regionally, variation still exists and the Strategy reinforces the need for a co-ordinated regional approach to recovery focused service delivery.

This scoping paper will seek to inform work relating to Action 16 of the Mental Health Strategy,

*"**Action 16**: Create a recovery model, and further develop and embed the work of Recovery Colleges, to ensure a recovery focus and approach is embedded across the entire mental health system."* ((Department of Health, 2021, p. IX).

The current approach to recovery-oriented mental health services comprises three key elements that require consideration and careful planning:
- Recovery-oriented health and social care services
- Recovery Colleges
- Peer workforce

Recovery at its simplest definition is 'living well' (Oades et al., 2017). This may involve: no longer experiencing mental health problems; improving some aspects of mental health and better managing ongoing problems; and knowing where and when to seek additional support and help if required. For some, the recovery process may involve a relatively rapid return to good mental health, for others this may be a repeated process and for many people it will be a lifelong journey. A important distinction is sometimes made between the traditional concept of 'clinical recovery' which usually focuses on the reduction or absence of symptoms and 'personal recovery' which is the focus of this review and refers to the process of getting on with all aspects of life often in the context of ongoing mental health problems. The recovery concept focuses on building resilience, supporting those in mental distress and helping people regain control of their lives. The concept of recovery also considers wellbeing within the context of other important factors, including the economic, social and environmental context of people's lives.

Central to the development of recovery-oriented services has been the establishment of Recovery Colleges that can play a central role in supporting people's recovery journeys and the development and expansion of a lived experience workforce.

Peer workers within mental health and social care can provide support and advocacy and a growing number of jurisdictions recognise the important role they can contribute to delivering high quality services. A helpful international exemplar has been the approach in Australia

where, since the 1990s, mental health services have employed consumer consultants to increase representation of service user views to improve quality. The employment of peer roles has been cascaded throughout adult public mental health services and across individual state services offering prevention, early intervention and out-patient and inpatient care (Ainsworth et al., 2020; Hancock et al., 2022). International research has evidenced that having a peer workforce can be an effective use of resources, help reach isolated communities, and one that demonstrates a positive impact on consumers, while driving innovation and improving overall quality of care (Ainsworth et al., 2020; Hoeft et al., 2018). However, lessons can be learned about how a peer workforce model can be implemented successfully and sustainably.

This scoping review will explore the relevant international literature. It has five key objectives:

- Discuss definitions of recovery and recovery-oriented services and propose a definition for Northern Ireland;
- Explore the international literature on Recovery Colleges with the aim of identifying considerations for future developments in Northern Ireland;
- Consider the role of the Recovery College network as a central resource for the lived experience workforce, providing training, staff development and peer support;
- Consider the issues facing the development and expansion of a peer workforce and consider the implications for the Northern Ireland context; and
- Identify the implications of these issues for the other key aspects of the Mental Health Strategy.

Methods

A rapid scoping review of relevant international mental health systems and grey literature forms the basis of this report. While this was not exhaustive, it has identified examples of good practice and builds on the experience of other health and care settings that have developed effective approaches to establishing recovery and peer support approaches.

Findings

Recovery

Defining recovery and recovery-oriented services

The historical development of the recovery approach

Roberts and Wolfson (2006) date the origins of recovery-oriented practice to the Quaker Tuke family who established The Retreat in York at the turn of the 18th Century. The Tukes showed that moral or psychological forms of treatment in a work-oriented, peaceful and pleasant environment could replace physical restraint. Contributions to the approach also were made as a result of the post-WW2 development of therapeutic communities, the deinstitutionalisation of services which began in the late 1950s and some of the more progressive aspects of rehabilitation within psychiatry (Shepherd et al., 2008). The civil rights movements of the 1960s and growth of disability rights in the 1970s, along with the advancement of the service user movement in the 1980s and 90s in the US and UK has also influenced the recovery approach (Cornes et al., 2007; Roberts & Wolfson, 2006). Self-help groups such as Alcoholics Anonymous also hold the central concept of being 'in recovery' although the meaning varies (Shepherd et al., 2008).

Definitions of recovery

The concept of personal recovery has been defined as 'a way of living a satisfying, hopeful and contributing life even with the limitations caused by illness' (Anthony, 1993, p. 15). The concept of clinical recovery has emerged from professional-led research and practice and differentiates from personal recovery in that it usually refers to 'returning to normal' (Slade, 2009, p. 354), the absence of symptoms, and/or externally set levels of social functioning such as employment, independence and relationships (Liberman & Kopelowicz, 2002). Anthony's initial concept of recovery developed for the US mental health service described the personal recovery journey and, since then, others have attempted to advance the model (Winsper et al., 2020). Whitley and Drake (2010) proposed a broader concept of mental health recovery incorporating five core domains:

- clinical (e.g. symptoms);
- physical (e.g. exercise);
- functional (e.g. employment);
- existential (e.g. self-determination); and
- social (e.g. social support)

Central to understanding the approach is the idea that people should not be defined or unnecessarily restricted by their mental health problems whilst recognising that many will have experienced negative interactions with people and services and may need help to rebuild their self-esteem and restore hope and meaning.

Fox et al. (2015) have also explored the important issue of what recovery can mean for carers and family members. Their research concluded that 'recovery-aware' carers feel more optimistic and hopeful about the future, feel more confident in the care they provide and therefore can contribute better in promoting recovery in their relative.

Concerns about the recovery approach

Recovery does attract some criticism. The use of the word 'recovery' can be misleading and create unrealistic expectations (Tew et al., 2007) and some representatives of the service user movement have found the approach of little use. Criticism has also been levelled that it is too individualistic and neglects the wider social, political and economic context (Price-Robertson et al., 2017). In summary,

"*recovery is old news, recovery-oriented care adds to the burden of already stretched providers, recovery involves cure, recovery happens to very few people, recovery represents an irresponsible fad, recovery happens only after and as a result of active treatment, recovery-oriented care is implemented only through the addition of new resources, recovery-oriented care is neither reimbursable nor evidence based, recovery-oriented care devalues the role of professional intervention, and recovery-oriented care increases providers' exposure to risk and liability*" (Davidson et al., 2006, p. 640).

Recovery has also been criticised as serving a neoliberal agenda with little empirical research involving those who continue to struggle with their mental health (Rose, 2014). The [Recovery in the Bin](#) movement has challenged the 'recovery' concept, accusing mental health services, commissioners and policy makers of co-opting it for neo-liberal/capitalist purposes. While the core principles underpinning recovery remain valid, they argue that chronic social and economic circumstances and oppression prevent recovery from being achieved under current service design, planning and delivery. They are also critical of tools that measure recovery and their lack of utility to inform policy or reduce mental distress. The promotion of the recovery narrative is characterised as disempowering because it compels people to justify their experience. Initiatives such as the Recovery Colleges, mental health community hubs, food banks and practitioners within GP surgeries also are criticised for embedding neoliberal approaches with the aim of facilitating privatisation, deregulation and ultimately reduce investment in services.

The recovery narrative

People's accounts of these processes, the recovery narrative, underpins the understanding of the concept of recovery and has helped foster empathy and understanding, reduce stigma, and nurture a collective voice that has been characterised by some as a civil rights movement. This approach has become central practice within recovery-focused healthcare (Davidson et al., 2011; Llewellyn-Beardsley et al., 2019; Spector-Mersel & Knaifel, 2018).

Rhodes and De Jager (2014) conducted a systematic review of recovery narrative research and although they only included four studies, they identified four higher order concepts that remain central to the approach, namely:

- recovery is possible;
- recovery is a journey;
- being in control of your own recovery is crucial; and
- the role of community in recovery.

Beyond the potential of personal stories of recovery to increase understanding and empathy and articulate a voice for service users, there are broader structural considerations that also challenge the dominant clinical narrative (Adame & Knudson, 2007). Llewellyn et al.'s (2019) review of recovery narratives demonstrated that they are multifaceted and multidimensional, reflecting not only individual interpretations of recovery journeys but also acknowledged the structural impact of wider socio-economic, political, human rights, cultural and systemic issues. They concluded that recovery narratives are distinct from physical illness narratives represented in the research literature because they recognise structural influences and include recovery both *within* and *beyond* mental health services. As with recovery, recovery narratives can be non-linear. Finally, this review highlights the voices that are absent in the literature including collective narratives, non-text medium, and the intersectionality of structural oppression.

Recovery-oriented systems

While a recovery orientation is incorporated within mental health policy in many countries, there is no one agreed definition and the term is used inconsistently. This presents challenges for working practice and the need for further conceptual clarity (Leamy et al., 2011; Slade et al., 2012). The systematic reviews and narrative syntheses of the recovery literature conducted by Leamy, Slade and colleagues (Leamy et al., 2011; Slade et al., 2012) identified three interlinked superordinate themes: characteristics of the recovery journey; recovery processes; and recovery stages. This work led to the development of the CHIME conceptual framework (**C**onnectedness, **H**ope and optimism about the future, **I**dentity, **M**eaning in life, and **E**mpowerment) with the aim of providing a foundation to developing a standardised approach of measuring recovery.

Figure 1. The CHIME framework for personal recovery
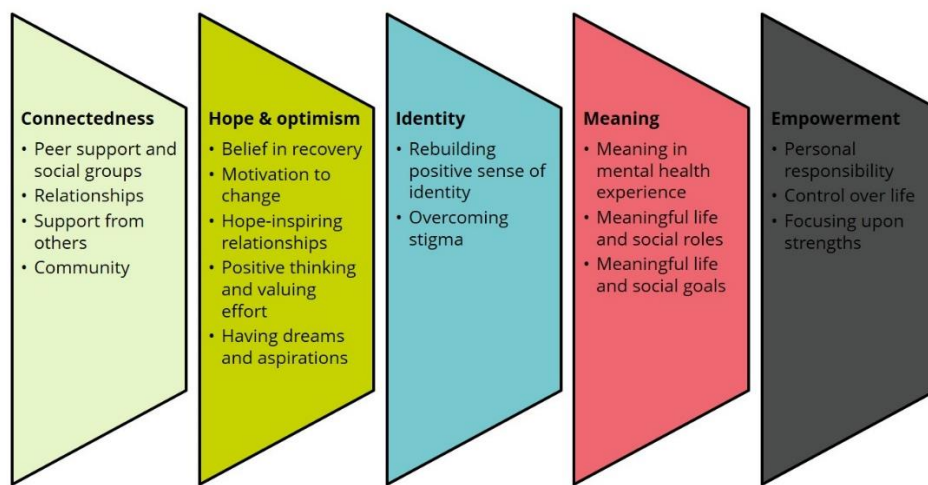
Leamy et al. 2011

A specific and popular approach developed to facilitate recovery is the use of Wellness Recovery Action Plans (WRAP). WRAP has five key principles (NHS, 2022) which have broader systemic relevance:

1. **Hope:** people who experience mental health difficulties get well, stay well and go on to meet their life dreams and goals.
2. **Personal responsibility:** it's up to you, with the assistance of others, to take action and do what needs to be done to keep yourself well.
3. **Education:** learning all you can about what you are experiencing so you can make good decisions about all aspects of your life.
4. **Self-advocacy:** effectively reaching out to others so that you can get what it is that you need, want and deserve to support your wellness and recovery.
5. **Support:** while working toward your wellness is up to you, receiving support from others, and giving support to others, will help you feel better and enhance the quality of your life.

Recovery-oriented practice

Recovery-oriented practice is reflected in UK guidelines, with policy focused on the concept of personal recovery rather than becoming symptom free (Slade, 2010). The operationalisation of the recovery principle is a significant gap in the mental health literature (Davidson et al., 2016). Practitioners are encouraged to foster trust, resilience, continuity of care, show empathy, honesty and establish non-authoritarian relationships (Duffy et al., 2016; Stratford et al., 2012), but there are limited examples of how recovery approaches can be measured (Gwinner et al., 2013) or implemented in daily practice (Karpetis, 2020).

Further work is also required to acknowledge the impact of poverty, social and structural disadvantage that can affect mental health and recovery (Swords & Houston, 2020).

Shepherd and colleagues (2008) have developed the 'Ten Top Tips' for recovery-oriented practice. After each interaction, mental health professionals should ask, did I…

- "actively listen to help the person to make sense of their mental health problems?
- help the person identify and prioritise their personal goals for recovery – not professional goals?
- demonstrate a belief in the person's existing strengths and resources in relation to the pursuit of these goals?
- identify examples from my own 'lived experience', or that of other service users, which inspires and validates their hopes?
- pay particular attention to the importance of goals which take the person out of the 'sick role' and enable them actively to contribute to the lives of others?
- identify non-mental health resources – friends, contacts, organisations – relevant to the achievement of their goals?
- encourage self-management of mental health problems (by providing information, reinforcing existing coping strategies, etc.)?
- discuss what the person wants in terms of therapeutic interventions, e.g. psychological treatments, alternative therapies, joint crisis planning, etc., respecting their wishes wherever possible?
- behave at all times so as to convey an attitude of respect for the person and a desire for an equal partnership in working together, indicating a willingness to 'go the extra mile'?
- while accepting that the future is uncertain and setbacks will happen, continue to express support for the possibility of achieving these self-defined goals – maintaining hope and positive expectations?

The 'Contributing Life' framework underpins the National Mental Health Commission's work to:

- Ensure individuals live a contributing life
- Have equitable opportunity
- Have the best possible mental health and wellbeing
- Are included
- Have knowledge, assurance and respect

Recovery-oriented interventions

Winsper, Crawford and Weich (2020), using a systematic review methodology, identified four main typologies for recovery-oriented interventions:

- "*Psychoeducational (individual or group)*: illness management and recovery (IMR), psychiatric advance directives (PADs), wellness recovery and action planning (WRAP), the recovery workbook, and recovery colleges.
- *Peer:* peer-support and peer-led programs delivered by peer specialists (i.e., individuals who use their lived experience to deliver mental health services).
- *Social inclusion*: supported employment (including individual placement and support and individual enabling and support), supported housing, community development programs, community wellbeing champions, personal budgets, and strengths model.
- *Pro-recovery and mental health literacy training*: recovery-oriented training for mental health professionals (e.g., REFOCUS/REFOCUS-PULSAR, the Collaborative Recovery Training Program: CRTP), and mental health first aid (MHFA) training for members of the public.

Winsper et al. (2020) also considered mechanisms of action or the underlying processes that underpin interventions to aid recovery outcomes. They found quantitative evidence for "putative mechanisms" but the bulk of the evidence was drawn from qualitative studies including descriptions of theoretical mechanisms or change models.

Recovery and organisational reform

Operationalising recovery

The Sainsbury Centre (2009) has identified ten key organisational challenges for implementing this approach:

- "Changing the nature of day-to-day interactions and the quality of experience
- Delivering comprehensive, service user-led education and training programmes
- Establishing a 'Recovery Education Centre' to drive the programmes forward
- Ensuring organisational commitment, creating the 'culture'
- Increasing 'personalisation' and choice
- Changing the way we approach risk assessment and management
- Redefining service user involvement
- Transforming the workforce

- Supporting staff in their recovery journey
- Increasing opportunities for building a life 'beyond illness".

In order to create a recovery-oriented culture, their guidance includes:

- Does it begin with a 'Mission Statement' and leadership 'from the top', or should it be built up from the bottom?
- What is the place of staff training?
- How – and by whom – should training be delivered?
- What is the importance of employing people with a service user background in the workforce?
- What should be the aims in terms of numbers of people with mental health problems in the workforce?
- What is the contribution of existing staff who have a 'lived experience' of mental health problems?
- How do we deal with stigma in recruitment and HR processes?

Implementing Recovery through Organisational Change (ImROC)

The ImROC programme aims to change how the NHS and partners operate to promote recovery and was introduced to Northern Ireland in 2013. ImROC recognises 10 key organisational challenges (Boardman & Shepherd, 2009):

1. Changing the nature of day-to-day interactions and the quality of experience of people using services and those close to them.
2. Delivering comprehensive service user led, co-produced, education and training programmes.
3. Establishing a Recovery College to drive the programmes forward.
4. Ensuring organisational commitment – creating a recovery-focused culture at all levels.
5. Increasing personalisation and choice.
6. Changing the way we approach risk assessment and management.
7. Redefining service user involvement.
8. Transforming the work force to include peer workers.
9. Supporting staff in their journey of recovery and transformation.
10. Increasing opportunities for building a 'life beyond illness'.

The development of ImROC in Northern Ireland will be explored further later in this review.

Measuring recovery

There are differences between measuring (a) recovery (or the recovery orientation of services) and (b) reductions in symptoms/increase in functioning (Burgess et al., 2010). Although recovery is associated with these clinical improvements, it may be completely unrelated to them. Measuring recovery should consider: clinical improvements, individual level outcomes, and service-level processes that equate to good quality care (Burgess et al., 2010). At an individual level, it is also relevant to measure recovery across the lifespan, across phases of illness and episodes of care. Measures that are culturally and linguistically appropriate, consider comorbid mental health and substance use problems and other needs also need further work (Burgess et al., 2010).

Table 1. Potential candidate instruments for routine use in measuring recovery (Burgess et al., 2010, p. 27)

INSTRUMENTS DESIGNED TO MEASURE INDIVIDUALS' RECOVERY	INSTRUMENTS DESIGNED TO ASSESS THE RECOVERY ORIENTATION OF SERVICES
• Recovery Assessment Scale (RAS) • Illness Management and Recovery (IMR) Scales • Stages of Recovery Instrument (STORI) • Recovery Process Inventory (RPI)	• Recovery Oriented Systems Indicators Measure (ROSI) • Recovery Self Assessment (RSA) • Recovery Oriented Practices Index (ROPI) • Recovery Promotion Fidelity Scale (RPFS)

Research on the effectiveness of the recovery approach

Research on the recovery approach is still developing, and being led by service users, carers and professionals rather than the research evidence (Mental Health Commission, 2005). One user-led tool is the DREEM (Developing Recovery-Enhancing Environments Measure) (Allot et al., 2006; Ridgway & Press, 2004) which concentrates on identifying where people are in their process of recovery and how recovery-orientated their services are. Tew et al. (2015) conducted semi-structured interviews with fifty-three people with serious mental health difficulties who had accessed personal budgets in 2012-13, concluding that this approach can support recovery thinking and processes and activate appropriate resources to make this possible. Using a co-produced approach with flexibility around resourcing that can react to fluctuating levels of mental wellbeing, they recommend that budgets should be linked to recovery goals rather than assuming what the long-term care needs will be. It has also been argued that, given the individualised nature of the approach, narrative research might be the best approach (Roberts & Wolfson, 2006; Roberts, 2000; Shepherd et al., 2008) and some excellent examples of this have emerged (Brown & Kandirikirira, 2007). A key aspect of the development of the recovery approach may depend on its effectiveness with people who are reluctant to engage with services and/or who are compelled (Tew et al., 2007).

Outcomes measuring recovery can include functional, existential and social connections, and some studies in Winsper et al.'s (2020) review also measured mental health professional and general public attitudes as a contributory factor in an individual's recovery.

A definition for Northern Ireland?

As outlined above, there are a range of recovery definitions and some key recurring themes about the importance of hope, peer support, actively looking after your mental health and getting on with whatever it is you want to do in life. The ethos of recovery would suggest that the development of a definition for Northern Ireland should be a co-produced process but these existing definitions and key themes would provide a good foundation for that process.

Tackling inequality and stigma

Supporting recovery should acknowledge the structural inequalities and related stigma experienced by people with mental health problems (Rose, 2014; Swords & Houston, 2020). Reducing mental health inequality and stigma remains an issue of concern because of the additional barriers they present for help-seeking and social inclusion and related stressors (Davidson & Leavey, 2010). Recovery-oriented services have an important role in helping to tackle stigma and inequality.

The INDIGO (International Study of Discrimination and Stigma Outcomes) Research Network has led a series of research initiatives exploring mental health stigma and discrimination (Thornicroft et al., 2019). This work has demonstrated the universal experience of stigma for people experiencing mental health problems regardless of diagnosis. For the many, this has involved concealing or being cautious about disclosing their mental health problems. Levels of discrimination experienced were found to be greater in higher income countries compared to lower and middle income economies highlighting the role of social exclusion in these processes. The INDIGO initiative has led to the development of a toolkit of freely available scales and measures of three stigma concepts: knowledge; attitudes and; behaviour. These have been translated into 31 languages and used in 67 countries, helping to establish a better understanding of the impact of stigma and discrimination globally. Subsequent research has reinforced the importance of:

> "a) social contact (i.e., interpersonal contact between people with and without experience of mental illness) is the strongest proven active ingredient to reduce mental illness related stigma and discrimination;
> b) such social contact is most effect in educational settings for young people;
> c) there is emerging evidence that virtual/social media contact may be effective as direct face-to-face contact" (Thornicroft et al., 2019, p. 29)

The Lancet's Commission (Thornicroft et al., 2022) on ending stigma and discrimination in mental health identified three key findings:

Figure 3. Key findings of the Lancet Commission on ending stigma and discrimination (Thornicroft et al., 2022)

The Commission made recommendations for five sectors:
1. **Health and social care staff** – All pre-qualifying courses to include mandatory training
2. Sessions on the needs and rights of people with mental health conditions, co-delivered by people with such conditions
3. **Employers** – Promote full access to educational opportunities, work participation, and return-to-work programmes for people with mental health conditions

4. **Policy makers** – Governments to implement specific policies, and international organisations to issue guidance, that aim to reduce and eventually eliminate stigma
5. **All media organisations** – Remove stigmatising content, and issue policy statements and action plans on how they will actively promote mental health and consistently contribute to the reduction of stigma and discrimination
6. **People with lived experience of mental health conditions** – Should be central to all these actions, and be empowered and supported to play active roles in stigma reduction efforts

The Mental Health Foundation's response to the Scottish Government's consultation on a new Mental Health and Wellbeing Strategy for Scotland appeals for, "a radical approach to improving people's mental health", calling for a greater emphasis on prevention, "We can't treat our way out of the mental health crisis." (Mental Health Foundation, 2022, p. 4). Among their recommendations, they highlight the need for an interdepartmental response that includes 'mental health in all policies' acknowledging how mental health affects every aspect of people's lives. Government should consider the impact of policies on mental health and on a practical basis, this could be facilitated by establishing a 'mental health in all policies' Forum to inform the work of each ministerial department.

All work should also be informed by engaging with people with lived experience, inequalities and/or discrimination. The Foundation has recently established the Diverse Experiences Advisory Panel (DEAP) designed to inform the Scottish Government's mental health policy on "how to recognise and reduce the impact of inequalities" (Mental Health Foundation, 2022, p. 7).

The work of the Foundation advocates a whole population approach including a strategic focus on prevention. This approach is a significant step forward in helping to tackle stigma and discrimination because it acknowledges the universality and importance of mental health and wellbeing. For many of us, the Covid pandemic has not only increased the prevalence of mental health problems and related inequalities (Pierce et al., 2020), but also highlighted population level variation in psychological vulnerability and resilience (Shevlin et al., 2021). Initiatives such as parenting programmes, increasing mental health literacy (starting within education settings and involves teacher training), reducing social isolation and loneliness in older people and promoting physical activity, art and leisure are all recommended. Strategies that help promote wellbeing within workplaces can also be an effective way to help reduce stigma. Recognition of the risk factors for poor mental health also needs to be acknowledged in prevention approaches, these include: gender; people experiencing poverty; people living with long-term conditions; black and minority ethnic communities; LGBT+; refugees and asylum seekers; people with care experience; and children and young people in the criminal justice system.

Recovery Colleges

The historical development of the Recovery College movement

Specialist mental health assessment and treatment are important but do not adequately reflect the range and depth of mental health services particularly, "if people are to participate as equal citizens in economic, social and family life and do the things they value." (Perkins et al., 2012b, p. 3). Recovery Colleges were first developed and implemented in the UK in 2009 (Lin et al., 2022) and have since been established in more than 20 countries including Australia, Canada, Hong Kong, Ireland, Japan and the USA (Perkins et al., 2018; Whitley et al., 2019). Modelled very much on adult education, they have registration, curricula, staff, and a yearly cycle of classes but what sets them apart is the meaningful involvement of people in recovery (peers) in all aspects of the College system (Whitley et al., 2019). Funding varies widely including statutory and voluntary sector sources; physical settings can include locations within hospitals and mental health services, in the community and increasingly online. Recovery focuses on the individual and the symptoms and,

"*involves making sense of, and finding meaning in, what has happened; becoming an expert in your own self-care; building a new sense of self and purpose in life; discovering your own resourcefulness and possibilities and using these, and the resources available to you, to pursue your aspirations and goals*" (Perkins et al., 2012a, p. 2).

Using an adult educational paradigm and a strengths-based approach rather than a clinical or therapeutic model (Whitley et al., 2019), they draw on clinical and lived experience to support people's recovery journeys (Thompson et al., 2021) beyond symptom remission (Whitley et al., 2019). An international community of practice has been established to promote research, knowledge exchange and improve understanding (Whitley et al., 2019).

Rachel Perkins has been instrumental in the Recovery College movement having established the first one in South West London in 2009. Her work has informed the development of the model and iterations of defining features have been published over the years (Perkins et al., 2018; Perkins et al., 2012b), these include:

- Educational
- Collaborative
- Strength-based and person-centred
- Progressive
- Community facing
- Inclusive

The Recovery College in practice

The European Union Regional Development Fund invested 7.6 million Euros to build on existing initiatives and create a 'Cross-Border Recovery College Network' serving 8,000 people facing mental health challenges in Northern Ireland and the border counties of the Republic of Ireland (Perkins et al., 2018). Northern Ireland has a particular relationship with the local library network to promote and deliver access to Recovery College courses which has helped to explicitly deliver services to rural areas that can often experience reduced access. There is also some evidence that, in Northern Ireland, there is improved/universal access to the Recovery College for those who may be experiencing emotional and mental health problems but who are not using mental health services (Perkins et al., 2018).

As Recovery Colleges are co-produced locally, peers and staff initially develop an initial prospectus which is added to when students and trainers get involved. Curricula tend to cluster around five areas (Perkins et al., 2012b):

1. **Understanding mental health issues and treatment options** – these can be single sessions highlighting challenges around specific disorders or provide a more general introduction to mental health difficulties or treatment options.
2. **Rebuilding life with mental health challenges** – can range from one day to longer courses that help people to develop their own recovery plans and narrative. These include self-management for specific disorders and wellbeing (physical activity, healthy eating, diet, sleep, stress, coping with anger etc.).
3. **Developing life skills** – managing a budget, tenancy, personal safety, e-learning and returning to work or study. There may also be courses that focus on maximising services e.g. understanding mental health legislation or making a complaint.
4. **Capacity building among the peer workforce**.
5. **Family and friends** – courses focused on the challenges experienced by family and friends.

Recovery Colleges – the research evidence

Colleges on average achieve an attendance rate of around 60-70% which is similar to adult education rates (Perkins et al., 2018). People enjoy attending them and report high rates of satisfaction (Gill, 2014; Meddings et al., 2014; Rennison et al., 2014) and would recommend their course to others (Bristow, 2015). Recovery Colleges can contribute to individual recovery goals (Burhouse et al., 2015; Rinaldi & Wybourn, 2011; Sommer, 2017), improve quality of life and wellbeing (Meddings et al., 2015; Secker & Wilson, 2014) and improve educational, employment and social outcomes (Hall et al., 2016; Meddings et al., 2015; Rennison et al., 2014; Rinaldi & Wybourn, 2011). Thériault et al. (2020) conducted a literature review of 'a decade of research' of Recovery Colleges and concluded that Recovery College attendance was associated with high rates of student satisfaction, attainment of recovery goals, changes in service providers' practice and a reduction in service use and cost. Their review also demonstrated evidence that quality of life and wellbeing improved.

Research presented by Perkins et al., has also demonstrated reductions in service use and improved cost-effectiveness (Barton & Williams, 2015; Bourne et al., 2018; Rinaldi & Wybourn, 2011; Secker & Wilson, 2014).

Thompson et al. (2021) conducted qualitative semi-structured interviews with 15 Recovery College participants to explore past student understanding of the Recovery College in their recovery journey at one-year follow-up. They identified three themes in their data:

- **Ethos of recovery and equality**: safe, supportive and accepting; normalising; inclusive, open and accessible; co-produced, collaborative and learning from each other. "The Recovery College explicitly recognises the expertise of both mental health professionals and people with lived experience such as the peer trainers, which students particularly valued. The co-production approach challenges traditional hierarchy through emphasising reciprocal relationships and equalising power,

reducing the "them and us" distinction that often exists in traditional mental health services." (Thompson et al., 2021, p. 9)

> "*I mean certainly I don't feel any stigma which I used to feel in the past, it's also normalised the experience of having a mental health problem. Spending so much time in an environment where everyone's got a mental health problem, everybody, even the clinicians, everyone had, all the staff, everyone!*" (Recovery College Participant).
>
> Thompson et al., (2021)

- **Springboard to opportunities**: encouraged to envisage a hopeful future; opening doors; finding balance, structure and purpose.

> "*I actually managed to start to get some structure back into my life*" (Recovery College Participant)*.
>
> Thompson et al., (2021)

- **Interpersonal changes**: increased self-awareness and understanding; increased confidence and worth; empowerment and control. Changes were emotional, psychological and cognitive.

> "*I know the signs to look for now...I think the Recovery College definitely helped with knowing what the signs are when things are going downhill*" (Recovery College Participant).
>
> Thompson et al., (2021)

There is, however, a growing need for their evaluation (Lin et al., 2022) including high quality quantitative research that considers additional outcomes such as empowerment and reduction in stigma and the impact on service users, families/carers and the everyday practice of practitioners (Thériault et al., 2020) to fully understand the mechanisms that lead to success (Kaminskiy & Moore, 2015). The impact on employment outcomes would also be beneficial (Whitley et al., 2019). Involving people with lived experience in the evaluation of Recovery College interventions would seem an acknowledgment of the ethos and rationale underpinning the Recovery College movement.

The Recovery College Characterisation and Testing (RECOLLECT) research project (Toney et al., 2018) produced a systematic review and developed a framework outlining mechanisms of action in Recovery Colleges based on 39 UK colleges, developing a theoretically grounded change model. This work identified three mechanisms of action:

- Empowering environment
- Enabling different relationships
- Facilitating personal growth

The team has also developed and psychometrically validated a recovery college implementation checklist and fidelity scale (https://www.researchintorecovery.com/research/recollect/).

There is evidence too that the colleges may have benefits beyond individual students and can positively affect mental health staff attitudes, reduce stigma within health and social service systems and help increase inclusiveness in wider society (Crowther et al., 2018) but there have been no formal evaluations of this broader impact (Perkins et al., 2018).

There remains an evidence gap in charting the success of Recovery Colleges and lack of Northern Ireland data that could shed light on their role and remit; this includes understanding more about the number of graduates and the diagnostic mix of service users. This could help us to explore whom Recovery Colleges are helping and where perhaps there are gaps in provision.

A peer workforce

There has been a long tradition of mental health peer support roles in a range of different settings and are now clearly recommended in policy; the World Health Organisation (WHO 2013, p.16) mental health action plan states that peer support workers (PSWs) are a "core service requirement."

Background to the peer workforce

Consumer workers were first introduced in Victoria, Australia in the 1990s in consumer consultant roles, "aimed at building dialogue between service providers and consumers and using systemic advocacy to represent consumer perspectives in quality improvement mechanisms" but their role has changed significantly within mental health services including post-discharge support. For the full potential of the peer support workforce, adequate resourcing, support and integration within the organisation is required. Poor implementation can lead to negative outcomes for both consumers and workforce. A recent review of the consumer workforce in Victoria, 'Leading the Change', used a mixed methods approach and concluded that despite consumer workers having long been established within the mental health workforce, there was room for significant improvement, criticism included:

- Lack of organisational support
- High rate of discrimination and bullying
- Clash of values between consumer work and the mental health system

Valuing lived experience work

Establishing the importance and agreeing a shared understanding of the peer/lived experience role is an important initial step. This will involve identifying the values and principles of the lived experience role, detailing the different types of work and providing direction to colleagues and managers about how they best support lived experience workforce development. Aiming to achieve parity of esteem and equality is important and this will involve recognising that while lived experience is an important element, it is not the only competency/skill required for the peer worker role.

Rose (2014) beautifully illustrates the contradictions of the peer support worker,

"First, they often find themselves in a position of tension because they have to fulfil two, sometimes contradictory, roles. They answer to two masters who require different things, that is, service users do not always want the things that clinicians prescribe (Fabris, 2011). But second, they are a subsidiary labour force commanding neither the respect nor the financial remuneration of mainstream staff. They are cheap labour. Some are not paid at all. So once again, we see an alignment between the financial restructuring of society and the recovery discourse. Peer support workers can be seen as part of the army of the Big Society."

There remains a contrast between the UK guidance and that of the Australian and US systems. While the UK guidelines 'Peer Support Workers: a practical guide to implementation' call for relatively low paid and low status Peer Support Workers who report to qualified nurses and should they want to progress their careers, are required to undertake professional training or move to a different role. In the USA, Peer Specialist Roles are evident at all levels from entry level to director with salaries commensurate with their role (Knight, 2014).

Australia's guidelines recognise the specialist knowledge and experience base that lived experience can bring to services.

Table 2. Knowledge, abilities and attributes of the Lived Experience role

Unique knowledge, abilities and attributes	What makes Lived Experience work effective?
• Profound life-changing mental health challenges that have led to a new life direction and concept of self **or** life-changing experiences while supporting someone with mental health challenges that have profoundly impacted their life/world view. • Personal identification with, and experiences of service use and/or advocating for someone using services. • Understanding experiences of marginalisation, exclusion, discrimination, loss of identity/human rights/citizenship. • Willingness to purposefully share experiences and parts of personal story in work role. • Understanding both experiences of hopelessness and the critical need for hope – how to move from a position of hopelessness to one of hope. • Willingness to use emotional understanding and knowing as key to work role. • Willingness to be vulnerable and publicly 'out'. • Understanding the personal impact of experiences of trauma. • The degree of empathy and what they are able to understand and empathise with. • Greater equality and efforts to reduce power imbalances with people accessing services, including no involvement with coercive or restrictive practice of any kind. • Being an advocate/change agent. • Level of awareness about self-care and skills/strategies to prioritise it.	• Applying lived expertise: not just having a lived/living experience but what has been learned through that experience and how it's applied. • Links with and understanding of the wider consumer movement and concepts. • Work that is values-based and authentically lived experience-informed, person-directed and aligned with recovery principles. • A social justice and fairness focus informed by understanding power imbalances. • Significant understanding and ability to use personal story effectively and appropriately, for the benefit of the other person or system/service reform. • Convey or inspire optimism and hope. • A bridge between organisations and people accessing services/supporting people accessing services. • Understanding of overlapping identities and experiences (intersectionality) and the impacts of culture and identification. • Trauma-informed: awareness of the role/impact of trauma and how to respond sensitively and appropriately. • Resilience in the face of discriminating, prejudicial and disempowering attitudes, practices and policies. • Focus on the relationship. • Greater flexibility/scope/ability to be responsive to the person, rather than being driven by a prescribed agenda. • Specialisation may be useful depending on the context and experience e.g. people from the Deaf community, Youth, people with experiences of family violence etc.

Adapted from Byrne, L., Wang, L., Roennfeldt, H., Chapman, M., Darwin, L. *Queensland Framework for the Development of the Mental Health Lived Experience Workforce. 2019, Queensland Government: Brisbane*

Lived experience/peer support as a distinct discipline

"*Lived Experience work or practice is recognised as a unique and separate discipline that offers a valuable contribution to the mental health sector. As its own discipline, Lived Experience work has distinct values, principles, and theories that define Lived Experience work and the way it is practiced.*" (National Mental Health Commission, p. 4).

Lived experienced workers in Australia's Peer Workforce Development Guidelines are described as 'change agents', both in terms of how they can support personal change in service users but also how they can influence cultural and organisational change. Research conducted in Victoria, Australia, recognised this valuable contribution which as a "mutuality creates a unique space for connection, one that may not exist in other relationships with health professionals". (Ainsworth, 2020; p. 2).

Table 3. A model of Lived Experience roles (Ainsworth, 2020)

Change mechanisms (1)	Change mechanisms (2)	Process outcomes	Impacts
• Building trusting relationships based on lived experience. • Establishing a connection. • Enabling talking and listening.	Role-modelling recovery and living well with mental illness	Personal outcomes • Hope • Empowerment • Social functioning • Self-care	Personal and recovery and wellbeing
	Bridging between mental health professionals and service users	Engagement between service providers and service users	Service use • Improved clinical outcomes • Reduced acute and crisis-care
	Developing mental health professional understanding of recovery	Recovery-oriented workplace culture and practices	Effective services demonstrate return on investment

Developing a peer workforce

Defining roles and responsibilities

In Australia, Lived Experience workers are employed in a range of roles including Consumer Consultants, Carer Consultants, peer support workers, family/carer peer support workers, specialist peer workers, and other designated roles in executive governance, paid board and committee representation, education, training, research, consultancy, policy design, and systemic advocacy in a range of different settings,

"*Designated roles have two different perspectives and ways of working and are informed by either: 1. **Personal experience** of mental health challenges, service use, periods of healing/personal recovery; or experience of **supporting someone** through mental health challenges, service user, periods of healing/personal recovery.*" (Byrne et al., 2021, p. 13).

A consultation process was carried out to agree a shared definition and use of language to describe the various roles. The term 'Lived Experience' was agreed as the most popular to describe consumer/peer roles. The term was capitalised to distinguish the professional from the personal, "i.e. working in a Lived Experience role as opposed to 'having a lived experience'. (Byrne et al., 2021; p.14). The need for culturally appropriate, inclusive terminology and concepts including acknowledging the importance of social determinants of health have been highlighted.

Terms to describe the 'experience' of designated roles were also explored in a consultation process. The majority preferred the term 'challenges with social and emotional wellbeing', followed by 'trauma', and then 'mental health challenges'. 'Mental health challenges' was adopted, as social and emotional wellbeing has specific cultural considerations for the Aboriginal and Torres Strait Islander communities and not everyone has experience of trauma.

While there is worry about the impact of stress and overwork on peer workers and the risk of symptom recurrence (Berry et al., 2011), there is little evidence that work-related burnout differs to that of other mental health workers in non-peer support roles (Park et al., 2016). This highlights the importance of establishing and promoting compassionate workplaces regardless of the role people undertake (Wahl et al., 2018).

The Australian guidance provides excellent advice on developing job descriptions informed by lived experience guidelines and principles and include appropriate management structures and opportunities for career progression.

Principles to guide workforce development
1. Co-production
2. Maintain the integrity of Lived Experience work – ensure that all work is consistent with the values and principles of Lived Experience
3. Create conditions for a thriving workforce – develop flexible, recovery-oriented workplaces where Lived Experience workers can achieve in their professional roles, with benefits for the whole workforce, service users and their families.
4. Respond to diversity
5. Reduce coercive and restrictive practice.
6. Support systemic change and professionalisation – identify areas for prioritisation in funding, policy, planning and service commissioning.

Figure 4. Priorities for Lived Experience workforce development (Byrne et al., 2021)

Recommendations for implementation
There are clear guidelines required to implement an effective approach:
- The workforce needs to be well supported;
- Sufficient in numbers – consumer workers can be isolated members in a team, often being the only lived experience role. Establishing teams of consumer workers embedded across all levels of the organisation could help reduce isolation;
- Roles also should be integrated across all areas of the mental health system;
- Responsibility for workforce development lies across a diverse number of stakeholders, engagement should be across all areas, with a collaborative approach to build and sustain the workforce;

- The 'Leading the Change' research also reported a lack of supervision and specific consumer specific supervision as a neglected aspect of the training and support for the role. Professional development and training was not well supported or invested in despite there being a number of appropriate and successful models e.g. International Peer Support;
- Ensuring people are treated equally, with comparable employment conditions to non-lived experience roles has also been highlighted as important. In the 'Leading the Change' survey, over half (53%) of respondents endorsed the statement "I feel that others in the workplace make judgements about me based on my disclosed lived experience." Frequent experiences of bullying included verbal abuse, feeling threatened by others, and workplace isolation were described. Participants also expressed concern about confidentiality in the workplace and their own use of mental health services. These experiences will have a significant impact on the sustainability of this workforce model.

Barriers to implementation

Gordon and Bradstreet (2015) conducted qualitative interviews about the introduction of peer workers with local decision makers in two Scottish health board areas. Their research found that senior decision makers were not always well informed about peer working and while they thought service users would value the role, they identified the need for evidence of their effectiveness in achieving patient and service outcomes in comparison to other professional roles e.g. nurse, occupational therapists. This was considered particularly important under current budget pressures. Building a business case that demonstrated how cost-effective peer workers and providing detail about the cost-benefits was considered helpful to persuade commissioners.

While there may be individual barriers facing workers, there are systemic issues that will need to be addressed:
- The medical model "that dominates culture and practice within mental health services is often at odds with the paradigm that underpins consumer work." (Gordon & Bradstreet, 2015);
- There remains a strong power imbalance across mental health roles, where consumer workers are seen to occupy the lowest level;
- Discrimination and derogatory comments about consumers and diagnoses were commonplace.

There also remains worry about the blurring of boundaries between lived experience, service users and the wider team (Kilpatrick, 2017) however with the establishment of clear guidelines, roles and responsibilities could help to reduce these fears. Gordon and Bradstreet's research further identified concerns about implementing and delivering peer support services including,

"how to ensure workers' compliance with professional requirements (such as patient confidentiality, information sharing with the wider multi-disciplinary team), maintenance of workers' wellbeing and risks to service continuity in the event of workers becoming unwell. In fact, there was a view that the significant challenges involved in establishing a service of this sort could lead to a "why bother?" attitude." (Gordon & Bradstreet, 2015, p. 164)

It is clear that "Embedding rather than tolerating a consumer workforce" (Ainsworth, 2020, p. 3) is required and this will involve developing an understanding of consumer work and work values at an organisational level and providing clear definitions of the consumer worker role and embedding their input in relevant policy and procedures. Until there is a requirement to

compel services to deliver a peer workforce, "Until there's an ultimatum, I don't think people are just going to do it". Strong leadership is required.

Practice case study – Peer Supported Transfer of Care (Peer-STOC), New South Wales

In a response to the increased risk of suicide, homelessness, relapse and rehospitalisation and pressure on community mental health teams who struggled to follow up post-discharge, a state-wide peer support initiative was introduced to increase recovery-focused support for individuals with complex mental health needs in the transition back to the community following an inpatient admission (Hancock, 2022). Peer-STOC peer workers are embedded within MDT community or inpatient teams and support begins in the inpatient setting prior to discharge to help, "build rapport, discuss wellbeing strategies, and collaboratively identify transitional supports needed" and is designed to last for around 6 weeks post-discharge. Support ranges from helping people to engage with communities and services of choice, providing social connections, and establishing routines such as leaving the house. An 18-month independent evaluation was conducted in 2021 using a survey (n = 82) and in-depth interviews (n = 53) led by lived experience researchers involving service users, peer workers and other health care professionals. The findings reported consistent and repeated positive outcomes for service users including: better, less traumatic inpatient experiences; feeling understood, cared about and less alone; easing the transition from hospital; enabling re-entry into daily life routines; building and re-establishing community connections; gaining new knowledge, strategies and skills; and feeling more hopeful about recovery.

Organisational responsibility and interagency collaboration

The Australian National Lived Experience (Peer) Workforce Development Guidelines consider lived experience as, "central to mental health reform" and,

"needs to be supported and embedded as in integral part of the way all mental health services are delivered...The responsibility for workforce development sits across a diverse range of jurisdictions, agencies, and professions. The partnership for change must be between employers, health professionals, Lived Experience agencies and Lived Experience workers." (Byrne et al., 2021, p. 2)

Development and implementation

Different organisations will be at different stages of the peer workforce development process and following a staged/stepped process is recommended, four simple stages of development have been identified:

1. Clarify – develop understanding of Lived Experience work and recovery.
2. Commit – put Lived Experience workforce development and recovery-oriented practice on the agenda as core business. Include it in all planned activities and budgets.
3. Co-develop – work with people with lived experience and their families and supporters to review existing practices and develop new approaches.
4. Continuously learn – collect data, service user and staff feedback.

Figure 5. A model for systemic change (Ainsworth, 2020, p. 4)
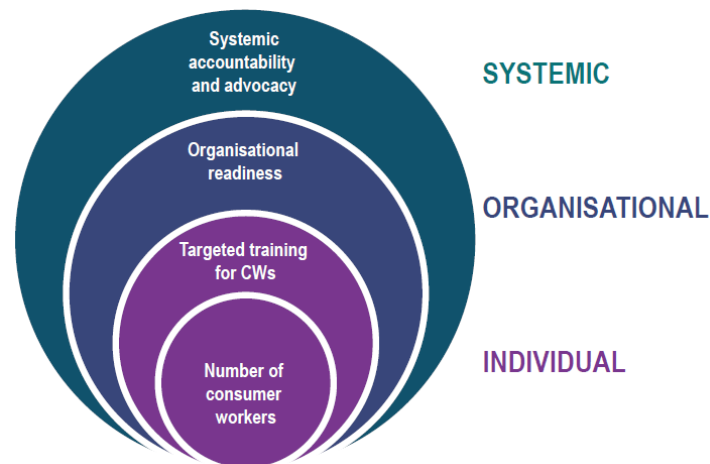
The Australian national guidelines identify five priorities aimed at fostering better understanding and collaboration across services:

1. Develop understanding as a foundation for workforce development – a lived experience workforce should be an essential part of recovery-oriented care. Workers need the support of employers and colleagues and a priority is to increase a shared understanding of the role of the lived experience work.
2. Support a thriving Lived Experience workforce – safety, training, support and recognition underpins a thriving work.
3. Planning for workforce growth – Lived Experience workers are needed everywhere, in all levels of service delivery and decision-making.
4. Integrate Lived Experience work in community care – community based stepped care must include lived experience-led and lived experienced delivered services. This will require an increase the integration of Lived Experience-led services and co-delivered Peer Support services into regional health care systems, increasing access for everyone including rural and remote areas and people from diverse communities.
5. Development is supported by a national Lived Experience strategy – investment is vital for consistent national development. Development of 'national professional peak bodies' (advocacy organisations) to support the development of professional leadership for both service user and carer Lived Experience workforces.

Other practical advice from the 'Learning for Change' report is the value of collective bargaining for the development and protection of working conditions for peer workers and the role that unions could play to support this process.

Task sharing

Hoeft et al. (2018) conducted a systematic review of tasking sharing as a way of tackling shortages in mental health specialists in rural settings. Task sharing typically "allows a limited number of specialists to practice in teams with other providers and community resources to reach populations in need. The mental health specialist role shifts from direct service provider toward trainer, supervisor, and consultant." (Hoeft et al., 2018, p. 49). These can be delivered via collaborative care, telehealth, and partnerships with local communities. Issues relating to professional boundaries, confidentiality, burnout and staff turnover have been identified but there is growing interest in the utility and flexibility of task sharing approaches which can help improve access where resources are limited. The authors recommend that tailored, community-level response appropriate to the needs of the

community should consider the population needs (cultural needs, range of mental health problems), geographical location, availability of local providers, training and supervision in order to identify a suitable task-sharing model for specific communities. All tasks should be specified, and systematically developed into a 'shared workflow' "to clarify how team members participate and co-ordinate care." (Hoeft et al., 2018, p. 58). Further research is required on the effectiveness and cost-effectiveness of these approaches.

Measuring progress
The importance of measuring progress is also highlighted to establish if:

- All mental health services are committed recovery-oriented practice;
- Everyone has access to care that supports recovery including people in rural and remote areas and people from diverse communities;
- Lived Experience work is valued and identified as 'core business' in all mental health services;
- Flexible workplace strategies support the wellbeing of all employees including the Lived Experience workforce;
- Employment opportunities support the integrity of Lived Experience work and fidelity to the professional values and principles of the profession;
- The Lived Experience workforce is reflective of diverse communities and different experiences of mental health and mental health services;
- Co-production in equal and respectful partnership between lived experience expertise and mental health service provider expertise is the foundation for all mental health service development and evaluation including development of the Lived Experience workforce;
- All stakeholders collect meaningful data and participate in evaluation and auditing to measure success and identify opportunities for ongoing development.

The 'Leading the Change' review highlights the need to build the volume of consumer workers, at all levels of service, including management and leadership roles.

Planning and supporting mental health reform
There is clearly an advocacy role required to develop the peer workforce, support system level development to support professionalisation and workforce growth and identifying funding priorities. Resourcing advocacy positions within consumer-led organisations could help provide individual and systemic advocacy for consumer workers – experience from Australia has evidenced that current complaint and employee assistance mechanisms in organisations can be ineffective in dealing with issues people face. Early experience of implementing peer workers within the Northern Ireland setting has not always been positive for everyone.

Practice case study: Leeds Survivor-Led Crisis Service
Leeds Survivor Led Crisis Service (LSLCS) was set up in 1999 by a group of service users, and was set up to be a place of sanctuary, as an alternative to hospital admission and statutory services for people in acute mental health crisis. LSLCS was established, and continues to be governed and managed, by people with direct experience of mental health problems. "We have our own unique perspectives on what it feels like to be in crisis and what helps and does not help. We have developed our LSLCS based on this knowledge and experience, while responding to the needs articulated by our visitors and callers".

LSLCS is part of a network of mental health services in Leeds. They liaise with and undertake joint work with other services, while maintaining their identity as an innovative,

service user led voluntary sector organisation providing face-to-face crisis services, telephone and video chat support and group work. They work as partners with other mental health services, and are part of the Leeds Suicide Bereavement Service and The Wellbean Cafe.

Research case study – Randomised Controlled Trial of Peer Worker Psychiatric Advance Directives (PW-PAD)

A multisite RCT of PADs facilitated by peer workers was conducted in 7 French mental health facilities (Tinland et al., 2022). Almost 400 participants with a DSM-5 diagnosis of schizophrenia, bipolar disorder or schizoaffective disorder who had a compulsory admission in the past 12 months were assigned to either the peer worker or treatment as usual control group. Compulsory admissions were significantly different in the 12 months after randomisation in the experimental group (27.0%) compared to the control group (39.9%). The participants in the peer worker group also experienced fewer symptoms, greater empowerment and a higher recovery score compared to the control group. No significant differences were found in the rate of overall admissions, therapeutic alliance score and quality of life.

An RCT of one-to-one peer support for discharge from inpatient mental health care (ENRICH) is currently underway in the UK (Gillard et al., 2020).

Intentional peer support

"*As peer support in mental health proliferates, we must be mindful of our intention: social change. It is not about developing more effective services, but rather about creating dialogues that have influence on all of our understandings, conversations, and relationships.*" (Mead, 2022).

Developed by Mead (2014), Intentional Peer Support (IPS) is an alternative approach with no service providers or service users but based on people who help each other. It is not based on psychiatric models or diagnoses but adopts a trauma-informed approach, 'what happened to you?', not 'what is wrong with you?'. IPS uses four tasks in its approach (Knight, 2014, p. 3):

- "Connection – developing and maintaining a connection with the other person
- Worldview – helping each other to understand how we've come to know what we know
- Mutuality – re-defining help as a co-learning and growing process
- Moving towards – helping each other move towards what we want, rather than away from what we don't"

Practice case study: National Empowerment Center

The US-based National Empowerment Center is a 'consumer/survivor/ex-patient-run organisation' promoting recovery support for people with lived experience of mental health problems, trauma or extreme states. They provide training and education, information and referral services, advocate service user views at all levels of policy, qualitative research and the development of education and self-help resources.

Accreditation and professionalisation

In the USA, the National Certified Peer Specialist credential was created and developed by peers to recognise those with extensive experience and advanced knowledge (https://flcertificationboard.org/certifications/national-certified-peer-specialist/).

Table 4. Summary of employer actions for Lived Experience workforce development (Byrne et al., 2021, p. 18)

	Preparation: Clarify	Preparation: Commit	Implementation: Co-develop	Transformation: Learn and grow
Leadership and culture	**Build** ✔ Leadership understanding of: • Lived Experience workforce • Recovery-oriented practice • Diverse perspectives and needs ✔ Strengthen commitment to diversity and inclusion	**Prioritise** ✔ Mission statements recognise Lived Experience work as core business ✔ Build whole-of-workforce commitment to lived experience	**Lead** ✔ Identify champions and allies for the Lived Experience workforce ✔ Partner with lived experience to develop and implement workforce strategy ✔ Consider opportunities to develop Lived Experience leadership roles	**Embed** ✔ Lived Experience roles represent diverse culture and perspectives ✔ Person-directed and recovery-oriented service delivery and practices are established ✔ Safe sharing of lived experience is prioritised for the whole workforce
Policies and planning	**Review** ✔ Identify the gap between current practices to recovery-oriented practice standards ✔ Current levels of diversity in service users, workforce and community	**Review** ✔ HR and other policies for flexibility to support Lived Experience work ✔ Outline a Lived Experience workforce strategy ✔ Include Lived Experience in long-term budgets and plans	**Plan** ✔ Develop an implementation plan ✔ Develop position descriptions and recruitment processes ✔ Budget for sufficient numbers of roles and Full Time Equivalent and all necessary supports and training	**Grow** ✔ Lived Experience roles are employed at all levels sufficient to meet needs ✔ Career pathways are available for Lived Experience workers ✔ A range of supervision and training options are available to Lived Experience workforce
Development	**Educate** ✔ Whole-of-workforce about Lived Experience roles and the value of diversity ✔ People accessing services and their families about Lived Experience roles ✔ Provide service users with information on peer support services in the region	**Connect** ✔ Create opportunities to listen to service users ✔ Build relationships with Lived Experience agencies ✔ Form a co-development steering group ✔ Work with other organisations for co-learning	**Equip** ✔ Ensure access to appropriate supervision and training for Lived Experience workers ✔ Consider Lived Experience apprenticeships/ traineeships ✔ Enable connections for Lived Experience workers with Lived Experience networks	**Learn** ✔ Review and evaluate the impacts of and remaining challenges to embedding the Lived Experience workforce ✔ Evaluate to contribute to a lived experience informed evidence base

Implications for a peer workforce for the Northern Ireland context

Kilpatrick et al. (2017) interviewed 10 voluntary sector staff in a variety of different roles about the role of the peer support workers in Northern Ireland. Four key themes emerged from the data about whether the role was tokenistic or genuinely effective in improving service provision and the skill mix within teams. There was concern too raised about the potential of discrimination advertising lived experience only roles. The value of the posts were also questioned,

"*My concern is that peer support workers are going to be seen as the cheap option to do something that always looks good and that's not going to be good for the peer support workers or the service users.*" (PO4 in Kilpatrick, 2017 p. 507).

Potential next steps could include:

- Agreeing the values and principles of a peer workforce are an important initial step and there are good international examples to draw on (National Development Guidelines, 2021);
- The governance and structures for supporting/training/professional development require development;
- Issues around maintaining/supporting mental health is important for the peer workforce, and for everyone working within the sector. Compassionate leadership is an integral part of staff care and should remain a priority for all staff;
- Mental health stigma remains an issue for all staff, particularly members of the existing workforce who do not feel secure to disclose their own mental health histories – until the stigma around mental health is tackled, people will remain reluctant to share their experiences and this will have a knock-on impact on building critical capacity of lived experience across all sectors and levels of the workforce;
- While there is an emphasis on lived experience in peer roles, it remains one of many competencies required across different roles. Lived experience must not be the defining identity of the peer workforce;
- Consultation on the definition will help to generate a common and shared understanding of peer workers;
- Australia's work around an agreed use of language to describe experience/consumer roles was an important process that could be replicated;
- Supporting non-statutory organisations that provide peer support models;
- Banding and structure of posts – many of the roles within the current system are banded at Band 3, creating a hierarchy without any potential progression or recognition of the other skills and competencies an individual may have or the role required;
- Practical implementation – including a supervision structure that recognises the discipline/profession of lived experience;
- Underpinning any design or development must involve co-production and co-implementation.

Discussion

A commitment to embed recovery approaches within mental health services has been made at regional, national and international levels but it is clear from the literature that special attention is needed to clearly define what recovery-oriented approaches are, how systems respond to deliver them. This will include specifying the identity, roles and responsibilities of a peer/lived experience workforce, and the role of Recovery Colleges in how further systems change may be initiated and implemented.

In the process of defining recovery-oriented approaches, further consider could be given to the potential for targeted approaches and whether these might result in improved outcomes. Currently everyone who comes into contact with mental health services (and are deemed to require assistance with their recovery) is supported; how the recovery approach might be tailored for different groups presents some interesting ideas to consider.

A broader remit of recovery beyond the scope of this paper would be to focus on wider societal factors and the role of vocational rehabilitation including the provision of meaningful and well-compensated employment opportunities. This is of relevance for the effective implementation of the Mental Health Strategy across mental health services, sectors and Government Departments. There is good evidence that employment may offer the fastest and most effective route to good mental health including for those with severe and enduring mental health problems. Developing a peer workforce with parity of esteem with other professional identities, scaffolded with appropriate supervision, and the opportunity to progress within the discipline could make a substantial contribution to understanding the mechanisms underpinning employment-facilitated recovery and realising meaningful opportunities for lived experienced individuals. Vocational or occupational approaches were better supported two to three decades ago and then fell out of favour in the era of mass unemployment. Officially, although we no longer have mass unemployment, we do have mass economic inactivity and many of those who are economically inactive will have mental health problems. A significant proportion of this group will be employed in low paid and low status jobs. There is a real issue to grapple with here with the provision of good employment (including supported employment) that could really make a difference, including for those with ongoing problems. As already stated, some people will have a mental health journey from being "unwell" to recovery, which is relatively quick and will require no assistance. The majority of people with a recurrent depressive disorder, for example, will recover within two years, returning to their previous level of functioning, including occupational functioning. A minority however, perhaps 10%, do not recover and will require a recovery-oriented approach. This proportion is little different now from the 1940s and the 1950s and comprise a relatively intractable group who do not recover and we do not fully understand why. Another group of concern include those with serious mental health conditions such as schizophrenia or schizoaffective disorder. Recovery rates for these individuals are no better now than they were 50 years ago (Jääskeläinen et al., 2013). Richard Warner, an anthropologist and psychiatrist, has argued for 30 years that the key to unlocking this problem is the provision of employment opportunities (Warner, 2009, 2013). He argues that recovery rates have been better in more traditional non-westernised societies where there is less stigma around mental health problems and where everyone has a socially useful role, no matter their mental health state.

Acknowledging that many existing staff will also have experience of mental health problems is an area that requires further consideration and support. Until stigma is challenged, people will continue to conceal mental health histories. How mental health services harness this potentially valuable resource that could improve empathy and understanding and build confidence in the therapeutic relationship is an interesting area of work. Further research is

needed to assess the effectiveness of the recovery approach and how this can be measured from an individual's holistic perspective, but also the impact on families and carers, and by reducing stigma and inequalities people with mental health problems routinely face.

Valuable guidance is available from other jurisdictions (e.g. Australia) who have invested considerable resource in consulting, developing and evaluating their guidance and they have shared important learning about how significant recovery and peer support is to transforming services but also how carefully it needs to be implemented to improve care. Having a co-produced approach is central and leadership is required from the very top to instigate change.

Could the Recovery Colleges become a central hub of education and training support, not only designing and delivering the continued successful suite of programmes and courses but providing a practical resource centre to support and inform workforce development, public policy, and provide advice? The Recovery Colleges could support peer worker advocacy to share global evidence, help establish and build the business case and promote understanding and acceptance of peer workers and the experiences of service users using digital/social media, case studies and sharing best practice. This structure could also support HSCT human resource functions to provide specialist advice and training on the recruitment, training and supervision and accreditation of a peer workforce. Underpinning this work should be a strong research and evaluation ethos to improve measurement and future planning of recovery-oriented practice. Before this work can begin, a clear co-produced definition of what the peer workforce should consist of at a strategic level needs to be agreed. This will require ambitious and dynamic thinking that could have the potential to transform services and care and in turn help reduce stigma and inequalities relating to mental health.

Figure 6. A proposed system for Northern Ireland?

Specialist HR Support
Job role/description development/banding profiles
Management & supervisory support
Training & progression of peer workforce

Peer Workforce Advocacy
Collective representation
Workforce development
Best practice/fact sharing/case studies

System Reform
Interdepartmental responsibility
System-level policy reform
International links & partnerships

Recovery Colleges
Ongoing coproduced development & delivery of courses
Accreditation

Organisational Reform
All Trust training at all levels
Regional policy development
Senior leadership leads

Research & Evaluation
Co-production
Measuring recovery
Measuring stigma & inequalities
International links & partnerships

Regional Workforce Planning
Capacity
Identification of gaps/ opportunities

Conclusion

The ImROC research reflecting on ten years of Recovery Colleges highlights the critical importance of leadership. The task ahead not only requires strong leadership but will need a bold approach to help build a critical mass of peer workers across all levels of health and social care. Building on an existing expert resource (the Recovery College network) could provide the structure, support and expertise to help deliver a vision and begin to stimulate organisational change, bring about the necessary transformations in policy and practice, in order to build a recovery-oriented system that extends beyond health and social care.

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