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***An Evaluation of the Impact of the
Dissemination of Educational Resources to
Support Values-Based and Recovery-Focused
Mental Health Practice***

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Executive Summary

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Introduction

This executive summary gives overview of the evaluation of an educational initiative within the field of mental health practice in Scotland. A much more detailed account and discussion of emergent issues is available in the full report.

Context and nature of the initiative

The initiative to disseminate educational resources to support values based and recovery focused mental health practice emanated from Rights, Relationships and Recovery (RRR) (SEHD 2006). In this first ever review of mental health nursing in Scotland the need to focus on individuals' journeys of recovery is seen as inextricably linked to the promotion of rights and values based practice.

Action 1 of the RRR Delivery Action Plan stated that: "All mental health nurses will have undertaken values-based training by June 2008", and the 10 Essential Shared Capabilities (ESCs; DoH 2004) were central to this educational agenda. Developed in England in response to mental health service user dissatisfaction with services, the 10 ESCs comprise:

Working in partnership	Identifying people's needs and strengths
Respecting diversity	Providing service user-centred care
Practising ethically	Making a difference
Challenging equality	Promoting safety and positive risk taking
Promoting recovery	Personal development and learning

It was planned that: NHS Education for Scotland (NES) would disseminate associated training resources; NHS Board Nurse Directors would ensure a programme of training was in place; and all mental health nurses would take steps to embed values-based practice in their personal development plans and clinical supervision. Moreover, development of linked training resources for recovery-based practice was planned to follow on from the 10 ESC training. Thus Rights, Relationships and Recovery set out a bold new agenda for Scottish mental health nursing that set values-based and recovery-focused practice as its foundation. While nursing staff were the main focus, the initiative's training resources were seen as being open and applicable to all mental health workers.

The educational materials

Following work with service users, carers and representatives from the voluntary and statutory sectors, NES developed the 10 Essential Shared Capabilities for Mental Health Practice - Learning Materials (Scotland) (NES 2007) <http://www.nes.scot.nhs.uk/mentalhealth/publications/default.asp>. The materials were based on an existing resource, produced and piloted in England that NES further developed for the Scottish context. Consisting of six modules available on the web and/or in hard copy, these materials are action focused, with specific learning activities incorporated throughout. The emphasis is on facilitated learning involving discussion with others to enable critical reflection and exploration of practice. In 2008, NES and the Scottish Recovery Network (SRN) produced the Realising Recovery Learning Materials (NES 2008; web link as above) These were designed to build on the 10 ESC materials by giving learners much more detailed knowledge and skills in recovery focused practice. The module format and the focus on interactive learning are similar to the 10 ESC materials.

Initial dissemination: the two phase regional training programme

The initial dissemination of the educational resources took place in two phases. Firstly, during 2007, NHS Boards nominated participants to be prepared, supported and accredited to disseminate and cascade the 10 ESC training within their organisations. The 68 nominees were drawn from a range of occupational backgrounds and workplace setting, but nurses were the predominant group. These “first wave trainers” received their training from Health in Mind and Penumbra (the “commissioned trainers”) who had been engaged by NES to deliver the core programme. This took the form of an initial five days where participants experienced being trained in the 10 ESCs, then a four day follow-up training that prepared them to deliver ESC training. The commissioned trainers delivered this Phase 1 programme in three different regions between autumn 2007 and spring 2008, with two additional local deliveries provided for one remote and rural NHS Board, to enable optimal attendance. In addition to the learning materials a Facilitators’ Toolkit was also produced as a resource pack to aid first wave trainers in the delivery of the training.

The Phase 2 programme aimed to enable the first wave trainers to train as recovery trainers, capable of delivering both the 10 ESC and recovery training and *also training others as trainers*. Attrition of first wave trainers between phase 1 and 2 was minimal, however some new trainers joined the second wave training to enable maximum uptake of the places available. The Phase 2 training took the form of an initial three days where participants experienced Realising Recovery training as both trainees and trainers, then a two day follow-up session that prepared them to recruit and train their own colleagues to deliver both ESCs and recovery training. Again the commissioned trainers delivered the programme in three different regions and in one NHS Board (between autumn 2008 and early 2009). In 2008 NES also funded three Regional Facilitators posts for two years, whose roles involved providing support to the networks of first wave trainers as they disseminated the training and also linking directly with NHS Boards.

Local dissemination

It was envisaged that the Phase 1 and 2 activities would enable a subsequent process of much wider dissemination within Health Boards and their partner organisations through further cascade training of mental health workers. In turn, the ultimate aim was not only to impact on working practices, but also thereby to impact positively on service user and carers' experiences.

Evaluation objectives and methods

Following a process of competitive tendering, NES commissioned us to undertake a national longitudinal evaluation (February 2008 – January 2010). The main objectives can be summarised as:

- 1) To explore the experiences of those involved in the regional training (i.e. the commissioned trainers and the first wave trainers)
- 2) To examine the planning, delivery and sustainability of further dissemination within specific organisational contexts
- 3) To explore the experiences of mental health workers who received training
- 4) To synthesise lessons learned

Elicitation of service user and carer perceptions of any impacts from the initiative was beyond the scope of the study as commissioned.

The evaluation used mainly qualitative methods to address objectives 1 and 2, although questionnaires were used to elicit perceptions from first wave trainers (34/68; 50% response) and key informants such as regional facilitators and service managers (37/71; 52% response). Thirty two individual interviews, four focus group interviews and analysis of relevant documentation provided the main basis from which experiences of regional training and subsequent dissemination were understood. Data synthesis facilitated the construction of case studies of approaches to translation and enactment in different Health Boards. In turn, comparison of these approaches enabled the construction of explanatory typologies.

A survey questionnaire in hard copy and web-based versions was used in autumn 2009 to try to access the views of all the mental health workers thought to have received ESC and/or Recovery Focused training (estimated number = 2091). Access to this population proved very difficult, primarily due to reliance on third parties for distribution, and the estimated response rate to the survey was around 10% (207 responses). Within this considerable limitation, however, these responses provided useful initial insights into the initiative's impact for some mental health workers. The study was judged to be research by NHS RES from whom approval was obtained. Significant delays (e.g. 4.5 months) were experienced in receiving R&D approvals from some of the 15 Health Boards, despite the study involving minimal intervention.

Findings relating to regional training experiences: key points

- The commissioning of a voluntary sector alliance (Health in Mind and Penumbra) to deliver the regional training programmes was seen as significant by NES in terms of precedence and consistency with the initiative's values
- The 68 first wave trainers were predominantly: trainers/practice developers with a nursing background; community mental health nurses; or senior ward nurses. However the cohort also included occupational therapists, representatives from carer organisations and the voluntary sector, psychologists, social workers, a service user, a chaplain and a psychiatrist
- The first wave trainers were a mix of volunteers and nominees, but were typically highly motivated because of identification with the values being espoused and/or the recognition of a development opportunity
- The 10 ESC and Realising Recovery core materials were widely valued as a basis for learning in terms of their content, quality and coherence, although some first wave trainers felt that the ESC focus on the 18-65 age group limited their application
- Both the commissioned and first wave trainers highlighted the need to plan and think through adaptation and application of the materials for facilitating group learning. The Facilitator's Toolkit produced by the commissioned trainers was seen as useful in this regard, as was pre-course contact with trainees to introduce preparatory work
- The value of learning groups that included a range of occupations and backgrounds was highlighted, along with the inclusion of the voices of those with lived experience of recovery in mental health
- The regional training experience was much more than just a knowledge/information giving event. Rather the experiential group learning included skills assessment and required emotional engagement with a view to enabling a cultural change agent role
- Attrition of first wave trainers between Phases 1 and 2 was minimal
- The Realising Recovery training had to adapt to the needs of new members joining an original cohort who themselves had a concurrent need to share their experiences of enactment of ESC training in practice
- The expertise of the commissioned trainers and the work of the three NES-appointed Regional Facilitators were widely valued
- The majority of concerns related to how to enact training and embed its content into local practice. The 10 ESCs and Recovery were seen as just one of a number of concurrent and competing initiatives that mental health services were required to respond to
- Questions were raised about the separation of ESC and Recovery training, and the different status and priority perceived to be given to them through policy.

Findings on translation and enactment within Health Boards: key points

- As pre-existing contexts, infrastructures and established working processes varied across (and to some extent within) the 15 Health Boards, it was clear that the Boards were not all starting from a similar baseline
- The local 10 ESC training programme formats that emerged during 2008 and 2009 were many and various, ranging from self study with two brief follow-up workshops through to a full four day classroom based delivery. A trend emerged, however, towards a two day format in many Boards as time went on, with several Boards adding on one day of training in Realising Recovery.
- Service managers were generally positive about the initiative but were acutely aware of related cultural, capacity and sustainability challenges
- The majority of the first wave trainers felt that they had good organisational support and that progress with delivering training to colleagues was fairly good, but there were tensions around encouraging engagement and meeting trainees' various needs while also judging the right level of challenge
- In November 2008, a provisional typology of progress indicated that the 15 Health Boards were fairly evenly divided into: *Vanguard* Boards where high strategic and on-the-ground development had taken place; *Mid-range* Boards where a moderate amount of strategic and on-the-ground development had occurred; and *Limited Enactment* Boards where there was little indication of such activities
- By November 2009 it was possible to construct a more developed typology differentiating the approaches taken within Boards as: *High Focus* (5 Boards); *Devolved Flexi* (2 Boards); *Push – Pull* (2 Boards); and *Low Focus* (3 Boards)
- Within this context, a number of factors were identified that appeared to be associated with positive local translation and enactments of the initiative (see recommendation 8)
- While almost all Boards had taken forward 10 ESC training by the end of 2009, only a few had substantively enacted Realising Recovery training locally. Undoubtedly the Action 1 requirement for 10 ESC training was an important factor, but some Boards were deliberately delaying Recovery training until the ESC training was more widely and deeply embedded, with a view to ultimate sustainability
- Less than a quarter of the mental health nursing workforce had received 10 ESC training by autumn 2009 (an estimated 1756 out of the 8570 WTE mental health nursing staff employed by NHS Scotland (ISD 2009))
- However, the training enacted in most Health Boards was not restricted to nursing staff, so that other NHS occupational groups and some non-NHS agencies also received training (an estimated 335 up to autumn 2009)

Findings from the survey of mental health workers: key points

- One hundred and sixty five respondents (80%) had received a distinct 10 ESC training programme; 36 (17%) had received a distinct Recovery training programme; and 14 (7%) did a programme which combined 10 ESC and Recovery training
- Perceived relevance and quality of local training was high
- Generally respondents were given preparatory work to do before training, but seldom received follow-up mentoring or support in relation to the training
- Respondents reported that the training raised awareness of a range of issues relating to values in mental health practice
- For some the main impact was to reaffirm/reinforce a perception that their practice already incorporated the values espoused in the training. However these types of positive self-assessment were sometimes questioned by other survey respondents (and by some trainers and service managers)
- For others there was more overt recognition of a need to develop aspects of practice highlighted during the training
- The main aspects that respondents wished to take forward after the training were: developing individual practice; developing related educational activities within the team; ensuring a patient/client/person- centred approach through increasing their involvement, and related development of care planning
- The majority of respondents reported that the training had positive impact on their individual practice in terms of assessment of service user needs and planning care/support
- Many respondents gave examples of team developments related to the training, including: use of the 10 ESCs as a framework for clinical supervision; improvements in service user involvement; care planning based on users' own perceived needs and strengths; and development of positive risk taking
- Factors seen to hinder progress were principally: lack of time; colleagues' attitudes and poor staffing levels/resource
- The dominance of the medical model and the nature/severity of service users' mental health problems were also mentioned as barriers to bringing about change by some respondents
- The main factors which helped respondents to progress values based and recovery focused practice were: resonance with personal values; attitudes of/ support from team colleagues; line management/supervisor support; and support from Board/national approach

Integrating the findings: concluding points

From the key points above it can be seen that the “dissemination of educational resources” has in reality represented much more than just a national broadcast of a couple of related folders/workbooks. Rather, the core materials have been but one part of a government policy initiative which has sought, through a variety of related structures and processes, to inculcate a core set of values and concepts to Scottish mental health nursing and allied workers. As such, it is essential to note the inherent ambition and historical significance of such an enterprise.

In this context it is perhaps not surprising that the very ambitious original timeline for Action 1 has required extending during the course of the initiative. Each Health Board has been faced with the challenge of how a core pool of trainers could train local colleagues in a way that would replicate not only the core content of the regional training, but also the key processes of interactive engagement in values based learning. Moreover, this cascade training has been taking place amidst a torrent of other training and service development/delivery initiatives (e.g. training on dealing with violence and aggression; Health improvement, Efficiency, Access and Treatment (“HEAT”) targets etc.). Pragmatic solutions to this have been various, but most local ESC programmes have tended towards a two day format using some of the exercises in the Facilitator’s Toolkit and other core materials. The obvious risk in all of this is that the learning experience may be significantly diluted. This risk is particularly apparent for the Realising Recovery part of the initiative. Despite the significant body of narrative and experiential content in the core materials, it has been translated into a one day, add-on format in a number of Boards.

Indeed, most Boards have been much less active on translation and enactment of the Realising Recovery part of the initiative. While this contrasts with the effect of the mandatory directive on the 10 ESCs (as Action 1 of the core RRR policy), it is clear that several Boards had well developed strategies and rationale for delaying substantive action on Realising Recovery until the ESC training was more widely and deeply embedded. During the evaluation, interviewees in senior strategic positions spoke both of the positive effects of mandatory directives (e.g. tendency to ensure action of some sort) and the negative effects (e.g. tendency for resultant actions to be superficial or “box-ticking” in nature). Clearly the timeline for Action 1 requires

considerable extension if it is ever to be realistically achieved. Furthermore, the Government and Health Boards should consider whether there is merit in setting an achievable timeline for more substantive roll out of the Realising Recovery materials.

These considerations raise the question of how best to achieve critical mass and momentum sufficient to begin to effect change within an NHS context. Although the evaluation found that Health Board translations of the initiative varied considerably, it has been possible to identify a range of factors that should be considered for optimising enactment of 10 ESC and/or Recovery training. These form a key part of the recommendations to emerge from the study.

In conclusion it can be seen that the evaluation has provided considerable insights into processes and impacts for those involved in the initial cascade of this educational initiative, and some initial insights into the experiences of the larger body of mental health workers who have received training. Within the latter context, there are some promising indications of development around patient involvement, care planning and positive risk taking in particular. The challenge for policy makers, educators, managers and practitioners who are committed to values based and recovery focused approaches is how best to further develop and sustain the initial progress made. Tension persists between the need to train sufficient staff to achieve critical mass and the need to ensure sufficient depth of engagement to optimise enactment of the espoused approaches. The challenge for researchers remains how best to apprehend the influence of the educational experience on practice. These challenges are now considered in the study recommendations.

Recommendations

Education

- 1) Given that the NES/SRN core educational materials were widely valued, it is recommended that NES continue to make them freely available in published folder and web formats to staff participating in local training
- 2) Given perceptions that the focus of the 10 ESC core materials on the 18-65 age group could be limiting, it is recommended that the materials incorporate examples and activities relating to older and younger people. There is particular opportunity to exemplify relevance to those with dementia and their families/carers
- 3) Given substantive positive perceptions about the educational impact of training that includes input from those with lived experience of mental health problems, it is recommended that this format is adopted wherever possible
- 4) Given the considerable variation in time and depth of 10 ESC and Recovery training across individual Health Boards, and the risk of significant dilution of core content, it is recommended that the *minimum* time allocated for *each* of these respective trainings should be two days (or four days in cases where the training is combined)
- 5) Given that less than one quarter of the mental health nursing workforce are thought to have received ESC training so far, it is recommended that the timeline for Action 1 of Rights, Relationships and Recovery is extended considerably
- 6) Given limited enactment of Recovery training to date, the Government and Health Boards should consider whether there is merit in setting an achievable timeline for more substantive roll out of the Realising Recovery materials.
- 7) Given that national support for the dissemination and embedding of Values-Based and Recovery-Focused approaches was valued by participants, it is recommended that NES should continue to promote the initiative. This work should include promoting the integration of the 10 Essential Shared Capabilities and Realising Recovery training within relevant undergraduate curricula, and joint work with the Scottish Recovery Network supporting use of the Scottish Recovery Indicator.

Practice development

- 8) Given identification of factors associated with positive local translations of the initiative so far, it is recommended that Health Boards wishing to develop values based and recovery focused practice should consider:
- Identifying a high-visibility mental health leader with executive responsibility for strategic implementation of the initiative
 - Enabling a multidisciplinary managerial Steering Group with service user representation to plan strategy in a way that integrates with other national and local mental health initiatives and oversees operational implementation
 - Supporting the sustainability and further development of a dynamic pool of trainers by enabling arrangements to cover their involvement, and by ensuring administrative support is available
 - Making 10 ESC/Realising Recovery training widely available to mixed groups of healthcare workers on an ongoing basis
 - Promoting participation from a wider range of healthcare workers, especially those in particular position to lead and influence such as executives, medical staff, and clinical managers
 - Supporting the involvement of service users, carers and the voluntary sector in training processes i.e. as both trainees and trainers
 - Ensuring that staff who receive training undertake a related individual or team-based practice development challenge with support and follow-up from a workplace mentor/supervisor/line manager
 - Promoting widespread integration of this training and practice development work into staff Personal Development Plans and clinical supervision processes (individual and group/whole team)
 - Promoting approaches that involve service users in planning their care, as in Action 4 of Rights, Relationships and Recovery
 - Enabling local practice development networks to share good practice, but also to critically evaluate values based care as espoused and enacted. This could involve local audit and evaluation processes, with inputs from: the Board's pool of trainers; consultants (nurses, psychiatrists and AHPs); Practice Education Facilitators; service user and carer groups; and Local Recovery Networks

Research

9) Further to this study, it is recommended that:

- National research is supported that explores the experiences of service users and carers, including in relation to any perceived impact of values based and recovery focused practices
- National research is supported that explores undergraduate healthcare students' experiences of values based and recovery focused approaches within HEIs and within clinical practice placements

NHS ethical and management approval procedures

10) Given difficulties experienced with the above in the context of a relatively low risk educational evaluation, it is recommended that:

- The operational interpretation by the regional Scottish NHS RECs of what constitutes research is audited and compared
- Audit is undertaken of the experience of applicants for NHS management approval for national studies to establish if procedures have improved

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