Transforming Scotland’s Mental Health System

How do we create and embrace big change within Scotland’s mental health system, towards a future that values lived experience and peer roles?

Julie Repper, Director at Imroc, has been driving recovery-focused change, including developing a peer workforce in mental health for 20 years. Julie is at the forefront of systems change. She has a wealth of experience and insight into what enables change to happen, and key knowledge on what helps to overcome and get around barriers to change.

Filmed in Edinburgh, at our Peer Connects event, this is another chance to watch / listen to Julie's presentation and reflect on how we ensure well-meaning policies are translated into action that will transform Scotland's mental health system.

Transcript starts

Julie Repper (00:06):

I'm going to just talk a bit about Imroc because we're not totally dissimilar from Scottish Recovery Network. We were set up after you in fact, but I've been there from the beginning and certainly there are some lessons to be learned. I just want to know who I'm talking to. How many of you have lived experience or living experience, and that's most of you. And how many of you have a professional qualification? How many of you are working in the NHS in statutory services? There are a few of you, and how many of you in the volunteer sector?

(00:54):

Great. So, there's a good mix actually, which is lovely because I noticed you were talking about working across the whole system and certainly that's what Imroc does now. But one of the fundamental differences between us and the Scottish Recovery Network is that we were set up to work into statutory services into the NHS. So, this is what I was asked to talk about really, is how mental health recovery has been translated into policy and practice in England, what's driven that change, what the impact of a focus on recovery has had on services and what kind of top tips could I share with you?

(01:39):

So, I'm just going to try and keep the presentation brief because I think it'll be more interesting for you to be able to ask questions which reflect what you want to know. And if you want to know anything in more detail, just go to Imroc's website where there's a whole series of briefing papers, which we try to write down whatever we have learned. We just keep renewing our papers to reflect where our learning's happening. I think it's important to recognise when I talk about Imroc that we're not exactly the same as Scottish Recovery Network. We were set up to shift culture and practice within services by a group of us who used services and worked in services, but recognised that the kind of movement, the ideas, were coming from people with lived experience and from community groups. The challenge was getting those reflected into the way that services work.

(02:41):

And from our perspective, we felt that there's very little choice. When things get really bad, when you hit a crisis, you go and use services. So, for us, it was really important to see that services changed.

(02:56):

We started with, as a founding team, we put ourselves together and we were all of us very frustrated. So, although we'd kind of read, written, presented, already started working in the area of recovery, we were frustrated by the lack of progress that was being found in services. It just wasn't being sustained within services. And once the group of us had got together, we were all people who'd already got a seat at the top table, had published quite widely, had been chief execs in services or were leading some lived experience work. We thought, well, we'll put together some funding to get a proposal to get funding to back up policy. And one of our priorities was to continually generate evidence, not to implement evidence that had already been generated, but to generate evidence about how to implement policy, what are the best ways of shifting culture and practice.

(04:05):

And having said that, we actually are, and some of this might be down to me, I'm somebody who really prefers to take quite an evolutionary approach rather than a revolutionary approach. I'm not someone who is going and campaigning for radical change. My vision is for radical change, I guess, my aspiration, but it's always about appreciating how people have got to where they are and what sustains what they currently do and then help them to recognise this or there are other ways of working. So, taking steps at the pace that people can go, always starting where they are. I think one of the big differences we started, actually, I think probably the same time as you, when Imroc started, there was real excitement about this notion of recovery, and recovery has really shifted meaning over the last 20 years, hasn't it? We currently don't use the term recovery in our title.

(05:05):

So, although Imroc originally meant implementing recovery through organisational change we actually don't use that line any longer. We are all about supporting people with mental health challenges and long-term health conditions to live well and recover. The focus is on living well because recovery actually has never really managed to free itself of its meaning, its original meaning in services.

(05:38):

It's about getting back to where it used to be. It's about getting rid of symptoms, whereas recovery as re-imagined as reclaimed by people with lived experiences is about living well even with ongoing challenges. I guess the big thing if we start by looking at policy, recovery is there in policy right from 1998. There was a policy document written in 1998 for Department of Health called Roads to Recovery and that really very much started to make the kind of ideas that Patricia Deegan and Ron Coleman had put forward, started to see what that might look like in services. And although a number of us were starting to bring it into professional training, we were doing training. I at that time was a director of a volunteer sector group called Roads to Recovery actually, which employed peer support workers. The problem was that we actually weren't seeing recovery being implemented in services.

(06:49):

And it wasn't until 2010 that there was an actual policy document that actually had implementation guidelines, 'No Health Without Mental Health', that we were able to find something that we could really say, "Look, if you want to achieve this, you're going to have to shift the way that services work." And you can see 'No Health Without Mental Health'. The aspiration was for more people who develop mental health problems will have a good quality of life, greater ability to manage their own lives, stronger social

relationships, a greater sense of purpose. They'll have the skills they need for living and working, improved chances in education, better employment rates, and a suitable and stable place to live. Funny that it was a health policy when in fact it applies to almost every sector of government, but that's exactly what recovery is about. It's not something that health services alone can achieve. It is about working across sectors. It's working with housing, with employment, with transport, with environment and so on.

(08:02):

So that was a great opportunity that mental health, 'No Health Without Mental Health', was a great opportunity for those of us who were feeling frustrated to get together. And this small group of us got our heads together, started meeting regularly in our own time and started to think, what is the challenge? Why isn't recovery making its way into services? And we were saying staff training isn't able to change practice. Organisational leaders are not grasping the implications, what's needed in services. Services need to change if people who use them have a chance to recover. Organisational cultures just weren't reflecting and modeling recovery-focused relationships and there were no existing methodologies on how to create that organisational change to support recovery.

We could see what was needed. We're saying there needed to be massive shifts. Shifts in culture from a focus on problems and symptoms towards goals and aspirations, shifts in workforce from professionals as the only experts, towards lived experience workforce who brought a whole different set of skills and supports, shifts in our canvas so that services stop just seeing themselves as the limits of people's lives. They need a day service, they need this, that's actually about seeing whole communities as being the canvas that people live in and how we work. And then shifts in decision-making. There need to be huge shifts from professionals

making all the decisions towards shared decision-making, what's now become known as co-production, but at that time we're thinking shared decision-making at different levels and interventions need to shift interventions from professionals administering therapy and treatment to enabling access for people to receive education, to be able to meet other people so that they can have a greater sense of their own efficacy, their own possibility.

That hope that self-efficacy is at least as important as the kind of psychological interventions and medical treatments that have previously been offered.

(10:26):

So, we got our heads together and developed a methodology between 2008 and 2010. And to do that we reviewed the literature on recovery. We held focus groups in organisations that were doing a great job in recovery, not just in England but internationally. We co-produced the kind of methodology, the policy implementation methodology, with different people who had experience of doing this and we published a review of recovery followed by our methodology and we wrote the proposal for the Department of Health, got £350,000. That's all that Imroc's ever had in terms of funding, 350,000 pounds to be used over three years, piloting our methodology with six mental health trusts. In fact, we went out to advert. We asked, "Is your trust interested in doing this?" And out of 45 mental health trusts in England, 36 wanted to join us. So, we actually started from day one working with all 36.

(11:30):

We nominated six that were national demonstration sites. They just became very places where you could model better ways of

doing things. We had six that we were actually working with and evaluating the change and then we ran regional learning sets for all of the others. We were quite ambitious in what we set out to achieve. And let me tell you, we did have quite a clear methodology and approach, but I think I'll just tell you who we were. You'll know these names. There was Rachel Perkins, someone who has lived experience, Jeff Shepherd, psychology and rehab, extensively written about rehab and recovery. Jed Bordman was a psychiatrist. There was myself, Glenn Roberts, a rehab psychiatrist who also has lived experience, Mike Slade, written a lot about recovery and we had a reference group of 12 people with lived experience from diverse communities. Now we wouldn't work with us and reference groups separately. We would all work very much together, but at that time that was quite a radical thing, having people with lived experience in the group and then saying, "Well, we will constantly generate and reflect ideas from this reference group." We initially hosted at the Centre for Mental Health.

(12:58):

We were just a project, but then about five years later we moved to the Confederation, National Confederation of Mental Health Services. That didn't work. They were very, very NHS led. So, we moved to Nottingham, were hosted by a trust there. And then last year, we're very, very proud to have become an independent registered charity. It's been a long journey. Just to let you know our methodology, and I think part of our impact and success comes from starting with a very clear methodology with all 36 of these organisations. We were very lucky to have our way in into services. So, the first thing was our methodology was 10 challenges that we set for services and we would assess them. We'd get around 50 people into a room from the service and from the communities around them and they would assess themselves

on 10 benchmarks that reflect the extent to which they're recovery- focused.

From there, we would then start to work with that group to identify between three and five areas that they wanted to work on that they felt were a priority for them, get some agreement about those three to five areas and then set up an action plan, set up a steering group for each one of those and then we would provide bespoke consultancy to support them with those areas. This will make sense when I tell you what the organisational challenges or the benchmarks are. So this was the kind of evidence base for a recovery focused service. The challenge to become recovery-focused is first that every interaction is recovery-focused, meaning that it's an equally valuing conversation. In everyone, there is an element of shared decision-making, of being genuinely interested in what people want, of giving people the information to make decisions that they want.

It was about also offering co-produced training for staff, because many staff had not actually had training not just in the basics of recovery, but in some of the ways in which recovery could be supported, like coaching skills, like personal recovery planning or WRAP planning, like problem solving, like genuinely equally contributing problem solving. So training for staff needed to shift from them being seen as experts and having the skills to fix people to much more working in ways that empower people, enabled people to see what they were bringing to that and to make their own decisions to identify their own goals.

(15:52):

The third one was around ensuring organisational commitment at all levels. To what extent from right in the services, from people working in services and using services, right up to the executive team, do people all understand what recovery means? Are they

committed to it? Do they understand what implications it has for the language they use, the policies they write. The culture, the environment, the culture? Is there a commitment to this or is it simply tokenistic? And then, fourth challenge, which is very culturally, is shifting. A culture of involving people with lived experience in *our* business as professionals to genuine co-production where we work together on issues that any of us might nominate.

(16:47):

The next set of challenges are very much around specific interventions which might drive the recovery cultural practice. The first one was the recovery education centres. And at this time we just developed and piloted the first recovery education centre in England, and this wasn't actually a direct replication of recovery education centres running in America or health education. This was something that was quite Imroc specific in a way, in that it's a very co-produced place and it offers courses which build on the needs and the suggestions of people living locally and uses subject experts from both within services and local communities so that everything is co-produced. So we said that if you're to be recovery focused, you need to have a recovery education centre, subsequently changed the language to recovery college and the purpose of this was to model co-production, to model the bridge into the communities and also to give people the skills to really take control of their own recovery and perhaps most importantly to shift their identity from one of being a patient to being a student, from having to ask someone what they should do, to learning themselves what they can do for themselves.

(18:13):

So it's really, really about driving forward and modeling best practice. The next thing was about transforming the workforce,

and this was, we were very bold in this. We said, "If you're going to be recovery-focused, you're going to have to employ peer support workers." So peer support workers was only one driver for change, and we knew this would be slow. Nobody at this time was employing peer support workers in statutory services. So we had to start by developing training and also by developing training for organisations and teams so that they understood what's the distinct identity and role of peer support workers, not just being kind enough to take an ex-patient and keep them under their wing in the workforce. So we've made this a big challenge, one of our 10 challenges. We also said that risk management doesn't work. We need to radically change from being a risk averse service, constantly assessing people's risks towards really working with them to develop a joint safety plan, to help to think about how we can understand when things are getting bad for them, how they can let us know what action they'd like us to take and what we would like them to take at times like that.

Who else needs to be involved in helping to keep them safe? Supporting staff, wellbeing and resilience. We knew at this time we'd undertaken surveys both in my own trust, which was Nottingham and in Glenn's trust. So he'd found 35% of staff had their own experience of mental health problems. I found 45% and then Phil Morgan, who is also one of our consultants in Dorset, found 62% of staff had their own experience of using services. So there's a really big issue here around what do we do about that? Peer support workers might be solely there working with the expertise of lived experience, but many staff were implicitly using that in day-to-day practice. How could we ensure that they not only got the support they need but also knew how to use that most effectively?

(20:28):

And of course here in 2009 we talked about increasing opportunities for life beyond illness. Now our language has changed dramatically. The really important thing is to right from the start to help people to retain or regain relationships, roles, activities, things that they want so that their life has meaning, purpose, connection. And then the final one is about working to support families and friends, probably the least used and least recognised resource that's out there. So those are the challenges which we set, and those are all the areas which we worked with. And you can imagine that is 15 years ago and since then each one of those challenges has developed a life of its own including peer support. Each one of them we've learned a huge amount about. You can see here [slide showing pictures of publications] some of our learning. If you go onto our website, you'll see these are some of the briefing papers that we've published.

(21:34):

So that first one was on recovery colleges when Rachel Perkins and I got our heads together and thought, what do we think is the most important? What are the principles underpinning these? Why would we do it? And then 10 years later we published another one on what we've learned about recovery colleges and just now there's another paper coming up which is called 'Recovery Colleges Fit for the Future' and that's about really making them community learning opportunities, really building up that kind of educational availability across whole neighborhoods. Perhaps one of the most interesting papers here is one that was led by Mike Slade and it's the business case for each of the 10 challenges. So it presents the evidence of their effectiveness, but also the cost effectiveness of each of those 10 challenges. The next paper to come out will be very interesting. That's called recovery and trauma-informed care and sort of extrapolates how the two complement each other.

They are different. There are similarities, but they work together. Peer support's one of the biggest, a lot of papers around peer support. There's a new one coming out. We've just started writing one about lived experience and gambling harm.

We're in danger of losing a huge amount of lived experience that has traditionally provided all of the support for people harmed by gambling. And now in England, all of the funding is being taken out of lived experience organisations has been put into the NHS and we have no idea how that lived experience, whether that lived experience, that expertise that's been supporting people quite well for a long while. We don't know where it's being used. One of the things we've started to do much more of is to recognise what our purpose is, and we reckon that it is very much around enhancing the power and voice and contribution of lived experience. So after three years, those 36 sites all had a recovery strategy. They'd set up a recovering steering group. Most of them had employed a designated recovery lead in the service all had identified three to five challenges and had an action plan.

(23:55):

Most often the action plans focused on cultural change, peer support, recovery colleges, risk and organisational commitment. Actually as facilitators, everybody wanted to do peer support. Nobody had any funding for this, and they wanted to do it because they seemed to think that you could just do this without having to shift the whole organisational culture. So in each case we'd say, no, no, no. Actually you will need to choose challenges from the cultural change as well as some of the more interventional ones. But recovery colleges as well, many of them want to set up a recovery college. This was easy. We just have to find a classroom and then co-produce your courses, but the recovery college will only have full impact if it's built into an organisational strategy.

So what had happened was four of these organisations had actually trained their first peer support workers. At that time, the only peer training that they could access in England was one that was run by Imroc and it was only slowly getting off the ground. Six had opened recovery colleges, many more were working towards it. Eight had introduced personal recovery planning, some kind of Wellness Recovery Action Planning. Two, focused on reducing use of restraint and reported remarkable improvements just through monitoring. You saw just when people know that every incident is being followed up, then there was a big reduction. And we found that there was less progress where there wasn't a designated recovery lead. Somebody needs to have time to coordinate this work.

(25:43):

So after three years, we thought that was the end of Imroc, but actually many of the sites we were working with said they'd like to continue to fund us to work with them. And then many more sites came on board, many voluntary sector organisations came on board. So we've now worked with every single mental health trust or trust offering mental health services in England, but we work with more voluntary sector organisations than NHS organisations now because in England there's a system wide approach. There's the integrated care boards which work across localities. So now it's much more likely that we would be working across a neighborhood or a community area and we will be inviting all of the providers within that area and probably the most people in there won't be service providers. They will be local businesses, local shops, the church, the library, the sports centre.

They'll be coming along because actually peer work has a huge job in coordinating, coordinating the kind of input, really helping from a GP surgery or from a community base, helping people to access the right thing for them.

(27:00):

Since that three years, we then started to get more research funding, working with universities to try to generate more evidence to support what we're doing. We've continued to write up briefing papers and then we've had a lot of interest from other countries. So we've worked with WHO. So I'm currently on the steering group of 'The Roadmap for Lived Experience in Organisations', and we've worked, that's for Europe, but also working with WHO in Africa and in Turkey. But also working in research, so at the moment working to bring peer support into low income countries in Africa, and worked on the Upsize Project, developing training for low income countries. We have to be really careful about our values and our reasons for doing this. There are some real questions about training peer support workers in the way that we do in England, when in fact there is such a strong sense of community in these places that often there's a lot of very, very good work happening without us professionalising it in some way.

Lots of questions about how this stuff translates, but overall we've shifted our focus away from recovery towards living well and much more engagement of whole communities, much more focused on co-production on lived experience roles. And we have shifted, Imroc shifted from being very much an organisation with professionals and lived experience to being a lived experience led organisation.

Just as an example, since over the last 15 years, each of the challenges have developed in their own right. You might have seen that we now have the national contract for training peer support workers. So NHS England, which is soon to be disbanded, but they made peer support a new role and it's expected that every service employs peer support workers so they pay for the training. There's a real problem in that in that people want services will send peers

for training, but the services themselves are not adequately prepared. Imroc just doesn't train anybody unless we also go in and prepare the organisation, but too often we end up preparing a team and there still isn't a kind of HR workforce strategy commitment. So it's really difficult to get this right. It's kind of careful what you wish for. We wanted funding for training, but we have to be careful that that doesn't not only put peer support workers individually at risk, but also it leads to failure of peer support.

They end up being unwell, taking time off sick, and then organisations say it doesn't work for us because they just can't cope with the stress. So we have to be careful about what we want. This has to be a lot of work at organisational level. Recovery colleges, we developed the fidelity principles. They've been tested by Mike Slade's team. We do peer reviews in recovery colleges. We've had funding for recovery colleges in new areas, whether that's in primary care or within prisons or within libraries.

Recovery colleges became one of the commissioning targets for forensic services. Again, perverse incentive. You get this funding; you set up a recovery college. So every forensic unit set up a recovery college, but they weren't necessarily effective. They weren't necessarily following the fidelity criteria. Recovery colleges are very, very positive. There is a good evidence to show the effect of them, but if they don't follow the principles, they often end up creating further dependence, becoming more of a day centre by a different name. So it's really important to keep evaluating what we do all the time. The big change over time has been the real shift from shared decision-making to co-production at every level, co-production at scale. And so now we work with many ECBs across regions, across countries, co-producing strategies. The other thing, really important piece of work, is that the groups of people who have lowest service uptake also have

poorest outcomes and they're often people who have the worst experience of services.

So currently we have a whole work stream that's really engaging with communities, whether they're gypsy travellers, people who are survivors of domestic abuse, asylum seekers. We've got Chinese elders, Somalian women. The point is these groups are met in their own spaces at their own time to work out what it is that they most want from services, what gets in the way, and then having established their kind of wish list we then bring services in to try to work out how they can shift and become more accessible and effective for those populations. So working a lot more at that community engagement level.

(32:32):

So we've evolved over time through continual learning and that's through ongoing evaluation all the time. We've actually been able to both influence policy but also be influenced by policy. So we're constantly identifying what's the gap. And at the moment we've got a new 10-year plan, and we can see that there's three shifts. There's the one that's from treatment to prevention, from inpatient care to community care and from analog to digital services. So we are actually putting ourselves into where are the gaps that Imroc can fill? How can we provide some answers? So we have now really developed a lot more work and support around lived experience leadership because we see that as being a gap. How do we support and enable lived experience leaders to work across the system and to have maximum influence? How do we support them to retain their distinct expertise without selling out to professionals?

So really just enhancing that contribution of lived experience and always thinking about co-production at scale. Who needs to be in

the room? Who else needs to be in the room? How can we ensure that the people who aren't in the room still get their voices heard?

(34:00):

So where we are now, we're a lived experience led charity. Just this year we've worked in 18 different countries. We've got around 93 consultants or trainers, but only still three of us on substantive contracts because, you know, in this area, you never know where the, or whether there will be another contract coming in. We've got seven programmes of work, each with identified leads and these include a programme on recovery colleges, one on peer support, on focusing on acute care, one on research and development, one on living well, co-production at scale. And then we've got communications, publications, education and training. And all of those have a comprehensive offer and a prospectus, but all of them are also open to supporting any organisation who wants to take that further. Anybody who's working in those areas and acknowledges our values and is prepared to work within our values, we will support them. We will say, yeah, we can work with you. We need to work out what, some kind of support you'd want from us, but we need a conversation to think about who'll be involved in that.

We don't go in there with answers. We go in there to enable them to find and develop the answers. So where's Imroc now or where's, where's recovery now? I guess this is more about where's recovery. So there's now 225 recovery colleges running in 34 countries, 88 England. I think that's a real success story for Imroc, that one. We facilitate an international learning set, which I think is just moving into its sixth year. We fund communities of practice in different countries. So we do some social responsibility work for recovery colleges, which are kind of great. They want to do it, but they don't have funding. So just trying to help them to really work to their full potential.

Yeah, we're developing new approaches to community engagement and development. We're working at, currently, with all acute care units in England offering the lived experience coaching for inpatient teams.

But this is where services are now. There has been progress and I think Imroc could say that we've been involved in that progress, but there's always a but, isn't there? So there are lived experience roles embedded in all services, but there's huge variation in the banding, in their responsibility, in how many there are in any trust. And most importantly, I've put inclusion here, but to what extent are they truly embedded in decision-making and to what extent is this tokenism? Co-production is now ubiquitous. Everybody uses this term, but whether it's actually done well, whether it's actually effective, whether it's inclusive, whether it truly is valuing the voice of lived experience, whether its respecting what people want and really trying to get there, it's not clear. Care planning is increasingly focused on personal goals, which is important, focusing on whether you want to work, what you want to do next in your life.

It's about where do you want to live, but actually the capacity of services to try to support people with those goals is incredibly limited. You can change the paperwork, but it doesn't change the practice. And most areas have at least one recovery college and to some extent they are a success story. They have on average 1500 students a year, but at least three of them have lost funding in the last 12 months because of there are real time cuts, 2% cuts in the NHS just this year. And you think, like you're saying, there's less of very little.

(37:54):

Yeah. Safety planning's replaced risk assessment in many areas, but that's at times just a paper exercise because decisions aren't

necessarily based on the plans. They're just based on people's worries. People tighten up and revert to what's traditional and familiar, times of stress. I think excitingly, relational psychiatry, open dialogue alongside kind of recovery-focused, trauma-informed ways are really seeding into services. But whilst there's such a cut in the numbers of staff, whilst there's so many vacancies, whilst it's in such crisis, it's really difficult to know how people can take the time to really work in these ways. I think financial pressures mean that the latest innovations are the first to be cut. I think that there's very little resource invested in empowerment or in prevention. It's always in risk management. There's a real perception that in order to make these changes in culture and practice, you have to invest a lot of money.

Actually, the evidence is that it's about doing things the way you want to. It's about doing things differently, not about doing things more. About, if we do these things, then we increase staff satisfaction and that leads to improvement in patient satisfaction, you get less turnover, you get lower lengths of stay. There's a lot of evidence to say this isn't more costly, but there's still ongoing cynicism about the value of lived experience. And one of the reasons for this is that if we employ people with lived experience into services that are overstretched, feel unsafe or working in very traditional, often coercive ways, those people we've employed in there just won't survive. They won't be effective. So that breeds cynicism, well, they didn't help. They didn't stay. Whereas if we really support them and we enable them, we work with the whole team, then we can actually lead to a much more positive experience and fulfill positive outcomes.

Big problem is that financial structures don't allow us to pull resources. So, we found that we got 100% return on investment when we employed peers in primary care. So there was less admission to secondary care, social care, specialist care services,

less use of crisis care, less use of ambulance services. That came to a hundred percent return on investment within 15 months. Amazing. We couldn't use it because, this year, there isn't any way to collect that money together to fund you because that bit has to be taken out of the ambulance service, that bit out of social services. So, this financial structure is prohibitive. I do worry that actually the main barrier is a resistance to change and this is a sort of post-war 'eclogue' it's called, that W.H. Auden wrote about the English people. "We'd rather be ruined than changed. We'd rather die in our dread than climb the cross of the moment and let our illusions die."

You know, there's this kind of paper, you know, agreement that things need changing, but then this absolute brick wall resistance to actually changing deeply, fundamentally.

(41:12):

So, what we've learned as Imroc. We have to know our purpose. We have to know our parameters. What are we prepared to do? What don't we do and what do we do and where do we want to be? I think the most important thing for us was to find a way in, to find a way into working in services and that gave us our reputation. It gave us our evidence. We always have to build credibility by demonstrating what difference we make. So evaluation is very important and that's built into what we do. I do think that although we are led by lived experience, that we need to be prepared to work with people with subject expertise and also with the evidence. There's three things that come into co-production and it's not purely about what I feel. It's also about what the research and evidence is and what other people might be able to contribute.

We have to engage from the top of organisations and the bottom and then work most closely with the middle managers because

they're the ones who make the decision and make it happen and always start where people are at. Start where people are, in an appreciative way. How did you get here? What made you decide to work like this? Have you thought about this? Did you know this? Have you visited this? It is around always appreciating why people do things the way they do and where they might want to be different and then offering other ideas about how things could be done.

And that's very much in line with how we work in a recovery-focused way with individuals, isn't it? Where do you want to be? What's getting in the way of where you want to be? What do other people find helpful to get to where you want to be? And we're not going in there to do things for people. We're in there to enable people to just move forward on their own. It's not a great business model actually because you're going in to really, really enable people to stand on their own two feet so you can get on and go and work with someone else. And that's it. A whistle stop tour.

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