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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<td>CHP</td>
<td>Community Health Partnership</td>
</tr>
<tr>
<td>CMHN</td>
<td>Community Mental Health Nurse</td>
</tr>
<tr>
<td>CMHT</td>
<td>Community Mental Health Team</td>
</tr>
<tr>
<td>CPN</td>
<td>Community Psychiatric Nurse</td>
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<tr>
<td>ESC</td>
<td>Essential Shared Capability</td>
</tr>
<tr>
<td>HEAT</td>
<td>Health improvement, Efficiency, Access and Treatment (target)</td>
</tr>
<tr>
<td>HEI</td>
<td>Higher Education Institution</td>
</tr>
<tr>
<td>LIG</td>
<td>Local Implementation Group (for Rights, Relationships and Recovery)</td>
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<td>MAPPED</td>
<td>Model for Analysing Policy to Practice Executive Developments</td>
</tr>
<tr>
<td>MDT</td>
<td>Multidisciplinary Team</td>
</tr>
<tr>
<td>MHW</td>
<td>Mental Health Worker</td>
</tr>
<tr>
<td>NES</td>
<td>NHS Education for Scotland</td>
</tr>
<tr>
<td>NHSREC</td>
<td>NHS Research Ethics Service</td>
</tr>
<tr>
<td>NIG</td>
<td>National Implementation Group (for Rights, Relationships and Recovery)</td>
</tr>
<tr>
<td>PATH</td>
<td>Partnership Action on Tobacco and Health (training)</td>
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<tr>
<td>PDP</td>
<td>Personal Development Plan</td>
</tr>
<tr>
<td>RF</td>
<td>Regional Facilitator (for the VBRFP initiative)</td>
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<tr>
<td>RRR</td>
<td>Rights, Relationships and Recovery (Policy document)</td>
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<tr>
<td>SCQF</td>
<td>Scottish Credit and Qualifications Framework</td>
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<tr>
<td>SEHD</td>
<td>Scottish Executive Health Department (up to 2006)</td>
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<tr>
<td>SGHD</td>
<td>Scottish Government Health Department (2006 onwards)</td>
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<tr>
<td>SRI</td>
<td>Scottish Recovery Indicator</td>
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<td>SRN</td>
<td>Scottish Recovery Network</td>
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<tr>
<td>STORM</td>
<td>Skills-based Training on Risk Management</td>
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<tr>
<td>VBP</td>
<td>Values Based Practice</td>
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<tr>
<td>VBRFP</td>
<td>Values Based and Recovery Focused Practice</td>
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<td>WRAP</td>
<td>Wellness Recovery Action Plan</td>
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SECTION 1: THE INITIATIVE TO DISSEMINATE EDUCATIONAL RESOURCES TO SUPPORT VALUES-BASED AND RECOVERY-FOCUSED MENTAL HEALTH PRACTICE IN SCOTLAND

Section preview
This section describes the origins and nature of the initiative, and gives details of the evaluation objectives. The aspiration to cascade an engaging educational experience to all Scottish mental health nurses, and thereby to influence practice culture, emerges as ambitious in both nature and scope.

1.1 Introduction: the overall policy context

During the past decade the Scottish Government and its agencies have been very active in developing policies aimed at improving mental health care. The Mental Health (Care and Treatment Scotland) Act 2003 can be seen as foundational in this respect in that it not only reformed legislation for people using mental health services under compulsion, but was informed by the 10 principles that the Milan Committee had earlier posited as fundamental for service delivery. The “Milan principles”, as they have become commonly known, promote aspects such as: equality, respect for diversity, respect for carers, and the need to enable service users to participate as much as they are able in all aspects of their care, treatment and support.

These principles in turn informed development of the Delivering for Mental Health (2006) policy which set out a service delivery model with social inclusion, prevention of illness and community based partnerships as prominent aspirations. More recently, the Towards a Mentally Flourishing Scotland: Policy and Action Plan 2009-2011 takes forward the emphasis on wellbeing.

Both the above documents also make explicit a commitment to the idea of Recovery as a central tenet for policy and practice. Founded in 2004 to raise awareness of this idea, the Scottish Recovery Network (SRN) describes recovery as:

“being able to live a meaningful and satisfying life, as defined by each person, in the presence or absence of symptoms. It is about having control over and input into your own life. Each individual’s recovery, like his or her experience of mental health problems or illness, is a unique and deeply personal process”. (Brown and Kandirikirira 2007)
Within this Scottish initiative, the influence of pioneering work on the “recovery approach” in the United States and New Zealand is clearly acknowledged (Scottish Recovery Network 2009). A comprehensive literature review of the issues around implementing a recovery approach in policy and practice is provided by Berzins (2005), while associated training issues are usefully reviewed by Ask Clyde (2007).

1.2 Rights, Relationships and Recovery: nursing policy context and content

As its title suggests, the above theme also features prominently in Rights, Relationships and Recovery: the National Review of Mental Health Nursing in Scotland (SEHD 2006). In this first review of the discipline in Scotland, the emergent need to focus on individual’s recovery is seen as inextricably linked to the promotion of an explicit values base for nursing practice. Specifically Rights, Relationships and Recovery (RRR) sees values-based care as being predicated on the 10 Essential Shared Capabilities (Department of Health 2004).

The 10 Essential Shared Capabilities (ESCs) were developed in England by a partnership involving the Department of Health, the Sainsbury Centre for Mental Health, the National Institute for Mental Health in England and NHSU in 2004. Following extensive review and consultation work which had highlighted mental health service user dissatisfaction with services and the related lack of a coherent values base underpinning practitioners’ skills, knowledge and behaviour, the following shared capabilities were posited for all staff to achieve best practice:

1. Working in partnership
2. Respecting diversity
3. Practising ethically
4. Challenging equality
5. Promoting recovery
6. Identifying people’s needs and strengths
7. Providing service user-centred care
8. Making a difference
9. Promoting safety and positive risk taking
10. Personal development and learning
This approach is informed by previous and related work on values based practice such as that by Woodbridge and Fulford (2004). A Learning Pack based on the 10 ESCs was subsequently produced and piloted in eight regions of England. Within the context of very positive evaluation (Brabban and Brooker 2006), the pilot highlighted that: such training is better based on group facilitation (rather than individual study); service users should be involved in training delivery; training takes significant time; and practitioners valued paper-based materials rather than CD Rom.

The Scottish Review went much further than the English pilot by making the ESCs foundational to its Delivery Action Plan, as seen in Action 1: “All mental health nurses will have undertaken values-based training by June 2008”. Towards this end it was also 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/portfolios and clinical supervision. Given the politically peripheral position of mental health nursing in the UK during the 20th Century (Dingwall et al 1988), and the related predominance of medical diagnosis-led care, such a Government commitment can reasonably be seen as historic. Moreover, it can also be seen as ambitious given that there were approximately 6708 (Whole Time Equivalent) mental health nurses working in Scotland when the RRR review started in 2005 (SEHD 2006).

Indeed the RRR document is inherently ambitious in its nature and scope, with a further 22 Action Points covering the Development of Specific Areas of Practice (e.g. acute inpatient care; increasing access to psychological therapies) and Developments across the Career Framework (e.g. development of newly qualified nurses; leadership in mental health nursing).

Under the ambit of Delivering the Values Base, Action 3 states that “A national framework for training in recovery-based practice to support the dissemination of recovery-focused frameworks into practice will be developed by the end of 2007”. Practical enactment of such frameworks is anticipated in Action 2 whereby “Mental health nurses will use recovery environmental audit tools to gauge their current practice and to inform development of recovery-based approaches to care by the
end of 2007”. The Scottish Recovery Network is seen as a key enabler of both these actions.

Thus it can be seen that Rights, Relationships and Recovery draws on wider national and international developments within mental health care to inform a bold new agenda for Scottish mental health nursing that sets values-based and recovery-focused practice as its foundation.

1.3 The development of educational resources

In response to Action 1, NES set about developing appropriate educational resources for values-based training. While the impetus came from a nursing policy, the aim was to design the materials in such a way as to be relevant to people in all mental health roles and settings (e.g. service users, families and carers, managers, practitioners, volunteers, peer support workers). To this end NES worked with an expert group consisting of service users, carers and representatives from the voluntary and statutory sectors. The outcome was a pack based on the pilot learning materials developed in England, but customised and developed to meet the needs of the Scottish context: the 10 Essential Shared Capabilities for Mental Health - Learning Materials (Scotland) (NES 2007)

The materials consist of six modules (see Table 1.1. overleaf for module learning outcomes). Module 1 (“Getting Started”) and 2 are designed to be completed first, while Modules 3 to 6 can be completed in any order. With a view to helping practitioners translate learning into developing better services for service users and carers, the materials are action focused, with specific learning activities incorporated throughout each of the modules. While scope for self-directed study is offered, the emphasis is on working with a facilitator/manager/colleague group to enable participation in group activities and discussion. The estimated completion time if delivered as an intensive facilitated course is 4.5 days. However, the recommendation is that the programme is studied over 6-8 weeks to allow time for reflection and application between modules. Although the programme is not formally assessed or academically accredited, completing all the modules links to Level 8 on the Scottish Credit and Qualifications Framework (SCQF).
Table 1.1: 10 ESC Learning Materials: Modules and Learning Outcomes

<table>
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<tr>
<th>The 10 ESCs</th>
<th>Learning Materials (Modules 2-6)</th>
<th>Module Learning Outcomes</th>
</tr>
</thead>
</table>
| • Working in Partnership                        | The 10 Essential Shared Capabilities                                  | • Describe the 10 ESCs and how they relate to mental health work;  
• Reflect on yourself and your practice in relation to the ESCs;  
• Understand how the ESCs relate to and support the delivery of mental health policy and legislation in mental health practice in Scotland;  
• Start to think about further developing your practice in line with the ESCs and recognise how they can help you to improve your experience of mental health work and the experiences of the people you work with. |
| • Respecting Diversity                          | Involving service users and carers                                     | • Describe the links between service user involvement, carer involvement and the 10 ESCs;  
• Discuss service user and carer involvement at individual, organisational and strategic levels;  
• Explore local approaches to increasing service user and carer involvement in their own care and in service design;  
• Describe the approach to service user and carer involvement you would like to see developed in the team, service or project in which you work;  
• Present ideas on how this improved approach can be achieved, defining the role you and your immediate colleagues can play. |
| • Practising Ethically                          | Values based Practice                                                 | • Explain what values-based practice (VBP) means in mental health and social care;  
• Describe the 10 pointers to good process in VBP;  
• Explain the relationship of VBP to The Ten Essential Shared Capabilities (ESC);  
• Begin to apply VBP in your work. |
| • Challenging Inequality                        | Equality and Diversity, respecting difference                        | • Reflect on what equality and diversity mean to you;  
• Describe current issues in inequalities in Scotland that impact on mental health;  
• Examine equality and diversity issues in relation to mental health services in Scotland;  
• Discuss broader issues in relation to health inequalities in Scotland that are relevant to mental health;  
• Reflect on your own experiences and practice in relation to equality and diversity issues. |
| • Promoting Recovery                            | Developing Socially Inclusive Practice                               | • Challenge the processes that lead to inequality and exclusion;  
• Adopt assessments and interventions that are inclusion-focused and user-centred;  
• Understand the importance of working in partnership with mainstream community organisations. |
| • Identifying People’s Needs and Strengths      |                                                                       |                                                                                                                                                                                                                                                                                                                                                       |
| • Providing Service User Centred Care           |                                                                       |                                                                                                                                                                                                                                                                                                                                                       |
| • Making a Difference.                         |                                                                       |                                                                                                                                                                                                                                                                                                                                                       |
| • Promoting Safety and Positive Risk Taking    |                                                                       |                                                                                                                                                                                                                                                                                                                                                       |
| • Personal Development and Learning.           |                                                                       |                                                                                                                                                                                                                                                                                                                                                       |
Secondly, NES and the Scottish Recovery Network (SRN) developed a framework called “Realising Recovery: A National Framework for Learning and Training in Recovery Focused Practice” (NES 2007). This framework outlined the knowledge, skills and values that mental health workers would need to practice in a recovery focussed way and guided organisations and individuals to initial learning activities. This laid the ground for the subsequent publication of Realising Recovery Learning Materials (NES 2008) These were designed to build on the 10 ESC materials by giving learners much more detailed insights into Promoting Recovery. Again the materials comprised six modules, with similar guidance on completion formats and styles, although these materials mapped to Level 9 SCQF.

1.4 The planned dissemination of the educational resources

As indicated in Section 1.2, the RRR Delivery Action Plan required each Director of Nursing to make strategic plans to support the dissemination of these educational resources by training the mental health nursing workforce within their organisation. Moreover the monitoring and performance management of NHS Boards’ progress in delivering the action plan was to be taken forward by bi annual reports to the RRR National Implementation Group (NIG). Thus close partnership working between Health Boards, NES and NIG was planned. The “roll out” of the training was planned in two distinct phases.

1.4.1 Phase One – 10 ESC Training for Trainers

Following a tendering and procurement process during 2007, NES commissioned Health in Mind and Penumbra (in partnership) to deliver Phase One of the training for trainers project. This would entail preparing around 70 individuals, drawn from across mental health services in Scotland, as trainers who would be prepared, supported and accredited to further disseminate and cascade the 10 ESC training within their organisations. To this end all NHS Boards and their partner organisations were invited to nominate participants for the training based on the following indicative criteria:

- Those with an existing or potential training/practice development role
- Those with a strong commitment to values based and recovery focused practice
• Those with a commitment to attending all components of the programme, undertaking assessments, and undertaking further training as a recovery trainer in 2008

• Those with an ability to influence their peers, motivate others, communicate creatively and work in partnership

• Those who will have organisational support to fulfil a future role in further disseminating the training within the organisation and engaging in cross working with a network of regional trainers

Thus it is important to note that the aim was to engage potential trainers from a wide range of occupational backgrounds and workplace settings, rather than just nurses and Health Boards employees. Training was to be delivered in three separate regional/local programmes (comprising around 20 participants per cohort in the South East, West and North programmes) with two additional local deliveries being provided to NHS Western Isles.

1.4.2 Phase Two – Realising Recovery Training for Trainers

For the second phase of the project it was planned to enable the same participants to build on the ESC training and to train as recovery trainers, capable of delivering both the 10 ESC and recovery training and also training others as trainers. Participants would be eligible to progress on to Phase 2 training if they had successfully completed Phase 1 and then delivered at least three of the 10 ESC training programmes within their organisation. Again this process would involve NES commissioning a provider of the regional-based training, scheduled to commence in September 2008.

A summary of the main NES/SRN initiated dissemination activities is presented in Table 1.2 along with indicative timescales.
Table 1.2: Main NES/SRN initiated dissemination activities

<table>
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<tr>
<th>Phase</th>
<th>Activity</th>
<th>Timescales</th>
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<tr>
<td><strong>Phase One</strong></td>
<td>10 Essential Shared Capabilities Learning Materials (Scotland) disseminated in NHS Scotland (via website publication and hard copy distribution)</td>
<td>April 2007</td>
</tr>
<tr>
<td></td>
<td>NES commissioned 10 Essential Shared Capabilities Training for Trainers Programme delivered in North, South East and West Regions (by Health in Mind &amp; Penumbra)</td>
<td>October 2007 – February 2008</td>
</tr>
<tr>
<td></td>
<td>NES commissioned 10 Essential Shared Capabilities Training for Trainers Programme delivered in NHS Western Isles (by Health in Mind &amp; Penumbra)</td>
<td>March 2008</td>
</tr>
<tr>
<td></td>
<td>10 ESC Learning Materials Facilitators’ Toolkit developed and published</td>
<td>May 2008</td>
</tr>
<tr>
<td></td>
<td>On successful completion of the training participants expected to deliver at least 3 sessions of the 10 Essential Shared Capabilities training programmes within their organisations to be eligible for Phase 2 training</td>
<td>March 2008 - end August 2008</td>
</tr>
<tr>
<td><strong>Phase Two</strong></td>
<td>Realising Recovery – A National Framework for Learning and Training in Recovery Focused Practice launched and disseminated</td>
<td>September 2007</td>
</tr>
<tr>
<td></td>
<td>Development and dissemination of Realising Recovery learning resources</td>
<td>April 2008</td>
</tr>
<tr>
<td></td>
<td>Commissioning of Recovery Training for Trainers Programme</td>
<td>June 2008</td>
</tr>
<tr>
<td></td>
<td>NES commissioned Recovery Training for Trainers Programme commences</td>
<td>September 2008</td>
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</table>

As Table 1.2 suggests, the Action 1 goal of all mental health nurses having received 10 ESC training by June 2008 was already proving to be unrealistic, and subsequently the National Implementation Group extended this target to the end of 2010. Nevertheless, the majority of the activities in Table 1.2 were substantially achieved within the timelines indicated.
1.5 The commissioned evaluation of impact

Following a process of competitive tendering, NES commissioned our team from RGU to undertake an external evaluation between February 2008 and January 2010. The overall aim of the evaluation was to: undertake a national longitudinal evaluation of the impact of the dissemination of educational resources to support values-based and recovery-focused mental health practice.

The specific objectives given by NES were:

1. To explore the perceptions and experiences of the trainers who delivered the training programmes including:
   - Trainers evaluation of the learning materials;
   - Trainers evaluation of the training programs including their approach to developing and delivering the content;
   - Trainers experiences and views on the process and outcome of the training;
   - Trainers perceptions of the trainees engagement with and experiences of the programmes;
   - Trainers views and ideas about the likely organisational barriers and facilitators that will enable trainees to further disseminate the training.

2. To explore the experience of participants who undertook the training for trainers programmes including their:
   - Evaluation of the learning materials;
   - Evaluation of the training programmes – including content and participants’ learning Experience in terms of both process and outcome;
   - Perceptions of the relevance of the training; perceived practically and potential for applying the learning.

3. To explore the perceptions of participants who undertook the training for trainers programmes of the learning achieved, including their:
   - Views and ability to demonstrate increased capability in relation to the 10 ESCs, recovery focussed practice and as trainers.

4. To examine the methods that participants who undertook the training for trainers programmes and their organisations used to disseminate and cascade the training/learning including:
   - Organisation and individual strategies formulated to roll out the training;
   - The number of people trained;
   - Trainers’ and participants’ evaluation of the training in terms of experience of the learning material, the training programme and experience training and learning achieved;
   - Methodologies used to deliver the training;

5. To examine the success and challenges experienced by participants who undertook the training for trainers programmes and their organisations in disseminating the training including analysis of organisational barriers and opportunities.
6. To explore the experience of people learning from the participants who undertook the training for trainers programmes including:
   Personal reactions to the learning materials and training programme and experience;
   Perceptions of the relevance of the training; perceived practicability and potential for applying the learning.

7. To evaluate the extent to which people learning from the participants who undertook the training for trainers programmes applied the learning and changed their attitudes, behaviour and practice including examination of their perceptions/reports of:
   How did put their learning into effect in practice?
   What noticeable and measurable changes did they make to their practice?
   Were these changes sustained and what were the organisational barriers and facilitators influencing the sustainability of changes made?

8. To explore issues in relation to organisational sustainability in disseminating the training including:
   Attrition of people originally trained as trainers;
   Reasons for attrition;
   Organisational plans to overcome this;
   The impact of competing demands and priorities on sustainability.

9. To produce a report of the evaluation for NHS Education for Scotland including:
   Recommendations for future educational, practice development and research activities that will support the impact of this initiative;
   Identifying future methodologies that can continue to capture the impact assessment of values and recovery focussed training and practice on the experiences and outcomes of care and services for service users and their families/carer.

Thus the evaluation objectives pertained closely to the envisaged educational cascade facilitated by NES, SRN, Health in Mind & Penumbra (as commissioned trainers), and Health Boards and their partner organisations (e.g. voluntary organisations). In effect, objectives 1-3 are about the regional training experiences; objectives 4,5 and 8 are about planning, delivering and sustaining training within specific organisational contexts; objectives 6 and 7 are about the experiences of local recipients of local training; and objective 9 is about lessons learned. As such, the objectives are concerned very much with exploration of dissemination processes and any proximal impacts on the practices of mental health workers. During the commissioning process the Steering Group made it clear that full spreading and substantial embedding of the initiative was unlikely to occur entirely within the timescale of the evaluation and that, accordingly, systematic elicitation of service users’ perceptions of any impacts (i.e. distal effects of dissemination) would be better saved for possible future study. Although this was seen as disappointing by our team
at the time, in retrospect, this reflected a realistic judgement about the likely nature and scope of dissemination by cascade within busy organisations with multiple competing priorities.

1.6 Terminology adopted for the evaluation

In order to try to optimise distinction between the different groups involved in the cascade of dissemination training, we adopted the following key terms:

**The commissioned trainers** The trainers from Health in Mind and Penumbra who initiated Phase 1 by training around 70 first wave trainers. They were also subsequently commissioned by NES to deliver the Realising Recovery Training for Trainers Programme.

**First wave trainers** The 70 or so individuals drawn from mental health services in Scotland who received training from the commissioned trainers in Phase 1. Most of these people then went on to receive Realising Recovery Training in Phase 2 with a view to disseminating this locally and training new trainers.

**Local trainers** Local mental health workers who were subsequently trained by the first wave trainers so that they could deliver the materials to their colleagues.

**MHWs** The local mental health workers who subsequently attended training/dissemination events held by either the first wave trainers or local trainers.

It was also useful to distinguish two other groups of staff who played important roles in organisational translation of the initiative, namely:

**LIGs** The Chairs of the Local Implementation Groups that were set up within most Health Boards to plan and monitor enactment of the RR Mental Health Nursing Review actions.

**Service Managers** key informants who were involved in managing provision of services (in a Health Board). Some of these managers had a mostly strategic remit while others had a more operational focus to their role.

Finally, it is important to acknowledge the key role played in developing the initiative by the:

**Regional Facilitators (RFs)** three very experienced mental health nurses who in Spring 2008 were seconded through NES on a part-time basis to support the roll out of the training in the North, West and East regions of Scotland. Each RF thus facilitated development by working concurrently with staff in several Health Boards. The RFs were also very helpful in supporting the evaluation study.
SECTION 2: EVALUATION DESIGN AND METHODS

**Section Preview**
This section gives details of the evaluation design and methods, including ethical aspects and the study’s limitations. The MAPPED model is introduced as an analytic framework. The use of qualitative methods such as case studies and typologies to construct understandings are highlighted as key strategies.

2.1 An analytic framework

Before detailing the methods used to address the nine specific objectives, it is firstly useful to visualise them within the wider context of the Values-Based and Recovery-Focused Practice (VBRFP) initiative. To this end we have drawn on the Model for Analysing Policy to Practice Executive Developments (“MAPPED”; Macduff 2007). Figure 2.1 depicts the VBRFP Initiative as a Policy to Practice development.

The green shaded areas within Figure 2.1 summarise key aspects of initial policy formulation, and subsequent mobilisation of these ideas. The various yellow shadings indicate the primary areas of interest for the evaluation of processes and impacts of the VBRFP initiative, specifically:

- The regional training as experienced by the commissioned trainers and the 1st wave trainers (objectives 1-3; see line a, Fig. 2.1)
- Local organisational structures, strategies and practices, in terms of: planning and facilitating the initiative, supporting individual 1st wave trainers in their dissemination and translational work, and monitoring of progress within the organisation (objectives 4, 5 and 8; see lines c and d, Fig. 2.1)
- The experiences of MHWs themselves in terms of being trained and any subsequent incorporation into their workplace practice (objectives 6-7; see Levels 1-3 and line d, Fig. 2.1)

The red lines in Figure 2.1 indicate the evaluation’s main scope and interactions. As explained in Section 1.5, systematic study of service users’ and carers experiences (see Level 3, Fig. 2.1) was outwith the scope of the evaluation.
Figure 2.1 The VBRFP Initiative as a Policy to Practice development

**Part 1: Initial policy formulation and advancement of VBRFP**

<table>
<thead>
<tr>
<th>Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspiration</td>
</tr>
<tr>
<td>Awareness and anticipation of opportunities</td>
</tr>
<tr>
<td>Alignment around advocated agendas</td>
</tr>
<tr>
<td>Authority</td>
</tr>
<tr>
<td>Alliances for advancement</td>
</tr>
<tr>
<td>Advantageous adaptation</td>
</tr>
</tbody>
</table>

**Part 2: Taking the policy initiative forward towards enactment**

<table>
<thead>
<tr>
<th>Level of analysis</th>
<th>Mode of technological development</th>
<th>Mode of knowledge production</th>
<th>Mode of containment</th>
<th>Mode of strategic expansion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ideation</td>
<td>Idea of a national educational initiative for all mental health nurses and other MHWs. Involvement of service users as key stakeholders. Expectations of impact.</td>
<td>Idea of supplementing formative intelligence gathering with formal impact evaluation.</td>
<td>Idea of maintaining control over integrity of VBRFP as one programme within RRR.</td>
<td>Idea of knowledge cascade through training in Health Boards and partner organisations.</td>
</tr>
<tr>
<td>Mobilisation</td>
<td>Core educational materials developed by NESTHR, key documents made available on the web. Commissioning of trainers.</td>
<td>Commissioning of external evaluation of programme impact.</td>
<td>National Implementation Group. Work of Project Director to maintain integrity.</td>
<td>Work with statutory and voluntary providers to identify around 70 1st wave trainers.</td>
</tr>
</tbody>
</table>

**Part 3: Key elements influencing articulation between policy and practice**

- The regional ESC and recovery training enacted by HIMP.
- The enactment of a national evaluation of impact.
- Structural constraints on dynamic instability:
  - Work of Project Steering Group.
  - Work of Regional Facilitators.
- Local organisational structures and practices:
  - Characteristics and developmental history of translating organisations.
  - Strategies for dissemination.
  - Effectiveness of communication, monitoring and feedback.

**Part 4: Translation and enactment of VBRFT at local level**

KEY TO BLUE --- --- LINES IN PART 4
- a = 1st wave trainers undertaking training and integrating it into practice
- b = Regional Facilitators support for 1st wave trainers
- c = Relationship between organisational strategy/processes and 1st wave trainers
- d = Communication between organisation and MHWs.

RED LINES INDICATE EVALUATION’S SCOPE AND INTERACTIONS
2.2 Design

The study was designed to follow the cascade of dissemination activity as envisaged in Phases 1 and 2 of the project (see Table 1.1). Our overall approach was informed particularly by: the stakeholder involvement perspective of Guba and Lincoln (1989); the explanatory case study methods suggested by Yin (1994); and Robert Stake’s early work on congruence between intention and enactment (1977). Within this context, qualitative methods were the primary means used for building understanding, but the study also at times used questionnaires with a view to achieving breadth of coverage.

2.3 Methods used to understand the initiative in context

A number of methods were used to gain understanding of the initiative in terms of its historical, political and social context. As indicated in Section 1, relevant policy documents were reviewed, and analysis of wider literature (e.g. web sites; research reports and journal articles) was ongoing throughout the study. At the start of the study in-depth interviews were undertaken with four people who had key roles in leading aspects of the initiative. These interviews explored the development of the initiative to date, using MAPPED as a basis for eliciting reflections and projections. Finally a number of relevant national and regional events, such as conferences, were attended during the course of the evaluation.

2.4 Methods used to explore regional training experiences

2.4.1 Perspectives from Health in Mind Penumbra trainers

The main sources of data for this part of the study were the commissioned trainers and those who were trained by them (i.e. the first wave trainers). A focus group interview was undertaken with five of the commissioned trainers in May 2008 in order to learn about their experiences of preparing and delivering the Phase 1 (10 ESCs) training at the regional venues. The commissioned trainers also shared the detailed evaluation feedback collected directly from participants at these events. Similarly the “in-house” feedback from the Phase 2 (Realising Recovery) training was passed on to us after that finished in Spring 2009. A member of the evaluation
team attended one of these regional Realising Recovery training events delivered by the commissioned trainers. In June 2009, one of the commissioned trainers was interviewed to gain insights into the preparation and delivery of Phase 2 training and to compare this with Phase 1 experiences.

2.4.2 Perspectives from first wave trainers

In order to obtain perspectives from the first wave trainers, a questionnaire was forwarded in Summer 2008 (by NES) to the 68 who had actually undertaken the Phase 1 training. This asked about: how they came to be involved; views of the content, processes and value of training with the commissioned trainers; and their early experiences of training their colleagues. Thirty four (50%) responded. In May and June 2009 focus group interviews were held with self-selecting first wave trainers in the North (9 participants), West (5 participants) and East regions (2 participants) respectively. The focus group interviews sought to explore recent Phase 2 training experiences and the overall enactment processes to date through the following thematic discussion guide:

- Experiences of training – processes and strategies
- Methods of dissemination
- Barriers and facilitators
- Own evaluations – what works, how and why?
- Initial reflections on any impacts
- Reflection on influencing factors and sustainability
- Looking ahead – what needs to happen?

2.5 Methods used to understand translation and enactment within organisations

A relatively large number of methods were used to gain insights into the way that individual Health Boards went about translating the initiative into action.

2.5.1 Review of Health Board reports

Firstly each Board’s bi-annual report to the National Implementation Group on progress on Action 1 was reviewed. These varied markedly in terms of quantity (some gave copious detail, while others were scant) and quality (some reported substantive and integrated developments that were verifiable by other sources, while
others were superficial and seemed to conflate aspiration and enactment in a way that was incongruent with other accounts).

2.5.2 Regional Facilitators’ perceptions

The Regional Facilitators’ bi-annual reports were also reviewed and these proved very helpful. More detailed views about strategic and “on-the-ground” progress within each of the Boards that they covered were sought from the RFs on two occasions during the study via a structured questionnaire.

2.5.3 Local Implementation Group leaders’ perceptions

As each Health Board was believed to have a Local Implementation Group (LIG) for Rights, Relationships and Recovery it seemed useful to seek LIG leaders’ perceptions through a structured questionnaire. This sought information about LIG leaders’ own involvement, views of the 10 ESCs, training processes, and organisational approach to roll-out. In Summer 2008, sixteen questionnaires were sent for forwarding through key contacts in relevant Boards, and nine (56%) were subsequently returned.

2.5.4 Key service managers’ perceptions

Through contacts established with the LIGs and the Regional Facilitators we also sought perspectives from at least one key informant involved in managing the provision of services within each Health Board (and several in the larger Boards). The rationale was to hear from clinical service managers involved in implementing the plans. Recruitment proved especially protracted with this group due to the difficulties of third party intermediary contact. The questionnaire sought information about service managers’ own involvement, training processes, and organisational approach to roll-out. In Summer 2008, 28 questionnaires were sent for forwarding through key contacts. Twelve (43%) were subsequently returned and these findings informed early understandings of translation (see Section 4.3.2). This process was repeated in Autumn 2009 with questionnaires sent out to the above 12 respondents and to nine other service managers who had more recently provided their contact
details (total = 21). Ten (48%) were subsequently returned, and these perspectives informed the later construction of case studies (see Sections 4.4. and 4.5).

2.5.5 First wave trainers’ perceptions

As explained above in Section 2.4, first wave trainers’ perceptions of strategic and “on-the-ground” developments in training and practice were sought via questionnaires and focus group interviews. Being at the centre of translational activity, the first wave trainers were able to give particularly valuable insights. Moreover some of them took forward their own local evaluations of the training that they delivered to colleagues. Two Health Boards in particular shared detailed collated reports which proved useful in understanding the nature and scope of local developments (see particularly Section 4.5).

2.5.6 Integrative case studies

In order to explore different experiences of progress in different contexts in more depth, integrative case study work was developed during the study as a key research strategy. By late 2008 it was possible to draw together data obtained (through the methods described above in Sections 2.5.1 - 2.5.5) in order to construct a formative mapping of progress in each Health Board. Health Boards were categorised as Vanguard, Mid-range or Limited Enactment to give an initial basis for sampling a range of progress experiences. These judgements were always seen as very broadly indicative and subject to change, rather than as being definitive or immutable reflections of progress.

The aim was to select two Health Boards to study within each category. In selecting six sites, we also sought to include a mix of sites with different geographical and social dynamics (i.e. coverage of urban, town, rural, and remote and rural populations) and some sites that had taken part in the Scottish Recovery Indicator (SRI) pilot. On this basis, our sampling frame prioritised six Boards that might give best scope for further exploratory study.

The idea was to carry out within each site (i.e. prioritised Board) individual in-depth interviews with representatives from each of four stakeholder groups; these being:
the Local Implementation Group (LIG) leader; a key service manager; a first wave trainer and a mental health worker (MHW). This would draw on those within the first three groups who had already consented to participate in the study, and a small but growing pool of consenting MHWs who had received our invitations to participate via first wave trainers in their area. The plan was to carry out initial interviews with all participants during the first half of 2009, then to carry out follow-up interviews in autumn 2009 to explore further progress and final reflections.

However in practice it was not always possible to recruit interview participants from all of the stakeholder groups in all of the prioritised Health Boards. It proved easier to recruit from Boards in the Vanguard or Mid-Range categories. Perhaps unsurprisingly, those which appeared to have Limited Enactment were difficult to engage. Thus a pragmatic approach to case study construction was taken which involved maximising insights from other data sources (e.g. focus group interviews with first wave trainers) when in-depth interview perspectives were not available. Moreover in the later stages of the study it was possible to integrate substantial insights from the questionnaire survey and brief telephone interviews with MHWs (see Section 2.6 below).

The schedule for the initial in-depth interviews aimed to elicit discussion around possible determinants of success. These included: strategic planning and development; dissemination strategies; composition of the trainers/ trained MHWs; application of the materials in terms of attitude or behaviour or practice change; experiences of training (barriers and successes); reflection on progress and influencing factors; future projections for ESC training and thoughts on Recovery Training. In addition, interviewees were also invited to raise alternative points of importance or issues of relevance beyond the specified questions. Thirteen such interviews were carried out in the first half of 2009, all on a face-to-face basis.

During October to December 2009, follow up interviews were held, where possible, with those initially interviewed. These were conducted by telephone and essentially sought to elicit: thoughts on recent progress; any examples of change in/development of practice related to the training; and overall reflections on the initiative. The opportunity was also taken to explore a number of questions that had emerged as important from ongoing analysis e.g. which, if any, of the 10 ESCs were
seen as most relevant at practice level?; how did staff understand/interpret the idea of recovery in their practice?; were there any points of tension/dissent regarding the initiative at local level? Where it was not possible to successfully contact initial interviewees (e.g. due to maternity leave, job change etc.), other contacts within the stakeholder groups were invited to participate. In total, eight such interviews were carried out in this second phase of in-depth interviewing.

2.6 Methods used to explore experiences of mental health workers who received training

By summer 2009, it was estimated that almost 2000 mental health workers had received some sort of ESC and/or Recovery training as a result of the initiative. Not surprisingly, given Action 1 of RRR, the vast majority of these people were thought to be nurses. As it had proved very difficult to contact and recruit these people into the study via those who had directly trained them, it was decided to adopt a different strategy. This involved seeking to distribute a questionnaire to each ESC/RR-trained MHW via those in each Health Board who kept training records. Substantial work was required to identify and liaise with these key intermediary contacts, and the Regional Facilitators were very helpful in this regard. Indeed in several cases the RFs acted as the intermediary and subsequently took forward distribution. This type of third party distribution was necessary as data protection legislation prevented us having access to the names and work contact addresses of those who had received training without their prior consent.

The intermediary contacts were asked whether the “hard copy” or web based version of the questionnaire would be most feasible in their Board, and we offered to supply each Board with a customised, aggregate collation of questionnaire responses in order to further inform local development. However, it proved consistently difficult in many Boards to obtain precise numbers in relation to those trained. Nevertheless, it proved possible to achieve agreement for distribution of questionnaires in 13 of the 15 Health Boards involved (87%). Two of these Boards opted solely for the web questionnaire, three opted for a mixed mode distribution, and the remaining eight received a requested number of pre-packed questionnaires from us for local labelling and distribution.
The questionnaire itself was designed to find out about:

- MHWs' characteristics (demographics, job, workplace etc.)
- Involvement with the training (e.g. preparation, process, evaluation etc.)
- Thoughts on taking the training forward into practice (e.g. plan?)
- Impact so far on individual and team practice with service users
- Any other comments

Recipients were also invited to say whether they might be interested in taking part in a brief telephone interview. This sought to explore the above areas in more depth and, in particular, to elicit front-line experiences of trying to take forward the training into practice.

The requested number of hard copy questionnaires was sent to each key Health Board intermediary for subsequent distribution. This ranged from 34 sent to one small Board to 411 sent to a medium sized Board. However it is very difficult indeed to ascertain how many were eventually sent out. While most Boards appear to have been able to distribute all those supplied, several subsequently revised their figure downwards and it was difficult to get a precise final figure. Moreover substantial delays in distribution (4-6 weeks) were evident in a few Boards, making the suggested “return by” date for the questionnaire invalid. Our final denominator of 1691 hard copy questionnaires distributed is likely to be an over-estimate of the actual number given out, with the consequence that the 165 actually returned is likely to reflect a response rate of more than 9.75%.

Our e mail invitations to complete the web-based version of the questionnaire were forwarded in five Boards, but it was even more difficult to obtain precise details on this. Again our estimate of distributions to 400 e mail addresses is likely to be an over-estimate, but it has been generated in order to reflect the numbers thought to have been trained within these Boards. Forty two questionnaires were returned via the web, giving a minimum response rate of 10.5%.

In total 207/2091 questionnaires were returned, giving a minimum response rate of 10%. Fifty six of these respondents indicated that they would be willing to be interviewed. We aimed to interview up to 20 such respondents and our selection was
based on a desire to cover a range of perceived impacts on practice. Moreover we prioritised respondents from the six case study sites, with a view to obtaining further insights. A total of 20 respondents were approached to take part in these brief telephone interviews, but it often proved difficult to establish a mutually convenient time and on several occasions respondents had to cancel due to unforeseen clinical commitments. Eventually six such interviews were conducted.

2.7 Methods used to analyse data

The interview methods described in Sections 2.3-2.6 involved a digital recording being made (with the prior consent of the participant) of each individual or focus group interview. The initial in-depth interviews undertaken for the integrative case studies (Section 2.5.6) were subsequently transcribed and imported into QSR NVivo Version 8. This enabled grouping into case study sets for within and across case analysis. This process was supplemented later by analysis of the second phase of in-depth case study interviews. The main approach to textual analysis was qualitative content analysis (Bryman 2001; Priest et al 2002) with mapping of emergent themes (Ritchie and Lewis 2003).

While the individual and focus group interviews described in Sections 2.3 and 2.4 were also transcribed, pressures of time prevented transcription of the brief telephone interviews with MHWs (Section 2.6). Rather these interviews employed a system of making written notes during and immediately after interview and checking the recording for key points.

All questionnaire data generated during the study were entered onto databases using SPSS Version 15. Analysis of numerical variables was principally descriptive in nature with generation of frequencies and measures of central tendency where appropriate. Limited use of inferential statistics was made to explore relationships within the data (e.g. cross-tabulations). Answers to free-text questions within the questionnaires were initially entered in their entirety as “string” variables, then analysed in terms of content and frequency of occurrence.
2.8 Ethics and management approval processes

Following consultation with the North of Scotland Research Ethics Service, a full NHS ethics application was required. This was seen as surprising by the Steering Group as similar national educational studies have often been viewed as “service evaluation” by other NHS RECs. As we were also concurrently involved in another national study of very similar design and methods that had been deemed “service evaluation” (Macduff et al 2009), we were also puzzled by this.

One of the main practical considerations in our application was how to best contact health service staff whose names were not in the public domain (i.e. the vast majority of our target sample). In order to strictly observe the Data Protection Act, we thus had to rely extensively on third parties to hand on our invitations to participate.

The ethics application was processed and approved promptly with a need for some points of clarification. However, despite application to the central NHS Research Scotland service for central NHS management approval, separate applications to each of the 15 Health Boards were also necessary. This caused substantial delay to the start of the study. In one case it took over 4.5 months to receive this approval despite there being no problematic points identified.

In the later stages of the research it was necessary to make some changes to the study design to try to improve participation and coverage (see Section 2.6). Accordingly, two substantial amendments were submitted to NHS Ethics and were approved. Again a process of contacting all relevant Health Boards individually was necessary to speed the management approval process, although the new NHS Research Co-ordinating Centre was helpful in making our electronic documents potentially available to all Health Boards.

In summary, although NHS patients were not directly involved in this study and the data collection methods with staff were standard and “low risk”, disproportionate time and effort had to be devoted to full ethical and managerial approval processes. In terms of practical enactment of ethical procedures, we have sought to report findings in a format that names neither specific individuals nor Health Boards, unless such information is already in the public domain (e.g. journal article by Taylor et al 2009).
The purpose of this approach has been to encourage participation so that generic lessons can be drawn at national level.

2.9 Limitations of the study

The limitations of the study follow mainly from the dependence on third parties to distribute our invitations to participate. As our previous research has shown (West et al 2006; Macduff et al 2009) this will usually reduce response rates by at least 12%. Even allowing for difficulties in distribution and quantification of an accurate denominator, however, the response to our mental health worker questionnaire is very low (although not unusual in this field; see Devlin/Beattie 2007). Other possible reasons for this low response are manifold. McGonagle et al (2009) speak of a UK mental health workforce “swamped by policy directives and guidelines”, and during the study we became acutely aware that the VBRFP initiative is only one of many within RRR, which itself is only one of many within Scottish mental healthcare. In addition to perceptions of initiative fatigue, people also spoke of evaluation fatigue, particularly with multiple concurrent evaluations focusing on discrete aspects of experience. Finally, even towards the end of a two year project, we often had people comment that it was too early to gauge impact.

Thus, in the absence of comparative national data about the profile of all those who have received ESC and/or Realising Recovery training, our particular sample of ESC/Recovery trained mental health workers must be seen as partial and likely to be skewed towards those with particular interest in the phenomenon. It necessarily follows that generalisation on the basis of statistical representativeness is neither reasonable nor advisable.

However, the strength of the study is that it is informed by many perspectives which collectively enable deeper insights into contexts, processes and associated impacts. This is important, as review of relevant literature (e.g. Ask Clyde 2007; Baker et al 2009) suggests that this study may be the first to try to evaluate the impact of a national educational initiative to promote values based and recovery focused practice. Due to the roll out of the 10 ESCs preceding Realising Recovery training, our report necessarily has greater coverage of the former than the latter.
### Table 2.1: Summary of main research methods used in the study

<table>
<thead>
<tr>
<th>Aspect of study</th>
<th>Review of policy, education and practice literature</th>
<th>In-depth, in-person interviews</th>
<th>Brief telephone interviews</th>
<th>Focus group interviews</th>
<th>Questionnaires</th>
<th>Other methods</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Understanding the initiative in context</strong></td>
<td>√</td>
<td>4 with leaders of VBRFP initiative</td>
<td></td>
<td>1 with 5 of the commissioned trainers May 2008. 3 with 1st wave trainers (total of 16 participants) June 09</td>
<td>34/68 (50%) return from 1st wave trainers in Summer 2008.</td>
<td>Attendance at national and regional events</td>
</tr>
<tr>
<td><strong>Exploring regional training experiences</strong></td>
<td>√</td>
<td>1 with commissioned trainer June 2009.</td>
<td></td>
<td></td>
<td>6/6 (100%) return from Regional Facilitators (autumn 08 and spring 09). 9/16 (56%) from LIG leaders Summer 08. 12/28 (43%) from service managers Summer 08. 10/21 (48%) from service managers Autumn 09.</td>
<td>Review of evaluation feedback commissioned trainers received from 1st wave trainers (ESC and Recovery). Attendance at regional training.</td>
</tr>
<tr>
<td><strong>Understanding translation and enactment within organisations – featuring integrative case studies of 6 Health Boards</strong></td>
<td>√, plus review of Action 1 reports from individual Health Boards and review of Regional Facilitators’ reports 13 initial interviews carried out within the 6 case study sites (Spring/summer 09) 8 follow-up interviews carried out within the 6 case study sites (Autumn 09)</td>
<td></td>
<td>6/6 (100%) return from Regional Facilitators (autumn 08 and spring 09). 9/16 (56%) from LIG leaders Summer 08. 12/28 (43%) from service managers Summer 08. 10/21 (48%) from service managers Autumn 09.</td>
<td></td>
<td>207/2091 (10%) returns from questionnaires sent to MHWs (Autumn 09).</td>
<td>1st wave trainers’ perceptions (see row above) were also central to this part of the study. Two Health Boards shared their own in-house evaluations of local training delivery.</td>
</tr>
<tr>
<td><strong>Exploring experiences of mental health workers who received training</strong></td>
<td>√</td>
<td>6 interviews following up questionnaire responses (Autumn 09)</td>
<td></td>
<td></td>
<td>207/2091 (10%) returns from questionnaires sent to MHWs (Autumn 09).</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>26</td>
<td></td>
<td>4</td>
<td>278</td>
<td></td>
</tr>
</tbody>
</table>
3.1 Overview of Phase 1 regional training on the 10 ESCs

Section 1.4.1 outlined the envisaged plans for the Phase 1 training and the recommended criteria for Directors of Nursing in each Health Board to nominate first wave trainers. The latter process was guided by NES who also gave indicative allocations of training place numbers, based primarily on the size of each Board. Table 3.1 indicates the main occupational roles within the cohort of 68 nominees from 15 Health Boards who subsequently undertook the training.

Table 3.1 Main occupational roles of first wave trainers

<table>
<thead>
<tr>
<th>Occupational group/role</th>
<th>Number attending</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trainer/Facilitator/Practice Developer (mostly nursing backgrounds)</td>
<td>16</td>
</tr>
<tr>
<td>Community Mental Health Nurses</td>
<td>14</td>
</tr>
<tr>
<td>Charge Nurses/Senior Ward nurses</td>
<td>10</td>
</tr>
<tr>
<td>Managers (mostly clinical area managers or project managers; mostly with nursing backgrounds)</td>
<td>8</td>
</tr>
</tbody>
</table>

Thus the first wave trainers who undertook ESC training were predominantly nurses. Importantly, however, a range of others also took part including: four senior occupational therapists; two psychologists; two social workers; two voluntary sector workers; one psychiatrist; and one chaplain. One service user also took part but, generally speaking, the majority of Health Boards did not achieve nominations from partner organisations such as service user and carer groups, and voluntary sector providers.
The Phase 1 training comprised two distinct sections. Summary details are given in Table 3.2.

**Table 3.2 Format of regional 10 ESC training**

<table>
<thead>
<tr>
<th>Section</th>
<th>Purpose</th>
<th>How delivered</th>
<th>When delivered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial 5 day training</td>
<td>For first wave trainers to experience being trained in 10 ESCs</td>
<td>Experiential, activity based group training using NES materials as core. One group trained in each of four regions.</td>
<td>October 2007 - March 2008</td>
</tr>
<tr>
<td>Follow-up 4 day training for each of the groups</td>
<td>To prepare first wave trainers to deliver 10 ESC training to their own colleagues</td>
<td>Guided facilitation to try training techniques, drawing on emergent toolkit of activities. Latterly, assessment of trainers’ performance</td>
<td></td>
</tr>
</tbody>
</table>

### 3.2 Experiences of the commissioned trainers in Phase 1

The commissioning of a partnership from Health in Mind and Penumbra to deliver this training was significant in several ways. Firstly, this was a departure from the usual pattern of NES commissioning education and training from the higher and further education sectors. Secondly it gave a voluntary sector alliance involving service users an opportunity to be at the heart of a major NHS Scotland training initiative. From the point of view of the commissioners this involved confronting their own perceptions of risk in a way similar to that required in the 10 ESC core materials. From the point of view of the commissioned trainers this involved rapid engagement with a very large organisation with established mores and sub cultures. Their experiences of doing so are conveyed in this section by drawing on a focus group interview with five of the team in May 2008.

As the six commissioned trainers had never worked as one core team before, rapid internal engagement was also required. The immediate task was to translate core materials that had been written primarily for individual reflection into an initial five day training programme. The difference in modes was substantial:

“...it’s one thing reading very excellent material and another thing doing it actually live with real individuals” (commissioned trainer 1)
This was made easier, however, by a shared perception that the materials resonated closely with the commissioned team’s collective values:

“...I think we role play as workers and as people – the values and the materials – so I think when we were at training I felt there was a great sense of – “we believe in this” – and I think that was very powerful” (commissioned trainer 2)

“....we were modelling the values all the time in our work and practising, as you say, the way we were with each other...” (commissioned trainer 1)

Preparing participants was important:

“....and I think another that was good about the preparation stage, was when we divided people into mentor groups and we all contacted them about three weeks before the training and made our selves known one to one, checking everything was alright, checking accommodation, checking their understanding about the work they had to have completed before they started, and a lot of people said they found that really helpful” (commissioned trainer 3)

Over the course of the first four regional group training sessions, there was collective learning for both the commissioned trainers and participants:

“There was adaptation between deliveries, depending on how things had gone, and on the improvised activities that emerged, the activities that sunk without a trace never to be repeated. So I think we just learned on the job” (commissioned trainer 4)

The training venue and mix of participants were important aspects for delivery dynamics.

“I think there’s something about getting people out of their ordinary institutionalised work environment and getting them into another environment, and mixing them up, because I think the mix was important. So there was a lot of NHS folk but there was also other organisations, and also service users, I thought that mix worked, probably could of done with other service users involvement, but when there was service user involvement it heightened the emotional impact I think, that’s what’s factual impact… (commissioned trainer 1)

“I think we tried to play down people’s status and identity” (commissioned trainer 4)

One of the features of the commissioned team was that several of their trainers had lived experience of recovery from mental health problems, and related experience of
using services. The theme of training that effected emotional engagement emerged as significant:

“....and we did another one where it was disempowering people, taking things away from them - how does that feel to them?-, and people had a real emotional/personal reaction to it, so it meant something. So because they are learning by that experience way, its more likely to affect their practice because have that recollection of what it felt like, so they had a mixture of different activities but their experiences , I think really did hit, to people who thought they couldn’t relate to what it would be like because they didn’t have a proper diagnosis” (commissioned trainer 3)

However, there was awareness of some resistance at times:

“There’s another aspect within that, I think there were degrees of cynicism, varying degrees within each...”(commissioned trainer 4)

“Health board” (commissioned trainer 2)

“Cohort, and we probably build that into our assumptions of the next training. Most people there will have an inner voice saying ‘I don’t need this I’ve been practicing recovery focused values base, all my days and who are these people?’” (commissioned trainer 4)

“Some very experienced trainers on the course” (commissioned trainer 1)

“ So I think we just had to roll with it, accept it, and in every instance it changed over the four days” (commissioned trainer 4)

“We monitored, identified individuals who might be having an issue with, we did keep an eye on it” (commissioned trainer 1)

“They seemed to have turned around by the end especially by the presentations, it was very positive” (commissioned trainer 3)

Some participants had voiced reservations about the core materials being focused on the 18-64 age group, and the training experience seemed to highlight more general application:

“...there’s a lot of people on the course who work with older people and saw them as being really relevant...” (commissioned trainer 2)

Within one regional group, some resistance surfaced with a greater realisation that they would be training others:
“a lot of the participants said to me was - “They had never had it explained to them by their employer”-, they had been told they were going on the training, not a voluntary thing, and then hadn’t realised what sort of commitment. They were happy to do the training, then when it came to the deliver - how much am I going have to do? - so a lot of them … it really seemed to come from a lack of explanation (commissioned trainer 2)

The second section of training (4 days) that prepared them for this involved trying relevant training approaches:

“I think people, when they did a facilitated task and they did a presentation, they were already in possession and had been for some time of the facilitators’ tool kit, so quite a lot of them used that. I’m thinking of the cohorts I was on, to design how they would do it or what activities they could use, so they found it really useful to have this resource at their finger tips, other people maybe more competent or maybe independent and wanted to do something different, did something completely different” (commissioned trainer 3)

This culminated in an assessment of capability:

“Because we encouraged self assessment from peers and assessment from us, there wasn’t like someone who was hearing a message from us that was like ‘what?’, and people were really encouraged to self assess” (commissioned trainer 2)

“The greatest improvement was in people who had no training experience at all, some revelled in the fact they had survived it and done it all...” (commissioned trainer 4)

Nevertheless, the assessment process did identify a few participants who were judged not to be ready to deliver on their own or to lead delivery to colleagues. The other first wave trainers received training certificates, although the programme never went down the route of specific academic accreditation:

A large part of the second section of training involved anticipating return to the practice environment and formulating strategies:

“We talked about cultural change quite a lot and we’ve drawn from our own experience a lot. We encourage them to think of them selves as cultural change agents and I think I would like to have, been added somehow in a written form but also some exercises around it was - when I get back to my work place, how do I become an effective cultural change agent? Because it’s actually very difficult. It’s alright when you’re with other people who were up for it, with supportive trainers but
when your in the ward or in your support team, it is actually quite difficult and you need to look after yourself very much in that” (commissioned trainer 1)

In turn this raised questions about how the commissioned trainers saw this working out:

“...have you formed any opinions where people might be successful or might be more successful?” (Interviewer 1)

“Well I think there are a couple of things that would be indicators of a likely successful outcome. One is that they are drivers in positions of power - have to be people near the top of the hierarchy who are driving and keep repeating the message: this is where we are going, this is how were are doing it, if we are going to do it needs to be cascaded down. And I think the other element is it has to be powerful and the voices of lived experiences that are heard. I think if they have those two things and it massively increases the chances of success. And I think it will be locally and very patchy, but that hopefully it will spread, will surround areas and join up areas eventually, I think as long as they have these people at the top and the voices of experience they will succeed and they have to be patient and persistent. It is about cultural change and there's something in the wider Scottish-UK culture that militates against it, like we said 'give us something you're proud of' and people really struggled with it” (commissioned trainer 1)

Other specific challenges were also anticipated:

“I felt there was a real sense of these people being champions, and being quite passionate champions and that was really exciting. There will be massive challenges with, supported risk taking, which I think is a really important part of taking this forward, will be, the only way to know who you are is to be allowed to take chances, make mistakes. I think the whole medical system is maintenance based, bureaucratic risk management, it's total risk aversion. That's not down to the people in the organisation, that's down to the organisation itself, so I think there will be challenges for people like that because they will, the belief might be there, but there might be organisation constructs and policies that prevent people…” (commissioned trainer 2)

However, the first wave trainers had generated ideas for practical enactment:

“....one of the things might be to look at work practice and support supervision, because that's what some people were hoping to do, so they could look at a piece of work they had done with their manager they had done, and say- did I make a difference here, was I working in partnership, was I promoting the person? So that can be a way work can be monitored or the values kept alive, and we also suggested people might want the 10 shared capabilities on the wall just to refer to them, say if they were having a discussion about practice, of a particular case they were working with and they want some guidance, to look at it, so it might be a source of reference
or used for supervision as a frame work for good practice...” (commissioned trainer 3)

Finally, the challenge of evaluating impact was clearly anticipated by the commissioned team:

“I think measuring evidence then will be a challenge but I think it has to be ... if you’re evaluating impact I think getting that evidence will be, even just the involvement. We did a lot of stuff around case meetings, and peoples voices being heard, and just people being more self aware and saying - I’ve realised there are these challenges and maybe the structure we have in place in the moment doesn’t allow for everyone’s voice to be heard. Ok they’ve not achieved people’s voices being heard but that level of awareness is the beginning of the start and I think that is strong evidence, people working with the ESCs within limitations and challenges as individuals...” (commissioned trainer 2)

“I think its also going to be hard to manage because this isn’t the only initiative going on, so hopefully we’re going to see lots more good practice, like more recovery focused practice, lot more hope, lot less stigma, although it will be difficult to pinpoint exactly where that’s come from. Has it been new recovery training that’s up coming, has it been the ESCs, has it been rights and relationships, so I think it’s going to be difficult to evaluate and actually say ‘we’re nabbing that from the ESCs, that’s happened because of the ESCs’ because it is one thing of something really important thing going on in mental health practice (commissioned trainer 3)

“I think that another challenge is that values practice assumes a much wider model than the medical model. I mean the medical model is in there and it has its place. There’s a much broader model which I would call provisionally a learning model, it’s a of recovery focused model” (commissioned trainer 1).

Thus the view from the commissioned trainers about Phase 1 training can be summarised as a very positive experience of engaging with a pioneer cohort of trainers who were facing significant imminent challenges. The extensive “in-house” evaluation feedback that the commissioned trainers obtained from the first wave trainers was very positive indeed in terms of: the NES ESC core materials; the Facilitator’s Toolkit; the content of almost all the training activities; and the support and facilitation received from the commissioned training team. In particular, the participants seemed to have very much valued the experiential, interactive style of group learning.
3.3 Experiences of the first wave trainers in Phase 1

The positive perceptions of the Phase 1 training experience reported above were largely echoed in our own survey of first wave trainers in summer 2008. Thirty four of the pioneer cohort of sixty eight (50%) returned our questionnaire.

This sample was evenly divided between those who had volunteered for training and those who had been nominated. Both groups generally reported high motivation. One of the main reasons for volunteering was personal/professional identification with the subject matter:

“I volunteered as I think values based practice, extremely important in mental health and felt I could make a difference within my work place”.

“Fitted my existing values and seemed to offer a solution to my frustrations at work in terms of the values of other staff”

This often co-existed with recognition of a potential development opportunity:

“I am always keen to develop my practice & saw this as an opportunity for both personal and professional development”.

Another reason cited by both volunteers and nominees related to their existing training role and previous involvement with recovery training.

“I was involved in recovery training for trainer’s pilot in (........) and have had a keen interest in promoting this approach since”.

“I had previously completed 5 day Recovery training for trainer’s course and my manager believed the two fitted together”.

The following responses were more isolated, but gave distinctive angles:

“I wanted old age psychiatry to be involved in the process”.

“As someone who uses mental health services I was interested in improving psychiatric services to meet the needs of the whole person and value the individual”.

“No one else in the team was interested at the time”.

38
As evaluators we were interested to know which module in the NES materials had demanded most new learning for participants. Table 3.3 summarises answers.

Table 3.3 ESC module with most new learning for respondents

<table>
<thead>
<tr>
<th>Module</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Module 2 The 10 Essential Shared Capabilities</td>
<td>5</td>
<td>15</td>
</tr>
<tr>
<td>Module 3 Involving Service Users and Carers</td>
<td>4</td>
<td>12</td>
</tr>
<tr>
<td>Module 4 Values Based Practice</td>
<td>6</td>
<td>18</td>
</tr>
<tr>
<td>Module 5 Equality and Diversity: Respecting Difference</td>
<td>7</td>
<td>21</td>
</tr>
<tr>
<td>Module 6 Developing Socially Inclusive Practice</td>
<td>4</td>
<td>12</td>
</tr>
<tr>
<td>Not sure</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>27</strong></td>
<td><strong>79</strong></td>
</tr>
<tr>
<td>No response</td>
<td>7</td>
<td>21</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>34</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

The reasonably even spread across the main modules suggests value in each:

“(4 and 6) seemed ‘common sense’ at first however really challenged views. Bit of an eye opener”.

“(5) its difficult to overcome the barriers preventing this happening, particularly for elderly clients with dementia”.

“Module 2 is the vehicle for delivery and practice. Mod 5 and Mod 6 relatively well embedded in practice at present. Mod 3 requires some development”.

“The 10 ESCs provide a more cohesive, logical framework for good practice which I had not encountered before. Nor had I considered values to any great depth previously”.

“Understood the concept but found that the materials made me think deeper about my practice and how to be inclusive. Recognise a lot of the scenarios”.

Respondents were also generally very positive about the Facilitator’s Toolkit (Table 3.4)
Table 3.4 Evaluations of the sections of the Facilitator’s Toolkit

<table>
<thead>
<tr>
<th>Rating</th>
<th>General Issues</th>
<th>Planning</th>
<th>PowerPoint</th>
<th>Resources supporting delivery</th>
<th>Evaluation</th>
<th>Alternative delivery modes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very useful</td>
<td>7</td>
<td>10</td>
<td>10</td>
<td>15</td>
<td>12</td>
<td>10</td>
</tr>
<tr>
<td>Useful</td>
<td>20</td>
<td>19</td>
<td>20</td>
<td>14</td>
<td>18</td>
<td>14</td>
</tr>
<tr>
<td>Unsure</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Little use</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Not useful</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>No response</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>34</strong></td>
<td><strong>34</strong></td>
<td><strong>34</strong></td>
<td><strong>34</strong></td>
<td><strong>34</strong></td>
<td><strong>34</strong></td>
</tr>
</tbody>
</table>

In terms of summative assessment of the overall quality of the regional training, thirty respondents (88%) judged it as either very good or good, with only one participant seeing it as poor. Again, the interactive nature of learning was prominent:

“Found the course content engaging with imaginative format. Trainers were bursting with enthusiasm which motivated me a great deal”.

“Lots of space to practice and learn from others, which develops creativity. Also reflection on workshops and being able to adapt”.

“As a group we have shared exercises which we have noted and circulated to each other. This has widened our toolkit of exercises and activities”.

“Having a service user as trainer was very useful”

However there were challenges:

“I did like the way we were encouraged to express ourselves, although at first I did find it hard to accept as it did seem like exercise in putting down the staff... again!”

“Felt it was pitched at a level below knowledge basis. There appeared to be an implied assumed judgement that we did not know about person centred, recovery based philosophies”.

Some of the aspects raised above led on to suggestions for improvements:
“Some feedback from courses indicates that a lot of the material is negative towards MH staff. To balance this some examples of positive aspects of care should be given, some recognition of good practice”.

“Include the presentations and training ideas delivered by participants during the training (with their consent)”.

“Perhaps establish a forum/mechanism for each area to share ideas and facilitated tasks that they developed and more importantly share positive experiences”.

The latter point was to some extent addressed with the appointment of the regional facilitators. However, there were still concerns for some about the challenge of training others. While 26 (77%) felt the training had prepared them well for this, five (15%) remained unsure, and three felt they were not well prepared. The following comments are typical:

“Found the training was excellent basis for when putting personal training package together”.

“Yes - helped me to design 2 day course and confidence as a trainer”.

“Thoroughly enjoyable and varied. Didn’t really prepare us for the amount of work we had ahead of us in developing and delivering the training though. I am unsure that anything would have.”

3.4 Overview of Phase 2 regional training (Realising Recovery)

In summer 2008, Health in Mind Penumbra were successful in being commissioned to deliver the Phase 2 (Realising Recovery) training. This followed on from the recent publication of the Realising Recovery Learning Materials (NES/SRN 2008) which had been developed by NES and SRN. While these core materials shared a similar format to the NES 10 ESC materials, they were much more distinctively Scottish in origin and content, drawing extensively on material from the SRN’s narrative research report Recovering Mental Health in Scotland (2007).

As with Phase 1 training, the Phase 2 training comprised two distinct sections. Summary details are given in Table 3.5.
Table 3.5 Format of regional Realising Recovery training

<table>
<thead>
<tr>
<th>Section</th>
<th>Purpose</th>
<th>How delivered</th>
<th>When delivered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial 3 day training</td>
<td>For first wave trainers to experience Realising Recovery training as both trainees and trainers</td>
<td>Experiential, activity based group training using NES/SRN materials as core. One group trained in each of three regions and in Western Isles</td>
<td>September 2008 - January 2009</td>
</tr>
<tr>
<td>Follow-up 2 day training for each of the groups</td>
<td>To prepare first wave trainers to recruit/select and train their own colleagues to deliver Realising Recovery (and 10 ESC) training</td>
<td>Guided facilitation to try training techniques, drawing on emergent toolkit of activities. Latterly, how to assess trainers’ performance and give feedback</td>
<td></td>
</tr>
</tbody>
</table>

In our questionnaire survey of first wave trainers in Summer 2008, 28 (82%) indicated that they were going on to undertake the Realising Recovery training. In the event 64 of the 68 who did the Phase 1 10 ESC training (94%) went on to do the Realising Recovery training. Thus there was a little attrition from the original cohort, but this was neither substantial nor unexpected. Reasons for being unable to follow on included: change of job; maternity leave; change of plans by line manager. To our knowledge, the sanction of preventing the original cohort from progressing to Phase 2 if they had not delivered at least three 10 ESC training programmes within their organisation (see Section 1.4.2) was never applied.

In total 70 undertook Realising Recovery training. Accordingly this included participants who did not undergo Phase 1 training with the commissioned trainers, but who were keen to become Recovery trainers and were supported in this by their Boards. Interestingly, it transpired that some amongst this number had not been trained in the 10 ESCs at local level before undertaking the regional Phase 2 training.
Experiences of the Health in Mind Penumbra trainers in Phase 2

Understandings of the Phase 2 commissioned trainer experience were derived principally from an individual interview with a trainer who was involved in two of the four regional delivery sessions. While this is necessarily a single perspective, many detailed and useful insights emerged. As Table 3.5 indicates, the purpose of Phase 2 training was considerably different from Phase 1, and processes changed accordingly. Thus the plan was to build on skills first wave trainers had developed since Phase 1 rather than undermining them:

“We were basically asking them to look at the materials in pairs before they came to the training and to develop a, em, facilitated task and also think how they were going to kind of chair open discussion with their group”

This meant that to some extent the Phase 2 participants would be training each other in Realising Recovery as a group, with facilitation from the commissioned trainers as needed (i.e. participants would be both trainees and trainers during the first 3 day section). In turn, this would prepare them for the final two days:

“We needed to look at…okay, so we need to immerse them in the materials, we need to continue to like keep them engaged with what they’re actually going to deliver but we also need to prepare them for the next step which is to train other people to become trainers which is a very different thing from training people”

Taking forward this substantial challenge was made difficult at times by two developments. Firstly, as mentioned above in Section 3.4, the original Phase 1 cohort was joined by others:

“So quite a few new people came on board and I think for them, and possibly for us, that…well that definitely brought new challenges”

As the new people included some who had not had any ESC training and some who were experienced recovery trainers, this changed the dynamics in some of the regional groups and meant that baseline understandings and processes could not necessarily be taken for granted:

“I think there’s no doubt that there were definitely like committed but I don’t think again it had been fully explained to them what they were part of”

“…..they were taking part in assessments, and yeah, it was and that’s actually not ideal considering that they were a newly established group and that there was people coming in, they were working with people they had never met before and I
think what we tried to do for the new people is give them the task towards the end, so at least they’d had one or 2 days to meet people and get to know them”

Secondly, and concurrently, those who had done the ESC training with the commissioned trainers in Phase 1 had a need to share and compare their recent local experiences of taking this forward:

“….they were coming back to us having had direct experience of trying to implement what they’d learned and there was something about people then brought their experience into the room and in some respects that was really positive because for some people the experience had been really positive and they’d felt really enabled by management and they’d been delivering it. And for other people, there was a lot of frustration and I would say that that then influences the dynamic of the training because they’re learning something and they’re thinking, “Well this is all very good, but how am I going to implement it?” and those questions just kept coming back and coming back which is very tricky when you’re then...you need people to be engaged and on board. And we almost wanted to provide space for people to...and then we thought, actually, no, we’ve just got to continue to forge forward with this because if we give people too much space to reflect on challenges and how it’s been, they actually get themselves to a point where they feel quite overwhelmed”

“…the module titles for the realising recovery stuff was like enabling self-direction, person-centred. There was stuff around which supported risk taking and there was lot of interesting...a lot of really valuable, interesting discussions around that and around like the different perceptions of risk from the organisation, the worker, the family member, the patient. And all that was explored and was positive. I think...it's kind of hard to kind of put into words, but I think people just had a little bit more of a barrier in their mind than they did when we were delivering the ESCs. And it was almost like they'd just become a little bit more jaded when they came back to us…”

Again, the commissioned trainers developed strategies to address this:

“....I think what we tried to do was to mix up the health boards, people from different health boards, and I think that really helped because they were quite tempted, you know if they were working on a group task to kind of be like, “Well let's work with the people that we’re going to be working with.”, but we were more of the mindset I think, “Let’s shake you up a bit because you’ll learn from each other.” And also there was a temptation I think if you got people together from a board where it had been very challenging, where it just became a negative spiral…”

Accordingly, the mixture of contexts and sub-texts in the Realising Recovery training were necessarily different from the preceding Phase 1 ESC training. In turn this was reflected in the range of perceptions of the main “text” of the training. While it seemed that the majority of participants found the materials and activities valuable, a few were reported to be more reticent:
…it’s maybe more from the fact that they didn’t say things, you know, that they maybe didn’t engage as much as other people did and then there was one in particular who basically found it just…found it really challenging because of their perceived lack of evidence base. But then, conversely, other people were you know very excited about the fact that the evidence base had been the narrative research that the Scottish Recovery Network had done and that this was actually something really forward thinking that they were part of, and some people really relished that. Other people were, not themselves cynical about it, but cynical about how much they could achieve in an organisation that was not like that.

Moreover, the core text for this training brought with it particularly personal demands:

“…there is some stuff in the materials, particularly use of self, module 2, that is very, very much getting people to look at their own values explicitly, and getting them to look at their meaning and purpose in their lives, emotions that they find challenging to deal with, quite intense stuff”

Latterly some participants were also taken into new territory with giving values-based feedback to colleagues:

“…the last part of the training was stuff that a lot people weren’t actually that familiar with, or necessarily that interested in because we were talking about…okay so if you are going to recruit people to become trainers, we needed to look at assessment, how people gave feedback…really actually the response to giving feedback, people really, really enjoyed that actually”

The challenge of enacting this was not underestimated:

“….if we’re talking about dilution as well, when you’re in a microcosm of people who have the same values and have the same beliefs and you’re working, and then you go back to a place where you’re maybe one of few, a minority…I’m sure that will have an influence as well”

Finally, reflections on the inter-relationship of the separate ESC and Realising Recovery trainings, considered: conceptual fit; policy influences; and practical issues for local training:

“…they existed separately and, yes, for some people that was hard to get their head around, but actually, in the end, they are totally complementary materials and they could be in the same folder really”

“If you’re going to start looking at enabling people to self-manage, person-centre of care, all that stuff, you do need to start with the sort of basics of your values, about being ethical and all the making a difference and all that. However, I think there were issues where I think it created a barrier because the essential shared capabilities are included in the Rights, Relationships and Recovery nursing plan where it says that all nurses will attend values based training but it seemed the
trainees were very, very aware of the fact that there was no...nothing saying that people had to do the realising recovery and was realising recovery part of the ESCs. To me, I saw it as part of one thing, because it's all again heading in the same direction. I don't think having it as two separate units aided that though“

“...I think they really struggled with that and it was a bit like, “What do we do now? Okay, so we've set up this programme of delivering this training and we're doing it in 2 days and then, what do we do with this? Do we add it on? Do we incorporate it? We can't add it on because we had to really struggle to get the 2 days, so we know we're not going to get another day, so we're going to have to incorporate this into what we do. How are we going to do that?”

Again the programme was adapted in response to this emergent need:

“...we provided like quite a lot of time for them...a whole afternoon I think...for them to think, “Okay, how are you going to make this happen? How are you going to incorporate?” And I think they found that useful and hopefully they went away and built on it and it looks like a lot of them have incorporated the two together”

Thus the view from one of the commissioned trainers highlights some key differences in contexts and processes between the Phase 1 and 2 trainings, but also stresses their inter-relationship. The “in-house” evaluation feedback that the commissioned trainers obtained from participants during and after the Realising Recovery training was very positive indeed about perceived relevance to personal practice and related impact. While the training’s relevance to the work of participants’ employing organisations was also generally seen as high, there was a little more doubt about this in feedback. Perhaps this again reflected participants’ recognition of the challenges inherent in the cultural change agent role.

3.6 Experiences of the first wave trainers in Phase 2

Direct elicitation of first wave trainers’ perceptions of the Realising Recovery training was very limited in nature and scope, as it took place in the context of three focus groups (June 2009) where discussion repeatedly gravitated towards local enactment of ESC training (reflecting the majority preoccupation). However, some trainers from Boards where there had been pre-existing developments around recovery, did highlight a resultant tension between local and national training initiatives/experiences. This is a sub-theme that will be explored further in the next section of the report which looks at organisational enactment of the ESC and Realising Recovery training.
3.7 Summary of key points

- The commissioning (through competitive tendering) of a voluntary sector alliance to deliver the training programmes was seen as significant by NES in terms of precedence and consistency with the initiative’s values.

- Health Boards used a range of methods to identify potential first wave trainers but typically put forward their own staff rather than including voluntary sector staff or service users/carers.

- 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 10 ESC training prepared first wave trainers to deliver this to their colleagues, whereas the Realising Recovery training also prepared them to select and train others to deliver training.

- 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.
SECTION 4: FINDINGS RELATING TO TRANSLATION AND ENACTMENT WITHIN ORGANISATIONS

Section Preview

This section focuses on how the regional training was translated into action within the fifteen Scottish Health Boards involved in the initiative. Data from a range of sources is used to give insights into these processes and three case studies exemplify differences in developmental approach and related progress. A typology of four main approaches to translation and enactment is presented and explained. This highlights a number of processes that appear to be associated with positive experiences of the initiative to date. A summary of key points is presented at the end of the section.

4.1 Introduction and overview

Within Section 3 the comments from the commissioned and first wave trainers have provided some initial insights into considerations for taking the regional training forward at local level. Section 4 now seeks to develop understandings of organisational translation and enactment in more depth by drawing from a range of data sources (see Section 2.5 and Table 2.1). This relates to Parts 3 and 4 of the MAPPED model (Figure 2.1).

In Section 4.2 an overview across Health Boards outlines the main elements in espoused strategies, while in Section 4.3 a similar “broad brush” approach is used to look at key groups’ initial experiences of enactment. Section 4.4 presents three summative case studies giving more in-depth insights into different Health Board approaches. Section 4.5 takes stock of the main approaches to training and “roll out” in Health Boards to date, exemplifying these further through use of findings from other case study sites and survey responses. Finally, Section 4.6 summarises key points relating to local attempts to translate and enact the initiative.
4.2 Health Board strategies: contexts, processes and envisaged impacts

Before looking at 15 Health Boards’ reporting of progress in regard to Action 1 it is important to understand something of the Scottish context. Firstly Scotland’s 14 territorial Health Boards (and one Special Health Board for forensic care, The State Hospital) are very varied in terms of geography, history and the nature of the populations served. Moreover there is evidence (Woods and McCollam 2002; Audit Scotland 2009) of differentiation and diversity in the structures, processes and per capita spending deployed by different Boards to provide mental health services.

Within mental health nursing some Boards have substantively developed community based primary care services, while large hospital nursing provision predominates in others. Some of the larger Boards have more developed infrastructure, such as specific nursing leads for mental health, but this is not the case in all such Boards. In recent times some Boards have also been proactive in developing use of person-centred approaches (e.g. Tidal Model; Barker 2001) collaboratively with service-user groups.

Consequently it is important to stress that each Health Board’s considerations for enactment of the VBTRF initiative would relate to particular contexts/cultures, infrastructures and established processes. In effect they did not all start from the same baseline. In looking across the initial and subsequent reports that Health Boards made on Action 1, the variation in breadth and depth is striking. Nevertheless, it is possible to identify a number of key features that characterise these reports, either by their presence or their absence:

- Explicit articulation of strategy in terms of what, how and why, rather than just who would do the training where and when. Strong reports explained how structures such as Local Implementation Groups would effect strategic enactment of an explicit plan to engage specific target populations in the training process. Rationale was made explicit (e.g. training senior staff first to lead by modelling values; seeking cultural change rather than just meeting training targets; sustaining development beyond a few years). Explanation of
existing strengths and anticipated challenges, solutions and support costs also gave evidence of forethought.

- **Identification of key personnel to lead the initiative locally at strategic and operational levels.** Strong reports gave a clear sense of the people and departments charged with leading on the initiative, and the support that first wave trainers were being given through this.

- **Identification of key mechanisms/processes through which the training would be taken forward.** These were manifold across the reports, but were made more compelling when rationale was made explicit. Amongst those mentioned were:
  
  o Awareness raising campaigns prior to training programme
  o Piloting different training programme formats (e.g. attendance on consecutive days v. a day every week; training existing teams v. diverse individuals)
  o Targeting priority groups for training
  o Specifically engaging local service user groups in the training process
  o Integrating the training within wider concurrent re-design initiatives through mechanisms (e.g. Integrated Care Pathways; Scottish Recovery Indicator)
  o Explicitly using Personal Development Plans, clinical supervision processes, and Protected Learning Time as a means towards embedding learning
  o “Backfilling” trainers’ time to release them to train others

- **Explicit consideration of goals, indicators for success and evaluation processes.** Although stronger reports considered their goals and evaluation processes, very few gave a clear idea of what success might look like for this initiative locally.

- **Explicit linkage to/involvement with other national initiatives in Mental Health**

  Strong reports showed how the VBRFP initiative could complement and link to other important national policy directives, but might also highlight where
tensions would occur (e.g. with demands of concurrent initiatives such as HEAT targets)

The local 10 ESC training programme formats that emerged in Action 1 reports during 2008 were also 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. More details of these local programmes will be given later in this Section.

4.3 Initial experiences of enactment as seen by key groups

As indicated in Section 1.6, key groups involved in the translation of the initiative to local context were: the Local Implementation Group (LIG) leaders; service managers and the first wave trainers themselves. This sub-section summarises their perspectives based on questionnaires returned midway through 2008 (see Section 2.5.3 -2.5.5) as the 10 ESC training was starting to be “rolled out” locally.

4.3.1 Local Implementation Group (LIG) leaders’ views

In summary:

- All of the nine LIG leaders had a background in nursing and three had completed 10 ESC training.

- All nine had been involved in managing selection processes for staff to become first wave trainers. Processes were typically mixed and included appealing for volunteers, nominating individuals, and/or delegating selection to colleagues

- The NES Learning materials ESC pack was seen as a valuable resource

- Almost all LIG leaders felt that their strategy and action plan for VBRFP was clear, and most felt that it was supported by senior management

  “we have a very structured approach for rolling it out and it is widely supported”

- There was more uncertainty over the adequacy of infrastructure support to enact the plan, with some having doubts about resource
“funding could be an issue to allow training to continue”
“length of time to train all staff and the financial impact”

- Roll-out strategies differed. Some had started with known areas of success, while others prioritised areas with known difficulties

  “we started in adult acute wards where we knew there was room for improvement”

- Most LIG leaders said that their approach involved the voluntary sector and service users

- However, one of the most commonly voiced needs was to involve a wider spectrum of NHS staff, beyond nurses:

  “We need to get other disciplines to buy into this package”

  “Consultant Psychiatrists should be involved via their Job Plans to avoid opt-outs and to challenge attitudes”

- Overall the LIG leaders were very positive about VBRFP. However there was awareness of the structural, cultural and evidential challenges associated with its introduction to the NHS:

  “Still systems are about fitting an organisation rather than fitting an individual”

  “There is a preference to avoid risk within NHS with partner organisations even when the patients’ choice is taking responsibility for their own safety”

  “Difficult to measure impact clearly, staff themselves comment on this. A complex area to explain as many staff do not have research/critical method of thinking”

4.3.2 The views of key service managers

In summary:

- All of the twelve service managers had a background in nursing and two thirds were hospital based. They came from a range of Health Boards.

- Four of the twelve had completed 10 ESC training themselves and nine had been involved in managing selection processes for staff to become first wave trainers. As with LIG leaders, processes were typically mixed and included
appealing for volunteers, nominating individuals, and/or delegating selection to colleagues

- Impressions of the training delivered by the commissioned trainers to first wave trainers were generally very positive

- Almost all of the service managers felt that their organisation’s strategic plan for VBRFP was clear

- However, only half felt that senior management had been very supportive of roll–out, and one third had doubts and/or difficulties in relation to infrastructure support:

  “little buy-in from senior managers and their lack of understanding”
  “agree to a point, only staff involved struggle with workload – backfill agreed but not sufficient”

- Roll-out strategies differed. Some had started with known areas of success, while others prioritised areas with known difficulties

  “wish to have staff trained who will be role models to others as training progressed”

- Only half of the service managers said that their approach involved the voluntary sector and service users

- Half felt that their organisation’s approach tended to focus on one professional group rather than being multidisciplinary in nature

- Service managers offered a broad spectrum of impressions about the training that had been delivered so far by the first wave trainers to staff in their Health Board:

  “There has been very positive feedback from training. Tangible improvements at the coal face”
  “It has been seen as enjoyable and not critical of practice. The exercises make a real change from other learning methods”
  “Well received by the majority of staff, majority of whom very experienced. Positive comments from some participants from inpatient continuing care”
  “Staff find VBT as a positive thing. Structure plan in place for delivery”
but

“Attendees have found sessions “patronising” and left feeling angry. Some did not complete sessions”

“Difficult to get service users to attend to ensure a mix”

“Limited engagement from medical staff and managers”

“Training staff have little support and a fluctuating framework to guide them”

• Overall the service managers were generally positive about VBRFP. However there was acute awareness of cultural, capacity and sustainability challenges:

  “Challenging attitudes – “institutionalised staff”. Training has not been made mandatory – need to ensure all staff attend and this is followed up in clinical areas by managers”

  “Culture of staff, service users and carers. Making significant changes rather than attending training with no follow-up re impact”

  “Multi-agency involvement – other priorities. Releasing clinical staff – limited resources, competing priorities”

4.3.2 The views of 34 first wave trainers

In summary:

• Around ¾ of the trainers felt that they had good organisational support, but others expressed doubts and problems:

  “Supportive from start, including line manager support, head nurse support and support from administration (clinical governance)”

  “Those responsible for the training have a clear plan, but the senior management are not so committed”

  “We had hoped for backfill, but none to date. This means colleagues covering working in addition to their own”

  “Financial constraints would appear most challenging. Query how much support will be available to embed this practice”

  “Initial difficulties were mostly about convincing senior nurses (charge nurses) about the value of releasing staff; involving some of them on the first few sessions has helped in convincing”
• The majority view was that progress with delivery of training was fairly good, but with some difficulties including initial resistance:

“**We have achieved what we set out to do so far. Now on hold until we have done all recovery training**”

“**Staff are being released to attend, and we have a programme agreed with trainers. We are also involving co-facilitators from staff who have completed training and users of services**”

“**Limited service user and carer involvement. Certain formats i.e. 2 day course over subscribed. Poor response from medics. Very good response multidisciplinary and multi agency**”

“**Some comments from participants stating, they felt they were ‘doing those already’ and felt the learning materials were patronising - however after the two days the same people said they had enjoyed and learnt from the two days and others on the course**”

“**The experience of delivering the training and listening to some of the comments made reinforces the need for it. How the training goes is very much down to participants and their contribution.”**

“…. (I)…feel training is taking a softly, softly approach, rather than challenging leading to change in practice”

“**Sometimes felt like I guess my clients feel. Judged, assumptions being made, hard mentally. This was because of lack of initial individual assessment**”

“**I have found out quickly that you can’t please everyone – for each exercise we have used, we have received very negative and very positive comments**”

“**As a group of trainers we have reflected and adapted course as we go so now feel more positive**”

“…**the staff who have engaged are the ones who (have) a good values base, but change does not come quickly or easily, so small steps are fine**”

• Trainers generally felt that their own colleagues were supportive but, as the above comments show, there were some tensions around encouraging engagement and meeting trainees’ needs while also judging the right level of challenge

• The importance of local and regional networks to sustain effort was particularly emphasised by the trainers
4.4 Three case studies of Health Board translation and enactment

4.4.1 Overview

As explained in Section 2.5, by late 2008 it was possible to integrate data from a number of sources in order to produce a tentative typology of progress (in terms of apparent extent of strategic and “on-the-ground” development). The perceptions of the Regional Facilitators were particularly useful in informing this process, given their ability to compare and contrast progress in the Boards in their respective regions. Table 4.1 gives details of formative judgements at this time.

Table 4.1: Tentative typology of Health Boards’ progress November 2008

<table>
<thead>
<tr>
<th>Type</th>
<th>Criteria</th>
<th>Number of Boards in this category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vanguard</td>
<td>High positive strategic development as evidenced by overall goals, associated action plan, and related structural and process developments. Early evidence of high positive on-the-ground activity by trainers with related involvement of supportive colleagues.</td>
<td>5</td>
</tr>
<tr>
<td>Mid range</td>
<td>Moderate positive strategic development as evidenced by overall goals, associated action plan, and related structural and process developments. Early evidence of some positive on-the-ground activity by trainers with related involvement of supportive colleagues.</td>
<td>4</td>
</tr>
<tr>
<td>Limited Enactment</td>
<td>Little positive strategic development evident in overall goals, associated action plan, and/or related structural and process developments. Little evidence of positive on-the-ground activity by trainers and/or related involvement of colleagues.</td>
<td>6</td>
</tr>
</tbody>
</table>

Again it should be emphasised that this formulation was indicative rather than definitive, especially as it was at times hard to form a judgement with the evidence available. During 2009 two Boards of each type were selected for case study, with further insights being obtained through a small number of in-depth interviews in these sites. This has enabled more understanding of contexts, processes and some initial indications of impacts. The emergent picture in each site was supplemented in autumn 2009 by the survey of mental health workers (see Section 5). In the following sub-sections of the report, case studies from each of the three types are presented.
4.4.2 A Vanguard Case: Health Board “0”

**Main data sources** The main sources of data used in the construction of this case study were: biannual Board reports; 4 in-depth case study interviews; 25 MHW survey questionnaire returns; 3 follow-up interviews; and Regional Facilitator perceptions.

**Context** Health Board with mixture of social geography: large towns, villages and rural settings. History of involvement in a number of relevant national and regional policy and practice development initiatives such as Scottish Recovery Indicator, Star Wards and Tidal Model implementation. Developed MHN infrastructure in terms of: a specific nursing lead (Associate Nurse Director), six senior nurses and dedicated service development staff.

**Processes**

Six staff from this Board attended the regional ESC training, and five attended Realising Recovery. Through a combination of on-the-job training and a specific 4 day “train-the –trainers” course, the pool of local trainers has been expanded to an active network of 17.

It is clear that Board O has adopted a very thorough ESC dissemination program. Board O originally piloted an ESC training programme which consisted of 5 half-days spread over a five week period. However this was amended into a course consisting of two full days. It was reasoned that a two day course would make it easier for colleagues to co-ordinate the off duty. It was noted that despite changing the structure of the training programme the content remained the same. However, it is worth noting that despite some individual staff members / managers of services preferring this more streamlined approach this was not the favoured method for the trainers. The trainers placed greater value on the extended course as it was their opinion that the expanded format afforded the trainees additional time between sessions in which they could reflect on both the training and their practice. This was seen as valuable in supporting the efficacy of the programme. Despite this participants were able to reflect upon the task pragmatically and understood that the
delivery was very much a balancing act between meeting the needs of the service and ensuring that members of staff receive values-based training. When reflecting about the tension between demands on services and the impact of the training one participant noted;

“there is a bit about the practicality, what we can do and is do-able and it’s better getting people all to it”.

Whilst also conducting the pilot dissemination project the 1st wave trainers in Board O prepared A3 posters explaining the 10 Essential Shared Capabilities. At least one poster was placed within each clinical area in mental health services. It was noted that the intention behind creating these posters was to act as a stop gap awareness raising campaign whilst giving the trainer’s time to construct their training programme and to refine their dissemination strategy/ies. As one trainer notes;

“so we thought how can we get the message out, its going to be a while before we can roll out the training so how do we get people interested and what not”.

Board O has reported some difficulties in encouraging the engagement of other disciplines outside of nursing. The technique often deployed by psychologists for resisting the training was to suggest that they did not need to take part in Values-Based programs as they believed that this was part of their core training and was essentially part of the core skill set of being a psychologist. Lack of engagement from social workers was seen as linked to a perception that the training was being considered as something by nurses and for nurses i.e. that the requirement to train all Mental Health Nurses becomes distorted into a need to train only Mental Health Nurses.

Similar difficulties were encountered when trying to get psychiatrists to attend the training. However through negotiation it was agreed that medics would do the 10 ESC training if it could be delivered in one day. This was considered to be wise strategically as it was noted that;

“on balance we are possibly better going for a watered down version that we can add to over time (.) than nothing so it’s a case of do you go hell for leather have the fight and potentially loose and get nothing (.) or do ok we’ll adapt but
its not the end (.) adapt and drip drip and other members of the team go. At least they are getting the foundation of it.”.

Interestingly a one day condensed version was also prepared for Board Executive members who subsequently took part in 10 Essential Shared Capabilities training as one of their annual two day training sessions. This was seen by many of our informants as a sending a powerful message that the initiative was seen as important and there seemed general consensus that the dissemination of the 10 Essential Shared Capabilities is well supported by senior managers at the very highest levels.

“So, again, that’s another message about “This applies not just in your practice, but how you deal with each other”

By November 2009, around 250 staff had been trained in the 10 ESCs and a planned programme of Recovery training (1 day format integrated with ESCs when possible) was just getting underway. Local service user involvement has been a feature of the design of the latter programme. Moreover there was substantial evidence of integrating the initiative and thinking beyond its time-frame:

“we are running an induction programme for everyone who comes into (Board O) ...values based practice, how we talk to people, therapeutic relationships, staff caring. We will incorporate a lot of stuff from the ESCs in that as well”

Several participants from Board O were also involved in planning a local evaluation of the values-based training to assess the effectiveness of the programme and to inform future developments with the intention of improving patient experience.

**Impact so far**

Perceptions of impact from interviewees and questionnaire respondents were very positive indeed, with very few exceptions. One of the striking features was that 39% of Board O survey respondents reported having some follow-up support or mentoring (compared to 16% across our whole sample). While numbers are small this does resonate with interviewees’ perceptions of a learning and practice development culture:
“But there’s a feeling around when I’m delivering the training that people are practising in a different way already…even if they haven’t done the training. There’s something about the message is getting across to people”

Survey respondents referred to improvements in involvement of service users and their families in care planning, and the impact reported by the Board O respondents in this area of activity was again substantially higher than for other Boards. The latter phenomenon was also seen in reported impact on relationships with service users:

“…where I see difference is when you go into wards, or into CMHTs, and hear what they’re talking about. That where they’re going and doing things with service users. One of our wards is setting up a recovery group which is bringing in previous service users as peer support workers in relation to that so they’re thinking around about how they’re going to do things is very different. The other situation…when we have things that go wrong, which we do occasionally…and you go to investigate this, the staff talk to us about the difficulty of positive risk taking versus promoting safety…

Overall, Board O appears to have demonstrated strong strategic development, leadership and significant on the ground development. Where ground work was still to be completed there was in existence plans for this work and clear evidence of consideration of ways in which to maximise impact and achieve some sustainability. Enthusiasm for a values-based and recovery-focused approach was evident throughout all meetings with representatives in addition to being evidenced physically around the premises. The importance of strong leadership and support was viewed as essential to ensuring wider reaching organisational commitment and to addressing any pockets of resistance. The influence of this approach seems to be reflected in some comparatively substantive evidence of positive impact of the training and some related examples of practice development.

Key points

- Strong leadership
- Executive management support
- Clear planning, with rationale for piloting and ongoing evaluation
- Momentum built with substantial, mixed pool of trainers
- Attempts to engage other disciplines and to involve service users
- Integration with other related local initiatives in mental health and beyond
- Engagement with, and enactment of, national policy initiatives such as SRI
4.4.3 A Mid-range Case: Health Board “H”

**Main data sources** The main sources of data used in the construction of this case study were: biannual Board reports; 3 in-depth case study interviews; questionnaire returns from service managers; 11 MHW survey questionnaire returns; 1 follow-up interview; and Regional Facilitator perceptions.

**Context** Health Board with wide mixture of social geography: city, towns, villages and rural settings. Some history of involvement in national MHN initiatives. Established Lead Nurse for Mental Health, but variable MHN infrastructure within the Community Health Partnerships (CHPs) which form key operational units within this Board.

**Processes**

Four staff from this Board attended the regional ESC training, and the same number attended Realising Recovery. Board H initially piloted a half-day ESC program delivered across six afternoons within one month. Unlike in Board O, the trainers felt that the dispersed format was less effective given that a portion of each session was required to be dedicated to reminding trainees of where they had been before the end of the previous session and this was seen as a waste of precious time. As one trainer notes;

“It was maybe too scattered in between I think because it took a wee bit of time to pull it back together again you had to get on with something quickly going over what you’ve done before to bring it back on again so”

Subsequently more condensed formats of two and three consecutive full-day courses were trialled before eventually settling on a two full-day format for the delivery of the 10 Essential Shared Capabilities. It was suggested that this then addressed the issue of memory and drive, as one trainer notes;

“So you still have that kind of momentum going (.) going in on the second day and its all fresh in peoples minds.”

It was proposed that the more condensed format was more attractive in terms of staff management. As one participant notes;
“I think we have to try and be realistic about that because we’re talking about people have to get time a way and their shifts have to be covered and all that kind of thing (.) you’ve got to get over those kind of obstacles (.) three days is good (.) “

Future planning was to amalgamate the 10 Essential Shared Capabilities with the Realising Recovery materials and to then return to a three day format for their dissemination. Where necessary an additional one day training course focusing solely on the Realising Recovery materials would be offered as a ‘mop up’ to those who had already completed either of the previous 10 ESC only courses.

Board H experienced difficulties getting colleagues from outside nursing to take part in the training and initiated a re-launch to promote engagement from medical staff and AHPs. However, it was noted that there was greater inter-disciplinary engagement in the more rural areas. One participant suggested that this might be due to a pre-existing culture of enhanced inter-disciplinary working within more rural areas. Similarly, it was also noted that the rural areas were inclined, and indeed given the autonomy, to traverse administrative boundaries to engage with the values-based recovery-focused training as best suits the needs of the service in relation to the local dynamics. This has been supported at senior management level with the stated objective being to do what is most likely to support success rather than necessarily doing what might be most convenient for the Board. To illustrate this point one participant noted;

“…it would have been easy just to get it I can’t remember how many it was X or Y additional trainers and it would have been very very easy just to take them to ***** but no it was very deliberate ..... there has been some discussion about the possibility about of the ***** joining together just to blurred the CHP boundaries (mumbles) and perhaps the same as the ******* so we are trying to blur in as much as possible ..... I think we are trying to reach as many in as diverse a way as possible meeting needs but at the same time trying to make sure that everyone is (.)…”

In relation, it was noted that one of the core areas of concern for this Board was to make a course which went beyond superficial training and was not necessarily driven by the targets but was instead driven by a commitment to facilitate long term
change, focusing the training more on efficacy and less on hasty delivery to the masses.

“my concern all day long has been that people not pay lip service but don't (.). you know I think when I look at the ESCs I think it could be done in a very superficial way and that we think this is something we've always done or because of equality and diversity training or whatever we already know this (.). my concern is it could either be done superficially or it could be done thoroughly (.).”

Such strategic planning was acknowledged in other areas of the evaluation, in particular questionnaire returns from key service managers in Board H all agreed that there was a clear strategic plan to enable the successful delivery of Values-Based training across a range of areas.

Overall the Board H approach seems characterised by strong managerial support but perhaps less managerial control or intervention, except where necessary for example in relation to supporting trainee recruitment. Whilst it may at first glance appear that there is less strategic planning and intervention in Board H it may instead be considered that this more free approach is purposeful in recognition of the unique and diverse demands on services. Less standardised strategic intervention is replaced with a more context driven approach supported with a delegation of power to individual areas and trainers, though nevertheless with the support of senior representatives as and when required. The stated focus for Board H was a greater commitment to delivering the ideals of the Values-Based Recovery Focused training rather than a haste based approach of meeting targets for delivery. As a result the Board were more concerned with ensuring reflection and change from staff than being able to have X numbers of staff trained by a specific date.

Impact so far

Perhaps the limitation of the above approach is that it seems to have resulted in variable focus on the initiative across the four CHPs within the Board. While two appear to have been very active, the remainder appear to have made only limited progress with training. Moreover, due to limited participation in the later stages of the study it has been difficult to gauge on-the-ground impact so far in this Board. Several replies to the MHW survey were, however, positive about cognitive impact:
“shared training has enabled us to use the common language and knowledge while discussing these themes.”

“more aware of patient centred care”

“We discuss this (Assessing needs) as a team, but I am unclear if this is impacting on clients’ experience of care”

**Key Points**

- Appears to have strong leadership
- Has flexible training programme
- Autonomy given to CHPs and local trainers to amend programme to suit specific needs
4.4.4 A Limited Enactment Case: Health Board “M”

Main data sources The main sources of data used in the construction of this case study were: biannual Board reports; 1 in-depth case study interview; a focus group interview that included three Board staff; 2 MHW survey questionnaire returns; and Regional Facilitator perceptions. Throughout the evaluation Board M proved to be difficult to contact. Due to recruitment difficulties, lack of contact details and consent, it was not possible to talk to as broad a sample of key informants as was our original intention and as was the case in other areas. Nevertheless some initial partial insight into the dissemination and related activities in Board M has been obtained.

Context Health Board with mixture of social geography: towns, villages, and rural settings. No specific professional lead for mental health nursing.

Processes

Four staff from this Board attended the regional ESC training, and five attended Realising Recovery. This cohort included staff from the voluntary sector. There has been no expansion of the pool of trainers during the two years of the project.

Board M began by offering awareness raising sessions encompassing the first two modules of the 10 Essential Share Capabilities Learning Materials but there has been no subsequent formal advertised delivery of a full training programme. The trainers have delivered a full day of training on the 10 Essential Shared Capabilities to individual teams but only as and when requested. Similarly the trainers have been invited to speak to individual teams on an ad-hoc basis when there were “problems within the team” and during such times they have used the values based training to “get folks to look at their practice”.

These experiences of engaging could be variously challenging and rewarding:

“Some of our initial awareness raising, it was quite shocking some of the feedback from people, a nurse, quite clearly saying she didn’t think we could train her and that we are all from different levels”

“Not quite hostility but people were quite clear; we did ask when we were delivering the training if folks would like to set up with folks they work closely with and service users and carers. But most areas said they wanted it for themselves”
“Certainly to the area we had gone out to, there were issues within the team, and we used that within their team to come up with a development plan for their team, suggesting that when they are facing a complex cases, they would sit and look at the cases using the 10ESC’s to go through it to see if they are practising in a values-based way. They were quite keen to do that”

From an early meeting with representatives from Board M it was apparent that there were emergent plans to facilitate a cascading of the training out to more staff members. However there was a feeling that these plans had not been created through consultation and there was a related degree of scepticism about the likelihood of success. It was viewed by some as a target driven exercise rather than a commitment to ensuring that staff members adopted a values-based recovery-focused approach to their practice.

There was perception of very limited strategic planning from senior management reflecting a lack of commitment. There seemed no support for those trainers who returned from training enthused and keen to begin delivering the training. Subsequently, despite trainers making plans for potential training programmes, very little training had actually been delivered. This under-utilised the existing skills and knowledge base for delivering the programme:

“I think it's just another thing on top of lots of other kind of initiatives that folks are being asked to do. But we were trying to get across the view that VBT underpins everything and is essential. People who have thought out are the people who want to look at their service – couple of pockets in individual areas who have thought this out themselves”

There was related difficulty in communicating information about the values-based, recovery-focused training more broadly, as one participant noted;

“people are hearing through the grape vine about it, showing a interest rather than it being cascading down from management that this is something we need to take on board”

To a certain extent there was some animosity about a perceived lack of engagement from the voluntary sector. There was a sense that NES had paid for external voluntary agencies to be trained yet the voluntary agencies had not delivered any training to NHS staff. Rather, they had successfully been delivering training within their own organisations. Questions were raised about value for money for the NHS. However it was noted that it was perhaps not due to reluctance on the voluntary organisations part and was instead attributed back to overall lack of planning at Board management level. At times this highlighted differences between the sectors:
“lots of the folk that are working in the Third Sector are more in touch with practice and putting the person at the centre of all their care and practice more in a Recovery kind of focussed way. So we find it quite difficult going out, certainly yesterday, people do not get Recovery focussed care”

Board finance for on-the-ground training delivery appeared to be lacking.

“… I said, look … the minister . ******…. could maybe give us the big hall for nothing and we’ll make the sandwiches for lunch …That’s the extent you go to, and isn’t that ridiculous … That’s what individual people’s commitment is, that they would go to that extent, but I’ve gone to that and I’m not going to go beyond that.”

Moreover, there was concern about the way local developments may be represented officially:

“... I'm not sure that what is actually happening is really reflected by management, I think what they will do is say something is happening and be very convincing, there is a plan this is what is happening it's going great, people below them are going, I don't know, I don't even recognise this …”

“Reeling off the names of people who are involved in it, oh yes such and such is doing that”

During 2009 there was continuing evidence of on-the-ground enthusiasm from trainers with several full day awareness sessions being held for staff and a workshop session featuring the SRI. These seem to have been well received, but it appears that service staff are still not aware of a co-ordinated senior management plan for roll out of the ESCs across the Board. Rather, the impression is that team leaders and charge nurses will be expected to develop their own plans for taking training forward.

Impact so far

From the limited evidence available, it would seem that positive impact must be very much localised to a particular few teams. Despite evidence of commitment and enthusiasm “on-the-ground”, Board M seems to have made little progress with dissemination and enactment.

Key points

- Initiative appeared to have very limited leadership and strategic management, and senior-level engagement variable. Related perception of lack of support on-the-ground
4.5 Taking stock of the main approaches to translation and enactment in Health Boards

While the typology presented in Section 4.4 has been useful in gaining some purchase on progress, as the latter case studies show, it has often been hard to gauge impact in any definitive way. In this situation, and faced with a picture of diversity in Health Boards’ approaches, we have tried to make sense of this by looking for patterns of context and process that might give greater insight/explanatory value. Looking across the Health Boards in November 2009, it is possible to group the Boards in another way. Table 4.2 presents a typology of translation, some of which remains formative in nature due to the limitations of the study.
## Table 4.2: Typology of translation in Health Boards November 2009

<table>
<thead>
<tr>
<th>Type</th>
<th>Boards</th>
<th>Key context features</th>
<th>Key process features</th>
<th>Impact trends to date</th>
<th>Evaluator comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIGH FOCUS</td>
<td>O</td>
<td>Mostly medium-sized Boards (geographically and population wise), but one small rural. Mostly established strategic MHN infrastructure and history of involvement in national initiatives.</td>
<td>Sustained central co-ordination. Developed action plans with rationale. Clear leadership. Most attempting multidisciplinary and user/carer involvement. Often initial awareness raising and/or piloting. Priority given to ESC training: often open to all but marketed as mandatory for nurses. Typically 2 day formats adding another to incorporate Recovery. Recovery training roll out typically not far advanced.</td>
<td>Some comparatively substantive positive evidence of impact in terms of peoples’ self-reported thinking and some examples of practice development.</td>
<td>Participation in evaluation usually comparatively good in these sites. Typically corroboration from a range of sources that positive development is likely to be relatively widespread in these Boards (compared to others). However, explicit Recovery training aspects not necessarily extensively developed.</td>
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<td></td>
<td>E</td>
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</tr>
<tr>
<td>DEVOLVED FLEXI</td>
<td>I</td>
<td>Large Boards, but in different ways (population-wise and geographic). Established strategic MHN infrastructures. Some history of involvement in national MHN initiatives.</td>
<td>In Board I Practice Development Nurses and ICP Facilitators initially trained 150-200 staff who would champion VBRFP through local networks. No further core sessions planned, now devolved. Board H described in Mid range case study Section 4.4.3. Devolved to 4 diverse CHPs – only 2 appear substantially active and do different training formats. Across both, priority given to ESC training. Recovery training now starting in Board H; picture in Board I less clear.</td>
<td>Some positive evidence of impact, mostly in terms of peoples’ self-reported thinking.</td>
<td>Variable participation in evaluation from and within these sites. Difficult to gauge progress, but several sources suggest progress very variable across Board areas. Some evidence of very brief ESC awareness raising sessions in Board I. Both Boards talking of having Recovery champions in clinical areas.</td>
</tr>
<tr>
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<td>H</td>
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<tr>
<td>PUSH – PULL</td>
<td>C</td>
<td>Large Boards with diverse CHPs. Strategic MHN infrastructures. Key feature for both of local development of Recovery approaches before advent of national VBRFP initiative.</td>
<td>Both struggled initially to adapt to national initiative. In Board F overt tension between broad ESC dissemination and in-depth Recovery approach. Compromise reached around an integrated programme but some perceived lack of senior management support. In Board C a continuing struggle to get clear senior management co-ordination despite some on-the-ground progress.</td>
<td>Some positive evidence of impact in terms of peoples’ self-reported thinking and some examples of practice development, particularly in Board F. Mixed picture within Board C.</td>
<td>Participation in evaluation usually comparatively good in these sites. Board F in some ways leading Recovery development in terms of depth of training and user involvement. In Board C some ESC training seems to have gone forward despite lack of management support in some CHPs.</td>
</tr>
<tr>
<td></td>
<td>F</td>
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<tr>
<td>LOW FOCUS</td>
<td>N</td>
<td>Rurality a common feature. MHN infrastructure limited.</td>
<td>Little sustained or coherent co-ordination. Action plans minimal/limited. Episodic or no clear leadership.</td>
<td>Very little evidence of impact</td>
<td>Little engagement; related low evidence, but clear from several data sources that the initiative has not had sustained development yet. Some on-the-ground progress despite lack of management support.</td>
</tr>
<tr>
<td></td>
<td>M</td>
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<tr>
<td></td>
<td>D</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UNCLEAR</td>
<td>A</td>
<td>Diverse yet distinctive contexts</td>
<td>Unclear</td>
<td>Unable to say</td>
<td>Lack of engagement/evidence prevents even tentative judgement</td>
</tr>
<tr>
<td></td>
<td>G</td>
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</tbody>
</table>
4.5.1 The High Focus type

The Vanguard case study (Board O; Section 4.4.2) has already given some insights into a High Focus approach to translating and enacting the VBRFP initiative. However it is useful to exemplify this further with brief reference to some of the other Health Boards that have taken this approach.

In Board K impressive forethought appeared to have informed design, delivery and sustainability considerations, driven by identification with the initiative’s values. This approach had started by delivering training to some of the areas that were seen as having most challenges, and at times focusing on training whole teams. Attempts had been made to involve a range of disciplines, with some success. The first wave trainers had trained a group of those who had shown interest in the role when receiving ESC training locally, thereby expanding the pool of trainers. There was also concern to stay true to the regional training principles:

“the other thing that we strongly valued from the training that we received was that it was delivered by a group of people, some of whom had had a lived experience. So we tried to replicate that in some ways. We have a ...small group of individuals who’ve used services or have cared for people using services, who come and facilitate and influence the training that we deliver”. (Board K; informant 1)

Moreover the vision extended beyond the training to look at how best to embed the ideas and then maintain developed practice. In this regard a pilot was being run within an ESC-trained clinical team whereby three different follow-up support/supervision strategies were being compared.

Reflecting on impact, an interesting distinction was made:

“...and if you’ve got enough people doing that, it becomes at some point where there’s a critical mass, where people are talking the language, and we’ve got there just now. People are using the language. I’m less sure if they actually live the language” (Board K; informant 1)

Making the language visible, as well as audible, was a tactic used by one of the clinical mental health workers who had been locally trained:
“..it’s where we dae most of our care planning and risk assessments. In that forum...we do them as a multidisciplinary team. So to have...I just thought having the ESCs visible would be a really good plan” (Board K; informant 4)

Board J's approach also seemed well thought through in that it sought to systematically train clinical leaders and key managers first by means of a four day ESC training. This Board always recognised that it would not be logistically possible to release all mental health workers for 4 consecutive days, and the standard training period subsequently became 2 days (as in many other Boards). Board J was also relatively successful in engendering involvement from beyond nursing.

Of all the Boards in the High Focus category, Board L was most vociferous in stressing to its mental health nursing staff that the training was mandatory. This unidisciplinary drive resulted in a very high proportion of its MHNs receiving training. Trainees have been asked to identify a change challenge in their workplace and to address this by working with their line manager in the following 3-6 months. Feedback from local service managers has been notably positive:

“It’s been a great opportunity to scrutinise what we do and how we do it. Staff appear to have been re-energised by the process”. (Board L, Service Manager 1)

“It feels right. It is changing culture and challenging clinical practice. There is a tangible change in attitudes and patient engagement”. (Board L, Service Manager 3)

Finally, Board E has pioneered a distinctive approach that uses the 10 ESCs to facilitate group reflection and supervision in relation to care and support practices (Taylor et al 2009).

4.5.2 The Devolved Flexi type

The Mid-range case study (Board H; Section 4.4.3) has already given some insights into a Devolved Flexi approach to translating and enacting the VBRFP initiative within a geographically widespread region. Although there are notable areas of contrast with Board I’s highly populated urban contexts and some of its roll out processes (see Table 4.2), both Boards H and I had a core strategic plan that evolved to facilitate devolution of operational aspects mostly to local teams. This contrasts with the High Focus type where ongoing planning, control and monitoring by a core group typically drives operational translation activities.
4.5.3 The Push-Pull type

As Table 4.2 stresses, the key contextual feature of the Push Pull type is that some local development of Recovery approaches had been relatively advanced prior to the advent of the national VBRFP initiative. Specifically, Working to Recovery training sessions had been piloted in both Boards F and C with a range of service providers, users and carers (Axiom Consulting 2006). This had led to some development of local Recovery networks.

Accordingly, within these large Boards with diverse CHPs, more adjustment was necessary to manage the conjunction of local interests with a national policy initiative. The Recovery network in Board F had been particularly active and Table 4.2 summarises a process of adjustment that to some extent inhibited co-ordinated translation and enactment during the first year of the process. At the heart of this was a tension between the national initiative’s prioritising of the 10 ESCs as the mandatory basis from which a fuller understanding of Recovery would be pursued, and local prioritisation of in-depth Recovery training as the basis from which the 10 ESCs would best be understood. After an initial period where both types of training were available in parallel, a compromise was reached whereby the 10 ESCs were incorporated into the first module of a six module Recovery programme (delivered over 5 days), giving trainees the option of doing shortened or full training. In-house feedback from training in this Board has been positive and the feedback we have had from MHW survey questionnaires is broadly similar and more multidisciplinary in origin than most other Boards.

The period of Push-Pull adjustment has been much more protracted in Board C which has struggled to achieve a co-ordinated senior managerial approach to taking the initiative forward:

“We’re still in the middle of that because there was recovery training happening before we did our training and they had a certain number of days they were doing training, and we’ve tried to get management to say “Right, this is what everyone’s going to do for recovery training” We’re not there yet, ...I don’t think...we’ve still not got an agreement from management that “This is how many days you’re getting and this is where the funding is coming from”, or anything like that...” (Board C; Informant 1)
“I think the struggle has been getting the whole of (Board) to work together because certainly our line manager has taken on board what we’ve said and she’s had to go and speak to all the other line managers and say “What are you doing?”” (Board C; Informant 2)

Despite this, personal and professional motivation has enabled some progress with training:

“....negotiating time back was a big thing. And because I do shifts, and I have to do night shifts as well, a lot of the things, like preparation and things, was done in my own time and even that was a struggle. And its just been through sheer determination and enthusiasm, because I do feel that it is going to make a difference and it has made a difference. But I really could have thrown the towel and said “Stuff this, I’m not doing it any more”. But now, you know, I do get time back and you know simple things like that...” (Board C; Informant 3)

When asked about the impact of training on team practice, respondents to our MHW survey from Board C gave a range of answers:

“Mixed – some take on board recovery, and it seems some don’t”

“Moderate change in team as a whole, but arranged team training on 10 Essential Shared Capabilities, but management not particularly supportive of this and postponing indefinitely”

“Service user more involved”

“Already worked in a recovery focused way”

“During MDT meetings”

“Despite nursing input, medical model remains”

“Team has become more patient focused on choice”

“Not pre-planned care. Individualised to patients’ needs and wishes”

4.5.4 The Low Focus type

The Limited Enactment case study (Section 4.4.4) has already given some insights into a Low Focus approach to translating and enacting the VBRFP initiative. As Table 4.2 indicates, these Boards all had rurality and limited MHN infrastructure as common characteristics. Nevertheless, the High Focus translation in Board E has shown how these factors need not necessarily inhibit development. As with Board C above, there was evidence that some local progress in training could still be made in the absence of sustained, co-ordinated leadership.
4.6 Key points about translation and enactment in organisations

- 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
- Health Boards’ formal reporting of progress on Action 1 varied considerably in breadth and depth
- Strong reports considered and explained most of the following: goals, strategy, rationale, involvement of key personnel, key mechanisms of enactment, evaluation approach, and linkage to/integration with other local and national initiatives
- 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
- Local Implementation Group leaders were very positive about the initiative, but tended to be aware of the structural, cultural and evidential challenges involved
- 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 who responded 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). The remaining 3 Boards were categorised as *Unclear* as there was prolonged difficulty in making a judgement due to lack of evidence and/or engagement

- Within this context, a number of factors were identified that appeared to be associated with positive local translation and enactments of the initiative
- 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)
SECTION 5: SURVEY FINDINGS ON THE EXPERIENCES OF MENTAL HEALTH WORKERS WHO RECEIVED TRAINING

Section Preview
This section presents the findings from a survey of mental health workers who received training. The 207 respondents typically report high perceived relevance and quality of training, with some perception of positive impact on practices such as assessment of needs and person-centred care planning. Within a predominantly positive picture, many respondents saw the training as reaffirming values that they already practiced, while many others also recognised some need for further practice development. A summary of key points is presented at the end of the section.

5.1 Introduction and overview
The evaluation study concluded with an attempt to survey all those mental health workers in Scotland who received 10 ESC and/or Recovery training (see Figure 2.1, Part 4, Levels 1 and 2). As Section 2.6 explains, the overall response rate of 10% is very low and accordingly the findings from the questionnaire survey cannot be seen as representative of the experiences of the total population of mental health workers who received training. Nevertheless, the findings do yield useful insights into the nature and scope of initial impact for 207 people, particularly in terms of the explanatory comments given in responses. Accordingly, this section of the report presents a summary of the findings from the main sections of the survey questionnaire.

5.2 Profile of respondents
In summary:

- The MHW replies were from 13 different Health Boards
- Response rates from different Health Boards ranged from 3% to 21%, with a tendency for higher response rates from High Focus and Push-Pull Boards
- 174 (84%) were nurses. The most numerous other groupings were: 8 Occupational Therapists; 5 Social Workers; and 3 Physiotherapists
• The main AFC nurse bands represented were Band 5 (59; 29%); Band 6 (44; 21%) and Band 7 (44; 21%)
• Only 3 of the respondents were working in the voluntary sector
• 123 (59%) worked in hospitals, while 58 (28%) worked in community based primary health care
• A very wide range of care settings were represented in the sample, from those with specialist focus through to those with a more general remit
• 148 (72%) were female
• The median age of respondents was 46 and the median length of time employed in healthcare work was 20 years
• The sample was fairly evenly divided between those who said they volunteered for training (85; 41%) and those who were nominated/mandated to attend (97; 47%)

5.3 Experiences of training and follow up

• The vast majority (172; 83%) were trained by their own Health Board staff, rather than other agencies
• 165 (80%) received a distinct 10 ESC training programme
• 36 (17%) received a distinct Recovery training programme
• 14 (7%) did a programme which combined 10 ESCs and Recovery
• 26 (13%) had done a programme that prepared them to deliver one or more of these programmes to their colleagues
• 126 (61%) were given some preparatory work to do pre-programme (e.g. reading materials)
• Only five respondents felt that the programme(s) they did had no relevance. Typically the others rated their programmes as relevant or very relevant.
• Volunteers’ ratings of relevance were significantly higher than those who were nominated (p = 0.004 for distinct ESC programmes and p = 0.006 for distinct Recovery programmes)
• 63 (30%) rated the overall quality of their training as excellent; 131 (63%) said it was good; 4 rated it as poor; and 1 very poor.
• 34 (16%) had received follow-up support or mentoring since they had done the training, but the vast majority (167; 81%) had not
5.4 Initial impact for respondents

The questionnaire asked “what is the one thing you learned through the training that made most impression on you?”. This yielded a wide range of responses spanning cognitive, affective and interpersonal/social aspects. One of the main themes to emerge from this was raised awareness in relation to a range of issues related to values and practice:

“How much our assessment of need can differ from client perspective – greater awareness of diversity” (Staff nurse, Acute admissions unit, Board C)

“More aware of carer needs” (Staff nurse, Community Rehabilitation Unit, Board N)

“Having greater awareness of the impact of practitioners’ attitudes and values, especially towards each other” (Community Mental Health Nurse, Older Adult Team, Board I)

“Further enhanced awareness of needs of patient through role play” (Physiotherapist, Specialist Unit, Board J)

Often this increased awareness entailed a process of reflection:

“Has made me reflect more on my own practice and how I treat people on a daily basis” (Staff nurse, Acute admissions unit, Board C)

“It brought knowledge that I already had back to the forefront of my mind and made me more conscious of how I treat others” (Community Psychiatric Nurse, Community Mental Health Team, Board I)

The involvement of service users in the delivery of training was particularly strong in one Board and this was often cited as leaving a lasting impression, both cognitively and emotionally:
“Hearing peoples’ own personal experiences and personal recovery” (Community Psychiatric Nurse, Community Adult Mental Health, Board F)

“Talk by service user about his experiences/treatment of his illness and the journey throughout the years” (Charge Nurse, Psychiatric Assessment Unit, Board F)

“The involvement of service users in delivering the training had a huge impact and made it real, not “theory”” (Quality Development Nurse, Board F)

“Listening to patients’ experiences, history, perception –reaffirmed” (Senior Occupational Therapist, Older People Mental Health, Board F)

The latter use of the word “reaffirmed” is indicative of one of the predominant themes that emerged across answers to this and other questions in the survey questionnaire. In effect many respondents felt that their current (and often past) practice was variously being “reaffirmed” and/or “reinforced”

“reinforced the validity of my own practice” (Staff Nurse, Forensic Unit, Board K)

“reinforced my professional identity and approach to patient care” (Occupational Therapist, Adult Mental Health, Board K)

“validated that much of our existing practice was indeed interlinked with a value” (Practice Education Facilitator, Board I)

“That Values Based Practice is the basis of mental health nursing and always has been. Not new just formalised” (Team Leader, Board I)

While at times these statements suggested consolidation only, there could also be recognition of developmental needs:

“Reassured that we provide a very good service and highlighted what we need to develop” (Acting Charge Nurse, Acute Admissions Unit, Board O)
For some respondents, a particular Essential Shared Capability was highlighted as having most personal impact:

“Promoting Recovery” (Senior Charge Nurse, Board C)

“The requirement for positive risk taking” (Staff Nurse, Board F)

This sort of literal re-iteration co-existed with a trend for respondents to articulate the values in the form of maxims:

“Everyone can make a difference. The power of hope” (Services Officer, Board F)

“Focusing on the positives, moving forward” (Assessment Nurse, Board L)

“Small things make big differences to quality of patient care” (Staff Nurse, General Adult Psychiatry, Board C)

“Not all good care is instinctive or intuitive, there are some areas that need training and are actually counter-intuitive” (Senior Staff Nurse, Board B)

Finally, the main initial impact for some respondents had been to highlight the need for improved development of specific skills:

“Listening more to people” (Healthcare Assistant; Board J)

“New techniques in care planning” (Community Staff Nurse, Resource Centre, Board K)

5.5 Planning enactment in practice

Two thirds of respondents indicated that they had a plan for applying the training in their own practice setting, and just over a half said that they were focusing on a particular aspect of practice. Within this context, there were four predominant aspirations: developing individual practice; development of related educational
activities within the team; ensuring a patient/client/person-centred approach through increasing their involvement and development of care planning.

Developing individual practice was often articulated in terms of role modelling and setting an example for others:

“To develop my own practice and positively impact on the development of others through leadership” (Charge Nurse, Board L)

“By role modelling and encouraging people to accept that change need not be feared. Introducing small changes that lead to a huge difference for people”. (Staff Nurse; Board O)

The aspiration to develop related educational activities within the team was envisaged in many forms but often focused on clinical supervision:

“Two initial awareness sessions to multi disciplinary team members. Introduce ESCs as an ongoing issue within our nursing/business meetings and clinical supervision sessions” (Community Mental Health Nurse, Board I)

“I plan to use clinical supervision sessions and ward reports to deliver training also to use computer based resources” (Charge Nurse, Admissions Unit, Board I)

The most pervasive particular aspiration was to ensure a patient/client/person-centred approach (respondents typically used one of these three terms for service users):

“To make my practice more patient focused and patient led to hopefully produce more positive outcomes” (Community Addictions Nurse, Board N)

“Although I think I put all of it into practice, I am especially focusing on person centred approaches and positive risk taking....” (Peer Support Worker, Board F)
“That client centred care based on the 10 ESCs works even in complex cases” (Community Psychiatric Nurse, Board E)

Almost always the aim was to achieve this by **increasing the involvement of service users:**

“**Involving client group in care and treatment planning (historically, as client group with capacity issues, relatives, carers made decisions)**” (Ward Manager, Older Age Care Setting, Board J)

“**Empowering people to steer their own recovery through PATH, WRAP etc.**” (Social Worker, Specialist Team, Board F)

“**Service user feedback on local mental health service delivery**” (Team Manager, Board E)

“**Encouraging people to take an active role in their care/treatment and to speak out**” (Staff Nurse, Board O)

Within this context, a few respondents noted that **advocacy and challenge** could be necessary:

“**Yes - more assertive, challenging, confident on behalf of my clients towards colleagues**” (Residential Worker, Board F)

“**Challenging inequality, transfer practice to new ways of working in hub & cluster environment emphasising joint working**” (Occupational Therapist, Board B)

However, aspirations for putting service users at the centre of care tended to focus on one key mechanism: **the development of care planning:**

“**Trying to make care planning more person-centred – a work in progress**” (Staff Nurse, Learning Disabilities Service, Board J)
“Ensure care planning is individualised and the patient is fully involved” (Senior Staff Nurse, Board K)

“To encourage use of SRN indicators” (Staff Nurse, Intensive Psychiatric Care Unit, Board C)

5.6 Perceived impact on own practice

To try to gain some purchase on actual enactment, we asked MHWs what impact, if any, VBRF training had made on various aspects of their personal working practices. Answers to fixed choice questions are summarised in Table 5.1.

Table 5.1: Impact of training on individual practice

<table>
<thead>
<tr>
<th></th>
<th>Substantial +ve impact</th>
<th>Moderate +ve impact</th>
<th>No change</th>
<th>Negative impact</th>
<th>N/A or Missing</th>
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</thead>
<tbody>
<tr>
<td>Assessing needs</td>
<td>27 (13%)</td>
<td>91 (44%)</td>
<td>68 (33%)</td>
<td>0</td>
<td>21 (10%)</td>
</tr>
<tr>
<td>Planning care/support</td>
<td>32 (16%)</td>
<td>85 (41%)</td>
<td>65 (31%)</td>
<td>0</td>
<td>25 (12%)</td>
</tr>
<tr>
<td>Implementing care/support</td>
<td>23 (11%)</td>
<td>77 (37%)</td>
<td>78 (38%)</td>
<td>0</td>
<td>29 (14%)</td>
</tr>
<tr>
<td>Evaluating care/support</td>
<td>20 (10%)</td>
<td>77 (37%)</td>
<td>77 (37%)</td>
<td>1</td>
<td>32 (16%)</td>
</tr>
<tr>
<td>Attitudes and expectations in relation to giving care and support</td>
<td>31 (15%)</td>
<td>72 (35%)</td>
<td>78 (38%)</td>
<td>0</td>
<td>26 (13%)</td>
</tr>
<tr>
<td>Relationships with service users</td>
<td>28 (14%)</td>
<td>71 (34%)</td>
<td>84 (41%)</td>
<td>0</td>
<td>24 (12%)</td>
</tr>
<tr>
<td>Relationships with colleagues</td>
<td>22 (11%)</td>
<td>54 (26%)</td>
<td>104 (50%)</td>
<td>2 (1%)</td>
<td>25 (12%)</td>
</tr>
</tbody>
</table>

As Table 5.1 shows, the most substantive positive impacts were seen to relate to **assessment of needs and planning care/support**.

“Acceptance that it is not what I feel peoples’ needs are but what they tell me their needs are” (Staff Nurse, Board O)

“Broader view taken. Assessing strengths, family supports” (Community Charge Nurse, Board O)
“Use daily in contact with patients, families and carers. Now use needs/strengths care planning” (Staff Nurse, Community Rehabilitation, Board N)

“Goal focused care plans, client completing care plan.” (Community Mental Health Nurse, Board C)

Nevertheless, around one third of respondents felt there was no change to their practice in terms of needs assessment and care planning. Typically, this was because they felt that they practised in this way already:

“Still offering PCP to find out what is important to people and what support they need to achieve it” (Nurse/Care Manager, Community Rehabilitation, Board F)

“Was doing this anyway” (Community Psychiatric Nurse, Board K)

Perceptions of positive impact on care implementation and evaluation of practice tended to highlight improvements in service user involvement and team working in these areas:

“Greater patient involvement – patients as participants in care, not recipients of care” (Charge Nurse, Board O)

“Looking at how this has positively impacted on the person and if it has not, then changing the goal to suit the person’s needs” (Staff Nurse, Board O)

“Implementation of the Tidal Model, implementation of the Scottish Recovery Indicator, Values/Recovery Based Practice” (Charge Nurse, Board L)

“More proactive discussion with MDT, nursing team, carers and patients” (Ward Manager, Board J)

However, there was awareness of related difficulties and limitations:
“Council have no money to implement packages of care for vulnerable people that we may highlight –not valuing them at all!” (Community Psychiatric Nurse, Board H)

“We’re not good at this (evaluation) apart from informally asking people and reviewing as we go. Being more aware of recovery focused practice has made me more frustrated...” (Occupational Therapist, Board F)

In terms of the perceived impact on personal attitudes and expectations, the themes of increased awareness and reflection were again prominent. Moreover, affective and social aspects were also highlighted:

“More energy and more positive practice. I found a new bunch of people who speak my language” (Social Worker, Board F)

“I am more reflective and more realistic with people I see, and share much more with them and feel much less paternal, more pro-active in my care” (Community Psychiatric Nurse, Board I)

Where no change was perceived, the underlying reason was consistent:

“Little has changed, I was taught to and have always had a values based/recovery focused approach to practice” (Charge Nurse, Board I)

Looking again at Table 5.1, the least change was perceived in regard to relationships with service users and colleagues. The former aspect in particular could be seen as disappointing, given the focus of the training, but again many respondents' comments highlighted perceptions that pre-existing relationships were already good and therapeutic in nature. Moreover, the change being promoted might entail adjustment for both sets of parties:

“Clients are often stunned to find that they are expected to make the decisions and I will follow their lead” (Senior Practitioner, Community Setting, Board O)

There was evidence of similar perceived need for adjustment in some staff attitudes:
“As with service users - some staff are ‘set in their ways’ and are reluctant to change” (Staff Nurse, Rehabilitation Unit, Board N)

“Mixture of positive attitudes and resistance to change” (Quality Development Nurse, Board F)

“It is up to each individual professional to bring to our own practice. Time constraints make it difficult for those with a passion for the subject to be involved in any meaningful discussion with colleagues. So many other demands on time. Sometimes not seen as priority on the front line” (RMN, Board J)

5.7 Perceived impact on team thinking and practice

As Section 5.6 above has shown, responses often indicated that the impact of the training was not restricted to individual practitioners alone. Rather there were many examples shared of an emergent impact on team thinking and practice. Some highlighted the value of the 10 ESCs as a framework for supervision and analysis of practice:

“Group supervision addresses each of the 10 ESCs and is discussed with the team at the core” (Community Psychiatric Nurse, Board E)

“10 ESCs and Recovery provide a framework for discussing our work with service users in our clinical forum (monthly)” (Manager, Board E)

“Tend to discuss and evaluate options of care. Assess whether values based and recovery focused through clinical supervision” (Community Psychiatric Nurse, Board O)

“Trying to evidence within our own PDP planning that we use this information to improve practice and we want to use it in our assessment paperwork to provide evidence in practice..” (Community Psychiatric Nurse, Board I)
“More staff, specifically unqualified, are discussing patient need, their approach and desired/potential outcomes of same, using 10 ESC to underpin” (Ward Manager, Elderly Care Setting, Board J)

However:

“The training needs to reach more people and be followed up with mentorship or it is in danger of being undervalued and seen as another fad” (Quality Development Nurse, Board F)

Again improvements in service user involvement and care planning were often cited in examples of impact on team practice:

“Patients are involved in evaluating their care using accessible media and planning and setting goals during their treatment period” (Senior Staff Nurse, Learning Disabilities, Board J)

“We are teaching patients to input own records with laptop computer and digital pen” (Charge Nurse, Board O)

“It has made us (in the day unit) question our practice and try to improve more we can, particularly around patient involvement and person centred care” (Staff Nurse, Board J)

“More opportunities for trial discharges, more encouragement of relatives, carers to think of options/support in community” (Charge Nurse, Psychiatric Assessment Unit, Board F)

As the latter comment suggests, one of the 10 ESCs that was prominent in comments on team thinking and practice was positive risk taking:

“Willing to take assessed risks and a belief in the abilities of users” (Residential Worker, Board F)
“Ward staff more relaxed and comfortable with positive risk taking aspect, leading to less stressful environment for staff and patients” (Ward Manager, Board J)

“Much more positive risk taking” (Staff Nurse, Intensive Care, Board K)

“More open to taking calculated clinical risks” (RMN, Board O)

“General focus of 10 ESC’s - positive risk taking has been good” (Senior Charge Nurse, Dementia Care, Board C)

Nevertheless, several comments raised cautions about this:

“Has probably raised awareness, although it has increased staff’s vulnerability to being subject to patient’s accusations” (Staff Nurse, Forensic Unit, Board K)

“Risk averse policies, systems unsupportive of approach i.e. do not reflect strengths etc.” (Community Mental Health Charge Nurse, Board O)

5.8 Hindering and helping factors

In this penultimate part of Section 5, it is useful to summarise the factors that were seen as hindering translation and enactment at clinical level and those that were seen as helpful. Policies (as in the comment on risk above) were occasionally cited as a hindrance. Much more commonly, lack of time, colleagues’ attitudes, and poor staffing levels/resource were cited as holding back progress with VBRFP:

“Lack of nursing staff. Numerous other demands. Increasing clerical work” (Acting Charge Nurse, Board O)

“De-motivated staff, who I think prefer to nurture patients with the ward rather than promote forward thinking, positive recovery” (Charge Nurse, Board F)

“Staff attitudes can place barriers. Some staff are reluctant as they feel it erodes their professional identity” (Community Psychiatric Nurse, Board I)
“Negative attitudes of medical staff/consultants” (Charge Nurse, Board O)

Indeed, the **medical model itself** was cited by some as a barrier:

“Culture is still medical model” (Manager, Board C)

“Patient care and treatment is dictated by medical staff” (Staff Nurse, Intensive Psychiatric Care Unit, Board C)

“Competing needs e.g. to free up hospital beds” (Nurse Manager, Community Rehabilitation, Board F)

“Seems to be mainly nurses undertaking Recovery training. I would like to see other agencies, mainly medical staff attend. I feel the medical model is still very much at the forefront” (Senior Staff Nurse, Board C)

Interestingly, however, **service user factors were also cited as difficulties:**

“The nature of the severity of the patient’s illness” (Physiotherapist, Board J)

“Time constraints, political issues and patient groups which it can be difficult to apply to” (Psychiatric Nurse, Board J)

“Difficult sometimes with elderly/institutionalised individuals to get them to voice their own values and thoughts” (Staff Nurse, Rehabilitation Unit, Board N)

As a counterpoint to the inhibiting influences, a large number of helping factors were identified. These principally comprised: **resonance with personal values; attitudes of/ support from team colleagues; line management/supervisor support; and support from Board/national approach.**

“Personal belief system” (Community Charge Nurse, Board O)
“The training I received not only helped me to work better but actually helped me a lot in my personal life, as I care for my mother who has dementia” (Technical Officer, Board C)

“For like-minded colleagues who also work in a person-centred and values-based approach” (Community Charge Nurse Learning Disabilities, Board O)

“Good management support” (Staff Nurse, Board J)

“The public health approach” (Health Improvement Officer, Board E)

“Shift towards recovery focus in NHS in Scotland” (Mental Health Nurse Specialist, Board F)

5.9 Key points from the survey of Mental Health Workers who received VBRF training

- The very low survey response rate precludes viewing the 207 respondents as representative of all the MHWs trained in Scotland
- Nevertheless the respondents came from a wide range of Health Boards and practice settings, and their replies yield some useful initial insights into the nature of impacts for individuals and teams
- 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 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 aspects of their individual practice, especially 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
SECTION 6: INTEGRATIVE DISCUSSION

Section Preview

This section takes a step back from the in-depth findings in order to explore some of the key issues to emerge. These comprise: trade-offs involved in cascade training; the reactions of those who trained; understandings of what the 10 ESCs and Recovery mean; and the nature and scope of cultural change within the NHS context.

6.1 Reflecting further on translation and enactment issues

Before concluding this report it is useful to reflect more on the experiences within particular Boards (as reported in Section 4) and the experiences of Mental Health Workers (as reported in Section 5) in order to further understand some of the common conceptual and practical issues that have arisen during translation and enactment. This relates principally to the policy to practice aspects depicted within Parts 3 and 4 of the MAPPED model (Figure 2.1). To this end, four main issues are now discussed.

6.2 Replicating the cascade: pragmatism versus dilution

Each 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. 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 NES 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, as has been seen, most Boards have as yet 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).

As has been seen, some Boards have been relatively successful in engaging some participants from outwith nursing, although very few psychiatrists are known to have taken part in local training. Moreover, some Boards have replicated the regional training principle of involving service users and have also involved carers. Where this has happened, the emotional and cognitive impact for staff often seems to have been significant. Nevertheless, one of the key issues that has arisen during this study is: what has the impact really been for the staff who attended local training?

6.3 Reactions of those attending local training

A way into understanding the above question is provided by one of the first wave trainers:

“I think you've predominantly ...you know when you’re delivering the training, you meet three types of people. You have one type of people who been there, done that, know it all anyway, so why are you telling me this? You have another group of people who...this is really great, this is fantastic, know nothing about it and that’s a great way to look at things. And you have a third group of people who, yes, recognise that I've been there and I've done this and I have this knowledge, but actually this is a different way of looking at it. And that’s good and quite challenging for the...in a positive way”

While recognising the dangers of typifying individuals within a study of a values based initiative (!), our study has accrued substantial evidence from both trainers and trainees that the above statement has some currency and explanatory value. However, our findings also suggest that any such typology would benefit from being expanded and refined as in Table 6.1.
<table>
<thead>
<tr>
<th>Type</th>
<th>Key characteristics of reaction</th>
<th>In their own words</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resisted</td>
<td>Initial negative, or lasting negative reaction based on a perception that the material is known and practised already, and there is nothing to learn from it. May be passive in manifestation (limited engagement) or, more rarely, active (voiced rejection). Sometimes overcome before end of training, but not necessarily so.</td>
<td>“seemed over simplistic and “teaching your granny to suck eggs”” (Senior Practitioner, Board J)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“the work book was mandatory and we made the best of it, but it was pitched at a low level, ‘teaching granny to suck eggs!’” (Community Psychiatric Nurse, Board H)</td>
</tr>
<tr>
<td>Resonated, Reaffirmed – Reinforced</td>
<td>Resonated with personal and/or professional values, and with perceived approach to practice, but the training experience has added a further positive dimension in terms of new thinking/learning and translation into practice.</td>
<td>“I found it very reassuring because in a lot of respects I think myself and the team that I work in, actually are very holistic and actually do use most of the principles” (Board K, MHW)</td>
</tr>
<tr>
<td></td>
<td>This was a common reaction amongst respondents to the MHW survey and was also evident in interviewee accounts.</td>
<td>“I have always had a positive attitude regarding person centredness and the training only validated this and made me feel good” (Staff Nurse, Board O)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“It consolidated and reinforced the values I already had &amp; try to practise” (Staff Nurse, Board H)</td>
</tr>
<tr>
<td>Resonated, Reflect, Re-cognised</td>
<td>Resonated with personal and/or professional values, and with perceived approach to practice, but the training experience has added a further positive dimension in terms of new thinking/learning and translation into practice.</td>
<td>“I thought we were already doing it in our day to day work but it made me think more about the day job and how to fit in the capabilities to make a difference to clients and carers” (Charge Nurse, Board M)</td>
</tr>
<tr>
<td></td>
<td>This was a common reaction amongst respondents to the MHW survey and was also evident in interviewee accounts.</td>
<td>“It has given me a more positive perspective and attitude towards care provisions for my clients” (Staff Nurse, Board O)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“Enhanced my current practice. Valuing the patient more rather than the therapist’s agenda” (Physiotherapist, Board J)</td>
</tr>
</tbody>
</table>

Table 6.1 A typology of reactions to ESC and Recovery training
Both the “Reaffirmed, Reinforced” and the “Resonated, Reflected, Re-cognised” types described in Table 6.1 were substantial and significant groups within our study. The former group is particularly interesting as their reaction can be seen very positively if they do indeed already practice in a way that embodies the espoused values. However a number of participants in the study pointed out that there could be disparity between self-view and self-as-viewed-by-others e.g.:

“The idea that staff have that they are already using values based approach when they clearly are not” (Board J; MHW)

Nowhere in our data is the contrast more marked than in this juxtaposition of quotes found during analysis of the “Any other comments” part of the MHW survey:

“In Learning Disabilities Services, believe we have been value based and person way for many years and have been person centred and have worked upon a person’s strengths and needs. However, although in a lot of cases, the training was a refresher, it also validated current practice and ensured I was even more person centred and focused upon the individual” (Community Charge Nurse, Board O)

“It concerns me that the majority of my colleagues who have been on ESCs training feel that they already consider the 10 ESCs in their practice and feel it is nothing new, but when I look at the current attitudes and values in Learning Disability Service I can see that there is room for great improvement - which leaves me with the questions, what did they get from the 2 days training? and did they not understand?” (Senior Staff Nurse, Board J)

The “Resonated, Reflected, Re-cognised” type was also well represented amongst study participants, with many very positive testimonies to the valuable new learning accrued. As Table 6.1 indicates, mental health workers who primarily resisted the training were less prominent in our survey respondents, but trainers often spoke of this group. One trainer who had lived experience of recovery from mental health problems described a particularly fraught session:

“ and a lot of...some people are just downright rude and a lot of people would come ...2 full days, and people would come in the morning and wouldn't bother coming back and take it as a day off. Em, they...they would sort of say, you know, “Just interrupt, going to introduce people” and at one point somebody went, “Oh for f***'s sake” and somebody on...a lot of people wouldn't do the exercises, and that was soul destroying”
However, much more commonly, trainers reported some initial negativity that was subsequently overcome (see first wave trainers’ perceptions).

6.4 Understandings of ESCs and Recovery: application, meaning and language

Linked into peoples’ reactions to the training and any subsequent enactment were their understandings of the main concepts involved. One of the issues that arose relatively often is the applicability of the 10 ESCs and Recovery approaches with older people. As noted in Section 3, to some extent this may have been engendered by the orientation of the core materials. In the context of the 10 ESC training:

“Things that we have done in relation to delivering to Learning Disabilities, older people is change some of the scenarios. Amended them so that they have a focus that they can relate to because the scenarios are very much written from an adult mental health perspective.” (Board K; first wave trainer)

The application of Recovery approaches to those with dementia was a fairly frequent theme in our findings. On one side there were strong endorsements of its relevance:

“Because recovery isn’t about...just get out my soap box here......( ). ........ not about getting back to the point where you’re completely well. Its about achieving the optimum you can within your physical, mental, emotional and psychological and whatever capabilities” (Board N; MHW)

On the other, participants saw it as difficult or different. In some cases, there seemed to be practical difficulty in envisaging application:

“Sometimes I struggle to see it working for people with advanced dementia and would be interested in visiting units where they are doing this” (Board O; MHW)

In others the difficulty seemed related primarily to the language and meaning of recovery:

“Not able to get recovery with dementia but can assist in making peoples’ lives as good as possible” (Board C; MHW)

While problems with understanding seemed more apparent with the language of Recovery, this does not mean that the ESCs were always understood in a uniform
way. When asked about the main thing learned from the training, one respondent replied:

“To treat others as you would wish to be treated yourself (Board J, MHW)

Although instinctively this seems a reasonable aspiration, it pre-supposes exact mutual congruence of values and desires, and in that sense is the opposite of the individualisation and personal choice agenda inherent in the initiative.

From an evaluator’s point of view, the language of VBRFP could be frustrating when seeking description of impact and any tangible changes in practice that had been made. Often replies seemed to default to generalities or rhetoric:

“More holistic” (Board J; MHW)

“Care/support is delivered using a values based approach and is more successful due to this as it actually makes a difference to the person’s life” (Board O; MHW)

As alluded to previously, one of the other interesting linguistic aspects of the study was the wide range of terms that participants used to refer to people who were in receipt of their services. This spanned patients, clients, service users, individuals, people, reflecting different cultures of care and support.

Despite the difficulties identified above, many of the participants in our study felt that the initiative had impacted on everyday speech:

“...as large cohorts have been through the training programme it is now part of the language” (Voluntary Sector Worker, Board H)

“...if you’ve got enough people doing that, it becomes at some point where there’s a critical mass, where people are talking the language and we’ve got there just now. People are using the language. I’m less sure if they actually live the language” (Senior Manager, Board K)

The further cultural shift desired is summed up in the idea of moving from “talking the talk” to “walking the walk”. Means towards achieving this are explored in a recent
case study relating to one of the Scottish Health Boards involved in VBRFP (Barron and Forrest 2010 *in press*).

### 6.5 Culture change considered in the NHS context: micro and macro dimensions

As has been seen, the evaluation has gained initial insights from Health Boards and MHWs who are actively trying to translate aspiration into action, and there are some promising indications of development around patient involvement, care planning and positive risk taking in particular. At times the latter processes were seen to raise difficult change issues:

“Unfortunately although I agree that theoretically values are pivotal the reality is that if families are unhappy and insist on paternalistic care then management back that and the patients needs are not what is paramount” (Acting Charge Nurse, Board L)

This echoes a question raised by Brooker (2007) namely, “How, should the, frequently conflicting, views of service users and their informal carers be balanced through a recovery approach?”. As he points out, the promotion of values in policy statements needs to acknowledge the challenges these present in practice.

Another interesting dimension to emerge from the training was the potential for highlighting the person within the professional role. This could bring both benefits and challenges:

“It has made me aware of my own needs and emotions. It treats me as a person rather than a nurse in a role” (RMN, Board J)

“I did not like the last when we had to tell our life stories” (Resource Worker, Community Team, Board L)

“The training I received not only helped me to work better but actually helped me a lot in my personal life as I care for my mother who has dementia” (MHW, Board C)

“Has probably raised awareness, although it has increased staffs’ vulnerability to being subject to patients’ accusations” (Staff Nurse, Board K)

“I appreciate the difficulty some staff have in facing their own issues but we expect the people we care for to ‘share’ and ‘share’ again. Think working on what makes us uncomfortable is a great mechanism for learning to respect dignity, see experiences
of others and what we expected of them” (Community Mental Health Charge Nurse, Board O)

Moreover, with Health Boards espousing the expectation that staff should enact these values with service users, there were perceptions that application shouldn’t stop there:

“VBT should be applied by management to their staff. Not line management, but Executive Board.” (Team Leader, Board J)

In effect, the latter comment challenges each Health Board to put their money where their mouth in regard to cultural change. In concluding this section of the report it is important to listen to one of the few voices in the study making a more sustained and fundamental critique of the way the initiative was being translated and enacted by organisations. While the vast majority of study participants seemed to accept that some NHS constraints were inevitable and took the view that the nature of the initiative was evolutionary rather than revolutionary, a different view could be taken:

“...but I don’t think some people were challenged enough because I felt they were going away with the neutralised version... some people most defiantly not...because some people – how do we fit this into our framework?. You don’t fit it into your framework. The whole point of doing it is to challenge the system as it stands”.

“I just don’t see enough people doing key positions who are going to challenge that whole culture change”

“...why are we getting such a patch thing? Some of the other people were saying we are getting no support from (.) and other Board areas are getting no support, this in their own time. If this is part of the Review of Nursing and the Rights and Recovery, where is the investment in it? Why are staff not being released to go on training? Why is it that on the Facilitator’s Manual the only thing that they’ve really given an outline plan for is for four and a half days... yet the maximum that people are saying they can do (.) did two and a half days ......some places haven’t even done anything yet’.

These comments question whether a gradual “drip, drip” approach to cascade training in local Boards will ever lead to sustained cultural change, and highlight the issues of critical mass and challenge to existing systems.
SECTION 7: CONCLUSION

In concluding the report it is useful to return to the title of the study. The given title for the study is important because 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 structural and process resources, 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. Put simply, this has never been tried before in Scottish mental health nursing, and there is also little international precedent.

Viewed in this context, it is perhaps not surprising that in the first two years of the VBRFP initiative only around a quarter of the total number of mental health nurses in Scotland appear to have received any training. The aspiration to effect culture change has required training with significant facilitation of experiential learning in many Boards. In these contexts where a myriad of mental health and other initiatives are taking place, the commitment of large numbers of people to even a few days for training is a substantial undertaking. In addition to the ongoing delivery of clinical services, VBRFP is competing with statutory and non-statutory training such as: moving and handling; dealing with violence and aggression; STORM training, training related to HEAT targets, and Cleanliness Champions, to name but a few. Indeed, in the Cleanliness Champions initiative it took over five years to achieve training of a similar sized nurse-centric cohort to that envisaged by VBRFP (Macduff et al 2009). Clearly the timeline for Action 1 requires considerable extension if it is ever to be realistically achieved. Furthermore, the SGHD and Health Boards should consider whether there is merit in setting an achievable timeline for more substantive roll out of the Realising Recovery materials.
The challenges of cascade training on this scale cannot be under-estimated. As has been seen, some dilution of the strength of the source materials during cascade is inevitable. Staying with a liquid analogy, some deflection is also inevitable in the process as the main source merges with other tributaries downstream. What has been striking in this national evaluation is the shaping power of the latter influences. One of the strengths of the evaluation has been its ability to apprehend and analyse these influencing contexts and processes. Its main weakness, however, has been the documented difficulty in fully apprehending downstream impact.

These considerations are visualised in a slightly different way in the MAPPED model (Figure 2.1) Returning to this analytic framework, it can be argued that as a national educational development (Parts 1-3) VBRFP has successfully established initial momentum. As has been seen, the role of individual Health Boards (Part 3, far right) in translating the initiative into local enactment has been pivotal. Indeed the idea of translation, rather than simplistic implementation of a fixed package, is a key idea within the MAPPED model (Macduff 2007). Nevertheless, the need for continuing drive at national level has been highlighted throughout the evaluation, with many participants valuing the idea of a national focus on the service user experience which, in the process, underpins more fundamental development/re-development of Scottish mental health nursing.

The challenge for those committed Health Boards is not only to expand delivery of VBRFP training, but more fundamentally to support sustainable related practice development (Parts 3-4). While our findings show that a number of Boards have led the way in developing and testing mechanisms to support this (e.g. use of team reflection/clinical supervision, PDPs, action learning sets), for most MHW survey respondents no follow-up support/mentoring processes had been enacted. As Part 4 of the MAPPED model suggests, situated power, service priorities and embedded culture of place (i.e. "the way things are done round here") will be key influences on any embedding of the espoused values into practice. In this regard it will be important that other key professional groups such as psychiatrists and executive management engage with the training available. Again some Boards have shown how leadership can influence this. Moreover, many participants in the study have expressed optimism over the way in which the 10 ESCs are becoming incorporated as the basis for pre-registration nurse education.
These considerations relate to 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.

Viewing this distinctive Scottish initiative from wider perspectives is also useful. Review of international approaches to recovery training in mental health practice (Ask Clyde 2007) shows a diversity of training formats that was replicated at national level across the Scottish Health Boards. Moreover, this review highlights that most evaluation activity has focused on the programmes themselves, with very few investigating the impact of the course on practice. None in the latter category were evaluating the roll out of a national programme.

As such, the Scottish initiative has significance beyond its borders. One of the natural benchmarks for comparison is national mental health nursing development in England. Interestingly, the Chief Nursing Officer for England conducted a Review of Mental Health Nursing (DOH 2006) which included aspirations to apply recovery approach values, and to strengthen relationships with service users and carers. An evaluation of the impact of the Review is currently ongoing, but its interim Stage 1 report (Baker et al 2008) found that:

“Whilst all organisations ranked highly the importance of adopting both recommendation 1 (Applying Recovery Approach Values) and Recommendation 5 (Strengthening relationships with users and carers) in terms of implementation progress these were rated low in Trusts and HEIs”

This suggests that there may be a gap between rhetoric and the reality of local translation into action. Hopefully the present report offers some useful insights into some of the processes involved, although it must be noted that the Scottish policy review has come with more mandatory directives than in England and the means of dissemination has been very different.
This is not to suggest that our study has begun to address all the relevant issues. Due to its remit and limitations our study has only explored initial perceptions of enactment in practice, and further study of the lived experience of care staff and service users and carers would clearly be useful. In this regard research into undergraduate students’ perceptions of values based practice as experienced on practice placements could help to gauge the extent of any embedding to date.

In seeking to learn what, if anything, service users and carers themselves understand by the VBRFP initiative (and what their questions about its translation, enactment and impact to date would be), it may be more productive to include this particular aspect within a wider study of their experiences. The current study has highlighted some of the difficulties of seeking to evaluate one initiative in the midst of many related developments. One approach would be to start by aiming to identify professional practice that service users received which they found helpful and supportive on their journey of recovery, perhaps focusing on the past 2-3 years. This could lay the basis for a more detailed exploration of the factors influencing this.

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, personalised 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.
SECTION 8: 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 SGHD 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.
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 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
REFERENCES


Barker, P (2001) Opening minds to a different way. *Nursing Standard* 16; 35


