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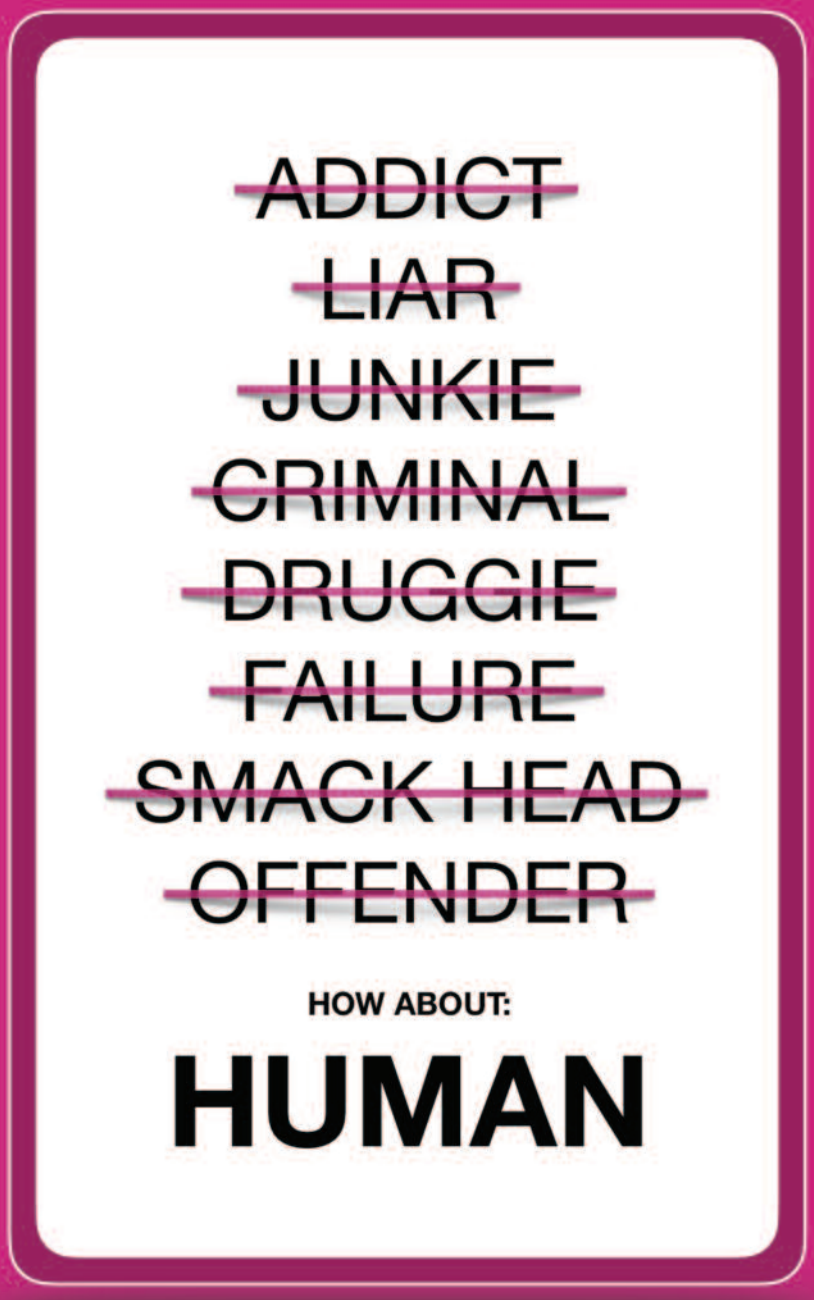

Special Edition

Recovery in Prison

Leadership in Recovery
Five Themes for Cultural Change?

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Leadership

Leadership is not telling people what to do or how to do it. Leadership is about inspiring and uniting people to a common purpose, cause or belief[1] and making everyone feel safe. Leadership is about helping people to come together to achieve more than they could accomplish on their own.[2] People at all levels can be leaders and we should encourage them to be so.

Today, in many health-related areas, leadership is seen as 'the most influential factor in shaping organisational culture'.[3] The NHS Leadership Academy recognises that strong leadership directly creates better patient outcomes and care and has accordingly set out nine dimensions of leadership behaviour. We don't have to look too far into the past to learn lessons from the observed correlation between poor leadership and a negative impact on patient outcomes.[4] More recently the NHS National Improvement and Leadership Board published 'Developing People—Improving Care'[5] which described a framework to enable improvements and better leadership in NHS Services.

In the substance misuse and mental health fields, leadership is required to transform cultures and promote positive outcomes.[6, 7] John Strang recognised how important leadership is in shaping visible recovery cultures across systems.[8] 'Operationalising Recovery-Oriented Systems' makes clear that 'strong leadership is an essential ingredient for transformation to a recovery-oriented system'.[9] So, leadership is vital in developing recovery orientated systems of care and in deploying resources to effectively address the full range of substance use problems within communities.[10]

What does this mean for recovery focused services that operate both internal and external to the NHS? In particular, what role must senior leaders play in the development of effective workforce cultures to achieve positive recovery outcomes and what does this mean for prisons?

The following five leadership essentials arose from a systematic review of research into effective leadership practices for recovery services.[11]

1. Clarity of vision, values and an agreed definition of what Recovery is

Despite there being at least two consensus groups there is no universally accepted definition of what recovery is.[12 13] This is probably because of the multiple pathways and experiences people encounter as part of a personal recovery journey. This paper adopts the definition that recovery is a personal process of change to attitudes, values, and feelings that allow the individual to develop new meaning and purpose to lead a satisfying and positive life.[14]

1. https://www.ted.com/talks/simon_sinek_how_great_leaders_inspire_action#t-132180
2. https://www.ted.com/talks/simon_sinek_why_good_leaders_make_you_feel_safe
3. West, M., Armit, K., Loewenthal, L., Eckert, R., West, T and Lee, A. (2015) Leadership and Leadership Development in Health Care: The Evidence Base. London: The Faculty of Medical Leadership with the King's Fund and The Center for Creative Leadership.
4. Francis, R. (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Executive Summary. London: The Stationary Office.
5. NHS Improvement and Leadership Development Board (2016) Developing People – Improving Care: A national framework for action on improvement and leadership development in NHS-funded services. NHS: London.
6. Alban-Metcalfe, J., and Black, J. (2013) How leadership style affects mental health recovery. Available at: www.hsj.co.uk/how-leadership-style-affects-mental-healthrecovery/ 5058380.fullarticle
7. SAMHSA (2012) 'Operationalising Recovery-Oriented Systems'. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration.
8. Strang, J. (2012) Medications in Recovery Re-orientating Drug Dependence Treatment. London: National Treatment Agency For Substance Misuse.
9. SAMSHA (2012), see n.7.
10. SAMHSA (2011) Recovery-Oriented Systems of Care (ROSC) Resource Guide.
11. King, D. (2018) What is the role of senior leadership in the development of effective workforce cultures to achieve positive recovery outcomes within mental health and substance misuse services - a systematic review. Unpublished thesis.
12. http://www.ukdpc.org.uk/publication/recovery-consensus-group/
13. https://www.naadac.org/assets/2416/betty_ford_recovery_definition.pdf
14. Anthony, W. (1993) 'Recovery from Mental Illness: the guiding vision of the mental health system in the 1990s', Psychological Rehabilitation Journal, 16(4), pp. 11-23.

Service providers must understand recovery and link their vision and values to it. At a local level, staff and service users should collaborate and agree a definition and associated vision and values: It is logical that staff and service users need to be involved in defining recovery in an organisational or service context so that it has meaning for them. People engage and relate to things better when they have helped to shape them. It is also critical that this collaboration should be extended beyond those who are in receipt of the care of services, to include those who are supporting those through recovery journeys. Co-production is really important (see theme 5).

Without a co-produced understanding of recovery, then both staff and those receiving and supporting care are likely to be working at cross purposes and the outcomes for all may be negatively impacted. Part of leadership, therefore, is to create the space, provide the context and empower staff and those with lived experience to be an active part of shaping this definition. The result is not a fluid definition that is constantly in a state of change, but an established definition, vision and associated values that people then subscribe to. Evidence suggests staff work better when they have some control over their working environment which is informed by an agreed recovery definition, vision and values statement.[15]

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2. Empowering staff to lead and develop change

Because everyone's recovery journey is personal, empowerment is important. We want to support people to have control over their lives and the goals they are working toward. Services with a clear recovery focus, strong leadership[16] and a team working ethos[17] better develops innovations in delivery in order to improve outcomes within a recovery orientated system of care. The work on Recovery Oriented Systems of Care makes this point clear—recovery is a holistic phenomenon[18] for everyone. By creating the environment and culture within which people feel empowered to lead change impacts on all people, not just those who are accessing services. The outcomes for professionals may differ from services users but the positive impact upon their lives is similar.

To enable empowerment leaders need tools and approaches to make this a reality, focused on the wellbeing and quality of life of staff. Communities of practice whereby staff meet regularly to discuss recovery and their own practices and functioning are an effective way of developing and sharing understanding.[19] There are a variety of examples including away days and World Cafés,[20] 'Vision Planning Days',[21] focus groups to promote collaborative action planning and action research style approaches.[23] Such formal and informal methods should be encouraged and built into the organisational plans to promote recovery focused outcomes and leaders should instigate this.

It is important that leaders guide staff to discover new ways of working and avoid feelings of having things 'done to' or imposed upon them. Leaders should encourage alignment to organisational objectives whilst allowing their workforce to lead activities as part of their core role, thereby sharing power and responsibility for influencing change.[24] Organisational structures need

15. Chandley, M., Cromar-Hayes, M., Mercer, D., Clancy, B., Wilkie, I. and Thorpe, G. (2014) 'The development of recovery-based nursing in a high-security hospital: nurturance and safe spaces in a dangerous world?'. Mental Health and Social Inclusion. 18 (4). pp. 203-214.
16. McLean, J. (2015) 'Recovery-focused leadership in the NHS'. Mental Health and Social Inclusion, 19(2), pp. 87-94
17. Sutton, J., Family, H., Scott, J., Gage, H. and Taylor, D. (2016) 'The influence of organisational climate on care of patients with schizophrenia: a qualitative analysis of health professionals' views'. International Journal of Clinical Pharmacy, 38, pp. 344-352.
18. SAMHSA (2012), see n.7.
19. Mancini, M. and Miner, C. (2013) 'Learning and Culture Change in a Community Mental Health Setting', Journal of Evidence-Based Social Work, 10, pp. 494-504.
20. Beckett, P., Field, J., Molloy, L., Yu, N. and Holmes, D. (2013) 'Practice What You Preach: Developing Person-Centred Culture in Inpatient Mental Health Settings through Strengths-Based, Transformational Leadership'. Issues in Mental Health Nursing. 34. pp. 595-601.
21. Best, D., Loudon, L., Powell, D., Groshkova, T., and White, W. (2013) 'Identifying and Recruiting Recovery Champions: Exploratory Action Research in Barnsley, South Yorkshire'. Journal of Groups in Addiction and Recovery. 8. pp.169-184.
22. Bhanbhro, S., Gee, M., Cook, S., Marston, L., Lean, M. and Killaspy, H. (2016) 'Recovery-based staff training intervention within mental health rehabilitation units: a two-stage analysis using realistic evaluation principles and framework approach'. BMC Psychiatry, 16, pp. 1-14.
23. Henderson, J., Curren, D., Walter, B., Toffoli, L. and O'Kane, D. (2011) 'Relocating care: negotiating nursing skillmix in a mental health unit for older adults'. Nursing Inquiry. 18(1). pp. 55-65.
24. Stuber, J., Rocha, A., Christian, A. and Johnson, D. (2014) 'Predictors of Recovery-Oriented Competencies Among Mental Health Professionals in One Community Mental Health System'. Community Mental Health Journal, 50, pp. 909-914

to be flexible enough to adapt work roles to include participation in such processes,[25] so that the workforce is given freedom to shape how they work[26] and has a sense of ownership of the recovery model.

3. Encouraging positive risk taking and a learning culture

Whilst considering such collaborative and empowered approaches to define recovery and lead change, a tension emerges that it is important to note. Traditionally within health services there is a biomedical model that is hierarchical in nature and has power and status located with the professional or clinician at the top.[27] This model emphasises the view of the clinician in terms of treatment adherence, symptom reduction and staying out of hospital, rather than the person having ownership of their recovery.[28]

A main driver behind the perpetuation of a biomedical or illness management model is the predominant risk averse culture that exists in many services. Studies have recorded staff discussing anxiety regarding risk that drove their approach to, and decisions regarding, those in their care.[29] Recovery workers have reported peer pressure to conform to their organisations' risk-averse culture that subsequently impacted upon the approach they took to encourage those in their care to take positive risks.[30] This has even extended to staff reporting that they are fearful of being sued[31 32]. The view of risk within individual packages of care differs between the professional (who tends to focus on the risk of harm or violence) and the person receiving care (who tends to focus more upon social inclusion, financial need and avoiding harm).[33]

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Positive risk taking balances the positive benefit to be gained from taking a risk against the negative impact of avoiding risk altogether. It views risk through the lens that it provides 'opportunities for learning and enabling people to make their own decisions, to exercise choice. It builds upon individual strengths and abilities rather than focusing on deficits'.[34] An interesting question therefore arises regarding how a biomedical model and/or risk averse culture impacts upon recovery where we want to encourage people to take positive risks. I believe that developing approaches at a local level that weave positive risk taking into biomedical approaches should be a priority for those in leadership positions. We need to balance keeping people safe with supporting them to move away from services when the time is right. Empowering staff to develop, lead and sustain change will be unsuccessful if at the same time they are constrained by cultures that perpetuate risk management strategies that are at odds with the philosophy and values of recovery.

Learning cultures involve collaborative working across all stakeholders to develop appropriate responses to incidents of harm as a means of promoting learning.[35] A learning culture actively seeks to understand and share both what went right and learn from what went wrong. Leaders promote lateral relationships within which all people, irrespective of hierarchy, are encouraged to be involved.[36] The workforce will not be as effective if they are constrained by risk-averse management strategies or are operating within a blame

25. Bhanbhro, 2016, see n.22.
26. Kristiansen, L., Hellzén, O. and Asplund, K. (2010) 'Left alone – Swedish nurses' and mental health workers' experiences of being care providers in a social psychiatric dwelling context in the post-health-care-restructuring era. A focus-group interview study'. Scandinavian Journal of Caring Sciences, 24, pp. 427-435.
27. McLean, 2015, see n.16.
28. Kwok, C.F.Y. (2014) 'Beyond the Clinical Model of Recovery: Recovery of a Chinese Immigrant Woman with Bipolar Disorder'. East Asian Psychiatry, 24, pp.129-133.
29. Tickle, A., Brown, D. and Hayward, M. (2014) 'Can we risk recovery? A grounded theory of clinical psychologists' perception of risk and recovery-oriented mental health services'. Psychology and Psychotherapy: Theory, Research and Practice, 87, pp. 96-110.
30. Holley, J., Chambers, M. and Gillard, S. (2015) 'The impact of risk management practice upon the implementation of recovery-oriented care in community mental health services: a qualitative investigation'. Journal of Mental Health. 25(4), pp. 315-322.
31. Kristiansen, Hellzén and Asplund (2010), see n.26.
32. Tickle, Brown and Haywood (2012), see n.29.
33. Reddington, G. (2017) 'The case for positive risk-taking to promote recovery'. Mental Health Practice, 20(7), pp. 29–32.
34. Morgan, S. and Williamson, T. (2014) 'How can 'positive risk-taking' help build dementia friendly communities?' Joseph Rowntree Foundation.
35. Tickle, Brown and Haywood (2012), see n.29.
36. https://www.scie.org.uk/publications/learningorgs/references.asp

culture. Leaders should embrace learning opportunities and encourage staff to discuss practice in this context, without fear that they will be isolated and blamed if things go wrong.

It is likely both safer and more effective to use strategies that are based upon recovery, rather than traditional control and consequence driven strategies that emerge from a biomedical approach. However, it is worth noting that there is a gap in the research on whether promoting positive risk-taking does in fact promote recovery.[37] However, if leaders are not prepared to work within their organisations to develop positive risk-taking strategies this gap will never close.

Developing a positive risk-taking culture requires a certain amount of bravery on behalf of those in leadership positions; it also requires a long-term strategy and patience. As many working within services will appreciate, recovery is not a linear journey, nor does it occur over short periods, with a time frame of five to ten years for recovery to become embedded.[38] Organisations need to accept and be open about this, with a clear commitment from leaders to support long-term development.[39]

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4. Patience is vital—change takes time to realise

The new relationships fostered through a recovery approach require significant nurturing. It is likely that this is true of not only the relationships between professionals and care receiver, but also of relationships between leaders and other professionals, families, peer supporters and mentors. It will take time for all stakeholders to be comfortable in a new recovery paradigm. Strategic leaders need to commit to enabling meaningful change[40] whilst acknowledging that both 'change and learning are slow, multifaceted processes that occur over time and across contexts'.[41]

5. Lived Experience needs to be central to change

The value of lived experience is explored in more depth by Damian Grainer and David Higham within this edition. It is important that leaders take account of the value it brings. Basset et al (2010), Gillard, Turner and Neffgen (2015), Byrne, Happell and Reid-Searl (2015), and Best et al (2017) are amongst those who have published material on the value of lived experience on developing care and social networks. As discussed above, involving and sustaining the involvement of the workforce in developing a recovery culture is of high importance. Including those with lived experience should be seen as of equal importance to those in leadership positions.

Co-production, co-facilitation and learning between professionals and those with lived experience can generate engagement, human connection and organisational commitment. All stakeholders become equal partners and co-creators in developing aspects of care and the environment within which care is located. In this approach, relationships are more lateral than hierarchical, and change is agreed rather than imposed. This idea of co-production creates opportunities that build upon the strengths of a partnership approach and if done correctly does not need to threaten professionals' knowledge, competency or autonomy.[42]

This approach to change is best viewed as the meeting of ground up and top down approaches.[43]

Values of Recovery

Values are traits or qualities that represent deeply held beliefs, they reflect those things that individuals or organisations feel are important and act as a form of behavioural compass.[44] Often values are not communicated effectively which minimises the impact

37. Reddington (2017), see n.33.
38. Kelly, J. and White, W. (2011) Addiction Recovery Management, Humana Press: New York.
39. De Vecchi, N., Kenny, A. and Kidd, S. (2015) 'Stakeholder views on a recovery oriented psychiatric art therapy program in a rural Australian mental health service: a qualitative description'. International Journal of Mental Health Systems. 9 (11). pp. 1-11.
40. Best, D., Irving, J., Collinson, B., Andersson, C. and Edwards, M. (2017) 'Recovery Networks and Community Connections: Identifying Connection Needs and Community Linkage Opportunities in Early Recovery Populations. Alcoholism Treatment Quarterly, 35(1), pp. 2-15.
41. Mancini and Miner (2013), see n.19, p.498.
42. Henderson et al (2011), see n.23.
43. Best, D., Loudon, L., Powell, D., Groshkova, T., and White, W. (2013) 'Identifying and Recruiting Recovery Champions: Exploratory Action Research in Barnsley, South Yorkshire'. Journal of Groups in Addiction and Recovery. 8. pp.169-184.
44. Williams A. and Payne, S. (2016) My 31 Practices: Release the power of your values for authentic happiness. LID Publishing: London.

that they have and prevent people from being able to engage with them.

So what can leaders do to help people align to the values of their organisation or service? Well the good news is that this is congruent with the approaches I've already articulated! For example, activities such as asking people what is important to them and establishing core values across the whole organisation (not just within management) are important. This will mean that the values are not just existential ideas dropped down from above but have been co-produced so as to engage people from the outset. They may differ slightly across recovery services but they should have meaning and value for all participants irrespective of the service. Next, establishing an effective means of communicating the values is required, after all what is the point of having values if no-one knows what these are? A clear communication plan is important.[45]

Leaders need to visibly live these values, incorporating them in their decision making, embodying them in their day-to-day interactions, and using them to engage people at all levels of the organisation. In doing so, this will reinforce the values helping others engage with them and to sustain cultural change. Recovery to a large degree is about relationships, whether it be building or rebuilding interpersonal ones, or developing relationships with communities or activities. For instance, if the relationship between nurse and person receiving care is vital, then it stands to reason that the relationship between organisational leader and nurse is of equal importance. These relationships should not be built upon different principles or values bases. Therefore, the values of recovery that each organisation has should be at the heart of all relationships within it.

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The 'behavioural compass' aspect of organisational values is in essence a sense check of activities within services. This doesn't need to be driven by managers if the work to generate, align and communicate the values has been effective. Remember, leaders exist at every level of organisations. People should feel confident to lead change if they are engaged with and understand the behavioural compass. Mike Wheatley provides the example of HMP Holme House within this edition that has followed this approach.

Conclusion

Implications for Practice

This article is intended to further the conversation regarding recovery from being focused upon interventions or service delivery elements, to consider the role and actions of leaders in the development of effective workforce cultures. A potential model of five themes or pillars that could be a guide for future practice is suggested. These are:

- ❒ Clarity of vision, values and an agreed definition of what Recovery is
- ❒ Empowering staff to lead and develop change
- ❒ Encouraging positive risk taking and a learning culture
- ❒ Patience is vital—change takes time to realise
- ❒ Lived Experience needs to be central to change

The overarching theme is that the values of recovery (as defined by organisations) should be at the heart of all relationships not just professional—client ones. Leadership needs to be seen to be in-line with recovery values, embodying these, whilst empowering those at different levels of the organisation to be leaders themselves. This model challenges some traditional views of leadership particularly in that they will be required to 'let go' of areas of control to enable co-production and the empowerment of staff.

Implications for Policy

There are potential policy implications and impact that such a model, if robustly evidenced, can help shape. Within the recovery field, the existing biomedical model and associated hierarchy that exists in many health services could be fundamentally changed. The transfer of power and influence away

45. https://hbr.org/2011/07/the-business-of-communicating

from being held within senior organisational positions is advocated. The values aligned to recovery within services and organisations support a cultural repositioning whereby power transfers from traditional hierarchical models to the front line. It is important to note that in the UK this does not conflict with the values of the NHS; rather it is congruent with them.

Organisational responses to risk need to better embrace positive risk-taking. This is not advocating reckless approaches that put staff or those receiving care in positions where they may experience harm, rather learning from the existing practices within recovery services that seek to empower people to be responsible for, and to lead, their own care.

Implications for the Prison System

Just like in many health services, prison culture is hierarchical; it is largely a top down structure with clearly defined power structures with people looking upward for clear instruction on what they should do, how they should do it and when. People can be fearful of being blamed if they try an innovation and it goes wrong. With this in mind, I argue that the five themes outlined above are just as relevant to those working a custodial role within a prison; the same rationale applies even if the uniform is different. If we do not understand or feel engaged with what we are working to achieve, it will fail. If all leaders (irrespective of employer) perpetuate the top-down, risk averse processes we will continually struggle with the same problems. If we do not engage those with lived experience within the prison (both prisoners and staff) then there will remain elements of 'them' and 'us'. If we are impatient and do not allow people and changes time to grow they will never succeed. I subscribe to the view that 'we cannot solve problems with the same thinking we used when we created them'. Therefore, the relevance to prisons is that leadership has a vital role to play in transforming them, alongside all the wonderful people and using all the ingredients within their communities, to truly become Recovery Oriented Systems of Care, because in doing so we give people the best opportunity to transform their lives. What an exciting and rewarding challenge to have! And best of all—everyone benefits.