Recovery Operational Committee

Guided interviews for the proposal for of a recovery-oriented model of care at SVHM

COLETTE CRIMMINGS with ROC members

ST VINCENT'S HOSPITAL
MELBOURNE

Team
ROC member

1. PREAMBLE

- This interview process is being undertaken to obtain feedback and ideas from all the clinical teams about the future model of care that reflects personal recovery

- There is the opportunity to develop our own model and use documents & tools to work with each consumer on their recovery goals.

- There is recognition of the new DH Victoria's MHA and Framework for recovery-oriented practice and is an opportune time to consider what the SVHM Mental Health model of care will look like in the future. There is variable understanding of recovery and what recovery-oriented practice is

- Currently the AIS and community/CCU use different recovery tools. The WRAP® is used by some clinicians in the community/CCU and is the mandated tool in the AIS

- There is replication of information within the current suite of documents (including the MH Treatment Plan; Case Review)

- There are some issues in determining what wellness management is and what clinical risk management is. This can lead to clinicians being fearful of the documentation/paperwork. There is scope to review the AIS clinical risk management tool to align it with the community one

- Recognition of the consumer being asked to work with the same documents and the continuity between teams/services

- There is a requirement to meet the DH for recovery-oriented practice. The focus is on strengths but also on good leadership, capabilities (knowledge, skills, behaviours and attitudes). Going forward, there is a need to make some cultural changes

- An individual recovery plan could incorporate strengths, goals and wellness management (including relapse prevention)

- Consumers would be facilitated to develop a WRAP® in group settings. The Strengths Assessment & Goal Plan would still be utilised by clinicians who have longer term engagement with consumers

- There is a need to simplify the process and documentation as there is a wide range of experience and expertise within the service

- The Risk Assessment, Risk Management Plan & Advanced Statement will remain and be used alongside any future document/plan

2. NON-NEGOTIABLES TO BE RELAYED TO THE STAFF BEING INTERVIEWED BEFORE THE QUESTIONS ARE ASKED

i. We need to have a plan for each consumer
ii. Documentation is required to evidence working with consumers on their recovery goals
iii. Any tool used to work with consumers will be evidenced-based (such as the Strengths Assessment; Back in the Saddle) has to be agreed and signed off by the Recovery Advisory Committee (RAC)
iv. There is an obligation to work within the DH recovery framework
v. The work and plan has to include wellness management (relapse prevention and crisis management)

3. INTERVIEW INSTRUCTIONS

i. Each member of the ROC to conduct the interviews with their own clinical team (including medical staff where possible)
ii. The interviews should be conducted as many times as is required to meet with as many staff as possible
iii. Each interview to be about 30 mins (maybe shorter if only one or two staff)
iv. Colette will support the AIS members with the interviews due to the larger number of staff
v. The interviewer is to document key points and collective themes to reflect the team as a whole and not the opinions of individuals

4. SUPPORTING MATERIAL

i. The Principles of the MHA 2014 aligned with the DH Framework for recovery-oriented practice domains
ii. The DH Framework for recovery-oriented practice

5. EVALUATION

i. The themes and trends will be written up to inform the next steps. The outcomes of this feedback process will assist the ROC in future work with the clinical teams
ii. The evaluation report will be tabled at the RAC for discussion
iii. Some decisions will be made based on the outcomes of the above
iv. This consultation process and outcomes will be part of the proposal presented to the RAC and Executive In January 2015

6. QUESTIONS AND COLLATED THEMES & KEY POINTS

A. What do you understand about personal recovery?

B. **Would you like to have a SVHM recovery model developed by clinicians within the service?**
(Consider: rationale for why or why not; fit for purpose; take what's working well and use these elements to create model developed form the 'ground up')

C. **Do you think it's important that each consumer has an individual recovery plan?**
(Consider: we need a document that the consumer drives that clinicians can work with in order to provide the appropriate care and support)

D. **Do you think it's important that an individual recovery plan is a mandatory document that is used is consistently across all teams (AIS, MST, CCT, CHOPs, CCU, CAT)?**
(Consider: Would replace the Case Review, WRAP®, MH Treatment Plan)

E. What do you think should be included in the plan?

(Consider: physical health; family & carer involvement; strengths focus; consumer's recovery goals; promoting self-management & autonomy; collaborative partnerships; meaningful engagement; holistic & personalised care; responsiveness to diversity; community participation)

F. **Do you think every consumer should be supported to identify some strengths and goals?**

(Consider: need to work with what the consumer sees as their recovery; goal achievement is a way of measuring recovery for a consumer; requirement to work with the consumer's strengths; gives a meaning and purpose to the collaborative therapeutic relationship; gives consumer hope when able to take positive steps)

G. **What do you think is positive and works well about the Strengths Assessment and Goal Plan both for the consumer and the clinician?**
(Consider: consumer driven; the clinician must have them for each consumer; simple but can be a complex process; collaborative working; documents evidence of working with recovery goals; focusses on the person, not the diagnosis)

H. **What are the benefits of Group Brainstorming? Would you want to keep it?**
(Consider: the process can be used regardless of what recovery document is used; any future model and documents will be strengths focussed; the process is about creativity & energising the team; it's not about an individual consumer; sharing of ideas)

I. **How can we ensure that staff behaviours and attitudes are strengths and recovery-focussed?**

(Consider: bringing about cultural change; hopeful & hope-inducing; supportive; leadership; role modelling; reflection & learning; responsiveness to diversity; collaborative partnerships; working positively with each other as well as with the consumers; be responsive to & value each other's skills and needs; value consumers' expertise)

J. **What skills & knowledge do you are think are required to work within a recovery framework?**
(Consider: therapeutic engagement; working with colleagues, family & carers, other agencies; leadership capabilities; interpersonal skills; clinical risk management; being transparent; showing empathy)

K. What do you think current staff need in respect of further training and development? What do new staff need?

(Consider: current Strengths 2 day training for all new staff; refresher modules; understanding recovery; basic counselling skills; motivational interviewing; coaching in the workplace; mentoring on the specific recovery tools; short session, half day, full day; workshops versus formal PPTs; responsibility of the clinical team to instruct and coach new staff on the documents and tools used within the service)

OTHER NOTES/OBSERVATIONS