

**Recovery and Independent Living  
Professional Advisory Group (R&IL PEG)  
Advisory Paper No: 2  
(+ amendments, March 2008)**

**A Briefing paper on the setting of standards and measurement  
of outcomes for  
The Mental Health and Wellbeing Networks of Devon and Torbay**

<b>Document history</b>	<b>Action</b>	<b>Date</b>
1. Intention of DPCT to commission outcomes measures reported to PEG.	Agreement to provide advisory document	23.10.07
2. Proposal put to CMHT coordinating group.	Proposal acknowledged	25.10.07
3. Discussion at PEG	Invitation to contribute	20.11.07
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5. Draft presented to PEG	Read and respond – consider next steps to complete task	19.12.2007
6. Final Draft to PEG	Reviewed and unanimously signed off	15.1.2008

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**A candle in the dark is worth more than a floodlight at midday<sup>1</sup>**

<sup>1</sup> From D.Malm et al 1981

## R&IL PEG advisory paper 2

### A Briefing paper on:

The setting of standards and measurement of recovery outcomes

### Orientation:

This is a long and complex document. It can be read at different lengths with or without the background material. If you are reading this on a computer connected to the internet the web references will connect you directly to many source materials including copies of the measures under discussion, articles reviewing them and PowerPoint presentations from national and international leads.

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## **Overview and summary:**

The guiding hope of redesign is to provide better services and that future networks of mental health and social care services will fulfil the LIT vision. 'Better' means many things but can be summarised as improved recovery for the people who need and use such services. How will we know whether this is happening and to what degree? The clear answer is by embedding systematic outcome evaluation into all new service developments. The problem is that there is not yet an agreed way of doing so.

This briefing paper reviews what is known and understood about outcome evaluation and the development of recovery outcome measures and makes recommendations on how to proceed. Most current measures record traditional parameters such as symptoms, disabilities and service usage e.g. HoNOS, or activity data such as waiting times and throughput. These fail to measure either personal recovery or the recovery supportive behaviour of services.

Both personal and service level recovery outcome measures are being actively developed in many pilot sites nationally and internationally. It is possible to identify a few leading measures but any outcome evaluation process must have a capacity to learn, change and adapt to benefit from progressive improvements in tools and methods as experience grows. The current aim is to get the most effective combination of simplicity, meaningfulness and usefulness, for managers, clinical leads, practitioners and people in recovery. Ideal outcome measures are not experienced as an imposition from outside but are of interest to the people using them and are supportive of both personal recovery and the development of recovery practice.

In making choices about how to adopt, adapt and implement best available recovery outcome measures and in seeking to construct a robust, simple and meaningful system of personal, practice and service evaluation the following need to be clarified:

1. What outcome evaluation information is wanted and by whom?
2. Who can take key decisions in commissioning an outcome evaluation process?
3. What authority will such a decision have?
4. How will an outcome evaluation process be resourced?
5. How it will be implemented, progress tracked and reported, and by whom?
6. How it will be structured and supported so as to progressively improve over time in tune with its own findings, national developments and emerging best practice?

To effectively answer these key questions it is proposed to use this briefing paper as the basis of a workshop drawing together Commissioners, providers and service users.

In addition to outcome measurement for individuals and services, there is an ambition to develop a set of core standards for future network services against which their performance and outcomes can be evaluated. This information could provide a means of tracking progress across and between organisations and inform planning and progressive development.

## Introduction

The justification for spending public money on mental health and social care services is that they should improve the lives of the people who use them. This is also the explicit aim of redesign for mental health and wellbeing services in Devon. In order to achieve this there is an essential requirement that we have meaningful measurement of service user outcomes. It is also essential that these measures are embedded in every new service development, so as to generate information that can be used to guide and shape and improve practice<sup>2</sup>.

The Joint Commissioners are concerned that future network services can describe their outcomes and that these are measured in ways that inform progressive improvement. Service users support the use of outcome measurement but have expressed concern that recovery does not become 'over-specified' by the choice of outcomes that are measured. They ask that a means is found of measuring personally defined outcomes and that outcome measurement develops as a method of both supporting service users and holding the service system to account for enabling individual and self defined journeys of recovery.

In support of these aims the R&IL PEG have reviewed what is currently understood by outcome measurement and what may be the guiding principles, options and preferences for doing so.

Measurement and evaluation can fulfill a number of functions which include:

- Accounting for quality and effectiveness.
- Assurance of equity and access.
- Audit of process and outcomes
- Ensuring value for money.

Measures and measurement should always be defined in relation to standards. Standards are either explicit and there are agreed goals of what should be achieved; for example 'is a practitioner, team or service 'up to standard', or else are covertly embedded in the measure itself – each measure also represents a set of values or assumptions concerning the issue under consideration.

There is also the important observation that the process of measuring things changes how people behave with respect to the items measured (the Hawthorne effect). This needs to be accounted for in interpreting findings but can also be a significant support for a progressive process of cultural change e.g. the skilful use of recovery measures will promote recovery oriented practice and outcomes. The downside is in motivating people to meet targets – to measure up – which then become the overriding purpose of the service i.e. meeting the targets rather than meeting the needs of the service users.

There are a very large number of measures and many already in use but most are related to activity or outputs rather than outcome, and few are focused on the personal recovery outcomes that we want services to deliver. They can tell us how busy we are but not what results from our activities. They can tell us we are doing a lot but not if we are doing well and say little about how the service user is doing at all.

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<sup>2</sup> Recovery and Independent Living Policy Implementation Guide 28.08.2007. P13

The national picture is similar. There is a growing concern for the limitations of existing measures and the drive to create more meaningful user-sensitive measures. Recovery outcome measurement is an active area for research and development with many promising examples from leading recovery services in pilot or experimental stages.

### **What are we trying to do?**

Traditionally we have either measured activity data e.g. how many people have we seen, how long did they wait, how quickly did we deal with them, or changes in clinical dimensions such as variation in symptoms and disabilities but this may be very poorly related to the experience of personal recovery and what people who use services want and value. Recovery based services are driven by values and the pursuit of desired outcomes – primarily the outcomes desired by the people using the services in support of their recovery, empowerment and social inclusion. And although we can ‘tuck in’ traditional measures into new services, this will not give us the information we want and value. To do justice to the aspiration of developing recovery oriented services the issue of measures and measurement needs to be thought through from first principles:

- Values lead to
- Standards which lead to
- Measures which lead to
- Evaluation (audit) which leads to
- Reports which lead to
- Action planning to deliver improved services that will conform better to the guiding values and uphold the agreed standards hoped for as a product of the full implementation of redesign.

### **How do we think about what to measure?**

We need data to support planning, review, governance, accountability, probity and validation but what do we measure? Why one thing and not another? For whom do we measure it? The overarching concern is to measure outcomes but which ones? Who’s wants or needs count? There are a number of candidates and viewpoints:

- The outcomes described in PCT commissioning documents or described as desired outcomes of redesign by DPT<sup>3</sup>
- Outcomes identified nationally and internationally by other recovery based services
- Outcomes suggested by Values Based Practice<sup>4</sup>

It can be expected that tension will arise between different viewpoints when selecting the outcomes to measure. For each person-in-recovery there are will be range of stakeholders all of whom may have a viewpoint on what is of interest. These stakeholders might include;

A person making a referral

The person concerned (Patient, Client, Service User or Customer)

Their carers or family

The General Practitioner

Those treating / helping / supporting the person

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<sup>3</sup> R&IL PEG advisory paper no.1 25.10.07 appendix 1

<sup>4</sup> NIMHE guiding statement on recovery and values based practice 2005 [www.nihme.csip.org.uk](http://www.nihme.csip.org.uk)

The commissioner of the resource or service providing the response.  
Civic and Societal Authorities  
The general public

Each might place value or emphasis on particular aspects of the situation and the outcome. Whose values and viewpoints should be considered or prioritised? A straightforward answer is in the aspiration to be 'person' or 'user-centred' but there are problems with taking a simplistic consumerist approach i.e. is being given what you want the same as getting what you need? <sup>5</sup>

There are well documented risks in taking too narrow a view, and inappropriately assuming that good or bad health outcomes are a direct response to health care interventions when the key variables may lie elsewhere. For example inequalities of health and wellbeing across different communities are a key concern. From 2004 this has been tracked by GPs being rewarded for compliance with the 'Quality and outcomes framework'. However none of the prescribed measures estimate clinically important outcomes so much as treatment processes that are *supposed to lead to* improved outcomes i.e. they measure clinical activities. The evidence is that whereas these incentives have improved the quality of documentation by GPs and their remuneration, they are having a much more limited effect on underlying standards of care. Furthermore there is concern that such a framework encourages the illusion that health inequalities can be solved by the health service and allows policy makers to ignore the extent to which health inequalities are a symptom of socioeconomic inequalities that continue to widen. This highly prescribed framework of outcome evaluation for GPs situates health inequalities at the level of the individual and ignores the political, social and cultural context within which people find themselves. In reality there is a socioeconomic gradient for the prevalence of almost every disease, the poor do poorly and patients living in adverse social circumstances are more likely to be taking maximal tolerated therapy without achieving the desired outcome<sup>6</sup>.

### **The seductions of 'satisfaction': is it a reliable indicator of 'good' services?**

We often take consumer satisfaction to be a very desirable goal – an outcome of a 'good service' but in general people value kindness over effectiveness. Expressed satisfaction with a service delivered to a high standard of customer care might not always reflect the most positive outcome in terms of personal recovery. In general, people do not want mental health services at all. They want work; accommodation; reasonable finances; good relationships and to be able to look after themselves successfully. People want to be able to get on with an ordinary life. However, if that is all people needed they could and should go to services that provide for these needs - job centres, housing departments, benefits agencies etc. People come to mental health services because mental health problems are getting in the way of being able to take responsible action to fulfil these needs through the use of 'mainstream' agencies. It follows that the 'success' of a service would be better judged by how well in enabled people to get on with and develop their lives, measured according to these major life domains, than by the individual's expressed satisfaction with the service itself (see the Outcomes Star, derived from working with homelessness later). Expressed satisfaction still has a value as a

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<sup>5</sup> Elwyn, G., Buetow, S., Hibbard, S., Wensing, M. (2007) respecting the subjective: quality measurement from the patients' perspective. *BMJ*, 335, 1021-2.

<sup>6</sup> Heath, I, Hippisley-Cox, J., Smeeth, L. (2007) Measuring performance and missing the point? *BMJ*, 335, 1075-76

service indicator, but it would also be possible for someone to express satisfaction with a service on which they had become unproductively dependant and for the service to remain unchallenging with little hope of life improvement and be experienced as supportive.

It follows that mental health services are often constructed in the context of a dilemma - people need a service they don't want or would prefer to get from elsewhere. It should then be reasonable to judge the success of such services in proportion with how well they enable people to get what they want from life whilst avoiding additionally detaching them from ordinary living. These criteria for success will include enabling people to leave mental health services once they can manage their own lives, and support people to manage their own lives in ordinary settings with ordinary resources.

A recovery oriented service therefore has goals that stretch well beyond reducing symptoms and risk and focuses on recovery of identity, personal and family relationships, capacity for work and participation, wellness, creativity and personal fulfilment. Recovery of an ordinary life and a valued place in society is a core ambition for most people who use services and come to us for help. Meaningful measures and service evaluation can be a major tool in promoting progressive service development.

### **The uncertain relationship between treatment and recovery**

There is a very uncertain relationship between treatment and recovery:

- Some people can and do recover with no treatment.
- Some people can and do have arrested or delayed recovery with the best 'evidence-based' treatment.
- Some people can and do only recover when they leave treatment.
- Some people can and do only recover when they get effective treatment.

We clearly prefer outcome evaluation over output or activity data as a user-centred basis for commissioning, governance and progressive service planning but it must be acknowledged that the relationship between service activity and personal outcomes is complex and unclear.

Within the service user literature there is little emphasis on favourable personal outcomes arising from being given expert treatment. And within the service provider, professional and conventional (clinical) outcome literature there is little emphasis on the personal parameters that people value and desire as part of their process of personal recovery.

It may be that an excellent (evidence-based) service will still not guarantee successful progress in personal recovery – as that critically depends on personal variables such as commitment, responsibility, choice, learning self-care and self-management skills, having hope and taking an active stance.

There is a considerable need for research into the dynamics of personal recovery to better understand how it happens, what may be the key or critical variables and what the optimal role is for professional and other supports.

## A cautionary tale

As we move towards seeking more service user feedback, we need to be mindful and 'person centred' in that too and concerned for what it is like to be on the receiving end – see 'Form of torment' (below).

### Form of torment

The NHS says it wants to really understand the experiences of mental health service users. So what, asks Clare Allen, is this pointless questionnaire doing on my desk?

Clare Allen

Wednesday March 28 2007

The Guardian

A few weeks ago, I received a questionnaire from a company called Quality Health. An accompanying letter informed me that I had been randomly selected to take part in a survey about my experiences of NHS mental health services over the past 12 months. My views, said the letter, were very important.

This was my chance to have a say in how mental health services would be provided in the future.

I confess I was excited. As a service user for the past 12 years, this was the first time I could remember ever being asked for feedback. Sure, I had offered feedback from time to time, but, generally speaking, it had been received with that special combination of irritation and embarrassment that is reserved for unwanted gifts. Now my opinion was being sought. I was cock-a-hoop! So why, weeks later, is the survey still sitting on my desk?

Find out at ...

<http://www.guardian.co.uk/society/2007/mar/28/mentalhealth.socialcare>

## What makes a good measure?

There is no simple answer separate from the needs and the context of the person asking the question - It depends on what information you want and why.

Basic measures are more doable whereas more complex measures are more meaningful. The art of measurement is in working out what is the most economic and doable measure to give the most useful information with which to answer any specific question at the required level of confidence. **(See appendix one)**

The skilful deployment and interpretation of measures can meet information needs at different levels. For example:

- A measure of personal recovery outcomes may be valued by the individual who uses it as a process of self reflection.
- The results may also be taken into work with those supporting them as an index of their self evaluation at that time and as a basis for measuring progress.
- At the same time, the data from a group of people will identify their collective needs and inform service design
- Repeat measures can comment on peoples' progression over time in association with particular services.
- Repeated group measures over time may be a commentary on service development

The content and format of some measures also fulfil a role as teaching tools for the staff using them and a support for cultural change. For example the user led service evaluation tools DREEM and ERFS correspond to a template of the desired attitudes, behaviours and interactions in recovery based services and therefore provide both a mirror for self and service reflection and a compass offering a sense of direction – the Hawthorne effect at its best.

Good measures and measurement processes will require the least adjustment to normal service function as possible in order to accommodate them. A good measure will be able to be embedded in normal service functioning where it will be valued by both service users and staff as an ongoing guide to progress and practice. A poor measure requires significant adjustments from both those who use it and those who receive it. Such measures are frequently experienced as intrusive or even irrelevant. Good measures are valued, well used and generate good data. Poor measures are resisted or used erratically and generate incomplete and poor data. The irritation cause by intrusive measures most often leads to the extrusion of the measure and rejection of the measurement project. As a general rule of thumb, measures that require any significant training to understand and use are only of value in well organised research projects and will be misused or neglected in routine practice.

*Before using any measure it is important to be clear and confident that the data generated will be used and valued, and there will be feedback to those who complete it.*

### **In what depth should we measure?**

Three basic dimensions can be described for any measure:

- The level at which a measure is applied; from the individual service user experience to the performance of a whole organisation or network.
- The degree of refinement of the measure itself. This may range from basic surveys gathering simple data, through middle measures that use formal schedules or tests and an interpretive methodology to complex measures which usually require skills training, care over 'rater' reliability and systematic analysis.
- The level at which the results from a measure are used to support understanding or explanation, for example gathering of simple data from service user experience could be used to give a performance profile at any level from individual practitioner to the whole organisation.

This is illustrated in the table on the next page which shows a profile of the complexity of some currently used measures in relation to the level of their application.

	Level of complexity		
Level of application	Basic	Middle	Complex
Network			
Organisation	Staff Survey <sup>7</sup> Financial Health <sup>8</sup>		
Service			
Team	Performance data - waiting times - productivity		
Practitioner		CPA Good practice checklist Symptom scales eg PSE	
User experience	Support services referral and outcomes <sup>9</sup> Marking recovery <sup>10</sup>	HoNOS <sup>11</sup> ERRES <sup>12</sup> Symptom scales eg BECK ERFS	DREEM <sup>13</sup> CANSAS <sup>14</sup>
Carer / family experience			

### Examples of measures of differing complexity applied at various levels:

- The Russell Clinic DREEM survey used a complex measure of user and practitioner experience to comment on service performance and inform service level action planning.
- HoNOS requires the skilled use of a standardised schedule by which practitioners make judgements of users current mental state, but the data is not used and it is therefore inconsistently completed with little commitment or value.

<sup>7</sup> NHS staff survey

<sup>8</sup> Healthcare Commission annual health check

<sup>9</sup> Referral and review form for support services contracts DCC/DPT

<sup>10</sup> Marking recovery: adapted from DREEM, used in CCT study

<sup>11</sup> Health of the Nation Outcome Scales

<sup>12</sup> Elements of Recovery and Recovery Enhancing Services. Adapted from DREEM, used in CCT study.

<sup>13</sup> Developing Recovery Enhancing Environments Measure; Ridgeway and Press. English edition 2004

<sup>14</sup> Camberwell Assessment of Need Short Appraisal Schedule 1994

- The Community Care Trust (South Devon) Ltd conducted an 18 month outcomes survey across all its services. This included a measure which was adapted from DREEM in collaboration with service users - the Elements of Recovery and Recovery Enhancing Services' measure (ERRES). This identifies those elements of recovery on which service users place most value and how well they consider they are supported to meet their needs in those areas. The information is being collated at service and whole organisation levels and has already informed service improvements at both.
- A recovery practitioner's good practice checklist' could be derived from a variety of sources of guidance in recovery based practice such as the New Zealand Recovery Competencies for mental health workers<sup>15</sup> or the 10 essential shared capabilities<sup>16</sup> Definitions could be developed for the practice of each competency at the three levels of skill. There would also need to be training and validation on the use of the checklist to ensure that responses are meaningful. A brief illustrative framework is shown below. (note: The CPA review schedule is somewhat similar for care coordinator and the work in progress at the SCMH will aim to develop something similar for psychiatrists, [see appendix two](#))

	<b>Item</b>	<b>1 Basic</b>	<b>2 Higher</b>	<b>3 Mastery</b>
	<b>Competency</b>	<b>(awareness)</b>	<b>(skilled)</b>	<b>(teacher)</b>
<b>1</b>	Understanding self-management approaches and how to support people to meet their own needs			
<b>2</b>	Understand the principles of social inclusion and how to reduce stigma and discrimination			
<b>3</b>	Understanding the value of personal stories and how to listen without judgement			
<b>4</b>	Understand how approaches and services can both help and hinder recovery			
<b>5</b>	Knowing how to identify and work with obstacles to personal recovery			

A good practice checklist could be used at multiple levels:

- A tool for self reflection
- A support for supervision
- A way of identifying training needs
- A way of identifying team or service development needs.

<sup>15</sup> Recovery competencies for mental health workers. New Zealand Mental Health Commission 2001

<sup>16</sup> The 10 essential shared capabilities. Department of Health 2004

Some services have developed a suite of recovery indicators, each focusing on a different level which collectively add up to an appraisal of the recovery activity and outcomes of that service. For example

- Denver has developed:
  - the recovery needs level
  - recovery marker inventory
  - recovery measure by consumer
  - promoting recovery in organisationsSee (click on presentation) [Roy Stark & Dr Almos from the Denver MH centre](#)
- Camden Joint Commissioners have used the Outcomes Star. This was originally developed by the London Housing Foundation as a user led / informed evaluation of housing projects for street homeless people as their contract monitoring measure for recovery outcomes of people using support and day services. This is a very attractive tool whose current content is a close approximation for measuring progress in personal recovery and whose format would be reusable to present other data sets – for example organisational performance against 10 core standards (see below). (<http://www.lhf.org.uk/Publications/OutcomesStar.pdf>)
- The Scottish Recovery Network are commissioned by the Scottish executive to produce an outcome evaluation tool – the Scottish Recovery Indicator (SRI) which is derived from another established recovery tool (ROPI) and is currently being piloted – this is a complex instrument which seeks to evaluate recovery oriented practice [http://www.scottishrecovery.net/content/default.asp?page=s16\\_4](http://www.scottishrecovery.net/content/default.asp?page=s16_4) (see below).

### **Current wisdom about measures and measurement<sup>17</sup>**

The NHS as a whole is being driven to measure outcomes rather than outputs and there is general interest across the whole of health and social care in how this could be measured. This has led to a series of review articles in the general medical press which summarise important aspects of current thinking:

- Those things that are easiest to measure are almost inevitably the least important and visa versa.
- By implication there is often an inverse relationship between what is meaningful and what is measurable, particularly when it comes to subjective and person-centred variables.
- There is a risk that focusing on process rather than outcomes reduces complexity to a series of tick boxes and encourages over treatment and medicalisation.
- Measuring performance in terms of recording risk factors rather than adequate treatment encourages inertia.
- Providing uniformly high quality of care is hard if not impossible even within a dedicated service, so people prioritise. This means that performance on one measure may tell you little about performance on others.

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<sup>17</sup>Goodlee, F. (2007) Careful what you measure. Editorial, BMJ, 335, Agins, B., Holden, M. Defining a high performance healthcare organisation, BMJ, 335, 1055-6, Heath, I, Hippisley-Cox, J., Smeeth, L. (2007) Measuring performance and missing the point? BMJ, 335, 1075-76. Lester, H., Roland, M. (2007) Future of quality measurement. BMJ, 335, 1130-31)

- Simple measures of global outcomes are likely to give false impressions.
- Steering a service through performance measurement can pervert the process so as to incentivise staff to perform to performance measures for personal gain or to avoid critical attention rather than healthcare benefit.
- The Hawthorne effect is temporary and change stimulated by measurement will tend to return to 'normal' until there is another change in the environment and hence the need to change the things we measure over time if performance is to improve.
- There may be value in rotating measures to encourage improvement over a range of conditions and areas.
- Sustained improvements will only come with the proper infrastructure which unifies organisational elements such as strategy, vision, leadership, commitment, quality and feedback.
- Time is needed for whole system transformation that includes changing culture, redesigning processes and crafting solid information systems that support useful and robust measurement.
- Indicators that seek to extend existing practice will always be more controversial than those reinforcing established practice. New indicators should therefore be introduced and evaluated with care through well designed pilots, so as to highlight any professional concerns, education and training needs, and IT problems.
- What really matters, for example compassion and dignity are hard to measure, but we must find ways to do so.
- Alongside consideration of measures there is equal need to consider the process and cycle of measuring: do indicators change or are they replaced or added too as standards are met? One option is to rotate measures regularly thus increasing the potential for informing action planning and improvement over a range of criteria or conditions. A master list of well validated measures could be established and strategic choices made about the next cycle of measurement in tune with desired outcomes – this is the recommended option<sup>18</sup>

### **Developing measures of recovery**

Recovery practice is developing rather than established and measures are largely at a pilot or experimental stage. There is broad agreement that established and familiar measures are unsatisfactory and there is a need to develop person centred measurement that focus on personal outcomes and lived experience. Traditionally psychiatric practice and services have focused largely on outcomes expressed as the amelioration of symptoms, service utilisation or changes in specific areas of functioning<sup>19</sup>. There has been a long search for good measures of Quality of Life and standard of living and the literature includes indicators that we would now recognise as measures of social inclusion. There is a long-term aspiration to securely identify what matters most to people and reconcile multiple viewpoints, in particular to find relatively simple ways of combining objective and subjective evaluations. Many of the recovery measures in development aim to do exactly that. **(See appendix two)**

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<sup>18</sup> Lester and Roland, 2007

<sup>19</sup> York 2002

## Measure of social inclusion: the same or different?

Social inclusion and recovery are closely associated and conceptually intertwined; this means enabling people to achieve and sustain:

- financial security
- adequate accommodation
- employment
- education
- relationships
- spiritual support
- social and leisure activities

Social inclusion is not a treatment or an intervention it is concerned with rights, choice, opportunity, Citizenship and equality.

Miles Rinaldi, key author of the Office of the Deputy Prime Minister's report on social exclusion is part of the SCMH steering group on development of recovery oriented practice (along with DPT and CCT) and takes the view that whereas social exclusion is universally bad, social inclusion is of value in as much as it supports valued ways of living and recovery. From the above it is clear that although social inclusion indices may describe many of the preconditions and supports for recovery, they do not guarantee it and it would be possible for individuals to have free and full access to the matrix of socially inclusive resources but still be stalled in their experience of personal recovery. Individual recovery outcomes by their nature will include securing valued social inclusion resources but will put these in a wider experiential context. Some broader measures of service / support effectiveness already exist as do a variety of frameworks for recovery based services and standards ([see appendix three](#)):

- CSIP National Social Inclusion Programme has identified social inclusion capabilities for practitioners and an evaluation tool by which to measure 'Socially Inclusive Organisations'<sup>20</sup>
- Carers and Users Expectations of Services (CUES)<sup>21</sup>
- The Public Service Agreements<sup>22</sup> set the Strategic Partnership Local Area Agreement targets –. eg *“Rate of worklessness reduced, particularly amongst those receiving incapacity benefit & people with disabilities, by providing improved pathways to work”*.
- The national initiative to promote self directed support has led to the local development of various tools for the self measurement of outcomes which have a strong social inclusion focus (eg enabling support referral and evaluation forms, 'in control' self assessments etc)

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<sup>20</sup> Reference awaited

<sup>21</sup> RCPsych, RCN, Rethink and University of East Anglia

<sup>22</sup> Reference awaited

**What measures do we currently use for recovery (R) or social inclusion (SI) outcomes** *or have firm commitments to develop (in italics)?*

The short answer is none – as illustrated by the table below.

Level of application	Level of complexity		
	Basic	Middle	Complex
Network			
Organisation			
Service			
Team		<i>Modified SCMH social inclusion tool (SI)<sup>23</sup></i>	
Practitioner			
User experience		<i>Service user Social Inclusion Questionnaire (SI)<sup>24</sup></i>	
Carer or family experience			

**Core standards for networked recovery oriented services**

The paper began with a description of the need to establish practice, service and organisational standards, derived from and consistent with the values of recovery and social inclusion - against which performance can be measured. Recovery values and principles are accepted as the overarching philosophy for the network services as a whole. They are imbedded in each of the Network Functional PIGs and endorsed by Clinical Cabinet (DPT) and the PCT / LIT. The declared ambition is that these values and principles will underwrite future mental health and social care services as having a common purpose, underpinned by common standards, supported and supervised through application of common measures which will give information to inform practice and service development and network relationships across and between.

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<sup>23</sup> See below

<sup>24</sup> Both are described as in development for DPT as part of the Social Inclusion Health Check project. Lead: Amanda Hesford

## How do we identify these core standards held in common?

The R&IL PEG has been asked by the joint commissioner to support the development of '10 core standards for network services' derived from the PCT / LIT and DPT goals of redesign and in a form amenable to subsequent audit and evaluation. An initial outline ([Appendix four](#)) will be used as a basis for a facilitated PEG workshop to critically evaluate this initial suggestion and further develop such standards for submission to the programme office for further review leading to high level endorsement. When such standards are agreed it would be possible to create a 10 point evaluation scale against each and use the Outcome Star as a means of recording and displaying the findings of evaluation – which can then be compared across time and across different organisations within the network.

## Taking it forwards

This paper has provided a comprehensive briefing on recovery outcome evaluation. At present there is a great deal of interest, experimentation and development, but there is no simple or accepted way forwards. Traditional measures of activity and process will continue to have value in answering some question but cannot offer a commentary on how well services are performing in enabling personal recovery or how well they are fulfilling core standards. There is a need to build the infrastructure for outcome evaluation and to adopt, adapt and develop suitable measures. Measures chosen should add up to a structured portfolio able to offer a commentary on outcome at every level following the Denver example (p 12).

### At present the most promising measures would appear to be:

**ERFS:** as a user led evaluation of their service experience (p 30).

**The Outcome star:** as a collaborative evaluative tool for service users to use with key workers and track their progress in dimensions of personal recovery – this is usable as it is but could be further improved if customised for mental health services (p12, 19, 29).

**10 core standards for network recovery services:** these need to be developed and the associated evaluative scales which could be displayed on Outcome Star format – and would then provide a measure of organisational and network recovery performance (p15/16, 34).

**SRI:** a reflective tool to measure practice and inform service development (p 12, 18, 26).

### Promising measures in development include:

**STORI,** the stages of recovery index: a self reflective personal outcome evaluation tool (p19, 24).

**SCMH (PIG-ROP):** the Sainsbury Centre for Mental Health policy implementation guide for recovery oriented practice and associated service standards and measures (approx march 2009) (18, 25, 28).

**Digital Dashboard:** a PC based self, service and organisational tool - Piers Allot (p 18)

**NIMHE / CSIP** recommendations via their recovery outcome work stream (19)

### Dimensions of need with measures of uncertain value:

**CPA:** tracking practitioner performance re Care Programme Approach standards (p 20)

**Recovery Practice Checklist:** a proposal (p 11)

**We recommend that the commissioners, with the support of the R+IL PEG use this briefing paper as a foundation for a network workshop to agree the detail of the 'commission' for outcomes measures.**

## Appendix one

**The itch-scratch relationship: what is the right tool for the job, and do I have the knowledge, skill and capacity to use it?**

**Useful questions to ask when selecting a measure:**

- Why do I want to use a measure?
- Do I need permission to do this study – research / ethics?
- What question am I trying to answer?
- Who am I trying to answer?
- What kind of data will answer my question?
- Who, where and what do I need to measure to answer my question?
- Is there an established measure well shaped for this job?
- Can I customise an established measure to make it well suited to the job?
- Do I need to design a measure fit for the job to answer my question?
- If so do I need to be concerned about its formal qualities as a measure – reliability, validity etc?
- Can I describe the time course and schedule of measurement and repeated measurement needed to produce data to answer my question?
- Do I have the capacity to analyse and interpret the data that my chosen measure will give me so that it proves useful in practice?
- If not: should I use a more simple measure or use it on a smaller sample or can I gain more supportive resources?
- Do I 'know a man who does?'
- Can I anticipate from the outset the report I will write in answer to my question with the data from this measure?
- Will I have too much or unnecessary information?
- Do I have access to expert advice to inform whether I've got the right measure for the job, and if I'm going about using it in the right way, before I start to use it?

## Appendix two

### Work in Progress

- **The Sainsbury Centre for Mental Health (SCMH)** has established a group of nationally recognised recovery leads, including MIND, Rethink, and representation from the mental health professions, to produce a national advisory document on 'implementing recovery oriented practice'. This will be developed through an exploratory seminar series – each will lead to an element of the final advisory paper. This work overlaps with a report being prepared by the Royal College of Psychiatrists Social Inclusion Scoping Group (due 2008). It will consider core standards and measures and include 'a practitioner guide to recovery and socially inclusive practice for psychiatrists' and what has been described as a 'Policy Implementation Guide for Recovery-Oriented Practice' (PIGROP) applicable across whole services. An initial briefing paper from SCMh on 'Implementing recovery oriented practice' setting out the work plan will be developed by Jan 2008. Alison Moores, Laurie Davidson and Glenn Roberts are invited members of this project. One of the four development workshops, bringing together national leads with local services will be held in Devon on June 5<sup>th</sup> 2008 coordinated by Liz Davenport and Ian Pearson.
- **Mary O'Hagen**, past commissioner of the mental health (recovery) services in New Zealand will be working with the mental health networks in Devon between June 23<sup>rd</sup> – 27<sup>th</sup> to offer an expert consultancy and review and support action planning for development of a network wide recovery orientation which will include outcome evaluation. Lead: Ian Pearson and the LIT
- **Piers Allott and Antony Sheehan**, NIMHE Recovery Fellow emeritus and previous Director General of Care at the DH respectively, are planning to work up a guide for commissioners to recovery oriented services provisionally titled 'Recovering the commissioning process'
- **Piers Allott is developing 'the digital dashboard'** as a WRAP based personal evaluation tool for recovery which is customised to an individuals preferences and values. Successive measures track progress over time, accumulative measures may be a proxy for how recovery supportive a service is. In state of advanced development. See (click) [Piers Allot from Wrapworks](#)
- **MIND** has convened a national MindThink Seminar to 'consider the strengths and limits of current understandings of recovery and its impact on front line service provision and on service users' and the purpose is 'to bring together experts, stakeholders and opinion formers to scrutinise examine and debate some of the most challenging issues for mental health policy – with a particular focus on future directions'. It is planned that this will lead to an advisory paper from MIND. Glenn Roberts was an invited member.
- **The Scottish Recovery Network (SRN)** have been commissioned by the Scottish Executive, in response to their CNOs report 'Rights, Relationships and Recovery', to produce service evaluation tools in support of developing recovery oriented services. Their Scottish Recovery Indicator (SRI) is a development of ROPI and is available in a draft version with the aim of full development and deployment as a measure for service providers to estimate service outcomes by 2010 download at : [http://www.scottishrecovery.net/content/default.asp?page=s16\\_4](http://www.scottishrecovery.net/content/default.asp?page=s16_4)

- **Camden (London) Mental Health Commissioners** are using a simple visual 'Outcome star tool for service users to measure change against various areas of their life' and are piloting its use. ([rebecca.harrington@camden.gov.uk](mailto:rebecca.harrington@camden.gov.uk))
- **Mike Slade, (South London and Maudsley Trust)** is setting up a cross validating research project to investigate the Stages of Recovery Index (STORI) a promising Australian measure of recovery outcomes at the level of personal experience. (For copy ask Glenn)
- **NIMHE (CSIP) national work stream** on outcome measurement  
See <http://www.outcomemeasures.csip.org.uk/>

#### CSIP Outcomes Website

Measuring outcomes can help us to improve our understanding of the impact of services on the lives of people who use them. It can help to give reassurance that treatments and care provided are producing results, and outcomes related to care and support are monitored on an ongoing basis. Although it includes collecting information, at its heart, it is a long-term development involving important cultural changes in working practices for practitioners.

The NIMHE (National Institute for Mental Health in England) outcomes project covers people of all ages and a range of settings where services may be provided. At a national level, our main aims are to raise awareness about measuring outcomes, share learning and address common practical issues for services across the county

CSIP recently sponsored a major conference – **Measures, Outcomes and Mental Health Recovery** 7th December 2007, Hilton London Kensington.

Recovery is a personal process that is active, ongoing and involves personal development and change. It is about people seeing themselves as capable of recovery rather than as passive recipients of professional interventions. For this reason it challenges traditional approaches in mental health. This seminar focused on how we measure outcomes in recovery. Presentations included an insight into work carried out in the UK and Denver.

The event programme and presentations are downloadable from <http://www.outcomemeasures.csip.org.uk/events/measuring-outcomes-in-mental-health-recovery.html>

These include presentations from (click to download)

[Piers Allot from Wrapworks](#)

[Roy Stark & Dr Almos from the Denver MH centre](#)

[Sarah Gillespie & Christina Vasiliou from Mental Health Foundations](#)

More information on the work being carried out in Denver at

<http://www.mh.state.oh.us/oper/outcomes/outcomes.index.html>

and the Denver recovery blog space at:

<http://www.mhcdrecovery.blogspot.com/>

Web contacts with UK initiatives:

[Recovery Devon website](#)

[Scottish recovery network](#)  
[The evaluation Centre](#)

Major background materials such as:

Downloads of the DREEM outcomes tool and updates:

[DREEM](#)

[Taking DREEM forward](#)

Access to a wide range of additional recovery measures and guidance:

- Recovery in Action : The Mental Health Foundation** has been commissioned by the Strategic Network for Mental health to work across 7 pilot sites in support of developing recovery oriented services and to evaluate change before and after intervention see [Sarah Gillespie & Christina Vasiliou from Mental Health Foundation](#) they plan to use a modified version of DREEM they also report on using a more exploratory qualitative method to evaluate the recovery experience of Richmond Fellowship service users.

**Summary of tools that aim to measure Recovery – existing and in development (*italics*):**

LEVELS	Level of complexity		
Level of application	Basic	Middle	Complex
Network		<i>Audit against 10 core standards</i> <sup>25</sup>	
Organisation		<i>SCMH</i> <sup>26</sup>	
Service		<i>European Measure of Best Practice for People with Long Term Mental Illness in Institutional Care</i> <sup>27</sup>	Recovery-Oriented Practices Index (ROPI) <i>Scottish Recovery Indicator (SRI)</i>
Team			
Practitioner		<i>CPA checklist</i> <sup>28</sup> <i>SLaM care planning review</i> <sup>29</sup> <i>Good practice checklist</i> <sup>30</sup>	

<sup>25</sup> Proposal agreed at Clinical Cabinet Nov 2<sup>nd</sup> 2007 lead: David Jeffrey

<sup>26</sup> SCMH project to develop standards and tools for evaluating Recovery Oriented practice and organisations see below: lead Geoff Shepard

<sup>27</sup> . EU 6 country survey to determine recovery best practice for people in institutional / residential care and associated measures and tools: Lead: Penny Turton

<sup>28</sup> Recently launched DPT practitioner evaluation schedule of CPA and care planning including many elements of recovery practice

<sup>29</sup> The in patient rehabilitation services at SLaM have piloted a care planning review schedule looking for a recovery orientation which was effective in gradually influencing the creation of recovery oriented practice. Lead: Mike Slade

User experience Evaluated by others		Stages of Recovery Index (STORI) <sup>31</sup>	
User experience Self evaluated	Mental Health Recovery Measure	The Outcome Star  Elements of a Recovery Facilitating Service (ERFS)	DREEM Recovery-oriented systems indicators (ROSI)
Carer and family experience		CUES	

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<sup>30</sup> We are suggesting the value of developing a recovery good practice checklist that could be used for self evaluation, supervision and other purposes.

<sup>31</sup> This Australian measure is currently being cross validated in a small study at SLaM. Lead Mike Slade. We are suggesting the value of developing a recovery good practice checklist that could be used for self evaluation, supervision and other purposes

## Appendix three

### Existing conceptual and practice frameworks for recovery based services

#### 1. NZ recovery competencies for clinicians 2001

A competent mental health worker will have recovery-based competencies:

1. Understanding of recovery principles and local experiences
2. Recognition and support for personal resourcefulness
3. Understands and accommodates diverse views on mental illness, treatment, services and recovery
4. Skills and self awareness to communicate respectfully and develop good relationships with service users
5. Understands and protects service users rights
6. Understands discrimination and social exclusion and how to reduce it
7. Acknowledges difference cultures and knows how to draw into partnership to provide services
8. Comprehensive knowledge of community services and resources and actively supports service users to use them
9. Knowledge of service user movement and able to support participation of service users
10. Knowledge of family and social group perspectives and able to draw them into participation in services.

For each competency they also list

- sub categories or elements
- examples and definitions
- supportive resources

For example, the category 2 Subcategories are:

- 2.1 They demonstrate knowledge of human resilience and strength and knowledge of how to facilitate it.
- 2.2 They demonstrate the ability to support service users to deal constructively with trauma, crisis and keeping themselves well.
- 2.3 They demonstrate the ability to support service users to experience positive self-image, hope and motivation.
- 2.4 They demonstrate the ability to support service users live the lifestyle and the culture of their choice.

[http://www.mhc.govt.nz/publications/2001/Recovery\\_Compencies.pdf](http://www.mhc.govt.nz/publications/2001/Recovery_Compencies.pdf)

## 2. Values based practice

### The 10 Principles of Values based practice

#### The Theory

1st Principle	All decisions stand on two feet, on values as well as on facts, including decisions about diagnosis (the "two feet" principle)
2nd Principle	We tend to notice values only when they are diverse or conflicting and hence are likely to be problematic (the "squeaky wheel" principle)
3rd Principle	Scientific progress, in opening up choices, is increasingly bringing the full diversity of human values into play in all areas of healthcare (the "science driven" principle)
4th Principle	VBP's "first call" for information is the perspective of the patient or patient group concerned in a given decision (the "patient-perspective" principle)
5th Principle	In VBP, conflicts of values are resolved primarily, not by reference to a rule prescribing a "right" outcome, but by processes designed to support a balance of legitimately different perspectives (the "multi-perspective" principle)

#### The Practice

6th Principle	Careful attention to language use in a given context is one of a range of powerful methods for raising awareness of values (the "values-blindness" principle)
7th Principle	A rich resource of both empirical and philosophical methods is available for improving our knowledge of other people's values (the "values-myopia" principle)
8th Principle	Ethical Reasoning is employed in VBP primarily to explore differences of values, not, as in quasi-legal bioethics, to determine "what is right" (the "space of values" principle)
9th Principle	In VBP, communication skills have a substantive rather than (as in quasi-legal ethics) a merely executive role in clinical decision-making (the "how its done" principle)
10th Principle	VBP, although involving a partnership with ethicists and lawyers (equivalent to the partnership with scientists and statisticians in EBM), puts decision-making back where it belongs, with users and providers at the clinical coal-face (the "who decides" principle)

(Adapted from Fulford, K.W.M. (forthcoming). Ten Principles of Values-Based Medicine. In Radden, J. (Ed) Companion to the Philosophy of Psychiatry. New York: Oxford University Press)

<http://visit.lincoln.ac.uk/C6/C12/CCAWI/ESC%20Learning%20Materials/ESC%20Module%204%20-%20June%202007.pdf>

### 3. Components of the process of recovery

(After Andresen, Oades & Caputi, 2003)

- I. ***Finding and maintaining hope*** – believing in oneself; having a sense of personal agency; optimistic about the future
- II. ***Re-establishment of a positive identity*** – finding a new identity which incorporates illness, but retains a core, positive sense of self
- III. ***Building a meaningful life*** – making sense of illness; finding a meaning in life, despite illness; engaged in life
- IV. ***Taking responsibility and control*** – feeling in control of illness and in control of life

#### ➤ Stages of recovery

(After Andresen, Caputi & Oades, 2006)

- I. ***Moratorium*** – A time of withdrawal characterized by a profound sense of loss and hopelessness
- II. ***Awareness*** – Realization that all is not lost and that a fulfilling life is possible
- III. ***Preparation*** – Taking stock of strengths and weaknesses regarding recovery and starting to work on developing recovery skills
- IV. ***Rebuilding*** – Actively working towards a positive identity, setting meaningful goals and taking control of one's life
- V. ***Growth*** – Living a meaningful life, characterized by self-management of the illness, resilience and a positive sense of self

**4. The 10 Essential shared capabilities:** A framework for the whole mental health workforce. Department of Health (R. Hope) 2004

1. Working in partnership
2. Respecting diversity
3. Practicing ethically
4. Challenging inequality
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

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4087169](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4087169)

## 5. Initial ideas for Sainsbury Centre for Mental Health Policy Implementation Guide for Recovery Orientated Practice.

1. Clarity about necessary building blocks:
  - a. Values and attitudes
  - b. Knowledge
  - c. Working practices
2. Recovery indicators at several levels:
  - a. Service user – what is the actual experience of people using services?
  - b. Team – what do teams do, how do they work, what skills do they need, what do they see their core purpose as?
  - c. Service – how are services managed, what demands are prioritised, which aspects are performance managed, what is seen as a good outcome?
  - d. Commissioning – how can services be commissioned which promote recovery (e.g. which minimise dependency and maximise empowerment), role of direct payments / voluntary sector
3. Concrete implementation guidance
  - a. Case studies of recovery-focussed initiatives
  - b. Lessons learned
  - c. List of 'good ideas'

This would lead to 2 outcomes

1. A Practitioner Guide to Recovery and Socially Inclusive Practice for Psychiatrists
2. A guide to implementation of recovery oriented practice and services addressing 5 questions:
  - *What constitutes 'recovery-oriented practice' among professionals?*
  - *How do services have to change in order to reflect a 'recovery-orientation'?*
  - *What changes need to take place within the culture of existing mental health services in order to support recovery-oriented practice?*
  - *What are the implications for changing the culture of mental health organizations in terms of training, HR and other procedures?*
  - *How best to support user-led training initiatives aimed at developing and supporting local service user 'Recovery champions'?*

## **6. towards Recovery Competencies in Scotland: The Views of Key Stakeholder Groups**

Marguerite Schinkel and Nika Dorrer 2007

This rather impressive project and review document was explicitly undertaken to lay the foundation for the development of recovery-oriented mental health services in Scotland, sponsored by the Scottish Executive and delivered in association with the Scottish Recovery Network.

It reviews the international and national perspective and reports findings from substantial focus group work in Scotland – giving examples and suggestions on training issues for each professional group and the workforce as a whole. It concludes:

*A review of frameworks and guidelines produced in the USA, New Zealand, Australia and the UK, revealed convergence on eight core principles on the basis of which more specific competencies are formulated. These principles are:*

- *Belief in and understanding of recovery*
- *Respectful relationships*
- *Focus on strength and possibilities (not deficit focused)*
- *Care and support directed by service user*
- *Participation in recovery of significant others*
- *Challenging stigma, discrimination, social exclusion*
- *Provision of holistic services and supports*
- *Community involvement*

<http://www.scottishrecovery.net/content/mediaassets/doc/Towards%20recovery%20competencies.pdf>

## **7. Dimensions of hope-inspiring relationships**

Repper, J., Perkins, R. (2003) Recovery and Social Inclusion

1. Valuing people as human beings
2. Acceptance and understanding
3. Believing in the person's abilities and potential
4. Attending to people's priorities and interest
5. Accepting failures and setbacks as part of the recovery process
6. Accepting that the future is uncertain
7. Finding ways of sustaining our own hope and guarding against despair
8. Accepting that we must learn and benefit from experience

## 8. National Target Indicators for MH Trusts

(From Performance indicators for assessment 2007/2008)

Audit of suicide prevention  
 Care in the community  
 CMHT integration (older people)  
 Data quality on ethnic group  
 Drug misusers sustained in treatment  
 Experience of patients – Pilot study (evaluation of Patient Experiences in inpatient care at the Cedars) by Lottie Granville-Chapman that I know of  
 Infection control – covered by GM  
 Obesity: compliance with NICE guidance 43  
 Schizophrenia – improvement towards compliance with NICE guidelines

<http://www.healthcarecommission.org.uk/nationaltargets2007-2008/newnationaltargets/mentalhealthtrusts.cfm>

Performance indicators for assessment 2007/2008, last updated October 24<sup>th</sup> 2007

## 9. Standards for Better Health framework (S4BH)

From Healthcare commission [www.healthcarecommission.org.uk](http://www.healthcarecommission.org.uk)

List of all Nationally Agreed Guidance as per the S4BH Inspection Guide (D2a)	Named DPT Lead
NSFs	
National Service Framework for Mental Health 1999 (Criterion 1/Assurance Statement 1 and 2)	
National Service Framework for Older People: Standard 7 – Mental health in older people 2001 (Criterion 1/ Assurance Statement 1 and 2)	
National Service Framework for Children, Young People and Maternity Services: Standard 9 – Mental Health and Psychological Well-being of Children and Young People 2004 (Criterion 1/ Assurance Statement 3 and 4)	
National plans And Other nationally agreed guidance (subsequent guidance under Criterion 1)	
Mental health policy implementation guide: Adult acute inpatient care provision	
Mental health policy implementation guide: Dual diagnosis good practice guide	
National Service Framework for Mental Health 5 Years on	
<b>NB Trusts may wish to show evidence that other subsequent guidance is being implemented as those listed above are provided as examples only</b>	
NICE clinical guidelines	
Depression in Children and Young People 2005 (Criterion 2/ Assurance Statement 5)	
Obsessive Compulsive Disorder 2005 (Criterion 2/ Assurance Statement 5)	

Anxiety 2004 (Criterion 2/ Assurance Statement 6 and 7)	
Depression 2004 (Criterion 2/ Assurance Statement 6 and 7)	
Eating Disorders 2004 (Criterion 2/ Assurance Statement 6 and 7)	
Post-traumatic stress disorder 2005 (Criterion 2/ Assurance Statement 6 and 7)	
Self-harm 2004 (Criterion 2/ Assurance Statement 6 and 7)	
Violence 2005 (Criterion 2/ Assurance Statement 6 and 7)	
*Schizophrenia 2002 (Criterion 2/ Assurance Statement 8 and 9)	

\*Schizophrenia Guideline part of National Target Indicator for MH Trusts 2007-08 with Obesity Guideline. Infection Control Guideline implicit in another target.

### **10. A tool for reflective practice and supervision: Ten Top Tips for recovery-oriented practice (after Shepherd, 2007).**

***After each interaction, the mental health professional should ask her/himself, did I .....***

- ✓ ..... *help the person identify and prioritise their personal goals for recovery - not professional goals*
- ✓ ..... *demonstrate a belief in the person's existing strengths in relation to the pursuit of these goals*
- ✓ ..... *pay particular attention to the importance of goals which take the person out of the 'sick role' and enable them to serve and help others*
- ✓ ..... *identify non-mental health resources – friends, contacts, organisations - relevant to the achievement of these goals*
- ✓ ..... *encourage self-management of mental health problems (by providing information, reinforcing existing coping strategies, etc.)*
- ✓ ..... *listen to what the person wants in terms of therapeutic interventions, e.g. psychological treatments, alternative therapies, joint crisis planning, etc. Show that you have listened*
- ✓ ..... *behave at all times so as to convey an attitude of respect for the person and a desire for an equal partnership in working together*
- ✓ ..... *indicate a willingness to 'go the extra mile' to help the person achieve their goals*
- ✓ ..... *identify examples from my own 'lived experience', or that of other service users, which inspires and validates hope*
- ✓ ..... *while accepting that the future is uncertain and setbacks will occur, continue to express support for the possibility of achieving these self-defined goals - maintaining hope and positive expectations.*

## 11. The Outcomes Star

The original concept of the 'Outcome Star' was developed for St Mungo's and then the London Housing Foundation by Triangle Consulting (2006). It was commissioned as part of the Impact through outcomes programme (<http://www.lhf.org.uk/IMPACTProgramme/IMPACTthroughOutcomes>) which began in 2001 to systematically evaluate service outcomes with respect to single homeless people and day services as a means of informing action planning and service improvement. Its origins and formulation are described at [http://www.homelessoutcomes.org.uk/Development\\_of\\_the\\_Outcomes\\_Star.aspx](http://www.homelessoutcomes.org.uk/Development_of_the_Outcomes_Star.aspx) and its current form has arisen from progressive development through use by 14 agencies over 4 years.

The outcomes star is both a method of displaying information in a way that is immediately accessible to the people it is about and has also been developed around specific domains or dimensions of outcome and progress of relevance to homeless people. The originators anticipated that this is a useful and flexible tool that would be amenable to further elaboration depending on the field of interest. In its original form the outcome star is suggested to the person using services as a way of reviewing their life in connection with common areas of interest or concern – these are:

1. Motivation and personal responsibility
2. Self care and living skills
3. Managing money and personal administration
4. Social networks and relationships
5. Drug and alcohol misuse
6. Physical health
7. Emotional and mental health
8. Meaningful use of time
9. Managing tenancy and accommodation
10. Offending

These 10 areas are described as '10 ladders' with the idea that an individual takes stock of their life with their key worker and works out what step they are on for each of the 10 ladders and marking this up on the star chart is a visual display of their current position. The aim is then to use this information for action planning and subsequent progress tracking.

Each domain has an associated ladder with 10 steps. Each mirrors a process of personal recovery from being passively stuck or overwhelmed by life problems to being in control of life and self directing.

The London Housing Foundation is clearly a highly creative organisation which is committed to developing services directed by 'user focused outcomes evaluation' and

describe how this is significantly different from either an 'output focus' or a 'user satisfaction focus'  
([http://www.homelessoutcomes.org.uk/resources/1/PDFsTwo/Paradigm\\_shift\\_paper.pdf](http://www.homelessoutcomes.org.uk/resources/1/PDFsTwo/Paradigm_shift_paper.pdf))

They also offer a newsletter update on outcomes work and a gallery of art by or about people who are homeless. They have commendably made all their materials freely available. All forms and charts are downloadable  
(<http://www.homelessoutcomes.org.uk/page122218.aspx>) as well as guidance and materials with which to run a training course.

Their experience to date is that this method of personal reflection, recording and progress tracking is of immediate interest to their service users and a significant support for staff in working with a sense of purpose, focus and direction. It has also been taken up by the Joint Mental Health and Social Care commissioner in Camden as a useful guide to support commissioning of day and support services and they are looking into extending its use as a measure of mental health outcomes more widely.

Whilst the Outcomes Star is primarily a qualitative tool, Camden ISB is developing a valuation system designed to assign a financial value to selected aspects of the star outcomes. The methodology assesses the likelihood that a user will have an outcome (for example 'being admitted to hospital') in a month when assessed on the relevant branch of the star. As the user progresses up the scales of the star (i.e. their 'star' becomes larger), there is an assumption that these costs will change and as the user approaches higher numbers and full recovery, should reduce.

Such recovery outcomes tracking can therefore be seen to have simultaneous value to people using services, those who work with them and those who commission and pay for services, as a recovery process in which people become more able to manage their own lives and less dependent on long term services meets everyone's needs.

**Reference:**

London Housing Foundation (2006) The outcomes star collection. At <http://www.lhf.org.uk/Publications/OutcomesStar.pdf> and subject to a creative commons licence via [info@homelessoutcome.org.uk](mailto:info@homelessoutcome.org.uk)

## **12. Summary of the ERFs (Elements of a Recovery Facilitating System) A consumer rated service assessment scale**

ERFS or "Elements of a Recovery Facilitating System" has been developed by the Yale Programme for Recovery and Community Health as a easy to use consumer led measure of their service experience using the framework of a recovery-oriented mental health system.

It aims to be educational – offering a template of a recovery oriented service system and for use in service evaluation and planning through repeated use of the measure to stimulate awareness of current strengths and areas for improvement in line with shifts in public policy and the systems transformation goals.

**Its objectives are:**

1. To increase understanding and awareness of 20 key principles of recovery-oriented practice.
2. To learn a critical set of positive (recovery-facilitating) practices and program characteristics associated with each principle as well those that hinder them.
3. To achieve a practical understanding of how to assess and create a plan for advancing recovery-facilitating practices in one's own local system.

**Through**

1. actively involve consumers and other stakeholders
2. education about recovery oriented care
3. developing a constituency supporting transformation efforts

**Background**

This is a development from DREEM, from the same recovery development group at Yale.

It was funded by a federal grant (Mental Health Transformation State Incentive Grant (MHT-SIG)) awarded to Connecticut to create a leading instrument with which to guide implementation of the President's New Freedom Commission Report, *Achieving the Promise: Transforming Mental Health Care in America* and its associated commitment to a national programme of developing recovery oriented services. It is public domain and free from copyright.

Field trial and progressive development over 2 years (2006-8) have resulted in simplification and improved comprehension

**There are a number of forms:**

1. Long – may be of research interest but in practice has been found too long
2. Short - easy to use 20 item, 5 point 'scorecard' user evaluation of service received
3. Child and youth version – where the language of recovery and consumer driven concepts were converted to resiliency and family orientation – parent or carer evaluation of service given to child.

**Problems**

1. The name – ERFSS is an unappealing unattractive term
2. The scoring – higher scores = less recovery supportive services i.e. it is counterintuitive
3. The inherent limitations of any pen and paper quantitative assessment and the need to elaborate the meaning of results through qualitative methodologies
4. Lack of normative or comparable data – it has been used and trialed on a couple of hundred service users and staff which has provided a rationale for modification to improve comprehension and ease of use – but it remains unclear how to interpret the findings – it therefore cannot be used to 'get at the truth' so much as provide a systematic way of describing how a service is experienced which leaves open the issue of how to interpret the findings and what may be the implications to take into action planning for service development. **There is no substitute for local understanding and judgment, there is no magic thermometer or barometer that can be inserted in a service and reveal the truth in some universally accepted fashion.** But such a tool can enhance understanding by providing systematic data and support judgment through analysis and interpretation of that data – **its use can support the work of**

**transformation but it is only a tool and no substitute for the human endeavor of working it out in practice.**

The content of the tool has been derived from a consensus concerning what constitutes a 'recovery supportive service' and therefore the instrument does directly measure a subjective affirmation of how well the present service conforms to that profile. The rank order of items points towards strengths and needs but less should be made of how the numerical scores add up as this reflects arbitrary design issues such as how many questions to put in each domain etc.

Interpretation will be improved through successive measures in the same service, comparisons between services, an accumulation of data to allow tabulation of service specifications and comparisons with norms.

The authors are aware of these problems and limitations and advocate for use and refinement on much larger samples with rigorous psychometric evaluation. This has yet to happen.

**The adult scale** is formed around 20 questions which incorporate issues under 3 main headings which are regarded as the foundations of a recovery oriented service system:

1. Person centered (questions 1-6)
2. Consumer driven (7-10, 16)
3. Community focused (11-15)
4. Access and integration of services (16-20)

It asks someone using a service to evaluate that service by using the questions to reflect on their experience and subjectively rate the service on a 5 point scale

**The child and family version** is also called ERFS which is taken to mean 'Elements of a Resilience Facilitating System' and is essentially the same in philosophy, intention, core domains but expressed throughout in family and carer oriented language and represents a parents or carers assessment of how a service responds to 'my child'.

#### **Interpretation of results:**

Guidance to date suggest ranking the summary results for each item for the service under review and taking high ranking items as something to celebrate – ie strengths of that service and low ranking items as a suitable focus for action planning and improvement.

## Elements of a Recovery Facilitating System (ERFS)

Thinking of all the mental health services you receive, please indicate which of the following choices is most true for you. Please answer all of the items.

	Always	Often	Sometimes	Rarely	Never
1) Staff treats me as a whole person (with a body, mind, social life, and spiritual life).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2) Staff helps me create healthy daily routines.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3) Staff treats me as person who can learn, grow and change.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4) Staff seems to hold hope for me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5) Staff helps me see and use my own strengths.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6) Staff cares about my race, religion, and culture.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7) My treatment plan is based on my own goals.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8) Staff respects me as a full partner.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9) Staff teaches me how to cope with my condition.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10) I have a say on how programs are run.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11) I can get services in my home and community.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12) Staff helps me with my basic needs, such as income, housing, and transportation.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13) Staff helps me succeed in normal life roles, such as worker, tenant and student.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14) I am told about my rights and how to uphold them.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15) Staff helps me get connected, or to stay connected to others including family and friends.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16) Role models I can learn from work in the program.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17) All the services I receive are well coordinated.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18) I am given choices among good service options/providers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19) Staff shares information clearly and openly.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20) I can receive services as long as I need them.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Appendix four

# MENTAL HEALTH AND WELLBEING NETWORKS 10 CORE STANDARDS (Draft 2)

### **The Recovery Approach**

All staff have a knowledge of recovery and social inclusion. They have and use recovery skills, capacities and qualities appropriate to their work role.

### **Recovery Outcome Evaluation**

All services and resources are organised so they are able to measure recovery outcomes and feed the results of this back into a continuous cycle of practice and service improvement.

### **Coherent and Effective Service Configuration**

Services are constructed on recovery principles and delivered by teams that are managed and led so as to be coherent and effective contributors to the overall network.

### **Network Partnership Relationships**

Network partnership relations are characterised by good communication, consistency and respect. The terms of the Devon and Torbay Compacts between the statutory and the voluntary sectors are honoured in spirit and in practice.

### **Staff and Service Performance**

All practitioners, teams and services are subject to regular performance review to ensure that staff are safe, appropriately qualified and equipped, and that they are supervised and supported in the requirement to deliver recovery based practice. Services and staff within them work together to promote safety and a positive approach to risk within and across team boundaries

### **The experience of networks**

There is excellent 'customer care' such that services are experienced as supportive of individual recovery as well as being receptive and responsive to all approaches. All interactions are conducted with timeliness, courtesy and respect.

### **Satisfaction**

There is a high level of satisfaction from those who use the services to support their recovery, their families and other supporters, and providers of related services. The general public have confidence in the services provided to their communities.

### **Social Inclusion**

All services demonstrate that they support people to meet their human needs in all aspects of their lives including occupation, education, housing, finance and participation in community life.

### **Building mental wellbeing**

All service users are supported to develop skills and strategies to achieve and maintain wellbeing and develop resilience to adverse life events. Support and intervention is offered at the earliest opportunity to reduce negative impacts on mental wellbeing.

### **Challenging stigma and discrimination**

All services challenge stigma and discrimination and demonstrate that they support mental health and emotional resilience within their own workforces and in the communities they serve.

## Amendments:

These follow comments and suggestions following circulation of the original paper in Jan 2008 and include both omissions to the original paper, commentary and criticism and updates.

25.2.2008

### RE: The Ohio Consumer Outcomes Initiative

<http://www.mh.state.oh.us/oper/outcomes/outcomes.index.html>

This substantial user informed portfolio of outcome evaluation tools and experience which escaped notice in the earlier drafting of this paper. It has been highly valued as a world leading initiative and national fellow in recovery (Piers Allott) gained permission for free use in the UK of their instruments (there was an earlier distribution of their materials by NIMHE).

It arose from the work of a task force in Ohio from 1996 who aimed to produce instruments to measure statewide consumer outcomes in publically supported mental health services. It was shaped substantially by service users and the 'outcomes users group' met regularly for several years to develop, pilot, refine and report on this work. An Outcomes System Quality Improvement Group was convened in 2005 to produce a summary report and recommendations (<http://www.mh.state.oh.us/oper/outcomes/osqig/osqig.rpt.1.pdf> , 2006), by this time they were processing data from 50 state wide health boards constituting 325 agencies working with 400,000 individuals. Unsurprisingly they saw a major goal as the need to to simplify and clarify the Consumer Outcomes System, and improve its clinical utility. They state that: While consumer outcomes are an end in themselves, the Consumer Outcomes System serves only as a tool in clinical, Quality Improvement, and accountability processes to help Ohio's public mental health system achieve these ends.

It is not easy to satisfactorily summaries their own 100+ page summary report of a huge amount of ongoing work – but here goes:

Their guiding concepts are:

The Ohio Mental Health Consumer Outcomes System does not stand alone. Positive consumer outcomes are the final destination in the course of treatment: it is our urgent hope that consumers served in our system build resiliency and achieve their life goals unimpeded by mental illness or emotional disturbances.

### Recovery

Recovery refers to the process in which individuals are able to live, work, learn and participate fully in their communities. For some, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms. Science has shown that having hope plays an integral role in an individual's recovery. (President's New Freedom Commission on Mental Health)

**Mental Health Recovery**—is a journey of healing and transformation for a person with a mental health disability to live a meaningful life in communities of his or her choice while striving to achieve full human potential or personhood. (U.S. Department of Health and Human Services)

**Resiliency** –Resilience is an innate capacity that when facilitated and nurtured empowers children, youth, and families to successfully meet life’s challenges with a sense of self determination, mastery and hope. (Resiliency Workgroup)

**Cultural Competence**—A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency or those professionals to work effectively in crosscultural situations. (Multi Ethnic Advocates for Cultural Competence)

Their core assumptions were:

- **Commonality** — *A common set of desired outcomes should be required for measurement statewide. A critical component of the use of outcomes data for all stakeholders is the ability to benchmark at both local and state levels. Without a standard set of measurements to capture outcomes, comparability across settings would be impossible to achieve.*
- **Integration with Other Data** — *Outcomes data should be used in combination with other data for continuous Quality Improvement. This means that outcomes findings are used as indicators of areas requiring further exploration and subsequent treatment, program and system planning.*
- **Availability** — *All stakeholders in Ohio’s publicly supported mental health system should be able to use the outcomes findings.*
- **Consumer Perspective** — *Outcomes should be measured primarily from the perspective of consumers and in a manner that complements rather than replaces the clinical judgment of practitioners.*
- **ValuesBased** — *The OTF approach is an incremental yet innovative addition to Ohio’s mental health data base and should be evaluated during implementation to ensure that it fulfills the OTF values (e.g., it is useful, cost effective and respectful of all participants)."*

(Which are very similar to the values base of the Devon Outcomes ambitions)

There are extensive supportive materials including a toolbox and planning kit <http://www.mh.state.oh.us/oper/outcomes/training.index.html>

They have used and continue to use their outcome data to produce a developmental model of ‘Emerging Best Practices in Mental Health Recovery’ ie those services associated with better reported outcomes using their measures.

The whole programme was funded at the level of several million \$. Individual participating agencies (hundreds of them) were given \$15,000 for set up and participation. The programme depends heavily on data management and software applications and there were subsequent tensions around participants in the role of ‘data vendors’ and compliance with the expectations of data returns. Where it worked – it worked very well and services were able to be compared via the ‘Outcomes Data Mart’ via various ‘Portals’. They appear to have experienced significant problems arising from setting up systems and services to respond and produce data in specified ways and then needing to change and change again as revisions are produced.

They conceptualised training in a similar way to that we have begun in Devon – ie the need for successive approaches to engage with:

Information/ Knowledge building (awareness)

Skills building (capabilities)

Attitude changing (qualities)

They also reinforce the need for successful training to be linked to coaching and supervision.

They refer (probably correctly) to their materials as a 'world class exemplar' and see applications in:

The use of outcomes in treatment.  
Recovery and resiliency based practices  
Outcomes in quality improvement.

Their findings (after a decade of working on these issues) is that they need to further develop their tools and approach and targets for improvement look towards:

**Simplification** —Makes Outcomes easier to understand or implement

**Clarification** —Resolves misunderstandings or misinterpretations by providing better definitions

**Clinical Improvement** —Raises the clinical utility of Outcomes System.

Although a 'world leader' this is an impossibly complex and unapproachable system of outcome evaluation for routine practice in Devon with minimal or no funding, huge competition for scarce training, support and supervision resources and a starting point of us using virtually no systematic assessment of anything.

However we could benefit greatly from taking their lessons to heart and from the outset seeking to design something that is fairly simple, underpinned by clear concepts and agreed definitions and is geared to be meaningful and useful from the outset. Their report concludes with a 14 point list of recommendations for their further development – many of which are artifacts of the complexity and administration of the tool itself.

The 2006 report also includes an interesting appendix from their own purpose built watchdog – the Outcomes Quality Improvement Group – who wished to append 'an alert' – they state that 'It's been a monumental effort and much has been accomplished. But there is much room for improvement' – including poor data returns from significant numbers of participating agencies, lack of actual use of the data – and there is an extensive tabulated list of 'performance problems' in terms of the outcomes system. It is commendable that they are self critical and include significant critique of their huge enterprise within their summary report.

The OQIG cluster their observations in areas of:

Financing & Reimbursement, Productivity & Quality, Information Technology, Workforce and Organizational Culture.

They give particular emphasis to the complexities of tying 'certification' and remuneration of services to their participation in and performance against outcome variables – and these are instructive materials to return to if we are ever in this position in Devon.

The Ohio Outcomes Initiative may be the most established and elaborated yet available anywhere but in its complexity appears inapplicable to an ordinary health care community seeking to embed recovery outcome evaluation in routine practice. However the issues raise and lessons learned by their work do have broad applicability and are valuable in themselves for services seeking to go down this road.

Instruments, procedures, scoring and guidelines are all found at:  
<http://www.mh.state.oh.us/oper/outcomes/instruments.index.html>

28.2.2008

**RE: REFOCUS: Developing a recovery focus in mental health services in England**

This is a major research proposal led by Mike Slade and based at SLaM with an authoritative group of experienced researchers as co applicants and an international advisory group. It has just submitted an application for £2m funding for a multiphase study beginning 1 October 2008.

This research proposal is based on a comprehensive review of national and international recovery perspectives which identifies that although there is a broad consensus of clinical, policy and consumer commitment to recovery based services there is still no fully satisfactory *guidance on implementation or tools for evaluation and governance it therefore aims to develop recovery-focussed:*

- (a) quality standards, fidelity measure and outcome measures;*
- (b) manualised interventions*
- (c) randomised controlled trial evidence.*

***The aim and purpose of the programme is described as:***

*The main aim of this programme is to improve the extent to which mental health services promote recovery. It will meet this aim in four steps. First, indicators of a recovery focus will be identified and applied throughout England. Second, interventions which promote recovery will be evaluated and synthesised into a coherent single 'recovery manual'. Third, measures of the impact on important aspects of recovery (e.g. hope, identity, meaning, empowerment) will be tested, as well as two approaches to individual patients identifying their goals. Finally, the findings from these studies will inform a randomised controlled trial in two mental health trusts in England. Teams in the two sites will be randomly allocated to either receive or not receive the interventions contained in the recovery manual, and the impact of the intervention will be tested by comparing the results for the two groups.*

*The findings will be disseminated in six forms: a report co-published with Rethink (the largest severe mental illness charity in the UK); a scientific book; an information leaflet; scientific and practice-focused conferences; on-line web-based resources; and by exploring the feasibility of setting up a user-led social enterprise consultancy business, employing service users and staff to provide training and consultancy to mental health services in England.*

*The research will help mental health services to work in ways which promote recovery rather than dependence. This is intended to lead to more patient-centred care, with a greater focus on effective interventions, supporting people to self-manage, and working in partnership. The overarching goal is to improve the quality of life for people with mental health problems.*

**The objectives and stages of successive research modules are:**

**Module 1: Define and understand the problem**

1. To develop and apply quality standards to identify gaps between current and recovery-focussed practice
2. To understand why those differences exist

**Module 2: Optimise the intervention**

3. To identify and evaluate candidate elements of a complex intervention
4. To develop economic models of the impact of each element
5. To manualise the intervention

**Module 3: Optimise the evaluation**

6. To develop and pilot cross-culturally valid measures of patient-level recovery processes and outcomes
7. To investigate the feasibility and equivalence of two innovative approaches to increasing the external validity of outcomes
8. To develop measures of treatment fidelity

**Module 4: Optimise trial parameters**

9. To evaluate the intervention in two sites
10. To establish and optimise trial parameters

**Module 5: Knowledge transfer**

11. To influence NHS mental health care

**Comment:** if this application is successful its outputs will be of direct relevance to our work in Devon – it explicitly seeks to develop meaningful and valid resources to support recovery practice and outcomes in ordinary services. However it is a research programme designed over 5 years and is therefore not intended to complete before October 2013 - so we cannot wait! However it fully illustrates that in deciding upon a local recovery outcomes process and evaluation tools we need to be mindful that this is an area being very actively developed and we must be open to change and subsequent improvement of means and methods.

5.3.2008

**Health care commission / CSIP**

**Measuring health and care outcomes in mental health  
Communications update, December 2007**

CSIP and the Healthcare commission through their outcomes programme aim to:  
' provide information on things you will need to consider if you are developing the practice of outcomes measurement within your organisation.'

They have developed outcomes implementation guidance which is downloadable from their outcomes measurement website at [www.outcomemeasures.csip.org.uk](http://www.outcomemeasures.csip.org.uk)

The website also provides details on available assessment tools and inform you of things happening as the use of outcomes tools develops.

A national work group is developing advice on a compendium of useful mental health outcome measures and anticipates that its first draft will be issued for consultation in June 2008. The compendium has been developed by the London Queen Mary's School of Medicine and Dentistry in conjunction with CSIP and the outcomes practice group. Rachel Webb, ward manager of Russell Clinic in Exeter sits on this national advisory body and this update includes a description of the DREEM study on Russell Clinic as a case example of mental health outcome measures in practice

For the compendium they are aiming to be able to comment as follows for each tool:

Instrument name

4.3 Instrument description, version number & population

4.4 Validity

4.5 Reliability

4.6 Practical considerations

#### 4.7 Utility

#### 4.8 Links – links to forms/website and further information

The present draft compendium is an 111page list of 164 evaluative tools and instruments which includes ever test I have ever heard of and a great many that I've never come across before – as an encyclopaedic overview it is usefully alphabetically indexed – as something that can provide guidance it is still in an over inclusive, unselected and unfiltered state. It will be very interesting to see how they take the next steps in developing something of use to clinicians and services. We will feed our PEG advisory paper into this national process.

This communications update has also formulated a list of 'Top tips' for implementing measuring outcomes in routine practice. These include:

1. Gain stakeholder support
2. Have a clear plan and communicate it
3. Develop mechanism for feedback and reporting of data
4. Plan training
5. Develop clear protocols for collections
6. Seek to integrate measures within existing care pathway and local initiatives
7. Demonstrate change

5.3.2008

#### **Update on national scene on implementation of recovery measures**

**From:** Piers Allott [mailto:wrapworks@blueyonder.co.uk]

**Sent:** 03 March 2008 10:58

**To:** 'Glenn Roberts'

**Subject:** RE:

Dear Glenn,

Life is a journey and measuring recovery outcomes is no different. We can learn from the journeys of others e.g. Ohio but we must always remember that that will not necessarily mean we don't make the same mistakes, indeed we may have to as part of the learning process.

I'm not aware of anywhere using outcomes measurement in the UK though I understand a number of places use the Ohio forms simply as a guide! The last NIMHE outcomes thing I went to had people from Denver (see <http://www.outcomesmhd.com/>) and they seemed to be working with Merseycare. Again they told the story of their own journey!

My take on this is the same as recovery in general – you simply have to start! You will never have a perfect system, tool or recovery!

I hope that this is of help.

Piers Allott  
WRAPWorks