Service users and the public

Supporting recovery: improving quality and outcomes in mental health

Chair: Stephen Dalton, Chief Executive for Mental Health, NHS Confederation
Mike Parsonage, Chief Economist, Centre for Mental Health
Jed Boardman, Consultant Psychiatrist, SLAM & Imroc Team Member
Katherine Newman Taylor, Consultant Clinical Psychologist & Lecture, In CBT, Southern health NHS Foundation Trust & University of Southampton
Michael West, Policy Manager, Mental Health Strategy, Department of Health
Measuring Recovery Outcomes
Key domains

NHS Confederation Annual conference 5 June 2013

Jed Boardman
ImROC Senior Consultant
Centre for Mental Health & NHS Confederation
Department of Health Project  Assessing recovery: seeking agreement about the key domains

- Examine and identify the consensus among key stakeholders, including mental health service users, carers, professionals, regarding the *main domains* for measurement of personal recovery
  - ‘Domains’ = conceptually distinct components of the outcome; e.g. quality of life, symptoms, satisfaction with care
- Focus on *individual measures* of recovery
- Roundtable discussion with stakeholders
- Review of Literature
What is Recovery?

Key ideas

- **Clinical Recovery**

- **Personal Recovery - Living a life beyond illness**
  “… a deeply personal, unique process of changing one’s attitudes, values, feelings goals, skills, and/or roles. It is a way of living a satisfying, hopeful and contributing life even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness.” (Anthony, 1993)

- Recovery is a process

- And a Civil Rights movement
What is Recovery?

Key elements

- Ideas of Recovery come from service users stories

- Key elements:
  - Hope
  - Agency (Control)
  - Opportunity
Recovery processes: The CHIME framework

- Connectedness
- Identity
- Empowerment
- Meaning and purpose
- Hope and optimism

Recovery Outcomes
What are we trying to measure?

- **Key elements:**
  - Hope
  - Agency (Control)
  - Opportunity

- **CHIME:**
  - Connectedness
  - Hope and Optimism
  - Identity
  - Meaning and Purpose
  - Empowerment
Recovery Outcomes

- Individual Outcomes – individuals recovery
  - Hope, agency, opportunity (or CHIME)
  - Objective improvements consistent with recovery themes
  - Experience of care
  - Recovery journey – progress
  - Quality of life
  - Relationships
  - Reduced Service use

- Organisational level
  - Recovery-orientation of services

- **33 instruments:**
  - 22 designed to measure individuals’ recovery
  - 11 designed to assess the recovery orientation of services (or providers)

**Promising candidates for routine use in mental health services:**

- **Individual recovery (n=4):**
  - Recovery Assessment Scale
  - Illness Management and Recovery Scales
  - Stages of Recovery Instrument
  - Recovery Process Inventory

- **Recovery orientation (n=4)**
  - Recovery Oriented Systems Indicators Measure
  - Recovery Self Assessment
  - Recovery Oriented Practices Index
  - Recovery Promotion Fidelity Scale
Department of Health Project - Key *domains*

- **DOMAIN 1** – *Recovery-related experience of mental health services (quality of care).* i.e. extent to which service users feel that staff are trying to help them in their recovery.

- **DOMAIN 2** – *Subjective measures of individual recovery reflecting key areas of personal recovery.* i.e. extent to which individuals feel that their hopes, sense of control and opportunities for building a life have improved as a result of their contact with services.

- **DOMAIN 3** - *Attainment of socially valued roles.* This domain reflects any change to a person’s status on indicators of social roles which show improvement as a result of their contact with services.

- **DOMAIN 4** - *Attainment of personally valued goals.* i.e. attempt to capture the unique individuality of the process. Not measurable on standardised measures. May be difficult to measure and record as routine indicators, but may be valuable for helping the individual record and monitor their own progress.

- **DOMAIN 5** – *Quality of life and well-being.* May not need to measure separately. Warwick-Edinburgh Mental Well-being Scale (WEMWBS) may provide a useful measure of well-being.

- **DOMAIN 6** – *Service use.* Lack of clear consensus about this. Care should be exercised not to represent reduction of service use or discharge as indicators of recovery. May use measures of in-patient use (e.g. bed use, admission and re-admissions, admissions under the Mental Health Act) can be useful proxies for recovery, and use of interventions like Joint Crisis Planning.
Quality of Life and Mental Health Problems

- Connell et al (2012) review identified six domains of quality of life important to people with mental health problems:
  - well-being and ill-being;
  - control, autonomy and choice;
  - self-perception;
  - belonging;
  - activity;
  - hope and hopelessness.

Measures of Domains

**DOMAIN 1** – *Recovery-related experience of mental health services (quality of care).*
This domain requires a Patient Rated Experience Measure (PREM).

Suggested measure: *Brief INSPIRE* measure (using the CHIME framework):

- My worker helps me to feel supported by other people (INSPIRE item 1, tapping *Connectedness*)
- My worker helps me to have hopes and dreams for the future (INSPIRE item 8, tapping *Hope*)
- My worker helps me to feel good about myself (INSPIRE item 10, tapping *Identity*)
- My worker helps me to do things that mean something to me (INSPIRE item 14, tapping *Meaning*)
- My worker helps me to feel in control of my life (INSPIRE item 17, tapping *Empowerment*)

Measures of Domains

**DOMAIN 2** – *Subjective measures of individual recovery reflecting key areas of personal recovery.*

This domain requires a Patient Rated Outcome Measure (PROM).

- Measures reflecting symptoms of mental and physical ill-health and/or measures of wellbeing ("I feel mentally/physically well")
- Measures reflecting hope ("I have hope for the future")
- Measures reflecting identity/self-esteem ("I feel good about myself")
- Measures reflecting personal meaning ("I am doing things that mean something to me")
- Measures reflecting control/autonomy ("I feel in control of my life")
- Measures reflecting personal support ("I feel supported by other people")
- Measures reflecting participation ("I feel part of my local community")
- Measures reflecting stigma and discrimination ("I feel discriminated against because of my mental health condition")
# The Process of Recovery Questionnaire (QPR)

**[15/10/2007- Version 1]**


<table>
<thead>
<tr>
<th>Statement</th>
<th>Disagree strongly</th>
<th>Disagree</th>
<th>Neither agree nor disagree</th>
<th>Agree</th>
<th>Agree Strongly</th>
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<tbody>
<tr>
<td>I feel better about myself</td>
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<td>I feel able to take chances in life</td>
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<td>I am able to develop positive relationships with other people</td>
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<td>I feel part of society rather than isolated</td>
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<td>I am able to assert myself</td>
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<td>I feel that my life has a purpose</td>
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<td>My experiences have changed me for the better</td>
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<td>I have been able to come to terms with things that have happened to me in the past and move on with my life</td>
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<td>I am basically strongly motivated to get better</td>
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<td>I can recognise the positive things I have done</td>
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<td>I am able to understand myself better</td>
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<td>I can take charge of my life</td>
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<td>I am able to access independent support</td>
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<td>I can weigh up the pros and cons of psychiatric treatment</td>
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<td>I feel my experiences have made me more sensitive towards others</td>
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<tr>
<td>Meeting people who have had similar experiences makes me feel better</td>
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<td>My recovery has helped challenge other peoples views about getting better</td>
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<td>I am able to make sense of my distressing experiences</td>
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<td>I can actively engage with life</td>
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<td>I realise that the views of some mental health professionals is not the only way of looking at things</td>
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<td>I can take control of aspects of my life</td>
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<td>I can find the time to do the things I enjoy</td>
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</table>
Measures of Domains

DOMAIN 3 - *Attainment of socially valued roles.*
Use observable indicators - measures of:

- **A safe life.**
  - Debt/Finances
  - Housing
  - Experience of crime
- **A contributing life.**
  - Employment (including volunteering)
  - Education, training
  - Other meaningful activities – community participation and leisure
- **A social life.**
  - Social networks
  - Community participation
Department of Health Project - Key domains

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Thank you

For further information, contact:
Jed.Boardman@centreformentalhealth.org.uk
www.imroc.org
Measuring Recovery based services; A pilot evaluation of patient reported outcomes

Dr Katherine Newman Taylor, Consultant Clinical Psychologist

On behalf of: Lesley Herbert, Trust Consumer Advisor
Chris Woodfine, Project Manager
Anna Lewis, Adult Mental Health Divisional Director
The Recovery agenda in mental health

“It is a way of living a satisfying, hopeful, and contributing life even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness”

(Anthony, 1993)
Excellence in mental health care

• **Agency** – Gaining a sense of control over one's life and one's illness. Finding personal meaning - an identity which incorporates illness, but retains a positive sense of self

• **Opportunity** – Building a life beyond illness. Using non-mental health agencies, informal supports and natural social networks to achieve integration and social inclusion

• **Hope** – Believing that one can still pursue one's own hopes and dreams, even with the continuing presence of illness. Not settling for less, i.e. the reduced expectations of others

(Sainsbury Centre for Mental Health, 2008)
Recovery - implications for clinical practice
Recovery – implications for organisations

Implementing Recovery
A methodology for organisational change

Geoff Shepherd, Jed Boardman and Maurice Burns
Southern Health NHS Foundation Trust; Pilot evaluation of services

• **What?**  Are we developing Recovery based services?

• **How?**  Pilot assessment of services across Hampshire using the INSPIRE patient reported measure; independent service user group commissioned to complete interviews

• **Who?**  Service users from AMH and OPMH services; in-patient and out-patient groups
INSPIRE
(Williams, Bird, Le Boutillier, Leamy & Slade, 2010)

Support subscale – Assesses aspects of provision considered important to the person, and the degree to which these are supported by their mental health worker

‘An important part of my recovery is feeling motivated to make changes’
No / Yes

‘I feel supported by my worker in this’

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<th>2</th>
<th>3</th>
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<td>not much / disagree</td>
<td>somewhat / neutral</td>
<td>quite a lot / agree</td>
<td>very much / strongly agree</td>
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</table>
INSPIRE (Williams, Bird, Le Boutillier, Leamy & Slade, 2010)

Relationship subscale – Assesses the extent to which the relationship between the service user and mental health worker is recovery focused

Please circle the option that best matches your relationship with your worker

‘My worker supports me to make my own decisions’

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### Results

<table>
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<tr>
<th>Sub-scale</th>
<th>Range</th>
<th>Mean</th>
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<th>Median</th>
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<tr>
<td>Support</td>
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<td>0.9</td>
<td>3.0</td>
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<tr>
<td>Relationship</td>
<td>3.6</td>
<td>3.3</td>
<td>0.7</td>
<td>3.5</td>
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</tbody>
</table>

0 1 2 3 4
not at all / not much / somewhat / quite a lot / very much / strongly disagree / neutral / neutral / agree / agree

- Means and medians indicate high average levels of recovery practice
- Ranges and standard deviations show considerable variation in services
CBT for Culture Change: Formulating Teams to Improve Patient Care

Katherine Newman Taylor and Suzanne Sambrook

Southern Health NHS Foundation Trust, Southampton, UK

Background: Increasingly, clinical psychologists and CBT trained clinicians work within teams. The cognitive model enables us to formulate the processes maintaining distress, and work with people to effect change. The model tends to be used to understand individuals’ difficulties, but may be effective in making sense of problems within teams.

Aims: This study aimed to (i) explore the value of the cognitive model in formulating key staff-service user relationships; and (ii) determine whether such an approach would yield useful team based interventions.

Method: The cognitive interpersonal model was used to develop an idiosyncratic conceptualization of key staff-service user interactions in an inpatient setting. This then informed management team planning aimed at improving provision for service users, and staff experience. Additionally, frequency of challenging behaviours and levels of staff burnout were assessed before and after service changes, as preliminary outcome data.

Results: The team formulation was effective in (i) making sense of interactions contributing to the maintenance of service users’ challenging behaviours and staff burnout, and (ii) deriving systemic interventions likely to effect change. This was then used to guide service development planning. In support of a CBT approach to understanding and intervening with teams, preliminary data indicate that staff burnout and incidents of challenging behaviours reduced over time.

Conclusion: The cognitive interpersonal model can be used to formulate relationships within teams and guide systemic change. This is likely to have a beneficial impact for both service users and staff.

Keywords: Formulating teams, challenging behaviour, burnout, cognitive interpersonal model.
Impact for service users: Frequency of incidents
Impact for staff: Burnout – emotional exhaustion

Level of EE

- High
- Moderate
- Low

Percentage

- April
- Dec
Recovery – Gold standard in mental health care?

• Recovery from mental health problems is dependent on hope, agency and opportunity – it’s about *living well with serious illness*

• We need to commission, determine and judge our work according to these principles and dimensions

• Measuring recovery is feasible and likely to identify excellent and poor practice

• Targeting recovery in teams is likely to benefit to service users, staff and the Trust
Thank you

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Peer Support Workers – are they effective?

NHS Confederation Annual conference 5 June 2013

Jed Boardman
ImROC Senior Consultant
Centre for Mental Health & NHS Confederation
Peer Support Workers

- PSWs - “offering and receiving help, based on shared understanding, respect and mutual empowerment between people in similar situations” (Mead et al., 2001)
- Draw on their own experiences to offer emotional and practical support
- Employed in addition to traditional staff, or instead of them (e.g. case managers).
- Deployed to some extent in most European, North American and Australasian countries
- USA - peer support reimbursable in 27 states under Medicaid
Peer Support in the UK

- Alleged Lunatic Friend (ALF) 1860s
- Peer support networks in service user led/self-help groups
- Peer workers in addictions services –especially addictions rehab (often in non-statutory sector)
- Peer workers in non-statutory services
- (A very few) peer run services
- Including the expertise of lived experience in mainstream, statutory mental health services has been much slower to develop …
- Some use in specific MH Trusts and development of Peer Trainers
Effectiveness of peer support

- Cochrane Review - identified 11 randomised controlled trials (Pitt et al., 2013)
- Other reviews also consider non-RCT evidence Repper and Carter(2011); Warner (2009)
Effectiveness - main findings

- Not result in worse health outcomes for those receiving the service.
- Commonly the use of PSWs produces the same or better results in a range of outcomes when compared with services without peer staff.
- PSWs tend to produce specific improvements in patients’ feelings of empowerment, self-esteem and confidence.
- Some studies show improvements in patients self-reported physical and emotional health and in clinician-assessed global functioning.
- Improvements in satisfaction with services and quality of life.
- In cross-sectional and longitudinal studies: patients receiving peer support have shown improvements in community integration and social functioning.
- Introduction of PSWs associated with a reduction of alcohol and drug use among patients with co-occurring substance abuse problems.
- When patients are in frequent contact with peer support workers, their stability in employment, education and training has been shown to increase.
Peer Support Workers
Benefits

- Shared identity
- Increased self-confidence
- The development and sharing of skills
- Improved mental health and wellbeing, accompanied by less use of mental health and other services
- An increased role in information sharing and signposting
- A feeling that peer support challenges stigma and discrimination.
- Benefit gained from helping others
- Greater focus on recovery in both the culture and practice of mental health services
- Increased community integration, quality of life, greater involvement in work or education. Lower levels of symptom distress
- Enhanced quality of life related to social relations.
- Shorter hospital stays, reduced bed days, reduced hospitalisations
- Reduction in costs
Peer support Workers in Uganda
Thank you

For further information, contact:

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www.imroc.org
Peer support workers: are they cost-effective?

Michael Parsonage
Centre for Mental Health
Peer support in mental health care: is it good value for money?

Marija Trachtenberg, Michael Parsonage, Geoff Shepherd & Jed Boardman
Contents of report

- Focuses on the relationship between employment of PSWs and psychiatric hospital bed use
- Six usable studies identified in the research literature
- In all six studies PSWs were employed as additional rather than replacement workers
Cost-benefit analysis

(1) Cost of full-time equivalent PSW

(2) Value of bed-days saved per PSW

(3) Benefit:cost ratio = (2) ÷ (1)
Results

• In four studies, savings are positive and exceed costs; in one study, savings are positive but do not exceed costs; and in one study, savings are negative

• Aggregated results:
  unweighted average: benefit:cost ratio = 3.8:1
  weighted average: benefit:cost ratio = 4.8:1
Limitations

• Evidence is limited in quantity and quality

• Differences between the studies, e.g. in the roles played by PSWs

• Only looked at impact on in-patient costs

• None of the six studies is from the UK
Conclusions

• Reasonably good evidence that peer support leads to improvements in a range of non-financial outcomes

• Now some preliminary evidence that peer support can also reduce mental health service costs