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Recovery Research Network Meeting

Measuring Organisational Support – What's possible?

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**Implementing Recovery –
Organisational Change (ImROC)**



The problem

- ❑ 'Recovery' refers to personal journeys with a set of outcomes reflecting the (re)claiming of a meaningful life (Farkas, 2010)
- ❑ These journeys may/may not involve significant contributions from mental health services
- ❑ Mental health services can certainly support these processes – they can also interfere with them
- ❑ The process of supporting people to live their lives may involve MH services in providing a range of 'recovery-oriented' interventions – personal care planning, shared decision-making, help to achieve socially valued goals (stable housing, employment)
- ❑ But it also requires a change in *values* and *culture* – placing the person and her/his life at the centre of the process, respecting their strengths and expertise, increasing their sense of control and supporting their personal hopes and ambitions for the future



- How to 'measure' these organisational characteristics?**
- Let's begin by looking at the existing measures**



Recovery Self Assessment (RSA)

- Developed on the basis of an extensive review by service users and providers on the topic of recovery from mental illness and addictions
- 5 factors emerged as being important:
 - (a) 'Is the service focussed on **user-defined life goals**'? (e.g. employment and education)
 - (b) 'Does it **involve** service users in the development and provision of programmes?'
 - (c) 'Does it offer a **diversity of treatment options**'? (including peer support and 'non-traditional' therapies)
 - (d) 'Are service **users' choices respected** by staff and is coercive treatment avoided?'
 - (e) 'Are services **individually-tailored** to different cultures and interests and are active **attempts are made to connect** with the local community?'
- The instrument has good internal consistency and some face validity, but there are doubts regarding its cross-cultural applicability (Slade, Luke & Knowles, 2009). It is probably most useful for self-assessment and collaborative service development.

Developing Recovery Enhancing Environments Measure' (DREEM)

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- Consists of an assessment of the person's stage of recovery and whether the services they currently receive are perceived as contributing to this process. Can be completed by the service user or staff.
- Items derived on the basis of extensive qualitative interviews and narrative accounts, includes questions such as, '*Staff believe I have a positive future; This service encourages me to do things that give my life meaning; Staff recognise and focus on my positive attributes and talents'(etc.)'*
- Each item rated on a 5 point from 'strongly agree' to 'strongly disagree'. The section on '*Organisational Climate*' then attempts to categorise whether the whole organisation is 'recovery-oriented'
- Has been widely used as a service development tool, generally agreed to be rather laborious and a number of items are very culturally specific, hence problems with 'inter-rater' reliability

Scottish Recovery Indicator (SRI)

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- Based ROPI (Mancini & Finnerty, 2005). Consists of 8 dimensions:
 - i. Meeting basic needs
 - ii. Personalisation and Choice
 - iii. Strengths-based approach
 - iv. Elements of a comprehensive service
 - v. Service user involvement/participation
 - vi. Involving support networks and promoting social inclusion
 - vii. Service user control
 - viii. Recovery focus

- Each dimension contains specific items rated on a 5-point scale from 'absence' to 'full adherence'.
- Ratings made by mixed groups of staff and service users working together to arrive at a consensus
- Contains areas which are clearly linked to achieving a more recovery-oriented service, but also contains dimensions which simply reflect basic good practice, so ?content validity
- Widely used across Scotland as a service development tool; little evidence available regarding its formal psychometric properties

Existing measures IV. – Recovery Promotion Fidelity Scale ‘RPFS’ (Armstrong & Steffen, 2009)

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- Development consisted of ratings of potential items by a series of focus groups consisting of service users, carers, managers and clinicians. Results then analysed using a ‘concept mapping’ technique
- Final analysis produced 12 items, organised into five domains, each corresponding to a different area of recovery practice.
 1. collaboration
 2. participation and acceptance
 3. self-determination and peer support
 4. quality improvement
 5. development
- Each item rated on a 5 point scale from ‘not implemented’ to ‘fully implemented’
- Instrument intended to guide self-assessments of recovery practice in community agencies.
- Authors acknowledge that further research is required to investigate the relationship between the items and outcomes.



INSPIRE (Williams *et al.* REFOCUS)

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Strengths/weaknesses of existing measures

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- *Content validity* - considerable common content, but also differences reflecting different cultural origins and inherent ambiguities in the concept. Not easily reduced to an agreed checklist
- *Inter-rater reliability* often unknown – not so important if the tool is primarily being used for service development, rather than cross-sectional comparisons or measuring change
- *Test-retest reliability* also often unknown – again not so important if being used as a service development tool
- *Discriminant validity* – completely unknown. Different measures, assess different things, so ‘*You pays your money*’
- *Construct validity* – again largely unknown, but important. Which items correlate most highly with recovery outcomes?
- ❑ Thus, some weaknesses in terms of formal psychometrics, but does this matter? A. It depends what you want to use the instrument for

IMROC methodology **(Shepherd, Boardman & Burns, 2010)**

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- Primarily a service development tool
- Traditional inter-rater and test/retest reliabilities judged not to be important. However, content validity is
- In addition, if you are interested in changing culture (which we are) and don't mind that the act of 'measurement' may affect the phenomenon being measured (and we don't) then a process of active engagement with the concepts through discussion and mutual agreement becomes an *advantage*, not a deficit.
- Similarly, if you want to use the instrument to track changes in the services, then you need to monitor these specifically (and reliably) rather than assess the test/retest reliability of the whole instrument

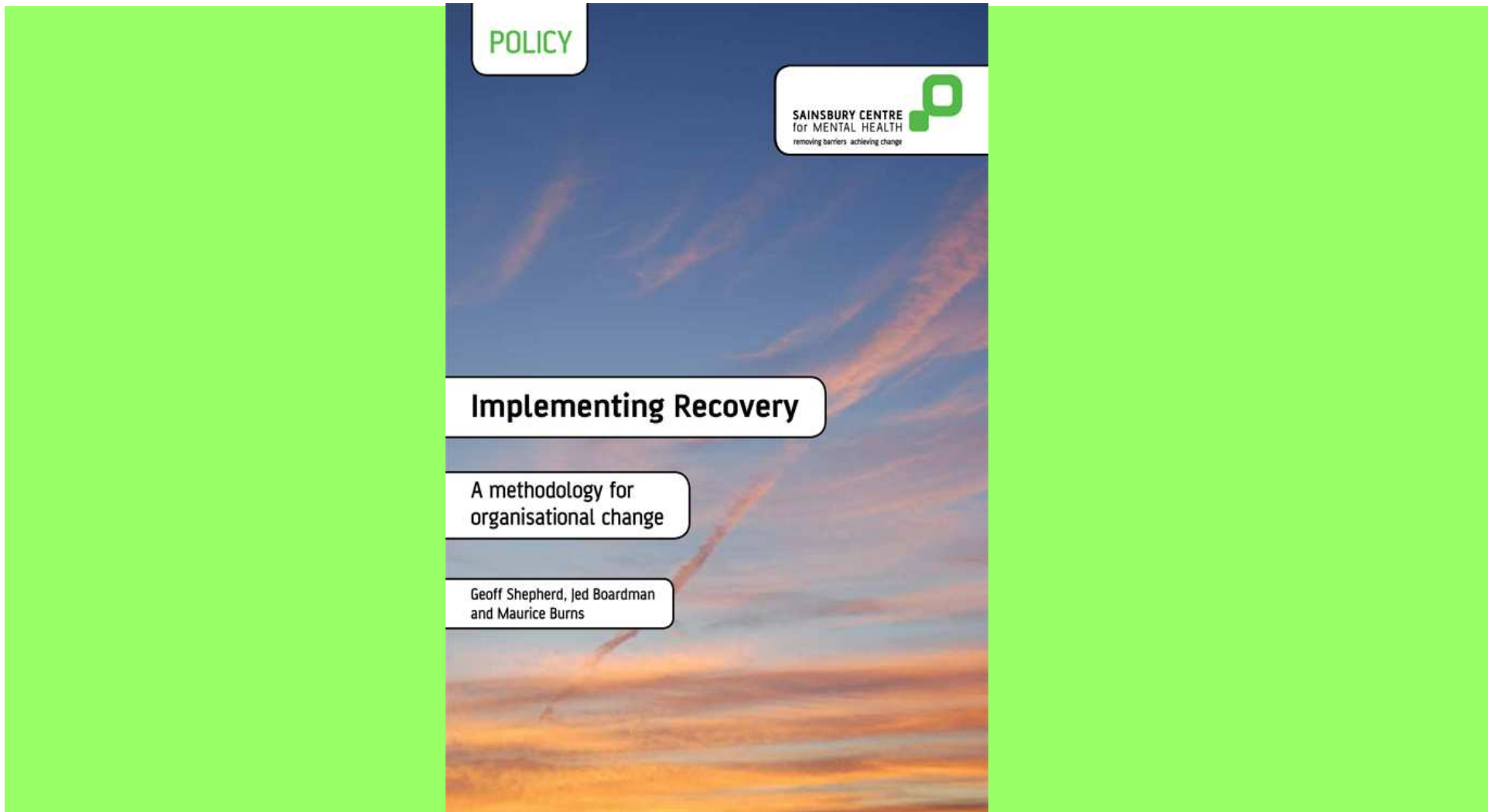


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The framework of 10 key organisational challenges





Key organisational challenges

1. Changing the nature of day-to-day interactions and the quality of user experience
2. Delivering comprehensive, user-led education and training programmes to increase staff awareness
3. Establishing a '*Recovery Education Centre*' to drive the training programmes forward
4. Ensuring organisational commitment, changing the 'culture' (from the 'top-down' and the 'frontline-up')
5. Increasing 'personalisation' and choice
6. Transforming the workforce ('peer support professionals')
7. Changing the way we approach risk assessment and management
8. Redefining user involvement as '*partnerships-between-experts*'
9. Supporting staff in their recovery journeys
10. Increasing opportunities for building '*a life beyond illness*' (ordinary housing, open employment, community integration, social inclusion)



The methodology

➤ Stage 1 – Understanding the concepts

- NHS providers work in collaboration with their partners in the local system (including commissioners)
- To explore the '10 key challenges', clarify the ideas and apply to the local context
- Undertake self-assessment according to a 3 point scale – *'Engagement'*, *'Development'* and *'Transformation'* (definitions supplied)
- Agree priorities and local targets for organisational change (not > 5?)



The methodology (contd.)

➤ Stage 2 – Setting specific goals, implementation and review

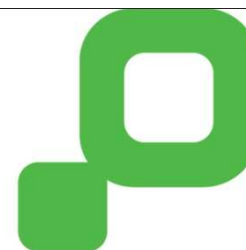
- For each challenge, formulate '**SMART**' goals – **S**pecific, **M**easurable, **A**greed, **R**ealistic, **T**imed
- Choose specific indicators (suggestions given)
- Identify information sources (suggestions given)
- Implement - working together to 'co-produce' change
- Review progress, modify goals, repeat cycle
- Choose another target

i.e. It is essentially a closed 'audit loop', or 'action research' cycle.

This is the most effective method of organisational change (Iles & Sutherland, 2001)

Possible indicators and potential data sources

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ORGANISATIONAL CHALLENGE 1: Changing the nature of day-to-day interactions and quality of experience

Examples of (service level) outcome indicators

- Proportion of staff trained in basic recovery-oriented practice;
- Adoption of Sainsbury Centre's 'Ten Top Tips for Recovery-Oriented Practice' into operational policy and practice;
- Systematic surveys of user (and carer) perceptions of staff behaviour in relation to recovery principles (e.g. using modified questions from the National Patient Survey);
- Supervision and appraisal systems are revised to promote staff interactions that demonstrate partnership working with service users;
- Proportion of instances of service users being involved in staff selection.

Possible data sources

- National Patient Survey data, or similar local projects;
- Systematic survey of user (and carer) views regarding the quality of day-to-day interactions with staff and the extent to which these reflect recovery principles and values;
- Records of composition of interview panels;
- Audit of staff appraisals/supervision.



The ImROC methodology – unsolicited feedback

“We have been piloting the use of the tool in a recovery-orientated unit within the Trust with really good results. We have chosen to pilot the approach by bringing the staff and user group together to decide how the unit is doing, how that should be measured and what they should be aiming to change next. This has brought about really positive changes in the unit and the relationships between the people currently using the service and the people staffing it. What has also been fascinating to me in this process is how the very act of conducting this methodology has brought about two, perhaps less predictable, outcomes.

1. People currently using the service have found the events (one hour each week on each relevant organisational challenge) to be therapeutic in themselves. Some people have found a voice not previously heard; some people have developed their assertiveness; some have discovered a desire or aspiration they had not recognised before because of the different conversations that arise.
2. The sessions embody the philosophy of the unit in such a way that feels really empowering to the people using the service. It is a really good way of ‘walking the walk’ of recovery. We cannot make every change that is suggested but there is an honest dialogue about what can and cannot change and why. In addition it is the people using the service who prioritise which changes are to be made first and who evaluate the effectiveness of the changes. There are also a lot more joint- or user-led - solutions being suggested as time goes on”.

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