

Measuring Recovery focused Outcomes

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Today

- What is an outcome measure?
- Why measure outcomes?
- What domains of Recovery should be measured?
- Examples of tools to use for each of these domains

Who decides on outcomes?

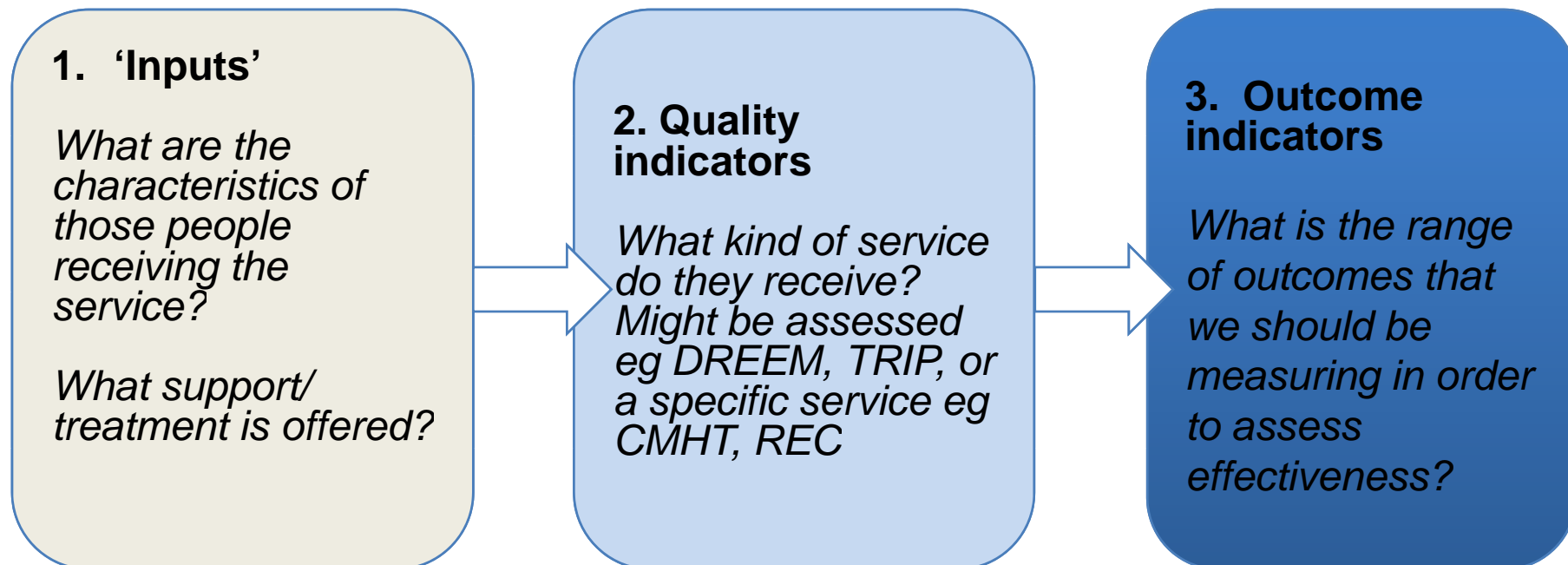
Different stakeholders have different priorities, goals and standards.

- NHS E/DoH
- Commissioners
- Managers
- Politicians/General public
- Practitioners? (Drs, AHPs, PSWs)
- People using services
- Family members, carers and friends

What is an outcome?

- The change in an individual, group of people or population which is attributable to an intervention or series of interventions.
- Routine outcome measurement involves collecting data as a part of routine practice rather than as part of a research project.
- Outcomes are only meaningful if they are related to specific contexts and interventions. (ie an outcome of a specified intervention)

Where do outcomes fit within a framework for evaluation? (Donabedian, 1988)



Why measure outcomes?

- To demonstrate the impact of the service on those who use it.
- To inform commissioning of different services (from 'commissioning for activity' to 'commissioning for results')
- To provide feedback to people using the service about their progression
- To provide feedback to staff about their impact
- To meet national/commissioning targets/requirements –

If an outcome is to be measured as part of routine practice it needs to be:

- specifically relevant to recovery (quality of life, social functioning, social networks, employment etc) rather than symptom or general measures
- brief, easy to understand and simple to complete
- relevant, with high face validity - people must believe they will generate information that is meaningful, readily applicable and useful for improving practice
- able to combine an assessment of individual progress with the possibility of aggregating quantitative data to describe the performance of groups.

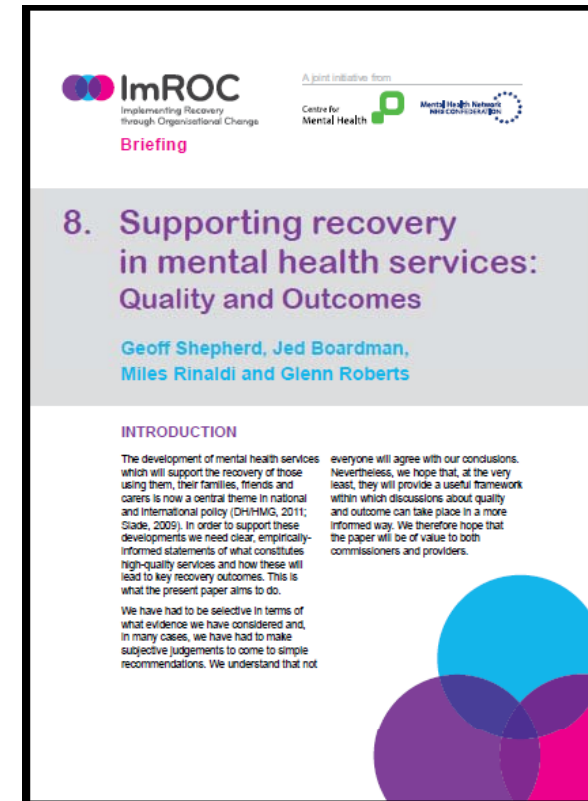
Evaluating outcomes to support recovery

- The development of services to support recovery is relatively new. This is therefore a very important time for the collection of evaluative data
- These data do not need to come from randomised research trials. Other, 'quasi-experimental' designs are more appropriate at this stage, when we are still struggling to understand both the nature of the '*independent variables*' (the interventions) and the '*dependent variables*' (the outcomes).
- Information about effectiveness requires *both* quantitative *and* qualitative data
- At the heart of this data must be information about the patient's ***experience*** of care and how it has/has not helped them achieve their ***personal recovery goals***.
- In times of financial austerity, we need information about ***effectiveness*** combined with information about ***costs***. We can then begin to make judgements about value for money

Suggested outcome 'domains'

'Expert group' - clinicians, service users, family members and researchers - suggested 6 areas (domains):

1. Improving experience (quality) of care
2. Achieving personal recovery goals
3. Improvements in subjective recovery
4. Achievement of socially valued goals
5. Quality of life and well-being
6. Impact on service use (costs)



#1: Experience of care – the INSPIRE tool

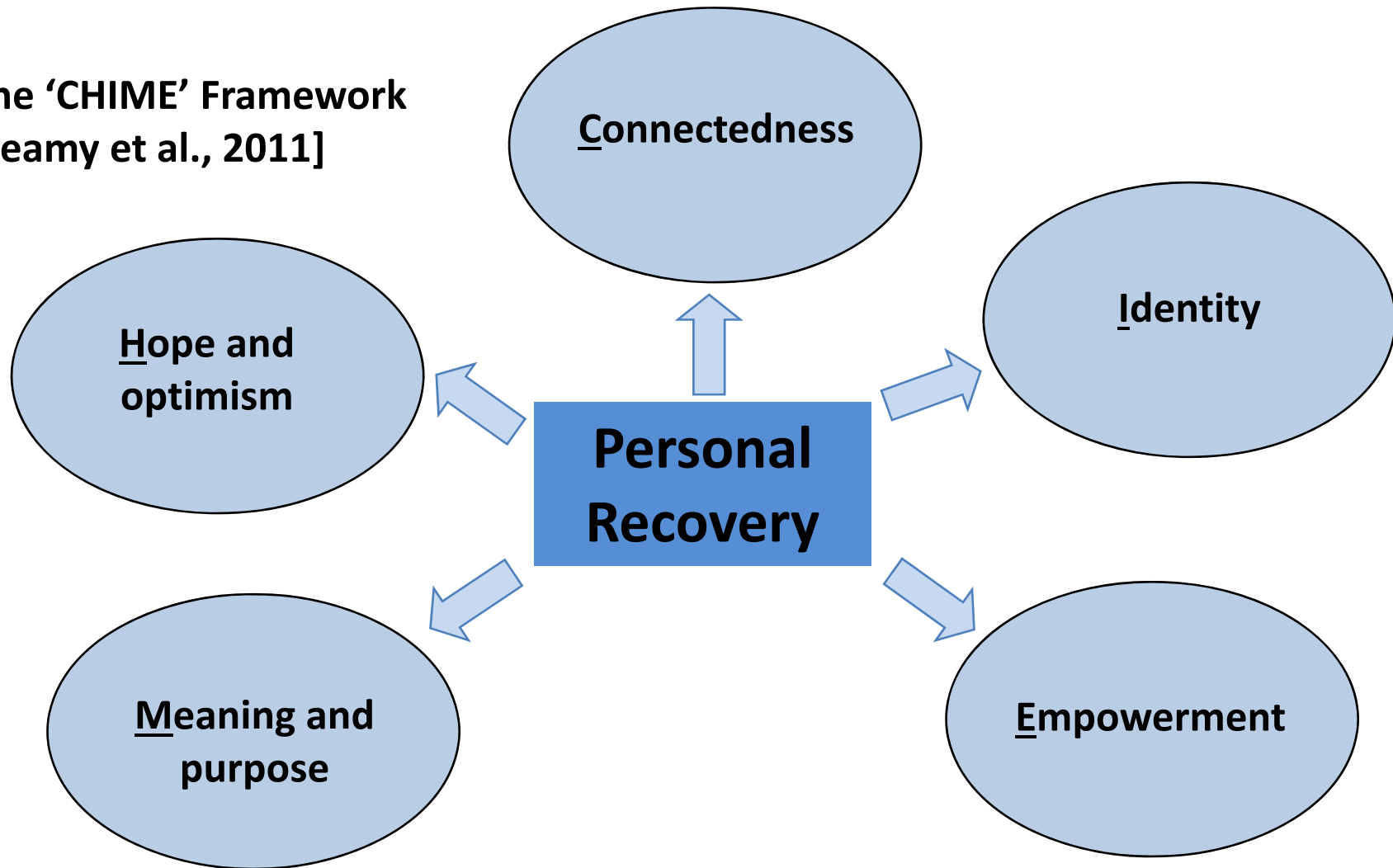
[<http://www.markslide.com/refocusstudies#inspire>]

- 21 item questionnaire filled in by the service user on the basis of her/his contact with **the staff member whom they judge to be most important** in supporting their recovery.
- Each item is rated on a 5 point scale, with an option to indicate that a specific area of support is not relevant to the individual. Contains 2 sub-scales; (a) 'Support for Recovery' and (b) 'Quality of relationship'
- Good face validity. Relatively quick and easy to use (generally takes about 10 mins. to complete)

e.g.

- REFOCUS study (Slade et al. (2015) *Lancet Psychiat.*, 2, 503-514)
- Newman-Taylor et al. (2012) administered to 58 service users as a structured interview, conducted by trained user researchers. Recommended as suitable for routine auditing of recovery-related service quality. Short version now available

**The 'CHIME' Framework
[Leamy et al., 2011]**



INSPIRE (short version)

Slade (personal communication) suggests that INSPIRE could be shortened to 5 items using the CHIME framework (Leamy et al., 2011). May then be used routinely.

Items	
1	My worker helps me to feel supported by other people [C]
2	My worker helps me to have hopes and dreams for the future [H]
3	My worker helps me to feel good about myself [I]
4	My worker helps me to do things that mean something to me [M]
5	My worker helps me to feel in control of my life [E]

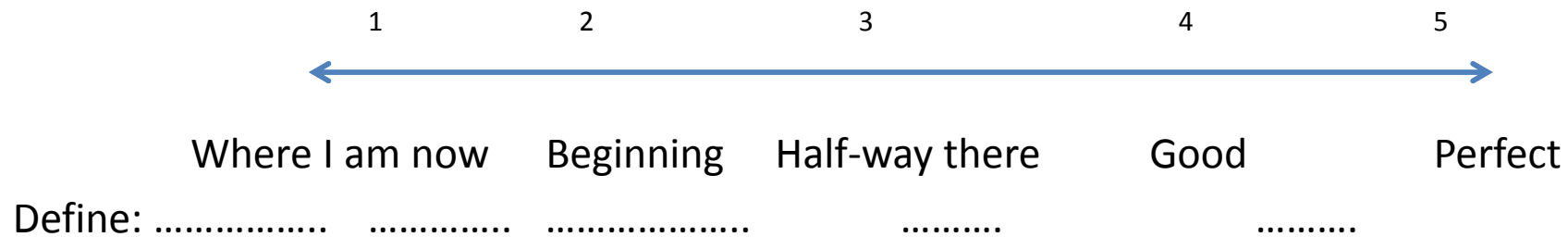
#2: Achievement of personal recovery goals

- ❑ Must be **specifically relevant to recovery** in mental health, i.e. not symptom measures (e.g. HoNOS), or general functioning (e.g. GAF).
- ❑ Needs to be **flexible** to cope with the range of individual goals ('Getting a job' > 'Swimming with dolphins'). But also, if possible, quantitative so that you can add and sum across groups. [N.B. You can't sum care plans]
- ❑ Need to be careful about **wording**, preferably 'co-produced' by professionals and service users working together.
- ❑ Should be **brief, simple, easy to understand** and quick to complete for routine use
- ❑ Needs to have **high 'face validity'**, so that service users, staff and families will be confident that the data produced will be interesting and useful – and help improve services

#2a: Achievement of personal recovery goals using narrative accounts (stories)

- Not to be neglected as a useful source of evidence (Roberts, 2000).
- Set alongside other data, can be a very powerful – and valid – method of measuring progress
- Uses patients' own words, therefore good face validity
- Often benefits from systematic sampling, but vivid, easy-to-understand and doesn't really require statistics!

#2b: Achievement of personal recovery goals using Goal Attainment Scaling (GAS)



- ✓ Goals are agreed with service user. Need clear definitions.
- ✓ Goals can be weighted
- ✓ Good inter-rater reliability, construct validity and sensitivity to change (Hurn et al., 2006)

If aggregation is not important, consider use of narrative accounts

#3: Improvements in subjective recovery

A. Standardised measures (well developed):

- a) **Herth Hope** Index
- b) Rogers **Empowerment** Scale
- c) **Recovery Assessment Scale (RAS)**
- d) **Questionnaire about the Process of Recovery (QPR)**
- e) **MANSA Quality of Life** instrument (available in short form and DIALOG)
- f) **WEBWMS** (Edinburgh Well-Being scale)

All rather long, with varying degrees of psychometric sophistication, some require translation and subject to cultural bias.

B. Co-produced, brief measures of subjective recovery (in development)

- a) Nottingham Recovery College Outcomes Scale
- b) Hope, Agency and Opportunity (HAO) scale

#3b Nottingham Recovery College Outcomes Scale

Each item rated on a 5 point scale: 'Strongly disagree' > 'Strongly agree'
at each individual review (approx. 3 monthly)

1. I am able to manage my own health and wellbeing
2. I have an understanding of my own mental/physical health
3. I feel good about myself
4. The quality of my life is improving
5. I have hopes and dreams for the future
6. I feel I have control of my life
7. I have the opportunity to build up my life
8. I feel part of my community
9. I am involved with family and friends
10. I am making new friends and go out more

Also asks about status of

1. Employment
2. Education
3. Housing

#3b Southern Health HAO

Next steps.....

- Your care plan
- Recovery college, www.southernhealth.nhs.uk/health-and-wellbeing/recovery/college/
- Recovery college toolkit, www.southernhealth.nhs.uk/health-and-wellbeing/recovery/recoverytoolkit/
- Wellness Recovery Action Plan, www.southernhealth.nhs.uk/knowledge/wrap

Further Details

Name:		Todays date:	
Team / Ward:		Date of birth:	
RiO number:		Care cluster:	
Questionnaire completed at:	Tick	Comments	
Admission	<input type="checkbox"/>		
Initial appointment	<input type="checkbox"/>		
Care plan review	<input type="checkbox"/>		
CPA	<input type="checkbox"/>		
Discharge	<input type="checkbox"/>		
Extended leave	<input type="checkbox"/>		
Other (please state)	<input type="checkbox"/>		
Did you need support to complete these questions?	Yes/ No/ Some of it		
Declined to answer			All
Q1 (Hope)	Q2 (Agency)	Q3 (Opportunity)	Q4 (Relationships)

Southern Health **NHS**
NHS Foundation Trust

Hope, agency and opportunity

This questionnaire is a Patient Reported Outcome Measure (PROM), it has been co produced by service users and health care professionals at the Southern Health Recovery College.

The information you share will help us to develop our services to become more recovery focused.

When you've finished answering the questions, your health care professional will talk to you about your answers. This will support us to understand what's important to you and develop your care plan.

This document is yours to keep as a record of your recovery. You can also leave comments inside.



#3b Secure Services PROM in development (Callaghan, 2016, Rethink)

1. Having hope
2. Having an equal say in my care
3. Being part of improving the service
4. Understanding my mental health and how to manage it
5. Feeling good about myself
6. Feeling safe and know what to do when things go wrong
7. There are enough things to do that I find interesting/helpful/enjoyable
8. Feeling supported to stay in contact with the important people in my life

All marked on a continuum to give a rating.

Repeated at each review.

#4: Achievement of socially valued goals

- 'Objective'** changes in social functioning/social inclusion, e.g.
 - ✓ Living in settled accommodation of their choice where they feel safe and secure
 - ✓ Engaged in full or part-time employment of their choice
 - ✓ In full or part-time education or training
 - ✓ Volunteering
 - ✓ Regularly participating (e.g. 2-4/month) in local community activities
 - ✓ Reporting increased social contacts
 - ✓ Availability of confidant

- Inevitably based on self-report, so important to clarify definitions, time period, etc.

- Look for relevant items in local information systems

[NB Problems with reliability of data if you rely on routine collection, so probably requires face-face interviewing]

#5: Quality of life & Well-being

Manchester Short Assessment of Quality of Life (MANSA)

- Short. Developed for use in a British context.
- Measures 'objective' and 'subjective' quality of life'. Relates subjective satisfaction to specific life areas (including leisure, safety, physical and mental health)
- Really a research tool. May be suitable for assessing impact of large scale, 'whole service' changes

Warwick & Edinburgh Mental Well-Being Scale (WEMWBS)

- 14 items. Refers to person's feeling over last 2 weeks
- Good test-retest reliability ? sensitivity to change.
- Correlates highly with symptom measures (e.g. GHQ-12)
- Relationship between WB, QoL and Recovery?

ReQOL (Brazier et al., Sheffield U. in development)

- Mixture of QOL + HAO-type items
- Carefully co-produced
- Very good psychometrics

ReQOL – 10 point scale

Answered for the last *week*, 10 point scale

- I found it difficult to get started with everyday tasks
- I felt able to trust others
- I felt unable to cope
- I could do the things I wanted to do
- I felt happy
- I thought my life was not worth living
- I enjoyed what I did
- I felt hopeful about my future I felt lonely
- I felt confident in myself

- Please describe your physical health

#6: Costs (service use)

- ❑ Reduced service use may be a *consequence* of recovery, but simply reducing services doesn't mean that people are necessarily more '*recovered*'
- ❑ Recovery is about building a meaningful and satisfactory life. This is obviously difficult if the person is in hospital repeatedly for long periods, hence the importance of reduced length and frequency of admissions
- ❑ Reductions in compulsory admissions and 'community orders' are particularly important
- ❑ Reduced use of community services is more controversial. Might be considered as a recovery outcome indicators - but might not. Must be taken in the context of other outcomes

Reducing service use (and cost) for n=40 attenders at Recovery College in South West Yorkshire (2013/14)

- ❑ For the 6 months prior to attending Recovery College the total average cost of support from local NHS and Social Services = £11,205. For the 6 months following attendance this cost = £3,757
- ❑ This means a (a non-cashable) saving of £7,447 which equates to £186 (233E) per person or a 66% reduction
- ❑ **For the Trust alone, this saving = £6,304, or £158 (198E) per person.**

- ❖ 21 people didn't require any on-going support after 6 months
- ❖ 10 people (25%) required an *increased* level of support which then tapered away.

Conclusions

- ❑ Recovery is a complex construct and measuring outcomes (and quality) is therefore also complex. It cannot be reduced to a single measure just because this is convenient.
- ❑ It is as important to think about what information you *can* collect (practicality) as what you would *like* to collect. Good information costs money.
- ❑ Considerable progress has been made. We are now in a position to describe in reasonable detail what constitutes effective services in supporting recovery. This may be reflected by different combinations of outcome indicators.
- ❑ The next stage will be to link these outcomes to quality indicators and ‘inputs’ (client characteristics). We will then be able to begin to answer specific questions of ‘*what works?*’, ‘*for whom?*’, ‘*as measured by what instruments?*’
- ❑ **Then we will be able to move forward towards Recovery focused services with a truly evidence-based programme.**

Thank you

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Or go to: www.ImROC.org