

Evaluation of the Scottish Recovery Indicator Pilot In Five Health Board Areas In Scotland

EVALUATION OF THE SCOTTISH RECOVERY INDICATOR PILOT IN FIVE HEALTH BOARD AREAS IN SCOTLAND

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EXECUTIVE SUMMARY

Introduction

Background

Central to *Delivering for Mental Health* (DfMH) (2006) is the promotion of a well-being and recovery-based mental health service model, Commitment One of DfMH states:

'We will develop a tool to assess the degree to which organisations and programmes meet our expectations in respect of equality, social inclusion, recovery and rights. The tool will be piloted in 2007 and be in general use by 2010.'

This evaluation is concerned with the Scottish Recovery Indicator (SRI). The SRI enables the assessment of whether and how organisations, and those who work in them, are ensuring that individuals who use their services and their carers' needs are met in terms of their rights to equality, social inclusion and support to recover. The SRI is intended to assist the successful implementation of Commitment One. The SRI is primarily a *developmental* tool and its key elements are:

- Meeting basic needs
- Personalisation and choice
- Strengths-based approach
- Comprehensive service
- Service-user involvement/participation
- Involving support networks and promoting social inclusion and community integration
- Service user in control and active participant even when subject to compulsion
- Recovery focus

The SRI data is collected from a range of sources, including: assessments and care plans, service information, policies and procedures and interviews with service providers and service users. Under the DfMH Leadership Programme *Leading Change*, four health board areas included recovery and social-inclusion focused elements within their *Leading Change* projects and along with two other interested areas agreed to pilot the SRI of whom one did so.

Evaluation aim and objectives

The overarching aim of the evaluation is to assess if the SRI results in real impacts in terms of the implementation of DfMH. The evaluation objectives are to:

- Assess the relevance and appropriateness of the tool to a variety of settings
- Identify what preparation organisations and individuals need before using the tool
- Identify how best the tool should be used (e.g. who to involve in gathering and providing information)
- Identify whether the tool may be able to measure changes in services
- Identify the potential for the use of SRI as a means of promoting change

- Assess whether service users and carers feel added benefit from being involved in the piloting of SRI

Methods

The evaluation explored and reviewed the developmental process of the SRI from the perspectives of all of the groups of individuals involved. The methods involved 4 stages.

Stage 1: Preparation

Stage one included local pilot site group discussions with local pilot site leads and other pilot participants to introduce the evaluation and gather contextual information and the development of a detailed database map of the planned and actual use of the SRI during the pilot.

Stage 2: Local case studies

Stage 2 involved documentary analysis of a maximum of 3 completed SRIs per pilot area, interviews with SRI administrators, service-user and service-provider group participants, a review of any action planning documentation and focus groups with those involved in action planning/implementing change.

Stage 3: Analysis

The analysis brought together the mapping and interview data to allow a full analysis of the use of the SRI within the range of settings provided by the pilot sites in order to provide evidence-based, realistic and thorough guidance for the effective use of SRI within mental health services. Qualitative data was analysed using a staged content process of identifying themes. Quantitative data from SRIs was cross-tabulated to compare scoring between the elements of the SRI and across pilot sites and settings.

Results

Potential of the tool as facilitator for change

The SRI appears to have good potential to influence change. The evaluation demonstrated how the SRI results can challenge service cultures and point to changes that can be made to promote a stronger recovery orientation.

A key strength of the SRI was found to be in its level of detail, which made it possible to pinpoint both areas of good practice and areas for improvement and which provided a structure for identifying what should change and how. However, evaluation participants were confused by the scoring of the SRI and felt that there was limited value in the summary scores.

Administering the SRI was time-consuming but participants accepted that the resource input was necessary and worthwhile especially when the SRI was part of a development process. Although considered to be very relevant by most evaluation participants, the SRI requires a thorough review to improve the clarity, quality and comprehensiveness of the content and to prepare guidelines for administration.

The SRI seemed to enhance local efforts to improve services by linking in well to current service development plans and recovery initiatives within local areas, and further developing local participants' insights into the recovery, equalities and inclusion agenda.

Participants were able to evidence changes already put in place and these were very much focused on activities that would promote social inclusion, equality and recovery, ranging from changing to strengths-based care documentation and procedures, to addressing the issue of ensuring equal employment opportunities for people with mental health problems

The evaluation demonstrated the value of the SRI process as much as its output. Participation in the SRI pilot brought with it a number of added benefits. The SRI created a sense amongst the service users that the SRI places those who use services at the centre of the change process and provides them with motivation to move forward in their own recovery. The tool helped professional and service-user team-working and embedded recovery concepts and language into everyday practice and communication, whilst providing a values-based framework within which to assess how the service system facilitates recovery by encompassing policy, services and practice.

Most pilot sites expressed an intention to re-administer the SRI within a year with the belief that they will be able to measure and demonstrate improvements in their practice.

Completeness and relevance of the SRI

The SRI was considered by most participants to be sensitive to the recovery, equality and social inclusion needs of the individuals and groups who use the range of services to which the tool was applied. However, evaluation participants, particularly those in the pilot area that focused on the inequalities agenda, were not completely convinced of the SRI's contribution towards identifying the extent to which services were identifying and addressing inequalities. There may be a need for further work to develop the SRI's potential on this.

The pilot demonstrated that the SRI can and should be used within and across all services (statutory and non-statutory) for mental health, although some work is required to make the tool less health and medically focused. The pilot has also revealed that the SRI is flexible enough to be used in a number of different ways, from a benchmarking tool or an impact assessment tool for new services, to a reference for everyday supervision. How the tool is used in the long term and how often, may be better dictated by local development needs rather than prescribed nationally.

Recommendations for the development and roll-out of SRI

The evaluation resulted in a number of detailed recommendations for those responsible for the development and roll-out of the SRI, including:

- Ensuring an inclusive approach to developing and rolling out the SRI, including support and learning networks and information on how SRI fits with other initiatives that promote recovery orientation
- Employing strategies to achieve and sustain buy-in to the SRI process, e.g. strong strategic commitment, creating clear lines of accountability and/or formal approaches to the use of SRI, producing national-level supporting documentation, building SRI in to local strategies on recovery and operational procedures, good project management and a non-judgemental and supportive ethos
- Improving SRI preparation days to increase the time available to cover the extensive ground, be responsive to the needs of different individuals, provide more on the background and evidence behind the recovery concept and on the practicalities of the administration process, including the teaching of sampling and data collection skills
- Supporting SRI implementation by local recovery awareness sessions prior to the administration
- Improving the content of SRI using the evaluation results to revise the content of specific questions and each whole part of the SRI. Sections 4 and 5 in particular needs to be simplified and reviewed to weed out any duplication. A crucial aspect of the revision of the SRI content should be adaptations to enable wider service setting applicability of SRI. The language should be less healthcare-focused and more generic to enable those in non-healthcare services to use the SRI.
- Involving service users in a number of ways including as interview participants, administrators, scorers and action planners. Consideration should be given to paying service users for their involvement in the SRI development process, especially as administrators, scorers and action planners.
- Giving consideration to using different people to administer different parts of the SRI and to work in administration teams
- Providing further guidance on the administration process, particularly sampling, recruitment and data sourcing
- Service-user interviews should be supported with prior provision of information, conducted in groups, less than one hour long, have a familiar interviewer and venue, support practical needs and allow carers or representatives to attend
- Service-provider interviews should be supported by provision of information on the purpose and content of SRI and implications of participation prior to the interview, recruited-for through open invitation to participate, held with multi-disciplinary teams with management representation
- Providing improved guidance on scoring methods
- Undertaking scoring as a group effort soon after administration with additional notes being made in the SRI during the administration and consulted during SRI scoring, allowing further investigation or follow-up of issues as required
- Providing forums for those leading SRI locally to network and share experience, not only in relation to SRI administration but more importantly in relation to service and system change (feedback and action planning templates could be produced nationally)

Those involved in the roll-out of the SRI need to address the key challenges and barriers to use of SRI by:

- Committing further attention to acknowledging the contribution to the recovery agenda of psychiatry and involving psychiatry in the future roll-out of SRI

- Challenging the persisting perception from some nursing professionals on acute wards working with those under MHA and those with dementia, who consider that aspects of the recovery agenda such as occupation or shelter are not relevant to their service
- Giving consideration to engaging foreign language and hearing interpreters to assist administration of the SRI

CHAPTER ONE INTRODUCTION

1.1 The Scottish Development Centre for Mental Health were commissioned by the Scottish Government to undertake this evaluation, entitled 'Evaluation of the Scottish Recovery Indicator Pilot in five Health Board Areas in Scotland'.

Background

1.2 Delivering for Mental Health (DfMH) was produced in December 2006 by the Scottish Executive's Mental Health Division to build on recent service shifts towards a community-based service model. The guidance in DfMH is based on evidence of what works in terms of achieving better outcomes for individuals through using appropriate services that meet their needs. It promotes a functional model of service design and requires local partners to ensure that services aim to perform well and achieve good standards in response to local needs. There are 3 main targets:

- To reduce the annual rate of increase in anti-depressant prescribing to zero by 2009/10
- To reduce suicides in Scotland by 20% by 2013
- To reduce re-admissions (within one year) to hospital by 10% by the end of 2009

1.3 Central to DfMH is the promotion of a well-being and recovery-based mental health service model. This is combined with a population-based approach to social inclusion to prevent mental illness and inequalities in mental health and highlight the link between mental and physical health.

1.4 The targets are supported by 14 commitments. This evaluation is concerned with the Scottish Recovery Indicator (SRI), the tool that is hoped will assist the successful implementation of Commitment One. Commitment One states:

'We will develop a tool to assess the degree to which organisations and programmes meet our expectations in respect of equality, social inclusion, recovery and rights. The tool will be piloted in 2007 and be in general use by 2010.'

Scottish Recovery Indicator

1.5 In response to Commitment One of DfMH, the Mental Health Division set up a working group to develop a tool to measure practice in relation to recovery-promoting values. The Scottish Recovery Indicator is the result of adaptations made to the Recovery-Oriented Practices Index (ROPI) which was originally created and subjected to research and testing by the New York State Office of Mental Health (Mancini & Finnerty, 2005). The adaptations were primarily to ensure that the tool was relevant within the Scottish mental health practice arena whilst maintaining those components of the tool that are known to measure those aspects of service that are known to promote recovery.

1.6 The suggestion that 'a recovery environmental audit tool' be developed for Scotland was first made in *Rights, Relationships and Recovery: The Report of the National Review of*

Mental Health Nursing in Scotland (2006). Following discussion, this action was later subsumed as a commitment in DfMH.

1.7 The SRI covers a wide range of issues, with the key elements being:

- Meeting basic needs; personalisation and choice
- Strengths-based approach (e.g. care plan format integrates strengths into goals)
- Comprehensive service
- Service user involvement/participation (e.g. service users employed in professional and/or support staff positions at equal pay and with equal responsibility)
- Involving support networks and promoting social inclusion and community integration (e.g. service makes active efforts to involve service-users' support system in care and treatment)
- Service user in control and active participant even when subject to compulsion (e.g. services should encourage service users to plan in advance for periods of incapacity)
- Recovery.

1.8 The SRI data is collected from a range of sources, including: assessments and care plans, service information, policies and procedures and interviews with service providers and service users. A summary version of the SRI tool under evaluation can be found in Appendix 1.

1.9 The SRI enables the assessment of whether and how organisations, and those who work in them, are ensuring that individuals who use their services and their carers' needs, are met in terms of their rights to equality, social inclusion and support to recover. It is primarily a *developmental* tool which engages the tool-user in a *process* of:

- Assessing the extent to which services, and those who work in them, meet the expectations of Commitment One of DfMH
- Identifying gaps in service provision, processes and policies
- Creating an action plan to improve the service
- Reassessing to identify progress.

Need for evaluation

1.10 To inform the success of local processes, policies and staff in promoting respect for equality, social inclusion, recovery and rights within mental health services, knowledge is required about the practical utility and validity of SRI as a development tool for this purpose.

1.11 In response to this, the Scottish Executive's Mental Health Division piloted the SRI in five health board areas in Scotland and commissioned an evaluation of the pilot.

SRI pilot sites

1.12 Under the DfMH Leadership Programme *Leading Change*, 5 health board areas have included recovery and social-inclusion focused elements within their *Leading Change*

projects and agreed to pilot the SRI in different ways that matched with their wider change projects. The pilot areas and their proposed approaches to using SRI were:

- Ayrshire and Arran used the SRI to measure the impact of system-wide cultural change in a number of wards in different hospitals. All of the pilot sites in Ayrshire and Arran were inpatient units, with one being adult acute admission wards (Ward 1D & 1E at Crosshouse Hospital, Kilmarnock), one a ward for adults with continuing care needs/rehabilitation (Ballantrae Ward, Ailsa Hospital in Ayr) and another acute admissions in old age psychiatry (Pavilion 2 in Ayrshire Central Hospital, Irvine and Croy House in Ailsa Hospital, Ayr).
- Greater Glasgow and Clyde explored the application and relevance of SRI within diverse communities, with particular reference to black and minority ethnic (BME) and deaf communities in a variety of mental health settings (involving some BME and deaf groups in the review of the tool). Greater Glasgow and Clyde had numerous pilot sites of which only three were selected for inclusion in the evaluation. One pilot site in North Glasgow was a linked acute inpatient ward (Armadale Ward in Stobhill Hospital) and community-based adult mental health service (Springpark Resource Centre). Another was the Crisis Team, a community-based service in South East Glasgow and the remaining pilot site was the continuing care/rehabilitation Ward 15 in Dykebar Hospital in Paisley.
- Forth Valley used the SRI to benchmark and audit change resulting from their culture change exercise, particularly acute in-patient and intensive home treatment teams and older people's services. Three pilot sites participated, all in adult inpatient services based in Falkirk and District Royal Infirmary. The wards that participated in the pilot were: ward 1 (acute inpatients), ward 18 (acute inpatients) and ward 19 (intensive psychiatric care unit). All pilot sites in Forth Valley were project managed by the local lead, the Project Manager (recovery).
- Tayside (Angus area) used the SRI to benchmark and inform redesign in relation to the reconfiguration of day services, focusing on community integration, potentially in wards and community services, but mainly in statutory day services operating from multiple sites. There were three pilot sites in Angus, one in an inpatient ward (general adult psychiatry) in Sunnyside Royal Hospital in Montrose, one in day-treatment services (general adult psychiatry) in Whitehills Health and Community Care Centre in Forfar and one in day services (adult community social work and health) within Angus Council's social work department at Gowanlea in Arbroath. Angus pilot sites also involved the service user-led voluntary organisation Augment (Scotland) Ltd to conduct the service user interviews for the SRI.
- Two further areas asked to be included, Grampian (Moray) and Lanarkshire. Unfortunately, due to sickness, Lanarkshire was not able to proceed with their pilot within the time scales of the evaluation which would have seen 2 further pilot sites, one in an adult inpatient ward (Ward 24, Monklands Hospital in Airdrie) and one in the community-based Cumbernauld Mental Health Outreach Team (a joint social work and health team).
- Grampian (Moray) used the SRI to monitor their independent sector community mental health services. Two SRI pilots were carried out in Moray, one in the

community-based Adult Day Services in Dr Gray's Hospital (NHS Grampian) and another in the voluntary sector in Horizons with Moray Anchor Projects, a drop-in centre for adults experiencing or recovering from mental health problems or distress. Both pilot sites were based in Elgin and were led by the same local leads.

Objectives

1.13 The overarching aim of the evaluation was to assess, at this early stage, if the SRI results in real impacts in terms of the implementation of the Mental Health Delivery Plan.

1.14 The specific objectives of this evaluation were to:

- Assess the relevance and appropriateness of the tool to a variety of settings
- Identify what preparation organisations and individuals need before using the tool
- Identify how best the tool should be used (e.g. who to involve in gathering and providing information)
- Identify whether the tool may be able to measure changes in services
- Identify the potential for the use of SRI as a means of promoting change
- Assess whether service users and carers feel added benefit from being involved in the piloting of SRI.

1.15 The evaluation also offers clear recommendations in relation to:

- Whether any amendments or additions are required to the tool
- Preparation required to use the tool
- Advice and guidance on how to use SRI as a developmental tool to effect improvement in services.

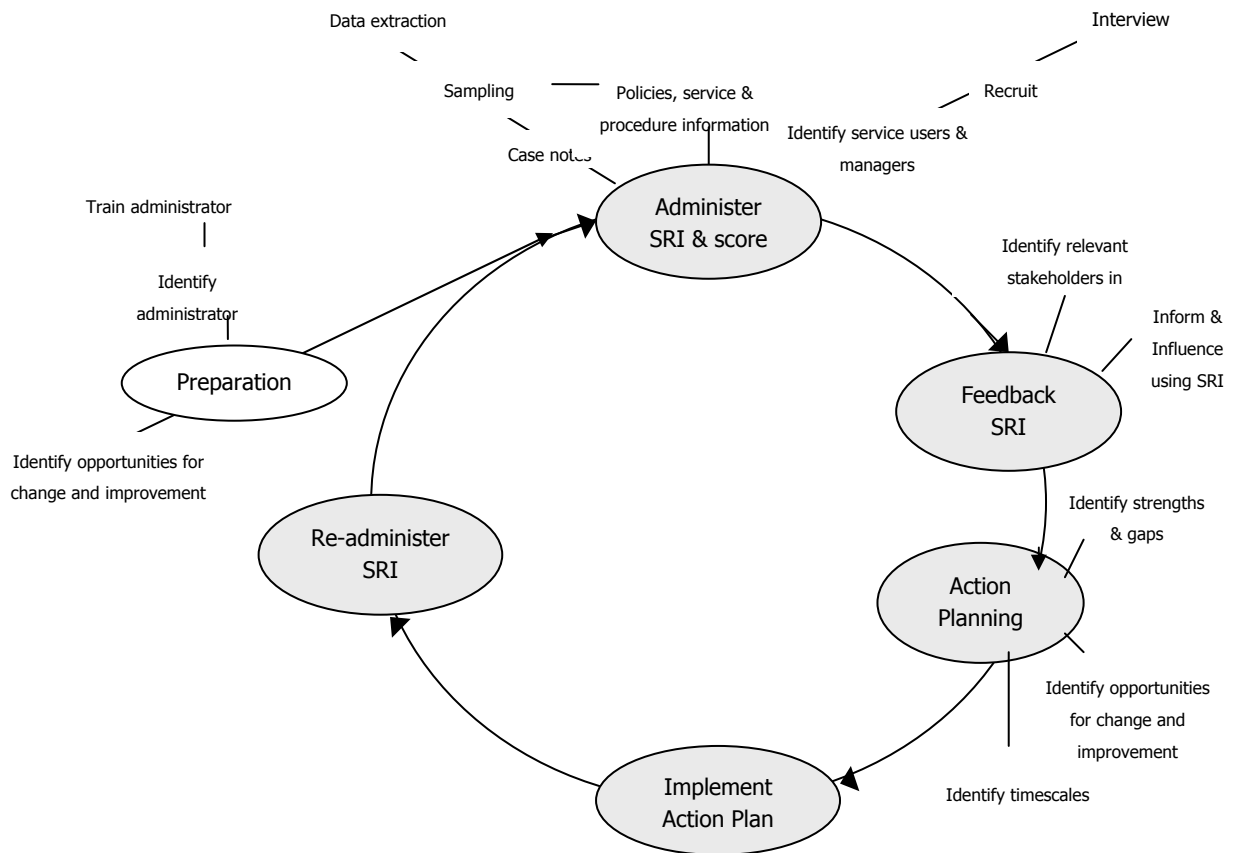
Approach

1.16 In line with the principle that services should be delivered in a person-centred way, recognising the uniqueness of each individual's experience, the evaluation examines the extent to which the tool identifies how well the services are identifying and then responding where there are inequalities, e.g. poverty, marginalized groups, stigma.

1.17 In order to meet the evaluation objectives, the primary focus of this report is the utility of the SRI as a *development* tool within the different pilot settings. The evaluation examines each stage of the 'SRI development process' individually (as detailed in Figure 1.1 overleaf) and the development process as a whole.

1.18 Viewing the process as a whole, the evaluation explores the extent to which SRI enables practitioners and managers to apply individual-level factors that promote equality, social inclusion and recovery to system-level *change*.

Figure 1.1 **SRI Development Process**



CHAPTER TWO METHODOLOGY

Introduction

2.1 The evaluation explored and reviewed the developmental process of the SRI from the perspectives of all the groups of individuals involved. Information was collected at each key stage including:

- Preparation
- Administration
- Collation and scoring
- Feedback
- Action planning
- Implementing change
- Re-administering.

2.2 The evaluation included 3 linked stages, each of which are detailed below.

Stage 1: Preparation

Local pilot site group discussions

2.3 Each local pilot site lead and representatives of the local DfMH project team/those involved with the project, were invited to a group discussion with the SDC evaluation team at a local venue with the following purposes:

- To introduce the evaluation, answer any questions and identify a main local contact
- To identify how and why they chose the services they did to pilot SRI
- To gather details of the proposed use of SRI in each contact and any other materials that will inform the mapping exercise
- To jointly plan and agree local case study data collection with each pilot team

Mapping SRI use

2.4 During the local group discussions, throughout the pilot evaluation, the research team developed a detailed map of the planned and actual use of the SRI during the pilot in each pilot site. The map was based on the key stages in the SRI development process (see Figure 1.1 on page 14) with the following information collated onto a database:

- Setting(s), service type, target group(s), delivery model, size
- Participants involved, backgrounds, where and when involved (administrators, practitioners, service users, service providers and commissioners)
- Structural links i.e. where the SRI pilot fits within local service planning and development
- Data sources used (e.g. case notes, service users input) including approaches to sampling

- SRI scores
- Method of feedback of SRI and to whom
- Action-planning processes and action plans
- Progress of implementation of action plan
- Details of re-administration of SRI
- Timescales and resources (e.g. manpower) for all of above

2.5 The research team sourced the mapping information mainly from the local main contacts and from completed SRIs.

Stage 2: Local case studies

2.6 A case-study approach was taken to the bulk of data collection, with the following approach applied within in each pilot area.

Review of SRIs

2.7 The review of SRIs involved a documentary analysis of the completed SRIs and interviews with SRI administrators, service providers and service users. If pilot sites were planning to administer multiple SRIs, SDC worked with the local teams to identify which SRIs should be included in the evaluation to provide a manageable sample of a maximum of 3 SRIs per area. Criteria used to assist selection of SRIs included those that:

- Were administered early on in the pilot (to increase opportunity to follow through to action planning/implementing change/re-administration)
- Focused on areas where it anticipated that there would be most learning

Documentary analysis

2.8 SDC invited each SRI administrator to provide the evaluation team with a copy of their SRIs as and when they were complete. Scores of each element of the SRI and any comments were entered into the mapping database.

Interviews with SRI administrators

2.9 Each SRI administrator was invited in writing to participate in a face-to-face interview with the SDC researcher following the administration of the SRIs they were assigned to complete (a maximum of 5 SRI administrators per site were interviewed). The interviews were held locally at a location convenient to the interviewees and lasted for an hour. The interviews covered the following areas:

Preparation and Set-up

- Quality of training and extent to which it prepared them to use the tool

- ‘Buy-in’ and ownership of the SRI process and how this was approached.

Administration

- Experience of the process of administration including each section of the SRI and each data collection method section:
 - Assessments and care plans – access, content, extracting data, sampling
 - Service information, policies and procedures
 - Service user interviews – recruitment and involvement
 - Manager interviews – recruitment
- Support from managers/practitioners and service users to carry out data collection
- Process of collation and scoring
- Timescales – how long to complete and with what resource?

Content

- Is the SRI sensitive to strengths and weaknesses of different services?
- Does the SRI provide useful information on service sensitivity to different user-groups’ needs?
- Does the SRI capture the administrator’s perception of how recovery-focused the service is? If not, why not?
- Are there any gaps?
- Should additional items be included in the Indicator? Should anything be removed?

Developmental

- How were SRI scores and other details fed back, by whom, to whom and in what format?
- What level of interest was there in the SRI results? What key issues were raised by whom?
- Extent to which SRI has the potential to influence change
- The SRI administration task is described in the guidance as onerous- is it? If so in what ways? Is it worth it?
- Impact on their own attitudes/knowledge/confidence regarding the factors that influence recovery - has/will involvement with the SRI project lead them to do anything differently?
- How could the administration of SRI be improved?

Interviews with SRI service user and service provider groups

2.10 At each pilot site all those who participated in service provider and service user groups for the SRI were invited to participate in a face-to-face interview. Offering an initial invitation to service users and providers to participate in the evaluation and obtaining consent to be contacted by SDC was undertaken by the SRI administrator, during or following the

SRI interview. SDC provided information sheets and consent forms. SDC then contacted those who had consented to participate to arrange an interview.

2.11 A maximum of six service providers and six service users (and carers where appropriate) were interviewed per pilot site.

2.12 The service user and service provider interviews covered the following areas:

Preparation

- In what way were they supported to prepare for the interview? Was this support adequate? What other supports would be helpful?
- Opinions on the recruitment process for SRI interviews

Administration

- Experience of the interview
- Support offered to participate in the interview e.g. interpreter, hearing loops, advocacy, emotional support
- Appropriateness of venue
- Interaction/dynamic with other group members
- Timescales – how long to complete and opinion on this

Content

- To what extent were the SRI questions relevant to the individual service user/ service provider? Were they able to answer all questions?
- Does the SRI include questions that are relevant to gathering information on service sensitivity to different user groups/needs and person centred care?
- How well does the SRI capture the service user's/service provider's perception of how recovery-focused the service is?
- Are there any gaps?
- Should additional items be included in the Indicator? Should anything be removed?

Developmental

- In what ways, if any, did they feel they benefited from being involved in piloting the SRI?
- How important do they feel their contribution to the SRI is?
- How were SRI scores and other details fed back, by whom, to whom and in what format? How useful was this?
- Extent to which SRI has the potential to influence change
- Did being involved with the SRI impact on their own attitudes/knowledge/confidence regarding the factors that influence recovery - has/will involvement with the SRI project lead them to do anything differently?

- How could the administration of SRI be improved?

Review of action planning

2.13 The review of SRI action plans included documentary analysis of any action plans and focus groups with those involved with action-planning and implementing change.

Documentary analysis

2.14 SDC was supplied with SRI action plans as and when they are completed by the main local contact in each site. Due to time constraints, only one action plan was submitted and this was after the data collection cut-off date. Therefore, any thorough analysis of the action plan itself was not possible. Instead, the action plan has been included as an appendix to the report (see Appendix 2).

Focus groups with those involved in action planning/implementing change

2.15 One focus group with those involved in action-planning was conducted in each pilot area. It was initially planned that the focus groups would take place following the production of SRI action plans where possible, allowing time for implementation of changes and possibly re-administration. In reality, no pilot sites had reached this stage and so those who were involved in beginning the process of action-planning were invited to attend. The focus groups were facilitated by the research lead, lasted for approximately 2 hours and were held at a location convenient to the participants.

2.16 The main contact for the evaluation in each pilot site provided the SDC research team with contact details of those involved in the action-planning process within their locality. In some cases this proved to be the same people who were involved in the administration of the SRIs or in the service user or providers interviews.

2.17 The focus groups were concerned with exploring the action-planning, implementing change and re-administration aspects of the SRI development process (see Fig 1.1 on page 14), and the following areas were covered:

Preparation

- Extent of preparation to use the tool to plan system level change
- Approaches to achieving ‘buy-in’, extent of buy-in and influence on the SRI process as a whole

Relevance and utility for action planning

- How useful was SRI in identifying areas for system level change, were some items in the tool more helpful than others, specific to the particular setting of the project?

- How well did SRI facilitate insight into and reflection on service-delivery values and practice in terms of equality, social inclusion, recovery and person-centred care?
- What were the key learning points in terms of the extent to which services are sensitive to recovery-related values? What did they learn that they did not know already from other approaches to service development?

Content

- Are there any gaps? Should additional items be included in the indicator and what should come out?

Utility in terms of promoting change

- What progress has been made in terms of implementing change?
- To what extent does the tool influence/facilitate/promote change in terms of practice and wider service development?
- Facilitators and blocks to change
- Impact on their own attitudes/knowledge/confidence regarding factors that influence recovery

Developmental

- What might improve the process of action-planning in order to ensure SRI can be useful as a means of promoting change in service culture
- How often should SRIs be used and within what timescales – what is the required investment of resource to complete the SRI process and is this realistic?

Consent and confidentiality

2.18 Informed consent was sought from all of those invited to participate in evaluation interviews and/or focus groups. Evaluation information sheets were provided to all those invited to participate with contact details for the research team. In all cases, interviewees and those participating in focus groups were assured confidentiality in that no personally identifiable information would be included in the draft and final reports unless the interviewee concerned had agreed to the content.

Stage 3: Analysis

2.19 The analysis brought together the mapping and interview data to allow a full analysis of the use of the SRI within the range of settings provided by the pilot sites in order to provide evidence-based, realistic and thorough guidance for the effective use of SRI within mental health services.

2.20 Qualitative data were analysed using a staged-content process of identifying themes. Quantitative data from SRIs were cross-tabulated to compare scoring between the elements of

the SRI and across pilot sites and settings. Each component of the SRI process was analysed separately as well as combining the components to gain a picture of the SRI as a development process in a range of 'live' settings. In particular the analysis included:

Assessing the completeness and relevance of the SRI in terms of:

- Sensitivity of the tool to the recovery, equality and social inclusion needs of the individuals and groups who use the range of services to which the tool was applied
- The extent to which the tool identifies how well the services are recognising and responding to inequalities, e.g. poverty, marginalized groups
- Views of participants on the relevance of the SRI to them and the service in question and any content gaps or surpluses identified.

Exploring the potential of the tool as facilitator for system level change by assessing:

- The range of action points raised by SRI and their potential to influence real change in terms of promoting social inclusion, equality and recovery
- The relationship between SRI scores and action plans and how strongly they are linked and what the SRI adds to current service development plans
- Influence of participation in the SRI process on the attitudes, knowledge and confidence of individuals, service providers, planners and users
- Progress made by projects towards implementing changes identified in action plans.

Identifying how best the SRI should be used by:

- Categorising the different approaches in which SRI has been used (including setting, target group, process, who is involved, timescales) and why
- Comparing the relevance and utility of SRI as a facilitator of change between the identified variations in approach
- Collating views on the thoroughness of the preparation training and preparation for action-planning.

Assessing the SRI as a measure of change by:

- Comparing differences in scores between first and second administration of the SRI where this has taken place
- Comparing differences in SRI score between different settings/wards and the perceived relevance of the tool to that setting to identify where the tool is sensitive to difference in levels of recovery promotion.

2.21 From this, conclusions were drawn regarding:

- The preparation required for the use of SRI
- The content of SRI

- Selection of appropriate service settings for the use of SRI
- Factors necessary for the successful use of SRI as a development tool that can effect relevant and desired change (including administration, action-planning and change implementation processes, readiness factors to do with the service in question, local context, organisational structures, buy-in , and leadership)
- The potential the SRI has to promote and facilitate service change and improvement
- The added benefit gained from being involved in the SRI process, from all perspectives but especially for service users.

CHAPTER THREE RESULTS

Introduction

3.1 This chapter provides a synthesis of all of the data collected during the evaluation. The chapter is structured to largely reflect the approach to the analysis of the data which was to analyse each main stage of the SRI development process separately, including:

- Preparation
- Administration
- Collation and scoring
- Feedback
- Action planning
- Re-administration.

3.2 The chapter also incorporates an element of cross-over between the stages, allowing the reader to gain a sense of the use of the SRI as a development process within a range of ‘live’ settings. A specific section focuses on the content of the SRI.

3.3 Much of the findings are reported generally because they were relevant across most or all of the pilot sites and areas and respondents. Where a particular finding is specific to a particular pilot area, site, setting, participant group or individual, this will be referenced.

Response

3.4 Five of the SRI pilot areas were able to participate in the evaluation. Of the five participating pilot areas, a total of 16 completed SRIs were included in the evaluation and mapping information was provided for each of these. For the remainder of this report, these 16 SRIs will be referred to as individual pilot sites within pilot areas.

3.6 A total of 40 interviews were carried out across the five participating pilot areas. This included 20 administrator interviews, 11 service user interviews and nine service provider interviews. One focus group was held in each pilot area and each focus group included key individuals from various pilot sites who were/would be involved in taking the SRI action planning processes forward. This included service-level staff, managers, service-user representatives and strategic managers.

Table 3.1 on page 24 provides a detailed breakdown of the evaluation data collection activity.

Table 3.1: Response

Pilot Area	No. of SRIs	Mapping information	Interviews			Focus Group
			Administrators	Service Users	Service Providers	
Ayrshire and Arran	4	3	4	0	0	1
Forth Valley	3	3	4	0	3	1
Grampian (Moray)	2	2	3	0	0	1
G. Glasgow and Clyde	4	4	5	6	3	1
Tayside (Angus)	3	3	4	5	3	1

3.7 Table 3.2 below provides further detail on the settings in which the SRI was piloted.

Table 3.2 Settings of SRI pilots by pilot area

	Inpatient	Community-based	Voluntary sector	Total SRIs
Ayrshire & Arran	4	-	-	4
Forth Valley	3	-	-	3
Grampian	-	1	1	2
Greater Glasgow & Clyde	2	2	-	4
Tayside	1	2	-	3
Total	10	5	1	16

Limitations

3.8 Service users who had been involved in the SRI pilot in Ayrshire and Arran, Forth Valley and Grampian did not consent to be interviewed as participants in the evaluation. Similarly in Ayrshire and Arran and Grampian, no service providers who had been part of service provider groups for the SRI pilot consented to interview. Reasons for non-consent for service users included that an evaluation interview as well as participation in the SRI groups would be too stressful. When service providers did not respond, the only reasons provided by pilot leads were that the service providers were too busy to take on the interview within the scheduled timescales. This does represent a gap in the completeness of the data for the evaluation, and therefore findings based on service user and service provider data should be interpreted with caution.

Findings: preparation

Preparation for administration of SRI

Preparation day

3.9 Administrators were asked to rate how well the SRI preparation day prepared them to use the tool on a scale of 1 to 5 (5 being that the preparation day prepared them completely and 1 being the preparation day did not prepare them at all). On average, interview

participants scored the preparation at 2.5 in terms of preparing them to administer the SRI. Reasons for this varied; however, the dominant themes that emerged are outlined below.

3.10 The most common comment was that a formal training environment can only prepare you so much and the practical implementation of the tool provided people with the most learning. Of the 20 interviews conducted, 10 advised that nothing could fully prepare people to administer the SRI. Six participants advised that no amount of formal training could prepare or explain the practicalities of what is involved with the SRI (e.g. ethical concerns, service user involvement, time commitment and timescales).

3.11 All of those who attended the preparation day advised that there was too much information included in one preparation day. There was widespread appreciation that training like this is extremely dense in information and that this may be inevitable.

3.12 Administrators gave a wide range of answers when asked what was particularly helpful and what could have been improved in relation to the SRI preparation and there was no distinction between areas. Table 3.3 below, summarises the positive and negative responses of administrators and the national support function.

Table 3.3 Participants' perspectives on SRI training

Positive aspects	Negative aspects
<ul style="list-style-type: none"> ▪ Going through the SRI documentation in detail/step by step ▪ Becoming familiar with the paperwork prior to implementation ▪ Opportunity to ask questions ▪ Discussion amongst peers in relation to the practicalities of implementing the tool and concerns ▪ Peer support: meeting other people involved in the SRI, networking, listening to other people's experiences and multi-agency learning ▪ Appreciation that the tool was nationally recognised ▪ The sense that it was a cooperative process and that service users are central to the SRI ▪ The emphasis on this as a pilot and a development tool, rather than a tool by which services were to be measured ▪ Explanation of recovery concept and the background to the recovery agenda ▪ Opportunity to sound out ideas for implementation locally 	<ul style="list-style-type: none"> ▪ Rushed – it could have been broken down as it was quite a lot of information in one day ▪ Lack of case studies/workshops/exercises to learn the practicalities of SRI ▪ Going through the tool as this seemed abstract when not familiar with it ▪ Lack of information provided prior to preparation day ▪ Having to learn all parts of the SRI (e.g. some only used certain parts of the SRI so not all preparation relevant if only using certain parts) ▪ Not prescriptive enough ▪ Group too large to promote participation or not equal in terms of encouraging discussion and questions ▪ Lack of service-user representation at the training ▪ Lack of preparation on involving service users in SRI process ▪ Perception that some people attending were not very committed to the SRI process ▪ A lack of general background information on recovery ▪ The trainers not very well-prepared (although there was acknowledgement this is new and trainers would become more confident and familiar with the SRI as time progressed) ▪ Did not look at processes in enough depth (e.g. how to conduct an interview, focus group, sample case plans, etc) ▪ Lack of time spent on the scoring and a downplaying on the importance of the scoring ▪ Central Scotland-based

3.13 Some of the positives identified by participants were directly contradicted by negatives identified by others such as the extent to which recovery as a concept was included or opportunities to participate. This highlights the diversity of needs of individuals attending the training. Familiarity with the concept of recovery varies, and there were indications that those who were already familiar with recovery found the preparation day to be more helpful as they shared an understanding of recovery language and principles. On the point of involving service users more in the training, local pilot leads were responsible for deciding who should attend training.

3.14 A number of suggestions for improving the preparation day for SRI were made, including:

- Including case study scenario workshops to run through the practical implementation of the SRI, providing trainees with a more accurate indication of the time and resource commitment required, alongside other practicalities such as understanding questions and sampling assessments and care plans
- Interviewing and group facilitation skills (required for Parts 3, 4 and 5 of the SRI)
- More focus on recovery in its broadest sense to ensure universal understanding of the background and concepts of recovery, alongside the language that administrators will come across during the administration of the SRI
- More guidance on the scoring of the SRI (this was considered by many as the most challenging part of SRI administration)
- Inclusion of service users at preparation day (acknowledging local responsibility for nominating preparation day participants) and, in terms of content, more on the service user involvement aspect of the SRI (one participant explained that the ethos of the SRI is the centrality of the service user to the process and this should be reflected in the training)
- Reduce the intensity of the preparation by allocating over more than one day (although there was acknowledgement that attendance at training can be challenging in terms of being released for training, backfill, etc)
- Increase opportunities for participation with smaller groups
- Provide locally-based preparation days

Achieving local 'buy-in' to the SRI

3.15 Buy-in from local stakeholders is imperative to the effective implementation of the SRI. Most participants claimed that there was support for the SRI pilot at operational and strategic management levels in their local area. This support often stemmed from an existing strategic commitment to implementing a recovery agenda throughout services.

National support

3.16 The level of national support, demonstrated through the formal commitment in Delivering for Mental Health to the implementation of SRI and the support to the process provided by the Scottish Recovery Network, was perceived to enhance local buy-in. National support was perceived to increase the impetus to drive the SRI forward locally and enable better local understanding and appreciation of the use of SRI and the recovery agenda more generally.

Close project management

3.17 All areas have had a central driver for the SRI locally, however, where these individuals have been involved in the actual administration of the SRI this was perceived by evaluation participants to have been the key to achieving buy-in from others. These dedicated project managers were able to develop a structured approach to building local engagement and support for the SRI process and recovery, and co-ordinating the administration of the SRI pilot.

Formal accountability

3.18 Another key approach to achieving local buy-in was to build SRI into official strategies, operational processes and service requirements. For example, in Grampian there are lines of accountability for the services that participated in the SRI to the Integrated Mental Health Services Manager who has joint responsibility (in partnership with the local authority) for commissioning mental health services locally. The Grampian mental health strategy emphasises the use of SRI to promote recovery-based services which has translated down to formal service level agreements with the use of SRI as a requirement of the commissioning process.

Implementing SRI with a supportive ethos

3.19 One of the issues that came through strongly in the interviews with the consultant and those administering the SRI in all the areas in the evaluation was a concern of staff and management of being judged and of the tool being primarily a means of performance management. The consultant commissioned to assist local implementation of the SRI, the Scottish Government, the Scottish Recovery Network and the evaluation team, reiterated that the SRI pilot was a trial and that services would not be judged by their scores or the outcome of the SRI. This seemed to provide some ease and relieve some apprehension.

3.20 There has also been considerable work undertaken at ward/service level by each of the managers of the services participating in the SRI pilot at pilot sites. Local meetings to discuss the use of the SRI and allocation of tasks within the SRI were particularly helpful. Local activities included discussions with staff and patients to make them aware that the SRI was not being used as an audit or judgement of services but instead as a developmental tool to indicate areas of strength and areas for improvement. However where this has been the only approach to build engagement and support for SRI, it appeared to be less effective than where a range of approaches were used to achieve this.

Access to helpful publications

3.21 National publications were also mentioned by the administrators of the SRI as helpful in terms of reinforcing the aims of SRI and gaining local commitment, specifically the Scottish Government publications *Delivering for Mental Health* (2006) and *Rights, Relationships and Recovery: The Report of the National Review of Mental Health Nursing in Scotland* (2006).

Reservations amongst psychiatrists

3.22 One key finding was of a common perception amongst interview and focus group participants of a lack of active involvement in and support for the SRI from psychiatrists. These participants acknowledged that psychiatry has a lot to contribute potentially to the SRI development process and the need to commit further attention to involving this group in the future.

Preparation for action planning

3.23 Feedback from the focus groups suggested that the somewhat limited timescales for the SRI pilot meant that in the rush to train and prepare for the administration of the SRI, planning for the process of action was not always given the time it required. Following the administration of the SRI, some pilot areas felt that in retrospect, if they had planned for the whole SRI development process, they would have ensured more momentum in moving on the feedback and action planning activities. In one pilot area, participants claimed that they were told that they were to focus on the administration and content of the SRI for the pilot only, and they were not required to think forward to action planning.

Administration

Preparation

Confidentiality

3.24 Administrator and focus group participants in each pilot area raised concerns about issues associated with protecting confidentiality and anonymity whilst administering the SRI, however, this concern was not shared by the service users or service providers interviewed. Confidentiality issues centred on accessing patient-related documentation and conducting interviews and focus groups.

3.25 In three pilot areas there were concerns around SRI administrators accessing confidential assessment and care plan documentation, (some of which had been awarded patient/doctor confidentiality status) to complete Parts 1 and 2 of the SRI. In one of these pilot sites, each ward manager administered the SRI in a ward that was not their own to ensure an amount of objectivity in completing the SRI, causing some concern. Where the ward or service manager administered the SRI in their own service, issues around recording confidential information on the SRI were important but less controversial, as these individuals have access to the assessments and care plans as part of their professional role. The national support individual was consulted on this issue by each of the three pilot sites and each ward/service manager was supported to come to their own decisions on this. In all areas, the emphasis was placed on the data being recorded anonymously with no identifiable data recorded on the SRI.

3.26 In the inception discussions with pilot areas, some people raised concern around the involvement of service users in Parts 1 and 2 of the SRI. It was suggested that only health service employees who are bound by internal codes of confidentiality, or those with honorary contracts, should administer and complete Parts 1 and 2 of the SRI.

3.27 SRI administrators, in planning the administration of the SRI, and on reflection having completed the process, felt that there were a number of important issues around the interviewing of service users for the purposes of the SRI. In many cases key workers or ward staff who knew the individuals conducted their SRI interviews. A main concern was whether a service user being interviewed by an individual, who also provided mental health care, was ethical in relation to the service user's ability to provide their genuine opinions of the service, which the individual interviewing them represents. Another concern was whether staff charged with providing an equal, accessible, approachable and supportive service could also be involved in contributing to an objective criticism of the same service.

Sampling

3.28 Some administrators expressed uncertainty around the selection of documentation samples for the SRI due to a lack of guidance on sampling techniques including the size of the sampling frame. The national support consultant was contacted on this issue by a number of individuals and supported local areas to come to their own conclusions in this matter after discussion.

3.29 For Parts 1 and 2 of the SRI, the selection of 10 assessments and 10 care plans seemed, for some administrators, to be a low number to achieve accurate representation across the service and also time constraints meant they chose to sample less than 10.

3.30 There was concern from some administrators that the service users who would agree to participate in the Part 5 group interviews would have some motivation for taking part (e.g. an outstanding issue/complaint in regards to a service) and so bias the results of this part of the SRI. However, there was also acknowledgment that the key aim of the SRI is as a developmental tool to identify areas for improvement and administrators were aware that even if, by chance, data was predominantly negative than this would still provide them with an insight into areas for improvement in the service.

3.31 The following five sections focus on the administration of specific parts of the SRI and scoring.

Parts 1 and 2: Assessment and care plan data

3.32 The overall consensus amongst the SRI administrators spoken to in the evaluation was that the process was found to be extremely time-consuming.

Selecting cases

3.33 Whilst most areas sampled the recommended 10 assessments and care plans, a significant number of local pilots used smaller samples due to time constraints: Three areas sampled five and one area sampled three. Sampling frames selected by pilot sites varied including:

- Those who had been in the service for a specific amount of time (between seven and 10 days or more in an inpatient setting, one year or more in community-based services etc)

- Geographical location (e.g. spread over a number of CMHTs)
- Those with a specific worker (e.g. three assessments and care plans taken each from three workers) or from within a specific team (e.g. three assessments and care plans taken each from three teams)
- Those who had not been in another service previously
- Available to participate in the SRI

3.34 The overall method of selecting the 10 case records for Parts 1 and 2 of the SRI was a random sample of current clients of each service. However, whilst this was the dominant sampling method, other administrators used stratified sampling (e.g. an equal split of men and women, split between long and short-term clients in a ward setting, informal and detained clients etc).

Administration experience

3.35 The main issues administrators mentioned during their interviews in relation to completing Parts 1 and 2 of the SRI are outlined in Table 3.4 below.

Table 3.4 Dominant issues in completing Parts 1 and 2

Issue	No of participants where this was advised as an issue	Local areas where this was an issue
Lengthy & time-consuming	5	Ayrshire & Arran, Grampian, Greater Glasgow & Clyde , Tayside (x2)
Confusion around language	5	Ayrshire & Arran, Forth Valley (x3), Grampian
Repetitive	3	Forth Valley, Grampian, Tayside

3.36 Despite initial difficulties, there was overall agreement amongst those who administered Parts 1 and 2 of the SRI that the process did become easier as they used and became familiar with the tool. One community-based service in Glasgow and one inpatient ward in Tayside used two people to complete Parts 1 and 2, another local pilot used three administrators to complete Parts 1 and 2. This seemed to be an effective way of splitting the workload.

3.37 Some challenges arose during data collection. Two administrators advised that discrepancies in the way different staff members record information and their writing was challenging when trying to extract information. Another advised that some information was electronic whereas other parts were hard copy and referring between the TWO was time consuming, and another advised that some of the records were incomplete.

Language and terminology

3.38 Six administrators (in Ayrshire & Arran, Forth Valley and Grampian) suggested that the language of Parts 1 and 2 – ‘assessment’ and ‘care plan’ – could be unreliable as not all services use this language. For example, two administrators advised that there was confusion locally about whether this referred simply to the official care plan, or all the case notes in an individual’s file because together, they all comprise the care plan. The health-based language

in these parts of the SRI was perceived to be particularly problematic for voluntary and social care-based services. Voluntary sector organisations, for example, do not have care plans for individuals but may use other terminology, such as personal plans. Additionally, there was confusion locally around what was considered assessment (i.e. was the SRI focussing only on initial assessment documentation or on ongoing admission and assessment). It was suggested by a number of interviewees that the title of these parts should be changed, for example, to ‘patient file’ to broaden out the applicability of these parts of the SRI to different service sectors.

Part 3: Service information, policies & procedures

Selecting relevant information

3.39 There was inconsistency throughout local pilots in perceptions of what constituted service information, policies and procedures, with many administrators taking a very broad approach and examining ‘everything they had’. In this sense, administrators overwhelmingly advised that it would be useful to have more specific guidance on what type of service information, policies and procedures to include when completing Part 3.

3.40 All local pilots placed an emphasis on:

- Local information and local policies (e.g. equalities policy, operational policy, missing persons policy, psychiatric emergency plans, vulnerable adults policy, etc)
- Information that was available and accessible in the pilot sites (e.g. user choice, involvement and information leaflets)
- Broad NHS information and specific service information

3.41 All areas reported easy access to the information required for completing Part 3 as the information was broadly accessible to service users and service providers.

Experience of administration

3.42 Administrators found Part 3 to be the most straightforward. Despite reports that the process of collecting and collating the information required was very time consuming, administrators did acknowledge that they became more familiar with the process the longer they spent completing Part 3.

3.43 Approaches to data collection varied across pilot areas and sites:

- In Forth Valley, the local lead for the SRI pilot completed Part 3 on ‘service information, policies & procedures’ and extrapolated the information across the three local pilots, freeing up time and resources amongst the ward-based administrators to focus on other parts of the SRI and service delivery commitments
- In Ayrshire & Arran, Part 3 was completed by the local Leading Change team to ensure an unbiased snapshot of information provision (this proved specifically useful in accessing strategic policy and procedural documents that local pilot sites may not necessarily have ready access to)

3.44 The task of administering Part 3 of the SRI was considered by interviewees as an unusual and useful audit to help ensure that the information provided to patients and clients of services is focused on their needs and requirements. Administrators from all local areas advised that the work involved in administering Part 3 of the tool highlighted gaps in information provision locally. In the two pilot areas that used the SRI in voluntary sector organisations (Grampian and Augment in Tayside, which used it independently of the pilot and evaluation), voluntary organisations were found to perform better than statutory services in providing information for service users.

3.45 Administrators felt that much of the statutory service information, policies and procedures available locally were:

- Not concise enough to fulfil the requirements of the SRI
- Available but not recovery-orientated
- Characterised by jargon and medical terminology

3.46 The point was raised, particularly in Ayrshire & Arran that if the SRI finds information is provided locally, this does not mean that clients use it; should the SRI be about what information is available or evidence that the information is used by service users?

3.47 Each participant that was asked about Part 3 of the SRI felt that the language was unclear and open to interpretation leaving potential for inconsistencies in individuals' interpretations of questions. The SRI Content section of the results provides further detail on this.

3.48 A common finding for local pilots in relation to Part 3 of the SRI was that it was difficult to find any information or policies and procedures that related specifically to a ward or health centre. Documents that were used tended to be generic across all wards or settings. When service-specific information could not be found there was acknowledgement (specifically in Greater Glasgow & Clyde and Tayside) that this was a gap in service provision that the SRI could pick up on to help improve and develop local services.

Part 4: Service provider group interviews

Preparing participants

3.49 The level of information provided to potential participants prior to the group interview varied, from in-depth information in Forth Valley, where it was provided to all sites by the local lead, to limited information in other areas. The amount of information seemed to depend on the time available for the administrators to prepare.

3.50 Ayrshire & Arran administrators provided the tool prior to participation in the service provider group interview, so that the participants could familiarise and prepare themselves for the interview.

Selecting participants

3.51 The number of participants in service provider interviews ranged from one to nine between pilot sites (with no pattern across pilot areas). In all of the local pilot sites service providers were selected to participate in a group interview if they worked in or with the service piloting the SRI. The dominant approach to recruiting service providers for interview was verbally, either by the person administering the SRI or by the service manager. Most pilot sites adopted a multi-disciplinary approach to sampling for the service provider group interview. All sites invited service providers to attend a group interview on a pre-arranged date, time and venue due to time constraints, given there was a deadline for completing the SRIs in this pilot.

3.52 Whilst some pilot sites reported rather last-minute ad-hoc recruitment for Part 4 of their SRIs, other pilots were more structured in their approach to inviting service providers to participate.

3.53 The Forth Valley service provider group interviews were all conducted by the local lead and a ward manager. Information was prepared prior to the interviews taking place and distributed to all those eligible staff in the three wards taking place in the pilot. Individuals from a range of backgrounds were invited to interview (e.g. administrative staff, qualified and unqualified nursing staff, occupational therapy, allied health staff, psychiatrists, etc) with information about the process and the date and time set aside for the interview. Using this method, no service providers refused to take part but administrators reported that attendance at the interviews was based on who was available to attend at the time.

3.54 In Tayside, the service provider group interview was added to the end of a regular allocation meeting, resulting in nine service providers in attendance.

3.55 In Tayside and Greater Glasgow & Clyde, administrators also interviewed certain strategic managers individually, in addition to conducting a group interview with other service providers. This was to ensure that managerial input was achieved when time commitments would not allow them to attend a group interview. Two administrators conducted all of their service provider interviews individually and reported that these were productive and informative meetings. However, another administrator who had only one person attending their 'group' interview found the interview intense and time-consuming and often the individual did not have all the information required to answer the questions.

3.56 The multi-disciplinary approach adopted by the majority of the pilot sites proved to be beneficial, with administrators in areas with this approach reporting that the discussion ensured that a range of different angles were covered and questions were answered by a range of different professions. They also reported that where questions were confusing (described in more detail in the section on content below), a multi-disciplinary group helped to ensure that a rounded and balanced understanding of the questions was employed.

3.57 Where low numbers were involved in the Part 4 group interviews, the administrators concerned felt that this was because of a low general 'buy-in' due to poor local planning, drive and organisation. In one site, the administrator had not made the numbers required to make the process meaningful or clear in their recruitment process. It was perceived that if local processes aimed at achieving 'buy-in' were improved, alongside an improvement in feedback and communication between those administering the SRI, management and

strategic planning and service provider staff, then participation in the SRI may have been improved.

Administrators' experiences

3.58 Table 3.5 below outlines the dominant issues that arose when questioning administrators of their experience of Part 4 of the SRI.

Table 3.5 Dominant issues for administrators in completing Part 4

Issue	No of participants where this was advised as an issue	Local areas where this was an issue
Confusion around questions/language/terminology	12	Ayrshire & Arran (x3), Forth Valley (x3), Grampian, Greater Glasgow & Clyde (x3), Tayside (x2)
Too many questions/too long	9	Ayrshire & Arran (x2), Forth Valley (x2), Greater Glasgow & Clyde (x4), Tayside
Repetitive/duplication	4	Forth Valley, Greater Glasgow & Clyde (x2), Tayside

3.59 Three administrators (in Ayrshire & Arran and Grampian) reported participants in the service provider group interviews as initially being quite reserved and suspicious of the questioning for the SRI. They put this down to a natural concern around the service providers feeling that they were being judged or questioned over their practice and re-emphasised by them the importance of explaining that the SRI is a developmental tool and was not being used to audit.

3.60 Grampian was the only area where a service user was involved in the administration of Part 4. The service user felt that the service providers who took part in this interview seemed to appreciate service user involvement and following some initial resistance to answer questions, her involvement was beneficial as she was seen as unthreatening. This individual felt that involvement in the administration of the tool was beneficial to their own recovery.

3.61 Whilst there was some confusion around specific questions and the terminology and language used in Part 4 (discussed in more detail in the content section below), administrators reported that most service provider groups were able to answer the majority of questions in detail.

3.62 Where questions were not answered, the primary reason for this was running out of time, and this was relatively common. Most pilot sites set aside between one and two hours to complete Part 4 and one pilot site in Tayside set aside one morning. Those who reported providing one hour found that this was too short and questions tended to go uncompleted.

Service provider participants' experiences

3.63 Service providers interviewed for this evaluation predominantly advised that the recruitment process was handled well by the local pilots. Most service provider participants

felt they could say ‘no’ if they did not want to participate, although one participant felt they could not say ‘no’ was because they felt ‘duty-bound’ to participate to set a good example. One criticism was the ‘closed’ nature of the recruitment process in most pilot sites where service providers were identified by the local pilot leads and then approached to participate at a set time rather than advertising and inviting any interested parties to join in on an agreed date. This was perceived by some as a lost opportunity to involve all those who were interested.

3.64 Six interviewees felt the support provided prior to participation in the SRI was adequate and the remaining three advised that it was not. When asked what was helpful about the support provided prior to participating, the service providers stated:

- Basic information on what questions/topics would be included in Part 4
- Explanation of what participating would entail (e.g. time commitment and expectations)
- Pre-existing knowledge of recovery and the context of the SRI.

3.65 The service providers who advised that the support provided was not adequate gave the following reasons:

- Too little information to prepare thoroughly, seeing Part 4 questions prior to interview would have been more helpful
- The interview was a considerably more time consuming and complex than anticipated.

3.66 It was suggested that facilitators of Part 4 interviews should explain briefly at the start of the interview what it would entail. Two participants in the evaluation also advised that local recovery awareness discussions/workshops prior to the group interview would have been beneficial. Another felt that a group discussion prior to the interview to discuss answers and views would minimise the time commitment required for the SRI.

3.67 Four of the service providers interviewed for this evaluation advised their experience of the Part 4 interviews was ‘very good’ and five advised it was ‘quite good’. All service providers participating in the evaluation reported the interviewer’s facilitation as being helpful to the process.

3.68 When asked how they found being interviewed as a group, participants all agreed that this method of interviewing was beneficial to them and elicited the most relevant information, as they could ‘bounce off’ others. The group interview was helpful when it was multi-disciplinary as participants found that when they thought a question was not as relevant to their profession and/or it was more appropriate for someone senior on the group, this took some of the pressure off them as individuals. One new staff member found the group interview particularly helpful in learning more about the service they had joined.

3.69 In inpatient settings, service providers from three pilot areas reported little support to participate in the interview on the day, with many reporting the time commitment as a key barrier. Seven participants advised that some form of support to release them from their daily duties would be beneficial to allow them to participate fully in the SRI process.

3.70 All nine service providers spoken to advised that the use of a local venue in close proximity to their usual place of work was helpful in terms of making the SRI process accessible to them as they could still attend work emergencies if required and felt relaxed.

3.71 All service providers interviewed reported that the group interview was participatory with wide and varied discussion where everyone had a chance to put forward their own stance on questions. All service providers spoken to advised they had found the group interview for Part 4 of the SRI an interesting process and that the discussion generated was helpful for them professionally.

3.72 When asked to rate their opinion on how important their own contribution (from 1, not important, to 5, very important) was to the SRI process, service providers gave their contribution an average rating of 3. When asked to rate other people's opinions of their contribution to the SRI process (using the same scale), service providers gave an average rating of 3.22. There was some variation in scores between pilot areas, ranging from 2.5 to 4.

Part 5: Service user group interviews

Selecting participants

3.73 In all of the local pilot sites participants for Part 5 service user interviews were given information on the purpose and content of the SRI (to elicit their opinions on their experience of the service) and then asked to volunteer to take part in a group discussion. In all areas it was emphasised that participation was voluntary and that people could withdraw at any time if they wished. In some areas, individual services recruited participants; in other areas, more systematic approaches were adopted with information (leaflets, consents and copies of questions) for service users provided centrally from the local lead and distributed by each of the wards participating in the pilot.

3.74 Whilst some pilot sites recruited widely, making the process accessible for all service users in the service (e.g. Grampian), others were more targeted in their recruitment (e.g. Ayrshire & Arran, Forth Valley and Greater Glasgow & Clyde) where the administrators provided information on the SRI to those service users they felt were well enough and able to cope with the interview or to those who were able and willing to engage. One administrator advised that there was less enthusiasm for participating in the group interview in inpatient settings as many service users in these services are in crisis.

3.75 The majority of administrators interviewed felt that they achieved quite low numbers of service users participating in the SRI and that they would have liked more service users to have taken part to gain a more accurate and representative picture of the service.

Preparing participants

3.76 Most potential participants for Part 5 were provided with information on the SRI in written format, with five pilot sites providing the Part 5 questions to potential participants. However, six pilot sites provided information to clients verbally only (this was more common in inpatient settings).

3.77 One administrator reported that they were not entirely convinced that some of the service users who participated knew what they were consenting to. Other services gave more notice to service users, especially community services who tended to give an average of about 10 days notice to potential participants.

Approaches to administration

3.78 A range of approaches to the administration of Part 5 of the SRI were used during the pilot, including:

- Administration by a service user who attended a voluntary sector service that was undergoing the SRI, where it was felt that this encouraged participation due to familiarity and trust
- Administration by a ward manager and staff nurse with the assistance of advocacy services within the ward
- Administration by statutory sector employees from other services to ensure people could talk freely

3.79 Where those who were administering Part 5 of the SRI were directly involved in a service user's care, the question of being objective enough so that any comments made by service users during the SRI interview would not have repercussions on their care at a later date was raised. It was suggested by administrators that it would be more beneficial for someone from another ward to conduct the service user group interview in each ward to ensure that people could talk openly and honestly about the service.

3.80 Whilst the majority of the pilot sites conducted the service user interviews as a group interview, four pilot sites (three in Greater Glasgow & Clyde and one in Ayrshire & Arran) opted to conduct these as individual interviews because of the personal nature of the questions being asked in Part 5 (specifically the questions around trauma). Another pilot area's focus group participants felt that in retrospect it was not appropriate to hold the service user interviews in focus groups as it involves talking about personal situations and some questions may not be appropriate to ask in groups.

Administrators' experiences

3.81 Table 3.6 below outlines the dominant issues for the administrators involved in conducting the service user interviews.

Table 3.6 Dominant issues for administrators in completing Part 5

Issue	No of participants where this was advised as an issue	Local areas where this was an issue
Confusion around questions/language/terminology	10	Ayrshire & Arran (x3), Forth Valley, Grampian, Greater Glasgow & Clyde (x4), Tayside
Surprise at honesty of service users	5	Ayrshire & Arran (x2), Grampian, Greater Glasgow & Clyde, Tayside
Time commitment required	4	Forth Valley, Greater Glasgow & Clyde (x3)

3.82 Administrators reported the questions in the service user interviews as being not user-friendly. In Forth Valley, the questions were altered prior to the service user interviews in an attempt to make them more user-friendly, although the facilitators of the group discussion still found themselves having to paraphrase and explain questions further.

3.83 The time set aside for group interviews with service users was between 20 minutes (when conducted as individual interviews) and two and a half hours. All the administrators who were involved in this part of the SRI reported this as being a long time for service users to participate in such a discussion. This was certainly perceived to be the case within inpatient settings, where some of the service users were acutely unwell. However the majority of the service user evaluation participants did not feel that their interviews were too long.

3.84 In terms of eliciting all the information required for completing the SRI, administrators reported varying levels of success for a range of reasons, including administrators' views that some questions were not relevant to specific service users (e.g. drug and alcohol services if the service user had never had an issue with this).

3.85 Comments from administrators in relation to the experience of conducting the interviews were all positive, with five reporting that they were amazed and surprised at how open and honest service users were during the discussion. This, they believe, provides added weight to Part 5 of the SRI. Administrators also reported the benefit of participating in the SRI for service users, with one advising that it opened participants' minds and highlighted the services to show service users what it actually is that they do.

Service user participants' experiences

3.86 Some service users reported being uncertain about how they had been selected to participate in the SRI and that they would have liked to have known this. All service users said that it was explained that participation was entirely voluntary and would be kept confidential. Ten of the service users spoken to advised that they felt they could say no if they did not want to participate in the SRI interview. One service user in Greater Glasgow & Clyde advised that they felt as if they had to take part and could not say no, whilst another in Tayside advised that they felt they should take part to 'give something back' and to help others who might be at a different stage in their recovery.

3.87 Most service users felt that they were provided with enough information prior to their interview but a few service users advised they would have liked more information on what the SRI is and recovery more generally. One service user felt that they did not have adequate support to participate and would have liked more information on the expectations and the background of the SRI to help prepare for the interview.

3.88 All of the service users reported being given enough time to consider participation and none felt that they needed longer to decide.

3.89 When asked of their overall experience of the interview, two service users advised their experience was 'excellent', seven advised it was 'very good' and two advised the experience was 'quite good' (one from Greater Glasgow & Clyde, one from Tayside).

3.90 When asked to rate how important their contribution was in their own opinion (from 1, not important, to 5, very important) to the SRI process, service users reported an average rating of 4. When asked to rate (using the same scale) how important other people felt their contribution was to the SRI process, service users reported an average rating of 4.

3.91 Table 3.7 below outlines the dominant issues for service users who participated in the service user interviews for Part 5 of the SRI.

Table 3.7 Dominant issues for participants in completing Part 5

Issue	No of participants where this was advised as an issue	Local areas where this was an issue
Confusion around questions/language/terminology	8	Greater Glasgow & Clyde (x5), Tayside (x3)
Length/too many questions	4	Greater Glasgow & Clyde (x3), Tayside
Time commitment required	4	Greater Glasgow & Clyde, Tayside (x3)

3.92 Service users who were interviewed individually had mixed views on the value of this approach. Half felt comfortable talking one-to-one due to the personal nature of issues being discussed, confidentiality and the similarity to clinical discussions which occur on a one-to-one basis. The remaining three service users advised that they would have preferred a group discussion as this would allow them to share experiences and listen to how other people recovered. One service user who did not speak much English advised that a group discussion would have been beneficial as it would have promoted her understanding of the questions.

3.93 Service users advised that the interview method of gathering information from them for the SRI was the most appropriate method for two reasons:

- It did not assume a certain level of literacy
- It enabled service users to give their true opinions without placing any restrictions on them (e.g. in terms of length as would be the case in a written questionnaire)

3.94 Of the five participants who took part in a group interview (all from Tayside), they all advised that this was helpful to them because:

- They received input from others and could provide more detailed in-depth answers as a result
- They gained knowledge of how other people recovered

3.95 The most helpful aspect of group discussion was considered by all participants to be peer support. One service user from Tayside was interviewed both in a group and also individually, in view of the personal nature of some of the questions. This person felt that some questions were more suited to group discussions and that individually it felt quite daunting. Another service user felt that it can be easier to discuss mental health generally in a group because in an individual interview it can feel as if you are 'being put on the spot'. The group discussion was felt to be more of an overview of experiences giving more reality. It was felt that group discussions encouraged a more informal and relaxed atmosphere, which service users really appreciated.

3.96 Despite the time commitment required, raising concerns about those with impaired concentration or memory, the majority of service users appreciated that to gain such in-depth information takes time and for this they were willing to give up their time to give their views and experiences. The average time commitment required was an hour, with service users advising the interview took between half an hour for an individual interview and two hours for a group interview.

3.97 Service user interviewees explained that their decision to take part was greatly influenced by the interview environment. Flexibility of interview venue was considered helpful, especially by those who were home-bound or who preferred to be in familiar or their own surroundings (their 'own territory') to ensuring they were comfortable throughout the interview process.

3.98 In terms of the interviewer, four service users advised that they were more comfortable with being interviewed by someone they had a pre-existing relationship with (e.g. CPN, Group Leader). In Tayside, the use of Augment seemed to be beneficial in terms of promoting a relaxed and informal atmosphere in the service user group interview. In this respect, it made the interviews more accessible for service users.

3.99 Of the questions asked, the majority (n=9) of service users advised they were able to answer all or most of the questions asked of them (all of the service users from Tayside and the remaining four from Greater Glasgow & Clyde). The wording of the questions and terminology used proved difficult for eight service users. Whilst this did pose a problem, paraphrasing, further explanation and examples from those who were administering the SRI seemed to assist. The questions where people felt they could not answer were predominantly questions which they thought did not apply to them (e.g. housing issues when they had never had an issue with housing and so could not provide an answer). However, one service user did not speak much English and there were real difficulties in completing the SRI because of language barriers and understanding of complex terminology and jargon. They were not offered any additional interpreters to assist in the interview, which she advised would have been helpful for her to understand the questions and provide a truthful answer.

3.100 Service users described the support they received to take part in the SRI, as centred on the explanation of questions and emotional support. Two service users felt that they did not receive emotional support, which they believe would have been useful. Additionally, a service user claimed that there was no option given to bring a carer along to the interview, neither were any of the more practical issues considered (e.g. interpreter, childcare, transport). In Tayside, free transportation was provided to ensure that service users could participate.

3.101 One service user reported feeling valued as a result of being asked to participate. Others felt that the SRI process to them was beneficial in terms of letting them get their views across and their recovery.

Collation & scoring

3.102 Approximately two-thirds of the queries and questions from local areas to the national support consultant were in relation to the scoring element of the SRI. This, coupled with the completed SRIs received from local areas, suggests that further guidelines and training are

required on scoring. Some of the completed SRIs received from services across all the local areas had not been scored at all, and those that had been scored were inconsistent in completeness and therefore incomparable. The overall method of scoring individual items and providing a total score was not consistent across local pilot sites (some areas have provided an average score of between 1 and 5, others have provided an aggregate score of all questions) making any further analysis of the scores for the purposes of this evaluation redundant.

3.103 In some service elements, pilot sites scored highly based on documentation evidence and service provider interviews but scored low in service user interviews. The average score then was quite high, but the important information for the pilot site was that service users did not know about the service elements and therefore they were not performing as well as they could. This left the administrators doubtful about the utility of using average scores to identify areas for development and for benchmarking.

3.104 Not all pilot sites completed the scoring exercise, with the administrators advising that the focus in the preparation day was not on the scoring but on the process of administering the SRI. In this sense, they felt that the scoring was not important and was secondary to the pilot. Conversely it is the detail in the tool that helps to pinpoint where things are wrong, the score can indicate that something's wrong, but it does not tell you what.

Helpful approaches to collation and scoring

3.105 Administrators found the scoring very time-consuming but appreciated that this could not necessarily be avoided due to the nature of the SRI. Some administrators felt that administrative support for scoring would have been helpful in speeding up the process. Three administrators found the scoring experience very interesting.

3.106 Whilst individual pilot sites tended to score individually, in two pilot areas a group completed the scoring, with each administrator being able to comment and discuss their views and opinions on how this should be done and what the overall scores should be, although one administrator also suggested that the person who collected the data for the SRI does not, and perhaps should not, be present for the scoring.

3.107 Of those administrators who were involved in group scoring, all felt this was an efficient, helpful and beneficial process; more so than attempting to score alone. The national support consultant was involved in the scoring group in one pilot area which they felt was beneficial as it gave the process a degree of objectivity and in another area a service user was involved.

3.108 The scoring process became quicker and more straightforward as a result of practice. However some mixed views on group scoring were expressed, ranging from 'tedious' and 'a laborious process requiring too many people', to 'very participatory and productive' and 'ensuring everyone got their say'.

3.109 Administrators found that the more notes they took during the administration process, the easier it was to score the SRI, especially where more than one person was involved in administering the tool. In one pilot area, notes were considered central to scoring as they

allowed scorers to cross-reference to get more accurate scoring, and also improve the opportunity to follow-up on issues identified.

3.110 Of those spoken to, those who scored the SRIs soon after they had administered the tool found it the easiest, compared to those who waited some time after administration to score.

Scoring challenges

3.111 A number of challenges were faced by those attempting to score the SRI including:

- It is difficult to give scores for areas that were not relevant to a service (e.g. housing support in an inpatient unit)
- Question 7c on the scoring sheet is not represented in the tool itself
- Confusion when the administrator thought that some of the scores for certain questions fell between two scores (e.g. 3.5) and there was uncertainty as to how these should be scored (in the event, administrators tended to score down)
- Lack of clarity on how to produce an overall score for questions included elements of different parts of the SRI. For example, the score for question 5a involved data gathered in Parts 3 and 4 of the SRI, resulting in confusion around how you would provide an overall score for question 5a given the scores in Part 3 question 5a and Part 4 question 5a might be different. Some areas provided an average score of both Part 3 and 4, others provided a total score and others listed two scores for the question.
- The scoring and administration guidance in the SRI contained some errors (e.g. parts of the guidance stated there were five basic needs when there were six)
- Perception that some questions were subjective, making scoring difficult, if not inappropriate
- Too much cross-referencing was required to make any sense of the data.

Benefits of scoring

3.112 All of the administrators who did the scoring exercise advised that the scoring process benefited the service as it pointed out areas where they were good at practice and those where improvements were required (e.g. ensuring paperwork is recovery-orientated and strengths-based) and put the recovery agenda at the forefront of service provision.

3.113 However, those administrators who did not score their SRI did not feel that they had missed out on any opportunities for service development. They felt that the utility of the SRI as a development tool was to be found in participating in the SRI process and the detailed data, not an overall aggregate score. In this sense, these administrators identified areas for improvement just by sifting through the data gathered for the SRI. Interviewees and focus group participants stated that it is the detail in the tool that helps to pinpoint where things are wrong; the score can indicate that something's wrong, but it does not tell you what, so it only has limited utility for action planning and benchmarking.

Reflections on administration of the SRI

Resource required

Manpower and time required

3.114 Due to the variation in approaches adopted in local pilots to administer the SRI (e.g. some administrators did not have to complete Part 3 as this was done centrally and some did not complete Part 5 as this was done by service user representatives), useful comparisons cannot be drawn between individual administrators in terms of the time spent on administering the SRI. All of the administrators reported two or more people being involved in the administration of the SRI in their pilot site. However, when combining the time spent by all administrators involved in the SRIs in any given site, an accurate picture of time spent in each pilot site can be obtained. The timescales to administer one SRI were varied, ranging from seven hours to 42 hours, and the majority of pilot sites (n=9) reported that the process took between 15 and 20 hours. The average amount of time spent on administering each SRI was 21 working hours.

3.115 Administrators were asked how they found the task of administering the tool, as the guidance states that it is 'onerous'. When asked if they thought this was the case, 14 administrators advised that they did not agree with this assertion and all of the administrators advised that the process is 'worth it', as long as there is a continuing drive for service change and development.

Support to administer the tool

3.116 Support provided to administrators to use the SRI, centred predominantly on the provision of time to complete the tool and support from management and/or peers during administration. The support provided in regions where an area-wide, strategic approach to administration (e.g. Grampian and Forth Valley) was adopted was reported as being more productive for administrators than the areas where pilot sites were largely left to complete the SRI independently.

Additional resources used

3.117 The majority of administrators (n=15) reported using no additional resources to complete the SRI, apart from the service information, policies and procedures used to complete Part 3. This documentation was located either in hard copy format by visiting services, or by searching the internet and local intranets.

3.118 Five administrators reported using administrative assistance (either from administrative staff or nursing staff, e.g. staff nurse) to prepare information for the SRI, set and arrange appointments and meetings and collate the information (i.e. typing it up). The rest of the administrators undertook the above administration tasks within the team who were involved in administering the SRI.

3.119 Some local areas involved other groups and/or organisations in certain parts of the SRI (e.g. in Ayrshire & Arran the Leading Change team completed Part 3 and in Tayside,

Augment conducted all the service user interviews). In-kind support was provided in two of the local areas (Grampian and Tayside) by service users who administered Part 5 of the SRI. In-kind volunteering was an additional and important resource in these two areas although paying service users for their involvement was raised in Grampian as an important development issue.

3.120 At the outset of the evaluation, not all of the pilot leads or administrators knew that they had access to a national support consultant during the pilot, although each pilot site had been informed about this by the Scottish Government. Local pilot participants tended to use peer support to resolve problems, but when they did consult the national support consultant they were appreciative of the resource.

Service user involvement

3.121 In pilot sites where service-user groups were involved in the local SRI pilots (Grampian, Lanarkshire and Tayside), a number of issues pertaining to service-user involvement were raised throughout the evaluation, in the inception interviews, the interviews with administrators and the final focus groups. Each of these areas utilised service-user involvement in differing ways, with varying levels of success.

3.122 In Grampian, a service user interviewed other service users for Part 5 of the tool and the service provider groups for Part 4 of the tool. They were also involved in the group scoring process of the SRIs for each pilot site in their area and action planning discussions. In Grampian, the SRI was uniquely piloted in a voluntary sector organisation which places strong emphasis on service-user involvement.

3.123 The Tayside pilot sites worked in partnership with Augment (Scotland) Ltd, a voluntary sector user-led organisation. Augment (Scotland) Ltd was involved in local discussions from the outset and representatives from Augment who would be involved in the administration of the SRIs attended the preparation day. However, unlike Grampian, service user involvement in Tayside comprised staff and service users from Augment administering Part 5 of the tool (the service user interviews) and attending the initial inception interview. Whilst the manager of Augment was involved in action planning, it seems at this point that service user involvement in the formal pilot ceased in Tayside.

3.124 In Lanarkshire, the local SRI team was developed in partnership with the local voluntary service user organisation 'Lanarkshire Links'. The idea behind this was similar to that of Grampian and Tayside, in that a service user representative from Lanarkshire Links would be trained in, and involved with, administering the tool for Part 5. However, the pilot had not been implemented at the time of the evaluation.

3.125 The following key learning points regarding service-user involvement in the SRI were raised in the evaluation:

- There was concern amongst the service-user groups that service-user involvement in the SRI should be meaningful and equal to that of NHS or local authority staff taking part in the pilot
- In Tayside there was some concern amongst staff around the use of service users to administer the tool when it was considered an 'internal' developmental tool

- Where service users were involved in the administration of the SRI (i.e. not just as participants in Part 5 group interviews) this method of administration worked well
- Service users involved in the administration process reported feeling equal to other professionals involved and important to the local pilots

SRI Content

3.126 This section provides a detailed account of the evaluative comments of pilot participants (mainly administrators and those involved in focus groups) and their suggestions for improving the content of the SRI.

Parts 1 and 2

3.127 Table 3.8 below outlines the comments on specific questions that were made by administrators.

Table 3.8 Evaluation participant comments' issues with Parts 1 & 2 questions

Question	Issue
1a	Whilst the heading for 1a advised that assessment for basic needs must be covered in detail in Part one, what is considered 'detail' is open to interpretation
1b	Whilst the heading for 1b advises that services for all basic needs must be provided routinely in Part 2, what is considered 'routine' is open to interpretation
6b	Difficult to answer these questions if in an acute inpatient setting where patients have been detained under the Mental Health (Care & Treatment) (Scotland) Act 2003, where concern is the patient's immediate crisis

3.128 The content of Parts 1 and 2 was generally considered to be appropriate and administrators were usually able to source the relevant information in the sampled assessment documents and care plans.

Part 3

3.129 Administrators were at times confused over what was to be included in Part 3, in relation to what service information, policies and procedures should be considered for inclusion. It was suggested by a minority of administrators that some of the questions in Part 3 (5a and 5b) are currently geared more towards management level and may be difficult for non-management staff to answer. There was a suggestion from one administrator that Part 3 of the SRI should be completed by senior strategic management, similar to the approach adopted by Forth Valley.

Part 4

3.130 The feedback from the administrators, focus groups and service-provider interviewees in relation to the questions asked in Parts 4 and 5 of the SRI, was that the language used was very medical, described by some as 'health speak'. This was by far the most common comment from the administrators and some focus group participants in relation to administering Part 4 of the tool. This was specifically the case in relation to administering

the SRI in voluntary sector settings, where medical terminology and ‘health speak’ are not used. As a result of this language, some administrators and service providers reported finding it difficult to understand some of the questions. Administrators reported having to interpret the questions and paraphrase them to make them understandable to the participants.

3.131 There was a sense that some wording in the Part 4 questions needs to be more clearly defined to ensure collective understanding of the questions. It was felt that by leaving some words undefined (e.g. ‘contact’ in Question 6a, ‘principles’ in Question 8b.ii) was leaving the question open to interpretation, thus allowing the potential for inconsistencies between areas.

3.132 Table 3.9 below outlines the questions which administrators had issues or concerns over, alongside the concern they expressed.

Table 3.9 Evaluation participants’ issues with Part 4 questions

Question	Issue
1b	Some basic needs (e.g. housing assistance) do not apply to some service users, it all depends whether the service user has had an issue with them in the past so some questions in this section can be difficult to answer unless the staff have specifically had to address these in the past. Whilst basic needs are central in some service provision, some professions (e.g. occupational therapists, dieticians) will only deal with these on a case-by-case basis as and when the individual service user highlights them as an issue.
4	Some of these questions (e.g. 4.iii drug and alcohol services) do not apply to some service users as they may not have had an issue with it in the past so staff can only answer where their experience has been, which might not illustrate the services that are available, just that they have never used them.
5a	Considered to be still fairly alien to staff so found it difficult to answer.
5c	These questions are geared towards senior staff and strategic management (e.g. recruitment procedures, etc) and lower grade staff are unable to answer. Questions about recruitment and HR processes cannot be answered by frontline staff, they are more applicable to organisational and management staff. Concern that involving service users in formal processes or getting them back into employment can hinder recovery if they are not well enough to participate.
6a & b	Felt that the SRI should include examples of agencies/disciplines which are specific to the ward/hospital as well as the community.
6b	Felt that this had already been answered in previous questions.
7a	Difficult to answer in an inpatient setting. Thought that perhaps this should have been included in Part 3 as it is more to do with policies and procedures.
7b	Difficult to answer in an inpatient setting, especially where people have been detained under the Mental Health (Care & Treatment) (Scotland) Act 2003, where concern is the patient’s immediate crisis.
8b.ii	Confusion over what principles the SRI was referring to – the core values of the service or more specific principles, such as the Millan principles.
8d.i	Although headed as being about ‘recovery-oriented practice’, it only specifically asks about recovery-orientated supervision in 8dii. This has led to concerns from administrators that a high score on 8di and a low score on 8dii could provide a misleading overall score in terms of the extent to which supervision is recovery-focused.

3.133 Overall, the feeling amongst evaluation participants was that the questions in Part 4 of the SRI were too long, convoluted and complex; six administrators advised there were too many questions in Part 4 of the SRI (across all local areas). The administrators and service providers reported that some of the questions were repetitive and they felt that questions appeared to be duplicated, thus making the process longer than it should have been. This was

considered a key issue given the time commitment required in amongst service providers' duty to provide efficient services. It was suggested that some questions could be broken down to make them more manageable and that they need reviewed to ensure that repetition is avoided.

3.134 The nine service providers interviewed for this evaluation provided an average score of 3.6 when asked to rate the relevance of the questions asked in the service provider group interview from 5 (completely relevant) to 1 (not relevant at all). The dominant answer provided when asked was 4, but a low score of 2 from one participant from an administrative professional background brought down the average score provided.

3.135 Some participants felt that the questions asked in Part 4 were more relevant and pertinent to nursing and allied healthcare staff than to administrative professions. There was an overall feeling amongst service providers that the questions in Part 4 of the SRI were meaningful and all service providers interviewed for this evaluation advised that, as a group, they were able to answer all of the questions asked (unless they ran out of time).

3.136 Service providers also advised that recovery is a relatively new concept and there could have been confusion around the relevance of some of the questions in Part 4 as a result of this.

Part 5

3.137 Table 3.10 below summarises the issues that administrators, focus group participants and service-user interviewees raised concerning the questions in Part 5 of the SRI. As a result of many of the questions being similar to those of Part 4, some issues are similar to those listed in Table 3.8 on page 45.

Table 3.10 Evaluation participants' issues with Part 5 questions

Question	Issue
1b	Some basic needs (e.g. housing assistance) do not apply to some service users, it all depends whether the service user has had an issue with them in the past, so some questions in this section can be difficult to answer unless they have had to address it in the past. Service users advised that not all of these apply to each person (e.g. religion) and some of these questions can be insulting or embarrassing (e.g. personal hygiene).
4	Some of these questions (e.g. 4.iii drug and alcohol services) do not apply to some service users as they may not have had an issue with it in the past, so they will only be able answer where their experience has been.
4.vi	Question on trauma is not suitable for interviews as can be emotive and distressing, rewording may be necessary to ensure de-personalisation of the question. Some of these questions (e.g. 4.iii drug and alcohol services) do not apply to some service users as they may not have had an issue with it in the past so they will only be able answer in terms of their own experiences.
6b	Felt that this had already been answered in previous questions.
8b	Questions regarding planning and looking into your own care is very much health service language – service users are not used to this and do not use this language, and neither do the staff when communicating with them.
8b.ii	The word 'principles' is not meaningful to service users.
8b.iii) & 8b.iv)	Language is not meaningful to service users.

3.138 Overall, evaluation participants felt that the questions in Part 5 were too long-winded and not user-friendly. They felt that they were full of jargon and health service language, which is difficult for service users to understand. Similar to the comments on Part 4 questions, it was generally felt that questions in Part 5 were too vague and that they needed more description and guidance to define the specific information required. As was the case with the comments for Part 4 questions, participants advised that some of the questions were too long and needed to be broken down to make them more manageable (e.g. 8b), especially for service users who may have difficulty with concentration. The questions in Part 5 were considered to be repetitive and participants advised that cutting down the number of questions would be more practical and effective.

3.139 In their evaluation interviews, when service users were asked to rate the relevance of the content of the questions asked from 5 (completely relevant) to 1 (not relevant at all), they gave an average score of 4.3. Three service users interviewed during the evaluation advised that the reason that the content was so relevant to them was that it was asking about their experiences and opinions. Similar to service providers, they also advised that whilst some questions may not have been relevant to their experience, they may be relevant to others and whilst they themselves may not have been able to answer, these issues were all still relevant to recovery more generally and so should still be asked.

“There were some [questions] where I could give an opinion, but it didn’t relate to my situation.” (service user, Tayside)

3.140 The overall feeling of service users was that the questions in Part 5 were very broad and all-encompassing and in this sense, they viewed the SRI as an inclusive process. Therefore, service users advised that they valued the opportunity to provide their experiences and opinions.

Comments on overall content

3.141 Evaluation participants also reported some additional concerns about the SRI content in general specifically:

- That Parts 4 and 5 are not identical (they believe that to get an accurate picture of services the questions asked of service providers and service users should be identical)
- Guidance does not assist in advising of the approach to adopt in Parts 4 and 5 (e.g. should interviews be conducted individually or as a group)
- Questions are too ‘politically correct’ and are not meaningful
- There should be scope to include service-user quotes in the SRI which could be used to provide more directive and powerful feedback.

Gaps in the SRI

3.142 Evaluation participants provided some suggestions on additional items that should be considered for inclusion in the SRI including:

- For the older people inpatient context, one administrator advised that for this group of service users, questions on vocation and employment might not apply and they advised that there should be questions on dementia support and other aspects of socialisation and support that are more geared towards older people, as opposed to service users of working age
- Communication needs (e.g. sign language, requirement for interpreter) should be included in the assessment data required
- Service users' goals should be included in Part 1 of the SRI as well as in Part 2 as goals and aspirations are often covered during assessment and this is not picked up in the SRI as it currently stands
- Carers' and relatives' perspectives are currently omitted from the SRI
- The use of peer support in service delivery
- Education and awareness around illness and medication
- Formal assessment of recovery-orientated training within services
- How services deal with patients who harass or who are abusive to other patients (considered key to how recovery-focused the service is and how much it promotes recovery)
- Lack of availability in other languages excludes some communities
- Just because you can tick all the boxes in the SRI doesn't mean you can work in a recovery-focused way. There's nothing in the tool about individual interactions and practices of individuals. The SRI doesn't reflect the skills in recovery coaching.

3.143 It was suggested that the SRI should be tailored towards different service settings, with one SRI available for inpatient settings, one for community-based services and one for voluntary and non-statutory sector services. This is contradictory to other evaluation feedback suggesting that the tool should be used across inpatient and community services to reflect mental healthcare delivery as one seamless service.

Extent to which the SRI is sensitive and recovery-focused

3.144 All SRI administrators were asked to rate how sensitive they thought the SRI was to the strengths and weaknesses of their service, from 1 (not sensitive at all) to 5 (very sensitive). The average rating provided by administrators was 3.

3.145 When asked to rate (from 1, not at all, to 5, very useful) the extent to which the SRI provides useful information on service sensitivity to different user groups and needs, administrators provided an average rating of 3. Differences did appear depending on which local area the administrators were from. The highest average score was given by administrators in Tayside (4.3) followed by Grampian (4.0), Ayrshire & Arran (3.8), Greater Glasgow & Clyde (2.7) and then Forth Valley (2.6).

3.146 In terms of how recovery-focused the SRI is, the administrators, service users and service providers were all asked to rate from 1 (not at all) to 5 (very) how well the SRI captures their own opinion of how recovery-focused the service is. The average score provided across all local areas were relatively consistent, with the average score from each local area falling between 3 and 4. The overall average score (4), suggests that participants in the SRI pilot process do believe that the SRI captures the majority of the information on whether services and organisations are recovery-focused.

3.147 Service-user interviewees commented that they were able to answer all the questions in the SRI which covered issues which assisted with their own recovery. For them, this was an indication that the questions asked were recovery-orientated and could measure how recovery-focused a service is. It was emphasised by one service user that people participate in their own recovery and just because certain things (e.g. housing and financial support and advice) exist, this does not mean to say that that will promote someone's recovery as they have to work at it themselves.

3.148 Service provider interviewees felt that the SRI puts a focus on the issues that are important in people's recovery and brings these to the forefront of practice. However, some ward staff felt that it can be difficult for a service to be recovery-focused if it is an acute admission ward where people are detained under law.

Feedback

Process

3.149 As indicated at the beginning of this Chapter, most pilot areas were at the stage of providing feedback on their SRI results and beginning the action-planning when data collection for the evaluation came to a close. Therefore there is little detail available on the different strategies that were used to feed back SRI data to those involved in SRI administration, working in the services that were pilot sites or strategic-level managers and groups. However, in most areas the administrators, pilot leads and those managing the pilot sites had informal access to the SRI scores and were aware of the key findings to the extent that they could feed back this information to the focus groups (see below).

3.150 Seven administrators reported feeding information from the SRI back to the staff within the service, however, no service users and only three service providers (all from Forth Valley) advised that they had received any form of feedback. Service users were more likely than service providers to express a desire for feedback to be provided.

3.151 Administrators and pilot leads who had fed information back had done so through various channels and, particularly at local level, through service managers (e.g. Charge Nurses, Ward Managers, etc) to cascade to staff and service users. The most common way for administrators to report feeding back information was verbally and relatively informally, through discussions with staff and management. It was less common for administrators to produce formal reports, with only one administrator advising that this would be the format in which the information from the SRI would be fed back to management. Some pilot sites claimed that this type of feedback to small groups takes time and resources, but it is necessary to discuss the findings and implications at this level before developing feedback for senior managers and strategic planning groups.

3.152 All pilot sites had also fed back to, or were planning to feed back to, strategic planning groups such as the Delivery Plan Partnership groups responsible for the development of mental health services via the pilot lead. Information was not yet available regarding the extent to which feedback 'upwards' had impacted, due to the time constraints of the evaluation.

Feedback as a learning opportunity

3.153 Of those who had fed back the SRI findings, there was a general feeling that the SRI provided a learning opportunity for services and service providers. In this sense, the SRI was seen as a positive process whereby it provided opportunities to identify gaps in services and skills. As a result, administrators advised that the people they had fed information back to had been interested and keen to improve on the areas where they had scored low.

3.154 The overall consensus from those who had fed back the information to services and service providers, was that services had scored a lot better than they thought they would and that the SRI had not highlighted issues that they were not already aware of. A number of learning opportunities were identified, including:

- The outcome of the SRI has been to open up the minds of patients and staff in terms of how the service performs in relation to recovery and what the concept of recovery more generally is about
- Staff working in statutory service pilot sites have learned from the voluntary sector pilot site about how they provide a recovery-focused service (in one area the voluntary sector service performed better than the statutory service in the SRI)
- SRI has provided managers with good insight into equality, social inclusiveness and recovery, as they can be far removed from service delivery, helping them to realise how things are doing at ground level
- In one area, service managers were “shocked” that all services do not routinely gather information on strengths in assessments and voiced concerns about the change in mindset required to address this
- Some pilot site staff were surprised to find that service users were not able to describe why they attended different parts of the mental health service (e.g. inpatient, community mental health team, day centres) at the same or different times, and what they should expect to gain from each of these.

“The SRI lets us look at where we are now; we have come away with new information on what is good and bad in our services.” (Focus group participant)

“The SRI picked up that the newer service was more inclusive and recovery orientated which is good as this is the way it should be.” (Focus group participant)

Impact of the SRI and Action planning

Approaches to the process of action planning

3.155 At the end of the data collection stage of the evaluation, some pilot sites had already started on a journey of change, usually at an individual pilot site level. Most were grappling with what they felt was the difficult part, which was planning change at a strategic level. However, pilot areas had some idea of the proposed formal approach they would take to action-planning.

3.156 Although all participants valued the necessity of a top-down approach to achieving buy-in to the SRI, the evaluation captured the way in which the SRI gave staff and management at service level, the confidence and ability to identify and make changes from

the bottom upwards. One focus group felt that this was consistent with the ethos of Leading Change.

SRI's fit with other current development processes and tools locally and nationally

3.157 In all pilot areas it was considered essential to join up the use of the SRI with other recovery initiatives currently underway in local services, such as recovery-awareness training. In the pilot sites, SRI was considered to fit well with a number of initiatives, development tools and patient information systems already available nationally and being implemented locally such as:

- Realising Recovery (it was reported that the SRI and recovery awareness training worked in conjunction to help service providers to better understand recovery)
- Mental Health Integrated Care Pathways (ICPs)
- Recovery Oriented Systems Indicators (ROSI)
- Tidal Model
- Specialist Single Shared Assessment
- Clinical Outcomes in Routine Evaluation (CORE)
- Wellness Recovery Action Planning (WRAP)
- Reclaiming Lives

3.158 Further information on the above can be found in Appendix 3.

3.159 Focus group participants felt that it was important to demonstrate how SRI connects with and complements these tools so that SRI is not seen by staff to stand in isolation.

3.160 In one pilot site, there are inequality champions and it was suggested by focus group participants that these people could be recovery champions too. In another pilot area, those working in wards pioneering the SRI and other recovery-related initiatives are already delivering talks to other staff groups in their area. In each pilot area, the pilot leads were making efforts to raise the profile of the SRI across their local services.

3.161 It was suggested that those in the Scottish Government who are responsible for rolling out the SRI nationally, should link with other national organisations that mental health services have to report to, such as Quality Improvement Scotland (QIS), the Mental Welfare Commission (MWC) and the Scottish Commission for the Regulation of Care (SCRC) to look at gaining their buy-in to SRI data. It is important to note here that QIS and the MWC are represented on the Scottish Government's SRI Steering group and have expressed their commitment to the pilot.

Perceptions of the SRI's ability to influence change

3.162 Administrators, service users and service providers were asked how much they thought the SRI had the potential to influence change, from 1 (no potential at all) to 5 (high potential). Administrators and service users were more likely to think that the SRI has a higher potential to influence change in services than service providers. The average local area scores are all relatively high, with Forth Valley providing the lowest average score (4) and Grampian providing the highest average score (5). The overall average of rating (4)

highlights that there is an overall general belief that the SRI has the potential to influence change within organisations and services.

3.163 When asked to explain why they had given the rating they had, service users advised that if the findings of the SRI process highlighted deficiencies in services then staff and management would have to change service-practice accordingly. Service users felt that services would listen more to the experience and opinions of people who use them, and so become more patient-focused:

“It [the SRI] will identify what people really think – the strengths and weaknesses according to the people who use them [services].” (service user, Greater Glasgow & Clyde)

3.164 No barriers were identified within the focus groups, in terms of implementing changes to services and practices as a result of SRI findings. There was a sense of acceptance amongst most staff and management that moving towards recovery-focused services was a laudable aim; however, a need to better involve psychiatry was identified. Service providers felt that the SRI’s potential to influence change depended on effective feedback to management, commitment at all levels and the SRI (and recovery) being high on the national and local development agenda, all of which were present in this pilot.

3.165 A key aspect of the SRI that encouraged evaluation participants to believe that it had potential to influence change was that the SRI, unlike many other more problem-focused tools, provides as much, if not more, positive feedback than negative. In most pilot sites, participants were encouraged to find that they were doing well in many aspects of delivering a recovery-focused service. A further positive way in which the SRI promotes change is by, unlike other tools, providing a useful guide to exactly what changes need to be made, and providing a structure for those changes due to the amount of detail provided on the various elements of recovery.

3.166 There was a sense amongst the service users that the SRI places those who use services at the centre of any change processes, and ‘looks at things from our perspective’. The SRI was perceived by focus group participants as a good approach to change because it involves a strong element of self examination by those involved in delivering the service under scrutiny.

3.167 In one pilot area, the focus group participants described the SRI as an intervention in itself, which resulted in an immediate impact on individuals and enabled quick and simple changes to practice to come about. For many, it was not the scores in the SRI that facilitated change, but the experience of participating in the SRI process itself that seemed to have a strong and positive impact on an individual’s ability to identify areas for change, and their motivation to take action to make the changes. In Tayside, two service users reported that during the group interview for Part 4, issues around social anxiety arose. As a result of this discussion, a local workshop for service users on social anxiety has been arranged and issues associated with social anxiety are now taken into account when planning social activities.

Impact of SRI process on knowledge, attitudes and behaviour of evaluation participants

3.168 All service users and service providers were asked to rate from 1 to 5 (with 1 being no impact and 5 being complete impact), how much participating in the SRI had had on their knowledge and attitudes of the factors that assist with recovery. Service users provided an average rating of 3. When service providers were asked the same question, they also provided an average rating of 3. The total overall average rating for all evaluation participants was 3.

3.169 Whilst these scores may seem low, the majority of participants felt that the SRI did not teach people anything about recovery that they did not already know. However, they felt that it enhanced their insight into recovery by helping them to understand what a recovery-focused service looks like by identifying the service components necessary for such a service.

3.170 Some service users reported a change in their behaviour following their participation in the SRI process:

- One service user advised they were now doing voluntary work as a result of participating in the SRI (this was because the discussion in the SRI highlighted the opportunities that were available)
- Another service user advised that they were now more aware of what the service they attend can offer them, so their participation in the SRI process had widened the support available to them
- Another service user advised that the discussion for the SRI that she participated in, had made her want to participate in activities again, such as gaining vocational qualifications and taking part in courses offered (e.g. health & safety)
- Two service users advised that the discussion for Part 5 of the SRI had made them want to become involved in things again, outside of the service they attend
- Seven service users advised that the process of being listened to, and their views being taken into account, really helps their recovery, with one describing it as a 'great compliment' even to be asked his views and opinions on the service he attended (this was something that service users believed should be measured in the SRI in some way)
- Service users reported that the very fact they had been asked to participate in the SRI had changed their own attitudes towards recovery. For example, one service user advised that they were now more aware of the things in life which they struggle with and their own strengths and weaknesses, helping them to focus
- Importantly, one service user advised that the process of participating in the SRI has made them realise that service users are able to question and participate in their own treatment and care.

3.171 The SRI was also perceived to have had a positive impact on the attitudes and behaviour of staff working in pilot-site services in the following ways:

- Following involvement in the SRI, teams were more enthusiastic and passionate about recovery and recording information in a recovery-orientated way
- Recovery has moved from being a buzz-word into everyday language
- Staff notice that service users now talk about 'recovery' and are adopting the same language as service providers

- Communication between staff and service users has improved, the SRI was considered as a mechanism to help improve communication if nothing else
- The SRI was perceived to have broken down barriers and increased trust amongst staff and different professionals and partnership working had increased as a result of the SRI.

Service development challenges raised by the SRI

3.172 The evaluation focus group discussions focused very much on the areas the SRI has highlighted for service development and the associated challenges this would bring, although, at the time of collecting this data, no pilot areas had produced formal action plans. This section provides a summary of the key areas where action for change is anticipated in pilot areas as a result of the SRI pilot.

Investing in cultural change

3.173 In the 1990's, mental health nurses were trained and taught to focus on problems and strengths-based, solution-focused therapies were not really supported. However, the Rights, Relationships and Recovery (2006) report signalled a change of direction and emphasised the need for culture change. All pilot areas were aware of the development challenges ahead in achieving real culture change to alter this approach to practice.

Assessing and meeting basic needs

3.174 The SRI was perceived by focus group participants to have directed them to reflect on the depth to which they address basic needs assessments. Participants in three pilot areas questioned the evidence-base behind the six basic needs identified in the SRI, and suggested that some reference to the rationale for selecting these basic needs be included in the SRI guidelines and training.

3.175 Pilot sites seemed to do less well in addressing the religious and belief needs of their service users, with many finding that they don't really explore this issue in any depth with service users to identify ways in which they can support them to meet their needs (often people are just asked what religions if any they ascribe to). One focus group discussed the potential to broaden out this need to include spiritual needs which are not always about organised religion.

3.176 Another basic need that was not so well addressed was that of shelter, with some sites finding that they could explore whether service users' accommodation was suitable for their needs and what actions they could take to support them in this (some inpatient ward staff felt this was not within their remit, but this was not the consensus across pilot sites).

Employing people with experience of mental health problems

3.177 One pilot area focus group explained how the SRI had challenged people's beliefs about the way in which they work in a recovery-focused way. For them, the SRI exposed the

difference between what people in their statutory services say and do in relation to their not being exemplars in employing people with mental health problems, and not routinely exploring opportunities to maximise service users' existing capabilities to increase their social inclusion.

3.178 Some pilot areas found questions about employing staff with mental health problems problematic in view of the fact people may not disclose their experience of mental health problems in the recruitment process. As a result of the SRI, one area has put 'positive discrimination within recruitment' on the human resources agenda.

Increasing the status of service-user involvement in organisational development

3.179 In one pilot area, it was anticipated that the SRI would raise the status of service users' views and increase their ability to influence recovery-focused service development. It was argued that the SRI is about the centrality of the service user and this has highlighted the need for service users to be central in terms of driving forward the recovery agenda in their local area and at a national level.

Improving assessment, care planning documentation and policies

3.180 In many areas, care-documenting systems and policies were found to be out of date and not enabling the recovery agenda. In one pilot area, focus group participants felt that staff use these policies as a guide to, and defence of, their practice. Evaluation participants felt that changing people's awareness of and attitudes to recovery, was only part of changing their practice and behaviour. To enable staff to move away from old procedures the appropriate changes to policies and documentation need to be made to set the new practice parameters.

3.181 Administrators reported finding that the assessments and care plans in their services were problem-focused and not recovery-orientated. There was a perception that this documentation tended to reflect what they described as a 'medical model' or treatment-focused model of mental healthcare. The SRI was deemed very useful in terms of measuring how recovery-focused the documentation was. Many pilot sites were planning to change their problem-based assessment and care planning documentation, to a strengths-based one, incorporating hope and aspirations.

3.182 One pilot area found that the SRI uncovered the duplication of information recorded in different patients' case notes (there was little to differentiate between individuals in the sample of notes selected), this has led to action plans to adapt the assessment and care plan documentation to ensure that person-centred care is provided and evidenced. This is an important point about the individualisation of assessment and care planning, which is key to one of the central tenets of recovery i.e. that everyone's recovery journey is unique.

3.183 The SRI also highlighted that although much good practice is undertaken, a great deal is not recorded. Many participants stated that they knew they were carrying out certain aspects of care planning, or asking questions in assessments that were in keeping with recovery principles, but were not evidencing this adequately in notes and records.

Educating patients and carers about recovery-focused services

3.184 Two pilot areas identified the need to not only educate staff, but service users and carers too, about what a recovery-focused service means.

Improving patient and carer information

3.185 In three pilot areas, focus groups reported that they would be re-writing new patient and carer leaflets to ensure they are recovery-focused and provide the amount of detail required by the SRI.

Awareness of equality

3.186 The process of administering the SRI itself was perceived to have helped to make staff more aware of equality and diversity issues relating to their practice. In one pilot area, the SRI demonstrated a limited awareness or uncertainty amongst staff of diversity issues, highlighting a need for basic awareness training on equality and diversity.

Re-administration

3.187 Focus group participants debated the potential uses and practicalities of the re-administration of SRI and a number of potential approaches were identified, these are summarised below.

Using SRI scores as benchmarks

3.188 In most pilot areas, participants envisaged some value in re-administering the SRI to measure whether the impact of the organisational changes they have implemented as a result of the previous SRI administration can be demonstrated through improved scores. However, participants were not sure whether a change in scores is the best way to demonstrate improvement through the SRI results.

3.189 All focus group participants thought that SRI scores should *not* be used to compare services locally or nationally for two main reasons. Firstly, the SRI was considered by many as a guidance tool rather than an outcome or audit tool. Using the SRI to create recovery league tables would go against the positive, participative and developmental ethos of the SRI pilot which has had a positive impact in terms of the awareness, attitudes and behaviour of those involved, and their motivation to improve. The second reason is that participants are not confident enough in the validity of scores as an ultimate measure of how recovery-focused services are because the real information is in the detail of the tool, and the ambiguity in some questions and guidelines provide potential for inconsistency in approaches to administration.

Frequency of SRI re-administration

3.190 A number of factors were considered by focus group participants when considering how often to re-administer the SRI including:

- The natural turnover of staff would mean a decreasing pool of those trained in SRI, and trainers, and create a need to reinvest in training for re-administration
- One team of staff trained to use SRI (a 'recovery team') could administer the tool across a range of services
- The costs to administer SRI across all services might be too high, criteria for selecting a sample of services would have to be introduced
- Certain elements of the tool, for example those where a service has performed poorly, and focused improvements could be re-administered alone
- Too much re-administration could prove too intense for the service users involved.

3.191 Some pilot areas planned to use the SRI as a yearly audit tool in the pilot sites to measure progress. It was anticipated that the need to re-administer would decrease in frequency as recovery-focused service delivery became more naturalised. Another pilot area planned to use the SRI six to 12 months after a change, then again after a year to see if they have achieved change, then bi-annually to see if change maintained. They considered that this would involve planning so it would be ready to administer when the time came.

SRI as a tool to assist contract monitoring

3.192 In one pilot site, the SRI will be written into an annual contract monitoring for mental health statutory and voluntary services, as part of their performance-management framework. It was anticipated that the SRI would be complemented by outcome data.

SRI as an impact assessment for new services

3.193 It was suggested by focus group participants that the SRI could be used to assist planned changes to services, such as to examine new operational procedures, new hospitals and policies in the way that other health impact tools are used. One focus group thought that the SRI would provide an excellent impact assessment tool for equality.

SRI as a reference for everyday practice

3.194 Another pilot area planned to use the SRI as a reference tool to assist staff and multi-disciplinary groups in structuring care planning and supervision sessions.

CHAPTER FOUR CONCLUSIONS AND RECOMMENDATIONS

Key Issues raised by the evaluation

Potential of the tool as facilitator for change

4.1 The purpose of this evaluation was to explore the extent to which the SRI enables practitioners and managers to apply the factors that promote equality, social inclusion and recovery for individuals to support system-level *change*.

4.2 The SRI appears to have good potential to influence change, at the individual and individual service levels. The pilot has demonstrated how the SRI results can challenge service cultures and point to changes that can be made to promote a stronger recovery orientation. The tool allows service providers the opportunity to test out their assumptions about what service users know, what they want and what they are getting from a service or an intervention. It is not yet clear whether the SRI can influence system-level change, as no pilot sites had reached a stage where they had fed back to strategic planning groups and management.

4.3 Administering the SRI was time-consuming but participants accepted that the resource input was necessary and worthwhile especially when the SRI was part of a development process. A key strength of the SRI was found to be in its level of detail, which made it possible to pinpoint both areas of good practice and areas for improvement, which provided a structure for identifying what should change and how.

4.4 Although considered to be very relevant by most evaluation participants, the SRI requires a thorough review to improve the clarity, quality and comprehensiveness of the content and to prepare guidelines for administration. This would include indicating recommended approaches to issues that proved problematic in the evaluation, e.g. sampling and confidentiality, as well as highlighting where local areas have scope to determine for themselves how best to implement the tool. The balance between standardisation and flexibility requires further consideration.

4.5 Despite the limited time available for the evaluation and the consequent cut-off of data collection between the feedback and action-planning stages of the SRI development process, participants were able to evidence changes already put in place and to highlight key areas that they anticipated would feature in their action plans.

4.6 The range of action points raised by SRI was broad with a high level of commonality across pilot sites and areas. The kinds of actions identified were very much focused on activities that would promote social inclusion, equality and recovery ranging from changing to strengths-based care documentation and procedures, to addressing the issue of ensuring equal employment opportunities for people with mental health problems.

4.7 The SRI seemed to link in well to current service development plans and recovery initiatives within local areas. The SRI enhanced local efforts to improve services by further developing local participants' insights into the recovery, equalities and inclusion agendas. The SRI also fits with the ethos of leading change by promoting and enhancing the ability of

practitioners and managers to make changes from below with support and buy-in from above, guided by the views and experiences of service users.

4.8 The multi-disciplinary approach demanded by the SRI development process reinforces the value of the SRI process as much as its output. The process envisaged for the SRI incorporates many of the key principles of effective change management, including:

- Stakeholder engagement
- Top down and bottom up approaches
- Working with multiple perspectives
- Creating opportunity to recognise areas of strengths in services and the service system
- Identifying areas where improvement is needed and planning actions to address these

The SRI as a measure of change

4.9 As there was no re-administration of the SRI within the timescales of the evaluation, the utility of the SRI as a measure of change could not be tested. However, most pilot sites expressed an intention to re-administer the SRI within a year, with the belief that they will be able to measure and demonstrate improvements in their practice.

Completeness and relevance of the SRI

4.10 The SRI was considered by most participants to be sensitive to the recovery, equality and social inclusion needs of the individuals and groups who use the range of services to which the tool was applied.

4.11 Service users in particular felt that it covered the aspects of their care that were important to their recovery. Service providers found the tool provided clarity for them on the components necessary to make up a recovery-focused service, and how well they incorporated these into their everyday practice.

4.12 The SRI pilot also demonstrated its potential to be useful as a tool that can establish the extent to which those working in the pilot sites were identifying and addressing inequalities. However, given that this is a central aim of the SRI, evaluation participants, particularly those in the pilot area that focused on the inequalities agenda, were not completely convinced of the SRI's contribution to this. There may be a need for further work to develop the SRI's potential on this.

Added benefit gained from being involved in the SRI process

4.13 Participation in the SRI pilot brought with it a number of added benefits, including:

- Creating a sense amongst the service users that the SRI places them at the centre of any change processes
- Allowing those working in services to focus completely on recovery as a main issue rather than a bolt on to other development agendas

- Embedding recovery concepts and language into everyday practice and communication
- Improved communication between service users and service providers as well as between different professions
- Beneficial to team-working through group discussions of SRI administration, planning and results
- Service users who took part found the experience motivational in terms of moving forward in their own recovery journeys
- Increasing service users' awareness of the services available to them
- Activities such as audits of patient information and policies are rarely conducted; the SRI highlighted shortcomings and new ways to think about delivering information that meets needs
- Increased service users' sense of peer support from sharing recovery stories
- Provides service users with an opportunity to give their views on services
- Providing a values-based framework within which to assess how the service system facilitates recovery, by encompassing policy, services and practice.

Recommendations for the development and roll-out of SRI

4.14 This final section of the evaluation report includes a set of recommendations for the future development and roll-out of the SRI.

Inclusive approach to developing and rolling out the SRI

4.15 Individuals involved in piloting the SRI as administrators and interviewees should be invited to assist with the re-drafting of the SRI, both directly as members of the re-drafting group and to provide comments on the revised SRI.

4.16 It also recommended that a support and learning network be developed, for those who have used or will be using the SRI.

4.17 It would also be useful to give further consideration to how SRI fits with other initiatives to promote a recovery-orientation locally and nationally, to avoid confusion and promote synergy.

Factors necessary for the successful use of SRI

4.18 The evaluation has identified a number of factors necessary for the successful use of the SRI as part of a development process.

Services SRI should be used in

4.19 The pilot demonstrated that the SRI can and should be used locally within all mental health services (statutory and non-statutory), although some work is required to make the tool less health or medically-focused.

4.20 To gain a more accurate picture of whether service users are being provided with a recovery-focused and inclusive service, it will be important to use the SRI across different service types within a service system; from primary care and specialist community teams, to wards, and not only within the individual services. This should include voluntary organisations too, as their role often fulfils key delivery of mental health services.

Achieving organisational buy-in

4.21 Strong strategic commitment to the SRI will encourage participation from service providers and service users. Creating clear lines of accountability and/or formal approaches to the use of SRI is a helpful way to achieve buy-in. This might take the form of national level DfMH documentation, the SRI being built in to local strategies on recovery and operational procedures or supporting information to set the SRI in current local and national development initiative, policy and knowledge contexts. However, more formalised approaches to the use of the SRI may lead to it being a source of information for performance management which could compromise the positive and developmental ethos that evaluation participants valued so much.

4.22 Another key factor to achieving and sustaining buy-in is a local project manager with time to champion the SRI (and recovery) and be close to the process, providing ‘hands-on’ support. This needs to be coupled with a non-judgemental and supportive ethos that emphasises SRI as a development process and not an audit, and engender trust amongst participants and those who use, manage and plan the service(s)

Flexibility in application

4.23 The pilot has also revealed that the SRI is flexible enough to be used in a number of different ways, from a benchmarking tool or an impact-assessment tool for new services, to a reference for everyday supervision. The SRI was intended to assess the extent to which organisations and services meet the expectations of DfMH. The pilot has demonstrated that the real value of the SRI is a locality and service-based development tool. How the tool is used in the long term and how often may be better dictated by local development needs rather than prescribed nationally.

Improved preparation

4.24 Preparation days should be improved to:

- Increase time available to cover the extensive ground
- Build in the flexibility required to be responsive to the needs of different individuals
- Include more on the background and evidence behind the recovery concept and the language of recovery
- Include the practicalities of the administration process including teaching of sampling and data collection skills

4.25 In addition, SRI should be supported by local recovery-awareness sessions prior to the administration, to assist with language and preparation for interviews for professionals and

service users. It proved invaluable for local areas to have access to central advice and information on the implementation of the SRI, and that this should be carried forward.

A team-based approach to administration

4.26 Consideration should be given to using different people to administer different parts of the SRI, e.g. a non-service based manager for Part 3 and a service user for Part 5, or the Leading Change team. It was also helpful for more than one administrator to be involved in each tool, creating a peer-support system.

Service user involvement

4.27 Service users should be involved in a number of ways including as interview participants, administrators, scorers and action planners. Consideration should be given to paying service users for their involvement in the SRI development process, especially as administrators, scorers and action planners.

4.28 The service user interviews should be:

- Supported by provision of information on the purpose and content of SRI and implications of participation prior to the interview
- Less than one hour long (but may require more than one session)
- Held in a group setting (converse to many professionals' views)
- Conducted by an interviewer with whom service users are familiar
- Open to a carer or representative
- Supportive of practical needs of interviewees including transport, interpreter, childcare and expenses
- Held in a flexible and familiar environment

Service-provider involvement

4.29 Service-provider interviews should be:

- Supported by provision of information on the purpose and content of SRI and implications of participation prior to the interview
- Recruited for through an open invitation to participate
- Held with multi-disciplinary teams with management representation
- More than one hour long
- Supported by release from duties to attend or added on to team meetings

Scoring

4.30 Scoring should be undertaken as a group effort soon after administration so that the findings are fresh in administrators' minds. Additional notes in the SRI should be made at

administration and consulted during SRI scoring, allowing further investigation or follow-up of issues as required.

Support with the completion of the change cycle

4.31 There is likely to be value in providing forums for those leading SRI locally to network and exchange experiences, not only in relation to SRI administration, but more importantly in relation to service and system change (see Figure 1.1). Existing support programmes may provide mechanisms to facilitate this.

Improved guidelines for the administration process

4.32 To address the inconsistencies and uncertainty in approach to the administration process guidelines for the administration process should cover:

- Confidentiality on recording data anonymously, clearing administrators for access, i.e. some form of contract with NHS
- Standard information sheets for service users and providers
- Sampling guidance, size and criteria for sampling frame
- Guidance on what specific type of patient data should be included, whilst broadening language
- The type of documentation that should be included in Part 3

Improved guidelines on feedback and action planning

4.33 A feedback report template should be produced, incorporating key aspects of the detail of the SRI results. This should include guidance on qualitative or narrative feedback to complement score sheets. An action- planning report template should also be produced.

4.34 It may be useful to consider producing different report templates for feedback to service-level staff, service managers, strategic managers and groups and service users and their carers.

Improved guidance on scoring

4.35 Detailed guidance on scoring needs to be developed to avoid the inconsistencies in approach and confusion experienced in the pilot.

Improvement to the content of SRI

4.36 The rewriting of the SRI was identified by participants as key to ensuring the SRI is accessible and inclusive to all services and individuals. The detailed evaluation information included in the results section of this report should be used as a guide to revising the content of specific questions and each whole part of the SRI. Sections 4 and 5 in particular need to be simplified and reviewed to eradicate any duplication.

4.37 A crucial aspect of the revision of the SRI content should be adaptations to enable wider service-setting applicability of SRI. The language should be less healthcare-focused and more generic to enable those in non-healthcare services to use the SRI.

Addressing key challenges and barriers to use of SRI

4.38 One key finding was of a common perception amongst interview and focus group participants of a lack of active involvement in and support for the SRI from psychiatrists. These participants acknowledged that psychiatry has a lot to contribute potentially to the SRI development process, and the need to commit further attention to involving this group in the future. A possible way to achieve this would be a top-down approach such as engaging the Royal College of Psychiatrists in the benefits and use of the SRI, building on the profession's existing commitment to the principles and values of recovery and its active participation in SRN.

4.40 It is important to challenge the persisting perception from some nursing professionals on acute wards, working with those under MHA and those with dementia, who consider that aspects of the recovery agenda such as occupation or shelter are not relevant to them and their service users.

4.41 Consideration should be given to engaging foreign language and hearing interpreters to assist administration of the SRI.

REFERENCES

Mancini, A.D. & Finnerty, M.T. (2005) *Recovery-Oriented Practices Index* unpublished manuscript: New York State Office of Mental Health

Scottish Executive (2006) *Delivering for Mental Health* Edinburgh: Scottish Executive

Scottish Executive (2006) *Rights, Relationships and Recovery: The Report of the National Review of Mental Health Nursing in Scotland* Edinburgh: Scottish Executive

APPENDIX ONE SUMMARY VERSION OF SRI TOOL UNDER EVALUATION

Please note this version of the tool will be subject to change and adaptation and SRN are not currently in a position to support it use out with the pre-testing exercise. It is provided for information only. It is important to note that additional data collection forms are not provided here.

SCOTTISH RECOVERY INDICATOR (SRI)

Version: April 18th 2007

This draft version was adapted for Scotland from the Recovery Oriented Practices Index* and will be subject to further change and adaptation.

1. About this tool

A commitment to develop a tool to assess practice against expected values was outlined initially in the report of the Mental Health Nursing Review (Rights, Relationships and Recovery) and then later in Delivering for Mental Health. Initial work in Scotland suggested that the Recovery-Oriented Practices Index (ROPI), developed at New York State Office of Mental Health following an extensive research, consultation and testing process, offered a good starting point for our needs. A stakeholder group was set up to consider how to adapt the tool and ensure relevance to Scotland. The group worked hard to ensure that the tool remained as faithful as possible to the original to ensure that the elements which are known to promote recovery are retained. The emerging SRI tool will be now be piloted in three Health Board areas and adapted and developed in the light of findings.

2. The context for using this tool

A recovery approach or recovery orientation is best described as applying individual level factors (the things which have been shown to help and hinder recovery on an individual basis) to system level change. In other words ensuring practice in mental health services relates to the factors which people have identified as helping or hindering recovery. The Scottish Recovery Network describes recovery as follows:

Recovery is being able to live a meaningful and satisfying life, as defined by each person, in the presence or absence of symptoms. It is about having control over and input into your own life. Each individual's recovery, like his or her experience of the mental health problems or illness, is a unique and deeply personal process. It is important to be clear that there is no right or wrong way to recover."

When using this tool it is important to take account of issues related to equality and diversity. The distribution of risk and resilience factors that can influence mental health and well-being is not random, some communities and people are exposed to greater risk than others. In particular:

1. The experience of poverty and economic inequality are associated with poorer mental health and well-being.
2. The experience of discrimination, prejudice and stigma on the basis of aspects of social identity, such as gender, race and culture, sexual orientation, age, disability or religion or belief can both be detrimental to mental health and well-being, and increase the risk of being in poverty or socially excluded.
3. For people with mental health problems the experience of discrimination, prejudice and stigma can have negative social and economic consequences.

In developing a recovery-orientated approach to mental health services, it is essential to recognise and respond appropriately to the individual needs and circumstances of people's lives. Services should be delivered in a person-centred way, fully respecting diversity and service user choice.

3. When using this tool

The item description and the five associated scale points serve as a guide for scoring services on the principle represented in each item. Where services or aspects of services do not fit the scale the following general instructions for scoring (adapted from Quality of Supported Employment Implementation Scale) should be applied:

5 = Full and complete adherence to all components of the principle and practice stated in the item narrative.

4 = A close approximation to the principle and practice, but falls short on 1 or more of the necessary components.

3 = A significant departure from the principle and practice, but nonetheless partially embodies the necessary components.

2 = Very little presence of the principle and practice.

1 = Absence of the principle and practice

Not all circumstances and characteristics of a service can be anticipated. If you feel that your service or team does not provide certain aspects which are expected then you should be sure that people who use your service are able to access that provision from elsewhere in the local service system. You should base your answer on the extent to which people are able to access that service.

*Mancini, A.D., and Finnerty, M.T. (2005). Recovery-Oriented Practices Index, unpublished manuscript, New York State Office of Mental Health

1. Meeting basic needs					
<p>Indicating that the assessment, planning and delivery of all services should first address basic needs. Services should include assistance in the following aspects:</p> <ol style="list-style-type: none"> 1. Shelter - service has relationships with housing providers and has placed service users in housing through referrals. Housing services, including housing with support, are basic components of care and not merely addressed in isolated situations. (Respondent should discuss role of housing in care.) 2. Nutrition - service routinely provides service users with assistance to ensure access to good culturally appropriate quality food and a balanced diet. (Respondent will need to evidence how addressed) 3. Physical health - service assesses physical health care of service users, makes referrals to primary care when necessary, and has follow-up arrangements on service users with any physical health needs. (Ask about two service users with significant general health issues and how service facilitated care.) 4. Entitlements - service assists with entitlements, advocacy and general advice eg legal, financial, housing. (Where indirectly provided, respondents should evidence knowledge of local agencies and offer examples of individual referrals.) 5. Personal care - provides service users, as required, with help with personal care, including as necessary personal hygiene, attention to clothing, haircuts etc (Respondents to evidence attention to this area, with examples) 6. Religion and belief - records expression of religious or belief-based needs and enables access as required. 					
	1	2	3	4	5
1a. Assessments should cover basic needs in detail.	Assessments do not cover any basic needs, including shelter, nutrition, medical care, entitlements, and personal care	Assessments typically (>60%) address basic needs in a cursory fashion (e.g. brief description of current housing or some assessment of medical issues)	Assessments typically (>60%) cover 1 or 2 basic needs in detail	Assessments typically (>60%) cover 3 or 4 basic needs in detail	Assessments typically (>60%) cover all 5 areas in detail
1b. Services related to basic needs should be provided routinely.	Service routinely provides 1 or no responses related to basic needs	Service routinely provides 2 responses related to basic needs	Service routinely provides 3 responses related to basic needs	Service routinely provides 4 responses related to basic needs	Service routinely provides all 5 responses related to basic needs

2. Personalisation and choice					
Indicating that the planning and delivery of all services be designed to address the unique circumstances, history, needs, expressed preferences, and capabilities of each service user.					
	1	2	3	4	5
2a. Service brochures/accessible information and documentation should identify service user choice as a fundamental principle of service philosophy.	Brochures/accessible information and documentation contain no mention of service user choice		Brochures/accessible information and documentation refer to service user choice but not as a cornerstone of expressed service philosophy		Brochures/accessible information and documentation make clear that service user choice is a fundamental principle guiding policies, procedures, and services
2b. Care planning should reflect self-set service user goals, with substantial variation across care plans.	Care plans are standardised, with minimal to no variation	Care plans show minimal variation in goals, with 90% of plans having at least 1 similar or identical goal (e.g. psychiatric stabilisation, medication compliance)	Care plans show moderate degree of variation in goals, with 50-89% of plans having at least 1 similar or identical goal	Care plans show high degree of variation in goals, with 20-49% of plans having at least 1 similar or identical goal	Care plans show substantial variation in treatment goals, with < 20% of plans having at least 1 similar or identical goal in most recent care plan
2c. Services should show considerable variation across service users, reflecting efforts to address individual service user needs.	Minimal to no variation across service users	Some variation but response is substantially the same across service users	Moderate level of variation across service users (e.g. substance abuse; some employment services)	Substantial variation (e.g. participation in range of group and MH activities) but efforts to address unique needs of individual service users are minimal	Substantial variation and active efforts are made to address unique service user needs (Should be able to identify at least 50% service user's with services that are unique to them)

3. Strengths-based approach					
Indicating that service delivery and planning should be focussed on service user's strengths.					
	1	2	3	4	5
3a. Assessment addresses service user strengths in multiple areas.	Assessment does not address service user strengths		Assessment Includes one aspect relating to strengths		Assessment addresses strengths in multiple areas of functioning
3b. Care plan format integrates strengths into goals.	Care plan format does not address role of service user strengths		Care plan format includes one generic section on strengths		Care plan format promotes integration of strengths into the achievement of goals
3c. Service documentation, policies or brochures include goal of promoting service user strengths.	Service has no documented goal of promoting a strengths-based approach		Service documentation includes mention of promoting service user strengths but aspect is not basic to service philosophy		Service documentation evidences clear emphasis on service user strengths as a basic principle of care

4. Comprehensive service					
<p>Indicating that a range of treatment services (medication, vocational, family-based, substance abuse, wellness, counselling, trauma) using different approaches (individual, group, and peer) should be provided or support given to make accessible by the service, including the following:</p> <ol style="list-style-type: none"> Medication - service provides access to individually tailored advice on effects/side effects of medication, prescriptions, medications, delivery of medications, monitoring of medication compliance, blood testing etc as appropriate. Vocational/employment - service provides a range of proactive employment services, including job assessment, development, placement, coaching, and ongoing supports for those able and wishing to work. (If service only assesses job needs and provides some coaching, then it does not pass for this indicator. There should be evidence of active job assistance that has resulted in at least 5% annual open employment and 20% job or voluntary sector placements.) Alcohol and drug misuse - provides or can access both individual and group substance misuse counselling for service users. Counselling - service provides, or is able to access, individual counselling and symptom management. (Should identify instances in which counselling or psychotherapeutic intervention was provided to address a specific service user's difficulty. For example, helping a service user suffering from panic symptoms overcome fears related to leaving the house.) Family/Social system based treatment - provides assistance to partners, families, friends, named persons, faith communities and spiritual advisers to engage them in service user's treatment and/or care as appropriate- demonstrated by frequent joint visits with service user's partners, families and friends. (This should include frequent visits with partners, families and friends and family/friends-based groups run by the team. If one or the other is not available, no credit is given.) Trauma services - service assesses and provides or accesses responses related to trauma, such as physical or sexual abuse, for service users in need. (Should include proactive efforts to identify service users suffering from trauma and targeted interventions to address it. Respondent should be able to identify a number of instances in which the team addressed an issue related to trauma...) Wellness management - service provides or can access interventions designed to help service users manage their own symptoms, address relapse management and achieve valued personal goals. (Should include assistance designed to promote service users ability to manage their symptoms). Health improvement - service provides access to a range of services such as diet, physical activity, smoking cessation, GP social prescribing. 					
	1	2	3	4	5
4. Services should provide or access response in each of the above areas.	Provides or can access at least 2 of the responses as part of routine care	Provides or can access 3 of the responses as part of routine care	Provides or can access 4-5 of the responses as part of routine care	Provides or can access 6 -7 of the responses as part of routine care	Provides or can access all 8 of the responses as part of routine care

5. Service user involvement/participation					
Indicating service user involvement as integral to the planning and delivery of all services and to the determination of policies and procedures for service operations. Service should also actively recruit service users who are hired with equality in pay, benefits, and responsibilities to other employees.					
	1	2	3	4	5
5a. Service has policy and formal mechanism for involving a diversity of service user input that has resulted in demonstrable changes in policies, procedures, or provision.	Policies do not specifically address diverse service user involvement in activities or operations and there is no formal mechanism for promoting involvement	Policies exist regarding diverse service user involvement but no formal mechanism for promoting involvement	Policy and formal mechanism for promoting diverse service user involvement exist but mechanism is cursory (e.g. yearly satisfaction survey) and has not significantly informed development	Policy and formal mechanism exist for promoting diverse service user involvement that has resulted in at least one significant change (must identify this change)	(In addition to 4) There is service user advisory board and/ or service user(s) on governing body. Service users also contribute to staff appointment process and training
5b. Service has policy and protocol for promoting service user involvement throughout the service planning process.	No policy or protocol for service user-directed service planning		Policy but no protocol for service user - directed service planning		Policy and protocol for service user- directed service planning
5c. Service users employed in professional and/or support staff positions at equal pay and with equal responsibility	No service users employed or service users not paid equally		Service users only employed in part-time positions or with limited responsibilities and/or no clear evidence of reasonable adjustments		Service users employed on permanent and temporary contracts(as appropriate) in part-time and full-time positions with equal pay and responsibilities and with clear evidence of reasonable adjustments

6. Involving support networks and promoting social inclusion and community integration					
Indicating that there should be active efforts in the planning and delivery of services to involve service user's social support networks (families, partners, friends, named persons, work colleagues, spiritual advisers, community leaders etc) in care and treatment. Also indicating efforts to promote social inclusion and community integration.					
	1	2	3	4	5
6a. Service makes active efforts to involve service user's support system in care and treatment.	Fewer than 10% of service users have some member of their support network involved in their care and treatment	11-20% of service users have a member of their support network involved in their care and treatment	21-30% of service users have a member of their support network involved in their care and treatment	31-40% of service users have a member of their support network involved in their care and treatment	> 41% of service users have a member of their support network involved in their care and treatment
Services to promote social inclusion and community integration include:					
<ol style="list-style-type: none"> Self-help - service makes routine referrals to self-help and collective advocacy groups. (A list or detailed knowledge of self-help and collective advocacy groups in team's immediate area should be readily available). Non-mental health activities - Service routinely facilitates service user's participation in non-mental health activities. (Should be able to identify significant instances in which service users were given assistance to participate in a desired activity, including educational, recreational, voluntary work or other pursuits. Group outings should not be counted toward this indicator). Vocational/employment services - service provides or facilitates referral to a range of proactive employment services for those able and wishing to work, including job assessment, development, placement, coaching, and ongoing supports. (Assessing job needs and providing some coaching does not pass for this indicator; there should be evidence of active job assistance). 					
	1	2	3	4	5
6b. Service provides a range of responses designed to promote service user's inclusion and integration into the community.	Service provides no responses related to community integration		Service provides 1 response related to community integration	Service provides 2 responses related to community integration	Service provides all 3 responses related to community integration

7. Service user in control and active participant even when subject to compulsion					
<p>Indicating that services takes steps to encourage service user's to:</p> <ol style="list-style-type: none"> 1. Make decisions in advance of possible future incapacity. This includes information and encouragement to appoint powers of attorney for financial and welfare matters, nominating a named person and making an advance statement. A recovery-oriented service takes active steps to encourage these actions when the service user has capacity. 2. Participate in own care and treatment when subject to compulsion. Legislation requires that service user's under long-term compulsion have care plans. A recovery-oriented service promotes the involvement of service user's in the design and content of their care plans. 					
	1	2	3	4	5
7a. Services should encourage service users to plan in advance for periods of incapacity.	No evidence of information or active encouragement to make decisions in advance		Information on advance decision-making displayed but no policy or active encouragement		Service information actively promotes advance decisions in its contacts with service user's
7b. Services should have policies and procedures for encouraging service user's to participate in their own care and treatment even when under compulsion (including access to independent advocacy).	No evidence of involvement of service user's in their care plans	Service user's know that care plans exist and that they can access them	Service user's are given copies of their care plans	Service user's are consulted over the content of their care plans, have copies and are involved in reviews	Care plans demonstrate that service user's are actively involved in their design and content, and have copies

8. Recovery focus					
Indicating that services should be oriented toward life roles, service user aspirations, and maximising independence, including techniques for self-management of mental health symptoms, development of meaningful activities and relationships, and, where relevant assistance with employment, parenthood etc.					
	1	2	3	4	5
8a. Care plan should address individual goals related to life roles, service user's aspirations, and relationships.	<20% of care plans include one goal related to life roles, service user aspirations, or relationships	21-40% of care plans include one goal related to life roles, service user aspirations, or relationships	41-60% of care plans include one goal related to life roles, service user aspirations, or relationships	61-80% of care plans include one goal related to life roles, service user aspirations, or relationships	>80% of care plans include one goal related to life roles, service user aspirations, or relationships
8b. Service provides interventions designed specifically to promote participation in life roles, to achieve valued goals and aspirations, to self-manage illness, and to enhance relationships with others.	Approximately <10% of total service provided is designed to address life roles, service user aspirations, self-management of illness, or improving relationships (e.g. one group on goals or illness management)	10-20% of total service provided is designed to address life roles, service user aspirations, self-management of illness, or improving relationships	21-30% of total service provided is designed to address life roles, service user aspirations, self-management of illness, or improving relationships	31-40% of total service provided is designed to address life roles, service user aspirations, self-management of illness, or improving relationships	>50% of total service provided is designed to address life roles, service user aspirations, self-management of illness, or improving relationships (substantial focus on recovery is evident in range of interventions and all embrace recovery as guiding philosophy)

Continued overleaf....

8. Recovery focus continued					
	1	2	3	4	5
8c. Service provides routine training to all staff in topics relevant to recovery-oriented practice (reflects service user's lived experience).	No training in the last year on a topic related to recovery		Training in recovery, empowerment, or person-centred planning within the last year		Training on a topic related to recovery, empowerment, or person-centred planning as a part of induction for each staff person
8d. Service provides routine supervision to all staff in relation to recovery oriented practice.	No supervision in last year	No supervision in last year focussed on recovery	Supervision occasionally focuses on recovery	Regular supervision with some focus on recovery	Regular supervision always focussed on recovery

APPENDIX TWO ACTION PLAN EXAMPLE

Performance Indicator	Improvement Indicator	Key Actions/Outcomes	Time Scale	Status	Trend
Scottish Recovery Indicators - Inpatient/Community Mental Health Team service to provide recovery-focused care and treatment	All Community Mental Health Team/ Inpatient Documentation Recovery-Focused	<p>Religion- Assessment document assesses service user's religious choice including how to access to their choice within the service. Written Information provided to all service users</p> <p>Nutrition – All service users are to be routinely screened for nutritional needs (MUST Tool) within Inpatient setting. Information given to CMHS to continue assessment/treatment.</p> <p>Healthy Lifestyle findings to be produced and evidence of good practice initiated in all teams and inpatients as appropriate</p> <p>Ensure ICP addresses financial assessment for service users</p> <p>Ensure ICP assessments and CMHS documentation reflects service user strengths and aspirations</p> <p>Ensure ICP addresses service user employment and vocational needs</p> <p>Care plans require to be strength-based, appariational, recovery-focused and socially inclusive</p> <p>Inpatient and CMHS to ensure all service users have wellness and recovery plans</p> <p>Ensure Inpatient Information Leaflet describes service user choice and involvement</p>		AMBER	Stable Trend

		CMHS Information Leaflet to be produced (In development for 3 years!)			
Scottish Recovery Indicators - Inpatient/Community Mental Health Team service to provide recovery-focused care and treatment	All Community Mental Health Service/Inpatient Staff Recovery-Focused	<p>Staff to receive recovery based training (minimum staff awareness training) current service percentage 20%</p> <p>Key staff require sexual abuse training</p> <p>Staff require education/training in recovery-based care planning (based on service user strengths, aspirations, social inclusion) , WRAP, wellness and recovery plans</p> <p>Staff require further advance statement training (provider AUGMENT) to promote service users addressing needs at times of incapacity</p> <p>Inpatient staff require training regarding Employment Disability Unit referral processes</p> <p>Induction booklets to include recovery-based training</p> <p>Staff require education regarding psycho-social interventions (benefits for service users)</p>		AMBER	Stable Trend
Scottish Recovery Indicators - Inpatient/Community Mental Health Team service to provide local service user/public Involvement strategy and policies	Service strategy and Policy for service user/Public Involvement	<p>Service Manager to develop local service user/public involvement strategy and policy</p> <p>Service manager to develop strategy relating to service user involvement within the recruitment process</p>		AMBER	Stable Trend

Scottish Recovery Indicators - Inpatient/Community Mental Health Team service to meet Service User needs	All Community Mental Health Service/Inpatient Staff Recovery-Focused	<p>CMHS to provide equality of service in relation to service user healthcare needs. Some areas provide healthcare checks but not all</p> <p>All areas to provide information about medication, side effects and ensure yearly review of medication. Documentary evidence required of same. Also require findings of Healthy Lifestyle Pilot</p> <p>All areas to provide explanation of individual one to one sessions. Examine current documentation As most service users do not feel they get 'individual' counselling sessions</p> <p>All areas to provide evidence of relative/carer involvement. Education of Service users to raise awareness that relative/carer can be involved in their care. Documentation to record evidence of relative/Carer involvement.</p> <p>All area to provide evidence of service user involvement in non- mental health mainstream activities. Social inclusive recovery-based care planning would provide this.</p>		AMBER	Stable Trend
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APPENDIX FOUR ADDITIONAL INFORMATION FOR OTHER DEVELOPMENT RESOURCES

Realising Recovery

NHS Education for Scotland & the Scottish Recovery Network (2007) *Realising Recovery: A National Framework for Learning and Training in Recovery Focused Practice* NHS Education for Scotland & the Scottish Recovery Network: Edinburgh (available online from <http://www.scottishrecovery.net/content/mediaassets/doc/Realising%20Recovery%20Framework.pdf>)

Mental Health Integrated Care Pathways (ICPs)

Information on ICPs can be found at http://www.nhshealthquality.org/mentalhealth/projects/4/Integrated_Care_Pathways/_14.html

Recovery-Oriented Systems Indicators (ROSI)

ROSI was developed in the USA after a number of states identified a need to assess the extent to which their mental health systems were 'recovery oriented'. After much scoping and investigatory work the elements identified as helping and hindering recovery became part of the ROSI assessment tool.

Tidal Model

More information is available on the Tidal Model at <http://www.tidal-model.co.uk/>

Specialist Single Shared Assessment

More information on the guidance on Single Shared Assessment of Community Care Needs is available from <http://www.sehd.scot.nhs.uk/publications/DC20011129CCD8single.pdf>

Clinical Outcomes in Routine Evaluation (CORE)

CORE was designed in the UK for use in psychotherapy, counselling and other psychological therapies to measure outcome and provide for service audit, evaluation and performance management. Further information can be found at <http://www.coreims.co.uk/>

Wellness Recovery Action Planning (WRAP)

Developed in the USA by Mary Ellen Copeland, Wellness Recovery Action Planning is a simple 'self-management' tool and is a way of helping people to take control of their wellness and work towards their recovery. Additional information on WRAP can be found at <http://www.scottishrecovery.net/content/mediaassets/doc/WRAP%20further%20information.pdf>

Reclaiming Lives

The Reclaiming Lives is a model of care to support patients who have long-term illness. Training is also carried out under the banner of Reclaiming Lives for mental health practitioners across the UK by Dr Chris Williams at the University of Glasgow.

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