

## Health and Community Care

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

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This Research Findings paper is based on the Evaluation of the Scottish Recovery Indicator (SRI) which was piloted in five health board areas in Scotland. The SRI enables services to examine whether individuals who use services and their carers' needs are met in terms of their rights to equality, social inclusion and support to recover.

## MAIN FINDINGS

- The SRI has potential to promote recovery-oriented change by challenging service cultures.
- A key strength of the SRI was found to be in its level of detail, providing a values-based framework which provided a structure for identifying what policies, services and practices were sound or should change and how.
- Administering the SRI was perceived by evaluation participants as time-consuming but worthwhile although participants were confused by the scoring process for the SRI.
- Although found to be relevant, the SRI requires improved clarity, quality and comprehensiveness of the content and guidelines for administration.
- The SRI linked-in well with service development plans and recovery initiatives and developed participants' insights into recovery, equalities and inclusion.
- Participants were able to evidence recovery-focused service changes already put in place
- Participation in the SRI pilot brought a number of added benefits for service users and workers regarding the relevance of recovery personally and professionally
- The SRI was considered by most participants to be sensitive to recovery, equality and social inclusion needs of the individuals and groups who use the range of services to which the tool was applied. However, there may be a need for further work to develop the SRI's potential for identifying inequalities and assisting participants to address this agenda.
- The SRI can and should be used in different ways within and across all services for mental health, although some evaluation participants felt that the language in the SRI may be too medically-focused.
- Most pilot sites expressed an intention to re-administer the SRI within a year to measure improvements in practice. How the tool is used in the long term may be better dictated by local development needs rather than prescribed nationally.

## 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.'*

The Scottish Recovery Indicator (SRI) 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 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 (subsequently reduced to one), agreed to pilot the SRI from September 2007 to April 2008.

## Research Aims

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

## Methodology

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 3 stages.

**Stage 1:** Local pilot site group discussions to introduce the evaluation, gathering contextual information, and the development of a detailed database map of the planned and actual use of the SRI during the pilot.

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

**Stage 3:** 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. 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.

## Main Findings

### **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 areas of good practice and areas for improvement, and which provided a structure for identifying what should change and how. However, 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 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 enhanced 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 agendas.

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, whilst providing a values-based framework to facilitate recovery-oriented change.

Most pilot sites expressed an intention to re-administer the SRI within a year with the belief that they will be able to measure improvements in 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, highlighting the need for further work to develop the SRI's potential.

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**

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

- Ensuring an inclusive approach to developing and rolling out the SRI, focusing 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 into local strategies on recovery and operational procedures, good project management and a non-judgemental and supportive ethos
- Improving SRI preparation days to provide more time, be responsive to the needs of individuals, provide more on the background and evidence behind the recovery concept and on the practicalities of the administration process particularly sampling, recruitment and data sourcing
- Supporting SRI implementation by local recovery-awareness sessions prior to the administration
- Improving the content of SRI questions, sections 4 and 5 in particular need to be simplified and reviewed to weed out any duplication. Adaptations should enable wider service-setting applicability of SRI and some participants felt that it could be less healthcare-focused.
- Involving service users as paid interview participants, administrators, scorers and action-planners.
- Giving consideration to using different people to administer different parts of the SRI and to creating administration teams
- Service user interviews should be supported with prior provision of information, conducted in groups, be 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 through open invitation to participate, held as 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
- 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
- Committing further attention to acknowledging the contribution of psychiatry to the recovery agenda and involving psychiatry in future roll-out

- Challenging the persisting perception from staff 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

## References

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

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

This document, along with “Evaluation of the Scottish Recovery Indicator Pilot in Five Health Board Areas” (the full research report of the project) and further information about social and policy research commissioned and published on behalf of the Scottish Government, can be viewed on the Social Research website at: [www.scotland.gov.uk/socialresearch](http://www.scotland.gov.uk/socialresearch). If you have any further queries about social research, or would like further copies of this Research Findings summary document, please contact us at [socialresearch@scotland.gsi.gov.uk](mailto:socialresearch@scotland.gsi.gov.uk) or telephone 0131 244 7560.



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