

Steps towards recovery-based services

The Russell Clinic Survey

**Implementing the Developing Recovery
Enhancing Environment Measure
DREEM**

**Russell Clinic, Wonford House Hospital,
Exeter.**

September-November 2005.

Dr Stephen Dinniss
Dr Glenn Roberts Jenny Hounsell
Rachel Webb Charlotte Hubbard

Executive Summary:

Background and Aim:

The recovery movement in mental health has a long history but has gained increasing prominence over recent years. In mid-2005 the National Institute of Mental Health for England (NIMHE), who had previously expressed a commitment to the recovery principles, communicated an interest in piloting a tool designed to measure how 'recovery based' a mental health environment and service is. A local service user group expressed an interest in being involved in the implementation of such a tool. Parallel to this the Exeter Rehabilitation and Recovery service were looking to perform a service evaluation that could be used as a focus for Staff and Service Development. From this came a decision to utilise the Developing Recovery Enhancing Environments Measure (DREEM) on Russell Clinic (the in patient component of the service at Wonford House Hospital, Exeter).

Method:

An advisory group was established incorporating both staff and residents on Russell Clinic and two representatives of the local Service Users Group. Following gaining their agreement, the DREEM was completed by the residents of Russell Clinic with the assistance of the Service User Group representatives. The initial results of this were evaluated in preparation for the Staff and Service Development Days. On these days staff completed the questionnaire and an initial analysis was performed and fed back. Further feedback was subsequently gained from staff on the qualitative and quantitative results as well as on the process of completing the questionnaire. Following this, further analysis was performed with the support of a statistician and using grounded theory analysis to evaluate the qualitative results.

Results and conclusions:

Results demonstrated that both staff and residents rated all identified factors of the DREEM as important in their own or their service users' recovery. Both groups appeared to show significant compatibility in their ratings of the factors as important demonstrating a shared vision of recovery. There was more significant discrepancy between staff and residents in how well they felt the Russell Clinic service met these identified needs with staff generally rating the aims as more achieved than the residents. It was felt most factors are being achieved to some level although several areas of deficit were identified. This included areas of spirituality, sexuality, providing role models and addressing service users' rights and knowledge around their illness and treatment.

Actions arising from conclusions:

From these results an action plan was developed in collaboration with staff and residents through a series of feedback and information gathering sessions which will form the basis of the service development plan for Russell Clinic for the following year.

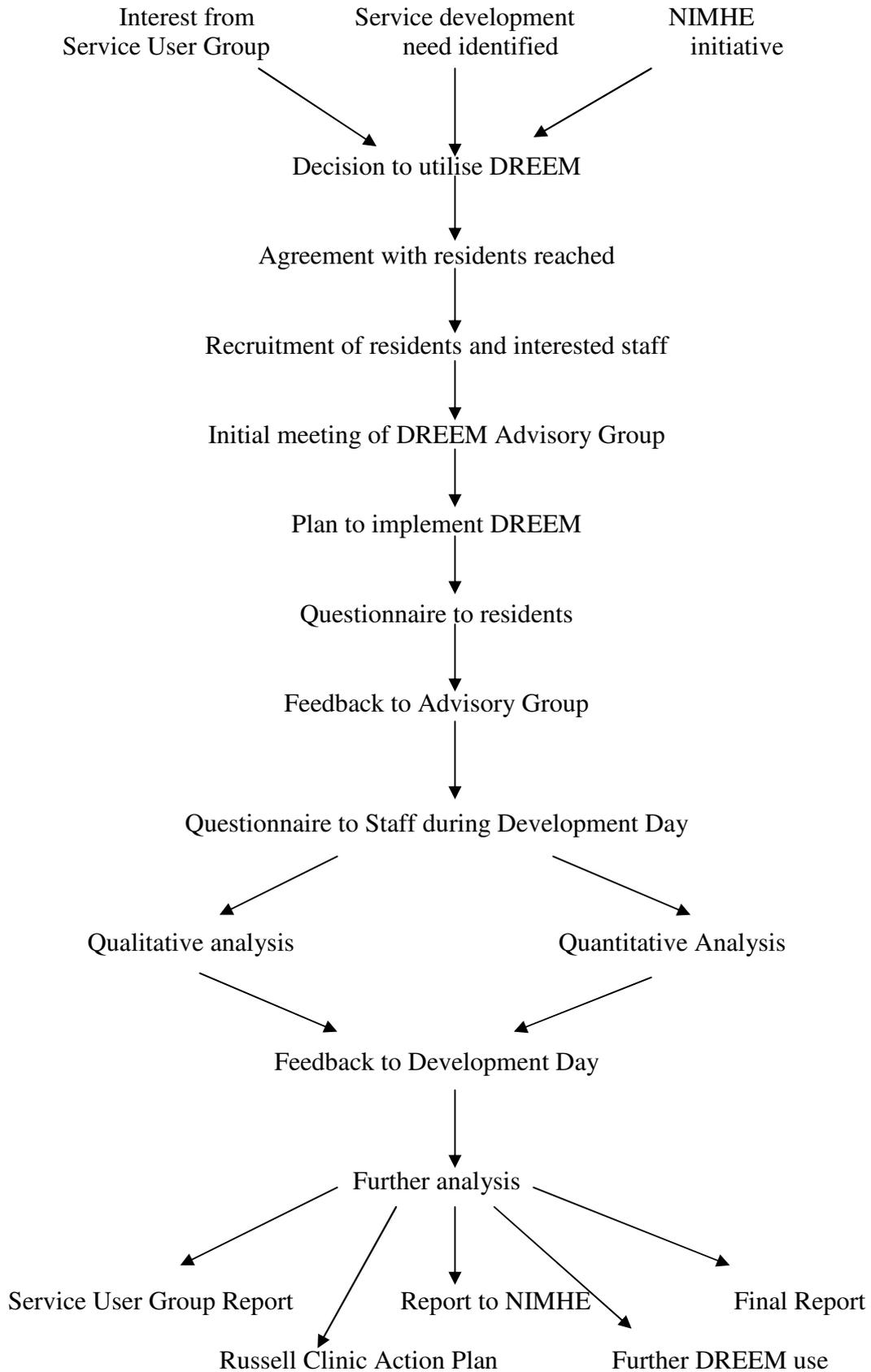
Following further analysis results, along with the feedback from staff and residents completing the questionnaire, were made available to NIMHE to inform their piloting project of the DREEM and decisions around whether to proceed with a wider, larger scale evaluation of the tool. The Service User Group will utilise the results to enhance their knowledge of local services and inform their further development. The results will also be disseminated to the other aspects of the rehabilitation service, Devon Partnership Trust and other agencies with an interest and investment in recovery based practice. The Exeter Rehabilitation and Recovery service will also use the results to inform a decision as to whether or not to further utilise the DREEM to measure the effectiveness of and assist in the development of further components of its service.

The study was concluded with a joint commitment from senior staff and the Service User Group representatives to repeat the survey after twelve months in order to evaluate implementation and the effectiveness of the action plan and to further assess the DREEM tool's ability to assess and support development in the recovery orientation of a service.

The Survey Team

Dr Stephen Dinniss (SpR Rehabilitation and Recovery Team),
Dr Glenn Roberts (Consultant Rehabilitation and Recovery Team),
Rachel Webb (Manager, Russell Clinic),
Jenny Hounsell (Exeter Service User Group Representative),
Charlotte Hubbard (Fieldworker, Exeter Mental Health Service User Project).

Overview of DREEM survey process and outcome:



Background:

The recovery movement

The principles underpinning what has come to be known as the recovery movement in mental health can be traced back to the Tukes at York (Tuke 1813) who established a clinical philosophy embracing the concept of the hope of recovery. It has been adapted to meet the needs of modern mental health service users but still embrace the basic principles. These focus on the ideas that all people with mental illness can recover. The focus is not necessarily on 'cure' and moves away from medical models of treating symptoms to focus on more holistic aspects of personal recovery. Various definitions of recovery have been developed with perhaps the most widely accepted being by Antony (1993) describing recovery as occurring even in the presences of ongoing symptoms but involving 'a way of living a satisfying, hopeful and contributing life even with limitations caused by the illness'.

Recovery and mental health services

More recently governments around the world have increasingly embraced these principles in a drive to modernise mental health services. These include New Zealand where the Blueprint for Mental Health Services (1998) and the Second Mental Health Plan (2005) place recovery principles at the centre of all mental health services. In the United States the President's New Freedom Commission on Mental Health (2003) makes mental health recovery a central concern and recommends that each person with a serious mental illness has a personal recovery plan.

In the United Kingdom the National Service Framework for Mental Health (1999) and the NHS Plan (2000) were summarised as 'The Journey to Recovery' (2001). These led, as part of the modernisation agenda, to the National Institute for Mental Health in England establishing a Fellow in Recovery who has led dissemination of an emphasis in recovery in England. This has included promotion of the Wellness Recovery Action Plan (WRAP) as a self management tool and the piloting of the Developing Recovery Enhancing Environments Measure (DREEM) as a tool for service evaluation.

Local picture

The Rehabilitation services for people with mental illness in Exeter and East Devon has developed to embrace these principles and has come to be known as the Rehabilitation and Recovery services. This includes a community based team working with people with mental illness living independently or in supported accommodation (LifeWorks), a community based residential unit where people live in a supported recovery enhancing environment (Denis Taylor House) and an in-patient residential unit, Russell Clinic, based at Wonford House Hospital, Exeter. Here people with serious mental illness that require an intensive period of inpatient care are admitted for, on average, 15 months. The service they receive is based heavily on recovery principles and looks to optimise clinical outcomes and to support people in understanding and managing their illness and develop a meaningful and purposeful pattern of living.

The Russell Clinic team is led by a ward manager as well as medical and nurse consultants. There is an established pattern of annual staff and service development days that review progress and set future directions. For 2005 there was a clear wish to review progress towards becoming a 'recovery-based service' and consider how best to inform the action plan in promoting 'recovery-based practice'. An awareness that NIMHE was looking for areas to pilot an experimental tool that had been designed to measure recovery enhancing environments seemed an ideal match to these ambitions and an early discussion confirmed that the local service user group (SUG) were interested in being involved in its implementation. We therefore looked to utilise this opportunity to use a DREEM survey as a focus for the Staff and Service Development Days. The central clinical aim of this was to develop a service action plan for Russell Clinic to continue its maturation as a recovery based service.

The Developing Recovery Enhancing Environments Measure (DREEM)

Despite the long history of the recovery movement and its increasing prominence in the recent development of services very few research tools have been developed to help services assess their recovery commitment. Therefore, a tool was developed by Pricilla Ridgeway (a mental health service user and worker based in the United States) with the explicit aim of developing a 'sound, useful and comprehensive measure that helps services learn about recovery and to assess the extent to which service users judge that the services' staff, offerings and organisational climate support their recovery' (Ridgeway 2004).

The content was developed through an examination of first person accounts of recovery and their description of the components of the service that assisted them in their recovery. A review of developing recovery services and a literature review of factors that facilitate resilience and rebound from adversity in general was also performed to assist in the selection of factors that make up recovery. The tool has been edited and adapted by Piers Allot, Recovery Fellow for NIMHE to support exploration of its use in the UK (Ridgeway 2004).

Its use to date has been primarily within the United States. It has not undergone formal validation or reliability studies and it therefore remains a tool with which there is limited experience and limited psychometric evaluation. Two significant field tests in Kansas and Massachusetts suggest it has validity and reliability but these lacked power to act as definitive evaluations. Its status then of an experimental instrument, one of an emerging range of tools designed to evaluate individual and service progress in recovery (Campbell-Orde 2004). Therefore, there is a need to interpret outcomes in this context.

The DREEM questionnaire has seven components-

- 1) Demographic data
- 2) Stage of recovery for the individual
- 3) Elements of recovery services
- 4) Specific needs of the individual
- 5) Organisational climate
- 6) Recovery markers
- 7) Final questions (qualitative component).

It therefore looks at aspects of the individuals' view of themselves in relation to recovery, an assessment of how they view the service they are receiving with respect to their recovery and addresses very specific issues of individual needs. It is designed to either be self administered or done with assistance of a person not involved in providing that individual with psychiatric care.

The full questionnaire comprises 160 elements which was regarded by service users as too many. The present study therefore utilised three components, 1, 3 and 7. A copy of the components of the questionnaire used is available in Appendix 1 and a full copy of the questionnaire is available in the compendium of recovery measures (Campbell-Orde 2004)..

Implementation of DREEM on Russell Clinic

Progress and process

This was a process of creative collaboration between service providers, and those within the services to working together so as to evaluate how the service is experienced in terms of supporting recovery, and of using those findings to shape a user-led action plan for service development over the following year. In describing how the study was developed initials refer to members of the survey team and authors of this report.

July – August 2005

We became aware of DREEM through the NIMHE Fellow on Recovery, and brought it to our ‘Rehabilitation and Recovery Forum’ where, following discussion, an initial working group was set up, consisting of Service User Group (SUG) representatives (JH and CH) medical (GR and SD) and nursing staff (RW). Having started together we were pleased when, late in the day, we discovered guidance that a key to collaborative work with service users ‘is the value of being involved from the very start of the project’ (Faulkner 2004).

This initial meeting sketched out what was to become known as ‘doing recovery based research in a recovery based way’, which amounted to staying very close to user centred guidelines for ethical research and evaluation (Faulkner, 2004). Faulkner emphasises that service users have frequently felt ‘disempowered research subjects’ in the past, and there is an associated need for active feedback and knowledge that their participation is important in making a difference – ‘if it is not about making a difference, what’s the point of the research?’ (JH)

This planning discussion between service providers and SUG representatives resulted in a commitment to using DREEM in both the residents and staff context, with the aim of having both available for a critical evaluation of the service by the staff in a user-informed fashion. It was agreed this should lead to development of action points and provide the service development plan for the following year.

The Service User Group representatives met with the whole resident group and explained the proposed survey, gained their agreement to go ahead and then helped to recruit three current residents to join an advisory group which steered the project as a whole. The advisory group met three times to keep track of the survey over three months and in fulfilment of the guidance that, ‘a clear and open approach towards all of the people involved in a project, co-researchers and research participants in particular, can avoid many problems further down the line.’ (Faulkner, 2004)

Some of the early issues that needed clarification in this advisory group were:

- a. Clarification of confidentiality – *this established that the SUG reps alone would know who had completed the forms (although we later regretted this as it made returning questionnaires to the residents at their request more difficult).*

- b. Where information was going – *several members had concerns about information management and were able to be reassured by the structure of confidentiality and the subsequent anonymity for reporting.*
- c. A clear undertaking that the findings would result in action – *Staff could commit to both using the outcome of the whole survey as a lead to the unit's cycle of action planning and service development, but also to feed these results into the national DREEM development group (NIMHE).*
- d. Establishing payment for both SUG project workers, service users attending the advisory group, and an honorarium for those completing the survey – *the Trust has a policy and funding stream established for service user payments which we easily accessed. This provided payment of £10ph for one of the SUG workers, £5ph for attending the advisory group and an honorarium of £5 for those completing the survey – this payment was felt to be significant in gaining a high level of resident participation (see SUG report, appendix 2).*
- e. The SUG, in company with some patients considered DREEM with all 7 elements as too big and complicated, to the point of being off putting – *in discussion we narrowed our pilot down to using 3 elements, 'a few questions about you', 'elements of recovery and a recovery enhancing service', and 'final questions' – this yielded demographic, quantitative and qualitative information.*

September – October 2005

The SUG workers then sought responses from all residents on Russell Clinic using the three chosen components of the DREEM. They experienced a range of responses and different levels of ease or difficulty in completing the questions. Residents took between 20 – 55minutes to complete, they varied on whether they appreciated help or not and most had difficulty with at least one element. Ten of the 14 current residents fully responded and 4 declined, but in each case were able to give reasons which were recorded by the SUG workers as part of a contemporaneous record of their experience (Appendix 2). Those that declined to complete the questionnaire still participated in the survey process giving 100% involvement in the procedure of implementing the tool.

After three meetings and the completion of the data collection, the advisory group members were thanked for their help and stood down. The survey team continued to meet to summarise and interpret the findings.

Staff and Service Development Days October 13/14th 2005

At the annual Russell Clinic staff and services development day, staff were asked to complete the same elements of the DREEM that their residents had previously. They completed these from the point of view of 'How the (their) service as a whole provided for its patients needs'.

Their responses were gathered and analysed over the lunch period, at which time the SUG representatives also joined the group. In the afternoon, staff were initially given sheets on which there was a summary of all their comments in response to the last four questions. They were asked to then individually cast two votes for what they felt were the most important comments or suggestions in each section. These were analysed later and a summary was given back to the ward team to inform action planning (Appendix 4).

During the Staff and Service Development Days, staff had a visual (graph) summary of their own quantitative results presented back to them and were shown how the staff perspective compared with that of the residents. This created a lively and engaged discussion, with input from the SUG representatives. Staff suggestions in response to the 'final questions' and the outcome of the comparative analysis of 'elements of recovery and recovery based services' led on to a discussion and initial identification of action points – what could we / would we like to do about these findings?

November – December 2005

The action points arising from the residents' survey and the staff development days were formulated into a draft action plan by the ward manager (RW), which formed part of our presentation to the national NIMHE DREEM pilot group. The draft action plan was then critically evaluated by the residents working confidentially with SUG, and a final plan agreed which will form the basis of service development on Russell Clinic over the next year (presented later in this report).

National DREEM Pilot Meeting November 7th 2005

Piers Allot, NIMHE Fellow for Recovery, convened a meeting in Birmingham to review experience and opinion concerning DREEM to date and to develop a proposal for next steps. There were presentations of the findings from the Devon DREEM survey and a report from a survey by a psychologist in SLaM (South London and Maudsley Trust). These studies were both conducted in rehabilitation services but had different response rates as well as different styles of survey. Despite this, they came up with the same findings in terms of 'most unsupported recovery elements'.

The outcome of that meeting was to invite Devon and four other pilot areas to complete their reports and submit them to Piers and Mike Clarke (National Manager for Mental Health R&D at the DoH). These experimental studies would support them developing a proposal for the DoH / NIMHE to fund and commission a thorough clinical and psychometric evaluation of DREEM, with Devon as one possible site. In recognition of the Devon findings the group found that, 'when a psychometric evaluation is commissioned it is essential that this is also done in a recovery oriented way and recognises the important to processes and the existence of contradictions within recovery and values based practice'.

In addition to the direct findings from the DREEM the present study also allowed those involved to critique the measure - offering additional guidance on how DREEM might be developed (detail of critique given later in this report).

Ethical issues

A discussion was held early in the process to clarify ethical considerations for this project. It was decided that it was primarily a service evaluation that was integral to the clinical work, service development and clinical governance of Russell Clinic. It was decided the project did not equate to research (no clear research question postulated) nor audit (no clear standards set). Therefore a decision was made that it did not require ethical approval from an external body.

Throughout the process constant assessment and awareness of ethical consideration occurred within the context of the advisory committee. These included considering the impact on residents (time taken to fill questionnaire and any emotional/psychological impact of completing it), impact on staff (being asked to evaluate their practice), confidentiality and the role of the honorarium (seen as a potential inducement to participate). It was felt that each of these issues was sufficiently addressed within the methodology of the evaluation to prevent any significant ethical concerns arising. The joint working format with the Service User Group representatives further ensured active consideration of all perspectives of the ethical issues. Additional guidance was taken from published guidelines on the ethical conduct of research carried out by mental health service users (Faulkner 2004).

Further analysis

Following the away days the data was also sent to the statistician for the Research and Development Service to request further analysis. This was performed using SPSS 11.1. From this t-tailed t-tests were performed to assess the significance of the difference between responses by staff and residents. A factor analysis was also performed to try and reduce the amount of data by finding components of recovery that statistically clustered together in a meaningful way.

Results- Demographic Data:

The results of the demographic data are given in Table 1 below.

Factor		Staff (n/26)	Residents (n/10)
Age	18-25	8% (2)	20% (2)
	26-35	15% (4)	30% (3)
	36-45	31% (8)	20% (2)
	46-55	23% (6)	10% (1)
	56-65	23% (6)	20% (2)
Gender	Male	42% (11)	90% (9)
	Female	58% (15)	10% (1)
Ethnicity	White British	81% (21)	90% (9)
	Other White	4% (1)	10% (1)
	Other	15% (4)	0% (0)
Length of time receiving/ working in services	Less than 1 year	0% (0)	10% (1)
	1-5 years	27% (7)	20% (2)
	5-10 years	19% (5)	40% (4)
	> 10 years	54% (14)	30% (3)

Analysis of Quantitative Results

The results were analysed using SPSS 16.1. The results of the stem questions focusing on the importance of factors were summarised as means. The three sub-questions regarding how well a factor was being achieved in the service were combined and again given as a mean. Two tailed t-tests were used to assess the level of statistical significance of the difference between the responses of the staff and the residents. An attempt was made to perform a factor analysis to reduce the number of factors and thus the amount of data. This yielded no meaningful results so is not presented here.

The results from the quantitative element of the questionnaire (Section 3: Elements of Recovery and Recovery Enhancing Services) are summarised in Tables 1 and 2. These demonstrate that overall both staff and residents of Russell clinic agreed that all components identified in the questionnaire held some level of importance to a patient's recovery. This is shown graphically in Figure 1 where items are ranked in order of decreasing importance as identified by residents. Items are scored from 2 (strongly agree a factor is important) to -2 (strongly disagree a factor is important). All items score above zero (neutral answer). Table 1 shows no significance difference between the scores of the residents and staff (no p values <0.05). Thus, there is overall agreement between staff and residents that these factors are important aspects of recovery.

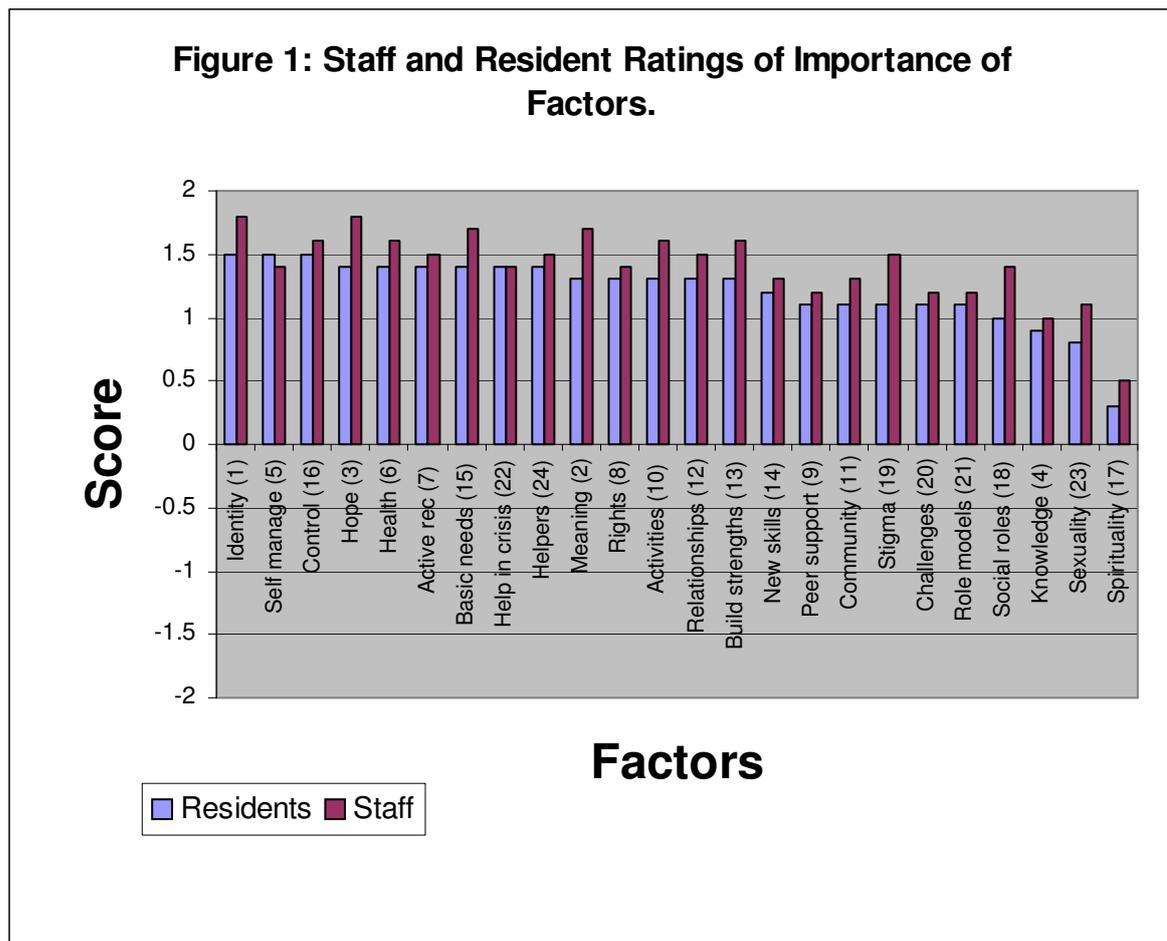


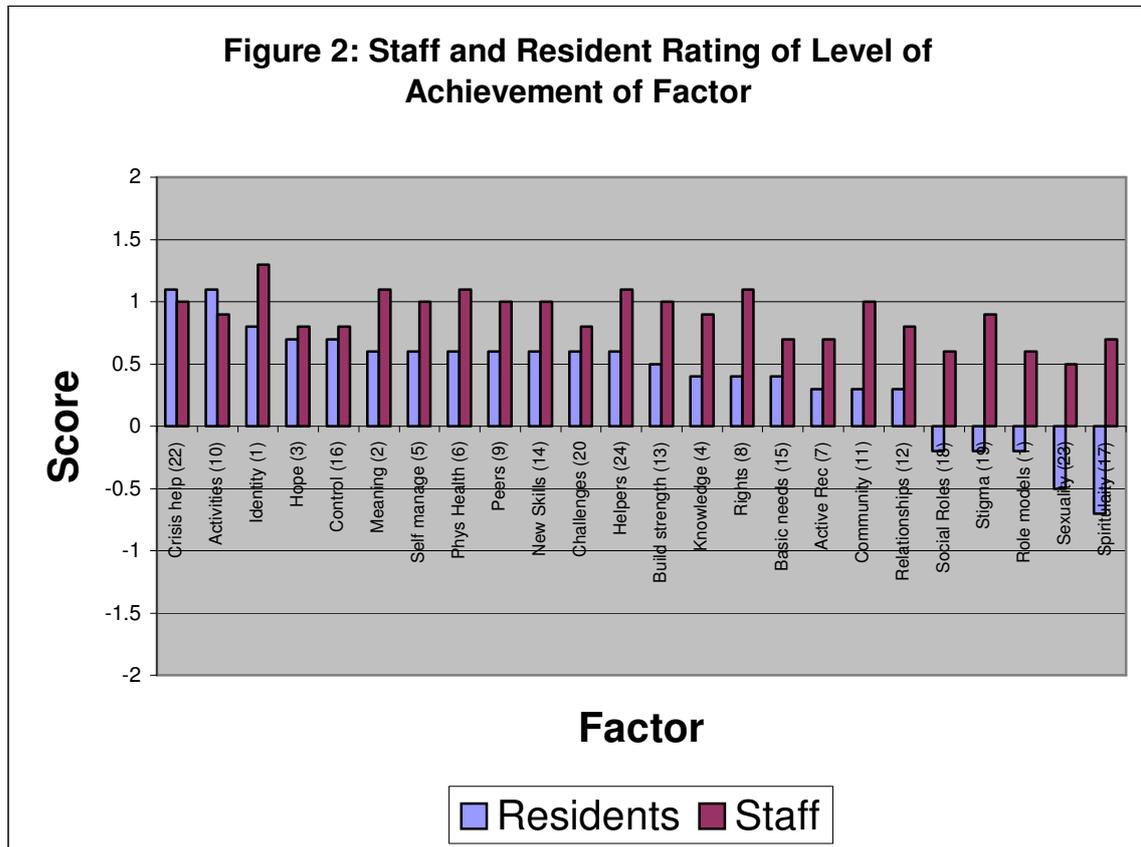
Table 1: Results of DREEM on Russell Clinic- the importance of factors of recovery.

Fact. No.	Factor description	Residents' rating of importance (mean)	Staffs' rating of importance (mean)	Staff-residents mean difference	Sign of diff (2-tailed t test- P value)
1	Self identity	1.6	1.8	0.2	0.359
2	Meaning in life	1.3	1.7	0.4	0.068
3	Hope	1.4	1.8	0.4	0.074
4	Knowledge	0.9	1.0	0.1	0.548
5	Self-manage	1.5	1.4	-0.1	0.780
6	General health	1.4	1.6	0.2	0.407
7	Active in recovery	1.4	1.5	0.1	0.455
8	Rights	1.3	1.4	0.1	0.471
9	Peer support	1.1	1.2	0.1	0.562
10	Activities	1.3	1.6	0.3	0.221
11	Community	1.1	1.3	0.2	0.409
12	Relationships	1.3	1.5	0.2	0.379
13	Build on strengths	1.3	1.6	0.3	0.072
14	New skills	1.2	1.3	0.1	0.613
15	Basic needs met	1.4	1.7	0.3	0.206
16	Control over life	1.5	1.6	0.1	0.406
17	Spirituality	0.3	0.5	0.2	0.498
18	Social roles	1.0	1.4	0.4	0.332
19	Challenge stigma	1.1	1.5	0.4	0.540
20	New challenges	1.1	1.2	0.1	0.562
21	Role models	1.1	1.2	0.1	0.831
22	Help in crisis	1.4	1.4	0	0.180
23	Sexuality	0.8	1.1	0.3	0.337
24	Helpers who care	1.4	1.5	0.1	0.576

Score:

- 2= strongly agree factor is important/achieved
- 1= agree factor is important/achieved
- 0= neutral whether factor is important/achieved
- 1= disagree factor is important/achieved
- 2= strongly disagree factor is important/achieved

Table 2 represents the staffs' and residents' assessment as to how well each item is achieved within the environment of Russell Clinic. It again demonstrates that most items are scored positively- representing an opinion that they are at least to some degree being achieved on the ward. Five items were rated negatively- role models, challenging stigma, social roles, sexuality and spirituality. All items were rated as being achieved (to varying levels) by staff. Figure 2 shows these results graphically with items rated in decreasing order of achievement according to residents.



Eight items showed a statistically significant difference when comparing the ratings by staff to that of the residents. In particular spirituality, social roles, challenging stigma and sexuality were significant to 0.1%. These are particular areas of disparity between staff and resident responses.

To further understand the results and the level of agreement between staff and residents, Table 3 and 4 rank the factors according to how well each was seen as being important/ achieved. Further analysis of individual factors can also yield more information by graphically showing all four factors (staff and resident ratings of importance and level of achievement) in one graph. This helps in trying to focus on specific areas of deficit when interpreting the results and converting them into tangible points of action for the service. This was done for factors deemed most important, most achieved and least achieved by both residents and staff. These graphs are available on PowerPoint as part of the electronic version of this report.

Table 2: DREEM on Russell Clinic- How well factors of recovery are achieved.

Fact. No.	Factor description	Residents' rating of achieved (mean)	Staff rating of achieved (mean)	Staff-residents mean difference	Sign of Diff (2 tailed t test -P value)
1	Self identity	0.8	1.3	0.5	0.266
2	Meaning in life	0.6	1.1	0.5	0.304
3	Hope	0.7	0.8	0.1	0.339
4	Knowledge	0.4	0.9	0.5	0.108
5	Self-manage	0.6	1.0	0.4	0.133
6	General health	0.6	1.1	0.5	0.087
7	Active in recovery	0.3	0.7	0.4	0.079
8	Rights	0.4	1.1	0.7	0.002**
9	Peer support	0.6	1.0	0.4	0.149
10	Activities	1.1	0.9	-0.2	0.565
11	Community	0.3	1.0	0.7	0.047*
12	Relationships	0.3	0.8	0.5	0.042*
13	Build on strengths	0.5	1.0	0.5	0.109
14	New skills	0.6	1.0	0.4	0.205
15	Basic needs met	0.4	0.7	0.3	0.353
16	Control over life	0.7	0.8	0.1	0.802
17	Spirituality	-0.7	0.7	1.4	0.000***
18	Social roles	-0.2	0.6	0.8	0.001***
19	Challenge stigma	-0.2	0.9	1.1	0.000***
20	New challenges	0.6	0.8	0.2	0.137
21	Role models	-0.2	0.6	0.8	0.011*
22	Help in crisis	1.1	1.0	-0.1	0.821
23	Sexuality	-0.5	0.5	1.0	0.000***
24	Helpers who care	0.6	1.1	0.5	0.059

Score:

- 2= strongly agree factor is important/achieved
- 1= agree factor is important/achieved
- 0= neutral whether factor is important/achieved
- 1= disagree factor is important/achieved
- 2= strongly disagree factor is important/achieved

- * significant to 0.05
- ** significant to 0.01
- *** significant to 0.001

Table 3: Ranking of importance of factors by residents and staff

Rank	Residents priorities	Staff Priorities
1	Self Identity (1)	Self Identity (1)
2	Self management (5)	Hope (3)
3	Control over recovery(16)	Basic needs met(15)
4	Hope (3)	Sense of meaning (2)
5	Physical Health (6)	Control over recovery(16)
6	Active in own recovery (7)	Physical Health (6)
7	Basic needs met(15)	Meaningful Activities (10)
8	Help in crisis (22)	Building on strengths (13)
9	Helpers available(24)	Active in own recovery (7)
10	Sense of meaning (2)	Helpers available(24)
11	Rights respected(8)	Relationships (12)
12	Meaningful Activities (10)	Stigma (19)
13	Relationships (12)	Self management (5)
14	Building on strengths (13)	Help in crisis (22)
15	New skills (14)	Social roles (18)
16	Peer support (9)	Rights respected(8)
17	Sense of Community (11)	New skills (14)
18	Stigma (19)	Sense of Community (11)
19	New Challenges (20)	Peer support (9)
20	Role models (21)	New Challenges (20)
21	Social roles (18)	Role models (21)
22	Knowledge of illness(4)	Sexuality (23)
23	Sexuality (23)	Knowledge of illness(4)
24	Spirituality (17)	Spirituality (17)

Table 4: Factors ranked by residents and staff as being achieved on Russell Clinic

Rank	Residents felt achieved	Staff felt achieved
1	Help in crisis (22)	Self Identity (1)
2	Meaningful Activities (10)	Sense of meaning (2)
3	Self Identity (1)	Physical Health (6)
4	Hope (3)	Helpers available(24)
5	Control over recovery(16)	Rights respected(8)
6	Sense of meaning (2)	Help in crisis (22)
7	Self management (5)	Self management (5)
8	Physical Health (6)	Peer support (9)
9	Peer support (9)	New skills (14)
10	New skills (14)	Sense of Community (11)
11	New Challenges (20)	Building on strengths (13)
12	Helpers available(24)	Meaningful Activities (10)
13	Building on strengths (13)	Stigma (19)
14	Knowledge of illness(4)	Knowledge of illness(4)
15	Rights respected(8)	Hope (3)
16	Basic needs met(15)	New Challenges (20)
17	Active in own recovery (7)	Control over recovery(16)
18	Sense of Community (11)	Relationships (12)
19	Relationships (12)	Spirituality (17)
20	Social roles (18)	Basic needs met(15)
21	Stigma (19)	Active in own recovery (7)
22	Role models (21)	Role models (21)
23	Sexuality (23)	Social roles (18)
24	Spirituality (17)	Sexuality (23)

Analysis of Qualitative Data

The qualitative data is that collected from the 'Final questions' component of the DREEM. It was collected from both the resident and staff population. The analyses of the two sources were performed differently. For the resident data, analysis was performed by the SUG representatives using a grounded theory method of analysis, looking for common themes among responses and collecting responses together that clustered thematically. The responses from the staff group were fed back to them on the Away Day and they were then asked to vote for the two responses they most strongly agreed with. The votes were then tallied and those responses achieving the highest number of votes were considered the most representative of the staffs' answers.

The full analysis and results for the residents can be found in the attached Appendix 3. The full range of answers given by the staff to the final questions can be found in the attached Appendix 4. A summary of this data will be presented here.

Question 1: What are one or two of the most important things a mental health service and its staff can do to support people with mental health problems in their mental health recovery?

Resident responses clustered into themes of practical help eg 'get me up in the morning', physical health and relationship issues especially focused on the value of building relationships between staff and residents. The staff voted involving service users in their own care, listening and understanding, and offering, holding and believing in hope as the most important components.

Question 2: What are one or two of the most important things you have learned so far on your journey of recovery?

Resident responses focused on the importance of making use of their own resources and taking control of their own lives as well as focusing on the benefit of relationships. Staff listed the following four points as most important:

- Be prepared for disappointments and set backs but remain positive
- To remain positive about the persons future outcomes
- Acknowledging and valuing the differences in people leading to an individual and personal approach to their problems and recovery
- To learn from the client about the client in order to work in partnership.

Question 3: What are one or two things you would want to say to a person who is just beginning his or her journey of recovery from mental health problems?

Resident responses focused on practical help including taking medication and avoiding street drugs as well as the importance of hope and seeking out expertise including staff and services. The responses voted most important by staff are listed below:

- There is light at the end of the tunnel – remain positive and hopeful
- Similar patients have made excellent progress
- There is hope – your life can improve – recovery can happen

- Take one step at a time – each step is an achievement
- Whatever the past was like the future can be different

Question 4: Are there any other comments or ideas that could improve the service that you want to include in the survey?

The recurring themes from the residents' responses were around the need to spend 1:1 time with staff, the physical environment of the ward and the need for more choice and control over the service they receive. Several respondents also expressed overall satisfaction with the current service. Staff responses voted most relevant are given below:

- Us getting a secure understanding of what is involved in developing a recovery based service
- Encourage staff to remain positive in their outlook towards a patients recovery
- More homely environment – less clinical more individual therapy
- Being committed to the recovery process for our patients and ourselves.

Overall the analysis of the resident data appeared to yield specific recurring themes which were given as:

- One to one time with staff
- Relationships
- Valuing oneself and valuing the individual
- Practical tips.

Further reflection on some of the key areas of agreement and disagreement between staff and resident responses will be given in the discussion and interpretation of the results.

Russell Clinic Action Plan

As a result of the above findings an iterative process involving consultation with staff, residents and the DREEM advisory group was utilised to develop a user led action plan to support and direct the continued development of Russell Clinic as a recovery service. As this was the main purpose and central clinical outcome of this survey, the copy prepared for the residents is given in full below.

Russell Clinic Action Plan Jan – Dec 2006

1. You said areas of identity, control and meaning are important

We will:

- a. Provide you all with diaries for personal use, for putting appointments in etc.
 - Time scale = Christmas 2005. New patients will be provided with them on admission.
- b. Your named nurse team will be talking to you at some point about how you manage your life, good times and tough times, and offering you ways to look at how to think about managing events.
 - time scale =1:1 time is ongoing. But your named nurse would like to talk to you about good times and tough times in your life, and how you may help yourself to feel, stay on track. Your nurse will talk to you about these times when it feels ok for you to talk about them. They will take it at your pace.
- c. You will all be offered time with your named nurses at least once a week, and the same with co-workers. We will be able to check this is happening by reviewing the nursing notes.
 - Time scale = this is to start happening now.
- d. The Nurse Consultant, Ward Manager and Team Leader will look at changing the nursing paperwork to something that helps you and your named nurse work together more easily on issues about identity, control & meaning.
 - Time scale = for meetings to look at this to start within 3 months. To change paper work is a big task that all the staff will have to be able to comment on.
- e. WRAP – wellness recovery action planning. Places on the next 2 day course will be available to you. Some of you found WRAP interesting. There will be information about it in the leaflet racks, and your named nurses will talk to you about it on an individual basis.
 - Timescale = 3 months

2. You said the area of physical health is important

We will:

- a. Give you a copy of the physical health screening paperwork that we keep. This has a list of the physical health checks that we offer you on it and will have your personal results for these. This paperwork asks your named nurse to check that any repeat tests are carried out. Your named nurse will encourage you to put dates for these in your diaries. Also the healthy eating group will carry on, and there will be leaflets available about healthy lifestyle.
 - Time scale = 2 months

3. You said the area of knowledge is important

We will:

- a. Get a new leaflet rack for the large lounge, that way you can look at leaflets etc with a degree of privacy from staff. The one in reception will stay.
- **Timescale = as soon possible**
- b. Provide up to date information leaflets on medication. These will be available in the reception, clinic room and large lounge. (They are currently in reception and clinic room).
- **Timescale = 2 months**
- c. You will be able to use the office computer for internet searching to support you gaining new up to date knowledge. We will put together a list of reliable sites for you to use. There are some rules around this, please see the ward protocol.
- **Time scale = 1 month**
- d. Some of you would like to learn how to use a computer and the internet. The Ward Manager will find out about any local courses.
- **Time scale = 1 month**

4. You said the areas of rights is important

We will:

- a. Ensure that there is information available about advocacy services that can support you. We will continue to work with the service user representatives. We will continue to acknowledge and respect you rights. We will recognize that you have the right to make a complaint if you feel your rights are not recognized, and if you want will be able to support you to do this.
- **Timescale = to continue as it has been for some time**
- b. Respect your rights, and attempt to ensure that you are aware of your rights if you are detained under the Mental Health Act. Your named nurse will check that you know your rights about this at the following times. On admission, if you have a managers hearing or a tribunal, or if your section is renewed or changed. If they think you may not have understood they will talk to you again about it. They will also give you some written information if you think this might be helpful.
- **Timescale = to start now**
- c. Be encouraging all of you at some point to have a benefits “health check” with the benefits advisor at Lifeworks. This is the responsibility of named nurses.
- **Timescale = on admission and prior to discharge**

5. You said the areas of stigma, sexuality & spirituality are important

We will:

- a. We will continue to try and get a Chaplin to visit weekly. There is a meeting between this Trust and the RD&E who provide us with a Chaplin this month to sort this out. Ward Manager will chase this and keep you informed.

- Timescale = 1 month
- b. Once we have a Chaplin we can think about how we/they may support people in the area of spirituality etc.
 - Timescale = 3 months
- c. Continue to support those of you who may feel you experience stigma, we will support you to challenge this if you are comfortable with this. We will continue to provide education to the public when possible about mental health and what it is we do at the Russell Clinic. We will continue to develop and aim to build new links with regular community resources.
 - Timescale = ongoing.

6. You said the areas of new skills & recreational activities are important

We will:

- a. Our Specialist Practitioner and Occupational Therapist will be talking to you and nursing staff about what may be offered both on and off the ward, to continue to build confidence and skills. They will then produce a plan for the year.
 - Timescale = 6 weeks

7. You said the area of role models is important

We will:

- a. Be advertising and support people if they want to go to the recovery conference in Barnstaple in April. Ward manager + named nurses responsible.
 - Timescale = January - April
- b. Be asking named nurses to talk to you individually as to whether you would like to talk to people who have had similar experiences to you.
 - Timescale = 2 months

Discussion of Results and Implications:

This assessment of Russell Clinic can be seen as a positive affirmation that the team and service are to at least some extent achieving their aim of providing a recovery based service. Both staff and residents were able to identify the factors within the DREEM questionnaire as important to recovery and overall there was a general level of agreement that these were being achieved on Russell Clinic.

Specific factors were rated by residents as being particularly important to their recovery including a sense of identity, self-managing one's own illness, a sense of control and a feeling of hope. Encouragingly, these factors were also identified by staff as being among the most important. There is also general agreement between staff and residents as to the relative importance of factors are in one's recovery. This indicates a compatible vision towards recovery being shared by staff and the service users with whom they work.

The analysis of the rating of the level of achievement of each factor shows less agreement and a wider variation in responses. There are a significant number of factors that residents did not feel were being achieved adequately on the ward. Interestingly, these were mainly factors that they did not feel were particularly important to their recovery at this stage, with the five factors rated negatively all being among the seven least important factors. This gives us a contradictory message as to whether this identifies areas that need to be addressed on the ward. These findings were fed back to residents to clarify prior to being interpreted as areas requiring action.

There are also areas of significant disagreement between staff and residents about how well some factors are being achieved. This in particular provides us with avenues to further look to develop the service that we would not have identified ourselves and to consider that how we see ourselves is not entirely how residents experience the service. In particular we plan to further try and understand how we can meet the service users' needs in the areas of sexuality and spirituality as well as addressing their rights and assisting them being active in the community and forming meaningful relationships. Both staff and residents felt the most important factor of completing this evaluation was that it should lead to action and therefore significant effort has been made to form a collaborative action plan arising from these results. This is further supported by a commitment to review the process and re-evaluate the service in a year's time.

With respect to trying to draw some meaning from the qualitative data this must be done in the light of the fact that the staffs' and residents' answers were analysed using differing methods. Despite this there are significant similarities. From both groups the focus on hope as a key factor is significant and reflects an agreement that this is a core component to working with a recovery focus (and corresponds with both groups rating it among the top five most important factors). Residents also focused on the importance of a relationship with staff and the value of 1:1 time. This is reflected in staff focusing on the need to understand service users as individuals and work in partnership. One difference in the themes identified however was that more often residents focused on practical tasks as important eg 'get me up in the morning' and help in taking medication, as opposed to more abstract concepts highlighted by staff

eg 'listening and understanding' (although staff were pleased to have this often unappreciated aspect of their work acknowledged by the residents).

The process involving staff included them individually generating and then evaluating their own conceptualisation of recovery based practice, the recovery process and the relative significance of different elements. Their contributions and evaluations were maintained as confidential. It was significant and encouraging, then, that the highest ranking items from staff amounted to a substantial commitment to what is broadly recognised as the core components of 'recovery based practice' including 'being committed to the recovery process for our patients and ourselves'.

Limitations:

There are significant limitations to the conclusions that can be drawn from this evaluation. The DREEM itself has not been fully psychometrically evaluated and so aspects of reliability and validity are unknown, and results must therefore be interpreted with caution. For instance, the impact of daily fluctuations in service user attitudes towards services is unknown as no level of test-retest reliability is given. There were also significant differences in some of the demographic data of the two groups with the staff being a more female dominated, older group. The numbers are not large enough to allow for stratification to occur to attempt to control for these differences and therefore an alternative explanation that some of the differences found between the two groups may be accounted for by demographic differences is possible. This does not reduce the significance of these findings however but simply offers a possible explanation for their source.

Other limitations include the small numbers included in this study. This leads to the increased possibility of type two errors (differences found to be not significant that in fact are significantly different). This issue can only be addressed by a larger scale study. The large amount of data and the subsequent large number of t-tests performed increases the risk of type 1 errors (apparent significance found in non-significant differences). Focusing only on those factors found to be significant to 1% rather than 5 % reduces this.

Furthermore, the tool is not specifically designed to be completed by staff. It required staff to interpret the questions in a more adaptable manner. This may lead to some variations in how they did this leading to variations in their answers. Also both staff and residents reflected that some of the language used in the tool was difficult to understand and some questions appeared ambiguous (see Appendix 2). This may further reduce the validity of the findings. Beyond these limitations the data resulting from this evaluation compares well to that found in other pilot sites (unpublished data). This suggests that there may be a significant level of reliability to the tool to find similar results between similar units. A larger study aimed at assessing this would be required before one could be confident of this finding.

Discussion of the experience of using the DREEM:

In addition to the direct findings from the DREEM the present study also allowed those involved to critique the measure - offering the national development team additional guidance on how DREEM might be modified so as to be easier to use and more acceptable and meaningful to those completing it.

Issues of concern were:

1. Size- we only used 3 of 7 possible elements. DREEM as a whole was felt too large and off-putting. There were additional concerns of how best to analyse the considerable volume of data that so many questions generate.

Suggestion: aim for it to be brief but significant.

2. Focus- the package as a whole contains a variety of measures. DREEM includes components aimed to measure both the environment and the individual's progress in recovery. Furthermore, it can be assumed that as a subjective evaluation, individuals would score the same service differently on different days depending to some degree on their mental state.

Suggestion: it would be valuable to have both individual and environmental measures and then study the relationship between the two BUT there is need for them to be separate and clearly labelled rather than muddled together.

3. Methodology- it seems that how you go about conducting the survey determines what arises from it, although the Devon and SLAM studies have superficial similarities the SLAM survey is on a very small sample of those they contacted due to high levels of non-response.

Suggestion: do recovery-based research in a recovery-based way to optimise not just the result collection but also the impact of the survey experience on the service as a whole. There is a need to be mindful that participation is an intervention too.

4. Language and presuppositions- our service user survey workers found a variety of difficulties for people completing the questionnaires for example, some questions presuppose the respondent already knows what 'recovery' means in the modern sense (see SUG report, Appendix 2).

Suggestion: in developing DREEM it will be particularly important to take care with words and meanings.

5. Application- what to do with what you find? It is not immediately clear how to analyse the results of these questions or what sense to make of the findings. If you have high or low scores – does that mean you are doing well?

Suggestion: a future version would contain guidance on analysis and application of results from a DREEM survey. It may also be possible to consider a range of norms for different sort of services e.g. CMHT, residential rehabilitation, forensic, which could form the basis of some fascinating comparisons between services.

In Summary:

The Russell Clinic DREEM pilot has proven to be an interesting, useful and stimulating experience for staff, residents and the authors of this report. It has provided the framework and opportunity to work collaboratively with our residents and the service user group to address our aim of meaningfully reflecting on our progress in developing a recovery-based service. It has met both the aims of enhancing the development of a service action plan and informing the national DREEM development group.

The Devon pilot identified a number of strengths and weaknesses in DREEM. These are summarised in Table 5. These will be significant in planning any further refinement of the tool. On balance it was felt to be an interesting, stimulating and clinically relevant tool, which, with further refinement, could be a very useful framework for service evaluation in the pursuit of developing recovery-based practice. This further study would lead to the creation of a valid and demonstrably reliable NIMHE (CSIP) sponsored tool for evaluating the recovery orientation of services, and furthermore to go about it in a recovery-based way would ‘facilitate the empowerment of service users’ (Faulkner, 2004).

Table 5: Perceived strengths and weaknesses of DREEM.

Strength	Weakness
Engaging	Too inclusive
Offers a model of recovery	Generated too much data for analysis
Promotes reflection	Interpretation uncertain
Valued by patients and staff	Some elements ambiguous and confusing
Educational	Lacks discrimination – everyone agrees with everything (as important).
Repeatable- auditable	Some findings = questions in need of clarification
Hospitable to co-working	Long and diverse.

Overall, the tool has proved to be an effective and useful device with which to evaluate our service. It provides a focus on which to base the further development of Russell Clinic and in itself it also acts to ensure recovery based practice by its requirement of needing collaborative work with service users to ensure its effective implementation. From our experience with this tool we would recommend it to other services wishing to evaluate their effectiveness in providing recovery based care and we are interested and willing to support NIMHE/ CSIP in their commitment to establishing a larger scale study to assess the psychometric properties of the tool to further enhance the measure itself and provide a clinically useful tool to recovery services.

Postscript:

Following completion of this evaluation the DREEM team became aware of a recently published critical and comparative evaluation of a range of recovery measures which includes DREEM from the HSRI Evaluation Center (2005). This covers 9 individual and 4 service recovery measures and includes copies of each. This includes a summary of evaluations and commentary by the originator of DREEM, Priscilla Ridgeway (pages 75-80). This includes her view that having 166 items is ‘fairly extensive’ and in practice a weakness suggesting a need to evaluate a shortened

version. General comments and concerns about measuring recovery noted in this review are included in the electronic version of this report and there is a strong overlap with the strengths and weaknesses analysis presented here.

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List of Appendices:

Appendix 1:

Components of DREEM Questionnaire used.

Appendix 2:

Service User Group Report on the Experience of Implementing the DREEM on Russell Clinic

Appendix 3:

Qualitative Results of Questionnaire (Residents).

Appendix 4:

Qualitative Results of Questionnaire (Staff)

Appendix 1: Components of DREEM Questionnaire used.

Recovery Enhancing Environment Measure (DREEM) UK Version 1

This questionnaire explores the process of recovery from mental illness, and the services and supports that people who use mental health services say help them achieve recovery. While **recovery is always a personal process based on self-responsibility/self-agency**, there are many things mental health services can do to support your progress or hold you back. This questionnaire looks at your personal experience of recovery, and the services and supports that are available to you.

Your answers to these questions will be confidential. This means your personal answers will stay secret. Your name will never be asked. Please do not write your name in the booklet. This study is completely voluntary. You can skip any questions that you do not wish to answer. Other people who use services have said that the questionnaire is very interesting and they enjoyed completing it. The survey takes about 25 minutes to complete. Be sure to read the guidance below before you begin to answer.

Guidance:

1. This is **not a test**. There are no 'wrong' or 'right' answers in this survey. Answer each question based on your personal opinions and beliefs.
2. All of the questions should be answered by marking one of the answer spaces that best fits your opinion or situation. If you don't find an answer that fits exactly, use one that comes closest. If any question does not apply to you, or you are not sure of what it means, just leave it blank.

For more information contact:

THANK YOU FOR YOUR TIME AND ANSWERS!!!!

A FEW QUESTIONS ABOUT YOU

1. What age group are you in (tick your current age group)?

- ___ 18-25
- ___ 26-35
- ___ 36-45
- ___ 46-55
- ___ 56-65
- ___ 65 and over

2. What is your gender?

- ___ Male
- ___ Female

3. How would you describe your ethnicity?

- White British
- White & Caribbean
- Indian
- Other Asian
- Other black
- Irish
- White & African
- Pakastani
- Caribbean
- Chinese
- Other white
- Other mixed
- Bangladeshi
- African
- Other
- Not stated

4. In total, how long have you received any form of mental health services?

- ___ Less than 1 year
- ___ 1 year or more but less than 5 years
- ___ Between 5 and 10 years
- ___ More than 10 years

ELEMENTS OF RECOVERY AND RECOVERY ENHANCING SERVICES

For each of the following questions you should circle one of the answers:

SA – If you *strongly agree* with the statement

A – If you *agree* with the statement

N – If you are *not sure*, or neither agree or disagree, or you are *neutral*.

D – If you *disagree* with the statement.

SD – If you *strongly disagree* with the statement

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1. Having a positive sense of personal identity beyond my diagnosis/mental illness/distress is important to my recovery	SA	A	N	D	SD
a) Staff view me as more than a “case” or diagnosis; they want to know me as a person	SA	A	N	D	SD
b) The service offers individualized services to meet my unique needs.	SA	A	N	D	SD
c) Staff treat me as a whole person with a body, mind, emotions, important relationships and spirit.	SA	A	N	D	SD
2. Having a sense of meaning in life is important to my recovery.	SA	A	N	D	SD
a) Staff help me make sense out of what is happening in my life.	SA	A	N	D	SD
b) Staff ask me what is meaningful to me.	SA	A	N	D	SD
c) This service encourages me to do things that give my life meaning.	SA	A	N	D	SD
3. Having hope is important to my recovery.	SA	A	N	D	SD
a) Staff believe I have a positive future.	SA	A	N	D	SD
b) Staff encourage me to feel hopeful again when I’m discouraged or have a setback.	SA	A	N	D	SD
c) Staff tell me most people do recover from mental health problems over time	SA	A	N	D	SD
4. Having up-to-date knowledge about mental disorders and the most effective treatments is important to my recovery.	SA	A	N	D	SD
a) Staff teach me about my mental disorder and symptoms.	SA	A	N	D	SD
b) The service provides me with up-to-date information about effective treatments.	SA	A	N	D	SD
c) Staff give me enough information about my treatment options and their risks and benefits, for me to give informed consent for treatment.	SA	A	N	D	SD

5. Being able to self-manage symptoms/distressing experiences and avoid setbacks is important to my recovery.	SA	A	N	D	SD
a) This service helps me to identify and monitor triggers/early warning signs.	SA	A	N	D	SD
b) This service helps me develop personalized coping skills so I can manage stress well.	SA	A	N	D	SD
c) This service teaches me ways to self-monitor and self-control psychiatric symptoms.	SA	A	N	D	SD
6. Improving my general health and wellness is important to my recovery.	SA	A	N	D	SD
a) Staff pay careful attention to my physical health.	SA	A	N	D	SD
b) This service encourages me to achieve higher levels of wellness.	SA	A	N	D	SD
c) This service offers wellness programming such as nutrition, movement and relaxation.	SA	A	N	D	SD
7. Being active in directing my own recovery is important to my recovery.	SA	A	N	D	SD
a) Staff assist me to explore options and set my own personal goals.	SA	A	N	D	SD
b) Staff treat me as a responsible partner in decision making.	SA	A	N	D	SD
c) I direct my own treatments in this service.	SA	A	N	D	SD
8. Having my rights respected and upheld is important to my recovery.	SA	A	N	D	SD
a) Staff inform me of my rights.	SA	A	N	D	SD
b) There is a clear complaints policy and procedure if any of my rights are violated.	SA	A	N	D	SD
c) Staff uphold my rights.	SA	A	N	D	SD
9. Mutual self-help/peer support is important to my recovery.	SA	A	N	D	SD
a) This service encourages users of service to help and support one another.	SA	A	N	D	SD
b) Self-help groups and peer support opportunities are available in this service.	SA	A	N	D	SD
c) This service actively links me to self-help groups and self-help resources in the community.	SA	A	N	D	SD

10. Being involved in personally meaningful activities is important to my recovery.	SA	A	N	D	SD
a) Staff encourage me to get involved in meaningful activities of my choice.	SA	A	N	D	SD
b) Service activities are meaningful to me.	SA	A	N	D	SD
c) The service assists me to become involved in personally meaningful activities (such as working, furthering my education, creativity).	SA	A	N	D	SD
11. Being involved in, and part of, the larger community is important to my recovery.	SA	A	N	D	SD
a) Staff help me find and use community resources.	SA	A	N	D	SD
b) Staff help me gain individualized supports so I can live, learn and work in the community.	SA	A	N	D	SD
c) I don't feel cut-off from the "real world" in this service.	SA	A	N	D	SD
12. Having positive relationships is important to my recovery.	SA	A	N	D	SD
a) Staff assist me in having positive relationships with my peers.	SA	A	N	D	SD
b) Staff support me in building or rebuilding positive relationships with family members and friends of my choice.	SA	A	N	D	SD
c) Staff assist me in forming friendships with people outside the mental health system.	SA	A	N	D	SD
13. Identifying and building on my own personal strengths is important to my recovery.	SA	A	N	D	SD
a) Staff recognize and focus on my positive attributes and talents.	SA	A	N	D	SD
b) Staff help me explore my dreams, values and goals.	SA	A	N	D	SD
c) Staff link me to opportunities and resources that build on and reflect my strengths.	SA	A	N	D	SD
14. Developing new skills is important to my recovery.	SA	A	N	D	SD
a) Staff help me assess how I am functioning and identify skills I need to develop.	SA	A	N	D	SD
b) This service teaches me the skills I want and need.	SA	A	N	D	SD
c) This service connects me to places and people who help me build important skills.	SA	A	N	D	SD

15. Having my basic needs met is important to my recovery.	SA	A	N	D	SD
a) This service assists me to get a basic income and/or benefits.	SA	A	N	D	SD
b) This service helps me get decent, affordable housing of my choosing.	SA	A	N	D	SD
c) This service helps me gain access to the full range of health care supports.	SA	A	N	D	SD
16. Having a sense of control over my life and feeling empowered is important to my recovery.	SA	A	N	D	SD
a) Staff encourage and support my sense of empowerment.	SA	A	N	D	SD
b) Staff assist me to gain or maintain control over important decisions in my life.	SA	A	N	D	SD
c) Staff do not try to maintain power and control over me.	SA	A	N	D	SD
17. Spirituality is important to my recovery.	SA	A	N	D	SD
a) Staff ask me about my spiritual beliefs.	SA	A	N	D	SD
b) Staff help me to connect with spiritual resources and groups, if I so desire.	SA	A	N	D	SD
c) Staff encourage me to explore spiritual practices such as prayer or meditation that can support well-being.	SA	A	N	D	SD
18. Taking on, and succeeding in, ordinary social roles is important to my recovery.	SA	A	N	D	SD
a) Staff offer to help me to get a real job and succeed as an employee.	SA	A	N	D	SD
b) Staff offer to assist me to return to college or University and be a successful student.	SA	A	N	D	SD
c) Staff offer to help me get housing and be a successful tenant or home owner.	SA	A	N	D	SD
19. Challenging stigma and discrimination is important to my recovery.	SA	A	N	D	SD
a) This service helps me overcome internalized stigma (feeling badly about myself because of my label of mental illness/distress).	SA	A	N	D	SD
b) This service raises my awareness of the negative impact of stigma and discrimination.	SA	A	N	D	SD
c) This service teaches me to be an effective self-advocate for my civil, human and personal rights.	SA	A	N	D	SD

20. Taking on new challenges and moving out of my comfort zone is important to my recovery.	SA	A	N	D	SD
a) Staff encourage me to take on new challenges.	SA	A	N	D	SD
b) I feel supported when I try new things that seemed out of my reach before.	SA	A	N	D	SD
c) Staff encourage me to stretch myself and grow.	SA	A	N	D	SD
21. Having positive role models is important to my recovery.	SA	A	N	D	SD
a) This service employs people who are positive role models of recovery.	SA	A	N	D	SD
b) Staff help me learn from others who are successfully in recovery (e.g. recovery narratives from users of service, internet sites, visiting speakers, mentors etc.).	SA	A	N	D	SD
c) I have opportunities to become a staff member or role model in the service, if I choose.	SA	A	N	D	SD
22. Having assistance when I am in crisis is important to my recovery.	SA	A	N	D	SD
a) This service has help available immediately if I am in crisis.	SA	A	N	D	SD
b) Staff stand by me through hard times, they help me see setbacks are a part of recovery.	SA	A	N	D	SD
c) This service has good options if I am in crisis that help me avoid compulsory treatment and hospital admission.	SA	A	N	D	SD
23. Intimacy and sexuality are important to my recovery.	SA	A	N	D	SD
a) This service supports me in forming and succeeding in intimate relationships.	SA	A	N	D	SD
b) This service adequately addresses my sexuality.	SA	A	N	D	SD
c) This service provides me with information on sexuality, such as safe sex, and medication side effects and sexuality.	SA	A	N	D	SD
Having helpers who really care about me and my recovery is important to my recovery.	SA	A	N	D	SD
a) The staff here really listen to me.	SA	A	N	D	SD
b) Staff here spend enough quality time with me on activities that promote my recovery.	SA	A	N	D	SD
c) Staff encourage, motivate and support me to move toward recovery.	SA	A	N	D	SD

FINAL QUESTIONS

1. What are one or two of the most important things a mental health service and its staff can do to support people with mental health problems in their mental health recovery?

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2. What are one or two of the most important things you have learned so far on your journey of recovery?

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3. What are one or two things you would want to say to a person who is just beginning his or her journey of recovery from mental health problems?

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4. Are there any other comments or ideas that could improve the service that you want to include in the survey?

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THANK YOU!

Appendix 2: Service User Group Report on the Experience of Implementing DREEM on Russell Clinic.

INTERVIEWERS' EXPERIENCE AND OBSERVATIONS OF USING DREEM

Two interviewers assisted Russell Clinic residents in completion of DREEM questionnaires, one a service user and the other a fieldworker from the local service user project.

The roles of the two interviewers within the local service user project brought two particular benefits to the DREEM survey:

1. Good practice guidance in involving service users.
2. Familiarity with Russell Clinic and its residents. Over many years of regular visits to gather views the service user project has established a respected and trusted working relationship with both residents and staff.

As promoters of service user involvement it was important for both interviewers that DREEM remained service user centred. As a result the following agreements and changes were made:

- The original DREEM survey would be shortened.
- The use of the DREEM survey would need to have the agreement of the residents.
- Residents could choose to participate in the survey.
- Their participation would remain anonymous.
- The acronym DREEM would not be used.
- Members of the steering group would try out the survey before involving residents (see below).
- Residents could have an active role in developing the survey and its findings via membership of an advisory group.
- Residents' time would be valued by the offer of payment, both for completion of the questionnaire and involvement in the advisory group meetings.
- An action plan was required to demonstrate that the residents' views were being used to make a positive difference to the service they used.

PLANNING HOW TO DO IT

Trying out the questionnaire on each other proved invaluable in helping the interviewers to plan how to offer the survey to the residents. In particular it highlighted:

- In 'laboratory' conditions the edited survey took a minimum of 25 mins. Therefore with distractions, varying abilities and levels of mental illness the survey could take much longer.
- A lack of clarity and difficult language in several of the questions.
- The questions were really statements.
- Residents should have the following choices for completion of the questionnaire:
 - By themselves, independently with freepost envelope provided.
 - By themselves with interviewer assistance.
 - By interviewer with resident direction.
- An awareness that residents might be distressed by the survey, ie they may find that some of the topics evoke distressing memories or are just too personal.
- The need to have 'debriefing' available for residents after completing the survey.

A heavy investment of time was needed by the interviewers to proactively encourage and support residents' involvement in the process. The interviewers worked one to one with them and this necessitated several return visits at times convenient for the residents.

RESIDENTS COMPLETION OF THE QUESTIONNAIRE: OBSERVATIONS

TIME

Questionnaires took between 20 and 50 mins. to complete.

One resident self-completed the first part of the questionnaire at a slower rate than the above, but asked the interviewer to complete the remainder of the form with them and this increased the speed with which the process was completed.

All other residents asked the interviewer to complete the questionnaire with them, by asking the questions verbally and writing down answers given by residents.

Many residents felt the questionnaire took too long. Some residents struggled to concentrate, although only one chose to take a break.

One resident was happy to complete the questionnaire as a 'one off', but stated that they would not wish to commit to undertaking it again at a future time as they felt it was quite a long task.

VALUING RESIDENTS' INPUT

£5 was offered to residents who undertook to complete all or part of the questionnaire. In fact all those who took part completed the whole questionnaire.

Male residents stated clearly that the money was the incentive for their completion of the questionnaire. Female residents stated that the money played no part in their decision and in fact 3 out of 4 females declined to undertake the questionnaire.

Residents who completed the questionnaire were very pleased to receive the cash from the interviewer immediately after completion.

The interviewers strongly felt that had remuneration not been offered the participation rate (10 out of 14 residents) would have been much lower. The financial incentive to complete the questionnaire is also understandable in the light of the extremely minimal incomes (approx. £16 per week) some of the residents receive.

FORMAT OF QUESTIONNAIRE

There were many comments from residents of there being too many questions on the form.

The number of multiple-choice questions was especially tedious for some residents, who preferred the free text Final Questions.

One resident found the free text Final Questions the most difficult to answer and did not feel it was their place to offer advice to other residents, they saw this as a staff role. Interestingly, this resident found the multiple-choice format easy and completed the survey in the fastest time (20 mins). (The interviewer conjectured that this resident preferred choosing from a list of other people's opinions, rather than originating them, or even feeling that they were entitled to an opinion.) The interviewers concluded that it was important to have a variety of approaches within the same survey.

One resident felt some questions were repetitive. They stated that they chose community activities they wished to undertake as part of their recovery programme and felt supported by staff in this. Therefore questions 10 – 14 were experienced by them as repetitive.

The need for a 'not applicable' option was raised by 4 residents.

One resident would have liked the option to give separate answers for nursing and medical staff.

CONTENT OF QUESTIONS

Residents found a number of questions ambiguous and therefore difficult to answer. This led to some questions being interpreted differently by individuals and therefore they were effectively answering different questions, eg Question 17 (see below).

There was also confusion that although referred to as questions the multiple-choice section was really a series of statements.

The interviewers rephrased some questions to assist with understanding and explained the definition of some words used in the questionnaire. However, the interviewers declined to interpret questions from their own personal perspective and the interpretation was decided purely by the resident themselves.

Problem questions were identified by the residents and interviewers as listed below:

Not understanding terminology

5c the term psychiatric was unfamiliar to one resident, who had only heard the term 'mental health' used before in relation to their care.

6c the term 'wellness programming' was meaningless to people.

9 One resident was unfamiliar with the term 'peers'.

15 the term 'basic needs' was not meaningful to one resident.

16 two residents did not understand the term 'empowerment'.

19 some residents struggled to understand what was meant by the term 'stigma'. When explained, some residents stated they did not experience stigma on Russell Clinic.

19 The term 'self advocate' was not understood by some residents and they also questioned what was covered by the reference to 'civil, human and personal rights'?

20 one resident did not understand the term 'comfort zone'.

21 some residents were not clear what was meant by the term 'role model'.

21b some residents did not understand the terms 'recovery narratives' or 'mentors'.

Imprecise wording, leading to different interpretations

2b resident asked 'meaningful in what context?'

5c one resident felt the question suggested mental illness should be controlled by people themselves without using medication and they disagreed with that in their personal case.

6b residents interpreted 'wellness' differently, some seeing it as purely mental health, others as covering both physical and mental health.

7a one resident was unclear what was meant by 'options' since they had not chosen to be detained under the Mental Health Act.

7c one resident wasn't sure what 'direct my own treatments' referred to, since 'only doctors can prescribe'.

9 the term 'peers' was interpreted differently by individuals. Some thought it referred to any people of the same age and sex, some that it meant only people who had mental health problems or the same diagnosis, yet others thought it related only to other residents on Russell Clinic.

9 One resident asked if self help or peer support included OT led groups.

17 the term 'spirituality' caused much confusion. Some residents felt it referred exclusively to religion, others referred to ghosts and one resident interpreted it as meaning being very happy and in high spirits.

23 some residents felt it was unclear what was meant by the term 'sexuality'.

23a one resident questioned whether this included support for mixed sex relationships on the ward between residents, as they felt this was not acceptable to staff.

Inadequate questions

13 one resident felt they had no 'dreams, values and goals' to explore. This resident questioned the existence of the recovery concept.

17c two residents felt strongly that staff should not be encouraging religious practices such as prayer on the ward, as people are vulnerable to persuasion when mentally ill and could be drawn in unwittingly.

19 One resident saw no reason why they should feel internal stigma just because they had a mental health problem?

23b one resident questioned if the service should address 'sexuality' as that was 'something private'?

Insufficient knowledge to respond to question in an informed way

8 some residents were unclear what 'rights' this question referred to. Some restricted themselves to answers relating only to the Mental Health Act, others thought it may refer to Human Rights law.

21a residents felt they could not answer this question properly as they had no way of knowing if staff had experienced mental health problems.

21c residents did not know if they could become a staff member, although some assumed this was not allowed.

Inappropriate point on 'recovery journey' to ask this question

22c one resident commented that they were not in a position to answer this question since they had been hospitalised in another area and had been moved on to Russell Clinic.

REACTION TO QUESTIONNAIRE

One resident struggled to concentrate and appeared quite anxious to 'get it right'. It was important for the interviewers to bear in mind, and alleviate where possible, the pressure some residents felt under to complete the survey.

Some residents cited examples from their personal care to illustrate their answers to questions. However, this could lead to prolonged discussion if not re-focussed by the interviewer. Some residents struggled to focus on the questionnaire and wished to discuss other issues.

One resident wished to know how the information was going to be used and what difference it was going to make.

REASONS FOR DECLINING TO UNDERTAKE THE QUESTIONNAIRE

4 residents declined – one male and 3 female.

Reasons given included:
'Boring'

It will bring back memories (this from a former resident who had recently moved on). In this case their carer had strongly felt the carer view should be heard too and wanted to fill in their relative's questionnaire. They thought that they could give clearer and more accurate views than their "unwell" relative. Although it was inappropriate for the carer to complete the questionnaire this led the interviewers to wonder where the carer fits in to the recovery survey and pathway?

One resident did not consider themselves as a resident, patient or service user of Russell Clinic or any other mental health service. They felt that by completing the questionnaire it implied that they agreed they have mental health problems, which they feel they do not (this person is residing on Russell Clinic).

One resident gave no specific reason for declining, but had discussed the issue with another resident and had considered carefully before making their decision.

CONCLUSIONS

The experience of using the questionnaire threw up several points to consider further:

- The structured interview approach to the questionnaire enabled the interviewers to observe the process, thereby gathering useful information on the residents' experiences of completing the questionnaire and their differing interpretations of the questions. These observations would not have been picked up if residents had chosen to independently complete the questionnaires.
- The process required a heavy investment of time to support resident involvement in both the questionnaire and the advisory group as well as the analysis of information.
- It also required financial investment in recognising the value of the residents' contributions.
- The concept of recovery and the recovery journey should not be assumed as 'givens'; two residents did not accept that recovery was currently a reality for them and one resident, who declined to complete the questionnaire, was clear they had nothing to "recover" from.
- Where do carers fit into DREEM?

Appendix 3: Qualitative Results of Questionnaire (Residents).

RECOVERY SURVEY: FOUR FINAL QUESTIONS

RESIDENT RESPONSES, THEMES AND COMMENTARY

Jenny and Charlotte worked with a Russell Clinic resident to examine the responses to the Final Questions section of the survey. The responses are from all ten of the residents who completed the questionnaire.

Although there is added impact in a collective response, it must be remembered that the ten residents who gave their responses gave them as individuals and from very differing experiences, backgrounds, age groups and lengths of time of using mental health services.

The method used to do this was literally 'cut and paste':

1. Residents' responses to each question were typed up.
2. The responses were then cut out and placed on 4 larger sheets of paper (one for each question).
3. Where possible, the responses were then grouped into themes.

This process, although crude and extremely 'low tech' was immediately involving, accessible, visible and meaningful to all those that took part.

Below is the result of this work, showing the responses to each question grouped into themes with accompanying commentary by those that looked at the responses.

QUESTION 1

What are one or two of the most important things a mental health service and its staff can do to support people with mental health problems in their mental health recovery?

PRACTICAL

Giving me leave.

Get me up in the morning.

Help with day to day continue.

Commentary – three responses highlighted very basic practical help can be important to recovery

PHYSICAL HEALTH

Feeling good about yourself physically.

Make sure they keep physically fit and eat the right things.

Commentary – two responses highlighted the importance of maintaining physical health, not just mental health.

RELATIONSHIPS

Really listen to them and act accordingly.

More one to one with patients. it's a caring profession and if they don't care they shouldn't be in the profession.

General conversations, ward rounds, one to ones.
Staff to get along with people and be caring and explain things.

Look after and protect you.

Take into account their personality – don't treat them as a label.

Commentary – five responses identified the value of building relationships between staff and residents. Being known as an individual was seen as important, ie recognising the person reduces the negative effect of labelling. Relationship building was seen as a skill requiring the ability to flexibly engage with a person in various ways, ie general conversations to one-to-one time; listening and, key to all of this, caring.

QUESTION2

What are one or two of the most important things you have learned so far on your journey of recovery?

TAKING CONTROL/SELF HELP

Try not to get ill.

Never give in, you can turn things around.

Be kind to yourself.

My health and meaning to life on inside and outside, ie hospital and community.

Keeping active and positive during the day.

Getting out, body work and doing different tasks.

Medication works.

Commentary – seven responses referred to the importance of making use of their own resources and taking control of their lives; practical examples of how to do this were also given, eg “Keeping active and positive during the day”.

INVOLVING OTHER PEOPLE, RELATIONSHIPS

Stay close to your family and friends.

To listen to advice

Listen to staff and have a close rapport with them.

Commentary – three responses highlighted the benefits of relationships with other people in supporting their recovery.

PERCEPTION OF NO CHANGE

Don't feel any different from when I arrived in Russell.

Commentary – one resident had not experienced their time on Russell as a journey, ie they didn't feel they had changed whilst on Russell Clinic.

OTHER RESPONSES

One resident declined to comment.

QUESTION 3

What are one or two things you would want to say to a person who is just beginning his or her journey of recovery from mental health problems?

PRACTICAL TIPS

Would offer help and chat about experience of being on medication.

Take medication.

Don't take street drugs.

Don't leave yourself out.

Be kind to yourself, love yourself.

Don't lose self-esteem.

Commentary – six responses offered practical suggestions: the first three focus on the benefits of prescribed medication and the negative effects of illicit drugs; the second three responses focus more on the importance of self-worth and valuing yourself.

HOPE

Keep up hope.

Don't give up hope.

Never give in, there is no reason why you can't turn things around.

Try and understand the meaning of recovery.

Commentary – four responses demonstrate that central to recovery is the importance of maintaining hope.

SEEK OUT EXPERTISE

Listen to staff.

Better to ask staff. Patients shouldn't give advice.

If you have any problems speak to Dr. X, don't suffer in silence, speak up.

Take all the help that's on offer.

Get information from staff and from relationships with them.

Commentary – five responses valued the expertise of staff and services and felt that residents could directly benefit from proactively seeking advice, information, support and problem-solving from them. Four of the responses expressed confidence in offering advice to others, however, one resident strongly felt it was not a patient’s place to do this.

UNTHEMED RESPONSES

Just let people be.

Commentary – one response highlighted the need to not intervene.

QUESTION4

Are there any other comments or ideas that could improve the service that you want to include in the survey?

MORE ONE TO ONE TIME WITH STAFF

Staff to give time for listening to patients’ views and needs.

Nurses should be trained to ask patients individually about how they are progressing.

Commentary – the need for staff to spend one to one time with people as individuals is a theme that runs throughout this Final Questions section.

ENVIRONMENT

Spend more on décor and comfy furniture. Should be homely, not so run down. Can’t pay to use cheap stuff all the time.

Commentary – one response highlights the importance of physical environment and it’s impact on recovery.

CHOICES

Food could be better.

Massages (aromatherapy etc.) should be made available for everyone at least once a week.

Better washing regime, more flexible.

Commentary – three responses focus on the need for more choice and make suggestions for improvements in areas where they feel they currently have no choice or control. The resident talking about a “better washing regime” is referring to the plan around their personal hygiene.

SATISFACTION

Happy as it is.

Very good service.

Everything ok.

It’s fine.

Commentary – four responses expressed overall satisfaction with the current service.

OTHER RESPONSES

One person had no comments to make.

SUMMARY

We have grouped the residents’ responses to highlight important themes and show where there is a collective voice on certain issues. The overriding themes appear to be:

- **One to one time with staff**
- **Relationships**
- **Valuing oneself and valuing the individual**
- **Practical tips**

The importance of the most basic of interventions, such as helping residents get up in the morning, should not be undervalued. Also, whilst such practicalities as meaningful activities and medication were mentioned by residents as being helpful, the importance of good quality one to one relationships with staff, where the resident felt valued as an individual, was a theme which ran throughout the responses to their final questions.

Appendix 4: Qualitative Results of Questionnaire (Staff).

Russell Clinic Survey Qualitative responses

RECOVERY SURVEY: FOUR FINAL QUESTIONS

STAFF RESPONSES, THEMES AND COMMENTARY

Completion of DREEM by staff was conducted as part of two consecutive staff and service development days each with half the staff group. This included ‘a few final questions’ which invited them to make suggestions and comments in their own words.

Method

Staff were asked to respond to the questions individually.

Responses were gathered in and typed up.

Later the same day the staff group were given a list of their collected responses and asked to mark these sheets with 2 ‘votes’ in each of the 4 sections – indicating which items they thought were the most significant.

Only after this was completed individually was it discussed as a group

Staff on day two also separately voted on Day one’s suggestions, Day one staff also voted on day two’s suggestions

The summary findings are therefore an aggregate of the responses of the whole staff group from days one and two and their votes on both.

Twenty two staff participated in the two development days, which would generate a maximum of 44 suggestions and 88 votes.

Many staff responses used exactly the same or very similar wording – where this is the case the votes for these items have been added together.

What follows is a summary of staff responses to the 4 questions, identifying which items they felt were most important through the above voting system.

Items suggested by staff but which did not subsequently attract votes cannot be taken to be of little importance but indicate that given 2 votes to cast staff regarded the wording of other items as more closely carrying a sense of what they regarded as most important.

The overall pattern of responses and in particular those suggestions or statements staff have identified as the most important could be taken as a fair indication of the attitudes and values of this staff group with respect to developing themselves as a recovery based service.

QUESTION 1.

What are one or two of the most important things a mental health service and its staff can do to support people with mental health problems in their recovery?

Summary: 22 staff offered 43 suggestions and cast 76 votes

Four suggestions stood out

1. Listening, empathy and involving service users in the planning of their own care (21)
2. Believe in and hold hope of recovery for someone(15)
3. To be valued and understood as an individual (13)
4. Provide a non-threatening good therapeutic environment (8)

Other scoring items

5. Be flexible and individualistic in their approach to treatment and recovery (3)
6. Be supportive and give encouragement(3)
7. Kindness (2)
8. Allow for failure –learning (2)
9. Genuineness realness connectivity (2)
10. Be compassionate (2)
11. Offer safety (1)
12. Give time(1)
13. To engage with them(1)

Non Scoring suggestions

14. More service user orientated resources
15. Regular training of staff to refresh the ideas about recovery
16. Give information and explain treatment and options
17. Quality time with patients
18. Chance to take in what patient is saying/experiencing/exhibiting
19. Help them to identify their own pitfalls and limitations
20. Make them central to planning their own long-term safeguards
21. Offer real choice
22. Staffing and the people that work here
23. Treat me as a friend
24. Aid

QUESTION 2.

What are one or two of the important things you have learned so far on your journey of recovery/helping people in their journeys of recovery?

Summary: 22 staff offered 41 suggestions and cast 75 votes

There was a wide spread of items that attracted votes

Two items stood out

1. All people are individuals and need to be treated as such (15)
2. To learn from the client about the client in order to support the client – ie work in partnership (13)

Other scoring items

3. Be prepared for disappointments and set backs but remain positive (6)
4. It takes time and understanding (4)
5. Be willing to negotiate – take risks (3)
6. To be proactive and involved in your own care/recovery (3)
7. There is more to mental health services than providing medication (3)
8. To remain positive about the persons future outcomes (4)
9. Open and honest communication (3)
10. You can't force people to change (3)
11. Not all journeys to recovery are the same as different people value different aspects of their recovery differently(2)
12. To look at improving a persons quality of life Things take time (2)
13. To set small manageable goals (2)
14. There is support and you can recover (2)
15. Be non-judgemental (2)
16. Tolerance – patience (2)
17. The need to be listened to and be values as a person(1)
18. Patience and being non-judgemental (1)
19. It is possible (1)
20. To look at improving a person's quality of life (1)
21. To 'fail' in order to learn(1)
22. There is no magic pill or cure (1)

Non-scoring items

23. There is a need to look at social and psychological needs and address these adequately
24. There are lots of pitfalls in recovery
25. Take time to really listen
26. We are all individuals
27. Supervision
28. Staff support
29. Involvement of family/friends/partners or carers
30. Requires a lot of work
31. Patience
32. Flexibility
33. Be able to listen
34. Information
35. Medication

- 36. To be more confident and liable as a person
- 37. Respect others
- 38. Over time our clients can have hope and recovery with the right support

QUESTION 3

What are one or two things you would want to say to a person who is just beginning his or her journey of recovery from mental health problems?

Summary: 22 staff offered 33 suggestions and cast 80 votes

Responses clustered closely around a set of ideas around conveying that there is hope for people that the recovery path is difficult and best taken slowly, but positively with an appreciation for small changes and an acceptance that there will be backwards steps – but that these can be learned from, and that the future can be different.

Four items stood out

- 1. There is hope – your life can improve – recovery can happen (16)
- 2. There is light at the end of the tunnel – remain positive and hopeful (12)
- 3. Take one step at a time – each step is an achievement (10)
- 4. Whatever the past was like the future can be different (10)

Other scoring items

- 5. Point out that similar patients have made excellent progress (6)
- 6. Be prepared for a long process with hope and occasional set backs (6)
- 7. You can(choices/chances) (5)
- 8. Never lose hope (4)
- 9. Be vocal about what support you feel you need (3)
- 10. Focus on what is important to you not what the service feels is important (2)
- 11. Keep a sense of your ‘self’ and your personality(1)
- 12. Be aware of changes in behaviour – find ways of checking yourself(1)
- 13. Things take time don’t be put off by set backs – to carry on the journey(1)
- 14. There’s real time and there’s NHS time (1)
- 15. Do not take other people’s problems to heart (1)
- 16. There’s a light at the end of the tunnel (1)

Non-scoring items

- 17. Don’t stop, keep up with meds – support each other after hospital
- 18. There is a future
- 19. To be patient
- 20. Talk
- 21. Life’s shit but not all of the time
- 22. Failing doesn’t mean you can’t achieve goals
- 23. They’re a nice lot
- 24. You can always start again
- 25. It’s if it is a long process
- 26. Trust the workers
- 27. It is possible
- 28. It might take longer than you think!
- 29. To have hope, take medication and work with the team

QUESTION 4

Are there any other comments or ideas that could improve the service you want to include in the survey

Summary: 22 staff offered 18 suggestions and cast 75 votes

One item clearly stood out from all the others

1. Being committed to the recovery process for our patients and ourselves (18)

Other scoring items:

2. More money for people on little benefits to be able to achieve 'normal' activities and options within the community – to enable more self-esteem with clothing and housing and moving on (9)
3. Us getting a secure understanding of what is involved in developing a recovery based service (8)
4. Encourage staff to remain positive in their outlook towards a patients recovery (7)
5. Give patients a sense of achievement (6)
6. More staff on duty per shift to be able to complete more individual work with people (5)
7. More homely environment – less clinical more individual therapy. (5)
8. Vocational, occupational, love and a home (4)
9. Peer discussions and meetings to help in identification and realise we are not alone. (3)
10. Would be nice to be able to spend more time with patients (3)
11. Patient wanting/owning their own notes and therefore their own story (2)
12. To eradicate cynicism and negativity towards patients within the service from staff members (2)
13. Move out of hospital (2)
14. Ring fenced staff away from rest of site(1)

Non-scoring items

15. R&R needs to move lock stock 'n' barrel
16. Seems to be a bit thin on the ground lately (more leave, more training, more sickness)
17. More money, staff – not just nurses
18. In would like to have more knowledge of drug awareness