

OP78



# Outcome measures recommended for use in adult psychiatry

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Royal College of Psychiatrists  
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# Executive summary

The Royal College of Psychiatrists recommends the use of the following outcome measures in adult psychiatry.

- Clinical effectiveness:
  - patient-identified goals
  - Health of the Nation Outcome Scales (HoNOS)
  - physical health measures (e.g. blood pressure, body mass index)
  - social outcomes (e.g. employment, accommodation, community engagement)
  - choice of symptom-specific scales.
- Patient safety:
  - benchmarking incident reporting
  - suicide and self-harm rates
  - harm caused to others
  - in-patient safety measures.
- Patient and carer experience:
  - validated measures drawn up using patient and carer expertise.

The College also recommends the use of accreditation programmes where available and benchmarked audits – recognising that these measures focus on process rather than outcomes.

# Introduction

The White Paper *Equity and Excellence: Liberating the NHS* set out the government's strategy for the National Health Service (NHS) in England.<sup>1</sup> Its intention is to create an NHS which is more responsive to patients and achieves better outcomes, with increased autonomy and clear accountability at every level. The government has made clear the importance of measuring quality of healthcare. There is an expectation that detailed information on healthcare providers will be available online enabling patients to choose more effectively.

The Department of Health document published in December 2010, *The NHS Outcomes Framework 2011/12*,<sup>2</sup> proposes an NHS outcome framework with five domains: preventing people from dying prematurely; enhancing quality of life for people with long-term conditions; helping people recover from episodes of ill health or following injury; ensuring people have a positive experience of care; and treating and caring for people in a safe environment and protecting them from avoidable harm. The *Framework* notes that the accountability should relate to patient outcomes and not the process by which this is achieved.

The measurement of quality is clearly expected to move beyond ensuring that structures and processes are in place, to measure the outcomes of care in a way that is of value to both clinicians and patients.

Although the White Paper is published by the Department of Health in England, all of the devolved administrations place quality at the heart of healthcare delivery. All want to achieve good outcomes for patients and all have to achieve this in the context of significant financial pressures.

The Royal College of Psychiatrists is well placed to provide guidance on the use of outcome measures in mental health based on what is of clinical value to patients and clinicians and what is feasible in practice. The College strongly supports the implementation of patient-reported outcome measures in mental health as a way of improving the quality of care provided.

# Quality and outcomes overview

In *High Quality Care for All: NHS Next Stage Review*,<sup>3</sup> quality was defined as incorporating three elements:

- 1 effectiveness of the treatment and care provided to patients
- 2 safety of the treatment and care provided to patients
- 3 the broader experience patients and their carers have of the treatment and care they receive.

In terms of measuring quality in these three areas, it is helpful to consider the following domains.

- The structure of care – based on robust evidence, how should treatment be structured to maximise the chance of a good outcome for the patient?
- The process of care – based on robust evidence, what are the things that should be done to maximise the chance of a good outcome for the patient?
- The outcome of care – what actually happens to the health of the patient, the outcome, as a result of the treatment and care they receive? The outcome needs to relate to the three areas of quality: effectiveness, patient safety and patient experience.

Considerable data are already collected by a range of organisations, including the Care Quality Commission (CQC), Monitor, the NHS Information Centre, the National Patient Safety Agency (NPSA), the NHS Litigation Authority (NHSLA), the Royal College of Psychiatrists' Centre for Quality Improvement (CCQI), health boards and trusts. The CQC is to be commended for bringing together evidence from multiple sources to compile the Quality and Risk Profile<sup>a</sup> of an organisation.

The *Next Stage Review*<sup>3</sup> describes an ambitious vision of teams being involved in developing and utilising quality indicators to monitor the quality of care they deliver. This includes outcome measures and patient-reported outcome measures, which capture the patient view of the success of their treatment and the quality of their experience. The *Next Stage Review* stated that:

'Within organisations, we know that a defining characteristic of high performing teams is their willingness to measure their performance and use the information to make continuous improvements. We want all clinical teams to follow this best practice and so we will support them by

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a. A tool for monitoring compliance with standards of quality and safety.

working in partnership with the professional bodies, specialist societies and universities to develop a wider range of useful local metrics than the national framework. We will also develop "Clinical Dashboards" which will present selected national and locally developed measures in a simple graphical format as a tool to inform the daily decisions that drive quality improvement.' (p. 50)<sup>3</sup>

The Commissioning for Quality and Innovation (CQUIN) scheme in England provides a financial incentive to improve outcomes against agreed objectives. Clearly some of these may be demonstrations of local improvement but others will permit benchmarking across organisations. It is likely that some of the data in the annual quality accounts which trusts in England will produce will offer such comparative information. This will include evidence of access to effective treatments as determined by National Institute for Health and Clinical Excellence (NICE) guidance, participation in national audits such as the Prescribing Observatory for Mental Health (POMH-UK), and accreditation schemes such as those run by the CCQI.

Revalidation and strengthened appraisal systems depend on good measures of quality and outcome. Given the importance of reliable data, it is essential that clinicians should be involved in data analysis.

Outcomes cannot be completely separated from standards for the process of care. For some services and disorders, standards of service provision and treatment have already been identified (e.g. NICE, accreditation schemes, quality networks). They have associated audit tools to demonstrate compliance with recommended treatment and service guidelines. Many of these measures of the process of care are well established and will need to be maintained until robust and reliable outcome measures are evaluated and bedded into the system.

Quality and outcomes cannot be divorced from productivity. Not only does it take time to collect and record information, but also the total cost of a service needs to be taken into account. To obtain a full picture of any service, data need to be viewed in the round, looking at staffing, interventions and outcomes from a range of perspectives. A service may be cost-effective but before recommending that model one would also want to know the quality of care and outcomes achieved. Appendix 1 gives a range of possible capacity and productivity measures.

# Principles underpinning the use of outcome measures

The Royal College of Psychiatrists has set the following principles as a useful guide to inform the development of outcome measures.

- Focus should be on what is important to patients and carers
- Measures should be relevant to patients and clinicians
- Measures should be simple and easy to use
- Measures should be clear and unambiguous
- Measures should allow comparisons between teams and services
- Measures should be validated for the purpose for which they are used
- IT support should simplify the data collection and analysis, and ensure maximum use of data already collected
- Data should be checked for reliability
- Data should be used at the clinical, team and organisational level
- Ideally, there should be immediate feedback of the data to patients, carers and clinicians so that outcomes can influence the treatment process

# Outcomes in mental health

Outcomes can be considered from a range of perspectives, for example that of the patient, carer, clinician, organisation and society as a whole. Outcomes in mental health, as with other chronic conditions, must reflect the quality of treatment provided and care received and not only the measurement of symptoms (which may be resistant to change). For example, there may be little change in reported symptoms and function but – in line with the recovery model – services may help the individual patient achieve their personal goals and aspirations.

To gain a comprehensive picture of the quality and effectiveness of care requires information across the three domains set out in the *Next Stage Review*.<sup>3</sup>

- 1 Effectiveness of treatment – in terms of:
  - achievement of patient-identified goals (in keeping with the recovery model)
  - reduction of symptoms of mental illness
  - achievement of desired social outcomes
  - quality of life.
- 2 Patient safety – the aim should be to ensure that fewer people will suffer avoidable harm, through being treated and cared for in a safe environment and protected from avoidable harm (e.g. suicide).
- 3 Patient and carer experience of care provided – the aim should be that more people will have a positive experience of care, through better processes for delivering personalised care.

## EFFECTIVENESS OUTCOMES

There are a range of outcomes that can be considered within the effectiveness domain. The Department of Health's *Outcomes Compendium*<sup>4</sup> is a valuable resource which offers a range of potential clinical outcome measures.

### *PATIENT-IDENTIFIED GOALS*

Work has been undertaken in the UK, the USA and Australia using numerical ratings to monitor individual patient goals. The use of such goals can provide both a focus for treatment and a measurement of outcome as to whether the identified goals have been achieved. The advantage of such a measure is that it allows a clear treatment focus on what the patient identifies as a

priority (the recovery model) and allows, on a numerical rating, progress to be evaluated over time. Patient-related problems can be analysed in groups, for example symptom-related, relationship-related, employment-related, to see how effective services are in helping patients achieve goals in different domains.

## *HEALTH OF THE NATION OUTCOME SCALES (HoNOS)*

The HoNOS and HoNOS for older adults (HoNOS 65+) are clinician-rated scales which measure outcome in 12 domains on a 5-point scale (0–4).

- 1 Overactive, aggressive, disruptive or agitated behaviour
- 2 Non-accidental self-injury
- 3 Problem-drinking or drug-taking
- 4 Cognitive problems
- 5 Physical illness or disability problems
- 6 Problems with hallucinations and delusions
- 7 Problems with depressed mood
- 8 Other mental and behavioural problems
- 9 Problems with relationships
- 10 Problems with activities of daily living
- 11 Problems with living conditions
- 12 Problems with occupation and activities

The domains cover both symptoms and social functioning. The scale can be reported as a total (although this combines several disparate factors) or by individual area, looking at the outcomes in each of the 12 domains.

The HoNOS has several advantages:

- it is already part of the minimum mental health data-set and is therefore collected throughout the NHS
- it is simple to use and most NHS staff have been trained in its use
- it covers both clinical and social outcomes.

In England the scale is being extended and proposed as a mechanism for allocating patients into payment by results clusters. This will enable case-mix comparisons to be made between teams and services.

The HoNOS is intended as an outcome indicator for individuals with severe mental illness and performs less well in those with mild to moderate disorders.

## *CONDITION-SPECIFIC SCALES*

There are many condition-specific symptom scales relating to specific areas of practice. These have the advantage of being well validated and many have been used in a large number of settings. The problem, however, is that they are not good at dealing with comorbidity which is often excluded from clinical trials in which the measures were validated. Condition-specific scales also do not necessarily focus on the areas of particular concern to patients.

Appendix 2 lists some suggested measures which clinicians and patients may choose to use.

## QUALITY-OF-LIFE MEASURES

Two simple quality-of-life measures are the 12-item Short Form Health Survey (SF-12)<sup>5,b</sup> and the EQ-5D.<sup>6,c</sup> The advantages of quality-of-life measures are that they are patient-reported and allow direct comparison between mental health outcomes and physical health outcomes. These two measures are currently routinely collected in the NHS in England for four physical health conditions: hip replacements, knee replacements, hernia and varicose veins.

## SOCIAL OUTCOMES

Social outcomes include:

- access to employment
- engagement in community activities, including volunteering
- reduction in personal debt
- satisfactory housing.

Public Service Agreement 16 related to adults aged 18 and over in contact with secondary mental health services and who are on the care programme approach. Data were collected on settled accommodation (defined as 'accommodation in which people have medium to long-term security of tenure or residence')<sup>7</sup> and employment which includes working full-time, part-time or casually as an employee or in self-employment. The College recommends that in future – when, for example, government objectives that replace Public Service Agreement targets come into force in 2011 – data be collected which include categories of supported accommodation (to be able to show move-on for those with longer-term conditions as a sign of recovery) and participation in training, further education and volunteering.

The Recovery Star approach has been developed in the third sector as a way to engage patients and professionals in identifying goals across a range of social areas. It has not yet been validated as an outcome tool and at this stage cannot therefore be recommended for this purpose. Given its current popularity it is described in Appendix 3.

## PHYSICAL HEALTH MEASURES

Given the impact of physical morbidity and mortality among those with mental illness, and the lack of engagement of some individuals with severe

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b. A multipurpose short-form survey with 12 questions, all selected from the SF-36 Health Survey. It is a generic measure which has been developed to provide a shorter, yet valid alternative to the SF-36, which can provide easily interpretable scales for physical and mental health.

c. A standardised patient-completed instrument for measuring health outcomes. It is ideally suited for use in postal surveys, in clinics and face-to-face interviews.

mental illness with primary care services, physical health indices should be included in outcome measures for mental health services. Measures could include:

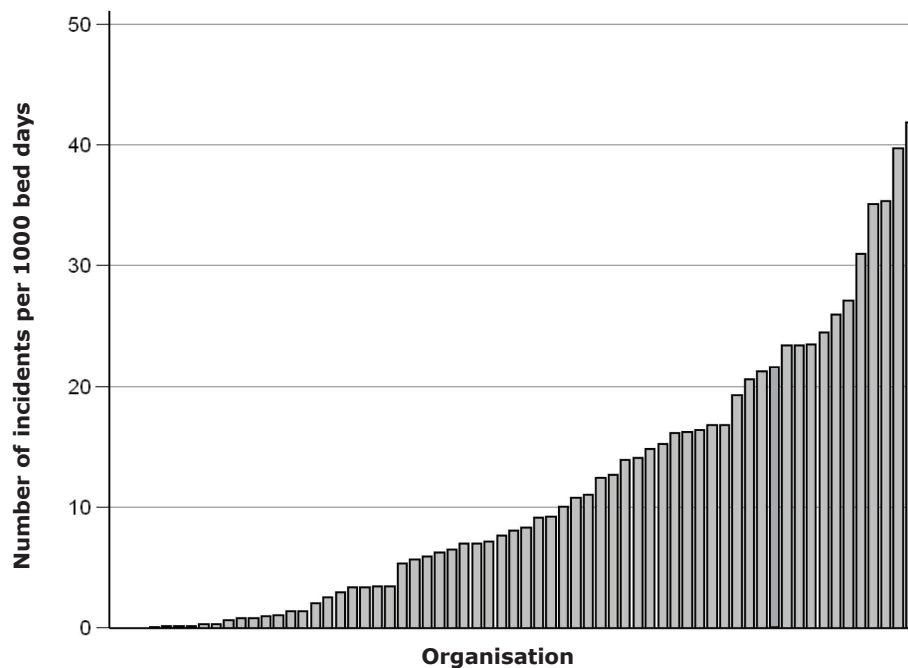
- number of cigarettes smoked, smoking cessation support offered
- blood pressure
- body mass index
- blood tests to measure lipids and glycated haemoglobin (HbA1c).

Standardised mortality rates of those on general practitioner severe mental illness registers may give a useful measure of the effectiveness of these interventions at a primary care trust or general practice consortia level.

## PATIENT SAFETY OUTCOMES

All provider services collect data on adverse incidents and, in England, these are collated and reported by the NPSA. It is important to recognise that high reporting of incidents is a mark of an open learning culture. The expectation of quality is that over time staff will report an increasing number of low-impact incidents or near misses but that there will be fewer events that cause significant potential harm.

One measure of patient safety is benchmarking the reporting of adverse incident data as done by the NPSA in Fig.1.



**Fig.1 Incident rate per 1000 bed days.<sup>8</sup>**

Patient safety incident reports successfully submitted to the National Reporting and Learning System where the incident occurred during the period 1 April 2007 to 30 September 2007.

Specific patient safety measures include:

- community measures
  - suicides and self-harming incidents
  - harm caused to others by individuals with mentally illness
- in-patient measures (outcome measures for patient safety):
  - violent incidents on in-patient wards: patient to patient, patient to staff
  - suicide and self-harming episodes
  - falls
  - medication errors resulting in significant harm
  - absconding of detained patients from in-patient units.

## OUTCOME MEASURES FOR PATIENT AND CARER EXPERIENCE

The service user experience picks up another focus of care. The CQC's Mental Health Acute Inpatient Service Users Survey,<sup>9</sup> for example, explores a number of facets of the service user experience. Questions include:

- During your most recent stay, did you feel safe?
- Do you feel the hospital helped you to keep in touch with family or friends?
- Were you given enough time to discuss your condition and treatment with the psychiatrist(s)?
- During your most recent stay, were you given any medication (including tablets, medicines and injections) as part of your treatment for your mental health?
- Did the hospital staff explain the possible side-effects of this medication in a way you could understand?

The CQC's Community Mental Health Services Survey<sup>10</sup> also looks at the service user experience. Questions include:

- Have you been told who your care coordinator is?
- Have you been given (or offered) a written or printed copy of your care plan?
- In the last 12 months have you had a care review?
- Were the activities provided by the day centre or day hospital helpful?

These questions are reported at trust level. There is need to have data collected at team level so that action plans can address any identified short-falls in the experience of care. A common tool would facilitate benchmarking at team level and complement the CQC data on provider organisations.

Patient experience measures also need to be collected via feedback for individual clinicians. The patient feedback questions used in the College's ACP 360° tool ([www.rcpsych.ac.uk/quality/quality,accreditationaudit/acp360.aspx](http://www.rcpsych.ac.uk/quality/quality,accreditationaudit/acp360.aspx)) highlight key areas of importance in the individual clinician–patient interaction.

## OTHER OUTCOMES

### *ACCREDITATION*

Service quality and performance are also measured by accreditation programmes such as the CCQI's Accreditation for Inpatient Mental Health Services (AIMS) programme for in-patient units. The Quality Indicator for Rehabilitative Care (QuIRC) is an internationally tested, web-based self-assessment tool for rehabilitation wards/community units, which is completed by the unit manager. It has been incorporated into AIMS for in-patient rehabilitation units (AIMS-Rehab) (Appendix 3).

### *AUDITS*

National audits provide further details about specific aspects of patient care such as those of the POMH-UK for medication.

### *PATHWAYS OF CARE*

A pathway of care sets out the assessments and interventions that service users and their carers should expect for a given diagnosis. For example, a patient with depression should expect an assessment which includes being asked about the full range of depressive symptoms, the level of social and occupational impairment, previous experience of treatment, risks of self-harm, etc. The pathway would set out a choice of interventions that are available and commissioned, and include, for example, a choice of antidepressant medication, a choice of psychological treatment and social interventions (e.g. befriending). Each intervention can be clarified for providers and commissioners as to the expertise required to both inform the commissioning process and to ensure the maintenance of standards. This will involve mapping out the assessments, interventions and time-frames that patients and their carers should expect for a given diagnosis or symptom cluster. A set of definitions is required for reliable information that explains which intervention is associated with a given outcome and by whom it is delivered (in terms of competences rather than staff group). This should link with NICE guidance. The general headings are likely to be:

- psychoeducation
- medication: choice offered, in line with NICE, changed as required
- physical health monitoring: ensuring that it happens if done in primary care
- psychological therapies
- social inclusion: recovery work including return to employment
- crisis planning and relapse signature.

Sequential outcome measures will be used not only to benchmark the quality of care but also, and more importantly, to inform the patient and clinician as to progress. If outcomes indicate that the patient is on a trajectory for recovery, that is reassuring. If the trajectory is falling short of this, additional interventions should take place in a timely manner.

# Appendix 1: Productivity

Quality and productivity are interrelated. The following measures may be of value in determining capacity and productivity to ensure that services are both of high quality and cost-effective.

## COMMUNITY TEAMS

- Number of patients seen as new to the team, with information on diagnosis, gender, ethnicity and age
- Cluster score (HoNOS, payment by results at assessment, care programme approach review and discharge)
- Total case-loads
- Waiting times from referral to assessment and to initiation of treatment
- Number of new and continuing contacts per patient (ratio of new:follow-ups)
- Number of admissions:
  - type of ward, coded as: acute, rehabilitation, psychiatric intensive care unit, low secure unit, medium secure unit
  - locality of admissions, coded as: local, out-of-locality treatment but within trust, and out-of-area treatment. This gives a measure of accessibility of local service provision.
- Length of stay
- Number of individuals detained under the Mental Health Act, including community treatment orders per population per year

## IN-PATIENT SERVICES

- Whether ward is accredited with AIMS, and at what level
- Number of admissions, length of stay (taking into account different average lengths of stay for different service user groups (e.g. acute and rehabilitation patients)) and readmission rate
- Route into hospital, for example crisis resolution home treatment team, detained under Section 136 of the Mental Health Act/by police, community team

- Bed occupancy
- Bed-blocking
- Similar information regarding diagnosis, payment by results clusters, gender, ethnicity and age as before
- Serious untoward incidents – subdivide by violence, self-harm, falls, absconding
- Use of bank and agency staff
- Mental Health Act use: per cent of individuals detained under the Mental Health Act, with information regarding diagnosis, gender, ethnicity and age

# Appendix 2: Condition-specific scales

This list does not claim to be comprehensive or exhaustive but is offered as useful suggestions.

## DEPRESSION AND ANXIETY

### *PHQ-9 (PATIENT HEALTH QUESTIONNAIRE – 9)*<sup>11</sup>

A 9-item depression scale assessing symptoms and functional impairment to make a tentative diagnosis of depression, and deriving a severity score to help select and monitor treatment.

### *GAD-7 (GENERALISED ANXIETY DISORDER ASSESSMENT – 7)*<sup>12</sup>

A self-administered, 7-item patient questionnaire used as a screening tool and severity measure for generalised anxiety disorder.

## *DRUG AND ALCOHOL MISUSE*

Addiction comorbidity is common in mental health and there should be specific monitoring tools used.

### *AUDIT (ALCOHOL USE DISORDERS IDENTIFICATION TEST)*<sup>13</sup>

A 10-item questionnaire developed as a transcultural screening tool to detect excessive alcohol consumption and dependence in primary healthcare settings.

### *MAUDSLEY ADDICTION PROFILE*<sup>14</sup>

A brief, interviewer-administered questionnaire for assessing people with drug and alcohol problems.

## OBSESSIVE—COMPULSIVE DISORDER

### *Y-BOCS (YALE—BROWN OBSESSIVE COMPULSIVE SCALE)*<sup>15</sup>

Widely used in research and specialist services. A clinician-rated, 10-item scale, each item being rated from 0 (no symptoms) to 4 (extreme symptoms). The scale includes questions about the amount of time the individuals spends on obsessions, how much impairment or distress they experience, and how much resistance and control they have over these thoughts.

## EATING DISORDERS

### *EDE-Q (EATING DISORDER EXAMINATION QUESTIONNAIRE)*<sup>16</sup>

A 41-item self-report questionnaire which concerns behaviour over the preceding 28 days. Body mass index should be calculated alongside this scale.

## ATTENTION-DEFICIT HYPERACTIVITY DISORDER (ADHD)

### *ADULT ADHD SELF-REPORT SCALE*<sup>17</sup>

A 6-item self-report questionnaire designed to recognise the signs/symptoms of adult ADHD.

## PSYCHOTIC DISORDERS

### *BPRS (BRIEF PSYCHIATRIC RATING SCALE)*<sup>18</sup>

A form consisting of 24 symptom constructs, each to be rated on a 7-point scale of severity ranging from 'not present' to 'extremely severe'.

### *PANSS (POSITIVE AND NEGATIVE SYNDROME SCALE)*<sup>19</sup>

A relatively brief interview (45–50 min). The patient is rated from 1 to 7 on 30 different symptoms based on the interview as well as reports from family members or primary care hospital workers.

### *KGV (KRAWIECKA, GOLDBERG AND VAUGHAN SCALE)*<sup>20</sup>

A structured interview schedule covering 14 symptom items designed to give a brief summary of the symptoms experienced by people with psychotic illness. All items are scored on a 5-point scale ranging from absent (0) to severe (4).

## *SSPI (SIGNS AND SYMPTOMS OF PSYCHOTIC ILLNESS)*<sup>21</sup>

This is a 20-item rating scale. The first 19 items provide a sensitive and reliable measure of the 5 major clusters of symptoms that occur commonly in psychotic illness: depression, excitation, diminished psychomotor activity, disorganised psychomotor activity and reality distortion. The last item assesses insight.

## BIPOLAR DISORDER

### *ALTMAN SELF-RATING MANIA SCALE*<sup>22</sup>

A 5-item self-rating scale designed to assess both the presence and the severity of the symptoms of mania.

### *MOOD DISORDER QUESTIONNAIRE*<sup>23</sup>

A 13-item (self-rating) checklist to assist with the diagnosis of bipolar disorder.

### *YOUNG MANIA RATING SCALE*<sup>24</sup>

A clinician-administered checklist of 11 manic symptoms, rated on a scale of 0–4 (7 symptoms) or 0–8 (4 symptoms), designed to measure the severity of manic symptoms.

## PSYCHOLOGICAL THERAPIES

### *CLINICAL OUTCOMES IN ROUTINE EVALUATION — OUTCOME MEASURE*<sup>25</sup>

A client self-report questionnaire designed to be administered before and after therapy. The client is asked to respond to 34 questions about how they have been feeling over the past week, using a 5-point scale ranging from 'not at all' to 'most or all of the time'. The 34 items cover four dimensions: subjective well-being; problems/symptoms; life functioning; and risk/harm.

# Appendix 3: Recommendations of the Faculty of Rehabilitation and Social Psychiatry in relation to effectiveness measures

## SOCIAL FUNCTIONING QUESTIONNAIRE (SFQ)<sup>26</sup>

Lavelle *et al* have recently completed validation (interrater reliability, test-retest reliability, convergent validity) of the SFQ that has been used for some time in several rehabilitation services in South London and Maudsley NHS Foundation Trust (H. Killaspy, personal communication, 2011). This measure appears to have some advantage over other well-known measures of social functioning (e.g. Life Skills Profile<sup>27</sup>) in showing change as an individual progresses (as well as groups). It is easy to use, quick to complete and provides a graphical representation of the results.

## CAN: CAMBERWELL ASSESSMENT OF NEED<sup>28</sup> (SHORT VERSION, CANSAS)

This instrument is well known, brief, easy to complete, widely used and has been tested psychometrically. It has the advantage of showing how a service improves a service user's proportion of met needs (v. unmet needs) even if the total needs do not change (as may well be the case in people with complex needs). This measure may be especially important for rehabilitation services to evidence the degree to which they are addressing service users' complex problems.

## SUGGESTED OPTIONAL SERVICE USER OUTCOME MEASURES

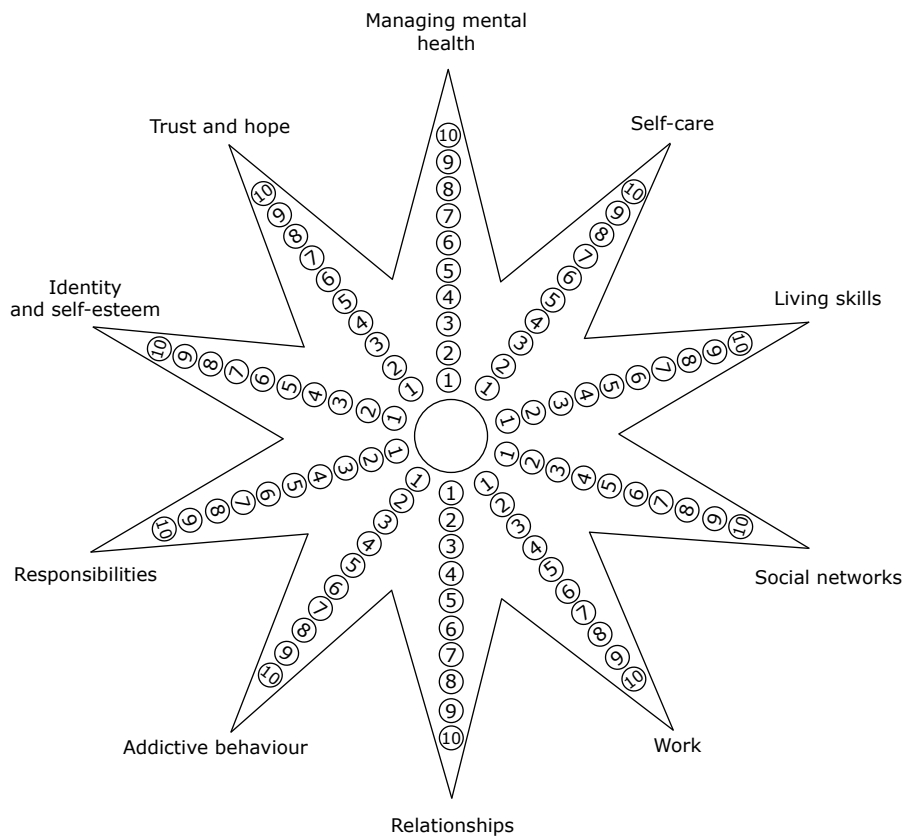
### *QUALITY OF LIFE*

The most widely used measure and one that is also well validated is the Manchester Short Assessment of Quality of Life (MANSA).<sup>29</sup> As it is rated by service users and requires an interviewer to complete, service users with complex needs may not participate and therefore sampling bias is a problem.

However, it has been applied in rehabilitation samples and those who use it have found it quick and easy to administer. Other measures (e.g. EQ-5D<sup>6</sup>) do not seem as popular.

### *RECOVERY STAR*<sup>30</sup>

Currently very popular in many rehabilitation and other services (Fig. A1). No psychometrics have been carried out, but this is now underway (H. Killaspy, personal communication, 2011). May be too cumbersome for use as an outcome measure, but useful for collaborative care planning. Results of psychometric assessments will be available in summer 2011.



**Fig. A1 The Recovery Star.** Adapted from Mackeith & Burns.<sup>6</sup>

## SERVICE QUALITY AND PERFORMANCE

### *QUALITY INDICATOR FOR REHABILITATIVE CARE (QUIRC)*

This is a web-based self-assessment tool for 24-hour rehabilitation wards/ community units completed by the unit manager. It has good psychometrics, takes about 90 minutes to complete and prints out a report on the unit

showing its performance against similar units in the same country. Results have been shown to correlate with service user experiences of the unit. It is already incorporated in AIMS-Rehab and the Rehabilitation Effectiveness for Activities for Life (REAL) study ([www.ucl.ac.uk/REAL-Study/](http://www.ucl.ac.uk/REAL-Study/)), so data on all in-patient rehabilitation units in England will accrue. It gives performance score (%) on seven domains of care (living environment; therapeutic environment; treatment and interventions; self-management and autonomy; human rights; social interface; recovery-based practice).

Service user/carer/staff satisfaction questionnaires are more difficult to use for those with complex needs as the questionnaire may miss out information from service users with complex needs who may not be well enough to be able to participate in interviews/complete questionnaires. Hence QuIRC was validated against service users' experiences and can be used as proxy measure of their experience.

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