Correspondence

The Mental Health Recovery Star: great for care planning but not as a routine outcome measure

Dickens *et al*'s paper[1] reporting on the internal validity of the Mental Health Recovery Star provides evidence for its internal consistency and factor structure. The authors state that it is assessing a single underlying recovery-related construct. However, there is a problem with this statement, since recovery in this context is, by definition, a subjective construct. For this reason, the application of any predetermined constructs (the ten domains of the Recovery Star) can only be considered to be assessing an individual's recovery if those domains happen to coincide with an individual's own priorities. A separate study (currently under review for publication) has investigated the external validity of the Recovery Star and found interrater reliability of nine of the ten domains to be below the generally accepted level (intraclass correlation coefficient >0.7).

Dickens *et al* present findings from routinely collected data and suggest these are evidence of the Recovery Star's sensitivity to change in an individual's progress over time (i.e. its responsiveness). The problem is that unless the same member of staff was involved in repeat ratings, these findings are likely to be invalid given the issues with interrater reliability. In addition, responsiveness to change needs to be corroborated by an established measure. Finally, if earlier ratings were discussed between the staff and service user before re-rating (as is encouraged through the training and manual accompanying the Recovery Star), then neutrality is likely to have been reduced, as both may have an investment in showing that progress has been made. One further, fundamental issue is that the 'ladder of change' used to assess progress in each of the ten domains has not been validated psychometrically.

The Recovery Star is very popular and has merit as a tool to enhance discussion of recovery goals between staff and service users. However, although Dickens *et al*'s findings have helped with understanding some of the Recovery Star's psychometric properties, they do not provide evidence for its adoption as a routine outcome measure.

1 Dickens G, Weleminsky J, Onifande Y, Sugarman P. Recovery Star: validating user recovery. *Psychiatrist* 2012; **36**: 45–50.

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Authors' response: Dr Killaspy and colleagues make some important points about the Mental Health Recovery Star, but they adopt a surprisingly dismissive tone about this innovative user-led tool and about our study. With careful caveats, we have argued from naturalistic data that the tool is measuring an underlying construct, and that it has the potential to record reported change. Killaspy *et al* criticise claims that we simply have not made. Our analysis was not intended to put the psychometric properties of the Mental Health Recovery Star beyond doubt. The development of the tool has employed a user-based approach and, as such, has lacked some of the formal and restrictive academic rigour associated with traditional psychometric testing. We would welcome further research and development to address this.

It is our understanding that the interrater reliability testing cited by the authors is largely based on staff-only ratings of service users' recovery journey. This is not how the tool is intended to be used. It is surprising that Dr Killaspy and colleagues would choose to evaluate a tool in a way which goes against the directions for its use. That intraclass correlation coefficient results fall short of the required 0.7 could reflect the inherent inaccuracy and instability of having sensitive personal recovery dimensions estimated by professionals without discussion with the service user. It is unclear how this fits with recovery as a construct built on individual service users' own priorities. Surely user involvement in the measurement of recovery should be central to the definition of their outcomes.

In relation to sensitivity, it is true that there is a lack so far of proven external validity for the Recovery Star. Again, our paper makes no claims about external validity but merely comments on the fact of change between readings and the promise that this holds. We agree that reported changes are small and that the underlying 'ladder of change' model remains untested. However, it is useful to provide a clear and accessible model of change, which is supported by training and the Recovery Star Organisational Guide. Importantly, this instructs that second readings are taken without reference to the first.

We would like to see future versions of the Recovery Star and other recovery tools that are both psychometrically robust and, crucially, of practical use and relevance to mental health service users and their carers. There is little point in adopting a scientific gold standard for tracking recovery outcomes if it eschews the involvement of people in appraising their own recovery.

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Psychiatric in-patients and the criminal justice system: are there any downsides?

The paper by Wilson *et al*[1] highlights the serious issue of in-patient violence. The potential benefits of involving the criminal justice system are well laid out and the suggested

approach is likely to be useful in practice. Unfortunately, the paper fails to look at the possible downsides of such a practice.

Potential adverse outcomes include short- and long-term stigma for the individual patient and loss of therapeutic relationship between the patient and clinician. These are likely to result in poorer services and longer periods of detention. The critical step in deciding whether to refer a patient to the criminal justice system will be the clinician's judgement of non-trivial violence. Good training can reduce lack of consistency but long-term follow-up and critical examination of this practice will ensure that adverse outcomes are kept to a minimum as we juggle to find the ethical balance here.

1 Wilson S, Murray K, Harris M, Brown M. Psychiatric in-patients, violence and the criminal justice system. *Psychiatrist* 2012; **36**: 41–4.

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Prosecuting violent in-patients: the importance of staff attitudes

The editorial by Wilson *et al*[1] highlights important dilemmas faced by mental health professionals in relation to reporting violence perpetrated by mentally disordered patients. We welcome the proposals made by the authors, but unless there is a significant change in staff attitudes to reporting non-trivial violence perpetrated by psychiatric patients, progress in this area is unlikely to occur.

Our observation is underpinned by the results of two surveys which we carried out in a medium secure unit in Middlesbrough in 2006 and 2008. There were 80 incidents of assaults on staff by in-patients, the majority of incidents having been perpetrated by a minority (2006: 43 assaults, $n = 10/100$; 2008: 37 assaults, $n = 14/100$). Despite being a medium secure unit, the majority of assaults were perpetrated by patients detained under Part 2 of the Mental Health Act and by female patients. Only 10 incidents (12.5%) were reported to the police, despite 70% of nursing staff being aware of the memorandum of understanding (www.cp3.gov.uk/publications/agencies/mounhs.html). We explored the attitudes of nursing staff using self-report attitude questionnaires (each of the 13 attitude statements measured on a 5-point Likert scale) to identify enablers or barriers to reporting incidents.

In both surveys, approximately a third of respondents feared that reporting incidents would result in a breakdown of therapeutic relationships with patients and a half feared reprisal from patients following reporting. In 2006, half of respondents considered being assaulted as an 'occupational hazard', but encouragingly this attitude was reported only by a quarter of respondents in 2008. Although 84% of nursing staff understood that they had a 'right to report', a fifth believed that reporting incidents was a bureaucratic exercise without any benefits and for 60% the required reporting forms and procedures were difficult to complete. Staff were more likely to report incidents perpetrated by patients with personality disorder than those with other mental illness. About 20% of staff stated that they would only report incidents which resulted in physical injury. Only 40% believed that reporting incidents would strongly deter patients from re-assaulting. Some of these free-text comments capture the ambivalence in this area: 'I came to the nursing profession to help patients, not to be a punch bag'; 'I would report only if the assaults were due to ''badness'' not ''madness'' '; 'Disillusioned towards the police dealing with incidents'; 'Waste of time'; 'Zero tolerance should mean zero tolerance'.

In summary, whereas we acknowledge the value in developing robust policies, procedures and systems to address this important issue, significant progress in this area is unlikely to occur unless considerable efforts are made to shift attitudes of mental health professionals. Campaigns and systems to report and reduce violence are akin to taking a horse to water. Making a change will require a change of attitudes in relation to reporting violent incidents to the police. We propose that this can be achieved by discussing patient assaults in staff induction training, appraisal, supervision sessions and trust audits.

1 Wilson S, Murray K, Harris M, Brown M. Psychiatric in-patients, violence and the criminal justice system. *Psychiatrist* 2012; **36**: 41–4.

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Discrimination between psychotropic and non-psychotropic treatment by patients

Perecherla & Macdonald[1] state that they found no evidence that patients discriminated between psychotropic and non-psychotropic treatment. Elsewhere, a lack of concordance with psychotropic medication has been reported to be as high as 75% over the course of a year.[2] Although this may be on a par with adherence to non-psychotropic medications, there were significant factors which were not taken into consideration in Perecherla & Macdonald's study.

Only patients who could communicate in English were included. This may have excluded patients from ethnic minority groups and other backgrounds, thereby ignoring their cultural and religious beliefs regarding medication. This surely must reduce the relevance of the results to populations with a significant proportion of ethnic groups. Further, the authors were unable to ascertain the duration of treatment in participants. This is an important factor as adherence improves with development of insight.[3] The opposite is true of acute relapse.

In addition, it is not clear whether the sample was drawn from acute or long-stay wards and whether it consisted of patients who were stable on psychotropic medication and had insight or were acutely unwell. It is quite possible that most of the sample were patients who were stabilised on a drug regime, had insight and knew the purpose of their psychotropic medication. However, this may not be the case in acute episodes of care where the patient often lacks insight and questions the need to continue psychotropic medications. The authors state that in case of participants on more than two psychotropics, the 'longest-term treatment option' was selected. We fail to understand how this was established if duration of treatment was unknown. In the example given of a patient with bipolar disorder, the mood stabiliser was selected rather than the antipsychotic as the primary treatment; this was based on the assumption that mood stabilisers had been used first. However, it is well known that many patients are treated with antipsychotics as first-line medication. It is quite