OUTCOME MEASUREMENT IN NON-GOVERNMENT ORGANISATIONS

a descriptive study of recovery-based mental health workers’ experiences and beliefs

Josephine Logan
Master of Mental Health Practice, Griffith University
MY BACKGROUND...

• Interest in mental health assessment from studying psychology
• Studying mental health revealed the spectrum of mental health practices & impacts of planning and policy
• Work placement with a non-government organisation (NGO) showed the significance of outcome measurement (OM) in non-clinical health environments
• When deciding on a research topic for my dissertation I chose to explore the experiences and beliefs of NGO mental health workers using OM
WHAT IS KNOWN ABOUT THIS TOPIC

- NGOs provide **diverse levels of services** in the community mental health (CMH) sector
- OM was introduced into the mental health sector to improve **service quality and effectiveness**, to inform **policy development**, & target **funding**
- Early outcome data in the **public mental health sector** was considerably inconsistent and unreliable
- **Criticisms** of OM in the literature are largely clinically-based & link to poor levels of **compliance, consistency & acceptance**
WHAT IS KNOWN ABOUT THIS TOPIC

• Issues with limiting recovery to a clinical definition for measurement - seen to devalue the meaning of experience and obscure loss
• Most clinical staff have purportedly come to value the OM process
• Still remains disagreement about the utility and feasibility of the process in mental health care
• Little documented research of NGO staff experiences of OM, despite evidence of many CMH organisations using OM

My research explored the experiences and beliefs of NGO staff using OM
METHODS

• Using a qualitative paradigm & phenomenological perspective interviews were used to discern:
  i. What challenges NGO staff faced in OM use
  ii. If key issues raised by clinical staff were shared by non-clinical staff
  iii. How OM was best used in their practice
• Questions included demographics, service questions, general OM questions, feasibility topics, & tool properties
**DEMOGRAPHICS**

- **75%** participants identified as female
- **40.7** Average age
- **75%** Working in mental health for > than 5 years
- Majority completed tertiary education ≥ a Bachelor degree
- **25%** Working in the field for > than 15 years
SERVICES & SETTINGS

Philosophies of person-centred care, recovery models, advocatory services, strengths-based perspectives and social inclusion

Types of services included: coordinating care & direct mental health care

Roles included
- Support workers
- Service coordinators
- Administrators & human resources
- Managers

Service users included: young to elderly; diagnosed & undiagnosed; mix of mental/physical disabilities
WHAT THIS PAPER ADDS

- No definitions of recovery were the same - similar concepts of individuality, personal, ongoing discovery, life beyond symptoms, working toward wellbeing, & meaningful change.
- The most commonly used tool reported by participants was the CANSAS.
- OM was mainly seen as a means of meeting key performance indicators, service planning, & tracking service user progress.
Four key themes emerged from analysing participant responses

- views and beliefs about OM
- tool validity
- flexibility
- training and support
• Views and beliefs about OM
  – Non-clinical staff shared many but not all of the negative issues experiences by clinical staff
  – They described new issues and experiences of OM
  – Participants also described positive experiences of OM use - OM was valued for shaping & framing practice, creating accountability, & enabling transparency within support roles
  – Some felt that OM should be accepted & supported by NGOs due to trends in funding development
Tool validity
• Most felt that tools were **accurate**
• Variable beliefs about the **reliability & sensitivity** of OM tools
• Many were challenged by **inconsistent data**
• **Mandatory and routine** use varied despite implementation guidance
• Fluctuating nature of **mental illness** significantly affected data accuracy & consistency
• **Issues of tools** not being individual, holistic, detailed or culturally appropriate
WHAT THIS PAPER ADDS

- **Flexibility**
  - Tools were *adapted* to suit service users, their practice, & NGOs
  - OM was used to promote *engagement, practical OM application, & information which reflects the service users true opinion*
  - Many participants described using *modified established tools*, even compromising validity & reliability for service users to gain meaning & understanding from OM
Training and support:
- Where OM was supported it was used for more than just data collection
  - including improving understanding and respect, collaborative practices, communication and rapport building, service user engagement, reflection, and feedback
- Training was highly valued for promoting and enabling positive practices
- Appropriate training and support was described as improving OM uptake
IN SUMMARY

**Clinical:**
- Large case loads
- Poor support
- Poor training

**Shared:**
- Time constraints
- Data input & reporting issues
- Unreliable outcome data

**NGOs:**
- Lack of resources
- Complex questions
- Clinical tools
- Tool length
- Nature of mental illness
- Incompatibility with recovery
This research expands literature of non-clinical mental health staff & their experiences using OM in recovery-oriented CMH organisations.

Imperative to the standardisation of OM are the experiences of the individuals who use these tools & processes.

NGOs want more information & guidance on OM, to develop greater understanding & respect for assessment, for the ability to better plan & coordinate services.

Exploring the experiences & beliefs of greater numbers of NGO staff can help future research work toward improved OM implementation & culture.

IMPLICATIONS
Thank you to all the individuals who participated in this study. I am profoundly grateful for their involvement and the time they took to share their experiences with me.

Thank you for listening.