



Australian Institute for Primary Care

FACULTY OF HEALTH SCIENCES

Improving Services through Consumer Population Outcome Measurement in PDRSS

INTRODUCTION

This paper was compiled for a project to develop a consumer measure for PDRSS. It is designed to assist PDRSS to make choices about the consumer outcome measures they will use and how they can use the data to evaluate and improve programs and services.

The Mental Health branch requires services to periodically collect and submit consumer outcomes data as part of a quality improvement strategy.

The data will assist individual PDRSS with their efforts to evaluate and improve programs and services. The Mental Health Branch will also use the data for state wide planning and evaluation purposes.

Evaluating consumer outcomes is a fundamental aspect of PDRSS work. The main way that this has occurred to date is through the monitoring of changes that occur in the lives of **individual** consumers.

In this paper we focus on the measurement of outcomes for the **population** of users for any one PDRSS (i.e., data collected from **all** users of that particular PDRSS irrespective of program or service used) or of a particular service program (e.g., data collected from **all** users of a particular program across all PDRS services state wide). N.B. The term 'population' only refers to a pre-defined group as that whole group, never as the sum of all the individuals that constitute that group (see discussion below).

The practical application of any type of outcome information is that it can be compared with other data and differences can be identified. For example, it may highlight that a program is successful at one PDRSS and not at another, and further it may help pinpoint **why** that is the case. For such comparisons to be valid the data must be collected in the same way and the issues that are examined must be the same and have a similar meaning to consumers being surveyed.

Effective population outcomes measurement requires the use of specific measurement tools: it is not necessarily the case that outcomes for individual PDRSS users can be added together to provide a valid picture of the outcomes that are achieved for the PDRSS population as a whole.

Section I of the paper describes the types of data that may be thought of as outcomes data and the role that consumer population outcomes data can play in service planning and evaluation.

Section II presents a strategy designed to assist PDRSS to choose one of three outcome measurement instruments. The strategy is designed to assist a PDRSS to select the instrument that most closely matches its particular need for outcomes data. By using this strategy, a PDRSS can accumulate knowledge about why these particular data have been sought and how they might be applied to assist with service planning and evaluation.

Section III includes copies of outcomes survey instruments and a more detailed discussion of matters that are raised in Sections I and II.

Once you have carefully read through this paper, the next step is for you to devise your service's own Consumer Outcome Measurement Strategy. To assist you in developing a strategy responsive to your organisation's specific needs, we have set out a seven-step guide for you to work through. You will then be ready to implement your strategy.

SECTION 1

WHAT ARE CONSUMER OUTCOMES DATA?

The official definition of an outcome that has been endorsed by the Australian Health Ministers' Advisory Council is as follows:

*A measurable change in the health of an individual, or a group of people or population which is attributable to an intervention or series of interventions**

While this definition is useful, it does not capture the full breadth of ways that the term "consumer outcomes" is used. 'Consumer' is understood in this context to refer to any user of a PDRSS service. Data can be considered outcomes data if they have the potential to be compared with other similar data so that an assessment about change or progress can be made. So any data that can be compared with population averages or previously collected data could be described as outcomes data.

As mentioned above, consumer outcomes can be measured at the individual level and at the population level.

They can also be measured using objective and subjective data. For example:

Subjective data involve a consumer and/or a practitioner making a judgement about aspects of a consumer and his/her situation.

Objective data may relate to a consumer's financial, housing and education status, hospitalisation rates and length of stay. These measures, while having the advantage of being objective, do not necessarily align with changes in personal characteristics, needs and desires or quality of life.

Therefore, the ideal way to evaluate outcomes is to collect both kinds of data: that based on people's perceptions, as well as objective measures of outcome.

Individual Consumer Outcomes

In the PDRSS context, a popular use of the term consumer outcomes is to use it when describing changes that occur for individual consumers. The information contained in individual case files and IPPs can be used to evaluate outcomes for individual consumers. Because these files include information that describes the history and current situation for each consumer, it is possible to evaluate the progress that has been made. Because files are meant to reflect the personal needs and situation of each consumer, the nature of what is recorded in these files will vary considerably. This is appropriate as the primary purpose of the information in the files is to facilitate services to the individual consumer concerned. However this variation, while

* Australian Health Ministers. (1998). *Second national mental health plan*. Canberra, ACT: AGPS, p. 27.

expected, makes the data in individual files inappropriate for adding together to make assessments as to how the population of service users as a whole is progressing. This is discussed in more detail below.

Population Level Outcomes

To obtain data that can reliably be used to evaluate PDRSS population outcomes the data sought must be consistent in the way it is sought and the issues that are investigated. This is a simple matter when the data that are collected are objective in nature. Where the data to be collected are subjective (i.e., people's perceptions) the questionnaires and methods of administration must be developed through research to ensure that they will produce reliable and valid results. By surveying populations, the natural variations – called error, in statistical language – that occur when any one individual completes a survey cancel each other out and so a true picture of change in the population is obtained.

In order that consumer outcomes data can be properly interpreted it is necessary, most of the time, to collect or obtain data about the consumer characteristics of the population being surveyed, the social context and the interventions that are used. Without knowing if there are variations in these other data it makes it difficult to reach any conclusions about the extent to which a change in outcomes can be attributed to a particular intervention or service. It is essential, therefore, that these other data be obtained and considered if any conclusions are to be reached regarding the effect that a service has on the outcomes that are measured for the user population. This issue is addressed in more detail in Section III on page 25.

WHY MEASURE CONSUMER OUTCOMES?

PDRSS practitioners appreciate the need to evaluate individual consumer outcomes for individual consumers. This is what they are trained for and the essence of what they do. The idea of monitoring the *population of PDRSS users*, however, appears less relevant and accordingly many practitioners question why it is necessary. Surely, they argue, it is sufficient to know about the progress and the outcomes achieved for each individual service user?

So what is the benefit of collecting consumer outcomes data on populations? Nocon and Qureshi¹ describe the purpose of outcome measurement as follows:

“... outcome measurement in routine practice is intended as a control mechanism, designed to give feedback to organizations, or individuals, about the effectiveness of services, with an expectation that such information will be interpreted and used as a basis for action.”

Population outcome measurement can be used to help PDRSS evaluate the nature and range of service types that they offer in a number of ways. It can help a service to make decisions about the relative effectiveness of the different types of activities it conducts. An individual service's consumer

¹ Outcomes of community care for users and carers : a social services perspective / Andrew Nocon and Hazel Qureshi. Buckingham; Bristol, PA, USA : Open University Press, 1996. p 7.

outcomes data can be compared with state wide consumer outcomes data. They can be compared with that which is collected within the same program at different points in time. By using outcomes data along with other information types conclusions can be reached about the characteristics of particular populations and the effectiveness of different approaches and what might be needed to improve them. It is an objective service improvement and development tool.

SECTION II

GUIDE TO DEVELOPING A CONSUMER OUTCOME MEASUREMENT STRATEGY

In this Section we describe in practical terms the 7 steps a PDRSS can take to develop a consumer population outcome measurement strategy.

A strategy is a comprehensive process that not only describes **what** will be collected but **why** that particular method was chosen. It incorporates awareness of the limitations of the data and how the data should be analysed. A carefully worked through strategy ensures that there is a good return for the effort of data collection and maximises the usability of data.

The capacity to accurately describe these organisational activities and outcomes will enable a service to be accountable to the full range of stakeholders that have an interest in the outcomes experienced by consumers using a PDRSS.

Step 1: Identification of key stakeholders.

The aim of this step is to ensure that key stakeholders are able to play a significant role in identifying the consumer outcomes that are relevant to consumers who use PDRSS.

If service improvement is the aim, a critical step when identifying consumer outcomes relevant to PDRSS is to determine the key stakeholders who have an interest in the outcomes for PDRSS consumers. The importance of gaining the support of stakeholders is in the role they will play if the outcomes data suggest that changes to programs and services are needed. Stakeholder support for service changes is necessary if service developments are to occur. If any stakeholder group is of the view that the consumer outcomes or measurement approaches are inadequate or inappropriate they are unlikely to value the findings arising from the data analysis. This is an obvious barrier to service change and development.

The key stakeholder groups in the PDRSS industry seem to be self-identifying. There are:

- funding bodies – primarily the Mental Health Branch of the Department of Human Services (DHS)
- service providers;
- consumers and consumer advocacy and support groups;
- carer and carer support groups; and
- providers of other services such as clinical mental health services and generalist services such as HACC providers and general practitioners.

Once the key stakeholders that should be involved in these decisions have been identified, it is important that they are clear about the purpose and limitations of the different consumer outcomes measures. They should understand that outcomes data of this type are collected so that changes in

PDRSS consumers as a group or population can be assessed². While data of this nature are not intended to be used in the care planning and review that occurs for each individual PDRSS consumer, it may be valuable as a means of orientating discussions between service providers and individual consumers. It is unlikely, however, that it will provide the detail or range of information that consumers and service providers need for successful planning and review of the services to each individual consumer. This limitation of outcomes data needs to be appreciated to ensure that stakeholders are clear about what they are being asked. They need to appreciate that the collection of consumer outcomes data is not an alternative to the discussion and information exchange that normally occurs between PDRSS workers and individual consumers when planning and reviewing care and support.

Record the key stakeholder groups whose views were sought at this stage.

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² See discussion in Section I, which addresses the difference between individual outcome measurement and population outcome measurement.

Step II: Identification of consumer outcomes that are consistent with the aims of PDRS Services.

The aim of this step is for the PDRSS to be clear about which consumer outcomes are important to its service so that it can then select existing data or decide on the data it wants to collect and the most appropriate measurement instruments and techniques to do this.

Many stakeholder groups will already have published policies, position statements and in the case of funding bodies, program guidelines that describe the outcomes that they believe are important for PDRSS to be aiming to influence. The Mental Health Branch, consumer and carer advocacy groups and VICSERV (the peak body for the PDRSS) have articulated policy positions and program aims. These need to be considered by the PDRSS in addition to reviewing its own policy objectives, previous service evaluations and feedback from consumers and carers about local issues that relate to outcomes for consumers³.

There appears to be general agreement in PDRSS that the Psychosocial Rehabilitation Framework (PSRF) captures the broad aims of PDRS. Some of the PSRF relate specifically to consumer outcomes as compared to service outcomes that are also included in the PSRF. Consumer outcomes that relate to the PSRF are:

- equipping people with skills (independence);
- self-determination (choice); and
- normalisation (rights).

Record the consumer outcomes that your service has identified as those that it wishes to evaluate.

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³ A listing of key policy documents that are readily available can be found in Section III on page 15.

Step III: Identification of consumer outcomes data that are already available which relate to these consumer outcomes.

The aim of this step is to identify consumer outcomes data already available that are a measure of outcomes that are of interest to the PDRSS. These data may be useful in addition to the outcomes data that PDRSS will be required to collect (See Step V below)

Approximately 70 per cent of PDRSS consumers are also users of government provided clinical mental health services. While not yet collected routinely it is proposed that clinical services will routinely collect outcomes data from consumers. The instruments currently being tested (Health of the Nation Outcomes Scale and the Life Skills Profile⁴) include particular types of issues (domains) that are consistent with the Psychosocial Rehabilitation Framework. With due consideration for privacy laws and principles these data can be relayed to PDRSS.

At the point where consumer outcome data are collected by the clinical mental health services, explicit consent should be obtained from consumers for the transfer of their questionnaire results to the PDRSS they are using. Flagging of the electronic data needs to occur so that requests from PDRSS to clinical services for outcomes data can be met with ease. To ensure that processes of this type are efficient and legal, agreed policy and procedures between the PDRSS and clinical services will be required. This may require some action by the PDRSS to commence the process for setting up these policies and procedures.

Record the consumer outcomes data that are already collected outside your service that your service wishes to obtain and describe any agreements that will need to be reached and with which services if this is to happen.

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⁴ For more detail on these two instruments see Section III page 16.

Step IV: Identification of important consumer outcomes that are not covered by existing data collections.

The aim of this step is to identify the consumer outcomes that are important to the PDRSS but that are not covered by existing consumer outcomes data that may be available through other sources (see Step III above).

Data that are already available through sources such as clinical mental health services may cover only a limited range of the full range of consumer outcomes with which a PDRSS may be concerned. The PDRSS needs to identify any gaps in the consumer outcomes data that are currently available so that it can select outcome measurement instruments that more closely cover the range of data types that it needs. The selection of appropriate outcome measurement instruments and techniques is addressed in the next step.

Describe the consumer outcomes that your service wishes to obtain, that are not already addressed by data collected from other sources.

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Step V: Identification of outcomes data collection instruments that can be used to fill the outcomes data gaps.

The aim of this step is to identify data measurement techniques and instruments that complete the outcomes data profile that PDRSS require for their outcome measurement strategy.

There is a range of other instruments, which in combination with the data that are already available, are likely to provide a more comprehensive coverage of the full range of consumer outcomes that a PDRSS wishes to investigate. These three instruments, together with some comments on their characteristics and applications, occur later in this paper⁵. **PDRSS need to select one or more of these instruments as part of the Mental Health Branch's quality improvement strategy for PDRSS.**

Record the consumer outcomes instrument that most completely covers the types of consumer outcomes data your service would like to collect. Record the outstanding consumer outcomes data types and how these might be collected.

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⁵ For a detailed critique of the relevant consumer outcome measurement instruments see Section III page 18.

Step VI: Selection of other types of data that will be needed to properly interpret the consumer outcomes data.

The aim of this step is to ensure that data types other than outcomes data are identified that will be needed in order to properly interpret the consumer outcomes data.

The interpretation of consumer outcomes data requires that other types of data be considered. These include data on consumer characteristics of consumers many of which are captured in the minimum data set (QDC). The nature of the service (intervention) that was used is also essential to consider when making sense of consumer outcomes data. This issue of interpreting consumer outcomes data by using other types of data is discussed in detail in a later section of this paper⁶.

Describe the other types of data that your service will need to consider when interpreting the consumer outcomes data.

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⁶ See Section III page 24.

Step VII: Plan for how the data will be analysed and its implications.

The aim of this step is to identify how consumer outcomes data will make a contribution to the planning for service improvement.

The importance of this step is to clarify how the consumer outcomes data might be used to inform service development. It should also be used to clarify limitations to the conclusions that can be drawn from consumer outcomes data⁷. The major analytic potential of consumer outcomes data arises when they can be compared with outcomes from other populations of PDRSS consumers or with the same population at different points in time. Comparisons of this type are most useful for helping to target program and service areas that are likely to benefit from continuous improvement activities. Comparisons of this nature, however, provide little insight into the *nature* of the improvements that may be required. For this reason, the analysis of these data should be one component in a comprehensive evaluation strategy that considers client characteristic data, the nature of the service provided and any other environmental influences that may have impacted on consumer outcomes.

This step, therefore, should be seen as the opportunity to consider different data types with the aim of providing a comprehensive analysis and recommendations for quality improvement activities.

Describe the important implications of the analysis of the consumer outcomes data for program development and future data needs.

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⁷ There are limitations to the conclusions that can be made linking service effectiveness and outcomes data. This issue is discussed in more detail in Section III page 25.

ACCOUNTABILITY AND OUTCOME MEASUREMENT FOR PDRSS

In summary, at the completion of Step VII of the consumer outcome measurement strategy each PDRSS should be able to describe the following:

- the nature of the consumer outcomes to be measured for each service type/program area;
- the outcome measurement instruments to be used, including the rationale for selection of the instruments;
- how frequently the data will be collected;
- how the data from the instruments will be analysed;
- the findings from the data analysis; and
- the primary implications of the analysis for program development and future data needs.

Through the systematic collection of audit data, information can be collated for the PDRSS as a whole. These data will also provide a comprehensive picture of the level of outcome measurement activity and its impact on service developments designed to improve quality and improve outcomes.

SECTION III

POLICY DOCUMENTS THAT CAN BE USED WHEN DESCRIBING CONSUMER OUTCOMES

- Aged, Community & Mental Health Division Victorian Government Department of Human Services. Mental Health Branch (Standards for Psychiatric Disability Support Services
- Commonwealth Department of Health and Aged Care. (2000). *National action plan for promotion, prevention and early intervention for mental health*. Canberra: Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care. This publication can be obtained at <http://www.mentalhealth.gov.au/resources/index.htm>
- PDRS Services Framework Document.
- Psychiatric Disability Support-A Resource Book 3rd Edition, Psychiatric Disability Services of Victoria Melb. 1998.
- VICSERV Practice Texts on the nature and purpose of practice:
 - a) Volumes I ("Towards Recovery"-the context and nature of PDRS practice) and II ("Sharing the Journey"- more on recovery and the context and nature of PDRS practice) were published last year. (New Paradigm Press, VICSERV, Melbourne 2002).
 - b) Volumes III (Groups in PDRS Practice) and IV (Rehabilitation Readiness and Goal-setting) are soon to be published and distributed within weeks.
 - c) Volumes V and VI on the core knowledge, skills and values of PSR Practice are due to be published next year.

CONSUMER OUTCOMES INSTRUMENTS CURRENTLY BEING USED IN CLINICAL MENTAL HEALTH.

The two measures described below are currently being trialed in the clinical services sector as part of a suite of outcome measures. Many PDRSS users will have been the subject of these measures and findings from them may provide useful consumer outcomes data that reflect the principles and aims of a psychosocial rehabilitation approach to service provision.

HoNOS (Health of the Nation Outcome Scales)

HoNOS provides a measure of clinician or service provider rating of health status and psychiatric symptom severity. It consists of 12 items divided into 4 domains as described below. Each item is rated on a five-point scale from 0 = 'no problem' to 4 = 'very severe problem'.

HoNOS DOMAINS/sub-scales	HoNOS QUESTIONS/ITEMS
Behaviour problems	Does this person have: Overactive, aggressive, disruptive, agitated behaviour Non-accidental self-injury Problem drinking or drug taking
Impairment	Cognitive problems Physical illness or disability problems
Symptomatic problems	Problems associated with hallucinations & delusions Problems with depressed mood Other mental & behavioural problems
Social problems	Problems with relationships Problems with activities of daily living Problems with occupation & activities Problems with living conditions

Abbreviated Life Skills Profile (LSP-16)

This scale was developed to assess a consumer's basic life skills abilities and relates to the previous three-month period. It contains 16 items over four domains and measures a person's functions in terms of social relationships and the performance of general day-to-day tasks. The domains are consistent with the psychosocial rehabilitation framework.

LSP –16 DOMAINS	LSP –16 QUESTIONS/ITEMS
Withdrawal	<p>Does this person: ...generally have any difficulty with initiating & responding to conversation ...generally withdraw from social contact ...generally show warmth to others ...generally make or keep up friendships</p>
Anti-social behaviour	<p>Is this person violent to others Does this person: ...generally have problems living with others in the household ...behave irresponsibly What sort of work is this person capable of</p>
Self-care	<p>Is this person generally well groomed Does this person: ... wear clean clothes generally, or ensure they are clean or dirty ...generally neglect his or her physical health ...generally maintain an adequate diet ... behave offensively</p>
Compliance	<p>Does this person generally look after or take his or her own prescribed medication without reminding Is this person willing to take psychiatric medication Does this person cooperate with health services</p>

DESCRIPTION AND CRITIQUE OF CONSUMER OUTCOME MEASURES

PDRSS will be required to collect one or more of the following consumer outcome measures, as part of the Mental Health Branch's Quality Improvement Strategy. They have been selected on the grounds of their psychometric properties and their applicability in the Australian context and for PDRSS usage in particular. They are all consumer rated scales and most are currently being used by some PDRSS in Victoria.

Factors taken into account by services when selecting appropriate measurement tools include the type of services provided and the characteristics of the consumers using the services. There can be significant differences in the criteria individual services use to determine the instrument that will best meet their needs.

Camberwell Assessment of Need – Short Appraisal Schedule (CANSAS)

This instrument is designed to assess the **health and social needs** of people with mental health problems. It assesses needs over the last month in 22 health and social domains. Assessments can be recorded from the perspectives of the service user and the service provider. These perspectives may differ.

The CANSAS has not been shown to be a reliable way of accurately tracking the progress of individual consumers. It may be used, however, as a framework or protocol for identifying needs in a qualitative sense and for discussing options with individual consumers, but it cannot be relied upon as a true measure of change in a consumer's condition or situation.

For each domain the goal is to identify whether the service user has any difficulties and if they do then to establish whether they are getting sufficient help to manage the difficulties.

The need rating for each item is based on a scale in which 0 = 'no problem', 1 = 'met need', 2 = 'unmet need' and 9 = 'not known'.

CAN DOMAIN	QUESTION/ITEM Consumer	QUESTION/ITEM Service Provider
Accommodation	What kind of place do you live in?	Does this person have suitable accommodation?
Food	Do you get enough to eat?	Does the person have difficulty in getting enough to eat?
Looking after the home	Are you able to look after your home?	Is the person able to look after their home?
Self care	Do you have problems keeping neat and tidy?	Does the person have difficulty with self care?
Daytime activities	How do you spend your day?	Does this person have regular appropriate day time activities?
Physical health	How well do you feel physically?	Does the person have any physical disability or physical illness?
Psychotic symptoms	Do you ever hear voices or have problems with your thoughts?	Does the person ever hear voices or have problems with their thoughts?
Information on condition & treatment	Have you ever been given clear information about your medication or other treatment?	Has the person ever been given clear information about their medication or other treatment?
Psychological distress	Have you recently felt very sad or low?	Has this person recently felt sad or low?
Safety to self	Do you ever have thoughts of harming yourself or actually harm yourself?	Is this person a danger to himself/herself or actually harmed himself/herself?
Safety to others	Do you think you could be a danger to other people's safety?	Could this person be a danger to other people's safety?
Alcohol	Does drinking cause you any problems?	Does drinking cause this person any problems?
Drugs	Do you take any drugs that aren't prescribed?	Does this person take any drugs that aren't prescribed?
Company	Are you happy with your social life?	Does this person need help with social contact?
Intimate relationships	Do you have a partner?	Does this person have a partner?
Sexual expressions	How is your sex life?	Does this [person have problems with his or her sex life?
Child care	Do you have any children under 18?	Does this person have any children under 18 years of age?
Basic education	Any difficulty in reading writing or understanding English?	Does this person lack basic skills in literacy or numeracy?
Telephone	Do you know how to use a telephone?	Does this person know how to use a telephone?
Transport	How do you find using the bus, tram or train?	Does this person have any problems using public transport?
Money	How do you find budgeting your money?	How does this person find budgeting their money?
Benefits	Are you getting all the money you are entitled to?	Is this person getting benefits he or she is entitled to?

PDRSS that have conducted their own evaluation of various instruments have come to differing conclusions about the value of the CAN measure. One agency that currently uses it identified a number of properties that made it an attractive option for the type of service they provide and the characteristics of their consumers. They have found it provides a structure for workers when assessing the health needs of consumers and aids the development of individual service plans. It also gives access to issues that participants may not normally be comfortable with and is a good tool for communication between PDRSS workers and other professionals. In addition, it identifies differences between worker and consumer opinion.

Other agencies rejected CAN as an option on the grounds that the tool was cumbersome to use, was problem-focused with negatively framed questions, and highlighted clinical/medical issues. They found that some questions were invasive and could only be asked when a close relationship between consumer and worker had been established thus making it irrelevant in the early stages of service provision. For agencies that provide short term programs the 12 monthly re-administration cycle was inappropriate.

Basis 32

Basis 32 is a measure of **Mental Health Status** (compare this with CANSAS which assesses **health and social needs**) that contains 32 items covering 5 domains. It is a consumer rated measure based on a five-point scale, with ratings ranging from 'no difficulty' to 'extreme difficulty'. Scores can be derived from each of the domains and for the whole scale. Although still controversial, the Basis 32 is considered by many to be a reliable way of measuring true change in the condition or situation of individual consumers. Its most common application, however, is in the measurement of a consumer population, where it has been shown to be a reliable and valid means of tracking change in population outcomes.

Basis 32 DOMAIN	Basis 32 QUESTION/ITEM
Daily living & role functioning	To what extent are you experiencing difficulty in the area of: Managing day to day life Household responsibilities Work School Leisure time or recreational activities Adjusting to major life stresses Goals or directions in life
Relation to self & others	Relationships with family members Getting along with people outside of family Isolation or feelings of loneliness Being able to feel close to others Being realistic about yourself or others Recognizing & expressing emotions appropriately Developing independence, autonomy
Depression & anxiety	Lack of self confidence—feeling bad about yourself Apathy, lack of interest in things Depression, hopelessness Suicidal feelings or behaviour Fear anxiety or panic Confusion, concentration, memory Physical symptoms Feeling satisfaction with your life
Impulsive & addictive behaviour	Uncontrollable compulsive behaviour Sexual activity or preoccupation Drinking alcoholic beverages Taking illegal drugs/misusing drugs Controlling temper, outbursts of anger, violence Impulsive, illegal or reckless behaviour
Psychosis	Disturbing or unreal thoughts or beliefs Hearing voices, seeing things Manic bizarre behaviour Mood swings, unstable moods

One agency had sought consumer evaluations of this instrument with favourable results. Other positive attributes were a written and structured interview format, the availability of guidelines and training and the provision of data and interview processes that could be used by service providers and consumers to develop individual service plans. On the other hand, another agency criticised the instrument for being illness-based, with a focus on medical treatments rather than 'whole-of-life measures'. These service providers were concerned that answering the questions would increase the level of consumer anxiety and have associations with hospital treatment.

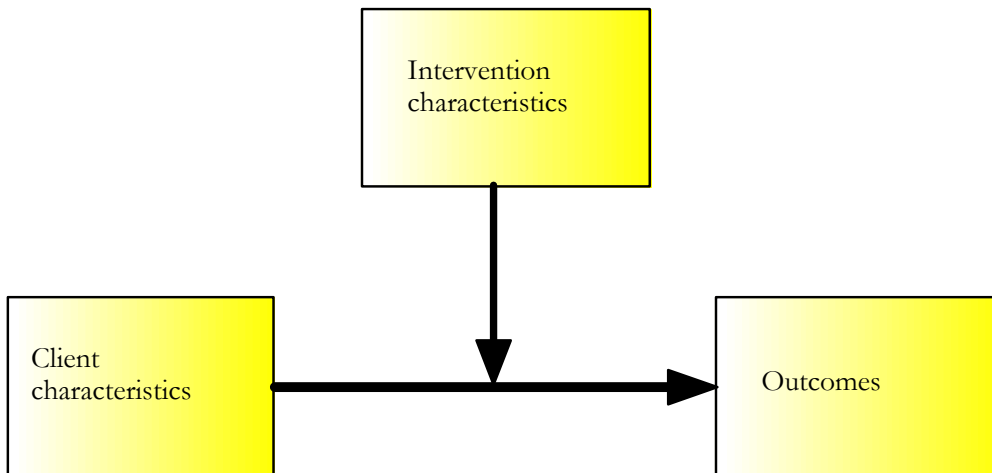
The Basis 32 is also used by a number of clinical mental health services in Victoria.

World Health Organization Quality of Life- Bref [WHOQoL (Bref)]

This instrument assesses **general health and well being or quality of life** (compare this with Basis 32 which measures **mental health status** and CANSAS which assesses **health and social needs**). It is made up 26 questions covering four domains and is rated using a five-point scale. There are also two global questions assessing overall quality of life and satisfaction with general health. The instrument has been tested locally and locally rated psychometrics are available. Detailed information about the WHOQoL and registration for it use can be found at the following web site:
<http://www.acpmh.unimelb.edu.au/whoqol/default.html>.

WHOQoL (Bref) DOMAIN	WHOQoL (Bref) QUESTIONS/ITEMS
Global	How satisfied are you with your quality of life? How satisfied are you with your health?
Physical health	To what extent do you feel that physical pain prevents you from doing what you need to do? How much do you need any medical treatment to function in your daily life? Do you have enough energy for everyday life? How well are you able to get around physically? How satisfied are you with your sleep? How satisfied are you with your ability to perform your daily living activities? How satisfied are you with your capacity for work?
Psychological health	How much do you enjoy life? To what extent do you feel your life to be meaningful? How well are you able to concentrate? Are you able to accept your bodily appearance? How satisfied are you with yourself?
Social relationships	How satisfied are you with your personal relationships? How satisfied are you with your sex life? How satisfied are you with the support you get from your friends?
Environment	How safe do you feel in your daily life? How healthy is your physical environment? Have you enough money to meet your needs? How available to you is the information you need in your daily life? To what extent do you have the opportunity for leisure activities? How satisfied are you with the condition of your living place? How satisfied are you with your access to health services? How satisfied are you with your transport? How often do you have negative feelings such as blue mood, despair, anxiety, depression?

Interpreting Consumer Outcomes Data



As shown above, outcomes are a result of the interaction between clients and interventions. In order to understand outcomes, one needs to understand the characteristics of the other elements.

The collection of data concerning client characteristics is a recommended component for an outcome measurement suite. While they are not outcome measures per se a uniform set of client characteristics should be measured so that the outcome measures can be properly interpreted. Many tools have age and sex specific benchmarks so at least these basic data need to be collected in order that the results can be correctly interpreted. In PDRSS the minimum data set (Quarterly Data Collection) is a source of such information. The MDS contains several items which, when collected over time, could be considered as measure of outcomes as they track changes in parameters such as living arrangements and income and work.

The client characteristics that should be recorded in a credible outcomes suite include a range of social and clinical characteristics. There have recently been several tools developed in the health and human services sector to provide a common approach to collection of these basic data. These include for example, the Initial Needs Identification tool developed for the community health sector and, of course, as previously mentioned the PDRSS and clinical service minimum data sets.

It must also be recognised that in order to interpret outcomes for a service one needs to understand what service was delivered. If one of the purposes behind the collection of outcomes data is to explore “what works” then we need to be able to describe the “what”. The description of the “what” must include some details of the program content and also its frequency and intensity. These descriptions enable us to relate program content to client outcomes. This is an important relationship that we need to know about for the purposes of service improvement.

Limits to the Certainty of Consumer Outcomes Data

The main objective of PDRSS is to assist consumers in their efforts to rehabilitate as is described in the psychosocial rehabilitation framework. When attempting to measure the effect that a PDRSS might have it is difficult to eliminate many of the extraneous factors that may contribute to the observations and measurements as well as the effects of the PDRSS. The major effects that can contribute to change other than the intervention (service) are:

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|------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Maturation | these are naturally occurring changes over time (e.g., ageing effects or the natural progression of an illness or problem). |
| History | these are other events in the lives of the participants that are unrelated to the intervention but that may affect outcomes (e.g., use of drugs or alcohol, enrolment in another treatment program at the same time). |
| Regression to the mean | this is a phenomenon that occurs when people with extreme (unusually high or low) scores are selected into a program. Because many of these people are likely to have measurement errors in a particular direction, when they are measured again, they are likely to spontaneously move in the other direction towards the mean. |

These effects are easily measured or even eliminated in a randomised control trial (RCT) where participants are allocated randomly to a treatment or a non-treatment group and then measured before and after the application of the intervention. However, in a service delivery context, it is ethically questionable as to whether it is appropriate to withhold treatment from a group to demonstrate that any gains observed are genuinely due to the effects of the program or intervention alone. This does mean that outcomes data are not useful for evaluating the impact of a service. It does mean that the data need to be assessed with the limitations in mind. Many of these potential confounding factors can be assessed by looking at serial measures over time and through an analysis of other data types as discussed on page 24.