

Review of the 2003–04 Victorian surveys of consumer and carer experience of public mental health services

Recommendations for future approaches



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1. Executive summary

1.1 Introduction

The statewide survey provides an important mechanism for consumer and carer feedback regarding service quality and involvement in service planning, development and evaluation. The survey will continue as part of the department's commitment to continuous quality improvement in Victoria's mental health services.

The review of the 2003–04 survey has identified a number of opportunities for improving the design and implementation of statewide consumer and carer surveys in mental health. These changes are important to ensure we continue to build on experience from implementation, as well as learn from national and international developments.

1.2 Objectives

The objectives of the survey review were to:

1. review implementation and outcomes of the recent survey encompassing feedback from key stakeholders and a literature review
2. identify and make recommendations for improving future survey approaches.

1.3 Methodology

The department monitored the 2003–04 survey via a series of observations, documentation reviews and consultations with service managers, staff, consumers and carers during and following implementation in clinical and psychiatric disability rehabilitation and support services. The department also worked with the consultants involved in survey implementation to identify strengths and issues with the survey approach.

A review of published and unpublished literature enabled further exploration of key concepts and issues and more recent developments in consumer and carer evaluation approaches nationally and internationally.

1.4 Recommendations

Specific recommendations were developed from the review and are based on effectively engaging key stakeholders and using the best available evidence to achieve the survey aims. It is critical that ownership and commitment to the survey process and outcomes are developed through the level of involvement and influence of the stakeholder groups.

Two options for a survey framework are proposed for consideration and wider consultation with the sector. The first option is consumer and carer led and the second option is service managed. However, the approaches are not mutually exclusive: both require partnerships between consumers, carers, service providers, peak bodies and the department.

Option 1: Conducted through consumer and carer organisations

This option would involve the department funding consumer and carer organisations to conduct the survey. The consumer and carer organisations would recruit, train and support a team of consumers and carers to be survey administrators, as well as project staff to coordinate activities and provide relevant expertise and support. The consumer and carer organisations would work with services and the department to plan and implement the survey, including reporting and using the survey findings for quality improvement. The organisations would need to ensure the consumers and carers involved as survey administrators are independent of the service they are evaluating at any give time to provide the necessary objectivity and methodological rigour.

Option 2: Conducted by mental health services

This option would involve strengthening the capacity of services to manage the survey. The department would need to fund services to conduct the survey locally in partnership with consumers and carers. To ensure a level of independence from the service of consumers and carers involved in implementing the survey, services would need to partner with other services or contract consumer and carer administrators through existing networks.

The benefits include opportunities for peer review and collaboration between services. Each service would report its survey findings to the department to enable the subsequent development of a statewide report for wider distribution.

Core elements of a survey framework

Irrespective of which option is chosen, it will be important to establish integrated partnership structures and processes at a statewide and local service level to enable planning and coordination of effort, as well as an ongoing dialogue for continuous improvement and evaluation of the survey approach. This includes establishing a statewide reference group and local service reference groups to actively involve consumers, carers, service providers, peak bodies and the department in the survey. In addition, statewide survey training and support will be essential to ensure a common understanding of the survey process and requirements and to further develop capacity for partnerships and change management.

The survey methodology needs to encourage the diversity of consumers and carers to participate and reflect recovery-oriented participation models to ensure choice and empowerment in the process. Therefore, it is recommended that surveys be administered by consumers and carers using interviews and focus groups, although written questionnaires asking the same questions would also be available if consumers and carers participating in the survey prefer. In addition, service providers may distribute the written questionnaires at regular intervals with the opportunity to add locally specific questions to strengthen the survey findings and outcomes.

It is recommended that the survey be conducted every six to 12 months to balance the amount of time and resources required with the benefits of providing a mechanism for regular feedback on consumer and carer experience.

2. Background

Victoria developed its first mental health consumer and carer satisfaction surveys in 1996. From 1997 to 2000, consumer and carer satisfaction with child and adolescent mental health services (CAMHS), adult mental health services (AMHS) and aged persons mental health services (APMHS) was measured and reported annually. Under the Second National Mental Health Plan (1998–2003), Victoria received funding for projects to further develop its statewide surveys.

In 2001–02, the department commissioned Taylor Nelson Sofres to redevelop the statewide consumer and carer surveys for area mental health services in collaboration with consumers, carers and service providers. The new survey of consumer and carer experience was developed through a comprehensive review of national and international practice, a series of stakeholder consultations and a pilot study.

The new survey represents a significant conceptual shift from measuring satisfaction to measuring perspectives of service quality, which better reflects the quality of care provided and is more easily interpreted and used for quality improvement purposes.

The new survey is a combination of mail-out mail-back semi-structured questionnaires, focus groups and individual interviews. The questions reflect the needs, priorities and expectations of services identified by consumers and carers. The questions are linked to the National Standards for Mental Health Services (1997) to provide meaningful benchmarks for consumers, carers and service providers. In 2003–04, TQA Research fully implemented the new survey in all public CAMHS, AMHS and APMHS in Victoria.

In 2002–03, the department commissioned the Australian Institute for Primary Care (AIPC) to further develop consumer and carer evaluation of psychiatric disability rehabilitation and support services (PDRSS). Surveys of consumer and carer experience were adapted from those developed for area mental health services in consultation with the PDRSS sector and then piloted. The AIPC subsequently implemented the surveys using mail-out mail-back semi-structured questionnaires across the PDRSS sector in 2003–04.

Victoria's approach to consumer and carer surveys is consistent with recent emerging trends locally and internationally. More specifically, there is a shift towards consumer and carer involvement, measuring consumer and carer perceptions of care, using a combination of quantitative and qualitative methodologies, and improving feedback for action.

3. Literature review

Comprehensive literature reviews were conducted to guide survey development in clinical and PDRSS sectors (Taylor Nelson Sofres 2002; Australian Institute for Primary Care 2003). Subsequently, the department reviewed additional literature to explore key concepts and issues and further developments in consumer and carer evaluation approaches.

Published and unpublished literature was searched for articles, texts and reports of consumer and carer participation, measures of service user satisfaction or experience, and the concept of recovery, particularly in mental health. Relevant literature is considered in this section.

3.1 Consumer and carer participation

Enhancing the involvement of consumers and carers at all levels of service delivery has been a priority of national and state government policies for more than a decade (Australian Health Ministers 1992 and 2003; Department of Health and Community Services 1994; Department of Human Services 2002). There is increasing evidence of improved health outcomes and quality of health care from consumer and carer participation (Consumer Focus Collaboration 2001b; Department of Human Services 2005). There is also an ethical dimension to consumer and carer participation in service delivery, which upholds individual democratic rights, community responsibility, social justice and accountability, as reflected in the Mental Health Statement of Rights and Responsibilities (1991) and the National Standards for Mental Health Services (1997).

Consumers and carers have direct experience of services, including what works well and how services could be improved to better meet their needs. The Victorian Strategy for Safety and Quality in Public Mental Health Services (2004) establishes a consumer and carer focus in mental health services as a key requirement for service quality. Professional standards, expertise and perspectives inform quality improvement and evaluation. However, to fully understand the impact and outcomes of service delivery, consumers and carers need to be involved in making decisions about their care as well as the

way services are provided. Thus, consumer and carer participation is viewed as a mechanism for continuous service and system improvement and innovation.

Effective models of consumer and carer participation in services need to reflect the needs and preferences of consumers and carers to facilitate active involvement at all levels of service delivery. In Victoria, the Alfred Psychiatry Consumer Participation Program (2001) found consumers of its inpatient and community-based services preferred verbal to written processes for participation. In South Australia, Johnson and Bament (2002) found consumers of a hospital preferred feedback activities rather than more active participation in focus groups, public forums, working groups or committees. Participation models need to include structures and processes that enable various levels and methods of participation in a systematic way, in order to capture the diversity of needs and preferences among consumers and carers. However, it is important that the variation between and within groups is also recognised. Stereotyped approaches to participation can marginalise consumer and carer groups.

Many factors influence the diversity of needs and preferences of consumers and carers for participation. These include health condition, age, gender, sexuality, religion, culture, education, ability, literacy and socioeconomic status (National Resource Centre for Consumer Participation 2000). More practical considerations include availability, time, child care, respite, expense, mobility and transport. Consumer and carer feedback through surveys, as one form of participation in service delivery, need to be inclusive of these factors as far as possible. It follows that feedback mechanisms that reflect and involve the diversity of consumers and carers can enhance participation. There are direct implications for survey response rates and the representativeness of survey samples. For example, survey questions, scales and tools need to be accessible, meaningful and understandable to consumers and carers to encourage their participation. Multiple strategies for providing feedback need to be available to support

the participation of diverse consumers and carers. Also, while it may be the case that some consumers and carers are not able to participate all the time, most consumers are able to give valuable feedback about services at any given point in time (National Resource Centre for Consumer Participation 2000).

Statewide and local survey approaches need to be sufficiently flexible to embrace consumer and carer diversity. For example, for older people, it is not only a question of their willingness and availability to participate, but also their ability as a result of problems associated with the ageing process and recovery from illness. Atwal and Caldwell (2005) highlight difficulties in obtaining the views of older people through surveys. Constraints include visual and hearing impairment, poor motor coordination, cognitive deficits and reduced mobility. Also, older people consistently provide more positive feedback about services compared with younger people, and are reluctant to criticise interpersonal aspects of a service. This trend is attributed to their unwillingness to express dissatisfaction for fear of losing services or generational values of not wanting to seem ungrateful or impolite. Atwal and Caldwell caution against excluding older people, including those with dementia, from being involved in surveys. They recommend a mixed approach, combining quantitative and qualitative methods, and the involvement of users in the design and implementation of the surveys, to address the issues identified for this target group.

Similarly, obtaining the views of younger people in surveys poses some specific issues. Participation depends on their capacity to provide valid consent and in most cases the consent of a parent or guardian (Taylor Nelson Sofres 2002). Consideration needs to be given to developmental level, social-emotional wellbeing and capacity to participate. The Australian Infant, Child, Adolescent and Family Mental Health Association (AICAFMHA) is currently consulting on the development of a national youth participation strategy (2005).

AICAFMHA is proposing three models for youth participation in order to provide a variety of mechanisms and levels of involvement:

- **model 1:** seeking information from young people about their views, ideas and experience through consultation
- **model 2:** young people collaborate with others through influence and delegation
- **model 3:** young people are involved in defining the issues and negotiating outcomes.

AICAFMHA highlights the importance of participation activities being fun and engaging as well as matched to interests, skills and resources.

Consumers and carers from culturally and linguistically diverse backgrounds are typically under-represented in surveys. This can be variably explained by cultural issues resulting in an unwillingness to participate, lack of access to bilingual interpreters or translated questionnaires, and lack of access to information and services (National Resource Centre for Consumer Participation in Health 2000).

Taylor Nelson Sofres (2002) and the AIPC (2003) highlighted that translation of the questionnaires still presents validity issues in terms of its cultural appropriateness and the influence of cultural values and norms on responses. In addition, the population size for identifying statistically significant trends is not available. Both Taylor Nelson Sofres and the AIPC recommended that the most appropriate means of obtaining feedback from consumers and carers from culturally and linguistically diverse backgrounds is to use bi-lingual interpreter-facilitated telephone or face-to-face interviews based on the issues underpinning the questionnaire. Taylor Nelson Sofres also suggested alternative sampling methods through cultural networks and groups, as well as providing the opportunity for self-completion via translated questionnaires.

3.2 Dimensions of service user experience

There are similarities between the dimensions of care measured in surveys of consumer and carer experience. The Picker Institute has undertaken extensive research in this area (Picker Institute 2000) and identified the following dimensions of care that impact on most service users' experiences:

- respecting patients' values, preferences and expressed needs
- communication and information
- access to care
- emotional support
- involvement of family and friends
- continuity and transitions
- physical comfort
- coordinated care.

The Picker Institute's dimensions of care are reflected in definitions of service quality from the perspective of service users (Sofaer & Firminger 2005). Other surveys in health and mental health (Pennebaker et al. 2000; Agency for Healthcare Research and Quality 2003; Henderson et al. 2004) are consistent with these dimensions, including the Victorian mental health consumer and carer surveys.

3.3 International surveys

3.3.1 United States

In the United States, the Consumer Assessment of Health Plans (CAHPS) is widely used to measure consumer experience of health care (Agency for Healthcare Research and Quality 2003). CAHPS comprises a kit of standardised questionnaires and reporting tools, supported by a survey users' network and benchmarking database. It aims to provide reliable and valid information to help consumers and purchasers assess and choose health plans. The core questionnaires can be supplemented with questions specific to particular groups (including mental health care) or areas of practice.

The Mental Health Statistics Improvement Program (MHSIP) consumer survey is also widely used in the United States (MHSIP Policy Group 2000). The survey tools include an inpatient and community adult questionnaire and youth (aged 13 and over) questionnaire, which were all developed with consumer input. Items are grouped into the domains of access, appropriateness, outcome and satisfaction. Methods of administration include direct mail, face-to-face interviews and telephone. Trained consumers and treatment and support staff administer surveys at varying intervals, including at time of treatment plan review, discharge, and one year post-discharge. They found consumer administration can achieve higher response rates and more open feedback compared with service provider administration, which can bias sample selection and favourability of responses. The survey is designed to be part of a continuous quality improvement process by incorporating data into a 'report card' for the service. In this way, the survey feedback is regularly reported back to services through performance monitoring systems, as well as state and service level survey reports.

3.3.2 United Kingdom

The National Health Service (NHS) in the United Kingdom conducted its first survey of mental health service users in 2004 (Osborn et al. 2003; Healthcare Commission 2004). The NHS survey advice centre at the Picker Institute Europe designed, developed and coordinated the survey. The dimensions of consumer experience measured in the NHS survey include:

- access to services
- relationships with health professionals
- coordinated care
- information and choice
- service environment.

Eighty-one mental health trusts and primary care trusts participated in the survey. The survey involved a random sample of consumers aged 16–64 years using mental health services on an ongoing basis. Services conducted the survey in-house or engaged with a contractor directly, and managed the survey locally via a working group comprising staff, consumers and carers.

The methodology involved a mail-out mail-back semi-structured questionnaire, with up to two reminders sent to non-responders. The overall response rate was 42 per cent (range from 32 per cent to 54 per cent), although it was the lowest response rate compared with acute health, youth, primary care and ambulance services.

An evaluation of the NHS patient survey highlighted several issues (Surrey Social and Market Research 2004). For response rates, key issues included:

- correct address details
- length of time allowed for completion/return (many received after closing date)
- length of questionnaire
- nature of respondents (postal survey seen as least appropriate for mental health)
- literacy skills
- ethnicity
- survey overload/fatigue.

Increasing the sample size was suggested as a way of improving the representativeness and size of the sample.

The use of core and locally relevant optional questions in the NHS patient survey presented some issues, including:

- cost to services of doing so
- identifying and prioritising local issues at the time of the survey
- maintaining continuity in data collections
- length of the existing survey.

Timing was also a challenge, with no ‘ideal’ time to run the survey and high demands on services. It was suggested to increase time for pre-survey preparation, sampling, mailing out of questionnaires and reminders, and return of data.

Also in the United Kingdom, the Sainsbury Centre for Mental Health developed a user-focused monitoring program in which mental health service users are trained and supported to actively participate in service evaluation (Sainsbury Centre for Mental Health 2005). Consumers with a serious mental illness developed and implemented the program and a number of services in the United Kingdom have used it.

3.4 National surveys

3.4.1 Victoria

In Victoria, consumer and carer satisfaction with CAMHS, AMHS and APMHS was measured and reported annually from 1997 to 2000. Subsequently, the department engaged Taylor Nelson Sofres (2002) and the AIPC (2003) to further develop the surveys in clinical services and PDRSS respectively.

Literature reviews detailed in the consultancy reports highlighted a number of limitations with satisfaction surveys, including the following conceptual and methodological issues:

- a lack of consensus on the definition of satisfaction in health, although it is well recognised as a multidimensional, unstable and relative concept
- detachment between satisfaction and experience, making it more open to interpretation and variability. Thus, satisfaction may or may not be related to whether the service experience actually met the person’s perceived needs
- the consistently high levels of reported satisfaction in surveys but lower levels of satisfaction when using semi-structured interviews with the same consumers

- the use of global ratings of satisfaction positively skewing results and limiting utility for service planning and improvement
- lower levels of satisfaction being reported when surveys are administered by consumers compared with service providers
- measures often not being developed with or by consumers and carers and therefore not necessarily reflecting their needs, priorities and expectations of services.

What resulted was a significant conceptual shift from measures of satisfaction to measures of perspectives of service quality from experience, which appears to be an increasing trend internationally and nationally. The questions were also linked to the National Standards for Mental Health Services (1997) to provide meaningful benchmarks for consumers, carers and service providers. Consumer and carer perceptions of care are influenced by their expectations and values, and therefore their understanding of and identification with service standards and pathways of care.

The current Victorian surveys of consumer and carer experience are tailored to CAMHS, AMHS and APMHS, and PDRSS.

3.4.2 New South Wales

In New South Wales, a partnership between the state's Centre for Mental Health and the Consumer Advisory Group is undertaking a project known as MH-CoPES. The project aims to develop a statewide process and tools for measuring consumer perceptions of mental health services (MH-CoPES 2005). The project commenced in January 2004 and is expected to make recommendations in 2005, with a 12-month pilot phase to follow.

MH-CoPES adopts a recovery orientation to consumer evaluation in that it is consumer-directed. Central to recovery is consumer hope, self-determination, empowerment and choice in life (O'Hagan 2004; Ellis & King 2003; Allot 2002; Davidson et al. 2001; Ralph et al. 1999). The measure of recovery-oriented

practices is in the amount of power and control service providers give or take from individuals (Brown 2001; Andresen et al. 2003; Davidson 2005). Thus, the role of service providers in recovery can be viewed as that of a companion or partner rather than an expert.

The service delivery domains for measurement identified in the MH-CoPES project are consistent with those in the current Victorian surveys as outlined in Table 1.

Table 1: Domains of measurement

MH-CoPES
Availability of services
Access to services
Getting information
Treatment and assistance
Staff
Participation
Victorian survey
Information about rights and responsibilities
Access to and responsiveness of staff and services (including availability)
Information about and provision of treatment and support (including participation)

3.4.3 Other states and territories

Within the literature, there are examples of mental health consumer and carer surveys in other states. In Queensland, there was a study of carers of people with a mental illness to determine their experience of service quality (Hodgson et al. 2002) and in Western Australia, Pennebaker et al. (2000) developed a questionnaire with consumers to measure their service experience. However, these surveys are not part of a statewide program.

At this stage, only Victoria has a statewide process for measuring consumer and carer experience of mental health services. New South Wales has made significant progress in this area more recently. The feasibility and benefits of greater national consistency in consumer and carer evaluation approaches are yet to be explored.

3.5 Consumer and carer involvement in survey development and implementation

The review of international and national measures of consumer and carer perceptions of care demonstrates an increasing involvement of consumers and carers in their development and implementation. In particular, the MHSIP, Sainsbury Centre for Mental Health and MH-CoPES surveys actively involve consumers and carers throughout survey planning, development and implementation.

Victoria involved consumers and carers, as well as service providers, in its recent survey redevelopment through networks, focus groups, interviews and pilot studies. Involving consumers and carers in survey development ensures questions reflect their needs, expectations and priorities for service and they are asked in a way that encourages their participation. Consumer and carer participation in the development of measures also guides other methodological considerations, including sampling and recruitment, administration and response rates (Taylor Nelson Sofres 2002; Australian Institute for Primary Care 2003; Pennebaker et al. 2000).

Victorian consumer and carer peak bodies and networks, as well as consumer and carer consultants employed by mental health services, were involved in facilitating the recent survey implementation through survey promotion, direct recruitment and handing out of surveys. However, consumers and carers were not involved in survey administration.

Consumer and carer involvement in the implementation of surveys may influence the type and number of responses. Lower levels of satisfaction are reported when surveys are administered by consumers and higher levels of satisfaction are reported when surveys are administered by service providers (Gill et al. 1998). However, the level of power the service user or service provider administrator has in the service mediates this effect. Thus, administrator bias is lessened by reducing the ‘professional distance’ or balancing the power between service users and service providers. Service user administrators can be effective (Ford 1997) and may be preferred by consumers (for example, MHSIP, Sainsbury Centre for Mental Health and MH-CoPES).

Clark et al. (1999) reported greater feelings of safety, trust, confidentiality and privacy when service users interviewed other service users about their satisfaction with mental health services. Consumer and carer involvement in survey implementation therefore needs to be considered in terms of the preferences of target groups, administrator bias and impact on response rates.

The Consumer Focus Collaboration (2000), United Kingdom NHS (2004) and the MH-CoPES project (2005) describe common barriers to consumer and carer participation. These include consumer, service and system barriers as outlined in Table 2. It is important that resistance is embraced and conflict managed by acknowledging its existence, identifying its strengths and weaknesses, and problem solving or negotiating responses (Service Quality Australia 1999; National Resource Centre for Consumer Participation in Health 2000; Mental Health Council of Australia 2000). In this way, the barriers to consumer and carer participation also represent opportunities for development and learning from experience.

Table 2: Barriers to consumer and carer participation in surveys

Consumer and carer barriers
Fear of discrimination or that services will be withdrawn or defunded if they provide negative feedback
Lack of interest in participation because of values, deferential attitudes or passivity
Lack of access to services and opportunities for participation
Level of choice, ability and support for participation
Level of burden of participation
Relevance of issues being considered to consumers and carers
Privacy and confidentiality issues
Service and system barriers
Insufficient value and priority given to consumer and carer perspectives
Limited understanding and ability to develop effective partnerships
Models of care in services do not sufficiently focus on recovery
Limited integration of quality management in everyday practice
Lack of skills and resources for evaluation and change management
Differing views within and between services about what information is required and useful in practice
Professional value attributed to quantitative and qualitative information
Management commitment, leadership and support for participation and change

Consumer and carer participation in surveys can be developed through a range of strategies. The following strategies for effective participation are taken from guidelines developed by the Consumer Focus Collaboration (2000) and research evidence reported by the United Kingdom National Health Service (2004):

- Commitment to participation is openly communicated by management and promoted through leadership and accountability at all levels.
- Organisational structures and policies facilitate participation and change, including processes for incorporating lessons learnt into daily practice or future planning.
- Staff should be provided with training and information on how to facilitate participation and evaluate its outcomes.
- Consumers and carers should be provided with training and support to enable their participation, including adequate resources and time.
- Consumers and carers should be engaged early in the process, including when developing the processes and defining issues for consideration.
- Multiple strategies are essential to respond to the varying needs and preferences of consumers and carers, as well as the variation and complexity of issues to be addressed by organisations.
- Information sharing encourages participation if it is understandable and timely, and followed up by information about the results of participation.
- It is important that consultations and meetings are inclusive and that consumers and carers understand the language and systems used by the organisation in which they are participating.
- Relationships based on respect, dialogue and trust are critical to participation.

The strategies for effective consumer and carer participation provide opportunities for Victoria to consider expanding consumer and carer participation throughout survey planning, development and implementation.

3.6 Reporting and action

Reporting and acting on survey findings is a vital part of survey implementation. To create effective change, service providers need to act with consumers and carers in service evaluation and improvement (Draper 1997).

The public release of survey findings and reporting to services, consumers and carers is critical to enhancing participation, improving public accountability, and promoting improvement. A Consumer Focus Collaboration review of existing models of reporting to consumers on health service quality found the most effective reporting systems are integrated into existing quality improvement programs (2001a). In this way, reporting is not an end in itself, but rather a mechanism for ongoing dialogue with consumers and carers and further opportunities for their involvement and service improvement.

Key factors in determining the impact of reporting systems on service providers include acceptability, understanding, timely access and ability to use the information. The impact of reporting systems on consumers and carers is influenced by their capacity to make choices about services, individual values and preferences for information about services, appropriate and timely access to information, and ability to understand the information (Consumer Focus Collaboration 2001a).

Reporting is one method of demonstrating how consumer and carer input has been interpreted and used to improve services. Survey findings need to be disseminated widely to ensure feedback to those who participated, as well as other consumers, carers and the wider community. In this way, participation is encouraged among those who are involved, as well as those who are yet to be involved but may wish to be. Involving staff, consumers and carers in reporting promotes responsibility and commitment to tackling the issues identified in the survey. Involving management in reporting activities reinforces the value and impact of the communication for consumers and carers (Mental Health Council of Australia 2000). Boards and executive members also need to be informed about the outcomes of

the survey, and involved in prioritising areas for improvement and shaping action plans to support change (Victorian Quality Council 2003).

The Picker Institute in Europe (2003) recommends a planned and coordinated approach to reporting, which involves all relevant groups in sharing information and planning change. Stakeholder committees or steering groups established to coordinate survey planning and implementation locally need to be involved in developing a dissemination strategy and action plan, as well as providing regular progress reports on responses and outcomes. However, those with lead responsibility need to have sufficient structures and processes in place to engage management, staff, consumers and carers throughout the organisation and in the wider community.

It is important that multiple and targeted communication methods are used to engage service providers, consumers and carers. Survey findings may be communicated effectively through forums, networks, groups, websites, email, posters, brochures, newsletters, radio and press (Picker Institute Europe 2003). For example, using bright, colourful posters to display information in picture and text format about the surveys findings and how they have been used is likely to capture the attention, interest and involvement of staff, consumers and carers. High profile events or forums can be used to make the information public, to promote understanding and to engage people in change management. It may be useful to segment target groups and tailor messages for staff with different roles in the organisation, for consumers and carers of different ages or cultural and linguistic backgrounds, and so on (Agency for Healthcare Research and Quality 2003). Focusing on a few key messages arising from the survey results, using graphs or tables to present data, and illustrating themes with verbatim comments can also promote understanding.

4. Implementation review

The department has worked to continuously improve its approach to consumer and carer surveys. It has dedicated considerable resources to the continued development, implementation and evaluation of approaches to measure consumer and carer experience of public mental health services in Victoria.

The following information has been gathered from observations, documentation and consultations with service managers, staff, consumers and carers during and following implementation of the new survey. The department also worked with the consultants during implementation of the survey to identify strengths and issues with the survey approach. Further details of consultations are included in Section 5 of this report.

4.1 Survey aims

An important aspect of providing services that meet the needs of consumers and carers is to ask them about their perspectives of the treatment and care they received. The aims of the 2003–04 statewide consumer and carer surveys were to:

1. provide an understanding of consumer and carer perspectives of service quality from their experience
2. encourage reflection on current practice, including the identification of strengths, weaknesses and priorities for improvement
3. provide information that assists services in planning for continuous improvement with consumers, carers and other stakeholders
4. facilitate sharing of information and collaboration between services for best practice development.

A service user focus is critical to service quality and dependent on systematic, appropriate and effective mechanisms for seeking and responding to consumer and carer perspectives of service delivery.

4.2 Survey tools

For each of CAMHS, AMHS and APMHS, there were individual consumer and carer surveys totalling six questionnaires for all target groups (see Appendix 1). The questions related to various aspects of service delivery from point of entry to the service to exit, which were grouped into the following domains:

- information about rights and responsibilities
- accessibility and responsiveness
- information about treatment and support
- provision of treatment and support.

The CAMHS questionnaire combined questions for the two domains of ‘information about treatment and support’ and ‘provision of treatment and support’ to simplify the format of the questionnaire for a younger age group.

For PDRSS, there were individual surveys for consumers, carer service users and carers, totalling three questionnaires for all target groups (see Appendix 2). The questions related to various aspects of service delivery and were grouped into domains as follows:

- Consumer questionnaire
 - information provision, service delivery, assistance with daily living
- Carer service user questionnaire
 - information provision, service delivery
- Carer questionnaire
 - information about services, service accessibility, information provision, service participation.

4.3 Survey samples

4.3.1 CAMHS

The consumer sample was aged 13 to 18 years and had used a CAMHS during 2003. It included consumers who had since been discharged from the service. Consumers who were admitted to an acute inpatient service at the time of the survey were excluded, although those with prior admissions were included to ensure feedback from this group of service users.

The carer sample comprised people who provided support or care to someone aged 18 years or younger who had used a CAMHS in 2003. This included family members, next of kin, friends and neighbours, but not carers employed by the service.

Passive parental or guardian consent was required for consumers aged 13–18 years to take part in the survey. The exception was for those consumers who were using the service without a parent or guardian's knowledge.

Survey questionnaires were distributed to a random sample of consumers and carers at all 13 CAMHS (five metropolitan and eight rural). Target sample sizes for each service were 300 consumers and 200 carers. Sampling protocols for recruitment of consumers and carers to focus groups and individual interviews were established with the eight CAMHS (four metropolitan and four rural) involved.

4.3.2 AMHS

The consumer sample was aged between 18 and 64 years and had used an AMHS during 2003. It included consumers who had since been discharged from the service. Consumers who were admitted to an acute inpatient service at the time of the survey were excluded, although those with prior admissions were included to ensure feedback from this group of service users.

The carer sample comprised people who provided support or care to someone aged 18 to 64 years who had used an AMHS. This included family members, next of kin, friends and neighbours, but not carers employed by the service.

Survey questionnaires were distributed to a random sample of consumers and carers at all 21 AMHS (13 metropolitan and eight rural). Target sample sizes for each service were 300 consumers and 200 carers. Sampling protocols for recruitment of consumers and carers to focus groups and individual interviews were established with the seven AMHS (three metropolitan and four rural) involved.

4.3.3 APMHS

The consumer sample was 65 years of age or older and had used an APMHS during 2003. It included consumers who had since been discharged from the service. Consumers who were admitted to an acute inpatient service at the time of the survey were excluded, although those with prior admissions were included to ensure feedback from this group of service users.

The carer sample comprised people who provided support or care to someone aged 65 years or older who had used an APMHS. This included family members, next of kin, friends and neighbours, but not carers employed by the service.

Survey questionnaires were distributed to a random sample of consumers and carers at all 17 APMHS (nine metropolitan and eight rural). Target sample sizes at each service were 300 consumers and 200 carers. Sampling protocols for recruitment of consumers and carers to focus groups and individual interviews were established with the seven APMHS (three metropolitan and four rural) involved.

4.3.4 PDRSS

All services receiving PDRSS funding (excluding services specifically for Koori groups) were expected to participate in the survey process. Mutual support and self-help services' participation was optional.

All service users from participating PDRSS were eligible to be involved in the survey. The majority of PDRSS service users are adult, although some services are provided to younger and older people.

People with a mental illness who use PDRSS completed the consumer questionnaire. People who care for someone with a mental illness and use PDRSS for carer support completed the carer service user questionnaire. People who care for someone with a mental illness completed the carer questionnaire.

4.4 Implementation

4.4.1 Area mental health services

Survey planning

Service engagement and identification of a contact person in each service

A TQA consultant was allocated to each service for planning, support with implementation and ongoing advice during the survey. The continuity in consultants was generally maintained within the survey period. Some services reported they would like to see greater continuity in consultants between survey periods, however this depends on the department's tendering process.

Due to budgetary constraints, TQA was contracted to make face-to-face contact with 24 services and telephone contact with 27 services. The consultants reported limited engagement with those services they contacted by telephone compared with those with whom they made face-to-face contact.

For each service, TQA initially made contact with the service manager, then a nominated staff member who was responsible for coordinating the survey locally. However, the consultants still experienced delays as a result of changes in service contacts or the contacts' availability.

Commitment to the survey at a management level did not always filter down to staff who were allocated tasks in the survey. In other cases, management delegated survey tasks with no further involvement or monitoring of progress.

Where consumer and carer consultants, as well as service managers, team leaders and case managers, were actively involved in survey planning, the response rates were higher. Greatest benefit was observed where stakeholders came together as a working group to coordinate and facilitate the survey locally.

Scheduling and allocation of survey activities

The consultants developed an agreed implementation plan with each service outlining:

- sampling protocols
- timing and process for distributing questionnaires and for any qualitative work
- management of issues and onsite support.

The statewide surveys have been conducted annually and, more recently, bi-annually. As a consequence, they are viewed as somewhat 'disconnected' from the culture and routine practice of services. Services reported there was insufficient time for planning (six weeks) and implementation (six weeks) in the recent survey, which limited engagement in the process and added to the burden on all involved.

Communication and promotion of the survey to service providers, consumers, carers, peak groups and the wider community

Prior to commencement of the survey, TQA met individually with the following relevant peak bodies and services to share ideas and strategies for engaging the diverse groups of consumers and carers:

- Psychiatric disability services of Victoria (VICSERV)
- Association of Relatives and Friends of the Mentally Ill (ARAFEMI)
- Victorian Transcultural Psychiatry Unit (VTPU)
- Victorian Aboriginal Health Service (VAHS)
- Action on Disability in Ethnic Communities (ADEC)
- Victorian Mental Illness Awareness Council (VMIAC)
- Victorian Aboriginal Community Controlled Health Organisation (VACCHO).

Several of these organisations assisted in promoting the survey by placing advertisements in newsletters and distributing posters and brochures to members and local consumer and carer support groups.

TQA consultants also distributed information and promotional material (including flyers, pamphlets and posters) to mental health services, community health centres and general practice clinics. Within mental health services, staff, including consumer and carer consultants where available, displayed and disseminated the promotional material.

To widen opportunities for participation, TQA placed advertisements in the major and local press and operated a freecall service during the survey.

Sampling consumers and carers, including those from culturally and linguistically diverse backgrounds

TQA provided sampling protocols and advice to services to facilitate a consistent approach among services. However, services were still required to select consumer and carer samples from their databases to maintain individual privacy and confidentiality during the survey.

Generating a sample took services up to four weeks for any one or more of the following reasons:

- Extracting the sample from the Redevelopment of Acute and Psychiatric Information Directions (RAPID) system often requires the technical expertise of health information managers or information technology staff.
- Data validity needed cross-checking by case managers for details that had not been updated (for example, deaths, change of address, and so on) or to identify primary carers. Some services advised it was common to use the carer field in RAPID to list emergency contacts and next of kin, rather than carers involved in the consumer's treatment.
- Random sampling is not always possible where the number of registered clients is less than the target sample size, particularly in smaller rural services. In such cases, all eligible clients were selected.

Some APMHS raised concerns about including people with dementia. This had been considered during the survey redevelopment, with consumers and carers arguing strongly against excluding these people from the survey. It was agreed with services that those who have dementia can have lucid periods and are affected to varying degrees. The literature did not support the exclusion of this group, although cognitive deficits were viewed as limiting an individual's capacity to participate. It was subsequently decided that if people with dementia were unable to or did not choose to complete the survey then they or their carers would make this decision at the time. The underlying principle was that, wherever possible, consumers and carers would be given an opportunity to participate in the survey.

Printing of required number of letters and survey packs for mail-outs

Services were asked to use the supplied letter templates for mailing out an introductory and reminder letter to consumers and carers. During the survey redevelopment, consumers and carers advised that this created a link between the survey and the service, as well as reinforced the service's commitment to seeking and acting on their feedback.

TQA provided services with the required number of survey packs containing a cover letter, information sheet, questionnaire and reply paid envelope. Barcodes were printed on questionnaires to enable data tracking to individual services. Unfortunately, a printing error occurred for some batches of questionnaires, which created delays in delivering survey packs to several services.

Services were required to meet the postage costs of all mail-outs except for the survey returns from consumers and carers, which were reply paid directly to the consultants. In some cases, services found the postage costs burdensome.

Survey implementation

Survey recruitment

Where recruitment occurred using multiple methods the response rates were greater. However, the impact on survey bias is unclear. Recruitment methods included:

- a mail-out mail-back process
- direct recruitment via case managers (or surveyors visiting with case managers if prior consent obtained)
- displaying survey posters and pamphlets in reception or waiting areas at service locations
- making contact at consumer and carer groups, which were on- or off-site
- a toll free information line, which the consultants managed.

Although TQA provided surveys translated into several languages, these were not always specific to the target group for all services. In addition, the bi-lingual interpreters available through the free-call service were not fully used.

Improved planning with services is required to ensure recruitment is targeted to the needs of people from culturally and linguistically diverse groups. This includes supporting services to use registration information on RAPID to profile their target population and engage local networks of people from culturally and linguistically diverse backgrounds. Services used these strategies variably, depending on availability of the information, time for planning and engagement, local partnerships with culturally and linguistically diverse networks, and resources.

Qualitative methods

Area mental health services were invited to participate in the qualitative component of the survey, which involved focus groups and individual interviews with consumers and carers. A cross-section of services participated in this component of the survey, although almost all services expressed an interest (Table 3).

Table 3: Services participating in the qualitative component of the survey

CAMHS	AMHS	APMHS
Orygen Youth Health	Orygen Youth Health	Central and outer east
Eastern	Inner urban east	Inner urban east
South east	Middle south	Middle south
North east	Northern	Northern
Gippsland	Gippsland	Gippsland
Grampians	Grampians	Grampians
Glenelg	Glenelg	Glenelg
Loddon Mallee	Loddon Mallee	
Total	Total	Total
46 consumers and 28 carers	77 consumers and 16 carers	54 consumers and 20 carers

The qualitative methods provided alternative opportunities for consumer and carer participation, as well as descriptive information to help interpret quantitative findings. TQA piloted the qualitative methods prior to establishing implementation protocols with each service participating in this component of the survey.

The consultants conducted the focus groups and interviews, but were reliant on services to provide an appropriate venue, undertake recruitment, and support participation on the day. Where services regularly used such methods within their local consumer and carer participation models the coordination effort was not viewed as problematic. However, the additional effort in coordinating the qualitative methods proved to be difficult for some services that struggled with scheduling and response rates.

Services that had high refusal and drop out rates identified these issues:

- recruitment being more effective by telephone than in writing
- staff availability and reluctance to actively recruit to the survey
- venue availability and suitability for the survey
- transport to and from focus groups, particularly for older people and those living in rural communities.

Quantitative methods

The primary source of data collection was the mail-out mail-back semi-structured questionnaires. All CAMHS, AMHS and APMHS distributed the questionnaires between August and October 2003 (Table 4).

Table 4: Area mental health services participating in the survey

	CAMHS	AMHS	APMHS
Metropolitan-based services	5	13	9
Rural/regional-based services	8	8	8
Total number of services	13	21	17

TQA monitored response rates during the survey period. They found response rates varied considerably between services. While some services generated more than the expected number of survey returns, 19 services across the state (seven CAMHS, three AMHS and nine APMHS) did not generate the minimum number of consumer or carer survey returns for a service level report (n = 20).

The variation in response rates appeared to be related to planning and implementation issues, including any one or more of the following:

- lack of ownership, commitment and involvement of managers, staff, consumers and carers during the survey
- distribution of significantly fewer than required questionnaires as a result of:
 - confusion about eligibility criteria
 - a limited number of eligible consumers and carers, particularly in rural services
- limited resources:
 - services were required to do mail-outs to protect the privacy and confidentiality of consumers and carers, and reinforce the link between the survey and service
 - although the department had met the majority of costs for the survey, some services still viewed the postage costs for mail-outs as burdensome
 - some services had limited access to health information and technical support
 - the survey represented as significant burden on administrative staff
- mail-outs:
 - some services mailed out the introduction letter with the questionnaire, and consequently did not ‘prepare’ the target group
 - some services did not use the one-reminder system
 - when services did send reminder letters, they often arrived just prior to or after the closing date
 - at least 2,000 surveys were incorrectly labelled or not labelled at all, and other surveys were sent without a postage stamp
- limited time for survey planning and implementation, which was exacerbated by:
 - delays in TQA and services making contact or establishing implementation plans
 - delays in extracting or verifying RAPID data, particularly where there was no local process for systematically updating or monitoring accuracy of data
 - delays in TQA getting survey packs to some services following a printing error
 - the survey materials not reflecting revised dates in cases where extensions were granted
- questionnaires were formal in appearance, lengthy and difficult to read because of font size, spacing and language
- consumers of APMHS required most assistance to complete the questionnaire (55 per cent), followed by CAMHS consumers (40 per cent) and AMHS consumers (20 per cent)

- the passive consent process used in CAMHS requires a greater amount of time between mailing out of the letter/consent form and mailing out the survey pack
- recruitment to the survey in APMHS is more effective if information is communicated verbally as well as in writing, and availability of assistance is promoted and readily accessible

From November 2003 to March 2004, a booster survey was undertaken with the 19 services that had not generated the minimum response rate of 20 in the initial survey. The department participated in joint meetings with services and the consultants, and provided advice and support to services during the booster. Strategies for boosting response rates were negotiated with each service to ensure a tailored and targeted approach and greater local ownership of the outcomes.

Response rates

CAMHS

In 2003–04, there were 9,450 consumers and 8,381 carers recorded on RAPID for CAMHS.

Overall, there were 728 respondents to the survey, which included 313 consumers and 413 carers, with a response rate of 15.7 per cent. The response rates for consumers ranged from 7.2 per cent to 29.9 per cent across services, with an average of 14.5 per cent. The response rates for carers ranged from 10.0 per cent to 30.4 per cent across services, with an average of 19.4 per cent.

Although the response rates are low, the achieved sample is generally representative of the target population for age, gender, geographic location, preferred language and use of services.

AMHS

In 2003–04, there were 38,643 consumers and 2,032 carers recorded on RAPID for AMHS.

Overall, there were 1,586 respondents to the survey, which included 908 consumers and 678 carers, with a response rate of 15.1 per cent. The response rates for consumers ranged from 7.3 per cent to 26.0 per cent across services, with an average of 14.2 per cent. The carer response rate ranged from 9.8 per cent to 26.5 per cent, with an average of 15.8 per cent.

Although the response rates are low, the achieved sample is generally representative of the target population for age, gender, geographic location, preferred language, involuntary status and use of services.

APMHS

In 2003–04, there were 8,772 consumers and 2,842 carers recorded on RAPID for APMHS.

Overall, there were 921 respondents to the survey, which included 461 consumers and 460 carers, with a response rate of 13.1 per cent. The response rate for consumers ranged from 7.5 per cent to 33.8 per cent across services, with an average of 13.0 per cent. The response rate for carers ranged from 8.8 per cent to 26.0 per cent across services, with an average of 16.2 per cent.

Although the response rates are low, the achieved sample is generally representative of the target population for age, gender, geographic location, preferred language, involuntary status and use of services.

Reporting and use of information

The survey findings are reported at statewide and individual service levels. The statewide reports are provided by program type (that is, CAMHS, AMHS and APMHS) and made available on the department's web site (www.health.vic.gov.au/mentalhealth/quality) together with summaries. Each service received a report of their survey findings and a copy of the statewide reports. Services are identified in all of the reports and listed in alphabetical order in order to promote sharing of information and collaboration between services for continuous quality improvement.

The reports aim to provide a better understanding of consumer and carer perspectives of service quality by identifying strengths and areas for improvement across key indicators of service delivery. Services are expected to use this information, together with other sources of performance information, to reflect on current practice and plan for further improvement. The department further explored this with service providers, consumers and carers at a statewide forum in February 2005 and through existing networks and groups.

Some identified strengths of the reports include the use of tables and graphs to help interpret data, analysis of respondent and service characteristics, and automation of reports to theoretically improve timeliness of reporting. However, the reports remain lengthy and less accessible to the layperson, which is not necessarily resolved by the availability of summaries on the web site. In addition, there was a 12-month delay in reporting to clinical services because of the booster survey. Although service level reports provide greater potential for specific feedback for action, they remain limited by poor response rates.

4.4.2 PDRSS

Survey planning

Survey timelines

Initially, it was planned that the survey would be implemented during October and November 2003, with advance notice distributed by the department and the AIPC in September 2003. However, services expressed concerns that this was inadequate time for survey preparation and promotion, particularly when the outcome measurement project for PDRSS was also being conducted during that period. Implementation was subsequently rescheduled and occurred between January and March 2004.

Similar to the clinical sector, the statewide survey is not integrated within the routine practice of PDRSS. Some services suggested that annual or bi-annual administration of the statewide survey fits with the resource constraints and usual program planning and development phases locally. However, there were also suggestions that it may be valuable to administer the survey at key points in service delivery.

Service engagement and support

Services were asked to identify a staff member to coordinate the implementation process locally and act as a contact for the AIPC.

In December 2003, the AIPC sent each service an implementation support package comprising:

- administration guidelines and instructions
- frequently asked questions fact sheet
- survey timeline
- requested number of surveys and reply paid envelopes for consumers, carer service users and carers
- consent forms for guardians of minors
- display posters to promote the survey and encourage timely completion and return.

The support package outlined a recommended process for implementation while still providing some flexibility for services to tailor the process to best meet their local needs and resources. In particular, services were encouraged to use existing processes for engaging consumers and carers in the survey in an attempt to balance statistical and pragmatic considerations. PDRSS vary in size, infrastructure, service models and target groups, all of which demanded a level of flexibility in the survey approach. The AIPC also provided services with a telephone advisory service and web site for further information and handling of queries during the survey.

It was apparent some staff simply did not read, understand or apply implementation guidelines and other written information about the survey. The AIPC recommended regular training for staff to assist with survey promotion and administration, engaging consumers and carers, and understanding how to interpret and use the data for quality improvement purposes.

Survey implementation

Survey recruitment

Recruitment methods included:

- mail-out mail-back process
- direct recruitment via a service representative in a one-on-one or group situation
- asking consumers to forward the survey to their carers
- promoting the survey in reception/waiting areas at service locations.

Having a service representative distribute the survey was perceived to be vastly superior to any other method and consistent with service delivery models. Asking consumers to forward a questionnaire to their carer/s was viewed as the least reliable distribution method. Any one or more of the recruitment methods' impact on survey bias is unclear.

Some services chose not to distribute the carer surveys, which reflected the philosophy or views of the individual service rather than a trend by program type. Service providers felt either they did not have a relationship with carers and therefore feedback would not be appropriate or useful, or asking carers to provide feedback would be a breach of confidentiality between the consumer and the service. Some PDRSS have subsequently undertaken work to clarify the role of carers and to develop carer engagement within service models and confidentiality regulations.

The suitability of the PDRSS survey for consumers and carers of culturally and linguistically diverse backgrounds was limited. A translation of the questionnaire still presented validity issues in terms of its cultural appropriateness and the influence of cultural values and norms on responses. In addition, the population size for identifying statistically significant trends was not available.

Implementation data indicated the proportions of PDRSS respondents whose main language was not English were 5 per cent ($n = 59$) for consumers, 1.6 per cent ($n = 2$) for carer service users, and 9.3 per cent ($n = 15$) for carers. The AIPC recommended that the most appropriate means of obtaining feedback from consumers and carers from culturally and linguistically diverse backgrounds is to use interpreter-facilitated telephone or face-to-face interviews based on the issues underpinning the questionnaire.

Quantitative methodology

The only method of data collection in the PDRSS sector was the semi-structured questionnaires. Statewide data collection occurred from 12 January to 3 March 2004. In total, 88 services distributed questionnaires and respondents from 56 services returned completed surveys by the closing date.

Response rates

In 2003–04, there were 12,204 consumers and 3,764 carers recorded on the Quarterly Data Collection system for PDRSS.

Overall, the survey response rate was 21 per cent (1,874 returns). The response rate for consumers was 25 per cent (1,527 returns), carer service users 16 per cent (142 returns) and carers 12 per cent (205 returns).

Response rates varied by program type, with 70 per cent of consumer responses coming from day programs and home-based outreach and support. This may reflect either the difficulty in engaging certain consumer groups in the survey or the greater proportion of consumers in these programs compared with other programs.

It is unclear to what extent the carer response rate was the result of carers not being asked to participate or choosing not to participate in the survey.

Reporting and use of information

Reporting to PDRSS occurred within three months, which services considered to be relatively timely. In April to May 2004, participating services received an individual service report, which included their service data and relevant statewide data, as well as guidelines for interpreting the data. A statewide report and summary are available at www.health.vic.gov.au/mentalhealth/quality.

The data are reported in a format that highlights the overall perceived benefit of services, together with the highest and lowest scoring items from each of the survey domains. Further analyses by respondent characteristics and program types were also undertaken where there were 50 or more responses for each category.

The survey reports provide insights into consumer and carer perspectives of service quality. Services are expected to use this information, together with other sources of performance information, to reflect on current practice and plan for further improvement. The department further explored this with service providers, consumers and carers at a statewide forum held in February 2005 and through existing networks and groups.

5. Consultations

5.1 Implementation monitoring and feedback

Consultations with services and consumer and carer peak bodies were undertaken during survey implementation to identify strengths in the approach as well as issues. This enabled a timely response to the issues during the survey, as well as feedback on what works well and what does not for consideration in future surveys.

Within the clinical sector, the department and TQA Research consultants met with service managers and staff at several existing statewide forums and locally. In addition, area mental health service representatives from Eastern Health, St Vincent's Health and Latrobe Regional Health met with the department to further explore some issues. There were consultations with the Victorian Mental Illness Awareness Council, the Carers' Network, and various local consumer and carer groups during the survey.

The PDRSS sector was consulted primarily through the Statewide Quality Reference Group established to provide input to this project and others under the Second National Mental Health Plan. The reference group included consumer, carer, service provider, peak body and departmental representatives. In addition, the AIPC consulted locally with service providers, consumers and carers during the survey development and implementation phases.

5.2 Post-implementation review

The department held a forum in February 2005 for clinical and PDRSS staff and consumer and carer representatives and consultants involved in the statewide surveys. The forum provided an opportunity to discuss key findings from the surveys and implications for service improvement, and to explore models for future consumer and carer evaluation approaches.

From February to the end of June 2005, the department's Mental Health Branch staff progressively met with consumer and carer peak bodies, service managers and clinical directors, and departmental regional contact officers to discuss these issues. A cross-section of local consultations with service providers (three from each of CAMHS, AMHS, APMHS and two PDRSS), consumers (two metropolitan and two regional/rural) and carers (one metropolitan and one regional/rural) complemented the meetings.

Table 5 outlines possible models for consumer and carer evaluation and the strengths and issues identified for each. There was no single preferred approach, but rather opportunity to consider a combination of strategies to improve future consumer and carer surveys. However, there was general consensus that consumer and carer involvement needs to be incorporated throughout survey planning and implementation, including reporting and developing actions from the findings. In addition, maintaining flexibility in the methodology and data items was considered critical for greater local relevance and tailoring to the diversity of consumers and carers. There was also general consensus that the survey would be more useful if it was conducted every six to 12 months at a minimum.

Table 5: Proposed models for future consumer and carer evaluation approaches

Note that options are not mutually exclusive or listed in any particular order.

Evaluation options	Strengths	Issues
<p>Continue with current statewide survey of consumer and carer experience.</p> <p>Clinical sector:</p> <ul style="list-style-type: none"> • semi-structured questionnaire • focus groups • individual interviews <p>PDRSS sector:</p> <ul style="list-style-type: none"> • semi-structured questionnaire • adapted from that used in clinical services 	<p>The model is developed and tested with consumers, carers and service providers.</p> <p>The questions reflect consumer and carer identified needs, priorities and expectations of services.</p> <p>The link to the National Standards for Mental Health Services provides meaningful benchmarks.</p> <p>The combination of quantitative and qualitative methods enhances opportunities for participation and depth of understanding of consumer and carer perspectives.</p> <p>A better response can be achieved when consumers, carers and service providers coordinate the survey locally.</p> <p>Reports of survey findings are available at statewide and individual service level.</p>	<p>There is insufficient time for planning and implementation.</p> <p>Questionnaire length, language, format and rating scale can be problematic.</p> <p>The overall response rates are between 13 per cent and 19 per cent in clinical services and between 12 per cent and 25 per cent in PDRSS.</p> <p>There is a significant burden on services for sampling, recruitment and mail-outs.</p> <p>Reports are lengthy, difficult to interpret for the layperson, untimely and limited by poor response rates.</p> <p>The use of survey findings in continuous quality improvement is limited.</p>
<p>Targeted evaluation by:</p> <ul style="list-style-type: none"> • program/service type • practice areas 	<p>This provides a strategic approach to identified priorities.</p> <p>There is greater capacity to tailor approaches to specific target groups.</p> <p>This model is potentially less burdensome on consumers, carers and service providers.</p> <p>A focused approach provides opportunities for more specific and actionable feedback.</p>	<p>The restricted scope carries a risk of some priorities not being addressed.</p> <p>The diversity of consumers & carers within target groups needs to be addressed.</p> <p>Evaluation methods may or may not overcome issues identified with the current survey.</p>

Evaluation options	Strengths	Issues
<p>Active involvement of consumers, carers and service providers throughout the survey process.</p>	<p>Participation models can be tailored to local consumer and carer needs and preferences.</p> <p>Services are given greater control over the process, including the option to ask local questions.</p> <p>Funding supports existing requirements of services, which minimises duplication of effort, survey fatigue and burden on all involved.</p> <p>This model is likely to improve response rates, appropriateness, and acceptability of the survey.</p> <p>There is a shared commitment and ownership of the survey process and outcomes among all stakeholders.</p>	<p>This model depends on leadership and commitment at all levels of the mental health system.</p> <p>There is a need to provide training and support for consumer and carer involvement.</p> <p>The level of independence of consumer and carer survey administrators from the service being evaluated.</p> <p>Some services are further developed in this area than others.</p> <p>Process and data items will need to be standardised at some level to enable statewide monitoring.</p>
<p>Web-based, on-line survey via:</p> <ul style="list-style-type: none"> • departmental web site • services' web sites • peak bodies • networks 	<p>This model provides a continuous and ongoing source of feedback, which can be analysed and reported at set intervals.</p> <p>There is less of a burden on services, consumers and carers.</p> <p>This model is cost- and resource-efficient.</p> <p>This model provides timely reporting, with electronic management of information.</p>	<p>There is limited capacity to influence response rates and therefore the level of information available for each service at set intervals.</p> <p>It is likely there could be a bias towards complaints rather than the quality improvement focus of the surveys.</p> <p>Other opportunities for access need to be provided.</p>
<p>Integrated with service delivery at:</p> <ul style="list-style-type: none"> • intake • case review • discharge 	<p>This model strengthens commitment and involvement in the survey within the service culture.</p> <p>Processes for consumer and carer participation are integrated within routine, day-to-day practice.</p> <p>The continuous sampling approach enables regular reporting and use of information within quality improvement cycles.</p> <p>Analysis and reporting of survey responses can be managed in-house or externally.</p>	<p>The link to other tasks at key points in service delivery may increase burden and confusion.</p> <p>Services may feel they are obliged to participate depending on time for engagement, amount of control in the process, and level of useful and actionable information.</p> <p>This model may not allow sufficient time for improvement between surveys.</p> <p>There is a need to clarify processes for data management.</p>

6. Recommendations

The survey needs to continue as a key mechanism for systematic consumer and carer input into service planning, improvement and evaluation. In this way, it can be a tool for strengthening consumer and carer participation models within services and a lever for change and innovation in Victoria’s specialist public mental health system.

The current approach to implementing the statewide consumer and carer surveys is not recommended as a future option because it does not empower consumers and carers to be actively involved in partnership with service providers and the department throughout the process. It duplicates existing models for consumer and carer participation in services and statewide, which reinforces a view that the survey is imposed on those involved and disconnected from the routine practice and service culture of organisations. The measurement of perceptions of care and links to the National Standards for Mental Health Services in the current survey tools should be retained in any future approach to address the methodological issues identified in the literature. However, the method of administration, format and content of questions will need to be revised in collaboration with consumers, carers and service providers in order to address the issues identified through implementation and consultation.

Two options for a survey framework, informed by the implementation review, consultations and update literature review, are proposed for consideration. The first option is consumer and carer led and the second option is service managed. The approaches are not mutually exclusive: both require partnerships between consumers, carers, service providers, peak bodies and the department. Partnerships need to be based on respect, empowerment and collaboration between all parties involved to enable effective participation. Ownership and commitment to the survey process and outcomes will need to be developed through the level of involvement and influence of these stakeholder groups and reflected in service agreements.

This section provides an outline of what each option may involve. It will be important to consult with the stakeholder groups to fully define the structure and processes for the preferred option.

6.1 Option 1: Conducted through consumer and carer organisations

The department would strengthen the capacity of and negotiate funding with existing consumer and carer organisations to conduct the survey. The consumer and carer organisations would be responsible for working with services and the department to plan and implement the survey, including reporting and using the survey findings for continuous quality improvement. The organisations would recruit, train and support a team of service user administrators for the survey, as well as project staff to coordinate activities and provide relevant expertise and support. The organisations would need to ensure the consumers and carers involved as survey administrators are independent of the service they are evaluating at any given time in order to provide the necessary objectivity and methodological rigour.

6.1.1 Strengths and opportunities

Building on existing infrastructure and strengthening capacity within the sector would provide appropriate, effective and timely mechanisms for engaging consumer and carer participation in a systematic and ongoing way.

The consumer and carer organisations would have an existing infrastructure for consumer and carer input to service planning, development and evaluation. They would have skills and experience, consumer and carer networks, training and support for participation, and accountability mechanisms. They would have the capacity to access the views and enhance the involvement of their wider consumer and carer constituencies.

6.1.2 Risk analysis and management

Risks would be managed through stakeholder partnerships at statewide and local service levels involving consumers, carers, service providers and the department. For example, the establishment of stakeholder committees within each service that the consumer and carer organisations link into for the survey. Also, a statewide reference group comprising stakeholder representatives to provide advice and support to the consumer and carer organisations about survey planning, implementation, monitoring and reporting. This would enable greater ownership and accountability for the process, outcomes, issues and solutions.

The consumer and carer organisations would need to be sufficiently supported to conduct such a large-scale and complex survey program. For example, a selection panel comprising departmental staff, consumer and carer representatives and service providers could be used to recruit suitable project staff. The department could establish a database for data entry, analysis and reporting, which may also be subcontracted via its tendering process.

6.2 Option 2: Conducted by mental health services

This option would involve strengthening the capacity of services to manage the survey. The department would need to fund services to conduct the survey locally in partnership with consumers and carers. To ensure a level of independence from the service of consumers and carers involved in implementing the survey, services would need to partner with other services or contract consumer and carer administrators through networks. The benefits would be in providing opportunities for peer review and collaboration. Each service would report its survey findings to the department to enable the subsequent development of a statewide report for wider distribution.

6.2.1 Strengths and opportunities

Services are continually developing, monitoring and improving mechanisms for consumer and carer participation at all levels of service delivery. Integrating the statewide surveys with local consumer and carer participation models within services strengthens the process and outcomes, and provides sufficient flexibility to tailor activities to local needs, preferences and resources. If service ownership and commitment to the survey are developed through this direct involvement and influence over the process, it avoids duplication of effort and reduces the sense of burden.

6.2.2 Risk analysis and management

Significant risks of this option include the highly variable models for consumer and carer participation currently operating within services, and levels of partnership between stakeholders. The survey will need to be linked to mechanisms for participation and supported by stakeholder partnerships. Training and support in effective consumer and carer participation models and strategies would also need to be available to contribute to ongoing development and improvement in partnerships.

Services could establish or charge an existing group comprising consumers, carers, managers and direct care staff to be responsible for coordinating the survey locally. The group would need to be linked to governance arrangements within the service to ensure sufficient priority is given to consumer and carer perspectives of service quality and the use of this information for service planning and improvement. Where it is not practicable to establish such a group because of service size, location and resources, services would be able to partner with other services to establish a local implementation group. This is more likely an issue for smaller rural services and PDRSS, and may build on existing relationships between services.

6.3 Core elements of a survey framework

6.3.1 Partnership processes

Irrespective of which option is chosen, it will be important to establish integrated partnership processes at a statewide and local service level to enable planning and coordination of effort, and an ongoing dialogue for continuous improvement and evaluation of the survey approach.

6.3.2 Survey planning

Local implementation plans will need to be established in each service to set out the allocation of activities, monitoring and timelines for cycles of:

- survey promotion
- sampling and recruitment
- implementation
- reporting
- action.

Where consumer and carer consultants are employed by services, they should be engaged, informed and facilitate implementation, reporting and change management as part of the survey program. However, they should not be involved in survey administration because they are part of the service being evaluated.

6.3.3 Sampling and recruitment

The sampling and recruitment protocols will need to promote a consistent approach between services while allowing some flexibility for tailoring the process to local consumer and carer availability, needs and preferences.

The recruitment methods need to be linked to existing processes for engagement within services but also increase opportunities for participation. It is important that both verbal (face-to-face or telephone) and written information about the survey and how people can be involved are provided.

6.3.4 Methodology

The survey methodology needs to encourage the diversity of consumers and carers to participate and reflect recovery-oriented participation models to ensure choice and empowerment in the process. Therefore, it is recommended the questionnaires be used as schedules for individual interviews and focus groups conducted by service user administrators either face-to-face or by telephone. Written questionnaires would also be made available if consumers and carers participating in the survey prefer.

Service staff may also distribute written questionnaires at regular intervals (for example, post-intake, service review or discharge) to enable greater opportunity and diversity of consumer and carer participation, avoid duplication of effort and resources, and provide more regular feedback. The department would make the survey materials available electronically for services to print and use locally.

The existing questionnaires need to be revised in light of suggestions to simplify the language, improve the format, reduce the length and amend the rating scale before they are used again. Amendments need to be validated by interviews with consumers and carers from each target group prior to implementation.

The survey needs to incorporate a standard set of core questions that enable consumers and carers to provide feedback on their service experience. The core set of questions may relate to the continuum of service experience or target identified priority areas. In addition, services should have the option to add locally specific questions. The statewide surveys are intended to replace similar surveys within services in order to reduce survey burden and respondent fatigue. This allows services to focus on more targeted and in-depth methods of inquiry to facilitate change locally.

It is recommended the survey be conducted every six to 12 months to balance the amount of time and resources required with the benefits of providing a mechanism for regular feedback on consumer and carer experience. The more regular and timely the feedback, the more likely the information will be used for continuous quality improvement.

6.3.5 Analysis and reporting

Any individual or organisation involved in data collection, entry, analysis and reporting must maintain the privacy and confidentiality of individual survey respondents at all times. The department would establish a database for data entry to enable consolidated analysis and reporting in a timely and regular way.

Statewide information from the survey and related developments would be posted on the department's web site and reported within the key performance indicator suite for Victoria. This would create a more balanced approach to performance monitoring that links consumer and carer assessments of service quality with service provider assessments of service quality. The department would use the information to guide policy, service planning and development, and quality initiatives.

Each service would be responsible for communicating its survey findings and how they are being used in an understandable, accessible and timely way to staff, consumers, carers and the local community. Clinical services would report on how they are using the information for quality planning and improvement when they submit their existing National Standards for Mental Health Services implementation progress reports to the department's central office, and PDRSS would report on this as part of the standards implementation plans established with departmental regional offices.

6.3.6 Training and support

Statewide survey training and support for services is essential to ensure a common understanding of survey process and requirements, and to build the capacity for partnerships and change management. Service managers, direct care staff, consumers and carers all need to be involved in the design and delivery of such training and support.

Table 6: Proposed options for future statewide surveys

Key considerations	Option 1: Conducted through consumer and carer organisations	Option two: Conducted by services
Partnerships	Consumer and carer led approach, in partnership with stakeholders.	Led by services, in partnership with stakeholders.
Infrastructure	Existing networks and groups for consumer and carer input.	Services are continuously developing and improving mechanisms for consumer and carer participation.
Capacity building	Strengthens existing capacity to minimise duplication of effort.	Strengthens existing capacity to minimise duplication of effort.
Coordination	Recruit, train and support a team of consumer and carer survey administrators, and project staff.	Consumer and carer survey administrators sourced from the community, other services or networks.
Reporting	Data submitted to the department by consumer and carer organisations and services or subcontracted.	Services prepare individual reports and submit to the department for statewide report.

Appendix 1: Child and adolescent, adult and aged persons mental health services questionnaires

Full copies of consumer and carer surveys in child and adolescent, adult and aged persons mental health services are available on www.health.vic.gov.au/mentalhealth.

Sample page

Carer survey of Victorian public adult mental health services

Your chance to help us help you

4. Mental health services are required to give carers information that they can understand about their rights and responsibilities as well as those of the person they care for. Thinking about the service that you MOST RECENTLY used, please cross the box that best applies to YOU for each of the following:

How good was the service at letting YOU know . . .	POOR	AVERAGE	GOOD	VERY GOOD	EXCELLENT	DOES NOT APPLY
a) What they can do for you and the person you care for	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) What they expect from you and the person you care for	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Your right and the person's right to privacy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Your right and the person's right to confidentiality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Your right and the person's right to speak to someone in your preferred language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Your right and the person's right to written information in your preferred language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) That either of you can speak to a male or female staff member if preferred	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Your right and the person's right to feel safe where you are seen by the service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) How to comment or complain about the service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) How to participate in overall service planning, improvement and review	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) Overall, how good was the service at helping YOU to UNDERSTAND the above information?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) Overall, how good was the service at providing the above information WHEN YOU needed it?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. Mental health services are required to provide carers with a service that is easy for them to access when needed. Thinking about the service that you MOST RECENTLY used, please cross the box that best applies to YOU for each of the following:

How good was the service at . . .	POOR	AVERAGE	GOOD	VERY GOOD	EXCELLENT	DOES NOT APPLY
a) Letting you know how and when they can be contacted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Being easy for you to travel to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Letting you know who you should talk to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Making it easy for you to find the person you needed to talk to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Being available when you needed them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Asking you about your views/concerns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Listening and talking to you about your views/concerns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Providing you with written information in your preferred language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Arranging an interpreter for you when needed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) Respecting your cultural beliefs and practices	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) Arranging for you to see a male or female staff member if asked for	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) Making you feel safe where you were seen by the service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m) Allowing you to comment or complain about the service freely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n) Providing opportunities for you to participate in overall service planning, improvement and review	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o) Overall, how good was the service at enabling YOU to GET HELP?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p) Overall, how good was the service at helping you WHEN YOU needed them?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Sample page

Consumer survey of Victorian public adult mental health services

Your chance to help us help you

4. Thinking about the MOST RECENT public adult mental health service you had contact with, please cross the box that best applies to you for each of the following:

How good was the service at letting YOU know . . .	POOR	AVERAGE	GOOD	VERY GOOD	EXCELLENT	DOES NOT APPLY
a) What they can do for you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) What they expect from you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) When you can choose to have others involved in your care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) That you have a right to privacy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) When you can choose who is told that you use the service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Your right to written information in your preferred language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Your right to speak to someone in your preferred language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) That you can speak to a male or a female staff member	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) That you should feel safe where you are seen by the service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) How to comment or complain about the service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) How to participate in overall service planning, improvement and review	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) Overall, how good was the service at helping you to UNDERSTAND the above information?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m) Overall, how good was the service at providing the above information WHEN you needed it?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. Thinking about the MOST RECENT public adult mental health service you had contact with, please cross the box that best applies to you for each of the following:

How good was the service at . . .	POOR	AVERAGE	GOOD	VERY GOOD	EXCELLENT	DOES NOT APPLY
a) Letting you know how and when they can be contacted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Being easy to travel to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Letting you know who you should talk to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Making it easy for you to contact the person you needed to talk to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Being available when you needed them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Asking for your opinion about your needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Listening to your opinion about your needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Providing written information in your preferred language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Arranging for an interpreter when needed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) Respecting your cultural beliefs and practices	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) Arranging for you to see a female or male staff member if asked for	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l) Making you feel safe where you were seen by the service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m) Allowing you to comment or complain about the service freely	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n) Providing opportunities for you to participate in overall service planning, improvement and review	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o) Overall, how good was the service at enabling you to GET HELP?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p) Overall, how good was the service at helping you WHEN you needed them?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Appendix 2: Psychiatric disability rehabilitation and support services questionnaires

Full copies of consumer, carer service user and carer surveys in PDRSS are available on www.health.vic.gov.au/mentalhealth.

Sample page

Consumer experience of psychiatric disability rehabilitation and support services (PDRSS)

5

*...please turn to page 5***5. Delivering services**

Thinking about the PDRS service **you currently have contact with**, please tick your preferred response.

	Poor	Fair	Good	Very good	Excel- lent	Does not apply
	1	2	3	4	5	6
a) How good is the service at letting you know how and when it can be contacted?						
b) How good is the service at making it easy for you to contact the person you need to talk to?						
c) How good is the service at providing a key worker who is responsible for coordinating your support and rehabilitation?						
d) How good is the service at introducing you to your new key worker?						
e) How good is the service at asking for your opinion about your needs?						
f) How good is the service at listening to your opinion about your needs?						
g) How good is the service at making you feel safe where you attended/received the service?						
h) How good is the service at making you aware and feel comfortable about making complaints or comments?						
i) How good is the service at providing opportunities for you to participate in the overall planning, improvement and review of the service?						
j) How good is the service at respecting your opinion about your program plan?						
k) How good is the service at working with you when decisions are made about your individual program plan?						
l) How good is the service at providing opportunities for you to involve people of your choice in the planning of your support/individual program plan development?						
m) Overall , how good is the service at providing the above information WHEN you need it?						
	Poor	Fair	Good	Very good	Excel- lent	Does not apply
	1	2	3	4	5	6

...please turn to page 6

Abbreviations

ADEC	Action on Disability in Ethnic Communities
AMHS	adult mental health services
APMHS	aged persons mental health services
ARAFEMI	Association of Relatives and Friends of the Mentally Ill
AICAFMHA	Australian Infant, Child, Adolescent and Family Mental Health Association
AIPC	Australian Institute for Primary Care
CAHPS	Consumer Assessment of Health Plans
CAMHS	child and adolescent mental health services
MHSIP	Mental Health Statistics Improvement Program
NHS	National Health Service
PDRSS	psychiatric disability rehabilitation and support services
VICSERV	Psychiatric disability services of Victoria
RAPID	Redevelopment of Acute and Psychiatric Information Directions
VACCHO	Victorian Aboriginal Community Controlled Health Organisation
VAHS	Victorian Aboriginal Health Service
VMIAC	Victorian Mental Illness Awareness Council
VTPU	Victorian Transcultural Psychiatry Unit

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