CMHDARN SYMPOSIUM PROGRAM

EXPLORING THE POTENTIAL – FEEDBACK, OUTCOME MEASURES AND PRACTICE

5TH JUNE 2019 – AERIAL, UTS

9:00am	**REGISTRATION**
9:30am	*Acknowledgement of Country* – Karlie Stewart, Speak Out, Weave Youth and Community Services
9:35am	*Housekeeping* – Jo Penhallurick, CMHDARN Coordinator, MHCC
9:40am	*Introduction to the Day* – Carmel Tebbutt, CEO, MHCC
9:50am	*Opening Address* – NSW Deputy Mental Health Commissioner Tania Skippen, Mental Health Commission of NSW
10:00am	*Keynote presentation* – Associate Professor Carolyn Day, School of Medicine, University of Sydney **"Making sense of what we know, what we think we know and what we should know" (ABSTRACT)**
10:30am	*Presentation* – Robert Stirling, Deputy CEO, NADA **"Making sense of measurement" (ABSTRACT)**
10:50am	*Discussion*
11:00am	**MORNING TEA**
11:20am	*CMHDARN Project Snapshots*
11:50am	*Keynote presentation* – Dr Grenville Rose, Centre for Social Research in Health, UNSW and Flourish Australia **"Bias, context and how they inform your work: The world is not black and white" (ABSTRACT)**
12:20pm	*Presentation* – Dr Suzie Hudson, Clinical Director, NADA **"Embedding client feedback into reflective practice" (ABSTRACT)**
12:40pm	*Discussion*
12:50pm	**NETWORKING LUNCH**
1:50pm	*Panel discussion* – Alice Hanna (Jarrah House), Genevieve Whitlam (ACON), Dr Grenville Rose (UNSW), Robert Stirling (NADA)
3:20pm	**AFTERNOON TEA**
3:40pm	*Early Researcher Presentations* – Dr Alana Fisher and Anna Doab
4:15pm	*Closing remarks* – Larry Pierce, CEO, NADA
4:30pm	Symposium concludes

The Community Mental Health Drug and Alcohol Research Network (CMHDARN) is a collaborative project between Network of Alcohol and Other Drugs Agencies (NADA), the Mental Health Coordinating Council (MHCC) and the NSW Mental Health Commission.

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EXPLORING THE POTENTIAL – FEEDBACK, OUTCOME MEASURES AND PRACTICE

2:00pm - Panel scenario

A community managed AOD service whose clients may experience co-existing mental health difficulties has been collecting client feedback on an ad hoc basis for a number of years. Client satisfaction measures have been collected, although to date the data has not been used systematically. Following a revised funding agreement, the service is required to collect more formal client experience and outcome measures data. The service has also been asked to consider how the data collected from these tools can be translated into practice. In their first two years under the new funding model, the following themes have emerged:

- The service provided is too generic and is not meeting the needs of individuals who have complex and diverse needs
- Staff are very responsive to the clients
- Clients report feeling well supported
- Clients want a more 'one-stop-shop' service delivery model, where there is no time limit on service access
- Clients/consumers want 24-hour support
- Clients are mostly happy with the services they receive

The following client outcomes have been noted:

- In AOD outcome measures at 'progress 1' (around 6 weeks), clients demonstrate some improvement, however, when measured again at exit, these positive outcomes are less evident.
- The majority of clients experienced a reduction in mental health related difficulties, independent of the specific intervention they received.

Abstracts:

"MAKING SENSE OF WHAT WE KNOW, WHAT WE THINK WE KNOW AND WHAT WE SHOULD KNOW"

Associate Professor Carolyn Day

This presentation looks at the differences between outputs, outcomes and experience. Output measures are defined as what we produce, most easily conceptualised as "throughput", whereas outcomes are what we aim to achieve. Experience is explored both as a narrow concept of satisfaction and more broadly as a way of unpacking what is actually occurring. Examples from different research and evaluation projects undertaken within the sector are used to illustrate both the differences across and value of each measure and explore how these can be used and interpreted. Each measure is considered in the context of how it can be used to better understand what services and/or programs do and how a better understanding and use of outputs, outcome and experience can contribute to service improvement and, potentially, expand funding opportunities.

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"MAKING SENSE OF MEASUREMENT"

Robert Stirling

Measuring the impact of mental health and alcohol and other drugs (AOD) services is complicated. The people that we support have varying levels of mental health and substance use concerns, require a range of health and social support services, and through a person-centred approach may receive care and support that differs to others at the service. It's not surprising then, that the outcomes and experiences of people that access these services will differ. Service providers have been facing the challenge of ensuring that the tools they use to measure their impact are useful for people accessing their service, the organisation, funders and the community. At the person level measures need to inform care planning and demonstrate the progress that is being achieved. At the service level, using aggregate data to then inform service planning and design. How then, can that data be used to demonstrate performance against funding agreements, as well as communicated back to the community to ensure there is confidence in the use of public funds to support people to address mental health and substance use concerns. This presentation will explore the commonly terms used in measurement, what they mean, and how they are currently used. It will also discuss what providers should be doing, and what needs to be done to progress the area of measurement.

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"BIAS, CONTEXT AND HOW THEY INFORM YOUR WORK: THE WORLD IS NOT BLACK AND WHITE"

Dr Grenville Rose

Properly executed evaluation of outcomes can form part of reflective practice and if we are about anything it is about reflecting on how to get better outcomes for the people accessing our services. Evaluation of the work that we do and service culture should help us improve what we do. This is the frame through which I view outcomes and evaluation, rather than as an administrative tool that is required by management or funders. However, our biases can affect the way we use and interpret outcomes. We may be aware of our biases or they may be an implicit part of our psychology due to our background. The context in which outcomes are collected can also affect the types of outcomes and

their interpretation. Outcomes collected in a clinical context, for example, may be different and have a different purpose and interpretation from those collected in a community managed context. A satisfaction survey collected in a group environment, particularly if an inducement such as BBQ has been offered, may yield different results than if it were collected online or over the phone. Outcomes are at the centre of what we are doing for the people who access our services and a focus on the biases and context in which they are gathered, as well as the uses to which the results are to be put have a prominent and useful place in improving service delivery.

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"EMBEDDING CLIENT FEEDBACK INTO REFLECTIVE PRACTICE"

Dr Suzie Hudson

We have seen some good progress across both the mental health and alcohol and other drug treatment sectors when it comes to outcomes measurement and client feedback – but how well do we use this information? In many ways feedback from our clients related to how they are tracking or experiencing a service can become routine rather than informing active reflection. Weaving the consumer/client voice into reflective practice is the gold standard in therapeutic work and we need tools and techniques to do that. One approach is Feedback Informed Treatment (FIT), a pantheoretical approach that can be applied in therapy to actively enquire about both the quality of the improvements that are occurring as a result of the therapeutic engagement as well as the experience of the relationship between practitioner and consumer/client. Through establishing client feedback as a part of routine practice we are able to more consistently respond to client need, adapting our approach in real-time rather than waiting until it is too late and the client simply decides to disengage. Reflective practice is key to quality therapeutic work that results in useful outcomes for clients – but without the client/consumer voice, we are missing an essential ingredient.

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