The MH-CoPES Framework and Questionnaires ready for statewide implementation

Final Report of the MH-CoPES Stage 2 Project



CONSUMER ADVISORY GROUP NSW CAG

NSW HEALTH

Written by Karen Oakley, Gillian Malins and Rebecca Doyle
First published in 2011 by NSW Consumer Advisory Group – Mental Health Inc.

NSW Consumer Advisory Group – Mental Health Inc.
501 / 80 William Street
East Sydney NSW 2011

Tel: 02 9332 0200
Fax: 02 9332 0299
www.nswcag.org.au

ISBN 978-0-9806722-6-8

For further copies of this document please contact
NSW CAG
501 / 80 William Street
East Sydney NSW 2011
Tel: 02 9332 0200

This report can be downloaded from www.nswcag.org.au

Contents

The appendices are available as a separate document from www.nswcag.org.au

Acknowledgements

The MH-CoPES Stage 2 project would not have been possible without the input, commitment and support of many people. In particular, we would like to thank:

- Greater Western Area Health Service, Mental Health Drug and Alcohol Services
- Northern Sydney Central Coast Area Health Service, Mental Health Services
- Staff and consumers at each of the services involved in the research sites
- Consumer Workers and Consumer Project Workers who worked with NSW CAG and the research sites during the project
- MH-CoPES Stage 2 Steering Committee members
- MH-CoPES Stage 2 Reference Group members
- People in the mental health community, particularly mental health consumers who participated in the research by completing Questionnaires, being involved in interviews, and attended and contributed to consultations.

The support and expertise of Dr Peter Caputi, Dr Lindsay Oades, and Professor Frank Dean from the Illawarra Institute for Mental Health, University of Wollongong in developing the research methodology and providing research consultation is gratefully acknowledged.

Thank you to the many people at the Mental Health and Drug and Alcohol Offices, NSW Health who have provided valuable advice and support throughout the project. In particular,

- David McGrath, Director Mental Health and Drug and Alcohol Programs
- Regina Osten A/Manager Prevention and Community Partnerships
- Robyn Murray, former Manager Prevention and Community Partnerships
- Carlton Quartly, Manager Clinical Governance Team
- Dr Grant Sara, Director InforMH
- Anna Hall, Project Manager InforMH

Thank you to the research assistants who have worked on this project at NSW CAG, Sylvia Kozlowski, Katarina Kobor, Francesca Corcoran, Susan Palmer, Patrick Beinke, and Michael Appleton. Thanks also to the whole team at NSW CAG, Cecilia Rais, Executive Support Officer, Magi Rai, Policy and Participation Officer, Lauren Whibley, Policy Assistant, Maureen O'Keeffe, Administration Officer and Yvette Cotton, former Communications Officer for their assistance throughout the project. Thank you to Allison Kokany, NSW Chairperson, and the NSW CAG Board of Trustees for their ongoing support and encouragement.

Finally, thanks must go to those who initiated the MH-CoPES project, Professor Beverly Raphael, former Director Centre for Mental Health (former Mental Health and Drug and Alcohol Offices), NSW Health and the founding members of the Mental Health Outcomes Assessment Training/Tools (MH-OAT) Consumer Consultative Committee (CCC), and to mental health consumers everywhere who inspire us to continue to strive for better mental health services and greater genuine opportunities for consumer participation.

Karen Oakley
Executive Officer, NSW CAG

Dr Gillian Malins
Former Executive Officer, NSW CAG

Rebecca Doyle
Project Officer, MH-CoPES

Executive Summary

This is the final report and recommendations from the Mental Health Consumer Perceptions and Experiences of Services (MH-CoPES) project, Stage 2.

The project was conducted by the NSW Consumer Advisory Group - Mental Health Inc (NSW CAG), in partnership with the Mental Health and Drug and Alcohol Office, NSW Health. The MH-CoPES project was initiated to develop a mechanism for consumer participation in service evaluation and quality improvement.

The work conducted during this second stage of the project sought to build upon the work of Stage 1 to test and finalise the draft MH-CoPES Framework for consumer evaluation of mental health services and the associated Questionnaires ready for full implementation in public, adult mental health services in NSW.

This report presents the work undertaken throughout Stage 2 of the MH-CoPES project to respond to three key objectives:

> Objective 1: clearly identify and document the properties, standards and cost implications of each step of the MH-CoPES Framework
>
> Objective 2: assess the cultural and change management issues to be addressed to support the future implementation and sustainability of the MH-CoPES Program
>
> Objective 3: clarify the role and place of MH-CoPES in service improvement.

Outcomes

The research process involved two research sites (metropolitan and rural mental health services) in a trial and pilot of the MH-CoPES Framework, including the MH-CoPES Questionnaires. This report presents the research work undertaken throughout stage 2 of the MH-CoPES project. It submits:

- a set of trialled and refined standards and protocols for each step of the Framework
- revised Questionnaires that have been evaluated and shown to have strong internal reliability, strong convergent validity and are measuring perceptions of care at the service for use in the *Data Collection* step
- recommendations relating to the cultural and change management issues to be addressed to support the full implementation of MH-CoPES statewide
- clarification of the role of MH-CoPES in ensuring consumer participation in service evaluation and quality improvement and of its place within quality improvement systems in mental health services in NSW

The MH-CoPES Framework: Consumer-Driven Service Improvement

MH-CoPES is one part of a complete quality improvement vision for NSW Health mental health services. The Framework and Questionnaires presented in this report were developed to stand alongside other quality activities occurring in each Area Health Service (AHS). The MH-CoPES Framework, including the MH-CoPES Questionnaires, is a successful and effective mechanism for consumers to participate in service change and quality improvement. The Framework enables the identification of service improvement needs at the local service, Area and state levels from the perspective of the people who use the service.

From its inception, the purpose of MH-CoPES has been to ensure that consumers have a genuine opportunity to participate in the evaluation of services and for this to drive service improvement. A distinctive and important feature of MH-CoPES is that it involves consumers in each of the four steps of the Framework. The Framework places consumers in a position of being people with valuable knowledge who can make valuable contributions to the planning and development of better services. It therefore provides a strong consumer perspective to considerations of quality service delivery, enabling services to be more responsive to the needs of the people who use them.

"MH-CoPES links in to the priorities of the NSW State Plan by increasing consumer participation in health services, improving access to quality health care, and improving outcomes in mental health."

A further unique feature of the MH-CoPES Framework is its inclusion of an "Action and Change" step whereby consumers and services work together to act on the findings to improve services. This component ensures a credible Framework where consumers are assured that their feedback will be acted upon and result in improved services. The processes for reporting back to both services and consumers of the outcomes from the Questionnaire and for reporting back on quality improvement initiatives resulting from this feedback ensures a transparent and accountable process that can drive service improvement.

The involvement of Consumer Workers, particularly in assisting and encouraging people to complete the Questionnaire enabled the research to achieve high response rates of 64% in inpatient units during the research. These high response rates are vital for providing AHSs and local mental health services with data that is reliable and useful and leads to greater acceptance by staff of quality improvement based on needs as identified by consumers. Therefore MH-CoPES is a comprehensive Framework that provides quality information about mental health services from the perspective of consumers.

Staff Engagement with Quality Improvement

Staff involvement in the process of implementing MH-CoPES creates a sense of ownership over quality improvement initiatives. It also facilitates closer working relationships between consumers and staff, and thus provides a mechanism for training staff around consumer participation and its value to service provision.

Inclusion of staff at all organisation levels in the change process ensures good outcomes are achieved. Inclusive discussions about results allow collective problem solving to occur, and positive discussion around practices that need improving. Reporting to all levels of staff where the service is doing well acknowledges staff for their work; it builds staff pride in providing quality services based on the needs of consumers, and pride in listening to and acting on consumers' experiences and perceptions of the service.

Cultural Change through MH-CoPES: Changes to Relationships between Consumers and Services

Throughout the research, it was demonstrated that MH-CoPES is also an important catalyst for promoting cultural change around staff attitudes towards consumers of mental health services and consumer participation. Having consumers participate in each step of the Framework and having consumers and staff working collaboratively on each step of the Framework has increased interaction between consumers and staff, adding value to the quality improvement process and breaking down stigma held by both staff and consumers. Those involved in the research felt that they were contributing to a better service, seeing MH-CoPES as a highly rewarding process, which led to the development of further collaborative activities between staff and consumers. The process highlighted for staff the value of consumer participation in services.

MH-CoPES: A Tool for Measuring State and National Priorities

MH-CoPES links in to the priorities of the NSW State Plan by increasing consumer participation in health services, improving access to quality health care, and improving outcomes in mental health. By providing a consistent tool to assist in meeting accreditation standards related to consumer participation and the evaluation of Government services, the need for services to conduct and analyse their own surveys is eliminated. MH-CoPES further assists in meeting several targets of the State Plan, particularly creating better experiences for people using mental health services, and providing a framework for highlighting risks and opportunities within the system.

MH-CoPES also offers a tool to measure *Responsiveness* of services to consumers, which is a performance indicator under the National Health Performance Framework (National Health Performance Committee, 2001). Furthermore it satisfies the performance indicator relating to consumer satisfaction with services and providing

services that are responsive to consumer's needs and contributes to the indicator of the extent of consumer involvement in decision making, highlighted in the *Report on Government Services* (Steering Committee for the Review of Government Service Provision, 2009).

MH-CoPES is also a suitable candidate as a national tool to measure consumers' perceptions and experiences of care to meet the outcome aim of the *Fourth National Mental Health Plan* (Commonwealth of Australia, 2009)

Stage 2 Recommendations

Based on the work and findings of both stages of the MH-CoPES project, the following recommendations are made to NSW Health for implementing a statewide process for consumer evaluation of mental health services in NSW:

1. NSW Health adopt the whole MH-CoPES Framework as a way for consumers to participate in quality improvement, and to ensure that consumer perspectives and experiences contribute to service change throughout public, adult mental health inpatient and community services in NSW as per the protocols in this report. This includes the adoption of the MH-CoPES Questionnaires for people who use public, adult inpatient and community mental health services as the main tool for providing their feedback.
2. The MH-CoPES Framework is integrated into current state, AHS and local service quality improvement structures.
3. A policy position around consumer participation in the evaluation of mental health services be adopted by NSW Health that:
   - articulates the value of consumer participation in service evaluation and quality improvement
   - defines consumer participation in service evaluation in accordance with the definitions provided in this report, and the Stage 1 Report (NSW Health, 2006)
   - is based on the nine principles underpinning MH-CoPES
   - articulates the purpose of the MH-CoPES Framework as providing a way for consumers to participate in quality improvement and to ensure that consumer perspectives and experiences contribute to service change and improvement.
4. MH-CoPES is incorporated into the regular reporting of NSW Mental Health Key Performance Indicators. It has been identified that this could be achieved by establishing MH-CoPES as a measure of services' performance in the area of *Responsiveness* to consumers, within the National Health Performance Framework (National Health Performance Committee, 2001). MH-CoPES could also be used to satisfy the performance indicator relating to consumer satisfaction with services and providing services that are responsive to consumers needs, and the extent of consumer involvement in decision making for mental health management, from the *Report on Government Services* (Steering Committee for the Review of Government Service Provision, 2009).
5. NSW Health develop strategies to support the implementation of MH-CoPES as highlighted above and throughout this report, including the development and implementation of a state Policy for Consumer Participation in Mental Health Services.
6. Further research be conducted to adapt the MH-CoPES Framework and Questionnaires so that they are appropriate for use by:
   - people from other cultural and language groups, including people from Aboriginal and Torres Strait Islander backgrounds
   - people who use child and adolescent mental health services
   - people who use older person's mental health services
   - people who use forensic mental health services
   - families and carers of mental health consumers.

1. Introduction

The Mental Health Consumer Perceptions and Experiences of Services (MH-CoPES) Stage 2 Project, was conducted by the NSW Consumer Advisory Group – Mental Health Inc. (NSW CAG) in partnership with the Mental Health and Drug and Alcohol Office, NSW Health.

1.1 National and NSW Context

Consumer perceptions and experiences of service delivery have been widely recognised in research as well as in state and national policies as crucial to the implementation of effective mental health services (National Mental Health Working Group Information Strategy Committee, 2004; National Health Performance Committee, 2001; NSW Department of Health, 2006; NSW Government, 2006; Steering Committee for the Review of Government Service Provision, 2009). However in NSW and nationally there is currently no agreed upon mechanism for the gathering of consumer perceptions and experiences of services or consumer participation in mental health service quality improvement and evaluation (Steering Committee for the Review of Government Service Provision, 2009).

While participation means a range of things to consumers, a central, collective understanding is that participation has an "end goal of creating services that better meet [consumers] needs" (Service Quality Australia, 1999).

The value of consumer evaluation of mental health services has been well recognised as an important factor in the implementation of effective mental health services. Nationally, there is commitment to understanding how consumer perceptions of services can contribute to improving services. For example:

- In 2004, a National Mental Health priorities workshop (National Mental Health Working Group Information Strategy Committee, 2004) identified the development and implementation of a nationally agreed measure of consumer perceptions of care as a priority.
- *The Fourth National Mental Health Plan* (Commonwealth of Australia, 2009) includes the reporting of consumers perceptions and experiences of care as an outcome in the improvement and innovation priority.
- The National Health Performance Framework (National Health Performance Committee, 2001) includes a measure of services *Responsiveness* to consumers, providing further evidence of the commitment to consumer perceptions as important to evaluating services. This commitment is reiterated by the performance indicators relating to consumer satisfaction with services and providing services that are responsive to consumers needs and measuring the extent of consumer involvement in decision making for mental health management, highlighted in the *Report on Government Services* (Steering Committee for the Review of Government Service Provision, 2009).

Underpinning this are national and state strategies that reiterate the importance of consumer participation and evaluation of services (eg. *The Fourth National Mental Health Plan 2009-2014*, Australian Health Ministers, 2009; *National Mental Health Policy 2008*, Australian Health Ministers, 2008; *National Standards for Mental Health Services*, Australian Health Ministers, 1997; *Framework for Managing the Quality of Health Services in NSW*, NSW Health, 1999; *NSW State Plan for Mental Health*, NSW Health, 2006; *NSW State Health Plan Towards 2010*, NSW Department of Health, 2007).

Furthermore, *the Report on Government Services* highlights that ascertaining consumer satisfaction with services is important to delivering quality services through ensuring the objective of providing services that are responsive to consumer's needs (Steering Committee for the Review of Government Service Provision, 2009).

Box 1.
Defining consumer evaluation of mental health services

What is consumer evaluation of mental health services?

"Consumer evaluation" of mental health services means the opportunity for consumers to:

- have their say about how the service is working: what is working well and how the service could improve
- help to assess what might need to change about the services they receive
- from their experience, explain the things that are important about mental health services
- participate in improving services, by developing solutions to problems they identified through evaluation
- assist to implement these solutions for change

Importantly, "consumer evaluation" enables this evaluation and improvement to be done from a "consumer perspective" rather than from the perspective of service providers or others in service provision and not limiting consumers to commenting on issues identified by service providers as important.

It is important to note, however, that there is not "one" (Epstein and Olsen 1998) consumer voice but rather, consumers hold a range of views and perspectives.

While there is not necessarily one consumer perspective, there are common issues that are of high importance to many people who use services.

1.2 Background: Stage 1 of the MH-CoPES Project

The MH-CoPES project was established to identify a framework for consumer evaluation of mental health services to use across NSW Health.

Stage 1 of the project was conducted between 2004 and 2006. Stage 1 aimed to:

- develop a framework for consumer evaluation of mental health services in NSW AHS mental health services; and
- develop tools to assist in the conduct of consumer evaluation, consistent with the Framework developed.

Details of this first Stage of MH-CoPES can be found in the report *A statewide approach to measuring and responding to consumer perceptions and experiences of adult mental health services: A report on stage one of the development of the MH-CoPES framework and questionnaires* (NSW Department of Health, 2006).

1.2.1 Outcomes from Stage 1

Stage 1 resulted in the development of a draft MH-CoPES Framework for consumer evaluation of mental health services detailed below and two versions of the MH-CoPES Questionnaire. Both Questionnaires are for use by consumers of public, adult mental health services. One is for use in community services and one is for use in inpatient services. A set of nine principles, detailed below, underpinning consumer evaluation of mental health services was also produced to guide the initiative.

1.2.2 The MH-CoPES Framework for Consumer Evaluation of Mental Health Services

The Framework was developed to provide a consistent approach for consumers of NSW public, adult community and inpatient mental health services to provide their perceptions and experiences of services and for this feedback to clearly contribute to directing service improvement initiatives. The Framework is targeted towards generating grouped feedback on the strengths and weaknesses of service quality and delivery, rather than individual issues or concerns.

Figure 1.
The MH-CoPES Framework

The Framework consists of four steps:

Data Collection

Consumers provide their perceptions and experiences of mental health services using the appropriate MH-CoPES Questionnaire, highlighting areas of service strength and areas in need of improvement.

Data Analysis

Consumers' combined fixed choice answers and written comments are statistically and thematically analysed to identify areas where mental health services are performing well and areas needing improvement.

Reporting and Feedback

Reports are produced and distributed to all stakeholders that outline identified areas where services are performing well, and areas needing improvement.

Action and Change

Results, as presented in reports, are used to produce local, Area Health Service (AHS) and state action plans with the aim of improving the quality of mental health services.

The four steps make up one complete evaluation cycle, with cycles of evaluation to occur repeatedly.

1.2.3 The Principles Underpinning the MH-CoPES Framework

Stage 1 of the MH-CoPES project also articulated nine principles that underpin the evaluation of mental health services by consumers. These principles were used during Stage 1 to guide the project and the development of the draft Framework and Questionnaires (see Table 1). They were produced to provide the foundation for further development of MH-CoPES as a Framework for consumer evaluation, and thus underpinned the work of Stage 2.

Table 1.
Principles underpinning MH-CoPES consumer evaluation

Recovery Orientation	A recovery orientation to service provision means that at a systems level mental health services are to be guided by consumers' views of what works and what does not. Consumer evaluation of services is a central feature of a recovery orientation.
Consumer participation	Consumer evaluation of mental health services is an enactment of genuine consumer participation, most particularly at service and systems levels.
Empowerment	Consumer evaluation of mental health services is fundamentally informed by, and directed towards creating opportunities for consumer empowerment.
Accountability	Services are accountable to consumers, families and carers, staff, funding bodies, and the NSW community.
Continuous improvement	Services should be striving to develop and advance their service delivery as a core part of their work. Continuous improvement is one of the quality indicators of NSW Health.
Privacy and safety	Evaluation of mental health services should be an activity that consumers and staff engage in knowing their individual privacy will be maintained without fear of adverse repercussions.
Accessible and equitable	Evaluation processes should be freely available to everyone wishing to become involved.
Efficient and effective	The process of consumer evaluation should be easy to engage in, without creating unnecessary extra burden for consumers, staff or services. The process should also be effective, in that it guides service change on the ground.
Service and systems focus	The primary focus of consumer evaluation of services is to identify problems within the system, and at service levels. It is not aimed at identifying problems at individual levels, which is the focus of other quality processes in services.

Consumer perceptions and experiences of service delivery have been widely recognised in research as well as in state and national policies as crucial to the implementation of effective mental health services. The MH-CoPES project was established to identify a framework for consumer evaluation of mental health services to use across NSW Health.

1.2.4 Recommendations from Stage 1

Stage 1 produced a number of suggestions relating to how each step of the MH-CoPES Framework could be enacted at local levels. These were based on consultations with stakeholders, and required testing and further development in partnership with consumers, staff and AHS mental health services to produce recommended standards and protocols for the implementation of MH-CoPES.

At the conclusion of Stage 1 of the project a number of recommendations were also made to guide the next steps to achieve consistent statewide opportunities for consumers to participate in service evaluation and quality improvement. Both the Framework and the Questionnaires required further testing and development before being ready for routine implementation. It was also acknowledged at the conclusion of Stage 1 that "implementing genuine consumer evaluation processes in mental health services across NSW will essentially involve a further shift in the current culture of services, toward improved consumer and service partnership, and inclusive consumer participation at all levels of services" (NSW Health, 2006, p. 58). Therefore further work was needed to understand these cultural issues and to develop a consistent vision for the role of MH-CoPES.

1.3 Background to Stage 2 of the MH-CoPES Project

1.3.1 Key Objectives

Following from Stage 1, NSW CAG was funded by NSW Health to conduct the MH-CoPES Stage 2 project in partnership with the Mental Health and Drug and Alcohol Office, NSW Health.

Stage 2 aimed to achieve three key objectives. These were:

Objective 1

- to clearly identify and document the properties, standards and cost implications of each step of the MH-CoPES Framework

Objective 2

- to assess the cultural and change management issues to be addressed to support the future implementation and sustainability of the MH-CoPES Program

Objective 3

- to clarify the role and place of MH-CoPES in service improvement.

To achieve these objectives, NSW Health funded two components of work to occur between 2006 and mid 2009:

The NSW Consumer Advisory Group – Mental Health Inc. (NSW CAG) was commissioned to:

- continue the development and research on the Framework and Questionnaires;
- explore the cultural and change management issues surrounding the implementation and sustainability of MH-CoPES; and
- explore the role and place of MH-CoPES.

Over the same time period, InforMH, NSW Health, introduced the draft MH-CoPES Questionnaires developed in Stage 1 to public, adult mental health services statewide. This was done with limited resourcing, with funding covering only the costs for producing the Questionnaires and data entry of returned Questionnaires via scanning and minimal reporting of results.

1.3.2 Project Structure

Steering Committee

A Steering Committee was formed to provide strategic oversight to the Stage 2 work, and report to the Mental Health Program Council on the project. Its role was to:

- monitor the project's feasibility, plan and achievement of outcomes/deliverables
- approve the project's budgetary strategy
- oversee project risks and risk management
- oversee project scope management, including assessment of requests for change of scope
- make state policy and resource decisions associated with the project

- reconcile differences of opinion and approach, and resolve disputes arising from them
- provide the NSW CAG Project Officer with guidance on business issues relating to the project.

A list of Steering Committee members is in Appendix A.

Reference Group

A statewide Reference Group was also formed to inform the project. The Reference Group consisted of a service provider and consumer representative from each of the eight Area Health Services (AHSs) Mental Health and Mental Health Drug and Alcohol Services. Each member from AHSs involved in the statewide introduction of MH-CoPES was also an MH-CoPES Coordinator for their Area.

The role of the Reference Group was to:

- promote MH-CoPES within AHSs
- liaise and consult with AHSs on issues relating to the project
- represent the views of AHSs at Reference Group meetings
- provide advice to the NSW CAG Project Team
- support the work of the NSW CAG Project Team
- provide input and feedback into the statewide introduction of MH-CoPES.

The major objectives for the Reference Group were to:

- provide statewide consumer, service provider and community input into the MH-CoPES Framework and associated tools, including the MH-CoPES Questionnaires
- work with the NSW CAG Project Team to determine the role and place of MH-CoPES in service improvement.

A list of Reference Group members is provided in Appendix A.

1.4 This Report

This report presents the work undertaken throughout Stage 2 of the MH-CoPES project. It presents the results of the research work conducted by NSW CAG on the further development of the MH-CoPES Framework. In order to make recommendations about the implementation of MH-CoPES and to address the three objectives of Stage 2, information from the work of the statewide introduction is also drawn on.

2. MH-CoPES Stage 2: NSW CAG's Research

NSW CAG's role in Stage 2 was to conduct the research needed to achieve the three project objectives listed on page 13. The research conducted is detailed here.

2.1 The Research Process

The research was conducted in collaboration with two Area Health Services who agreed to work as research partners: Greater Western Area Health, Mental Health Drug and Alcohol Service (Greater Western AHS) and Northern Sydney Central Coast Area Health, Mental Health Service (Northern Sydney Central Coast AHS). The research was also guided by the principles underpinning MH-CoPES (see Appendix B for an analysis of the implications of the principles for the MH-CoPES Framework).

To address the three Stage 2 objectives, NSW CAG embarked on the following process:

1. An initial trial of the Framework was conducted with the research partners, testing protocols for each step of the Framework. The trial involved a one-month *Data Collection* period. It occurred during June/July 2007 in Orange, and August 2007 in Ryde.
2. A pilot of revised protocols, refined from the trial experience and consultations, was held in the two research sites, involving a three-month *Data Collection* period.
3. A series of formal and informal consultations was held in conjunction with the trial and pilot with consumers, carers, Area Mental Health Service staff and NSW Health. Consultations were held with:
   - Reference Group
   - Consumers and staff at the services involved
   - Consumers at the O'Brien Centre, Orange
   - Pilot Implementation Committees
   - Ryde Consumer Forum
   - Northern Sydney Consumer Network
   - AHS Executive from the research sites
   - InforMH
   - NSW Health
   - NSW CAG's email network
   - Ryde consumer and carer evening
   - Consumer Workers' Forum
   - Consumers at the Croyden Health Centre

A list of consultation topics is provided in Appendix C.

Together, the evidence gathered from these processes was used to produce:

- standards and protocols for each step of the Framework
- revised Questionnaires for use in the *Data Collection* step
- recommendations relating to the cultural and change management issues to be addressed to support the full implementation of MH-CoPES statewide
- recommendations about the role and place of MH-CoPES in service improvement.

2.1.1 NSW CAG's Research Team

A project team comprising a Project Officer and Research Assistants (including three consumers) were employed by NSW CAG to coordinate and conduct the research component of the project. See Appendix A for NSW CAG Project Team members.

2.1.2 The Research Sites

NSW CAG worked in partnership with consumers and mental health services in Orange (Greater Western AHS) and Ryde (Northern Sydney Central Coast AHS) to test and refine the MH-CoPES Framework.

The following mental health services were nominated by Greater Western AHS and Northern Sydney Central Coast AHS to participate in the project. These services did not participate in the statewide introduction until the conclusion of NSW CAG's research work.

Greater Western AHS – Rural Services (Orange)

- One acute admissions unit
- One sub acute unit
- Two medium term rehabilitation units
- The Satellite Housing Integrated Programmed Support (SHIPS – a community based clinical rehabilitation/life skills program and respite care for people suffering from major mental illness)
- Two community mental health services

Northern Sydney Central Coast AHS – Metropolitan Services (Ryde)

- Two recovery units
- Two extended care open units
- Two medium term locked units
- One short term unit for 18 to 35 year olds with dual diagnosis
- One acute, locked admissions unit
- One community mental health service

2.1.3 Pilot Implementation Committees

A Pilot Implementation Committee (PIC) was established in Greater Western AHS and Northern Sydney Central Coast AHS to oversee the project's implementation locally and provide advice to the NSW CAG Project Team on solving issues that arose during the course of the project. Table 2 below describes the members of the two PICs.

Table 2.

Members of the PICs in Greater Western AHS and Northern Sydney Central Coast AHS

Greater Western AHS PIC

- The Mental Health Promotion and Prevention Unit Coordinator
- Nurse Unit Managers from each unit involved in the research component of MH-CoPES
- Senior Nurse Managers (one each for inpatient, community and rehabilitation services)
- Consumer Project Workers
- A Consumer Consultant
- A representative from the Mid Western Consumer Advisory Group
- The Area Quality Coordinator
- The Area Allied Health Manager
- A Senior Occupational Therapist

The PIC reported directly to the Cluster Senior Clinical Quality Committee.

Northern Sydney Central Coast AHS PIC

- The Area Mental Health Services Director of Operations
- The Area Mental Health Information Manager
- The Area Mental Health Services Community Participation Coordinator
- The Acting Director, Macquarie Hospital
- The Director of Patient Services, Macquarie Hospital
- The Quality Manager, Macquarie Hospital
- The Team Leader, Acute Services, Ryde Community Mental Health Service
- A Consumer Advocate, Macquarie Hospital
- The Consumer Coordinator for Macquarie Hospital and Ryde Community Mental Health Service
- A Senior Nurse Manager

The PIC was chaired by the Area Mental Health Services Community Participation Coordinator and reported directly to the Area Mental Health Services Director of Operations.

2.1.4 The Trial: 2007

The initial trial was conducted to finalise the development of the MH-CoPES Framework. The trial was designed to:

- test a number of options available at each step of the Framework that were raised in Stage 1 of the project
- test the MH-CoPES Questionnaires in practice, and
- answer a number of questions, also raised in Stage 1 of the project, about how the Framework should be implemented in order to understand fully the standards and protocols necessary to implement the MH-CoPES Framework in AHSs in NSW.

Protocols for the trial were developed based on the findings of the Stage 1 project, the implications of the Principles underpinning MH-CoPES, literature reviews, and input from the PICs and individual services involved. A number of consultations were held with consumers and service staff and management over the course of the trial to gather information about their experiences and best practices for the Framework.

Because of the research nature of the trial, the Greater Western AHS and Northern Sydney Central Coast AHS Human Research Ethics Committees approved the process and protocols being tested.

A series of questions about the Framework guided the trial. Table 3 overleaf outlines these questions and methodology used to address each.

Consumer Project Workers

Consumer Project Workers[1] were employed in each pilot site to distribute Questionnaires, provide support to people who needed it, promote MH-CoPES, and to participate in the PIC. Most Consumer Project Workers were already employed as Consumer Advocates or Consumer Consultants within the AHS; therefore additional hours were funded for them to take part in MH-CoPES. The research partners employed other Consumer Project Workers specifically for the MH-CoPES project. Consumer Project Workers received two half days of training facilitated by the NSW CAG Project Team in the research methods and protocols for the trial. This included a briefing on the ethical requirements for the conduct of the trial. All Consumer Project Workers were provided with a manual detailing the procedures for each service involved in the trial. This included a script specific to each service that was to be used when handing out the Questionnaire and when assisting people to complete the Questionnaire.

Service Visits

Prior to the commencement of the trial, all services were visited by the NSW CAG Project Team to ensure that staff were aware of MH-CoPES. During the visits, where staff were to be involved in the distribution of the Questionnaire, a description of the process and a script was provided. A manual was prepared detailing the procedures for each service for the MH-CoPES trial and was left for staff information.

Participants in the Trial *Data Collection* Step of the MH-CoPES Framework

All eligible consumers using the nominated services during the trial were provided with an opportunity to complete a Questionnaire. As an ethical requirement, consumers under the age of 18 years, those who had been in an inpatient unit for less than four days, and those in distress or crisis at the time were excluded from participating in the trial.

All participants who received a Questionnaire during the trial were also asked to complete an evaluation survey (see Appendix D) about the Questionnaire and how it was administered to them.

One hundred and forty five (145) people provided feedback about inpatient services, and 133 provided feedback about community services. The response and return rates are presented in Table 4 (page 21).

Further information about participants in the trial is presented in Appendix E.

[1] A Consumer Project Worker was a person who identifies as a user of mental health services and who was employed and trained for the purposes of the MH-CoPES project.

Table 3.
Questions guiding the trial and methodology used to address them

Research question	*Method adopted to answer the research question*
Whole Framework Implementation	
Who should be responsible for the management of MH-CoPES?	◆ Literature reviews of relevant models for the management of different steps of the Framework ◆ Consultations (via issues papers, discussions and consultation forums)
How often should the steps of the MH-CoPES Framework occur?	◆ Consultations ◆ Analysis of responses to the MH-CoPES Questionnaire comparing the trial, pilot and statewide introduction
Step 1: Data Collection	
Are the MH-CoPES Questionnaires acceptable to consumers?	◆ Examination of response and return rates ◆ Analysis of responses to evaluation survey ◆ Consultation with consumers involved in the research
What are the psychometric properties of the MH-CoPES Questionnaires? (reliability, validity, and Questionnaire structure)	◆ Reliability: ❍ The Questionnaires' internal consistency was measured by calculating the correlations between the questions on the Questionnaire using all Questionnaires fully completed during the trial and pilot. ❍ Test-retest reliability was calculated based on responses by a sub-sample of consumers who completed the Questionnaire twice during the trial and pilot. ❍ Analysis of responses to the Questionnaire based on demographic variables collected through the evaluation survey during the trial. ◆ Validity: ❍ Fourteen interviews conducted with consumers during the trial/pilot. See details below. ❍ An examination of the correlation of an individual's total MH-CoPES score with responses to the NSW Health Survey question "Overall, what do you think of the care you received at this community health centre/hospital?" ◆ Questionnaire Structure A Factor Analysis was conducted to understand the overall structure of the Questionnaire.
Does indicating the name of the service unit on Questionnaires influence responses?	◆ Four research sites (one inpatient service and one community service in each research AHS) were involved in studying the impact of identifying the mental health service unit on Questionnaires on return rates. Questionnaires were distributed randomly in these four services with either: ❍ Only the AHS label; or ❍ Both the AHS and the service unit's name. Differences in return rates between these two conditions, and differences in responses themselves were measured to assess whether including the name of the service unit impacted on consumers' responses.

How do consumers prefer to provide their feedback?	◆ Literature review to identify strengths and weaknesses of possible feedback options ◆ Consultations ◆ A question on the evaluation survey asked specifically whether completing the MH-CoPES Questionnaire was the best way for participants to provide their perceptions and experiences of the mental health services. If they answered no participants were asked to provide information about how they would prefer to provide this information.
What support do consumers need to complete the Questionnaire?	◆ Consumers in research sites were able to seek assistance from the following: ❍ Consumer Project Workers ❍ Friend or carer ❍ In some services, the option of completing the Questionnaire verbally with a Consumer Project Worker was available ❍ A local phone number was provided for participants in Orange with a phone available in services, providing an option of completing the Questionnaire verbally by telephone in some services The total number of consumers accessing each method of assistance during the trial was recorded ◆ Analysis of impact of support method on responses to the Questionnaire
How should the Questionnaire be distributed?	◆ Trial of five distribution methods during trial: Questionnaires handed to consumers by: ❍ A Consumer Project Worker ❍ Administration staff member ❍ Nurse ❍ Care coordinator/case worker ❍ Mail to consumers' residential address by AHS administrative staff who in the course of their normal role have access to consumers' contact information. This method was trialled in one community service in Orange. ◆ Analysis of differences in responses based on how the Questionnaire was distributed ◆ Evaluation survey questions ◆ Consultations
When should the Questionnaire be distributed?	◆ Trial of distribution: ❍ Upon discharge ❍ While using the service Analysis of differences in responses based on when the Questionnaire was distributed ◆ Evaluation survey questions ◆ Consultations

What options for Questionnaire return need to be available?	◆ Two return options were trialled: ❍ Reply paid mail, with addressed envelopes distributed with the Questionnaire ❍ Locked boxes available within each service unit ◆ The number of Questionnaires returned by each method during the trial was recorded

Step 2: Data Analysis

Research question	*Method adopted to answer the research question*
How should analysis of the fixed choice section of the Questionnaire occur?	◆ Consultation with statisticians and research psychologists at the Illawarra Institute of Mental Health, University of Wollongong ◆ Consultations with consumers and service staff to determine the type of information these stakeholders want from the Questionnaires ◆ Consultation with Reference Group ◆ Review of feedback from research sites regarding the usefulness of reports produced ◆ Consultations with InforMH to determine the broader reporting needs of the NSW Department of Health
How should the analysis of the written comments section of the Questionnaire occur?	◆ Consultations as above ◆ Trial of analysis methods

Step 3: Reporting and Feedback

Research question	*Method adopted to answer the research question*
How should reporting and feedback occur?	◆ Consultations with each stakeholder group ◆ Experience with the trial and pilot
What is the best format for reporting from Step 1 to: ❍ consumers ❍ individual services ❍ Area Health Services ❍ NSW Health?	◆ Consultations with each stakeholder group to develop an understanding of the reporting requirements of each group ◆ Feedback on reports developed for the trial and refinements made

Step 4: Action and Change

Research question	*Method adopted to answer the research question*
What structures and processes are needed to ensure the results of MH-CoPES are used to inform quality improvement initiatives?	◆ PICs in each pilot site developed processes for the development of action plans in response to MH-CoPES reports ◆ The PICs and relevant AHS staff undertook reviews of the processes implemented after the trial

Table 4.

Response and return rates from the trial

	Number of Questionnaires handed out	Number returned	Response rate	Return rate as a percentage of population using services during the trial
Inpatient	225*	145	64.44%**	43.81%
Community	Approximately 524[a]	133	25.35%**[a]	13.77%

* Number of Questionnaires handed out is an approximation. Some services did not track exact numbers distributed. Approximation is based on anecdotal evidence.

** Response rate (% of Qs returned from those handed out)

[a] Exact numbers of Questionnaires distributed were not available

The Evaluation Survey for Consumers

An evaluation survey was developed to assess consumer's thoughts about the Questionnaire and how it was administered to them (see Appendix D). This enabled an assessment of the acceptability of the MH-CoPES Questionnaire to consumers and assisted in the development of protocols for the distribution of the Questionnaire. The last section of the survey contained demographic questions including sex, age, place of birth, diagnosis, and whether the person was in treatment voluntarily or involuntarily. This section enabled an analysis of whether responses to the MH-CoPES Questionnaire varied based on the demographic variables collected. The purpose of this analysis was to assist in determining the reliability of the MH-CoPES Questionnaire. To enable this examination, each MH-CoPES Questionnaire and evaluation survey was coded; people received a Questionnaire and survey with the same code. Details identifying who received each code were not recorded, except in the case of the examination of test-retest reliability to enable participants who agreed to take part in this to be offered a second Questionnaire.

With the exception of services involved in the examination of the Questionnaire's test-retest reliability, the evaluation survey accompanied each MH-CoPES Questionnaire handed out. In services where the Questionnaire's test-retest reliability was being assessed, the evaluation survey was disseminated with the second distribution of the MH-CoPES Questionnaire. This was to ensure that completing the survey did not impact on how people completed the MH-CoPES Questionnaire on the second occasion.

One hundred and thirty three (133) people completed the evaluation survey during the trial. A further two people returned their survey late.

Validity Interviews

To explore whether the MH-CoPES Questionnaire effectively measures consumers' perceptions and experiences of services, the NSW CAG Project Team conducted interviews with consumers. During the trial and pilot members of the NSW CAG Project Team attended research sites and invited people who had completed a MH-CoPES Questionnaire to participate in an interview. Advertisements requesting people to participate in these interviews were also displayed in some services.

The interview involved people relating their experiences and perceptions of the quality and delivery of the service (see Appendix F). These open-ended interviews were, with the permission of participants, audiotaped, and transcribed verbatim for analysis. The audiotaped and transcribed interviews were coded with the same code

as used on the participant's MH-CoPES Questionnaire. These interviews were analysed to look for themes, and responses compared with their responses to the MH-CoPES Questionnaire. Seven people using inpatient services and seven people using community services completed this interview. For more information about participants see Appendix G.

The Evaluation Survey for staff

An evaluation survey, which asked staff about their experience with MH-CoPES, was made available at each service involved in the research. Staff were informed of this survey during the service visits by the NSW CAG Project Team. As only a few surveys were returned, this survey is not considered any further in this report.

2.1.5 The Pilot

A period of consultation and review followed the trial during which the protocols trialled for the Framework and the MH-CoPES Questionnaires were revised. The changes made to the Questionnaires are in Appendix H.

A pilot was then conducted in 2008, which allowed for a 'dry-run' of the protocols developed and refined through the trial process. While the trial was conducted to test a number of options for the Framework protocols, the pilot aimed to test more specifically the proposed protocols, and answer the question: *Do the proposed protocols for the MH-CoPES Framework work in practice?* A small number of research activities were conducted to test refinements from the trial and to answer some remaining questions:

- what are the psychometric properties of the revised MH-CoPES Questionnaires?
- what are the best methods for the analysis of the fixed choice and open comments questions of the Questionnaire and the presentation of MH-CoPES reports to all stakeholders?
- how often should each step of the Framework occur?

The methods used to answer these questions were based on those outlined for the trial in Table 3.

Consultations accompanied the pilot to further build on the standards and protocols.

Consumer Project Workers

As occurred during the trial, Consumer Project Workers were employed for the pilot. A half-day training session was conducted by NSW CAG to inform Consumer Project Workers of the protocols for the pilot. Manuals and scripts were provided to guide Consumer Project Workers in handing out Questionnaires only where an examination of the Questionnaires' test-retest reliability was being conducted. In all other cases, a sheet was provided to Consumer Project Workers to prompt what information needed to be conveyed when handing out the Questionnaire.

Participants in the pilot *Data Collection* Step of the MH-CoPES Framework

As in the trial, all eligible consumers using the research mental health services during the pilot *Data Collection* period were provided with an opportunity to complete a Questionnaire. Again, consumers under the age of 18 years, those who had been in an inpatient unit for less than four days, and those in distress or crisis at the time were excluded from participating in the pilot.

Two hundred and forty nine (249) people provided feedback about inpatient services and 177 people provided feedback about community services during the pilot. Table 5 details the return rates from the pilot. Numbers of Questionnaires distributed during the pilot were not recorded; therefore response rates are not available.

Further information about participants during the pilot is presented in Appendix I.

The Evaluation Survey

During the pilot, only people involved in the re-examination of the test-retest reliability were provided with an evaluation survey as per the protocol for the trial.

Twenty five (25) people completed the evaluation survey during the pilot. The total of people completing this survey was therefore 160.

Addressing Project Objectives 2 and 3

The experiences from the trial and pilot were also used to:

- inform an understanding of the cultural and change management issues that need to be addressed to support the full implementation and sustainability of MH-CoPES statewide
- clarify the role and place of MH-CoPES in service improvement

In addition, the following methods were used to answer the key questions (see Table 6) about these objectives:

- literature reviews
- discussion and issues papers
- surveys of Area Health Services about their structures
- consultations

Table 5.

Return rates for the pilot

	Number of Questionnaires returned	Return rate as a percentage of population using services during the trial
Inpatient	249	50.4%
Community	177	8.9%

Table 6.

Questions guiding the work to address objectives 2 and 3

Objective 2:

Cultural and change management issues that need to be addressed

What are the barriers to the implementation of MH-CoPES?
What are the factors that support the cultural change required?
What structures/resources are required to implement and sustain MH-CoPES?
What drives Area Health Services and local services to implement MH-CoPES and act on the findings?

Objective 3:

Role and place of MH-CoPES

What functions/roles does MH-CoPES have?
What structures and processes does MH-CoPES connect with?
Where does the responsibility for MH-CoPES lie?

3. Outcomes

Objective 1:
The Revised and Tested MH-CoPES Framework and Associated Questionnaires

This section details the outcomes of the research conducted to address the first objective of the project, to document the properties of each step of the MH-CoPES Framework. It provides the research results from the trial and pilot of the Framework and Questionnaires, and presents the finalised MH-CoPES Framework and associated Questionnaires.

3.1 Protocols for the MH-CoPES Framework

The experiences of the trial and pilot as well as the consultations conducted throughout both stages of the MH-CoPES project have resulted in the development of tested and refined protocols for the implementation of the MH-CoPES Framework. These are presented in Figure 2.

Implementation of the MH-CoPES Framework throughout NSW will have associated costs. Costings are not provided in this report, but will be presented in accompanying reports to the NSW Mental Health Program Council for consideration.

The revised MH-CoPES Questionnaires recommended for implementation are presented in Appendices J and K.

The Whole MH-CoPES Framework

Management:

- Processes for *Data Collection* are developed at local services based on the procedures detailed below.
- A central body, separate from individual Area Health Services and working in partnership with a consumer directed organisation, manages *Data Analysis* and *Reporting and Feedback*. It is recommended that this organisation be InforMH, NSW Health, working with a consumer directed organisation.
- *Action and Change* is managed at the different levels at which it occurs (ie. state, Area Health Service, and local service) as per the procedures below.
- To ensure commitment to the MH-CoPES Framework it is recommended that the MH-CoPES Questionnaire be implemented as the key tool in Area Health Services for the measurement of the key performance domain of *Responsiveness* under the National Health Performance Framework (National Health Performance Committee, 2001).

Frequency:

The MH-CoPES Framework is a ***continuous evaluation cycle*** with four key steps.

- *Data Collection* is an ongoing process, with consumers being offered Questionnaires on each discharge from a service and once during each year they are using a service.
- *Data Analysis* and *Reporting and Feedback* occur twice a year.
- *Action and Change* is an ongoing process within the current system of continuous quality improvement.

Data Collection

Tool for Data Collection:

- The MH-CoPES Questionnaires are used as the primary tool for collecting consumers' views of services

Support to complete the Questionnaire:

Assistance to complete the Questionnaire can be given by

- Consumer workers
- Family, carers or friends
- Administration staff
- Clinical staff if a consumer has specifically requested assistance.

Distribution method:

- Consumer Workers can hand out Questionnaires (as they can then provide immediate assistance if needed)
- Administrative and clinical staff may hand out Questionnaires
- Distribution may occur individually or in a group setting
- Questionnaires may be included in discharge packs
- Questionnaires may be mailed to consumers (ONLY where data systems are up to date)

When to distribute the Questionnaire:

- Acute inpatient services: upon discharge
- Long term inpatient services: once a year while using the service and upon discharge
- Community services: once a year while using the service and upon discharge

Return methods:

- All Questionnaires include a reply paid envelope
- All services have an MH-CoPES Questionnaire locked return box
- Questionnaires are returned unopened to the organisation undertaking data analysis

Action and Change

MH-CoPES is incorporated into state, Area and local service quality improvement processes and systems

- Aspects identified in MH-CoPES reports as most in need of improvement are key aspects guiding quality improvement initiatives at the state, Area Health Service (AHS) and local levels
- Action and Change is an ongoing process informed by each MH-CoPES report
- NSW Health, Area Health Services (AHS) and local services have processes in place to ensure consumers are involved in state, AHS and local quality improvement processes
  - ✦ providing opportunities for consumers to express their views on how changes should happen
  - ✦ consumer representation on quality improvement committees
- Service staff are involved in discussions around how improvements can happen within their service

Feedback mechanisms are developed for informing consumers and staff at the state, Area and local level about:

- the *Action and Change* that has resulted from MH-CoPES

There are local MH-CoPES champions

- who can drive MH-CoPES and have clear lines of responsibility and management for *Action and Change* at state, AHS and local service levels

Data Analysis

Analysing the fixed choice section of the Questionnaire:

Two methods of analysing the fixed choice questions are adopted:

- Method 1 uses the average score for each question to assign it to one of three categories:
  - Strengths
  - Needing some improvement
  - Needing lots of improvement

This allows for comparison of results with other services and the Area average

- Method 2 ranks the service's average scores for each question with each other to allow for the individual service's strengths and weaknesses to be identified

Analysing the written comments section of the Questionnaire:

- The information from the three written comments questions in the MH-CoPES Questionnaires are analysed together and presented as one set of findings
- Written comments are grouped into topic areas that have been identified from the comments to produce results for local level reporting
- The topics that emerge in local level reports are merged into broader categories for reporting at Area Health Services and state level
- A maximum of ten final categories/topics are included in reports

Reporting and Feedback

Processes:

- Reporting occurs twice a year
- Results are made publicly available and accessible to current and former consumers
- Results are made available to the Official Visitors, the NSW Consumer Advisory Group – Mental Health Inc, and local consumer networks and groups

The Reports:

A range of mechanisms is used to report back to consumers including posters, newsletters, and discussion of findings at consumer groups

- Reports are produced for:
  - Individual services/units
  - Area Health Services
  - NSW Health
- The reports recommended as templates for presenting MH-CoPES results are presented in Appendices Z and AA
- Raw de-identified data is sent to each Area Health Service so they may conduct further analysis if required
- Raw de-identified data is NOT to be sent to individual service units; this means that quotes from people's comments in the written comments section of the Questionnaire are not to be included in reports. This ensures anonymity

Figure 2.
Protocols for the MH-CoPES Framework

3.2 Results from the Trial and Pilot

The results of the trial and pilot, which informed the protocols presented above, are discussed in this section.

3.2.1 The Whole MH-CoPES Framework

Management of the MH-CoPES Framework

Who should be responsible for the management of MH-CoPES?

The research indicated that different components of the MH-CoPES Framework will be best managed by different parts of the mental health system. It was determined that:

Processes for *Data Collection*, based on the protocols outlined in this report, need to be managed at a local service level to make sure they match the available local resources and structures.

Data Analysis and *Reporting and Feedback* steps should be managed by a central body that is separate from AHSs working in partnership with a consumer directed organisation. This organisation would receive returned Questionnaires.

The distribution of reports to local consumers within the *Reporting and Feedback* step of the Framework is the responsibility of AHSs and local services/units. NSW Health is responsible for the production of state reports that are available to the public.

Action and Change is managed by the quality improvement committees or relevant structures at the different levels at which it occurs (ie. state, Area Health Service and local service) as per the protocols presented in this report. This management responsibility is required to ensure that the processes for improvement are built into, and adaptable to current structures and processes, and involve relevant consumers and service providers.

A central body, specifically InforMH partnered with a consumer directed organisation, is recommended for the *Data Analysis* and *Reporting and Feedback* steps of the Framework for the following reasons:

Analysis of the data needs to be consistent across the state. A central body conducting this function will ensure consistency. Consultations highlighted that Area Health Services may not have the resources available to conduct the quantitative and qualitative analyses required for MH-CoPES and therefore, to ensure consistency and cost effectiveness, centralising this function is proposed.

Organisations entirely external to NSW Health were considered for the undertaking of these central functions, however, this was considered a risk to obtaining results and reports that would be easily understood and relevant to practice within mental health services in NSW. It was expressed that having a body such as InforMH involved in the process would enhance credibility of the results to services and ensure the production of suitable reports. This structure was also considered to enable flexibility in analyses and reporting.

The importance of consumer involvement in the analysis of data from MH-CoPES, particularly the open-ended sections of the Questionnaire, was emphasised in both stages of the project. Feedback from consultations made it clear that this is critical for the realisation of the principles of MH-CoPES and to the commitment to meaningful consumer participation at all levels of service evaluation. The trial and pilot, where consumers were employed by NSW CAG to work alongside the Project Officer to analyse the open comments section of the MH-CoPES Questionnaire, provides a model for how consumer involvement in data analysis can be achieved.

Frequency of cycles of the MH-CoPES Framework

How often should the steps of the MH-CoPES Framework occur?

During Stage 1 of the project, a range of opinions were expressed, with views ranging from the cycle repeating every three months to once a year. The research, resulted in the recommendations that:

- *Data Collection* occurs as an ongoing process. This means that consumers are offered a Questionnaire upon each discharge from a service and once during each year they are using a service.

"the research results along with the return and response rates from the trial and pilot evidence that the MH-CoPES Questionnaire is an acceptable mechanism for mental health consumers to provide feedback about their perceptions and experiences of mental health services"

Comparison of the responses from the pilot with those in the trial and statewide introduction found that there was a greater correlation between responses to individual questions on the Questionnaire in the pilot. That is people responded more similarly to all questions during the pilot than they did in either the trial or statewide introduction (see Appendix L). The pilot data collection was conducted six months after the conclusion of the trial in Orange and only three months after the trial in Ryde.

An explanation for this finding may be that many respondents from the pilot had already been involved in the trial. These people would have completed the Questionnaire twice within a short period of time. The high correlations could be owing to people experiencing questionnaire fatigue. This could lead to people responding similarly to questions because they give each question less thought the second time they complete a Questionnaire. This possibility has not been confirmed, and would need to be tested using a controlled experimental method to be verified. The high correlations, however, suggest that caution should be taken in asking consumers to complete the Questionnaire too frequently. This supports the recommendation that consumers of community and long-term inpatient services be invited to provide feedback using the MH-CoPES Questionnaire once a year.

- *Data Analysis* and *Reporting and Feedback* occur twice annually. This is the most effective means for ensuring that MH-CoPES provides information upon which AHS can structure quality improvement projects and monitor the effectiveness of current and previous projects. The research found this regularity of feedback to be important in keeping MH-CoPES "on the agenda".
- *Action and Change* occurs as an ongoing process within current continuous quality improvement systems and processes.

3.2.2 *Data Collection* Tool for *Data Collection*

The six questions from the evaluation survey (See Appendix D) about the MH-CoPES Questionnaire informed the recommendation that the MH-CoPES Questionnaire be implemented as the key tool for *Data Collection*. The Stage 2 research resulted in changes being made to the MH-CoPES Questionnaires after both the trial and pilot. These changes are documented in Appendix H and M, and the revised Questionnaires in Appendices J and K.

Table 7.

Return and response rates from the trial and pilot

		Number returned	Response rate	Return rate as a percentage of population using services during the trial/pilot
Inpatient	Trial	145	64.44%*	43.81%
	Pilot	249	N/A	50.4%
Community	Trial	133	25.35%*[a]	13.77%
	Pilot	177	N/A	8.9%

* Approximate response rate (% of Questionnaires returned from those handed out). Some services did not track exact numbers of distribution therefore the number of Questionnaires handed out is an approximation. Approximation is based on anecdotal evidence.

[a] Exact numbers of Questionnaires distributed were not available.

Are the MH-CoPES Questionnaires acceptable to consumers?

The research results along with the return and response rates from the trial and pilot, evidence that the MH-CoPES Questionnaire is an acceptable mechanism for mental health consumers to provide feedback about their perceptions and experiences of mental health services.

Return rates

Return rates in the trial and pilot were strong, as shown in Table 7 on previous page. The strong return and response rates indicate that consumers were prepared to complete the MH-CoPES Questionnaire as a means of providing feedback to services.

While return rates for inpatient services involved in the pilot increased when compared to the trial, there was a fall in return rates for community services. This may be due to a combination of factors such as consumers being approached to complete the Questionnaire twice within a six month period, once during the trial and again during the pilot (and therefore less inclined to participate the second time around) and that Questionnaires were not mailed out to consumers of community services during the pilot. It should be noted that the statewide introduction also had lower return rates from people using community services compared with inpatient services. This highlights the need for varied approaches to distributing the Questionnaire to people using community services.

Results from the Evaluation Survey on the MH-CoPES Questionnaire

Results from the evaluation survey (Box 2 and Appendix N) demonstrate that people participating in the trial and pilot found the MH-CoPES Questionnaire to be generally acceptable as a mechanism to provide feedback about their perceptions and experiences of services.

Feedback from Consultations

Consultations with consumers and Consumer Project Workers generally confirmed the acceptability of the MH-CoPES Questionnaires to consumers.

Box 2.

Summary of results from the evaluation survey on the MH-CoPES Questionnaire

160 people completed the survey

80% (n=128) said the length of time it took to complete the Questionnaire was 'fine'

86.9% (n=139) said that the Questionnaire was 'very easy' or 'easy' to understand

76.3% (n=122) said instructions on the Questionnaire were 'easy' to follow

78.1% (n=125) said they felt 'very comfortable' or 'comfortable' using the Questionnaire to provide negative feedback about their Mental Health Service

61.9% (n=99) said they thought their feedback would be 'very useful' or 'useful' in improving the service

62.5% (n=100) said they were 'very confident' or 'confident' that providing feedback would make a difference to the service

(n.b. % are % of those who responded).

What are the psychometric properties of the MH-CoPES Questionnaires?

Psychometric properties refer to the statistical properties of a questionnaire or survey to determine whether it is measuring what it is supposed to and whether it does so consistently.

The revised MH-CoPES Questionnaires recommended for adoption were tested during the 2008 pilot. Therefore the psychometric properties discussed here relate to the findings from the pilot. Information on the psychometric properties of the draft MH-CoPES Questionnaires from Stage 1 of the project used during the trial is presented in Appendix O.

The psychometric properties of the MH-CoPES Questionnaires for people using public, adult inpatient and community mental health services generally indicate that the Questionnaires are consistently measuring people's perceptions of the care they receive at their mental health service. A summary of these findings is presented in Box 3 on page 32. For full details, see Appendix P. Discussion about particular aspects of the psychometric properties is provided below.

Reliability

Internal reliability[2]

Through examining the internal reliability of the MH-CoPES Questionnaires it was identified that a number of questions were correlating highly (or highly associated) with each other and/or with the overall Questionnaire. The results of this analysis (see Appendix L) suggested that some of the questions in the MH-CoPES Questionnaire were not adding anything of significance to the overall measure of consumer perceptions and experiences of services. Consultations were conducted with the Reference Group and NSW CAG's network to consider these questions. People were asked whether any of the questions should be deleted from the Questionnaires to improve their reliability. The recommendations were for all questions to remain in the Questionnaires as they provide additional information for quality improvement initiatives and provide strength to the face validity[3] of the Questionnaires.

Test-retest reliability[4]

Sixteen (16) people completed the Questionnaire twice during the trial and thirty one during the pilot. The results from the examination of the test-retest reliability do not allow conclusions to be drawn as to whether the Questionnaire is able to achieve the same response from an individual over a short period of time, where there has been no significant change in their experience. The lack of significant correlations between the total scores of the MH-CoPES questions on the first and second completion of the Questionnaire indicates that the Questionnaires do not achieve this consistency. However, the finding that there are no significant differences between the total scores of the MH-CoPES questions on the first and second completion of the Questionnaire indicate that there is consistency in how people answered questions (see Box 2 on page 30 for the statistics in brief, and Appendices Q and R for more information). This inconsistency in findings may be a result of the small number of people who completed the Questionnaire twice. Should conclusions regarding the test-retest reliability of the MH-CoPES Questionnaires be required, it is recommended that further testing of this aspect of the Questionnaire be undertaken with a larger population group.

2 Internal reliability refers to whether the questions on the Questionnaire consistently measure the same thing (Aiken, 2003).

3 Face validity refers to whether the questions on a questionnaire appear to be measuring what the questionnaire is meant to (Aiken, 2003). In the case of MH-CoPES it is whether the questions appear to be measuring consumers' perceptions and experiences of services.

4 Test-retest reliability is a measure of whether people answer the questions in the same way within a short period of time. It is another measure of the questionnaire's consistency (Aiken, 2003).

Validity[5,6]

In the analysis of the 14 open-ended interviews conducted to test the Questionnaire's validity, a strong relationship of about 75%+ was found between the responses to the MH-CoPES Questionnaire and the interview comments. It was found that consumers were able to report with good sensitivity on more tangible questions that affected them directly, such as information provided. The overall relationship of 75%+ suggests that the MH-CoPES Questionnaire successfully collects information about the actual experiences of mental health consumers, and thus has good construct validity.

Reliability between population groups

The evaluation survey conducted during the trial asked demographic questions of participants. This information

Box 3.

Summary of psychometric properties of the MH-CoPES Questionnaires

Inpatient

Internal Reliability

Coefficient alpha = 0.961, *n* = 187

Test-Retest Reliability

No significant correlation between the total score of questions 1 to 24 on the first and second completion of the Questionnaire, *Spearman's r* = 0.521, *p* = 0.101, *n* = 11.

No significant differences between total scores on the first and second completion of the Questionnaire, *t*(10) = 1.120, *p* =0.289, *n* = 11.

Convergent Validity

Strong correlation between the total score for questions 1 to 24 and question 25, *Spearman's r* = 0.320 *p* <0.001, *n* = 238)

Factor Analysis

Uni-dimensional scale

Community

Internal Reliability

Coefficient alpha = 0.973, *n* = 144

Test-Retest Reliability

No significant correlation between the total score of questions 1 to 23 on the first and second completion of the Questionnaire, *Spearman's r* = 0.4, *p* = 0.198, *n* = 12.

No significant differences between total scores on first and second completion of the Questionnaire, *t*(11) = 0.788, *p* = 0.447, *n* = 12

Convergent Validity

Strong correlation between the total score for questions 1 to 23 and question 24, *Spearman's r* = 0.313, *p* <0.001, *n* = 172

Factor Analysis

Uni-dimensional scale

Both Questionnaires

Construct Validity

Strong relationship between responses on the Questionnaire and in interview (concordance rate approximately 75%+)

[5] Validity refers to whether a questionnaire measures what it is designed to (Aiken, 2003). In the case of the MH-CoPES Questionnaire it refers to whether it actually is measuring consumers' perceptions and experiences of services.

[6] Dr Robyn Maddern, MAPS, was engaged to conduct the analysis of the recorded and transcribed interviews using content analysis and comparison between interview responses and responses to the Questionnaire.

together with the information collected on the Questionnaire about how long people have been using mental health services, and for people using inpatient services, how long they have been using these services and when the Questionnaire was completed was used to examine whether these variables or characteristics impacted on how people completed the Questionnaire. Overall there was no difference between population groups in responses to the Questionnaire. The detail of these results is presented in Appendix Q.

Analyses of the demographic variables collected during the pilot (length of using mental health services, and for people using inpatient services, how long they have been using these services and when the Questionnaire was completed), revealed no impact of these variables on how the Questionnaire was completed. Details of these results are in Appendix R.

Does indicating the name of the service unit on Questionnaires influence responses?

The research revealed that including the name of the service unit on the Questionnaires does not negatively impact on:

- the number of Questionnaires returned or
- how consumers respond to the MH-CoPES questions (see Appendix S).

Having the service unit name on Questionnaires ensures reports are made relevant to specific service units as well the AHS. Consultations revealed that best practice is to have a space available on the Questionnaire for service units to stamp their name prior to distribution.

How do consumers prefer to provide their feedback?

The literature review revealed several different ways that consumers may be able to provide their feedback during the *Data Collection* step of the MH-CoPES Framework. Possible methods identified included focus groups, individual interviews, verbal completion of questionnaires, online questionnaires and self-administered questionnaires.

The benefits and challenges of each method were explored through both the literature review and during consultations with the Reference Group. When consumers indicated a preference for providing verbal feedback in consultation or on the evaluation survey, many indicated that this should be done on an individual basis. One way to facilitate this option is to make available Consumer Workers to assist individuals to complete the Questionnaire when they require help. This option was explored during the trial and the pilot, and discussed overleaf "Support to complete the Questionnaire"

During consultations with the Reference Group and PICs, it was suggested by some people that a representative sample of consumers from each AHS could be drawn on to reduce the number of individual interviews and focus groups needed for statewide comparative data. However this is inconsistent with the underlying principle of MH-CoPES to provide all consumers using services with an opportunity to participate in evaluating services. Focus groups and individual interviews are considered to provide a rich source of data (Perreault, Pawliuk, Vielleux & Rosseau, 2006; Sim, 1998; Stallard, 1996), however, for ongoing, statewide collection of consumer views the resources, including staff and or Consumer Workers that would be required to conduct these make them impractical options. Therefore, focus groups, made up of a representative sample of an Area or service and individual interviews are not recommended as tools for *Data Collection* within the MH-CoPES Framework.

An internet-based MH-CoPES Questionnaire was suggested during Stage 1 of the project and again through consultations with consumers during Stage 2 of the project as a possible complement to the hard copy Questionnaire. Discussions with the research sites and the Reference Group particularly highlighted the possibility of an internet-based Questionnaire as a way to increase return rates in public, adult community mental health services. It has been communicated to NSW CAG through its core work and regular contact with consumers that many consumers do not have access to the internet; therefore an internet-

based MH-CoPES Questionnaire could be used only as a complement to the paper based Questionnaires.

Consultations and results from the evaluation survey (see Box 4 below) revealed that in general, consumers report that completing a written questionnaire and specifically the MH-CoPES Questionnaire is the best way for them to provide feedback about services. As the Questionnaire is also relatively easy to analyse, it is recommended as the key tool for measuring consumers' perceptions and experiences of mental health services; various ways of using the Questionnaire including through consumers completing it verbally and an internet based version would provide greater access for consumers to provide their feedback.

Box 4.
Results of question on evaluation survey regarding ways to provide feedback

"Is completing a written MH-CoPES Questionnaire the best way for you to provide feedback about mental health services?"

Yes:	61.9% (n = 99)
No:	8.1% (n = 13)
No response:	5% (n = 8)
Don't know/no opinion:	25% (n = 40)

Support to complete the Questionnaire

What support do consumers need to complete the Questionnaire?

The following support options were available for people in the research sites who needed assistance to complete a Questionnaire:

- Consumer Project Worker or Consumer Worker
- Friend or carer
- Telephone assistance with a NSW CAG Project Team member.

Consumer Project Workers and the NSW CAG Project Team kept records on how many people accessed each option during the trial and consumers who completed the evaluation survey also reported on support they used. Table 8 shows the type of support to complete the Questionnaire accessed during the trial.

Of the 278 completed Questionnaires from the trial, approximately 51% of consumers accessed support to complete the Questionnaire.

During the trial at least 80 people completed the Questionnaire in person with a Consumer Project Worker. This represented at least 29% of Questionnaires returned. An additional 50 people asked Consumer Project Workers for some help or asked them further questions about the Questionnaire. The anecdotal evidence from discussions between the Consumer Project Workers and people requesting assistance was that in the majority of cases, consumers requested assistance to complete the Questionnaire as a result of poor literacy, vision or to explain in more detail the meaning of questions.

An analysis comparing the responses to the Questionnaire between those who completed the Questionnaire in person with a Consumer Project Worker and those who did not revealed that completing the Questionnaire in person with a Consumer Project Worker did not impact on how people answered questions. These statistics are presented in Appendix T.

These findings indicate the importance of consumers having access to Consumer Workers for assistance in completing the MH-CoPES Questionnaire to ensure equal opportunity to participate.

Distribution Method

How should the Questionnaire be distributed?

Table 9 presents information on the return rate for each method of distribution trialled. It was not possible to accurately record how many Questionnaires were distributed by each method; therefore, response rates (percentage of Questionnaires returned as a function of how many were distributed by that method) are only available for the mail out.

Table 8.
Support people accessed to complete the Questionnaire during the trial

Assistance method	Number of people accessing option	Percentage of total number of people who completed the Questionnaire
Consumer Project Worker	130*	46.76%
Friend	2**	0.72%
Carer/family member	7**	2.52%
Nurse	1**	0.36%
In person with member of the NSW CAG Project Team	1**	0.36%
Telephone with member of the NSW CAG Project Team	0	

* Approximation; data from evaluation survey and records of Consumer Project Workers
** Data from evaluation survey

In the inpatient setting, distribution by Consumer Workers was the most effective method used during the trial. This may relate to the findings surrounding support required to complete the Questionnaire; where a Consumer Worker distributed the Questionnaire, they were immediately available to answer any questions consumers had about it and/or to complete the Questionnaire verbally with consumers when requested. The return rates achieved in the inpatient services involved in the research are considerably greater than those achieved in other research (Bjørngaard et al., 2008; Druss, Rosenheck & Stolar, 1999).

Low return rates are a common problem in mental health consumer satisfaction surveys, largely due to low rates of literacy, and reduced concentration and/or visual impairment due to medication. Thus, the results achieved during the trial are likely to be due to the availability of Consumer Workers to assist and encourage people to complete the Questionnaire. Further evidence of the success of this method during the trial is presented in Box 5 (overleaf).

Clinical and administration staff distributing the Questionnaire proved to be a viable method. Distribution by case managers/workers was trialled in community

Table 9.
Return rates for each distribution method during the trial

Distribution method		Community (N = 133)	Inpatient (N = 145)
Consumer workers	number of people using the method	51	104
	% as a % of all Questionnaires returned	38.35	71.72
Administration staff	number of people using the method	36	1
	% as a % of all Questionnaires returned	27.07	0.69
Mail out	number of people using the method	27	N/A
	% as a % of all Questionnaires returned	20.30	
Service staff (including clinical staff, e.g. nurses and care coordinators)	number of people using the method	0	5
	% as a % of all Questionnaires returned	–	3.45
Other	number of people using the method	13	0
	% as a % of all Questionnaires returned	9.77	
Unknown	number of people using the method	6	35
	% as a % of all Questionnaires returned	4.51	24.14

Box 5.
Example of return rates based on method of distribution

Inpatient Service
Sole method of distribution

- Consumer Workers return rate = 82.98%

This return rate can be considered as "remarkable" (Sitzia & Wood, 1998, p. 311)

Community Services
Method of distribution

- Mail out return rate = 18%
- Staff distributing Questionnaires return rate = 28.57 %

services, particularly where consumers received home visits. One service that used this method achieved a return rate of 28.57%. However, in other services where this method was to be used, no Questionnaires were distributed. Discussions with services revealed that a variety of factors, including management engagement and support for the project, staff resourcing levels and staff perception of MH-CoPES as important and the distribution of Questionnaires as part of their role, impacted on whether staff actually handed the Questionnaire out.

Achieving good return rates from people who use community mental health services proved challenging both during the research and the statewide introduction of MH-CoPES. This highlights the need for a range of approaches to be implemented for the distribution of the Questionnaire in this setting. As highlighted during the trial, a mail out of the MH-CoPES Questionnaire to people using community services can achieve a good return rate. Stage 1 of the project (NSW Health, 2006) highlighted the risk of sending MH-CoPES Questionnaires to people who had not consented to this. The trial of a mail out confirmed the importance of vigilance in using this method. In one case, a Questionnaire was mailed to a deceased person that caused some distress to the family. Therefore, it is recommended that, where adequate systems are in place including having up to date lists of current consumers and permission from them to be sent mail from the service, distributing the Questionnaire via a mail out be considered by community services as a way to increase their return rates.

In addition to the distribution methods explored during the trial, a range of different ways to manage the distribution of the Questionnaires were discussed during consultations with PICs and the Reference Group. Two of these were explored during the pilot and trial, and are discussed in Table 10.

Through consultations and the evaluation survey, consumers generally reported being happy with the way the Questionnaire was given to them. Additionally, analyses revealed that the method of receiving the Questionnaire did not impact on how people answered the questions. These statistics are available in Appendix U.

Table 10.
Successful strategies for managing Questionnaire distribution

Strategy	Discussion
Group distribution	In some research services, Consumer Workers distributed Questionnaires during groups either arranged specifically for the research or already conducted by the service. During the trial, 28 Questionnaires were identified as having been returned via this method, representing 19.31% of all Questionnaires returned from community services.
Discharge processes	Incorporating the Questionnaire into the discharge section of consumer files was found to be very effective. One acute admissions unit that used this method combined with the availability of Consumer Project Workers, who visited the unit once a week during discharge meetings, achieved a return of 98 Questionnaires, representing 65% of the population who used the service during the pilot.

The research and consultations highlighted the need for the Questionnaire distribution to be built into current systems, such as the discharge checklist, consumer file notes checklist or discharge planning packs or groups. Staff from research sites and in the Reference Group indicated that where a process is in place and incorporated into everyday procedures, distribution of the Questionnaire is more likely to occur. Further, the experience of the research and statewide introduction revealed the usefulness of a guide for Consumer Workers and staff outlining what needs to be said when distributing Questionnaires. An example of this guide is provided in Appendix V.

When should the Questionnaire be distributed?

The protocols for the distribution of the Questionnaire should be read in conjunction with the protocols for the frequency of the whole MH-CoPES Framework.

Based on the experience of the trial, and advice in consultations with consumers and service staff, along with feedback through the evaluation survey, it was found that distribution of the Questionnaire either upon discharge from the service or whilst using the service is appropriate. Some difference was found between how people perceived their care at the hospital (question 30 on the inpatient Questionnaire used during the trial) when they completed the Questionnaire after leaving the hospital compared to those who completed the Questionnaire while still in hospital during the trial. This finding was not however replicated during the pilot. Further, in both the trial and pilot, there was no difference between how people responded to the MH-CoPES questions (ie questions 1–24 for inpatient and 1–23 for community) based on when they completed the Questionnaire. See Appendix W.

Feedback through consultations and the evaluation survey indicated that it is important to ensure that the person is well enough to consider and complete the Questionnaire. It is also important that a person has had an 'experience' of the service before they are asked to complete a Questionnaire. Therefore, it is not appropriate for people to be approached to complete the Questionnaire

- On admission
- Within the first week of admission to an inpatient unit (unless discharge occurs during this period)
- When in crisis.

It is also recommended that within acute and sub-acute inpatient settings, consumers be offered the Questionnaire upon discharge. In non-acute inpatient settings, however it is appropriate for people to be offered the Questionnaire whilst using the service.

Return Methods

What options for Questionnaire return need to be available?

Details of the success of the two return methods trialled are provided in Table 11 (overleaf). These results indicate the importance of having both reply paid envelopes included with Questionnaires and return boxes located at each service unit. Both methods provide an easy and immediate way for consumers to complete and return their Questionnaires. In order to maintain confidentiality of responses, it is recommended that someone external to the service unit, for example Official Visitors and/or Consumer Workers be responsible for emptying the boxes and posting Questionnaires to the central data analysis body. Questionnaires are to be returned directly, unopened, to the central body managing *Data Analysis*.

3.2.3 *Data Analysis*

This section presents the recommended protocols for *Data Analysis* for both the fixed choice and open comments sections of the MH-CoPES Questionnaires.

Analysing the fixed choice section of the Questionnaire

How should analysis of the fixed choice section of the Questionnaire occur?

Any methodology used to analyse the MH-CoPES fixed choice data needs to ensure that all responses from

Table 11.
Percentage of Questionnaires returned by each method during the trial

Service Type		Percentage returned by mail (reply paid envelope) (%)	Percentage returned through the boxes located at the service (%)[a]	Not recorded (%)
Community Services	Trial	46.62	53.38	N/A
	Pilot	28.2	64.97	6.8
Inpatient Services	Trial	2.8	97.24	N/A
	Pilot	16.87	79.52	3.61

[a] When a Questionnaire was handed to a Consumer Project Worker this was counted as being returned through the boxes, as Consumer Project Workers were instructed to place all Questionnaires returned to them in boxes.

consumers are considered. Thus, it must use grouped information from all Questionnaires returned, and include all three response options:

- needs no improvement
- needs some improvement
- needs lots of improvement.

During the trial and through consultations with PICs and the Reference Group, it was identified that a data analysis method that allowed individual services to drive quality improvement is essential. Therefore, a method that enabled the service to examine the areas where they can most improve was required. For the data analysis to serve this purpose, areas in need of improvement are relative rather than absolute, which ensures a continuous quality improvement approach, whereby there is always room for improvement. Consultations and experience with the research sites also identified that data analyses methods that enable the individual service to compare themselves with other individual services and the average for the AHS are also needed from a benchmarking perspective.

These requirements resulted in two methods of analysing the fixed choice data being developed and recommended for implementation. For each method, a mean score is calculated for each individual question.

- **Method 1** uses the mean score for each question to assign it to one of three categories:
  - Strengths
  - Needing some improvement
  - Needing lots of improvement

This enables services to compare how they are performing on each question in comparison to other services and the Area Health Service average.

- **Method 2** ranks the service's mean scores for each question against all other questions to allow for the individual service's strengths and weaknesses to be identified. This assists in guiding service quality improvement activities for the individual service. This allows the service to prioritise improvement activities and follows the philosophy of continuous quality improvement that even when a service receives positive feedback, improvements can still be made.

The detail and procedures for these two methods is provided in Appendix X.

"all comments are considered and therefore the voice of each consumer is heard and given weight"

Analysing the written comments section of the Questionnaire

How should analysis of the written comments section of the Questionnaire occur?

Both versions of the MH-CoPES Questionnaire include three open-ended, written comments questions that require analysis. The purpose of these questions is to allow consumers to expand on areas where they perceive that the service is either doing well or is in need of improvement and provides space for issues not covered in the fixed choice section of the Questionnaire to be raised. It is therefore necessary for the analysis of this section to enable the written comments provided by consumers on the Questionnaire to be presented clearly, and taken into account in the *Reporting and Feedback* and *Action and Change* stages of the Framework.

Experience from the analyses conducted in the research and feedback from PICs shows that in order to reduce repetition in reporting it is most effective for the three written comments questions in the Questionnaire to be analysed together. They can then be presented as one set of findings under a single heading, for example "Written Comments Section – Questions 26–28".

A review and analysis of possible written comments data analysis methods, and consultations with the Reference Group concluded that, for the purpose of individual service level reports, ethnographic content analysis[7] is the most appropriate method for analysing the written comments of the MH-CoPES Questionnaire. This process allows categories to emerge from the data (Bryman, 2004), 'rather than forcing the comments into predefined categories' (Altheide, 1987, p.68). This ensures a consumer-centred approach to the analysis of data: all comments are considered, and therefore, the voice of each consumer is heard and given weight. It has been noted, however that, given the volume of expected Questionnaires returned (approximately 40,000 a year), a purely ethnographic content analysis where the categories are derived from the responses as they appear may not be practical. Rather, and as tested during the pilot, it may be useful for a list of categories arising from previous analyses of the MH-CoPES Questionnaire to be used during the data analysis. New categories can be added as they arise. Only categories that are found within the current set of responses would be reported.

Results from an ethnographic content analysis would be presented in the format demonstrated in Figure 3 in individual service unit reports:

(Topic) **Smoking**

Eight (8) people commented about smoking. They indicated that smoking should be permitted within the hospital grounds.

Figure 3.
Example of reporting of results of written comments analysis for individual service unit reports.

Consultations and the experience of the research also highlighted that while ethnographic content analysis is an appropriate method for managing the written comments for individual service unit reports, for the purpose of Area Health Service (AHS) level reporting the categories that emerge from the ethnographic content analysis need to be further refined.

An inductive thematic approach[8] that allows for broader themes and issues to be identified as they emerge from the data is recommended to reduce the number of categories reported and therefore facilitate the management of the greater amount of data for

[7] An approach or style of analysing written comments (qualitative data) which involves adding up or quantifying the number of times a word or topic is addressed within the written comments (qualitative data) and placing the topics into created codes, for example "smoking"

[8] Inductive thematic analysis is an approach or style of analysing written comments (qualitative data) which allows for broad themes and issues to be identified as they emerge from the data

presentation in AHS and NSW Health reports. Figure 4 exemplifies how the results from this method of analysis for the above example of 'smoking' would be presented in AHS reports.

A thematic approach may result in placing "smoking" within the broader category of "consumer rights".

(Theme) **Consumer Rights**

Consumers highlighted a range of areas relating to their rights that they feel need improving.

Many people commented about disliking different restrictions/ lack of freedom placed on them.

Some people commented on the inflexibility around, and restrictions on smoking.

Figure 4.
Example of reporting of results of written comments analysis for AHS reports

Feedback from the research sites and consultations with the Reference Group highlighted the need for the number of topics in individual service reports and themes in AHS and NSW Health reports to be limited, ensuring services do not become overwhelmed. It was suggested at a maximum, the ten most recurring topics or themes are discussed for the purpose of guiding quality improvement initiatives.

3.2.4 *Reporting and Feedback*

This section presents the recommended protocols for *Reporting and Feedback*. It firstly presents the recommendations for the presentation of reports to various levels of mental health services, and then the processes for this step of the Framework. As noted in the protocols for the frequency for the MH-CoPES Framework, *Reporting and Feedback* is to occur twice yearly.

Processes

How should Reporting and Feedback occur?

The consultations conducted throughout the project highlighted the need for processes and structures to be developed at state, AHS and local services to ensure the distribution and filtering of feedback and reports to the different people and stakeholders involved. These include:

- Consumer networks
- Consumer Workers
- AHS Directors, and executive and management staff
- AHS and local service quality committees
- Local service Directors and management
- Local service staff
- Local consumers
- NSW Consumer Advisory Group – Mental Health Inc.
- Official Visitors

Consultations particularly re-iterated the need for timely reporting to consumers at all levels (state, Area Health Services and local services).

The Reports

What is the best format for reporting results from Data Collection to consumers, individual services, Area Health Services, NSW Health?

Consultations conducted during Stage 1 of the project (NSW Health, 2006) highlighted the need for three levels of reporting:

- Statewide
- Area
- Local

Within each level, reporting is required to mental health services and staff, consumers, and other key stakeholders. During Stage 2 consultations were conducted to establish the specific reporting needs for mental health consumers and mental health services and staff at each level. Many of these consultations were guided by draft versions of reports.

The experience from the research and statewide introduction has highlighted the importance of the production of reports that are targeted to the specific stakeholder group, easy to read, contain the right amount and type of information and are clearly able to guide service improvement and change. This has an impact

on staff and consumer engagement with the whole Framework including the distribution of Questionnaires. The reporting protocols presented in this report are designed to meet this requirement.

Consumer Reports

The research and consultations revealed that a range of mechanisms is required to report back to consumers on the results of MH-CoPES. The three key methods identified and used during the research are detailed in Table 12.

Individual Service Unit

The importance of providing MH-CoPES reports for individual service units was highlighted during the research and in consultation with PICs, staff and consumers at research sites, and the Reference Group. This level of reporting was emphasised as essential to guide individual service level quality improvement processes.

Individual service unit reports (Appendix Z) have been developed in consultation with consumers and staff to provide information that indicates where the individual service is performing best and the areas in most need of improvement, as rated by consumers' feedback through the MH-CoPES Questionnaires. The results are presented for individual questions, and for questions grouped under the domains or topic areas in the Questionnaire, ie treatment and care, information, privacy, choice of treatment and discharge. Tables and figures are used to illustrate findings.

Table 12.
Methods of reporting back to consumers

Mechanism	Discussion
Posters and newsletters	During the research, posters and newsletters (see template in Appendix Y) outlining areas where the service is performing most well, areas where it is most in need of improvement, and a section outlining "what happens next?" were used as one mechanism to report back to consumers. These were made available in waiting rooms and other common areas so that consumers could obtain the grouped information as well as the changes that were being implemented as a result. Consumers and staff reported that these provided a useful tool to provide clear feedback to consumers. Staff also found them useful as continual reminders about areas of the service that needed improvement.
Group discussion and presentation	During the research, discussions of the outcomes of MH-CoPES detailed in reports were held during consumer groups at services. These discussion groups were reported by Consumer Workers to be useful in not only reporting the results, but providing a forum for discussion around ideas consumers had for initiatives to improve the service.
Publication of reports on internet	The Reference Group proposed that AHS and state reports be made available on a website maintained by NSW Health. This web address would need to be widely advertised, for example by including it on each Questionnaire. Web based reporting was tested in Orange using the Mid Western CAG website.

"the entire Framework—which includes Action and Change—is what sets MH-CoPES apart from other evaluation surveys and tools"

A comparison of the results for different questions highlights priority areas for improvement. These reports also provide the Area mean to enable comparison of individual service results with the Area Health Service average.

To ensure anonymity, it is recommended that quotes from people's comments in the written comments section of the Questionnaire not be included in reports.

Area Mental Health Service

AHS Reports (Appendix AA) were developed in consultation with the PICs, Reference Group and Executive staff in the research Areas to provide AHS Executive, management and staff with the overall results for the Area. They contain the findings for each individual service within the Area, and a comparison of results between individual services and the AHS average.

In addition to written reports, the experience of the research and statewide introduction highlighted the usefulness to Areas of having access to the raw, MH-CoPES data for further analysis and comparison over time. To ensure that information provided by consumers remains anonymous, and in accordance with the principle of *Privacy and Safety*, this raw data is to be de-identified before being released to AHSs. It should be noted that consultations with service staff revealed that, despite not being provided information about which consumers had actually completed the Questionnaire, some staff thought they could guess which consumers had made certain comments through the quotes used in the service reports. Therefore to further ensure anonymity to consumers, raw data is NOT to be provided to individual services; this means that quotes from people's comments in the written comments section of the Questionnaire are not to be included in individual service level reports.

NSW Health

Reports to NSW Health will be included within the regular reporting of NSW Mental Health key performance indicators.

3.2.5 Action and Change

The entire Framework, which includes *Action and Change*, is what sets MH-CoPES apart from other evaluation surveys and tools. Having this step as an explicit part of the Framework:

- provides assurance to consumers that something will actually be done in response to their feedback
- increases confidence that feedback is not tokenistic and therefore may add to consumers' motivation to complete the Questionnaire.

In this section the structures and processes that are required to support this step of the Framework are outlined.

What structures and processes are needed to ensure the results of MH-CoPES are used to inform quality improvement initiatives?

Throughout the project investigations were conducted to establish what processes and structures are needed to support *Action and Change*. This was done through consultations and the experience of the trial and pilot. Before elaborating on the protocols for *Action and Change* resulting from this investigation, the processes that were developed by the two research sites are presented.

Processes for *Action and Change* developed by the research sites

The PIC in each research site was responsible for developing processes for engaging in the *Action and Change* step of the Framework. The NSW CAG Project Team with the PICs and relevant AHS staff undertook reviews of the processes implemented.

Greater Western AHS (Orange)

The following processes were used in the Greater Western AHS research site for *Action and Change*:

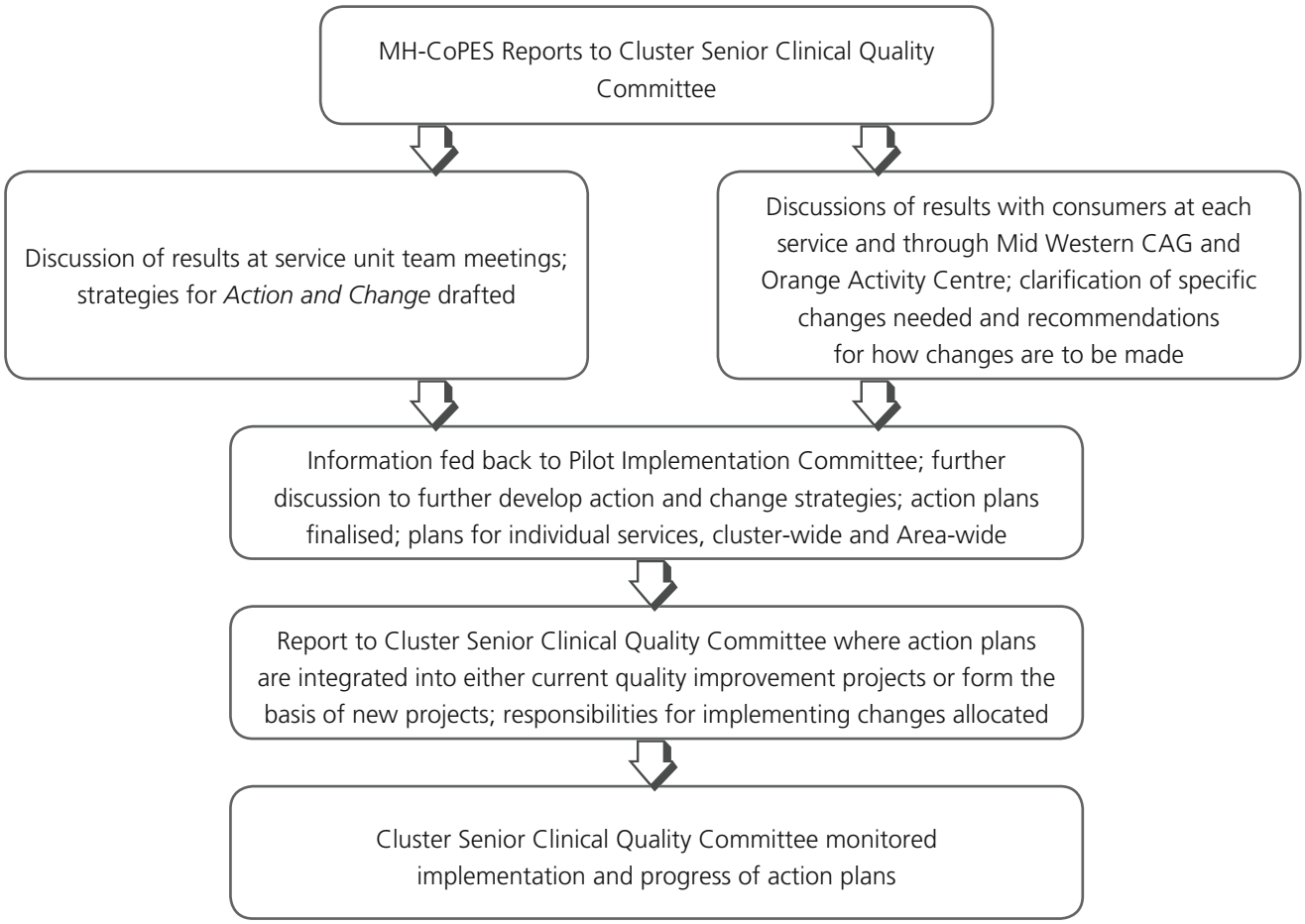

Figure 5.

Diagram of processes used in Greater Western AHS for *Action and Change* during the trial and pilot

Northern Sydney Central Coast AHS (Ryde)

The following processes were used in the Northern Sydney Central Coast AHS research site for *Action and Change*:

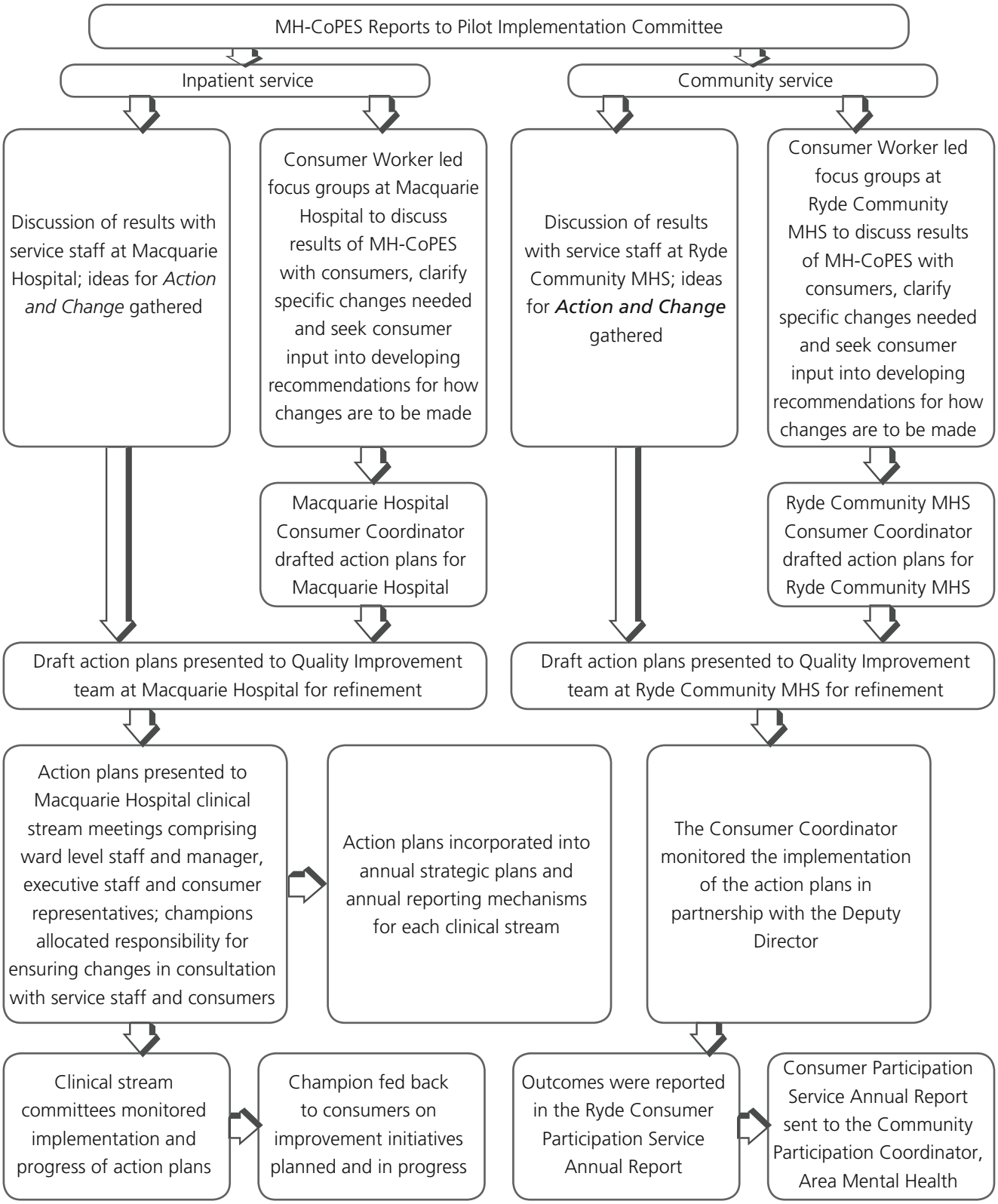

Figure 6.

Diagram of processes used in Northern Sydney Central Coast AHS for *Action and Change* during the trial and pilot

Alongside the work for the trial and pilot, Area management at Northern Sydney Central Coast AHS also developed a longer-term procedure for managing MH-CoPES across the Area for both inpatient and community mental health services. This involves managing MH-CoPES across the portfolios of information management, quality improvement and community participation. The Northern Sydney Central Coast AHS MH-CoPES Management procedure is depicted in Figure 7 below.

Figure 7.
Northern Sydney Central Coast AHS process for managing MH-CoPES

Structures and processes required for *Action and Change*

The implementation of *Action and Change* in each of the research sites highlighted the effectiveness of the Framework in facilitating dialogue between consumers and staff about issues that are important to consumers. It also paved the way for partnership building around *Action and Change* initiatives and encouraged creative thinking about how to resolve issues that were highlighted in the reporting.

Despite different approaches undertaken in the research sites, common requirements for, and barriers to implementing effective *Action and Change* were identified. Additional barriers and success factors for *Action and Change* were identified through consultations with the PICs, consumers and staff from the research sites, and experiences from people involved in the statewide introduction communicated through the Reference Group. This culminated in defining the structural requirements and other key factors for the successful implementation of this step of the Framework. These are discussed in Table 13.

Box 7.

Example of an area noted by consumers needing improvement that services were not able to act on

During the research, some people noted in the written comments that they did not want Community Treatment Orders to exist. Initially some staff considered this as a clear indicator that the results of MH-CoPES were not useful, as they could not act on this recommendation. However, further discussion highlighted that there may be some things that staff are unable to change that arise through MH-CoPES, but that this should not stop them from working on the things that they could change. It also revealed the importance of communicating back to consumers what things cannot be changed and why.

Box 6.

Example of the value of consumer participation in quality improvement committees

In one research site, the MH-CoPES reports revealed that consumers felt that the provision of information needed improvement. At the PIC staff indicated confusion around this noting that brochures were available at the service. When Consumer Workers entered this discussion, it was identified that in one inpatient service these brochures were available only in the reception area, which is not accessible to consumers. An easy solution was found to add brochures stands to the recreation room, which is accessible to all consumers at the service.

The MH-CoPES report also revealed in this research site that consumers felt that the provision of information about rights and responsibilities needed improvement. Staff noted that brochures were available, however, Consumer Workers identified that people may not be reading the brochures. This encouraged further discussion between Consumer Workers and staff where alternatives to the way the information was being presented were brain stormed.

Table 13.
Success Factors for *Action and Change*

Success factor	Discussion
Integration into current systems	• To be successful and sustainable MH-CoPES needs to be integrated into current systems; *Action and Change* needs to be integrated into current continuous quality improvement and accreditation systems at state, Area Health Service (AHS) and local service levels • Areas identified in MH-CoPES reports as most in need of improvement are a key aspect guiding quality improvement initiatives at state, Area Health Service (AHS) and local service levels
Consumer participation	• Involvement of consumers through discussion of results, clarification of specific improvements needed and suggestions for how this can occur. Focus groups were found to be a good way to do this at a local service level • Involvement of consumers and Consumer Workers on quality improvement committees at state, AHS and local service level. See Box 6 for an example of how this was valuable during the research
Staff engagement	• Clear communication to staff about the purpose and benefits of MH-CoPES • Processes to involve staff in the development of action plans and improvement initiatives • Ensuring adequate return rates from *Data Collection* supported by the implementation of protocols in this report • During the research, staff found that the information being provided through MH-CoPES often supported what they already knew, and provided something concrete to draw on in supporting arguments for change • Feeding back to staff positive feedback coming from MH-CoPES
Monitoring and reporting	• Mechanisms to report on the progress of improvement projects and actions stemming from MH-CoPES to consumers increase confidence in the process and provide motivation to participate in MH-CoPES. This also enables feedback to consumers about changes that cannot be made (see Box 7 for an example from the research) • Mechanisms for the state, AHS and local services to monitor improvements at all levels
Responsibility	• Establishment of a clear line of responsibility and management for the *Action and Change* processes at state, Area Health Service and local service levels • Local MH-CoPES champions who can drive *Action and Change* • Visible management commitment and support of MH-CoPES and improving services based on consumers' feedback
Culture	• Culture of valuing and accepting the perspective of consumers is essential for *Action and Change* to result from feedback from consumers. Where consumers are viewed as too unwell to provide valid feedback, this hinders *Action and Change* • Culture of valuing consumer participation in all aspects of service delivery, planning, and evaluation and policy development • Culture of continuous quality improvement fostered, whereby any feedback, regardless of how many people provide this feedback, is considered as being able to drive change
Resourcing	• Adequate resourcing and allocation of time for the involvement of consumers in this step, for example participation on quality committees at all levels

Objective 2:

Cultural and Change Management Issues that Need to be Addressed for the Successful Implementation and Sustainability of MH-CoPES

To effectively implement and sustain the MH-CoPES Framework in mental health services it is essential to understand the culture of mental health services in NSW and the organisational change that will be needed to support MH-CoPES, and to develop strategies to facilitate the required change. Three key considerations inform this work:

- Implementing the MH-CoPES Framework means introducing a new program into mental health services. The literature review and the work conducted in Stage 1 of the project highlight the challenges of introducing and achieving change in any organisation. In particular, resistance to change is commonly faced when introducing any new program to an organisation.
- Part of the vision of MH-CoPES is to introduce a mechanism by which consumers' views contribute to service change and quality improvement. Adopting MH-CoPES and implementing the *Action and Change* step in particular will result in changes for everyone within mental health services. It can be anticipated that at times MH-CoPES will challenge practice and culture within mental health services.
- MH-CoPES is fundamentally about consumer participation in the quality improvement of mental health services. It is well recognised that the area of consumer participation is not always well understood, and that conflicting values and attitudes are held about consumer participation (Hansen, Hatling, Lidal, & Ruud, 2004; Lloyd & King, 2003).

A number of factors important in driving and supporting change were identified during Stage 1 of the project (NSW Health, 2006). These factors:

- consultation and communication
- a sense of ownership
- organisational culture
- credibility

guided the way the Stage 2 research was conducted.

To clarify how these factors apply to MH-CoPES and to identify specific cultural and change management issues involved in implementing and sustaining the MH-CoPES Framework, observations were made by the NSW CAG Project Team during the research. Consultations were held with the research partners, including consumers, staff and management, and the Reference Group. Culture and change management was also regularly discussed by the Steering Committee.

3.3 Implementing a Sustainable MH-CoPES Framework

The following presents the features that were identified through the research, literature review and consultation processes that are central to MH-CoPES being a sustainable Framework.

3.3.1 Introducing a new program, the full MH-CoPES Framework, into public, adult inpatient and community mental health services throughout NSW requires:

1. Leadership

It was identified that strong leadership by senior management at state, AHS and local levels and MH-CoPES Champions at each of these levels are critical to the successful implementation of MH-CoPES.

Strong leadership at the senior management level, and establishment of a Project Champion during the research resulted in:

- strong communication throughout the service
- clear messages about MH-CoPES conveyed in the AHS
- visible leadership throughout all phases of the Framework
- staff commitment to MH-CoPES and the fulfillment of roles, for example distributing Questionnaires

One research site established a consistent and visible Project Champion for the life of the project. The Champion held a senior role, and was able to lead change in the AHS. In this site, the following were observed and identified as important:

"the engagement of consumers in all steps of the Framework itself led to the commencement of cultural change and more positive attitudes towards consumer participation"

- staff felt empowered because they were included in the development of all processes for implementing MH-CoPES in their services
- staff in service units were aware of what was occurring in relation to MH-CoPES
- tasks and responsibilities were clearly delegated
- strong mentorship promoted the value of consumer participation in the evaluation of mental health services.

The importance of strong leadership was also reinforced by members of the Reference Group involved in the statewide introduction of the program. MH-CoPES Coordinators in these AHSs reported that they did not always have the seniority or authority to enforce the implementation of MH-CoPES, or support the program in the ways they considered necessary. This was considered a serious limitation to the effectiveness and sustainability of MH-CoPES in their AHS.

2. Communication and information strategy

A clear communication and information strategy at state, Area and local service levels is also key to the successful implementation of MH-CoPES. Messages that need to be communicated include:

- the purpose of MH-CoPES
- how MH-CoPES works within current quality and accreditation processes
- the importance of consumer evaluation of mental health services
- that MH-CoPES provides a common, statewide Framework and tool for consumer evaluation of mental health services
- the benefits that MH-CoPES can bring to the work environment
- the portrayal of MH-CoPES as "positive" and "needed for change" within the AHS
- the processes that will be used in each step of the Framework.

Communication strategies that proved successful during the research were:

- NSW CAG Project Team presenting on MH-CoPES at staff meetings
- AHS staff promoting MH-CoPES through visiting individual service units to talk to staff about it
- a brief sheet providing guidelines on how to distribute the Questionnaire (see Appendix V)
- a "Q & A" fact sheet for staff and consumers about MH-CoPES (See Appendix AB)

A DVD was also suggested as a way to inform consumers and staff about MH-CoPES.

During the trial and pilot, the Project Champion was central to the communication strategy in ensuring staff remained well informed about MH-CoPES. This communication aided in overcoming the barriers posed by some staff such as that MH-CoPES would increase the amount of paperwork to be managed by staff, and that MH-CoPES is not needed because they had their own survey tools. Conversely, poor communication channels where staff members were inadequately informed about MH-CoPES and its benefits resulted in staff resistance, as staff were unable to see the direct relevance of MH-CoPES to their every day work.

3. Clearly defined responsibilities for MH-CoPES

Having clearly defined and articulated responsibilities during the trial and pilot assisted in ensuring that people understood and fulfilled their role in MH-CoPES. The Reference Group also identified this as being crucial for the success of MH-CoPES.

3.3.2 Building and promoting a shared understanding and value of consumer participation

During the research and through consultations it was observed that the definition and value of consumer participation was not shared across the state or across an AHS. It was clear that many staff support the concept of

consumer participation, however, to varying levels, and staff hold different ideas to one another about what type of participation is valuable. The following were observed at times throughout the research:

- some staff reported seeing funding for consumer participation as directing funding away from direct service provision
- some staff expressed the view that consumers may not have the capacity or could be "too unwell" to participate in service evaluation
- some staff placed greater value on views of staff members, rather than those expressed by consumers. It was observed that this impacted on overall acceptance and engagement in MH-CoPES, a limited view of results from the Questionnaire and a subsequent barrier to acting on consumers' feedback
- a reluctance to share power with consumers through involvement of consumers in each step of the Framework.

Three factors were highlighted during consultation as being essential to build and promote a shared understanding of consumer participation that is necessary to support the successful implementation of MH-CoPES:

1. State Consumer Participation Policy

Leadership from state level by the Mental Health and Drug and Alcohol Office, NSW Health through the development and implementation of a state policy around consumer participation was articulated by the Reference Group as needed to overcome some of the barriers towards consumer participation that impact on the implementation of MH-CoPES.

2. Leadership from AHS and local service management

Clear leadership at AHS and local service management level was identified during consultations and exemplified in the trial and pilot as being a core component to changing staff attitudes towards consumer participation, and ensuring a culture where it is valued. Methods reported by the research sites and identified by the Reference Group to facilitate this were:

- promotion of partnership and working alliance between consumers and services through establishing other projects that exemplify consumer participation
- implementing processes to facilitate dialogue and partnership between consumers, service staff and management, and Area Health Service management. Such processes that were effective during the research were ensuring consumer representation on quality committees, supporting consumers to sit on committees and ensuring their ability to contribute, and developing projects and events that see consumers and staff working together or participating on an equal level
- promotion of the benefits of consumer participation to services and consumers
- developing a positive relationship between service and AHS staff and Consumer Workers. During the research this was facilitated by Consumer Workers being engaged in every component of the Framework, including sitting on quality improvement committees, including Consumer Workers in team meetings, and enabling adequate access for Consumer Workers to services and consumers
- ensuring that aspects where the service is doing well are highlighted, and staff are acknowledged for their work to reduce the feeling of threat posed by consumers' feedback
- education and training of staff about consumer participation.

3. Engaging consumers in all steps of the MH-CoPES Framework

As discussed below, the engagement of consumers in all steps of the Framework itself led to the commencement of cultural change and more positive attitudes towards consumer participation.

"it's empowering consumers to make a change for consumers" (Consumer Worker)

3.3.4 Embedding MH-CoPES in the daily functions of mental health services

1. Integrating MH-CoPES into current systems and processes

The research and consultations highlighted the importance of integrating MH-CoPES into current systems and processes. Where this was achieved during the trial and pilot, it resulted in greater engagement by staff.

3.3.5 Getting and keeping staff engaged

1. A sense of ownership

Early during the establishment of the trial, it was identified that to ensure that staff were engaged in the process, they needed to have a sense of ownership over the project. Indeed, the most effective implementation of MH-CoPES during the research occurred when staff members from all levels of the organisation were involved in the initial and ongoing stages of its implementation.
This process enabled staff to:

- discuss concerns about the introduction of a new program
- develop local strategies for implementation and protocols for each step of the Framework based on the protocols provided by the NSW CAG Project Team
- be involved in decision making and problem solving about the implementation of MH-CoPES and around any difficulties, barriers or changes that needed to be made.

This resulted in stronger staff engagement in each step of the Framework, and a sense of ownership of MH-CoPES was developed across the AHS. The process also assisted in working through the barriers and any sense of threat felt by staff because of the implementation of MH-CoPES.

Inclusion of staff at all organisation levels in the change process was also found to be crucial during the research. During the *Action and Change* step of the Framework, good outcomes were observed when inclusive discussion about results occurred and when problem solving occurred collectively. This enabled any staff defensiveness about current practices that were reported by consumers as needing improvement to be addressed in a positive way.

2. Communication

Three communication strategies were found during the trial and pilot to assist in engaging staff in MH-CoPES. Project Champions and staff within the AHS and individual services who supported and promoted MH-CoPES were key in communication strategies.

- ensuring that service staff were regularly updated on the progress of the implementation of MH-CoPES, the work being conducted in each step of the Framework, any changes to the implementation or protocols, and the progress of the development and implementation of action plans during *Action and Change*.
- communicating quality improvement in positive terms and as an ongoing process. It was found important to communicate that MH-CoPES is about moving towards better services, rather than away from current practice.
- building staff pride in providing quality services based on the needs of consumers, and pride in listening to and acting on what consumers think of the service.

3.3.6 Getting and keeping consumers engaged

1. Promoting the benefits and outcomes of MH-CoPES

A key aspect to getting and keeping consumers involved in MH-CoPES established during the trial and pilot is informing consumers of the purpose and benefits of MH-CoPES. In one service where a Consumer Project Worker was responsible for handing out Questionnaires, when people declined to take a Questionnaire the purpose of MH-CoPES and the benefits that can stem from consumers completing the Questionnaire were explained. This was reported to result in more consumers accepting and completing a Questionnaire, and likely contributed to the sound return rates achieved by this service.

Another component essential to keeping consumers

"the Framework provides a catalyst for cultural change" (senior AHS staff)

engaged in MH-CoPES is informing them of the improvements to the service that have resulted from MH-CoPES. During the research, a successful strategy was having Consumer Workers discuss these with consumers during groups at services.

2. Involving consumers in developing strategies for *Action and Change*

Involving consumers in developing and implementing improvement initiatives for *Action and Change* based on the results of MH-CoPES was also found to be effective in keeping consumers engaged during the trial and pilot. This, in conjunction with receiving updates on the improvements made, gave consumers confidence that their feedback was being seriously considered and acted upon. It appeared to increase motivation to continue to provide feedback through MH-CoPES.

3.3.7 Keeping the momentum of MH-CoPES going

1. Leadership

The Reference Group highlighted that to keep the momentum of MH-CoPES going, local MH-CoPES champions will be key. Further, they highlighted that the coordination of MH-CoPES at AHS and local service levels needs to be built into position descriptions and roles of suitably placed staff to ensure that MH-CoPES is conducted.

2. Promotion of outcomes and benefits attained through MH-CoPES

Promoting the improvements to services and the other benefits of MH-CoPES, such as improved relationships between consumers and staff, was also found during the trial and pilot to be important in keeping the momentum of MH-CoPES going. Again, Project Champions and AHS and service staff who were supportive of MH-CoPES were key in this process during the trial and pilot.

3.3.8 Enabling improvements to services to occur as a result of MH-CoPES

1. Culture of learning led by senior management and MH-CoPES champions

During the trial and pilot, staff were encouraged by Project Champions and senior AHS and service staff to learn from the feedback produced through MH-CoPES rather than to consider the feedback as threatening. In the research sites where this occurred, processes for acting on the feedback and developing improvement strategies occurred more readily, and resulted in changes to services being more quickly implemented.

To facilitate this learning approach, senior management identified the need to present the MH-CoPES findings in a way that did not place blame on staff for negative results. It was found that presenting results as an opportunity to move forward and improve led to greater staff engagement with the findings.

3.3.9 MH-CoPES – A Change Agent

During Stage 1 of the project it was clearly identified that engagement in the MH-CoPES Framework would likely challenge the dominant culture in mental health services (NSW Health, 2006). The very nature of the MH-CoPES Framework involves a mental health service identifying and then acting on feedback to change their practice. However, the trial and pilot work during Stage 2 has demonstrated the effect of MH-CoPES as a change agent beyond this, and through the very process of staff and consumers engaging in working together.

Consultations with staff and consumers at both of the research sites (including Area Executive, senior Area and service staff, consumers, Consumer Workers, service staff, and quality improvement staff) revealed that changes were occurring to how staff and consumers interact. Definitive evidence of why this was occurring was not collected. However those consulted attributed it to engagement in MH-CoPES; not just because of responding to and acting on feedback from consumers, but through the engagement in the whole MH-CoPES Framework.

"a round of applause to MH-CoPES for letting us have our say"
(consumer attending an MH-CoPES consultation)

The research partners reported:

- that a change in thinking was occurring, which involved "actually listening to consumers' perspectives" about the services
- the need for cultural change around how staff interact with consumers was highlighted and initiatives considered to enable this change, for example how information is given to consumers
- stigma and stereotyping towards consumers by staff was being reduced as AHS workers were seeing consumers as colleagues – people who are "well and holding down a job"; "capable, dependable, competent, lovely, honest, open, and very funny and enjoyable people"
- while employing consumers in temporary and casual roles proved an initial challenge to the AHS, it was seen to be "paving the way for policy around the employment and payment of consumers for their time and work"
- as a result of the work of the Consumer Project Workers and the positive impact they had not only on return rates to MH-CoPES but also in communicating with consumers (giving hope) during the trial, a directive to hire more Consumer Workers in other sections of the AHS in one research site was given
- staff in some services began seeking out Consumer Workers to consult and problem solve; previously such consultation and engagement did not occur
- Consumer Workers in the AHS found they were gaining better access to units, including more time, and more easy access to staff and consumers on the units. They reported feeling a change in staff attitudes to their visits
- in one site, Consumer Workers were invited to the staff Christmas party as a result of working more closely with staff through MH-CoPES
- MH-CoPES was a catalyst for other initiatives. In one service further collaborative projects and events were developed and engaged in as a result of the experience of MH-CoPES.

These outcomes demonstrate the power of MH-CoPES as a change agent. MH-CoPES brings staff and consumers together to work on improving services in a collaborative way, and in many instances during the research, there was clear evidence of people involved realising an alignment of their goals. Frequently when staff reviewed the reports provided, comments of agreement about the issues raised by consumers were made. MH-CoPES therefore assists staff and consumers to find common ground to work together to improve the service. In addition, the reporting of positive feedback about services from consumers through MH-CoPES was found to enhance staff morale and facilitate one way for staff to feel appreciated by consumers.

The repetitive cycle of MH-CoPES will result in improvements to services that both staff and consumers will benefit from. As consumers experience these improvements, it is anticipated that, over time, this will be reflected in the way consumers respond in the Questionnaire, and thus provide staff with further positive feedback that the process of change is leading to better services. The whole process of MH-CoPES will therefore ignite cultural change through shifting services to better meet the needs of consumers, as identified by consumers.

The implementation of MH-CoPES, a Framework developed by and for consumers and a Framework that engages consumers in all aspects of service evaluation, throughout public, adult mental health services in NSW makes a clear statement about the value of consumer participation in practice. The Framework provides one mechanism for consumer participation in service evaluation, development and monitoring. Through placing consumers in a position of being informants and as people with valuable knowledge, the MH-CoPES Framework assists in altering the power balance between services, staff and consumers and works to change how consumers are perceived.

Objective 3:
The Role and the Place of MH-CoPES

It was apparent throughout Stage 1 that different stakeholders held a range of views about the role of MH-CoPES. Different people held a variety of aims for the program, and while these aims were not always incompatible, they held very different focuses, from local unit level change through to meeting national Key Performance or Scorecard Indicators. These different focuses have different needs of, and implications for the MH-CoPES Framework and Questionnaire that cannot always be satisfactorily met. Different roles also then place responsibility for and management of MH-CoPES with different parts of the AHS. Therefore, a risk to the success of MH-CoPES is that stakeholders continue to have divergent views as to its purpose.

Part of the work of Stage 2 was to clarify the role and place of MH-CoPES to build a unified vision for the program with clear and achievable aims. Building a clear understanding about what MH-CoPES is to be used for and establishing agreed aims then leads to clarifying where the program sits in terms of its management and implementation, and what existing programs MH-CoPES intersects with, and relates to within AHSs, NSW state policy and at a national level. Consultations throughout Stage 2 of the project were conducted to ascertain the role and place of MH-CoPES.

3.4 The Role of MH-CoPES:
A Mechanism for Consumer Participation in Quality Improvement

The consultations identified that the fundamental purpose and core aim of MH-CoPES is to provide a way for consumers to participate in service quality improvement. It is to ensure that consumer perspectives and experiences of services contribute to service change and improvement. MH-CoPES is a process that provides defined steps and tools for services and consumers to identify areas of service provision needing improvement and to follow through by creating changes to improve services. MH-CoPES exists to drive quality service delivery at local, AHS and state levels, and to make quality services be defined by and in line with consumer identified needs.

As part of the quality improvement processes, it was identified that MH-CoPES may have an important secondary role to provide a measure of services' performance in responding to the views of consumers. It has been identified that NSW Health currently does not have a tool to measure state, AHS and local service performance of how well services are seeking, and responding to, consumers' views about service provision under the National Health Performance Framework domain of *Responsiveness* (National Health Performance Committee, 2001). While the primary role of MH-CoPES is to assist service change at local, AHS and state levels, it is also an appropriate candidate to measure performance under this domain. Incorporating it at this level places MH-CoPES as a component within the regular reporting of NSW Mental Health Key Performance Indicators. For MH-CoPES to have this secondary role would enable a gap in the system to be filled. It will also assist in ensuring services are accountable for MH-CoPES implementation. Furthermore, MH-CoPES, when implemented as recommended in this report, provides one tool for NSW Health to assess its performance of consumer involvement in decision making, which is a further component of the domain of *Responsiveness* as defined in the *Report on Government Services* (Steering Committee for the Review of Government Service Provision, 2009).

3.5 The Place of MH-CoPES:
Quality Improvement Systems

Clarifying the place of MH-CoPES allows a better assessment of how MH-CoPES fits within existing mental health service practice. During Stage 1, and the consultations during Stage 2, it was highlighted that aligning and relating MH-CoPES to existing systems, processes and programs to ensure that the process is not standing alone will be essential to its success. Indeed, it will only succeed and be sustainable if integrated into the day-to-day work of mental health services. As the MH-CoPES principles highlight, MH-CoPES aims to be efficient and effective; it must therefore inform practice, and be informed by existing practice.

"MH-CoPES exists to drive quality service delivery at local, Area Health Service and state levels and to make quality services be defined by and in line with consumer-identified needs"

Figure 8 captures the systems, structures and policy areas within the mental health system that MH-CoPES links to in some way, assisting to define the place of MH-CoPES.

To serve its principal function of providing a way for consumers to participate in quality improvement, and to ensure that consumer perspectives and experiences contribute to service change and improvement, it is essential that the responsibility for MH-CoPES sits with local, AHS and state quality improvement committees, processes and structures.

As highlighted in the discussion of the protocols for the MH-CoPES Framework, the responsibility for each step of the Framework needs to be coordinated at different levels. However, it is also important that NSW Health and the AHSs lead the way in promoting MH-CoPES and ensuring that it occurs. To guide this and ensure commitment to MH-CoPES, it is important to incorporate MH-CoPES as a key performance indicator, as discussed under the role of MH-CoPES.

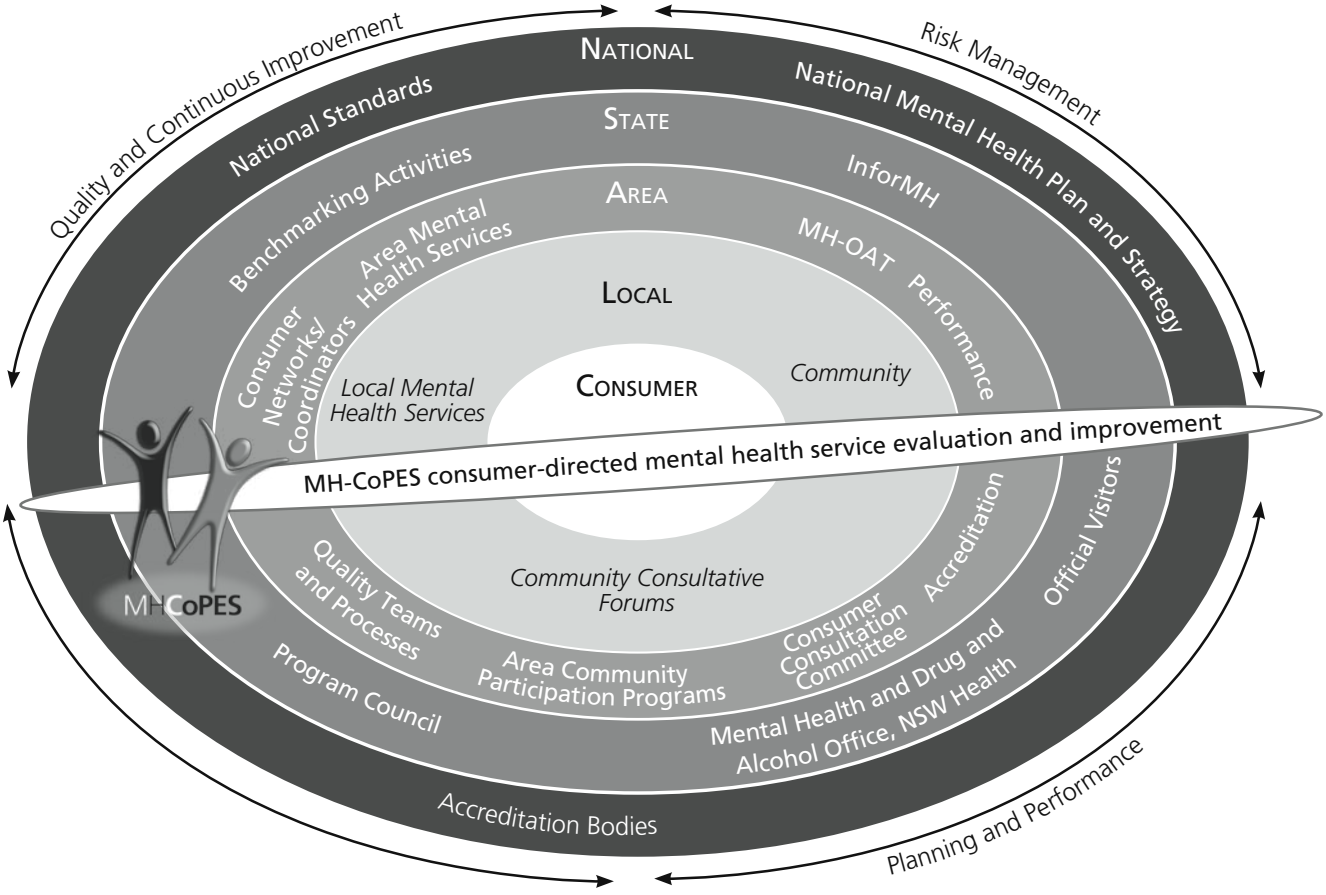

Figure 8.
MH-CoPES and the Mental Health System

4. Conclusion

As evidenced in the various state plans (the NSW State Plan, the NSW State Health Plan and the NSW State Plan for Mental Health, NSW Health, 2006a,b, 2007), NSW has been advocating for greater consumer participation in all aspects of service delivery.

MH-CoPES provides a Framework for realising strong consumer participation in practice, from evaluation of services right through to informing and implementing service improvements. It thus provides a mechanism for consumer participation in service evaluation, development and planning, and policy development.

The MH-CoPES Framework provides the necessary strategies and structures for implementing consumer evaluation of mental health services to ensure service improvements are derived from consumer feedback. Further, the work of Stage 1 and 2 of the MH-CoPES project has highlighted that only a statewide program such as MH-CoPES can ensure that consumers' feedback drives service change at a local services, AHS and state level.

The MH-CoPES Framework has been developed over six years, with extensive consultation with consumers, carers, service providers, NSW Health and other stakeholders, and testing through the research in metropolitan and rural services, as well as across services in NSW through the statewide introduction. It has been informed by the nine principles underpinning MH-CoPES. The experiences of the trial and pilot as well as the consultations conducted throughout both stages of the MH-CoPES project have resulted in a set of protocols that form a comprehensive strategy for the effective implementation of MH-CoPES throughout public, adult inpatient and community mental health services throughout NSW.

For the MH-CoPES Framework to achieve its purpose of ensuring consumer participation in quality improvement it is essential that the Framework be viewed as a whole. Importantly, the MH-CoPES Framework and Questionnaires have been developed by and for mental health consumers. Any changes, therefore, to the recommended Framework presented in this report need to first be subject to extensive consultation with consumers before testing.

Throughout both stages of the project, the need for evaluation processes and tools to enable specific groups to participate in the evaluation of mental health services was articulated. Owing to the scope of the Stage 2 project, this work could not be undertaken during the project. It is a recommendation that further research and projects be conducted to adapt MH-CoPES to meet the needs of these groups and enable their participation in mental health service evaluation.

4.1 The MH-CoPES Framework

The purpose of MH-CoPES is to provide a way for consumers to participate in quality improvement, and to ensure that consumer perspectives and experiences contribute to service change and improvement. It is therefore essential that MH-CoPES be embedded within quality improvement structures at state, AHS and local service levels. Responsibilities for the conduct of MH-CoPES lie predominantly with NSW Health and the AHSs.

The protocols and lines of responsibility for each step of the Framework are detailed on pages 26–27. The trial and pilot of the MH-CoPES Framework demonstrates what can be achieved when it is implemented using these protocols. The outstanding return rates attained in the trial and pilot, when compared to those of the statewide introduction (see report – *The First Year of the MH-CoPES NSW State-Wide Data Collection* 07–08, InforMH NSW Health) highlight the importance of ensuring that the processes and procedures, resources, allocation of responsibility for MH-CoPES and a comprehensive communication strategy are put in place to guarantee the successful implementation of MH-CoPES. Further, these protocols allow for the additional benefits to services discussed in the cultural and change management section of this report, and that include changing attitudes towards mental health consumers, building more positive relationships between consumers and staff, and creating a

"the work of Stage 1 and Stage 2 of the MH-CoPES project has highlighted that only a statewide program such as MH-CoPES can ensure that consumers' feedback drives service change at a local services, Area Health Service and state level"

more consumer-focused service and system. Best practise of implementing MH-CoPES is detailed in the protocols on pages 26–27 and includes consumer participation in all steps of the Framework.

The effective and successful implementation of the MH-CoPES Framework at the state, AHS and local service level depends on a range of supportive factors. It has been identified that these include:

- incorporation of MH-CoPES as a component within the regular reporting of NSW Mental Health Key Performance Indicators
- strong leadership by senior management at state, AHS and local levels
- MH-CoPES champions at state, AHS and local levels
- integration of MH-CoPES into the position descriptions of suitable roles within each AHS
- a clear communication and information strategy for AHS, staff and consumers
- clearly defined responsibilities for MH-CoPES at state, AHS and local service levels
- the development and implementation of a state Policy for Consumer Participation in Mental Health Services
- integration of MH-CoPES at all levels into current systems and processes
- development of a sense of ownership of MH-CoPES amongst staff
- engagement of staff and consumers in all steps of the Framework, and in particular in *Action and Change*
- promotion of the benefits and outcomes of MH-CoPES
- development of a culture of learning within mental health services.

5. Recommendations to NSW Health

Based on the findings of both stages of the MH-CoPES project, the following recommendations are made to NSW Health for implementing a statewide process for consumer evaluation of mental health services in NSW.

1. NSW Health adopt the whole MH-CoPES Framework as a way for consumers to participate in quality improvement, and to ensure that consumer perspectives and experiences contribute to service change throughout public, adult mental health inpatient and community services in NSW as per the protocols in this report. This includes the adoption of the MH-CoPES Questionnaires for people who use public, adult inpatient and community mental health services as the main tool for providing their feedback.
2. The MH-CoPES Framework is integrated into current state, AHS and local service quality improvement structures.
3. A policy position around consumer participation in the evaluation of mental health services be adopted by NSW Health that:
    - articulates the value of consumer participation in service evaluation and quality improvement
    - defines consumer participation in service evaluation in accordance with the definitions provided in this report, and the Stage 1 Report (NSW Health, 2006)
    - is based on the nine principles underpinning MH-CoPES
    - articulates the purpose of the MH-CoPES Framework as providing a way for consumers to participate in quality improvement and to ensure that consumer perspectives and experiences contribute to service change and improvement.
4. MH-CoPES is incorporated into the regular reporting of NSW Mental Health Key Performance Indicators. It has been identified that this could be achieved by establishing MH-CoPES as a measure of services' performance in the area of *Responsiveness* to consumers, within the National Health Performance Framework (National Health Performance Committee, 2001). MH-CoPES could also be used to satisfy the performance indicators relating to consumer satisfaction with services and providing services that are responsive to consumers needs and consumer involvement in decision making for mental health management, from the *Report on Government Services* (Steering Committee for the Review of Government Service Provision, 2009).
5. NSW Health develop strategies to support the implementation of MH-CoPES as highlighted above and throughout this report, including the development and implementation of a state Policy for Consumer Participation in Mental Health Services.
6. Further research be conducted to adapt the MH-CoPES Framework and Questionnaires so that they are appropriate for use by:
    - people from other cultural and language groups, including people from Aboriginal and Torres Strait Islander backgrounds
    - people who use child and adolescent mental health services
    - people who use older person's mental health services
    - people who use forensic mental health services
    - families and carers of mental health consumers.

References List

Aiken, L.R. (2003). *Psychological testing and assessment,* 11th Ed. USA: Pearson Education Group.

Altheide, L. (1987). Reflections: Ethnographic Content Analysis. *Qualitative Sociology, 10*(1), 65-77.

Australian Health Ministers (1997). *National Standards for Mental Health Services*. Canberra: Australian Government Publishing Service.

Australian Health Ministers (2009). *Fourth National Mental Health Plan 2009-2014*. Canberra: Australian Government.

Australian Health Ministers (2009). *National Mental Health Policy 2008*. Canberra: Commonwealth of Australia.

Bjørngaard, J, Garratt, A, Grawe, R. W, Bjertnæs, A & Ruud, T (2008). Patient experiences with treatment in private practice compared with public mental health services. *Scandinavian Journal of Psychology, 49*(4), 385-392

Bryman, A. (2004). *Social Research Methods*, 2nd ed., Oxford University Press, Oxford.

Druss, B.G, Rosenheck, R. A., & Stolar, M (1999). Patient satisfaction and administrative measures as indicators of the quality of mental health care. *Psychiatric Services, 50*(8),1053-1058

Epstein, M & Olsen (1998), A. An introduction to consumer politics. Journal of Psychological Nursing and Mental Health Services, 36, 40-49.

Hansen, T, Hatling, T, Lidal, E, & Ruud, T. (2004). The user perspective: respected or rejected in mental health care. *Journal of Psychiatric and Mental Health Nursing, II*, 292-297

Hayes, N. (2000) Doing Psychological Research: Gathering and Analysing Data, Open University Press, Buckingham

Higgins J.M., & McAllaster C. (2004). If you want strategic change, don't forget to change your cultural artefacts. J*ournal of Change Management, 4*, 63-73 2004.

InforMH, NSW Health. (2008). *The first year of the MH-CoPES NSW State-wide Data Collection 07-08*. Unpublished report.

Issac, G.,Rajendran, C. & Anantharaman, R. N. (2006). An instrument for the measurement of customer perceptions of quality management in the software industry: An empirical study in India. *Software Qual Journal*, *14*, 291-308

Kanee, E., Steven, A., Cassidy, P., & Vardy, C. (2003). Implementation of a model for service delivery and organisation in mental healthcare: a qualitative exploration of service provider views. *Health and Social Care in the Community, 11*, 519-527

Lloyd, C & King R (2003). Consumer and carer participation in mental health services. A*ustralasian Psychiatry,* 11 (2), pp 180-184

National Health Performance Committee (2001). *National Health Performance Framework*. Brisbane: Queensland Health

National Mental Health Working Group Information Strategy Committee (2004). National Mental Health Information Priorities Workshop Sydney 26-27 February 2004, Proceedings. Canberra: Department of Health and Ageing

NSW Consumer Advisory Group – Mental Health Inc. (NSW CAG) (2007) *Procedures for Data Collection for pilot to be conducted in 2008 in Ryde and Orange, 3rd.* Unpublished paper

NSW Department of Health (1999). *Framework for Managing the Quality of Health Services in NSW.* Sydney: NSW Department of Health

NSW Department of Health (2006a). *A statewide approach to measuring and responding to consumer perceptions and experiences of adult mental health services: A report on stage one of the development of the MH-CoPES framework and questionnaires*. North Sydney: NSW Department of Health

NSW Department of Health (2006b). *NSW: A new direction for Mental Health*. North Sydney: NSW Department of Health

NSW Department of Health (2007a). *A New Direction for NSW: State Health Plan Towards 2010*. North Sydney: NSW Department of Health

NSW Department of Health (2007b). *Future Directions for Health in NSW - Towards 2025 Fit for the Future*. North Sydney: NSW Department of Health

NSW Government (2006). *A new direction for NSW: State Plan*. Sydney: NSW Government

NSW Health Department (2001) *NSW Mental Health Outcomes Assessment & Training (MH-OAT) Facilitators Manual* NSW Department of Health Sydney

Perreault, M., Pawliuk, N., Vielleux, R., & Rousseau, M. (2006). Qualitative assessment of mental health service satisfaction: Strengths and limitations of a self-administered procedure. *Community Mental Health Journal, 42*(3), 233-241

Service Quality Australia (1999). *Evaluation of consumer participation in Victoria's public mental health services*. Melbourne: Mental Health Branch, Department of Human Services

Sim, J. (1998). Collecting and analysing qualitative data: Issues raised by the focus group. *Journal of Advanced Nursing, 28*(2), 345-352

Stallard, P. (1996). The role and use of computer satisfaction surveys in mental health services. *Journal of Mental Health, 5*(4), 333-348

Steering Committee for the Review of Government Service Provision (2009). *Report on Government Services 2009*. Canberra: Productivity Commission

The Appendices are available as a separate document from **www.nswcag.org.au**

List of Tables, Figures and Boxes

List of Tables

List of Figures

List of Boxes

Glossary

Acute:	Recent onset of severe clinical symptoms of mental illness
Area Health Service:	The system of Area Health Services established by the *Health Services Act 1997* extends throughout the whole of the state. There are eight Areas in NSW. Greater Western, Greater Southern, Hunter New England, North Coast, Northern Sydney Central Coast, Sydney West, Sydney South West and South Eastern Sydney Illawarra
Action and Change:	Step 4 of the MH-CoPES Framework, were the results of MH-CoPES Reports guide quality impovement action planning at a state, Area and local service unit
Co-efficient alpha:	A statistical test that provides an indication of the internal reliability of a tool such as the MH-CoPES Questionnaire. It measures how much the individual items on the Questionnaire are correlated or directly connected to each other in order to measure whether the Questionnaire is consistent in what it is measuring
Consumer:	A person utilising, or who has utilised, a mental health service
Consumer Advocate:	A person who intercedes for and acts on behalf of a consumer when the consumer is unable to do so
Consumer participation:	Consumer involvement in the decision-making process of services
Consumer Project Worker:	Worker employed by the MH-CoPES project to: assist individuals to complete the Questionnaire when they required help; distribute the Questionnaire and to participate in *Action and Change*
Construct validity:	A statistical measurement of whether a tool such as MH-CoPES actually measures the theoretical concept it was designed to measure (Hayes, 2000). For MH-CoPES it is about whether the Questionnaire actually measures consumers' perceptions and experiences of services
Convergent validity:	A statistical measurement of how well a tool such as MH-CoPES is measuring a concept through comparing it to other measures of that concept. For the whole MH-CoPES Questionnaire, which was to measure people's perceptions and experiences of services, it was important to make sure that people's responses were consistent with another measure of perceptions and experiences of services. For this, the responses to the question from the NSW Health Survey "Overall, what did you think of the service" were compared to the overall responses to the questions on the MH-CoPES Questionnaire
Correlation:	An approach to the analysis of relationships between questions, that seeks to assess the strength and direction of the relationship between them
Data Analysis:	Step 2 of the MH-CoPES Framework, where information gathered through the MH-CoPES Questionnaires is collated and analysed
Data Collection:	Numerical and non-numerical forms of information and evidence that have been carefully gathered according to rules or established procedures

Ethnographic content analysis:	An approach to analysing written comments which involves adding up the number of times a word or topic or idea is addressed within the written comments. This results in main ideas being repeated as topics, such as 'smoking'
Face validity:	Whether the questions on a questionnaire appear to be measuring what the questionnaire is meant to measure (Aiken, 2003). In the case of MH-CoPES it is whether the questions appear to be measuring consumers' perceptions and experiences of services
Factor analysis:	A statistical technique used for large numbers of questions to establish whether there is a tendency for groups of them to be inter-related
Inductive thematic approach:	An approach or style of analysing written comments which allows for broad themes and issues to be identified as they emerge from the data
InforMH:	The service that centrally manages collection and analyses of mental health service information for NSW Department of Health
Internal reliability:	Internal reliability refers to whether the questions on the questionnaire consistently measure the same thing (Aiken, 2003)
Mean score:	The everyday average – namely, the total of all scores divided by the number of scores
MHOAT CCC:	A committee established to provide a mechanism for consumers to provide input into the implementation of MHOAT in NSW (NSW Health Department, 2001)
Mental health service:	An inpatient or community mental health unit or centre
Official Visitors:	Official Visitors are appointed by the NSW Minister for Health to visit people in mental health inpatient facilities in NSW and are available to assist consumers on Community Treatment Orders
Pilot:	A miniature versions of a full-scale study, as well as the specific pre-testing of the MH-CoPES Questionnaire or interview schedule. The pilot involved a three month *Data Collection* period and a dry run of the protocols at each step of the Framework
Pilot Implementation Committee (PIC):	The Committee was established in Greater Western Area Health Service and Northern Sydney Central Coast Area Health Service to oversee the project's implementation locally and provide advice to the NSW CAG Project Team on solving issues that arose during the course of the project
Project Champion:	A Project Champion is an individual or group assigned to support and drive a project forward and is crucial to its success
Psychometric properties:	The statistical properties of a questionnaire or survey to determine whether it is measuring what it is supposed to and whether it does so consistently
Quality improvement:	Measures undertaken in order to increase efficiency of actions and procedures with the purpose of achieving additional benefits for the organisation and its users
Qualitative data:	This is usually written or verbal information that cannot be added or counted. It is information which deals with descriptions

Quantitative data:	Information that is in numbers; it can be described in terms of quantity, and measured or analysed using statistical methods; it can also be displayed using tables, charts and graphs
Reference Group:	The role of the MH-CoPES state-wide Reference Group was to liaise and consult with AHSs on issues relating to the project, represent the views of AHSs provide advice and support the work of the project
Reliability:	The degree to which a measure of a concept is stable or consistent
Reporting and Feedback:	Step 3 of the MH-CoPES Framework, where reports are produced and distributed to stakeholders that outline identified areas where services are performing well, and areas needing improvement
Return rate:	Refers to the percentage of returned Questionnaires based on the population using the service during the specified timeframe
Response rate:	Refers to the percentage of Questionnaires returned from those handed out
Separations:	An administration process by which a hospital records the completion of treatment of a consumer. E.g. the are discharged from the service or moved to another facility
Statewide introduction:	The commencement of a program, policy or procedure which occurs or extends throughout the state. In this report, this refers to the introduction of the MH-CoPES Questionnaires statewide, without the accompanying MH-CoPES Framework
Test-retest reliability:	A measure of whether people answer the questions in the same way within a short period of time. It is another measure of a questionnaire's consistency (Aiken, 2003)
Trial:	An initial trial of the Framework was conducted with the research partners, testing protocols for each step of the Framework. The trial involved a one-month *Data Collection* period. It occurred during June/July 2007 in Orange, and August 2007 in Ryde
Validity:	A concern with the integrity of the conclusions that are generated from a piece of research. In the case of the MH-CoPES Questionnaire it refers to whether it actually is measuring consumers' perceptions and experiences of services

Abbreviations

AHS:	Area Health Service
CCC:	Consumer Consultative Committee
CTO:	Community Treatment Order
KPI:	Key Performance Indicator
MH-CoPES:	Mental Health Consumer Perceptions and Experiences of Services
MH-OAT:	Mental Health Outcomes and Assessment Training/Tools
MH-OAT CCC:	Mental Health Outcomes and Assessment Training/Tools Consumer Consultative Committee
MHS:	Mental Health Service
NSW CAG:	New South Wales Consumer Advisory Group – Mental Health Inc
NUM:	Nursing Unit Manager
PIC:	Pilot Implementation Committee

NSW Consumer Advisory Group - Mental Health Inc.

Suite 501, Level 5, 80 William Street
Sydney NSW 2000

Telephone: (02) 9332 0200

Fax: (02) 9332 0299

Email: info@nswcag.org.au

www.nswcag.org.au

Office Hours: 9.00am to 5.00pm Monday to Friday