Implementing Routine Outcome Measurement in Community Managed Organisations

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1. Introduction

You have picked up this guidebook, because you are interested in implementing routine outcome measurement for mental health services provided by your community managed organisation (CMO/NGO[1]).

It is important to remember that this is a very brief guide. It is intended to give you a broad brush stroke of some measures that you may consider using and some ways you may consider using them, along with the opportunities and challenges you may face as you implement routine outcome measurement in your service.

This guidebook will provide you with advice on how to go about introducing the collection of routine outcome measurement information.

It will show that this information may be useful for the individual receiving your service, to better understand how they are at one point in time or how they may be changing.
Managers of services might use the information to understand how groups of consumers are presenting, or how they may be changing, and this same information may also be used to demonstrate to the people that fund you what you produce as a result of that funding. It is important to remember, if you choose the right measure, you may just manage to do all three.

2. Background

Government funders are beginning to look favourably on mental health CMOs that build their capacity to demonstrate outcomes through validated instruments. National documents set out the commitment by State, Territory and Commonwealth governments to work toward both the use of tools by CMOs and the need to collect outcome information in a nationally consistent manner.

The Fourth National Mental Health Plan: An agenda for collaborative government action in mental health 2009-2014 (Commonwealth of Australia 2009) includes a priority area that outlines the importance of accountability across the mental health service system through better measurement and reporting of progress.

The Roadmap for National Mental Health Reform (Commonwealth of Australia 2012) commits State, Territory and Commonwealth governments to increase the levels of mental health services (including CMOs) achieving accreditation against the National Standards for Mental Health Services (Commonwealth of Australia 2010), which in turn stipulates the use by services of evidence-based outcome monitoring tools.

Also, the Contributing Life: the National Report Cards on Mental Health and Suicide Prevention (National Mental Health Commission 2012 and 2013) indicate that State, Territory and Commonwealth governments continue to work towards a national system for measuring and reporting on client data, including outcomes.

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[1] *Community Mental Health Australia uses the strengths-based term Community Managed Organisation for organisations operating in the community managed mental health sector. These organisations have historically been called Non Government Organisations or Psychiatric Disability Rehabilitation and Support Services.*

3. What is outcome measurement?

Outcome measures include tools, instruments, scales, or questionnaires that can be used to show how a person's recovery may be progressing, providing the opportunity to demonstrate change over time.

Outcome measures can help to identify specific areas where the consumer and their carers might require support but can also highlight key areas of strength which can be harnessed to support consumer recovery. Outcome measures provide information about consumers and their carers which can also assist services to better understand the effectiveness of the programs that they provide and encourage a culture of service improvement.

There are a wide numbers of tools available designed to measure psychosocial changes over time. Each of them have been developed and scrutinised to varying levels of rigor, resulting in robust debate over the validity and effectiveness of each tool.
Of the three major types of mental health services provided in Australia – public, private, and community managed – the community managed sector is least consistent in their measurement of outcomes.

There has, to date, not been any broad imperative towards consistency. The National Community Managed Organisation (CMO) Outcome Measurement Project Final Report (Australian Mental Health Outcomes and Classification Network and Community Mental Health Australia 2013) found that most people accessing CMO mental health services in Australia are encountering a formal outcome instrument of some sort, however it is rarely the same tool, and implementation methods vary to the point that few collections of outcome data are comparable.

4. Why should my organisation implement outcome measurement?

First and foremost outcome measurement should be a means to provide accurate feedback to consumers and carers about their progress in response to their interaction with your service.

Using the data to improve the quality of your service comes a close second. The introduction of outcome measurement to your CMO, in a consistent fashion, is therefore more than simply implementing the collection of data.

It represents a significant change to the way that your service has probably worked. It is about the collection of information in a way that may fundamentally change the way that you relate to the people you work with, empowering them to take greater charge of their own recovery. It is about being open and transparent about what you do as a service and what you achieve and demonstrating that to others.


adidas
Los Toros

5. The best practice pathway to implementation

The process of implementation of outcome measurement might be considered to take place over four phases:

- planning for outcome measurement;
- implementing the system;
- using and reporting the data; and
- monitoring, evaluating and reviewing the use of outcome measurement.

It is recognised that community managed organisations have limited resources and therefore may not be able to implement all the actions described below. You will need to consider what is do-able for your organisation, keeping in mind why you want to implement outcome measurement in your organisation.

5.1. Planning for outcome measurement

When planning the introduction of outcome measurement in your CMO you might wish to consider the following:

5.1.1 What measures could you use?

To support instrument selection, the National Community Managed Organisation (CMO) Outcome Measurement Project Final Report (Australian Mental Health Outcomes and Classification Network and Community Mental Health Australia 2013) conducted a literature review along with detailed consultations with consumers, carers, CMOs and funders of CMOs. A total of 136 tools were identified across six primary categories of outcome (see Table 1).

Table 1

Recovery	The personal process of individual recovery.
Thoughts and Feelings	Individual consumer cognitive performance and emotional experience. Individual carer cognitive performance and emotional experience.
Daily Living and Maintaining Relationships	Simple and complex functional abilities are covered here including the ability to undertake activities of daily living consistent with developmental stage. The quantity and quality of interpersonal relationships consistent with developmental stage.
Social Inclusion	Education, employment, citizenship, stability of housing.
Quality of Life	General life satisfaction, physical health and wellbeing
Experience of Service	Service satisfaction, consumer or carer experience of service provision. Care or service co-ordination.

All tools were checked for free availability and then a set of selection criteria were established. The consultations confirmed general acceptance that individual client outcome measures appropriate for mental health CMOs in Australia should:

- have been developed for use or used in the mental health sector;
- have been developed or used in Australia, with identified potential for further development;
- be able to be completed by either the client (consumer or carer) and/or CMO employee;
- be brief and easy to use (time and/or number items);
- yield quantitative data (does not exclude instruments that also yield qualitative data); and
- have undergone scientific scrutiny and have demonstrated strong psychometric properties (e.g., of internal consistency, validity, reliability and sensitivity to change).

Using these criteria the CMO Outcome Measure Project identified 31 measures that may be suitable for implementation in the CMO sector. This candidate list, as well as a detailed literature review on all identified tools is available in the project's final report.

5.1.2 Recommended Tools

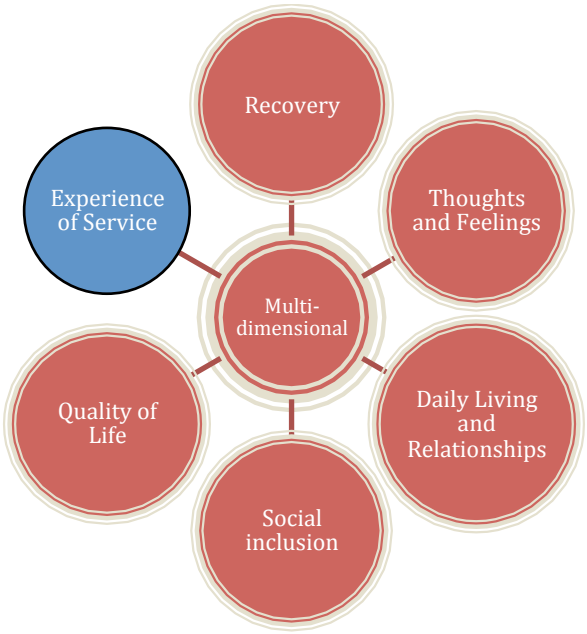
The National CMO Outcome Measurement Project held a national workshop, involving most major government and CMO sector stakeholders, seeking their advice on how a nationally consistent approach to outcome measurement could occur within the sector.

The conclusion of the stakeholders was that an initial candidate set of 31 tools identified in the project final report required further refinement and that, while technically ideal, a single tool would not be sufficient to cover the diversity of outcomes achieved by the sector.

It was proposed that the sector could start with the simplest and most universal CMO outcome - Experience of Service (inclusive of service satisfaction), see Figure 1 - and that CMOs can then select the most appropriate additional measures for the type of service that is being delivered, or the kinds of outcomes that they are aiming to achieve with their consumers and carers.

It is hoped that this will support progress towards some national consistency with Experience of Service measures and the types of measures that are being used to demonstrate change in other categories. The workshop participants also recommended that this guidebook be developed to provide information and advice about the introduction of outcome measurement to CMOs.

Figure 1



In 2014, an expert technical advisory group was formed to assess the candidate list of 31 tools and further refine it. The group included representatives from CMOs with extensive experience in routine outcome measurement, as well as representatives from the public and private mental health sectors, consumer and carer groups, and the National Disability Insurance Agency.

The following tools are recommended as the most appropriate tools, in most situations, for community managed organisations delivering mental health or psychosocial disability services in Australia (see Table2). While mostly there is no cost per use, permission to use or acknowledgement of the tool developer may be required.

Table 2

Recovery	Recovery Assessment Scale **(RAS)**† or Stages of Recovery Instrument **(STORI)**†
Thoughts and Feelings	Kessler-10 **(K-10)**† or CarerQoL **(CarerQoL-7D+VAS)**† or Strengths and Difficulties Questionnaire **(SDQ)** (used in Child and Adolescent services)†
Daily Living and Maintaining Relationships	Work and Social Adjustment Scale **(WSAS)**†
Social Inclusion	Living in the Community Questionnaire **(LCQ)**†#
Quality of Life	World Health Organisation Quality of Life –Brief, Australian Version **(WHOQoL- BREF)**†
Experience of Service	Your Experiences Survey **(YES)**† or Carers Experience of Service Provision†#
Multi Dimensional	Camberwell Assessment of Need – Short Appraisal Scale **(CANSAS)** †*

† Consumer or carer rated
†* Consumer, carer and worker rated components
†# Measure in development

These tools are not necessarily the "best" of all tools available; however the technical advisory group identified them as representing the best balance between ease of use, reasonable psychometric properties and appropriateness for the community sector. An important feature of the measures selected is that they are all completed by the consumer or carer as relevant. They need to be offered by the staff but they collect the consumer's or carer's view.

Another reason for recommending these tools to the sector is to develop an opportunity for comparability across services, including public services.

Other tool choices may not be viewed as equally valid by administrators of mental health and psychosocial disability programs.

It is OK to add additional items after the chosen measure(s) but if you remove items or change items in any way you effectively change what is being measured and will lose the ability to compare your outcomes with others. It may also bring into question the accuracy of your data if the tool has not been re-validated prior to use.

You may of course decide to select other measures. Evidence for and against specific measures can be subject to change; however the tools listed above are those that best met the criteria for use in Australian CMOs at the time of publication.

Be sure to read the full National CMO Outcome Measurement Project Final Report, available at:

http://amhocn.org/static/files/assets/1db71d07/CMO_OM_Final_Report_Ver1_1.pdf

to learn about the large range of tools available and the key psychometric properties relevant for different kinds of outcome measure.
At the cross-jurisdictional level, there is constant pressure to standardise and reduce the number of tools used by government funded services.

However, this is not an easy request of not for profit organisations. Even if CMOs were to limit their tool use to the eleven listed above, it would be too costly and burdensome to implement all of them in all cases. Services will need to consider what is most relevant for their consumers, carers and their service.

New measures are also being developed all the time and we are learning about ways of measuring important aspects of the consumer's experience, as well as those of their families and carers. So these categories and the suggested measures may change in years ahead as we learn from the process of implementation. Changes do tend to occur quite slowly as it takes some time to validate new measures and establish that they are useful in practice.

The community managed mental health sector provides a diverse range of service offerings, so the aim of each specific program will largely determine the category of outcome to measure. Other factors that may determine tool selection may include how focused or broad the program is, the frequency of consumer or family/carer contact, and the mode of service delivery.

5.1.3 What makes these tools measures of outcomes?

The answer to this question is really quite simple. Any of the suggested tools become measures of outcomes when they are completed more than once. The collection of the same information over time is what indicates change, and therefore a potential outcome. The more challenging part is deciding when to collect the measures. These collection schedules are called the collection protocols.

Part of your implementation plan will be to ensure that you have a very clear protocol for when the measure will be offered by staff and completed by the consumer or carer. The first decision to make is when should the measure be offered for the first time? Is this when the person first arrives at your service, when they are attending a new program for the first time or at a set calendar point in the year?

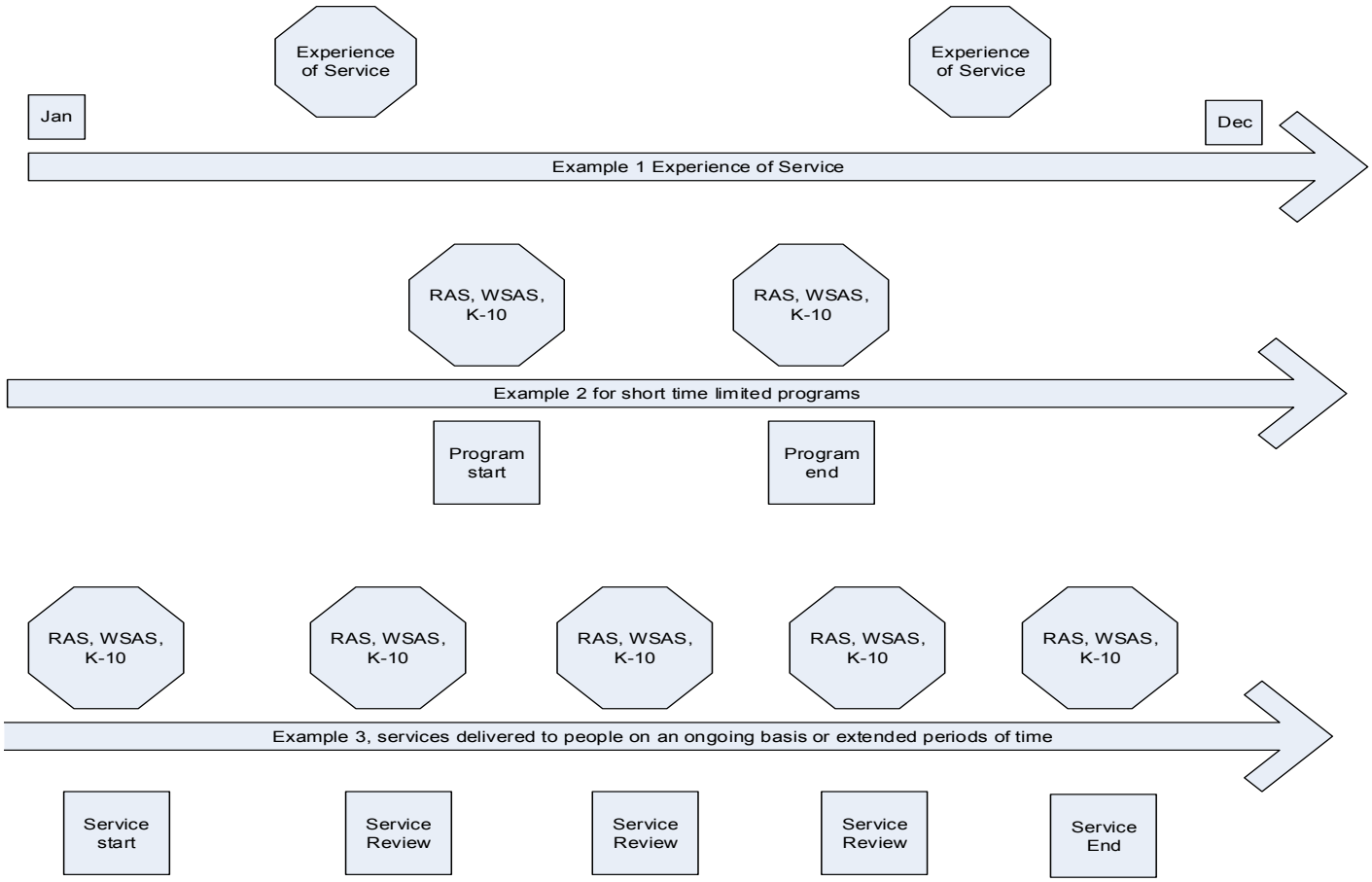
You should make clear who offers the measure to the consumer or carer and when the offer takes place. Once this first collection is decided, then the timing of the second and subsequent collections needs to be determined. Is it when the consumer or carer exits your service, or at a significant point in the program, or again a calendar trigger? This calendar trigger could be once a week, once a month, once every three months or once a year. Deciding when the measure is offered for the first time and when they will be offered for the second and subsequent times will depend on what you are trying to achieve with the implementation of routine outcome measurement in your service.

Many tools have supporting documentation suggesting collection protocols. Other protocols may be suggested in peer-reviewed literature surrounding the tool. In the public mental health system there is an agreed prescribed set of protocols for all services – this is part of the National Outcomes and Casemix Collection (NOCC).

5.1.4 Examples of collection protocols

Below are some examples of protocols for collection. Example 1 is a possible data collection protocol for an experience of service measure. It could be offered to consumers every six months as a census type activity. It is best to keep experiences of care information separate from the collection of information about personal experience because of the potential for people to give you the answers they think you want to hear.

Example 2 is for services delivered in a specific, time limited program, these programs may have a fixed structure and you want to see if you have made an impact or any change has taken place as a result of the program. Example 3 is for ongoing service provision. You want to see if there are changes over time and period reviews are the best way of monitoring change. How often should those reviews take place is something that you have to consider based on how your service operates.



5.1.5 Reviewing the current system

Your ability to measure outcomes is dependent on the ability to consistently collect relevant consumer information at regular intervals. Initially, what you are reviewing is the current system of data collection and outcome measurement (or its absence). At its most basic, a good information system should be able to:

- collect the data you need at every occasion of service (e.g. outputs – some funding bodies require this);
- collect specific data at regular intervals (e.g. outcome measures);
- have the capacity to view and aggregate the collected quantitative data; and
- report on trends in outputs and outcomes.

Qualitative data is useful and can be collected at regular intervals by providing open-ended questions or by holding focus groups. This information will require qualitative analysis. Many organisations do not have this expertise internally and may need to seek external help.

5.1.6 Leadership

You may expect resistance to the implementation of routine outcome measurement. For many workers, this may be the first time that they have used a structured tool to support consumer or carer engagement and assessment, or to demonstrate change. For other services it may be that you are moving from an occasionally used but beloved tool to one of the suggested measures in this guide book. It may not be the use of a standard measure that generates resistance but the perception of the additional workload that the introduction of routine outcome measurement would bring to your service. Some people may feel that the use of outcome measures might lead to criticism of their work.

People respond to any change in often predictable ways: they have to first understand and come to terms with the change; they have to explore how the change helps or hinders what they are trying to achieve; and they have to take time to build the change into their everyday lives. The implementation of routine outcome measurement will require the adoption of all of your change management skills.

Strong and consistent leadership is central to successful implementation. The CMO leadership should ensure that key aspects of implementation are followed through and that staff have the opportunity to receive feedback about the ratings on the measures and the outcomes for their consumers and carers.

However, managers at all levels can facilitate the implementation of outcome measurement - through clear and consistent messages that explain the reasons and rationale for outcome measurement and by engaging and motivating staff. Following implementation, managers should ensure that they also routinely utilise outcome measures in their work practices. Managers need to visibly demonstrate the behaviours that they are seeking of other staff.

5.1.7 Consumer, carer and staff involvement

A successful implementation will require a commitment to genuine consultation and engagement with consumers, carers, peer workers and staff from the very beginning. It is also worth remembering that key staff members may not always be those in leadership roles. There are often people, who you can identify in your organisation, who have “informal” leadership and who may often be sought after by colleagues for guidance on various workplace issues.

5.1.8 Formation of a planning and implementation working group

The involvement of consumers, carers, peer workers and staff in the planning and implementation working group is vital. This group will need to have a real shared understanding of the purpose and the process of undertaking outcome measurement and be able to articulate and promote a clear vision of the place of outcome measurement in your service. Issues for the consideration of the working group include:

- assessment and review of the current consumer and caerer - worker processes and data collections and consideration of where
- review of the measures to be used to ensure understanding of why they are being used, how they will be used, the impact of their use across the various parts of the organisation, and how the information will be reported back;
- establishment of the collection protocols for the selected measures;
- assessment and review of information systems required to support the use of the agreed measures; and
- development of an implementation plan, including strategies for communication (to consumers, carers, peer workers and staff), education and training, use of the outcomes data, reporting and evaluation.

5.2. Implementing outcome measurement

Some issues that should be considered during the implementation of routine outcome measurement:

> *"It just made me stop and think about what was going on, what did it really mean for me"*
>
> *Consumer*

5.2.1 Communication with stakeholders

Successful implementation will be aided by a communication plan or strategy that ensures that all stakeholders are informed about the introduction of outcome measurement within the service. All relevant means of communications should be employed e.g. face to face meetings, emails, newsletters, flyers on notice boards, intranet / web site etc. Communications about the introduction of outcome measurement might describe what currently occurs when providing services to a consumer, what will change, when, and the rationale for change.

Importantly, the communications designed specifically for either staff, peer workers or consumers and carers should be clear about the impact of the implementation of outcome measurement upon day-to-day activities and what it means for them. Ensure that the communications also contain information about who to contact if people have questions.

Start the communication process with stakeholders early, be consistent, and ensure that the frequency of communications does not lessen once the initial burst of implementation activity takes place.

5.2.2 Education and training

CMOs should consider an education and training strategy for staff and peer workers that will best support the use of outcome measures. These sessions might include:

- what is outcome measurement;
- what measures are being used and how they will benefit practice;
- how the measures are to be used across the organisation;
- what are the collection protocols;
- use of the measures with consumers or carers e.g. offering the measures, rating the measures, discussing the results of the ratings with consumers, using the measures to work collaboratively with consumers on the development of a plan that considers their support or care needs and goals; and
- what sort of reporting will be available.

5.2.3 Dealing with the practical

The introduction of new organisational and service delivery processes will bring about unexpected challenges. CMOs should consider the establishment of feedback processes to quickly resolve problems that arise during the implementation.

Depending on the issue, should it be considered by the implementation working group? Will a team leader have responsibility for resolving an issue? Document the issues and the solutions and determine whether there needs to be broader communication about the issue and the solution to staff or consumers and carers.

Ensure that there are mechanisms for general feedback on the implementation of outcome measurement in the service, even if it is as simple as a standing agenda item at meetings. As time goes on, include feedback and examples of service use in your communications to staff, peer workers, consumers and carers.

5.3. Using and reporting the data - What are you trying to achieve?

In deciding on which measure to use, you have to consider what you are trying to achieve with the introduction of a routine outcome measure. The introduction of routine outcome measurement can support a variety of activities within your service. These include:

5.3.1 Engaging with people and understanding their perspective

Some service providers have found the measures to be useful simply to support a more structured approach to assessment or promote a discussion between the person receiving services and the staff that work in the organisation. Used in this way, the measures are not so much about demonstrating outcomes but asa tool to support discussion. Offered again it becomes a measure of outcome.
What has changed for the consumer?

As an example, focusing on the first completion, presented below in Table 3 are the first 4 items of the Camberwell Assessment of Need Short Appraisal Schedule (CANSAS). It asks the consumer, the staff and carer or family to identify if there is an unmet need, a met need or no problem for the consumer across twenty four different areas of the consumer life.

Table 3

Client Name		**Need rating** **0 = no problem; 1 = met need** **2 = unment need; 9 = not known**					
		Date: 1/2/15			Date:		
		Consumer	Staff	Carer	Consumer	Staff	Carer
1	**Accomodation** *What kind of place do you live in*	0	1	2			
2	**Food** *Do you get enough to eat*	0	1	1			
3	**Looking after the home** *Are you able to look after your home*	1	2	2			
4	**Self care** *Do you have problems keeping clean and tidy*	0	2	0			

Things to consider

- Are we measuring our core business?
- Will there be training implications with the measure we choose?
- How regularly should this information be collected?

"I could see the relationship between the measure and what was happening in my life"

Consumer

The measure allows these three perspectives to be compared. You can see from the example provided in Table 3 that there are indeed differences in opinion between the consumer, the carer and the staff. The consumer does not see any problems in relation to their accommodation, while the staff member identifies that there are problems, but need in this area has been met.

This is in contrast to the carer who has an even different opinion, identifying that accommodation is an issue with unmet need. The completion of the CANSAS gives the opportunity to expose these differences of opinion and start a conversation about issues that are important to the consumer, carer and staff member. These conversations can provide the foundation for ensuring that consumers are receiving the services they need.

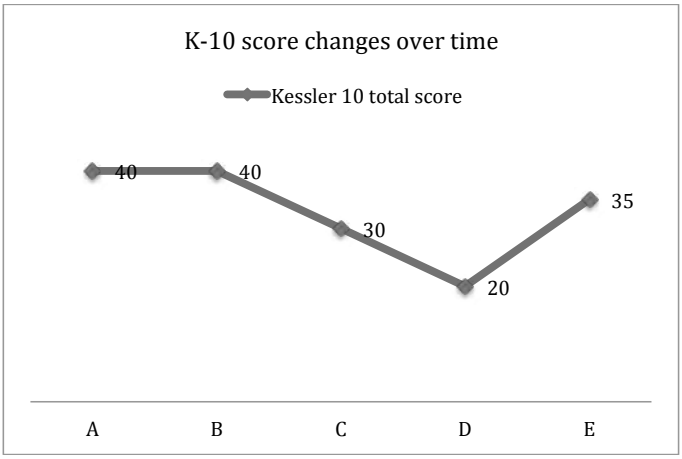
All of the suggested measures can be used to a greater or lesser extent to promote these types of conversations.
For example, the Work and Social Adjustment Scale (WSAS) can be used to promote a conversation with consumers around home management, their ability to work, social activities, private leisure activities or close relationships.

Similarly, with the Living in the Community Questionnaire (LCQ), what social activities, work and educational opportunities is the consumer interested in exploring? Is their housing stable? Do they have physical health concerns? Organisations should consider the services that their organisation provides and how using a measure would help staff deliver collaborative consumer focused services.

5.3.2 Understanding change in individuals

As well as prompting a conversation about how the consumer is at one point in time, the measures can also be used to support a conversation about what may have changed over time. Consider the following example using the Kessler -10 (K-10).

Higher scores on the K-10 indicate greater psychological distress. In the graph in Figure 2) the consumer scores highly on the first two times they complete the measure, the third and fourth time there is a marked decrease in scores. On the final most recent collection there is a higher score. Why is there a change in the ratings?



The completion of the K-10 over time provides an opportunity to start a conversation around what has been occurring for the consumer and what might have brought about this change.

The other measures suggested for introduction can be used to promote the same type of conversations. For the CANSAS, what needs have or have not changed? For carers when using the CarerQoL (CarerQoL-7D+VAS), has their sense of burden changed? Can the staff member of your organisation help them to identify the reason for these changes?

When choosing a measure it is important to consider the type of services you deliver and the types of conversations you want your staff to be having with consumers and carers. Using measures at the individual level to understand how the consumer is experiencing the world and how things may change over time is important information to support service delivery.

5.3.3 Understanding change in groups

The additional use of these outcome measures is that individual ratings can be aggregated so that a service might understand how groups of consumers and carers are experiencing your service, including information about how things have changed.

Consider, for example, the Your Experience of Service (YES) survey. This survey provides services with an opportunity to identify those areas of service provision that may or may not need improvement.

In Figure 3, we see the results of the collection of the Your Experiences Survey on two occasions in a hypothetical service. At Time 1 the score for "Choice and Involvement" was around 50% and was one of the lowest rated of the survey domains.
This organisation then undertook some focused work on how they could they provide their consumers with greater choice in their program.

At Time 2 this domain was rated over 90%, indicating that the hard work of the organisation around increasing consumer choice had paid off.

Collecting this information can demonstrate to funders that your service is working hard to improve the quality of the services you are providing.

Things to consider

- What kind of conversations do you have when things don't change?
- What kind of conversations do you have when things get worse?

"We get these reports and we can see what we have to work on, and hopefully we can see the change that takes place as a result of our hard work"

Service Manager

Things to consider

- Are we sure we are getting accurate information?
- What do we need to do to improve the quality of information?

5.3.4 Understanding the performance of your service

Once the measures are in place and information is being collected. Service managers are able to use the information collected to understand the performance of their service compared to other services. Benchmarking is the process of comparing organisational performance to improve the quality of service provision.

For example the WHOQoL - BREF is reported across four domains, physical health, psychological health, social relationships and environment.

In Figure 4, we see variation across four services. Comparing this information provides service managers with the opportunity to ask interesting questions e.g., Is this variation across services the result of variation in consumer characteristics or is it the result of different practices within the services?

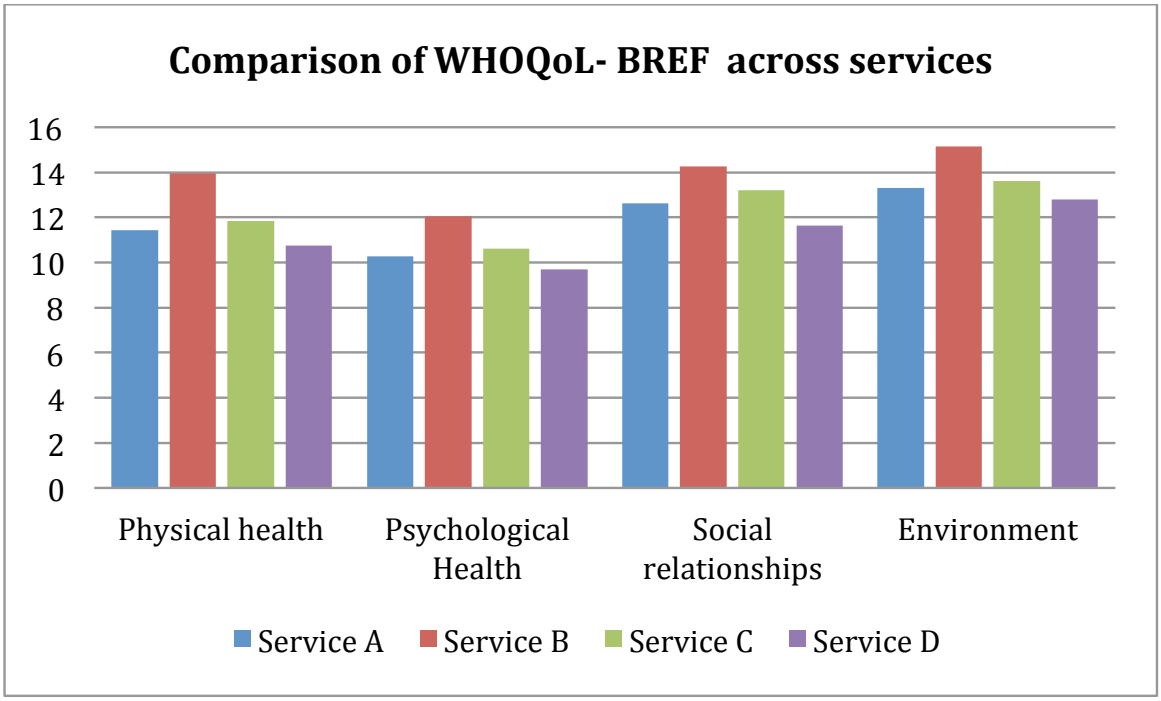
The routine collection of this information means that services can compare their practices and the results they are achieving and they can decide that some practices are worth emulating, leading to quality improvement across the system.

Things to consider

- Who should we compare to?
- Is this the right measure or indicator to compare?
- What do these differences really mean?

"I can't manage my service without good quality information, and I want to know how I compare to other similar services because I want to demonstrate what a good service we provide"

Service Manager



5.3.5 Reporting the information

As we have seen, it is important to be clear about who offers the measure and how often the measure should be offered, but it is equally, if not more important, to decide how you are going to report on the information that has been collected.

Reporting on the information collected depends on how you are going to store the information collected and what and how you have decided to report. Again, answers to these questions depend on what you are trying to achieve with the introduction of routine outcome measurement as well has the infrastructure you have in your service to store and report information. Some large CMOs will have access to computer infrastructure that captures activity as well as outcomes data.

These systems not only have the capability of storing information but also reporting. Other, smaller CMOs may only have access to Microsoft Excel to store and report on data.
Regardless of the capacity of your organisation you should take time during your initial implementation processes to consider what and how the information being collected will be reported.

Is it individual consumer level data that shows change over time, like the K-10 shown earlier? Is it aggregated data showing service performance, like the results of the Your Experience of Service survey shown earlier? Either way, the message should be clear that you should not begin to collect routine outcome measures unless you have decided on how you are going to report on the information being collected.

Things to consider

- Decide why you want to undertake routine outcome measurement.
- Get “buy in” from informal and formal leaders in your service.
- Form an implementation group.
- Choose the measure or measures that are best for your service.
- Document your collection protocol – determine who offers the measures and when they are offered.
- Communicate your reasons for change - how outcome measurement will benefit consumers, carers, staff, and the service.
- Expect resistance, understand the reasons for it, and how it is best handled.
- Decide what and how to report the information collected.
- Seek feedback on the successful and not so successful aspects of implementation and what you would change.

5.4. Monitoring and evaluation - How will you know that you have been successful?

How will you know when you have achieved success in the implementation of outcome measurement? In many ways it depends on what you were trying to do in the first place. Were you simply introducing the measures to support assessment and engagement practice? If so, then you may notice a change in the quality of conversations between staff and consumers and carers of your service. It may be that you wanted to be about to report on your service performance relative to others, did you collect enough information to enable you to do that will confidence?

To start, you will want to report on the amount of information being collected - does every consumer who entered your service have a completed measure? Does every consumer have a second or subsequent collection as your collection protocol describes. While this is important information to report, simply collecting information is not the purpose of routine outcome measurement. It is the use of this information for the variety of purposes outlined above that is important.

There are many examples of organisations that can have excellent collection rates of information but it is not used at all to support practice improvement and service development. You will know that you have successfully implemented routine outcome measurement when you not only collect information but use that information to demonstrate change.

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6. Additional Resources

The full report forms the foundation for this guidebook can be accessed at the following address:
http://amhocn.org/special-projects/community-managed-organisations-outcome-measures-project

Further information and resources on outcome measurement in Australia are available at the AMHOCN website:
http://www.amhocn.org

Further information about the community managed mental health sector can be found at the CMHA website:
http://www.cmha.org.au

Information or copies of the recommended measures can be accessed at the following:

Recovery Assessment Scale: http://www.power2u.org/downloads/pn-55.pdf

Stages of Recovery Instrument: http://socialsciences.uow.edu.au/iimh/stori/index.html#sv

Kessler 10: http://amhocn.org/static/files/assets/bee05b2a/Kessler_-10.pdf

Carer QoL: Brouwer, W., et al., The CarerQol instrument: A new instrument to measure carer-related quality of life of informal caregivers for use in economic evaluations. Quality of Life Research, 2006. 15: p. 1005-1021
Strengths and Difficulties Questionnaire: http://www.sdqinfo.com/

Work and Social Adjustment: http://bjp.rcpsych.org/content/bjprcpsych/180/5/461.full.pdf

World Health Organisation Quality of Life - Brief:
http://www.who.int/substance_abuse/research_tools/whoqolbref/en/

Camberwell Assessment of Need – Short Appraisal Scale:
http://www.rcpsych.ac.uk/publications/books/rcpp/1901242250.aspx

Your Experience of Service: https://mhsa.aihw.gov.au/committees/mhissc/YES-survey/
A version specifically for the CMO sector is currently in development.
For information contact: info@amhocn.org

Living in the Community Questionnaire: For information contact: info@amhocn.org

Carers Experience of Service Provision: For information contact: info@amhocn.org

Glossary

Consumer
A person who uses, or has used, a mental health service. (4th National Mental Health Plan 2009)

Carer
A person of any age who provides personal care, support and assistance to another person because the other person has a disability, a medical condition, a mental illness or is frail. Carers may include the consumer's family as well as other people significant to the consumer. (Mental health statement of rights and responsibilities 2012)

Collection protocols
Collection protocols describe the outcomes information that is required to be collected and when it is to be collected.

Community managed organisation
Private, not-for-profit organisations that flexibly respond to the identified, unmet needs of communities and are managed by a board of representative and elected community members. (Taking our place – Community Mental Health Australia 2012)

Outcome measures
Outcome measures include tools, instruments, scales, or questionnaires that can be used to show how a person's recovery may be progressing, providing the opportunity to demonstrate change over time.

Peer Worker
A person with lived experience of mental illness that provides services to others affected by mental health problems; lived experience of recovery is an essential criteria of this job role. (Taking our place – Community Mental Health Australia 2012)

Psychosocial Disability
Disability associated with a person's psychosocial experiences. (Taking our place – Community Mental Health Australia 2012)

Psychosocial Rehabilitation
The process of restoration of community functioning and well-being of an individual who has a psychosocial disability; it seeks to effect changes in a person's environment and in a person's ability to deal with his/her environment. (Taking our place – Community Mental Health Australia 2012)

Recovery
Personal recovery is defined within the Australian document A national framework for recovery-oriented mental health services as being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues. (A national framework for recovery-oriented mental health services 2013)

Clinical recovery, within the Australian document A national framework for recovery-oriented mental health services, is primarily defined by mental health professionals and pertains to a reduction or cessation of symptoms and restoring social functioning (Victorian Department of Health 2011). (A national framework for recovery-oriented mental health services 2013)

Social Inclusion
There are many definitions of social inclusion. Two are presented below.

Having the resources, opportunities and capability to learn, work, engage in the community and have a voice. (Taking our place – Community Mental Health Australia 2012).

Social inclusion refers to policies and programs that promote the reversal of circumstances or habits that lead to social exclusion, which is associated with disadvantage. Indicators of social inclusion are that all Australians are able to secure a job, access services, and connect with family, friends, work, personal interests and local community. (Mental health statement of rights and responsibilities 2012)

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