Presentation to Outcomes Measurement NGO Workshop

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1. Introduction *(Stephanie Cairns)*

I am Stephanie Cairns from Take 5 & Te Whare Marama and this is Stephanie Drake Brockman from the Lower Hutt Women's centre. We are both hold contracts with our local DHB for provision of mental health services. Both are small grass roots community organisations that happen to be in the same street. We are not residential services and are probably fairly typical of a lot of small NGO's in the sector.

First of all, we need to point out that we do not hate outcome measurement and we don't see all information gathering as a useless exercise!

But in the limited time we want to share some of the concerns that we share as smaller grassroots community organisations about this emerging world of outcome measurement in mental health and to add a little fuel into the debate. We are questioning the appropriateness of blanket measures for all.

***2.* Community Development Based Organisations** *(Steph Drake-Brockman)*

The organisation that I work for was established before the contracting era. It was developed out of a recognised community need and is based around a community model. A community model gives importance to being responsive to community needs, it's about individual growth and development and the individuals needs in the community, it's about self responsibility, it's about the whole person – not just an illness or a problem and it's about living in and being part of the wider community.

When we were established we developed our philosophy, our purposes, our aims and objectives - all derived from the community. Then years later the contracting era arrives. We find ourselves under the power of funders prescribing what is important and what the purposes for the community should be.

The community model grew out of people in institutions identifying that a whole range of healing and growth can happen in a community organisation that can't happen in an institution.

We are a grass roots community organisation that was developed as being different to institutions e.g. hospitals, government social welfare agencies. We don't want to become, or see that it would be helpful to the people that come to

our service to become a "mini institution".

As the pressure to prescribe to measuring outcomes as defined by funders increases I see that the funders are pushing us in that direction – to create mini institutions – in the community.

An example of these differing views is at my last interview with a funding representative he said that he was going to want more details – hospital numbers and details of what we do with the people that come to our organisation. And this highlights the difference in world views of community versus institutions. We don't do anything with the people. The people come and they themselves do something with and for themselves. They are in charge of their own self development, recovery, growth and learning. We provide opportunities but we hand over to the people the responsibility of their life to them. I don't have team meetings about people, I don't decide what is best, I encourage people to become more aware of themselves living in the world. And in this they develop greater awareness and use their ability to choose to grow, to change, to learn, to experiment, to experience- to choose the direction of their life.

3. How do you measure the intangibles? *(Stephanie Cairns)*

So within the context that Steph has just outlined, there are some issues for us when it comes to gathering information and measuring outcomes are:

- Why measure?
- What to measure??
- What to count??

And who do we count it for?? Ourselves? The people who use our services? The funders? Government departments?

The organisation I work for holds contracts with DHB and MSD – broadly speaking, under these contracts, we are working to deliver health outcomes and vocational outcomes.

Currently we collect numbers of attendances, age, ethnicity, hours spent using the service, hours onsite and off site, number of staff (and number of suicides!)

E.g. Some of the debates are around community participation (if the services users themselves see their involvement in an organisation such as ours as community participation, but funders don’t unless it occurs off site!!)

While this information is somewhat useful to the organisation – does it capture what those who use the service think is important?

Our organisation recently did some strategic planning – the majority of participants were members who use the services.

We looked at the <u>values</u> that make the organisation:

Responses included words such as :

A belonging atmosphere, Fun , non-hierarchal structure, Transparency, Equality, Non judgmental , Flexibility, Non regimental, Home away from home, Consumer driven , A safe place Understanding, Friendliness, Acceptance , Rights are respected, Ownership, Privacy is respected , Listening, Respect, Honesty, Mentoring, Support, Great communication, Caring, Learning environment, Inclusiveness, Healthy living, Catering for needs, Being yourself.

Note that it did not include fiscal excellence or how many hours did I spend in the art room today!

We looked at the resulting benefits – the responses included:
Discovery, growth, new experiences, connection, community, freedom from isolation, friendship, love of people, belonging, support, inspiration, empowerment, skills developed, creativity, a place where people want to come and be, breaking free from a solitary lifestyle, a second chance at life, a place of recovery, overall health, wellbeing and independence etc

These kind of responses are what I consider "the real stuff" – these are the intangible components that go towards creating an environment in which recovery can occur. These are the bits we might want to measure.

So can measuring these intangibles 'the real stuff" be done effectively?
It is not simple – it is very complex.
As small organisations, do we have the capacity to undertake the initial research and for ongoing compliance?
And if so will the collection of this data kill the dynamic that makes the good stuff happen?
Do we want to take that risk?

***4.* Voluntary / Self Responsibility** *(Stephanie Drake-Brockman)*
Everybody comes to our organisation for different reasons. Many don't know why they come, but they have some kind of need — whether they can actually articulate that or not. Sometimes the learning is figuring out over time what it is they need. Life isn't clear cut, learning, self development, learning to connect with others and learning to belong in this world isn't a step by step linear process.
An example to illustrate this: A women comes into the centre to unload a whole lot of stress and shame about abandoning her children. She gets from me a person to listen, to hear her pain and to witness her shame. Then she goes away and might not come back for two years — but in that one moment I gave her respect, connection and was a companion to her.
How do I measure an outcome? Would there be any point to measuring an

outcome? Would the service I gave be better if I measured an outcome? Would the client have experienced a better service if the outcome was measured? Am I supposed to get her to fill in a registration form, take a list of goals, and then mark off after what was achieved in that moment. Would this make my service more valid?

People choose to come to community agencies, even though many government institutions do try and compulsory make their clients come – often so they can tick off a box that this women has attended this particular group. (An official outcome achieved).

People like coming to community agencies because they are given the opportunity to make choices, make decisions, learn to take action, learn to feel – make the decisions about what they are going to learn. Our focus as workers is connection, listening, reflection – rather than putting energy into measuring an outcome. I would like to leave measuring outcomes to the women themselves.

We run self esteem workshops twice a week and each week has a topic. We run roughly to that topic. I might have a set of ideas or principles I have planned to put forward but if the group itself takes the ideas and principles to something different – that is being responsive in the moment to the clients needs. I might be thinking I'm teaching abc but in reality the participants are learning anything from d-z: depending on where they are at in their own learning. Somebody may go away from the workshop and achieved surviving a two hour workshop, and someone else may have made a big shift in understanding about the difference between self blaming and self responsibility. Each of our learning is so individual.

We all have connections everywhere; sports groups, spiritual groups, crafts groups, friendship groups, families, friends, - how do we really know what is making a difference in someone's life. We can measure outcomes but how do we actually know what creates that outcome.

6. Measurement and collection challenges. *(Stephanie Cairns)*

The collection of data poses its own challenges.

If we <u>can</u> measure it – how can we do it in a way that preserves integrity?

All information is subject to being skewed.

Just look at the example of Client Satisfaction Surveys. Research shows if you use them, you <u>will</u> get a good result. So if you want some good feedback – do a client satisfaction survey.

Results can also vary depending on who does the asking.

An example comes from my own experience in moving from working in a clinical mental health setting to a community setting. The majority of the people I was working with were the same. What had changed was the hat I was wearing. As a clinician I got "what I think you want to hear" and as a community worker I got "what's really going on".

As mentioned earlier, what people are learning isn't always what we think they are learning. The gains made are not necessarily the things that our funders want us to measure.
It isn't always the thing on the outcome register.

The medical model wants to measure a bit of us.
The community model wants a holistic approach – it is about wholeness.

Most people are familiar with Maslow's Hierarchy of Needs in one form or other. I find it interesting that the outcomes expected from the contracts we hold (Health outcomes, Vocational outcomes) sit in the fourth tier.
Underpinning this tier are belonging and love needs, safety needs, basic life needs – food, shelter, warmth etc.
So while one organisation is working on one tier and others are working on more basic levels – who gets the tick?

Is it the one who is provided a supportive living situation?
Is it the one who is provided the self esteem course?
Is it the one where the artwork was created that just fetched a record price at auction?
Is it the one that dished out the medication?
Is it the family that has been there through the hard times?
Is it the support found in building a friendship with a peer?
Or is it the organisation with the flashest IT system?

7. Summary
(Stephanie Cairns)
So in summary, these are some of the challenges and debates in some of the smaller organisations providing mental health services in today's climate.

Are organisations set up to work towards specific outcomes <u>or</u> are the outcomes achieved as a sideline of being responsive to the felt needs of the individuals who participate and find connection and community?

Each service wants to look good. Will outcome measurement become another way of looking flash and shiny on paper? While still doing a crap job!!

Our caution is about embracing measurement and information strategies that do not capture the real stuff, or the dynamics that enable the real stuff to happen.

We don’t mind embracing if it actually measures what we want it to and consumers see value – not because we want to look good or that funders find it a convenient way to report to their bosses.
We want to be responsive to those who are part of our services and so far no members/ consumers/Tangata whaiora have asked us to develop outcome measures.