



Routine outcome measurement in mental health service consumers: Who should provide support for the self-assessments?



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ABSTRACT

This study examined whether mental health community service users completed outcome self-reports differently when assessments were supervised by internal vs. external staff. The examination of potential differences between the two has useful implications for mental health systems that take upon themselves the challenge of Routine Outcome Measurement (ROM), as it might impact allocation of public resources and managed care program planning. 73 consumers completed the *Manchester Short Assessment of Quality of Life* (MANSA), a shortened version of the *Recovery Assessment Scale* (RAS), and a functioning questionnaire. Questionnaires were administered, once using support provided by internal staff and once using support provided by external professional staff, with a one-month time interval and in random order. A MANOVA Repeated Measures showed no differences in outcomes of quality of life and recovery between internal and external support. Functioning scores were higher for the internal support when the internal assessments were performed first. Overall, except for the differences in functioning assessment, outcome scores were not determined by the supporting agency. This might indicate that when measuring quality of life and recovery, different supporting methods can be used to gather outcome measures and internal staff might be a good default agency to do this. Differences found in functioning assessment are discussed.

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1. Introduction

It has been well-established that mental health consumers should and can take part in Routine Outcome Measurement (ROM; Linhorst & Eckert, 2002; Oakley, Malins, Riste, & Allan, 2011; Trauer, 2010). Consumers' involvement in the evaluation process is consistent with several models of program evaluation and can enrich evaluations. Furthermore, the actual process of participation can empower consumers (Linhorst & Eckert, 2002).

Since taking part in ROM requires cognitive and attentional abilities, consumers might benefit from support, namely, assistance

tailored to their specific needs and requests (i.e., explaining the meaning of a certain word, reading the questions aloud, using the computer keyboard and mouse). However, it remains unclear whether the way in which the support is provided might affect the reporting of outcomes.

The use of internal service providers to aid data collection has several advantages. First, they usually know the clients and the context within which the evaluation is conducted (Fitzpatrick, Sanders, & Worthen, 2003; Love, 1991; Spaulding, 2008). Second, they might be sensitive to cognitive and attentional abilities and subtle cues regarding whether questions were understood. Third, internal supporters are likely to be cheaper and available, leading to better long-term implementation of ROM, thereby improving service provision (Australian Health Ministers, 1992).

Nonetheless, legitimate concerns can be raised as to whether providers, who might have a stake in the outcome of the evaluation, should be involved. Indeed, they might pressure consumers to answer questionnaires in a certain fashion, for

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economic, administrative, or personal reasons (Mathison, 1999). Previous research has also reported that clients tended to overstate psychopathology and rate themselves worse in aspects such as well-being when they wished to gain eligibility for services. Conversely, they might rate their mental health as better when seeking discharge or to please their service providers (Bilsker & Goldner, 2002; Choi & Pak, 2005).

Although the literature has focused mainly on potential biases of internal service providers, bias might also occur with external support. For example, a client might use the opportunity to speak to an external administrator, sent by the “authorities,” to overstate grievances about service provision. Furthermore, the encounter between the client and an external supporter with whom the client is not familiar might cause suspicion and anxiety and therefore undermine the evaluation process (Linhorst & Eckert, 2002).

While ROM is increasingly becoming a requirement by planners of mental health services (Trauer, 2010), the examination of potential differences between internal and external support might have useful implications for service providers taking up the challenge of ROM.

Therefore, the purpose of this study was to test whether discrepancies existed in outcome data when support was procured by internal service providers vs. external professional assistance. As the literature suggests, bias might occur in cases of internal as well as external support. We hypothesized that no differences would be found between outcomes following internal and external support.

2. Methods

The present study was part of a pilot study of the Israeli National Outcome Measurement Project of Community Rehabilitation Services (CRS; Roe, Lachman, & Mueser et al., 2010). These services are provided by law to all people with a psychiatric disability and include housing, vocational, social, and educational services (Roe et al., 2010). Inclusion criteria were being adult and eligible for CRS following a diagnosis of severe mental illness, and at least a 40% psychiatric disability determined by a medical committee. Exclusion criteria, as determined by the client's case manager within the rehabilitation service, were being in an acute psychotic state, hospitalization (and thus absent from the premises), current violent behavior, lack of basic cognitive ability required to answer a questionnaire or to give informed consent.

Ethical approval was obtained from the Ministry of Health. Written informed consent was obtained from the study participants.

The self-report questionnaires consisted of three outcome measures, chosen, developed in cooperation with local practitioners, and repeatedly pilot tested over the course of 6 months with numerous groups of consumers ($n = 220$ in 20 different services).

The chosen measures represent the key variables in which outcomes of the rehabilitation process are to be expected and are considered important by both providers and consumers of rehabilitation services (Fossey & Harvey, 2001). The measures have been widely used in previous outcome studies of adult mental health services (Royal College of Psychiatrists, 2010).

The Manchester Short Assessment of Quality of Life (MANSA; Priebe, Huxley, Knight, & Evans, 1999) is a 16-item instrument assessing quality of life focusing on satisfaction with life as a whole and within life domains (employment, vocational, social, familial, accommodation, leisure, financial situation, physical and mental health). For this study, we included the 12 items assessing subjective satisfaction ($\alpha = .76$). We used a shortened 5-item version of the Recovery Assessment Scale (RAS; Corrigan, Salzer, & Ralph, 2004) that included items related to one's ability to cope

with life, hope, asking for help when needed, coping with mental health problems, feeling good about oneself ($\alpha = .80$). These items were rated on a 5-point Likert scale. Finally, we included a 10-item functioning questionnaire, rated on a 4-point Likert scale developed specifically for this project (Roe & Gelkopf, 2012). Participants were asked to rate their functioning level in several domains such as personal hygiene, house chores, finances (e.g., paying bills on time), mobility (e.g., going from place to place independently), coping with daily problems (e.g., solving problems), medication intake, medical supervision, social life (e.g., participating in social activities), community participation, and work (or studies) ($\alpha = .83$). All instruments were previously tested in an additional pilot project and showed satisfactory reliability and validity (Roe & Gelkopf, 2012). Software was used to fill out the questionnaire on computers.

Two methods of assistance for completing the questionnaire were evaluated: support by an internal service staff member and support by an external, trained individual, who was not personally acquainted with the consumer.

Each service participating in the study had up to three mental health case managers available to provide the internal support, depending on which of them knew the clients best. A pool of up to three external professionals for each service was available to provide the external support. All questionnaire administrators had a degree in social sciences or health sciences, or worked in the rehabilitation field. None of them had consumed rehabilitation mental health services. Both the internal and external teams had received basic training in questionnaire administration, although the external administrators were more experienced. Some administrators were men and some were women.

In both internal and external support provisions, the type of support provided was according to the client's request. For example, sometimes a client asked the meaning of a certain word, or asked for someone else to click the answers on the computer if the software was intimidating. Sometimes, a client wanted to discuss the interpretation of a question with a supporter (for further elaboration on types of support, see Section 2).

Both types of supporters underwent similar training, which included explaining the study to the client, learning the software used for completing the questionnaires, and being taught strategies of providing support while maintaining maximum consumer independence (Morrell-Bellai & Boydell, 1994). The supporters received a written manual with specific guidelines on how to deal with different situations that might occur during the evaluation process. For example, if the consumer wished to stop filling out the questionnaire, the supporter was guided in to encourage the client to continue (e.g., “you've done a great job so far and have only a few more questions to answer”). If the consumer was reluctant to proceed, the supporter was to thank him/her for cooperating, with an invitation to continue at another time; if the consumer did not understand a sentence, the supporter would repeat the sentence, rather than provide an answer, etc. The manual was built on basic principles of questionnaire administration, on our own experience of training during the pilot studies, and on our own and other researchers' studies on the rehabilitation of people with mental illness. The manual also included a unified “dictionary”, which included a bank of words and clear instructions on how to explain their meaning in case a consumer had difficulty understanding certain words (for example: “frequency” should be explained as “how many times”). The administrators were asked to fill in a written report, which included the type of support the consumers received and whether they encountered additional problems not addressed in the manual. The written reports further verified the manual's consistency with the consumers' and supporters' needs.

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