Te Tāhū Hauora
Health Quality & Safety Commission

Ngā Poutama Oranga Hinengaro: Quality in Context survey of mental health and addiction services

Technical Report

April 2023

Document purpose

This is a technical report to accompany the results of the national survey – Ngā Poutama Oranga Hinengaro: Quality in Context in mental health and addiction services. The survey was conducted in June 2022 for Te Tāhū Hauora Health Quality & Safety Commission's national mental health and addiction (MHA) quality improvement programme to inform the future direction and focus of MHA quality improvement initiatives. This survey was a follow-up to a baseline survey conducted in 2018.

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Available online at: https://www.hqsc.govt.nz/our-work/mental-health-and-addiction-quality-improvement/projects/quality-in-context-survey-of-mental-health-and-addiction-2022/
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Methodology at a glance

The following table provides an overview of the key methodological aspects of the survey.

	Details
Target population	People working in publicly funded mental health and addiction (MHA) services in New Zealand. This includes MHA staff in: • District Health Board (DHB)[1] inpatient and community services • Non-governmental organisation (NGO) services (Vote Health funded) • Primary mental health care (excluding GPs) Older persons mental health services were included
Sample size	A final sample size of 1,859 people. This includes 1,604 fully completed responses and 255 partial responses.
Response rate	We have not been able to provide a response rate for the 2022 survey given that there has been no update to the workforce data since Te Pou o te Whakaaro Nui's 2014 *More than Numbers* organisation workforce survey
Survey period	10 May to 10 June 2022
Survey mode	Online questionnaire, with options for paper-based or telephone interviews on request
Invitation to participate	Invitations to participate in the survey were sent through points of contact in the sector. Targeted follow-up and promotion of the survey was done throughout the survey period to maximise response rates and representation of the sector
Survey content	Questions relating to quality and safety organisational culture in mental health and addiction services
Survey framework	The framework for the survey content fits under the following 4 domains (aligning to Te Tāhū Hauora Health Quality & Safety Commission's *Clinical Governance: Guidance for health and disability providers*): 1. Consumer engagement and participation 2. Clinical effectiveness 3. Quality improvement and consumer safety 4. Engaged, effective workforce
Question development	The survey content was developed from sub-domains within these four framework domains. In 2022, four additional cognitively tested questions were added to assess participation in, and impacts of Te Tāhū Hauora Health Quality & Safety Commission's mental health and addiction quality improvement programme, and to assess the impact (if any) COVID-19 has had on the quality improvements initiatives in workplaces.
Question reporting scale	The quality and safety organisational culture questions were asked against a 1 – 7 Likert scale, ranging from 'Strongly Disagree' to 'Strongly Agree', with 'Don't know' and 'Not applicable' options. For reporting, the Likert scale responses were converted to 6-7 = Positive; 4-5 = Neutral; 1-3 = Negative. The % of positive responses to each culture question was reported. 'Not applicable' responses were excluded from the denominator in these calculations, whilst 'don't know' responses were included.
Data cleaning	The survey responses were checked for any data errors, potential duplicates, or inclusion of people outside the target population.
Data analysis	Weighting was not applied when analysing the data. A measure of statistical variability, the margin of error, is provided. Any comparisons between groups is tested for statistical significance.

[1] This survey was undertaken and the report primarily written before the Pae Ora (Healthy Futures Act) 2022 came info force. As such, we refer to DHBs throughout for ease and consistency of reporting.

Methodology

Research approach

This was an online survey conducted with people working in publicly funded mental health and addiction (MHA) services in Aotearoa New Zealand. This included MHA staff in:

- DHB in-patient services
- DHB community services
- NGO services
- Primary mental health care (excluding GPs).

Older persons mental health services were also included.

Potential participants were offered the opportunity to alternatively complete the survey on paper or by telephone if online was not suitable. There were no requests for alternative methods of completing in 2022.

Final sample size

A total sample of 1,859 was achieved. This included 1,604 fully and 255 partially completed surveys.

Questionnaire design

The 2022 survey was a replication of the 2018 survey which was developed through a comprehensive process of peer review and cognitive testing. There was no further cognitive testing for the original set of survey questions. In 2022, four additional questions were added and cognitively tested:

- I have participated in the Te Tāhū Hauora Health Quality & Safety Commission's (Te Tāhū Hauora) mental health and addiction quality improvement programme (eg, Zero seclusion, Connecting care, Learning from adverse events, Quality improvement facilitator course, Quality in action) – yes, no, unsure
- The programme has provided me with the quality improvement knowledge and tools to apply in the workplace (1-7 Likert-type scale)
- I have made changes to my workplace practices as a result of my involvement in the programme (1-7 Likert-type scale)
- What impact (if any) has COVID-19 had on the quality improvements initiatives in your workplace? (open-ended).

Cognitive testing

Once again, there were two phases of cognitive testing:

1. Core cognitive testing phase
2. Confirmatory testing phase.

The first phase involved testing the four additional questions with 24 MHA staff volunteers across the sector. The purpose of this cognitive testing phase was to identify any wording changes that might be required, along with any clarity and interpretation issues.

The confirmatory testing phase was with 10 MHA staff members, half of whom had been interviewed as part of the core cognitive testing phase and half who were new participants. The purpose of the confirmatory testing phase was to check and confirm the final survey changes with previous interviewees and also to test the final survey with MHA staff who had not previously provided feedback (ie, participants seeing the survey for the first time as would be the case when it was formally launched to the MHA sector).

In addition to the MHA staff participating in cognitive testing, the questions were also tested on wider group of health professionals to test the suitability of the culture survey questions for other surveys run by Te Tāhū Hauora. A total of 15 health professionals from the wider group were included across the core and confirmatory testing phases.

Participant profile

Table 2: Cognitive testing MHA staff participant profile – core cognitive testing phase

Participant breakdown	Number
Mental health nurses	9
Mental health consumer/family advisors	7
Cultural advisors	6
Psychiatrists	2
Total	**24**

* The 16 participants taking part in the confirmatory testing phase were, as much as was possible, a mix of the above

Cognitive testing process

The cognitive testing process was iterative in nature with changes made to the questions throughout the process, and in consultation with Te Tāhū Hauora, once consistent feedback had begun to be received.

Interviews were 30 minutes in duration and were conducted by telephone and Zoom.

Data collection

Survey programming and invitations

The survey was programmed in Verint (an online survey software used by Mobius).

Invitations to participate in the survey were sent out through cascading key points of contact. Points of contact included MHA Portfolio Managers, MHA general managers and their executive assistants and other senior staff. The points of contact that were identified through this process were then also asked to cascade the survey.

A prize draw of three team morning teas was offered as a way of acknowledging participants' time in completing the survey.

Survey period

The survey went live on 10 May 2022 and was closed on 10 June 2022.

Survey materials

A3 posters were provided to the key points of contact with the survey invitation. The posters provided background information about the nature and purpose of the research, how the results were going to be used, reiterated anonymity of responses and provided email and 0800 number contact details for a Director of Mobius for any questions or to request a paper version of the survey or a telephone interview.

Reminders and follow-up

Two reminders were sent out also via the key points of contact described above. The first reminder was sent out halfway through the data collection period. A final reminder was sent out four days before the survey closed.

Participant queries

An 0800 number for any participant queries or technical issues was available during the entire fieldwork phase. Few queries were received.

Analysis of results

Data cleaning

The survey responses were checked for any data errors, potential duplicates, or inclusion of people outside the target population.

Data analysis

Weighting was not applied when analysing the data.

Significant differences were reported at the 95% confidence level.

Margin of error calculations

Margin of error calculations were based on the standard margin of error at the 95% confidence level.

Analysis of open-ended comments

There were three open-ended questions in the survey.

The first question asked participants to identify what one thing in their service could make things better for tāngata whaiora care/support. The second asked participants to describe one thing that currently works well for tāngata whaiora care/support in their service. The third question asked about the impacts of COVID-19 on quality improvement initiatives.

A majority of the survey participants provided a comment for each of these questions.

An inductive coding approach was used in the analysis of these open-ended questions. Comments were randomised and the first 150 comments for each question were reviewed in order to create a set of draft thematic codes. A key word search was undertaken across the remaining open-ended data set using these thematic codes (words) in order to identify the incidence of themetised comments. Multiple variations of words to describe similar themes were included where relevant (eg, environment/spaces/rooms/buildings). Each time the word search located a word, a review of the entire comment was undertaken in order to check and confirm the context of the comment. Through this process, additional thematic codes were added where relevant. In addition, a further 100 comments for each question in the randomised data set were reviewed and compared against the initial thematic codes identified.

There was considerable consistency in core thematic themes across the comments provided for the two questions.

Reporting

The overall results are presented in *Ngā Poutama Oranga Hinengaro: Quality in Context survey of mental health and addiction services National Report*. For reporting, the Likert scale responses were converted to:

- 6-7 = Positive
- 4-5 = Neutral
- 1-3 = Negative.

The percentage of positive responses to each culture question was reported. ‘Not applicable’ responses were excluded from the denominator in these calculations, whilst ‘don’t know’ responses were included.

A seven point scale was used in order to provide participants with more choice options and to allow for greater sensitivity of analysis. The decision to group responses on the scale into negative (1-3), neutral (4-5) and positive (6-7) was based on a number of factors:

- Harvard University’s School of Public Health utilises a seven point scale in their Surgical Safety Culture Survey (SSCS), and for analysis purposes converts this scale into 1-4 =

negative, 5-6 = neutral and 7 = positive. Te Tāhū Hauora has replicated this survey twice and has used the same scale conversion (to provide a direct comparison). However, labelling a score of 6 out of 7 (86 out of 100) as a neutral response is a relatively narrow measure of 'positive' agreement and there are very few other examples of this approach to determining levels of agreement. For the purpose of the survey it was therefore determined that a more appropriate representation of a positive response would be to convert a score of 6-7 into a positive response

- While a score of five out of seven provides a symmetrical scale, a review of Likert scale response anchors identified that five is variously labelled as eg, "slightly acceptable", "somewhat agree", "moderately important", "sometimes true" etc. If 5-7 responses are grouped as positive responses, this can over-represent the level of positivity (agreement) of aggregated survey responses. In the case of all surveys, the higher the score, the higher the level of agreement.

Other resources available

A number of other resources are available to access results from the Ngā Poutama staff survey. These are available at:

https://www.hqsc.govt.nz/our-work/mental-health-and-addiction-quality-improvement/projects/quality-in-context-survey-of-mental-health-and-addiction-2022/

Resources available online include:

- summary pamphlet
- national report
- questionnaire

Information not contained in these other resources is available by request. Refer to the above link for contact details