New Zealand WHOQOL – Mental Health Recovery NGO 1-Day Conference.

Report of the NZ WHOQOL Conference held at Pathways, Manukau. 26th September 2012

Objectives:

The conference was designed to provide a forum for those NGOs servicing mental health recovery in New Zealand to discuss the use of the WHOQOL tools, principally the WHOQOL-BREF in their operations. The intent was:

1. To share information and discuss practical issues in using the NZ WHOQOL-BREF as both an outcomes assessment tool and a clinical aid.

2. To explore if there was interest to form a network of those attending which would serve to facilitate co-operation and share experiences between the NGOs in the future.

An invitation was sent to NGOs known to be using, trialing or considering the use of the WHOQOL. Appendix 1 is the invitation letter. Attachment 2 is the list of those invited and who attended. 21 participants representing 12 NGOs.

Pathways New Zealand offered their facilities in Harakeke House, Manukau, as the venue, where they provided the appropriate conference technologies and refreshments including lunch. This was much appreciated and a letter has been sent expressing thanks.

Rex Billington of AUT University opened the proceedings by welcoming all participants who then introduced themselves. Rex then outlined the objectives for the conference.

The role of AUT was explained as an institution interested in supporting WHOQOL developments in NZ as part of its service role. Other than authorizing the use of WHOQOL tools in NZ AUT did not want user organizations to feel bound in any way to it. WHOQOL data was the property of the NGO to use as they see fit. By providing information AUT would help the NGO decide whether they wished to adopt the NZ WHOQOL in their programmes. They would also assist programmes where they could in trialing and adopting the WHOQOL tools for their assessment and counselling roles.

NZ WHOQOL –NGO Mental Health - 1 day Conference Programme.

9:00am Welcome, Introductions and Purpose of the Conference. Rex Billington

9; 25am Earthquake drill

9:30am NGO Reports of their Organizations progress highlighting challenging issues in their use of the WHOQOL-BREF (about 20 minutes each).

Speakers from: Connect – Melissa Rowthorn
Pathways – Ross Phillips
Kites Trust – Sarah O'Connor

10:30am Morning refreshments.

10:45am NGO Reports contd.

Speakers from: Richmond – Sarah Andrews
Health Care NZ – Sandra Te Huia & Sarah Hamilton
IRIS (NZ Cerebral Palsy Trust) – Annie Angus

12 noon Lunch.

12:45pm NGO report contd.

Speaker from: Mind and Body – Jim Burdette

1:00 pm Group discussions 3 groups formed to discuss any 2 or 3 of the following topics.

Recording scores.
Reporting scores.
Use of the WHOQOL as a counselling aid.
Adapting the WHOQOL to facilitate use.
Training staff to use and administer the WHOQOL.

2:30pm Afternoon refreshments.

2:45pm Each group report back the highlights of their discussions.

4:00pm Establishing a collaborative network?

4:30 pm Conclusion - Thanks.

Notes - Each group discussion will require a reporter. Notes will be taken and a formal report will be written to be sent to participants later. The individual morning reports may cover some of the afternoon topics. This would be appropriate.

Summary of Presentations:

Melissa Rowthorn – Connect.

An overview of the organization of Connect was given to introduce the context in which the WHOQOL BREF was being used. The vision and mission of Connect was briefly outlined with their organizational values. This NGO's activities include a variety of residential rehabilitation services [high and complex, dual diagnosis, 18 month residential rehabilitation and longer term residential rehabilitation], a range of mobile services, peer support services, respite, a social enterprise, and employment services. Connect Supporting Recovery started using the WHOQOL BREF in 2010.

Connect's broader outcomes assessment plan was to adopt an organizational wide measure [this is where the WHOQOL BREF fits into the outcomes strategy], to work with clinical stakeholders to involve clients in their HoNOS reviews [obtaining copies of HONOS for client files], and using service specific measures for specialist contracts. When these stages have been completed with sufficient compliance the aim is to be able to evaluate outcomes by comparing WHOQOL, HONOS, and service specific outcome measures – thereby using a combination of subjective, objective, and symptom focused measures.

Currently Connect are at the stage of implementing the organizational wide measure. However alongside this, some services are also using service specific measures. The next stage of the project will look at including HoNOS.

The appeal of the WHOQOL-BREF for Connect were:

- It empowers the client's voice about their own life and this can be used to drive service delivery and outcome evaluation,
- Has international validity, and different modules for a variety of client populations – for example, spirituality, OLD, different language versions.
- NGO friendly, as the facets of life focused on in the tool are aligned with the work NGO's do with people and fit well with the SNAP focus areas. Being multifaceted fits with a diverse service range and multiple goal areas NGO clients want to focus on. Being non clinical but able to assess the impact of clinical interventions that are appropriate for multi-stakeholder involvement fits with their vision: "In partnership towards healthy communities".
- Fits with Connect's mission: "People living satisfying lives of their choice".
- Able to be used across services – can unite all our services together and encourage collaborative working relationships between services.
- Able to explore changes on multiple levels – G1 and 2; Domain and Facet level – for multiple purposes.
- Works well with a recovery philosophy and approach - focusing on the core human experience and individual life experiences, and allows exploration of these in relation to changes in quality of life to deepen insight into what enhances and alters quality of life, for better, or worse.

Key steps in the roll out of the WHOQOL-BREF involved:

- Staff training - in a staged approach aligned to staff capacity.
- Development of an implementation team & train the trainer workshops.

- Empowering services to take ownership of the ways they integrated the use of it in their services and have a key role in deciding how they are going to use the data gathered for their own service's evaluation.
- Integrating the measure into service delivery protocols and processes.
- Formation of an organizational outcome team to share insights and learning throughout the process and in the future as a resource for data interpretation.

Highlighting the connection between our outcome measurement process and the WHOQOL to the vision, mission and values of the organization was important. Connect could see how the WHOQOL tool helps them to work on recovery outcomes and measure progress against their mission. The process and way of using the tool also needed to fit with the organization's values.

Connect's implementation plan includes the following priority areas:

1. Orientation of staff to outcome measurement, the tool, and how using it can enhance recovery work.
2. Ensuring the WHOQOL can operate as an outcome measure – attending to compliance, measurement points, and developing data recording systems.
3. Focus on quality of life discussions, importance areas, and actions for change.
4. Evaluative learning approach to outcomes – continuous quality improvement.
4. Supporting the development of service level champions as local resources to gain insight into the meaning of changes being observed.
5. Champion team sharing service level insights and awareness for organizational learning around domain and facet changes.

Connect believe that interpretation needs to have a bottom up and empowerment focused approach – client – support worker – champion – outcome team. Some of the challenges with this approach have included:

1. Perceptions of increased paperwork and quantitative record keeping being a barrier to client-support worker relationships.
2. Need for visual data displays for staff to take to clients when reviewing changes from previous WHOQOLs.
3. No additional budget, time, or sufficient IT infrastructure initially.
4. The heterogeneity of service needs and their many priorities and cultures.
5. Variable compliance outcomes within services depending on the dedication of the specific champion in place, the above dynamics within a service at any point in time, and the level of local manager support in that service.

The approach however has also brought innovative solutions from different champions and a strong shared team-work approach to the project. An example of the difference a specific champion can make, was in one service where within 6 months compliance had moved from 21% to 84%. Other residential services obtaining and maintaining 100% compliance. Other examples, include peer and peer workers completing the WHOQOL together, champions presenting graphical representation of WHOQOL results within the context of other assessment results in client reviews and larger complex mobile services developing systems to support their staff to retain high levels of compliance over time.

A brief look at some results of data that has come in was presented today included domain averages across the organization and average G1 and G2 scores. In comparison with preliminary NZ reference values, provided by AUT, results were at the low end of the range of average scores for the NZ population. Comparing 2010, 2011 and 2012 averages score on the 2 general questions of QOL and health in general there was good positive change for the first period and which have been sustained the second time period. Until all the data has come in we are unable to confirm final data outcomes. We have also started using the 31-item tool this year which includes the 5 new NZ national items, so 2012 domains are not fully comparable with 2010 and 2011.

The database now offers staff the following options for looking at individual client changes and taking them to clients for discussion:

- Overview table of facet score changes from initial survey.
- Comparison table of any two surveys – facet score changes.
- Facet graphs.
- Domain graphs.

The following service level reports have been developed for Champions:

- Compliance by service.
- Facet level changes by service.
- Domain changes by service.
- Export to excel – select any demographic to compare facet / domain changes and capacity for services to extract their data from a multiservice situation.

We are at the point of testing our system currently and ironing out database issues, which should be complete within the next month. We would like to improve graphing options and to find accessible visual ways to display changes for staff.

The areas Connect are interested in exchanging views are:

- Collecting / use of qualitative data to aide in data interpretation
- Sharing collaborative learning and insights discovered when interpreting data
- Visual data displays easily accessible by staff
- Sharing of risk identification and mitigation strategies
- Different ways multiple services are tracking one client's outcomes together

Ross Phillips – Pathways.

Ross saw the values of the WHOQOL at several levels.
At the personal level it:

1. Increases accountability and participation from people using services.
2. By being a self-rated measure it gave clients a voice.
3. The WHOQOL provides a measure of subjective well-being to compliment other social indicators Pathways also collects.
4. To assist future planning it helps measure and tracks progress, wellbeing and recovery for those people using services.
5. It helps Pathways understand the outcomes people experience.

At a service and organizational level the WHOQOL can:

1. Build evidence and contextualize practice.
2. May complement good recovery planning processes.
3. Assist in evaluating services, especially new services.
4. Assists in setting performance targets and strategies.
5. And the WHOQOL is recognized and validated outcome measure.

In collecting information it was important to inform people about the tool and encourage its use. Allied to this is the need to address their concerns that those have in using the scale, their rights, getting client consent and ensuring them of the privacy and confidentially of the answers.

The WHOQOL is recommended for use at entry to service and prior to each service review, which is usually at a minimum of 3 months. The tool is administered with the appropriate staff present and the answers entered into the clients personal information management system called “Recordbase”.

The User Guide is provided for staff. Personal reasons are given to staff why collecting outcomes are important and advice is given about collection protocols. Assistance is provided with the data entry process. It is important to be sure that definition is provided for items and that FAQ’s are answered. Philosophically it is important to records and outcome assessment is regarded as essential to service and not considered an add-on.

“Wild Bamboo” who provides “smart” information systems has helped develop the IT data recording and analyses capability. Biographical, medical information and particulars of the interview are recorded with the WHOQOL facet scores. Graphic domain presentations are a feature of the analytic output.

The implementation of the assessment programme requires staff training workshops, identification of early adopters and champions. An outcomes intranet page is used where communication templates exist. Also important is the information for service users emphasizing their rights and empowerment in the assessment process.

A challenges found in introducing the WHOQOL involves convincing busy staff about the importance of clients having a voice. Allied to this, is also getting key staff leaders on board, particularly through their seeing evaluation as complementing recovery practices. To facilitate understanding it is useful for all staff to have easy to read guides.

Two issues of importance are for programmes not to spend too much time deciding on evaluation tools, yet not to think it is something that can be done easily. It takes time. It can be unproductive to over-think the assessment process and get bogged down or put off decision taking. It is useful to identify what is required to implement your selected system of assessment but not to wait till all parts of the system are in place. Best to get going or you might not pass.

There are technological challenges including gathering information electronically, having the internal capability to analyse meaningfully the recorded information. It is considered important to have the IT people involved right from the start of the project and not to begin when IT consideration come about. Information needs to flow and be easily accessible.

Institutional decision making regarding how to go about outcome assessment is not an easy matter because there are different horses for different courses. No outcome measure can point clearly to the causes of change in mental health recovery so from that perspective outcome assessment results will always be interpretable. Vested interests want outcome assessment. The challenge is to realize and decide its strengths, its limitation and the most suitable approach to satisfy the vested interests, as well as directly benefit clients.

Sarah O'Connor – Kites Trust

Sarah outlined the mission of the Kites Trust as a peer support organization with a recovery and strengths based focus. Their interest is in understanding the processes and outcomes being supported by NGO support services and what resources and procedures are needed to initiate and undertake ongoing evaluation of these services. This involves an evaluation of both the evaluation process as well as an evaluation of what are the outcomes of value being achieved by the consumers of the peer support services. There was a need for evaluation of outcomes, to cover one-to-one and group peer support, drop in centres, recovery houses and telephone help-lines.

Presently Kites Trust is considering the WHOQOL, satisfaction surveys, feedback from consumers/whanau/clinicians, annual surveys and PRIMHD data. These tools are meant to embrace recovery, quality of life, service satisfaction, Maori wellbeing and reciprocal support. The criteria being used to select tools include the ease of application, their acceptability, their practicality, their use in NZ, the administration time and the authors of the assessments.

Presently The Kites shortlist of outcome measures is:

NZ WHOQOL-BREF.
Hua Oranga
Taku Reo Taku Mauri Ora
Warwick-Edinburgh Mental Wellbeing Scale
Welllink Outcomes Matrix
Human Givens

The preferred candidate at this time is the NZ WHOQOL-BREF because of its relevancy to the consumers of services. It is already used in addiction and mental health services. However the core tool does not include enough items covering spirituality. An additional module to the WHOQOL-BREF is the Spirituality, Religiousness and Personal Belief (SRPB) module but it has 36 additional items. (A shorter version of this module is being prepared in Australia.)

Another contender is the Taku Reo Taku Mauri Ora, which was developed in NZ for Maori by Maori. It was developed by consumers and has outcomes of value to consumers. However it is rather long.

The reality of selecting a satisfactory outcome tool is that no tool by itself is comprehensive yet brief enough to include all facets of quality of life considered important to those in recovery as well as important to help evaluate service delivery. Selecting tools in the Kites Trust is work in progress.

Sarah Andrews – Richmond

Richmond is a large provider of mental health and other support services across New Zealand. In 2011 Richmond began to roll out a new service delivery model (Intentional Practice), which included the use of WHOQOL- BREF. The WHOQOL - BREF was chosen as it aligned with the wellbeing focus of service delivery and was not a mental health specific tool.

Use: WHOQOL is offered to all adult clients on entry, as part of their three monthly review preparation and on exit from the organization. Completion is not mandatory as this process informs rather than drives assessment, personal planning and review. However around 85% of eligible clients have completed a baseline WHOQOL.

Preparation/Delivery: In an attempt to standardize delivery as much as possible staff had a half-day training on the use of the tool, plus a practice and refresher session. Resources to support delivery included a prompt sheet for staff, which lists alternate phrasing and a prompt for each standard item. These were developed by service delivery staff based in those available in the ID and disabilities version of WHOQOL. A version of the tool with five smiley to sad faces for the Likert scale was also developed to increase its visual appeal and ease of use.

Data collection and reporting at individual level: Key workers enter the ratings into the client information a system (CIS), which can print out reports for individual clients in a number of formats for discussion and comparison. This includes items and raw scores or charts presenting global ratings and domain scores transformed to percentage scores.

Data reporting at organisational level: By the end of June 2012 Richmond had 897 completed baseline WHOQOL surveys. At this time the mean scores were:
Overall wellbeing 3.4, Overall heath 3.2, Physical wellbeing 57%, Psychological wellbeing 55%, Social and relationships wellbeing 55% and Environmental wellbeing 62%. Slides showing the distributions of these ratings were shared. Further work is planned to break down this data by service types and other variables.

Messages: The use and value of WHOQOL with individual clients is straightforward. At aggregate level the interpretation of results is limited, particularly in the short term. Over time it hoped patterns would emerge from these large data sets and a combination of population "snapshots" and selected cohorts alongside some qualitative enquiry will provide some valid interpretation and meaningful use of results.

In the short term my response to the question "what does it mean?" is to remind people that WHOQOL is what it is; an individual's self-rated measure of wellbeing. As a service provider we hope to *contribute* to improve QOL (alongside many other influences) but results or changes cannot be *attributed* to a service provider (in whole or part) without evidence.

Annie Angus – IRIS Cerebral Palsy New Zealand.

IRIS is not a mental health recovery organization as such but they have adopted the WHOQOL-BREF as a trial outcome measure for their rehabilitation support activities. The philosophy of this NGO is that the programmes activities are person centered and are designed to help clients fulfill their goals and aspirations through autonomy and self-control.

Currently IRIS is developing an outcomes based framework using evidence-based tools. They are measuring:
- Participation and Autonomy.
- Quality of Life.
- Mobility/Functionality.
- Levels of Dependency.

These assessments are important to measure meaningful outcomes; to assess the impact of and effectiveness of current practices; to assess service interventions and delivery; and to obtain information for future strategic planning.

IRIS chose the WHOQOL-BREF with the advice support of Dr Paula Kirsten of AUT School of Rehabilitation. They wanted evidenced based assessment (found the EUROQOL not specific enough). They discovered in the WHOQOL-BREF a tool that covered several important domains of QOL, was easy to administer, could be used to collect data for several years with the same clients and that the tool was aligned to the IRIS vision. Currently they are trialing the BREF with clients with physical disability residing in Auckland.

The tool is designed in a book format that allows 4 years of data to be collected. Each client has their own book that they keep read and manage. The book and answering format have been adapted to make the scale more attractive and this will continue with the adding of visuals.

The WHOQOL is administered with trained clinical leaders (RNs) and House Coordinators. The clients complete the WHOQOL without staff support or oversight if they choose. Sometimes house coordinators or team leaders read the questions to clients and record their responses.

WHOQOL responses are recorded on spreadsheets and data is currently being entered onto the computer. No analyses have been done yet. Important issues learned so far are:

- Some clients cannot complete the BREF in one session.
- There is a need to engage everyone from all levels.
- The involvement of expert evaluators is helpful.

- That entering data takes time.
- That further training is required.

The future activities for IRIS are to analyse the data for programme trends and to advise clients of the findings. From the data they would like to be able to review service delivery models and interventions in order to get continuous quality improvement while getting individual results to support the client centred programme approach.

Major features of the way IRIS uses the WHOQOL include the adaptation and presentation of the tool itself and in a book form plus the sense of identification/ownership that the data is the clients. The approach is one of "building the ship as you sail it".

Jim Burdett – Mind And Body.

After lunch Jim spoke of his reservations of the use of the WHOQOL as an outcomes assessment tool for mental health recovery programmes. He saw its value more as a discussion tool with clients both individually and in groups. This, Mind And Body had been doing for several years. The major difficulties he saw as an outcome tool were in the attribution of change in responses by clients over time and client reliability. Are changes in scores a reflection of the programmes activity or of other outside influences? This is a key question to all outcome assessment. Another problem he suggested is the inconsistency (unreliability) of client responses. One day they may be more positive or negative than others.
Jim posited that symptom analyses by trained clinicians using such instruments as the HoNOS are more valid as outcomes measures.

Group discussion:
General issues:

Each of the 3 groups covered most of the areas suggested in the programme for groups to discuss. This section will present major discussion points and suggested strategies for those wishing to introduce the WHOQOL-BREF to its programme as an outcome measure and/or a clinical aid to help those considering or currently involved in piloting or using the instrument.

1. A major issue surrounding outcome-testing concerns the attribution of change that occurs with scores over repeated administrations. Is the change reflective of the programme activities alone or due to other non-service factors, chance, family matters and/or the daily environment are examples? As with other outcome rating scales, objective or subjective, including the HoNOS, clear attribution of what lead to any change is difficult to ascertain. One may ask the client or the service provider, but this would still be opinion. The fact of the uncertainty of what has caused the change may give comfort to some service providers particularly where changes have been negative and pleasure when change is positive. It may also be interpreted by some organizations not to attempt outcomes assessment at all. However, there are many advantages to be gained from outcome assessment. Recognition of the uncertainty of attributing

change should be made with the service users and providers as well as the programme managers so that all are aware of this reality.

2. Where data has been accumulated for a group of clients and compared to past scores or compared with other groups, then the differences may engender further examination of possible causes. In this way the tool becomes a problem finder or an indicator for closer scrutiny of the programmes effectiveness. Some of the diurnal variations expected from individual client data may be averaged out through group data analyses. Group data is more reliable. Even so, group test results require careful interpretation. It is recommended and expected that other service delivery measures would be used with the WHOQOL including the HoNOS and service delivery data. We are reminded that all mental health outcome measures have similar limitations and that one instrument does not cover all outcome assessment.

3. An emerging real value found of the WHOQOL-BREF in MNH recovery has been its usefulness as a tool to broaden discussion with clients and broadly enhance interventions. By completing the self- assessment process and completing the scale gives clients a feeling of importance in making such assessments about themselves and in tracking their own progress. The client can identify with their recovery progress and feel some ownership of the outcomes. But, there is a need to understand the impact of using the WHOQOL with people and the impact of the conversations that result. It was agreed that the use of the tool can encourage good conversations and an increased understanding for staff. And it was also agreed that these effects will be 'operator dependent' and that the tool could be used in a non-therapeutic way. The tool fits with the "strengths approach" which permeates much of NZ NGO mental health recovery philosophy too. Using the WHOQOL should be to co-create understandings. It is the role and business of service providers to show interest and learning from people about their view of subjective wellbeing.

4. There are multiple levels of reporting and understanding test scores:
    - By item, by domain and by groups
    - At an aggregate or individual level.
    - By service type, specific populations groups or geographic regions.
    - By benchmarking for subsequent comparison.
    - The use of data to produce these client and programme markers need to be rationalized and agreed by administration and staff at the outset.

5. Regular reporting systems should be built and automated in order to indicate:
    - What the service is good at.
    - What is needed to be improved upon.
    - What different population groups experience.

    These reports will not be achievable by the WHOQOL alone. Other measures will be and are being used. The WHOQOL is one tool in a comprehensive evaluation strategy or package.

6. There will need to be institutional expertise and leadership to achieve the above, to build relations and collaborate with those that can do it. In a sense

this will require an on-going internal marketing exercise and ongoing training of staff. Even changes in staff job descriptions to include assessment of clients QOL at fixed intervals could be regulated. There are training materials available among several of the NGOs that could be shared.

7. It is not necessary to compare domains (analysis by domain and item is fine without needing to necessarily report one domain against another). Domain analysis also does not provide the detail needed to select particular issues that can be addressed. That is to say, that to report the social factor domain composite score does not provide clarity of what particular social domain facet might need to be concentrated on.

8. A decision on the frequency of collecting information is required by the service. Each 3 months has been suggested. But the decision would need to consider the use of the tool as an outcome tool and or conversation aid.

9. A suite of recommended reports and a user guide (technical set up and interpretive use) for organisations who are interested could be developed. This may be posted on the NZ WHOQOL website.

10. Likewise a template could be developed to guide how to collect protocols make records and report results that can be easily adapted for use by interested organisations. One NGO has the client keep their own book of scores, so they feel ownership and some control.

11. Further considerations are required about understanding the experiences of people that the WHOQOL doesn't capture. There is a research project now underway to develop a module of additional quality of life facets particular to the in MNH recovery and additional to the BREF. Such facets as stigma and autonomy may possibly emerge. This work will take at least 2 ½ years. It is being pursued by Melissa Rowthorn of Connect.

Recommendation about WHOQOL-NGO networking

The conference agreed that it would be valuable to continue to share ideas and materials amongst each other. The sharing of data recording and data analysis software programmes would reduce costs and permit data comparison where the latter is considered useful. Of paramount importance is the confidentiality of data and individual NGO ownership. The conference did not take any decision about how exchange of software and programmes may proceed. Such steps would involve NGO senior management decision. However it was considered sensible that individual NGOs contact each other for advice and guidance. To this and other ends, the e-mail address of conference participants are presented in appendix 2.

It was suggested that another get-together forum be held next February. Phillipa Gaines representing Lattice and Platform offered to host the meeting in Platform Trust's offices in Wellington. (Since this conference, the 19th and 20th February has been reserved for the Wellington meeting).

It was recommended that the NZ WHOQOL website be updated. A suggestion for a Blog capability was also suggested but this would require funding to purchase expertise to set this up. This topic could be one for discussion at the proposed Wellington meeting perhaps?

No official infrastructure was discussed nor decided for the NZ WHOQOL-NGO group. This could also be an agenda item for the next forum. In the meantime Rex Billington will coordinate.

Appendix 1

One day conference for NZ WHOQOL users.

Wednesday 26th September 2012.

Host- Pathways, Auckland. 3 August 2012

Dear All,

Several mental health recovery services and NGOs have suggested a get-together to share information about WHOQOL data scoring, storing, analysis and reporting. The objectives are to find out what each of you are doing and sharing it with others who are also establishing their data systems. Hopefully a useful network of users would evolve. Ross Phillips at Pathways has kindly agreed to host a one day conference on the 26th September at their head offices in Manukau, Auckland from 9am to 4pm.

The programme would be arranged to allow each organization 30 minutes to describe, if they wish to do so, what they are doing to develop and roll out their WHOQOL system from information gathering to reporting. There would be the opportunity in the 30 minute presentation to show a video or have a power point presentation if you wish of your operation's way of collecting and handling the data. The presentation session would be followed by discussions in groups about sharing experiences, describing problems and proposing solutions. We recognise that different organisations are at different stages, so it can be an opportunity for some to learn from others, and all to consider the issues of the next stage of their implementation plans.

Each organization could bring 2 people. There is no cost, but you would have to bring your own lunch. Pathways will look after coffee and tea. All in all this is a no budget affair. We have chosen to go outside AUT premises in order for the WHOQOL activity for mental health recovery outcome assessment to be identified as a development of NGOs and health boards and not as an AUT project.

Please let me know if you and a colleague would like to attend. I don't need names at this stage just numbers. Once you have all responded to this e-mail then we will provide more details of the venue and a detailed agenda for the day.

Thanks and good wishes.

Rex

Yes I will come. _____

Yes I will bring a couple of colleagues if I can. _____

Yes I would like to make a half hour presentation. _____

We would like information on the following over the course of the day:_____

Appendix 2

NZ WHOQOL-BREF 1 day NGO Conference - September 26th 2012

Host- Pathways - Harakeke House, 15 Ronwood Ave, Manukau

Participants:

Sarah O'Connor	Kites Trust	<admin@kites.org.nz>
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Total	21 participants	