

# Introducing the routine use of outcomes measurement to mental health services

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## Abstract

*Significant progress has been made in preparing for the introduction of the routine use of outcome measurement instruments to mental health services. However, limited attention has been paid to the linked issues of the practical challenge of their implementation and their possible uses in clinical practice.*

*This paper reports on a qualitative study examining the views of clinicians, service managers, consumers and carers on how to effectively introduce a suite of measures to a public mental health service and use ratings generated by them in clinical practice. These findings are combined with practical experience gained in introducing a suite of outcome measures in order to suggest future strategies for implementation.*

## Introduction

Those who fund, plan and deliver mental health services are increasingly focusing on value for money and this necessarily involves consideration of individual patient outcomes. This trend is amplified by an increasing expectation that health services listen and respond to the needs and views of their consumers. Outcome measurement instruments can be used to measure outcomes of individual consumer care and, by aggregating ratings, allow comparison of outcomes between different interventions and between different health services.

Rating scales for the measurement of outcomes in individual patients have been available for some time and usually consist of a series of questions which allow for a numerical value to be placed on the clinician's or consumer's evaluation of the consumer's mental state, disability and social circumstances. Their use in routine practice has been increasing in both public and private mental health services (Goldney et al. 1996; Hugo 2000).

In Australia, the promotion and implementation of routine outcome measurement has been an important goal of the National Mental Health Strategy (1992). The Victorian Government has commenced a statewide implementation program for public Area Mental Health Services (AMHS) and four AMHS, including Barwon Health, Geelong, introduced a suite of outcome measures into routine practice in August 2000. It is proposed that the remaining 16 Victorian AHMS will introduce this suite of outcome measures over the year 2001. The instruments chosen for introduction in Victoria comprise the following:

- The Health of the Nation Outcome Scales (HoNOS); a twelve-item clinician rated outcome scale developed in the U.K. by the Royal College of Psychiatrists which focuses on behavioural problems, problems caused by symptoms and social and interpersonal problems (Wing et al. 1996).
- The Abbreviated Life Skills Profile (LSP-16); a 16-item clinician rated scale developed in Australia, which focuses on impairment (Buckingham et al. 1998).
- The Behavior and Symptom Identification Scale (BASIS-32); a 32-item consumer rated inventory (Eisen et al. 1994).

The protocol for the use of these three measures in Victoria has been finalised. All three measures will be completed at first assessment, 6-monthly review, discharge from acute or residential inpatient care and case closure. The HoNOS alone is to be completed at admission to acute inpatient care. The Barwon Mental Health program has been using the HoNOS in routine clinical practice since being one of the five Victorian sites that piloted its use in 1996 (Trauer et al. 1999).

Most of the 120 or so clinicians in Barwon Health who are required to use these instruments view them as additional work and are sceptical of the proposition that they may add value to their clinical work. If outcome measures are to be incorporated in a meaningful way into clinical practice, their introduction will require changes being made across the whole patient management system.

## Literature review

Most of the literature in this area explores the issues of the choice of outcome instruments, their statistical properties and the results of studies using instruments on selected groups of clients. As instruments are increasingly used routinely, some of the practical issues associated with their implementation and acceptability have begun to appear.

Australia is well advanced in preparing for the national introduction of routine outcome measurement and five Australian publications have particularly contributed to this. The first of these is a review of all available outcome measures, which nominated six measures for evaluation in Australia (Andrews et al. 1994).

The second major work is the report on the field testing of those six outcome measurement instruments by Stedman et al. (1997). Their conclusions were that there is more to the introduction of outcome measures than simply choosing and administering questionnaires and that greater attention needs to be given to the implementation of outcomes and less to the measures themselves (Stedman et al. 1997).

A further advance in the literature is the national information plan and strategy agreed to by all Australian State Health Ministers (Department of Health and Aged Care 1999). Two other Commonwealth Government reports are worth noting. The first concerns outcome measures in child and adolescent psychiatry and the second discusses the introduction of outcome measures into the private psychiatric system (Bickman et al. 1998; Morris-Yates et al. 2000).

Andrews et al (1994, p33) concluded that measures which are suitable for use in routine clinical practice are “likely to be brief, low cost, multidimensional measures which require minimal training in their administration, scoring and interpretation, but which are sufficiently reliable, valid and sensitive to change to indicate the outcome of the therapeutic intervention”.

Most agree that no one measure exists which fits all the criteria described above and that no single ‘set of numbers’ will successfully convey a person’s experience of mental illness. Instead what is required is a broad range of outcomes, including the data gathered using outcome measurement instruments, integrated with developments in quality management and evidence based practice (Herrman 1999).

In their report, Bickman et al (1998, p27) observe that stakeholders had made it clear that unless outcome instruments are demonstrably valid and useful, they will not be accepted. They also emphasise the importance of the process of implementation observing that “the imposition of a measurement system without consultation and co-operation is likely to alienate frontline clinicians to the extent that they refuse to use the system or even sabotage it”. The ease with which outcome measures can be implemented as part of routine service practice and the extent to which they are taken seriously, will be determined by the degree to which consumers and clinicians value their clinical utility and consider them to be relevant (Smith et al. 1997).

Staff members must feel a strong sense of ownership of outcomes data so that they are committed to the use and benefits of the measures (Blankertz & Cook 1998). Clinicians have traditionally seen their responsibility in terms of the individual patient and the use of outcomes measures requires them to adopt a group or population perspective (Hall 1996). The consideration of group or population outcomes is unfamiliar territory for many clinicians. Consequently the use of aggregated outcomes data for comparison between teams and diagnoses, or other such uses, may not be seen as useful to them.

Staff attitudes to outcome measures have been looked at. In one Australian study, 67% of respondents said they were disinclined to use outcome measures even if it meant providing a better service to patients and the authors of this study also point out that negative staff attitudes may result in poor quality of data collected (Walter et al. 1998).

The time taken to complete measures must be acknowledged (Walter et al. 1998; Blankertz & Cook 1998; Stedman et al. 1997; Smith et al. 1997). Consideration must be given to extra resources (Walter et al. 1998). These may include resources to allow for a reduced caseload for individual clinicians or the appointment of data entry staff.

There is a need for adequate training, including training of medical staff (Marks 1998; Smith et al. 1997). Clear explanation of the purpose of outcomes measurement must be given (Dept. of Health and Aged Care 1999; Spear 1998) and arguments for the implementation of health outcome assessment should be given on practical rather than theoretical grounds (Meadows, Rogers & Green 1998).

It is important to collaborate with consumers in the choice and development of outcome measures (Herrman 1999; Stedman et al. 1997). However, despite the central role of consumers, there is surprisingly little in the literature which recommends or describes consultation with them either in the choice of instruments or in practical aspects of their introduction. In her address to the 3rd 'Getting Better Conference' (Sydney, 2000), consumer consultant Carolyn Graham argued that "outcome measurements need to be undertaken as a partnership between the clinicians' and consumers' experience if understanding and realistic evidence-based information is to be achieved". Stedman and colleagues found that a consensus emerged among participants that mental health consumers want a voice in their individual treatment plans and that a collaborative approach is necessary to break down the walls between professionals and consumers (Stedman et al. 1997). The issue of confidentiality and the uses to which outcome measures information is put is of concern to consumers (Stedman et al. 1997). No references could be found to the issue of consumer training or service responsibility in informing consumers of their opportunity to have a voice in their own management.

Attention needs to be given to the process of data collection and this is at least as important as any other link in the chain (Dornelas et al. 1996). The central theme of one Commonwealth Government report is that a well designed computerised information management system for the collection, analysis and provision of timely feedback to clinicians, is critical if outcome measurement instruments are to be routinely used (Morris-Yates & Andrews 1997).

It is clear from the literature that the integration of outcomes assessment into routine clinical care is at an early stage (Smith et al. 1997; Sederer, Dickey & Hermann 1996). For example, one author suggests that outcome measures should be applied at the beginning and end of treatment, which reflects a narrow focus on the outcome dimension of their use (Bieber et al. 1999). This view ignores the role that outcome measures could play in the treatment endeavour, for example, by being used to contribute in an ongoing way to treatment planning (Stedman et al. 1997; Morris-Yates & Andrews 1997). In a recent study, consumers who had completed a BASIS-32, and subsequently had an opportunity to discuss their responses with their treating doctor, reported that they had been treated with more respect and dignity by staff than did those who had not completed the measure (Eisen et al. 2000).

Staff will need to incorporate outcomes measures into routine clinical practice and they must see value in doing this if implementation is to be successful (Stedman et al. 1997). Interestingly, only one reference recommended the inclusion of outcome measures into routine paperwork (Blankertz & Cook 1998).

The introduction of outcome measures will require a strategy of implementation, which it will be the responsibility of the management team to develop (Hall 1996). One such 'step by step' strategy is described (Rissel et al. 1998).

## Research methodology

The objectives of this research were to explore ways of implementing the use of a suite of outcome measurement instruments such that they will be used in routine clinical practice and will enable service management and planning.

A collaborative exploration of strategies for introducing the suite of measures was conducted in parallel with introducing the suite of measures in practice. This approach is referred to as 'action research'. Action research is an increasingly popular approach, particularly for those working in professional areas such as education, social care and health (Meyer 2000). The action research cycle involves planning, action, observation and reflection (Klemmis & McTaggart 1988).

Data were generated using two major sources. First, an outcome measures Implementation Group was convened and met regularly for two months before, and two months after the introduction of the measures. This group included three consumers, three carers and four clinicians. Although the choice of outcome measures and the protocol for their use had been already determined by the State Government, the Implementation Group was invited to formulate plans to encourage their use by case managers and consumers in everyday clinical practice.

Second, individual interviews lasting 45-60 minutes were conducted and recorded with three psychiatrists, three team co-ordinators, three case managers and three service managers (none of whom were members of the Implementation Group).

## Results

Data analysis proceeded using grounded theory techniques (Martin & Turner 1986) and are presented under the following five headings.

### 1. Consumers and carers.

Consumers and carers on the Implementation Group believed the consumer-rated measure (BASIS-32) to be potentially the most clinically useful of the outcome measures. They had few specific criticisms of the instrument itself. They believed that differences in perception of the consumers' state of health and wellbeing could be used as a foundation for dialogue and that this required trust between clinician and consumer.

Carers and consumers believed that the exercise of using outcome measures must be of clinical value to individual consumers in its own right and the potential for benchmarking or establishing a more rational mechanism for funding was not of interest to them. However both carers and consumers expressed the hope that the introduction of outcome measures could lead to a fundamental change in the relationship between clinicians and consumers and carers.

An important theme in the Implementation Group's discussion was the need for a carer-completed measure to be added to the suite of outcome measures. It was argued that the consumer's rating may be unreliable and may need to be supplemented by the carer's perspective.

### 2. Managers and clinicians.

Most clinicians also believed that the outcome measure with the most clinical potential was the BASIS-32. Managers and clinicians described a wide range of hypothetical advantages of the introduction of outcome measures. They believed that it would lead clinicians to think more critically about consumers' needs on the basis of a wider range of issues, including social functioning, compared with the focus in usual practice which is often limited to the consumer's symptoms. Other hypothetical advantages for the introduction of outcome measurement put forward included encouraging interaction with and listening to consumers and carers, promoting collaboration rather than being judgmental and the introduction of a common language between clinicians, consumers and carers.

A recurring theme for clinicians and managers was that of respect for their professionalism. They argued that the introduction of outcome measures could be seen as an attack on clinicians' professionalism in that it suggested that clinicians are not already discussing issues with consumers and including them in planning, which good clinical practice entails even without the use of specific measures.

Almost every person interviewed was suspicious of management and government rhetoric about their motivation in introducing outcome measures. Most managers and clinicians believe that outcome measures are being introduced to increase accountability, which most accepted as reasonable, or to find a funding formula for mental health, which most had reservations about.

In much of the data there is a sense that the clinicians, as well as consumers and carers, are asking to be respected. Their grievances, where they exist, emanate from a perception that they are not respected or their views heard; consumers by clinicians (and sometimes carers), carers by clinicians and clinicians by management and government.

### **3. Integrating the use of outcome measures into everyday clinical practice.**

Consumers and clinicians made widespread reference to the place of outcome measures in the case management system. The case management system refers to a system of clinical management whereby each consumer will have a case manager and that case manager will be responsible for ensuring that a clear sequence of management steps are followed including assessment, formal individual service planning and formal case closure. Frequent references were made to the advantages of actually embedding the outcome measures into the patient records so that outcome measures can be completed while completing patient records without having to go searching for separate forms.

An initiative trialled during the course of this project was the inclusion of outcome measures on the Individual Service Plan (ISP) document, which is completed by case manager, consumer and carer together every six months. This was done to promote the use of outcome measures as a basis for service planning. Consumers and clinicians expressed their enthusiasm for this approach rather than allowing outcome measures to be completed in isolation from service planning. Clinicians repeatedly stated that this approach to the formulation of the ISP made it a more meaningful exercise than had been the case previously.

A major focus of concern by all groups interviewed was the issue of technical support. Both managers and clinicians stated that while it is possible to complete ratings on paper and place them in a file, this does not facilitate comparisons with previous ratings to track progress, comparisons with other consumers or group comparisons for benchmarking purposes which appropriate computer software would enable. The availability of graphs showing comparisons between ratings was linked by some clinicians to the possibility of using outcome measures to stimulate discussion at team meetings.

All clinicians interviewed raised the question of resources. They particularly raised the issue of time spent on outcome measures and repeatedly stated that they felt under pressure with high caseloads and rapid caseload turnover.

### **4. Education and Training**

Managers and team co-ordinators emphasised the importance of adequate staff training both during the introduction of outcome measures and later as newly recruited staff joined the organisation. Many emphasised the need for understanding the basic purposes of outcome measures rather than just how to complete them. Consumers and carers were also concerned that some form of education about outcome measures be given to all consumers, one suggestion being an information leaflet provided to each consumer when they are first assessed by the service.

### **5. The use of Outcome Measure Data**

Consumers and clinicians were concerned that confidentiality be guaranteed. They also expressed a desire that consumers be given the option as to whether or not their ratings be entered on a database even if they had agreed to complete the measures. An important issue was the consumers' and carers' desire that the clinician's rating of outcome measures be made available to the consumer. A number of clinicians expressed their unease with sharing their own ratings with consumers.

Consumers and clinicians were worried about the use to which data would be put. The major concern which consumers had was that the organisation ensures that data are put to good use by facilitating communication and service planning as described above. Clinicians worried that data would be used against them in some way. They were concerned that their own performance would be monitored and judged using outcome measures. Finally, both consumers and clinicians expressed concern that outcome measures might be used as a mechanism for deciding which consumers should be given treatment and which not. They were particularly concerned to point out that consumers may not improve in their mental state but still require considerable input in order to maintain a reasonable level of mental health.

## Summary

The findings of this research strongly suggest that the introduction of a suite of outcome measures is a challenge to the entire system and its workforce, from senior management through to all clinicians and including administrative staff. Three matters are crucial, as follows.

### 1. Engage management

Assuming that the measures and protocol for their use has been determined by the State Health Department, senior management will have to review the current case management system, the continuity between community and inpatient care and where in that system outcome measures are most appropriately completed and by whom. They will also have to consider a complete revision of the patient record system so as to embed outcome measures at appropriate points in the paperwork. This will encourage their routine usage.

Consideration will need to be given to the development or use of existing technical support systems. This will mean reviewing the service's access to a computer network, reviewing the availability of hardware and the finding or developing software designed to gather, store and display ratings in graphical form and to provide reports for management. A review of the case management system, a major overhaul and revision of the patient record system and the introduction of new technology cannot be successfully achieved without engaging clinicians, consumers and carers.

### 2. Engage clinicians

The evidence presented above shows that clinicians have considerable knowledge of and advice to offer on the implementation of outcome measures. Moreover, it is the clinicians who will be required to use outcome measures on a daily basis and the effectiveness of the initiative will depend on their agreement, enthusiasm and willingness to encourage consumers to use them. In preparing for and implementing a review of the case management system, a revision of the patient record system and the introduction of support technology, it will be necessary to form working groups to engage clinicians and use their expertise.

None of this is surprising. We are all more likely to modify our behaviour when we participate in problem analysis and developing solutions and we are likely to be more committed to solutions we have helped design rather than to carrying out 'expert advice' (Weisbord, 1987).

### 3. Engage consumers/carers

There has been increasing recognition of the need to incorporate the perspectives of consumers in planning, delivering and evaluating health services. The promotion of consumer participation is not only a matter of democratic rights but is also an effective way in which services can gather information and ideas from those who know and use our services (Draper & Sillburn 1999). In the introduction of the outcome measures suite in Barwon Health, the Implementation Group itself was an important exercise in including consumers and carers in planning and in listening to their views. In particular, the clinicians in the group accepted suggestions about change and strategies to improve the system offered by consumers and carers more readily than they were likely to have accepted them directly from the management group. These included the inclusion of BASIS-32 in the initial assessment document and ISP document, their completion with the case manager rather than on their own except when an individual consumer requests otherwise and a trial of a carer outcome measure which is currently under way.

## Conclusion

The evidence presented above suggests that the introduction of outcome measures can provide public mental health services with an opportunity to redesign the case management and patient record system so that outcome measures can become an essential ingredient of the development of ISPs. Such an approach encourages engagement with and respect for the consumer and clinician. Without this approach there is a real risk that outcome measures will be viewed by clinicians as a bureaucratic and clinically irrelevant task.

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