

Routine outcome measurement in public mental health — what do clinicians think?

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IN ORDER TO FULLY EVALUATE and manage a service, one should be able to answer all parts of the question “Who receives what services, from whom, at what cost, and with what effect?”¹ While there is good information on the first four elements, mental health services generally do less well in demonstrating the effectiveness of what they do, and it is here that routine outcome measurement (ROM) can make a contribution. Despite the very real progress that has been made in implementing ROM in Australia it is evident from a variety of sources, formal and informal, that not everyone is convinced of its necessity or value.

The onset of routine outcome measurement (ROM) in mental health in Australia is generally taken to be 1992, when the Australian Mental Health Policy² proposed a number of objectives, one of which was “To institute regular reviews of outcomes of services provided to persons with serious mental health problems and mental disorders as a central component of mental health service delivery”. This was followed by a review of potential instruments,³ and field trials of some of these.^{4,5} Also in the mid-1990s, a large project to develop a casemix classification system for psychiatry used a number of the same measures.⁶ In 1999, Victoria was the first jurisdiction nationally to introduce ROM (into the adult programs of

four area mental health services⁷) and over the last four or five years ROM has been introduced for all age groups (child and adolescent, adult, older persons) in all mainstream public mental health services throughout Australia, as well as in private psychiatric hospitals. Most direct care staff in mainstream public mental health services have received training in the use of the instruments. Outcomes data collected at the service level are assembled at the jurisdictional level and forwarded for aggregation at the national level, a process that yields reference data for use at the local level; these aggregated data are available in both printed⁸ and electronic form.

The purpose of ROM can be understood in terms of the potential benefits to various stakeholders — for consumers and carers there are opportunities to communicate their perspectives and be involved in care planning, clinicians can more objectively track progress, team leaders and local managers can manage caseloads and benchmark performances, and policy makers and planners can make better informed resourcing decisions. ROM is part of mental health policy partly because provider and consumer views as to what constitutes a good outcome are not identical, and consumers have long pressed for their voice to be (more) heard in the process of care. ROM, which includes consumer self-assessment, provides one avenue for this.^{9,10} In light of the wide array of potential benefits, we may wonder why opinions and attitudes are so variable. The remainder of this commentary is devoted to this question.

At the outset, it is important to recognise that ROM is an ambitious aim, and that the task is complex. Whereas many clinicians grumble about the burden of the extra paperwork, it is clear that the full implementation of ROM involves much more than getting people to fill in

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a few extra forms. Callaly and Hallebone¹¹ identified the need to integrate outcome measures into everyday clinical practice, and Huffman et al referred to “. . . an organizational culture in which treatment progress and outcomes measurement is integral to clinical work”¹² (p. 165). Given that the introduction of ROM involves changes that permeate the service system, it was never likely to be quick and easy. One Australian worker in the field quipped that the first 25 years would be the most difficult (Bill Buckingham, consultant to the Australian Government, 2002, personal communication); even this may be optimistic, given that an article entitled “Outcome assessment 70 years later: are we ready?” was published in 1987!¹³

In one of the earliest reports of what staff thought about outcome measures, Walter et al¹⁴ surveyed staff from a Sydney area mental health service who had been required to record daily activity and rate patient outcome fortnightly over a 3-month period as part of the Australian mental health casemix project.⁵ The major concern expressed by respondents was that rating outcome was too time consuming. More than half were not in favour of measuring outcome routinely, even if it meant providing a better service to patients. Another Australian study published the same year¹⁵ identified some pessimism about what focusing on health outcomes would achieve for community mental health clinicians or their clients. Factors relevant to the uptake of outcome measurement among clinicians working in the community included training in practical applications of health outcome measures, involvement in and ownership of health outcomes projects and recognition of health outcomes achievements. The following year, in an editorial introducing a special edition of the *British Journal of Psychiatry* devoted to the Health of the Nation Outcome Scales, Stein¹⁶ wrote: “To complete a rating scale which has an ulterior motive such as assisting the purchaser, or helping to gather national statistics, is to act on behalf of third parties. It would therefore serve as an intrusion into the clinician–patient relationship and would not be tolerated except for a very brief period, for example in a research project”.

Samar et al’s¹⁷ assessment of staff attitudes towards routine outcome measurement in Western Australia “. . . revealed a need to provide staff with reasons and incentives for incorporating outcome measurement into routine practice, in addition to provision of a thorough and on-going training and support in time and resources from management”.

Gilbody et al,¹⁸ in an article entitled “Psychiatrists in the UK do not use outcome measures” listed numerous barriers, including: inability to capture the subtlety of multifaceted outcome; being “simplistic” and “pseudo-scientific”; being psychometrically suspect; the use of scales detracting from the therapeutic relationship; and conferring little benefit to the psychiatrist or to patient care. They did concede, however, that outcome measures can help to bring the multidisciplinary team together, and felt it was good that they can be completed by non-clinicians.

Close-Goedjen and Saunders¹⁹ echoed an earlier finding²⁰ that “. . . most physicians and nurses reported positive attitudes toward outcome measurements used in the care of their diabetic patients, but that almost half were uncertain how to utilize the information” (p. 100). They themselves evaluated the effect of technical support on attitudes to outcome measurement, and obtained results that “. . . suggested that clinicians are not opposed to OA [Outcomes Assessment] per se, but rather were opposed and resistant to the potential additional paperwork and administrative requirements that OA protocols often represent” (p. 107). In a similar vein, Garland et al²¹ found that “Although all participants had received scored assessment profiles for their clients, the vast majority reported that they did not use the scores in treatment planning or monitoring . . . perceiv[ing] little clinical utility of OM”. Limited clinical utility, difficulties in interpretation, and low “user-friendliness” of reports were all implicated in their respondents’ views.

Such attitudes are important for clinical behaviour. Söderberg et al,²² studying attitudes and accuracy in the use of the Global Assessment of Functioning Scale (GAF),²³ which is widely used in Sweden as an outcome measure, found that

raters' subjective attitude towards the GAF and motivation to use the scale and other measurement instruments in psychiatry were positively associated with a more reliable use of the instrument.

In a recent evaluation, the staff of two Victorian area mental health services were surveyed by questionnaire.²⁴ Over 200 staff (77%) responded. Results showed that attitudes to ROM were very varied, ranging from very positive to very negative, with the preponderance of respondents being slightly positive. Attitudes were least positive among medical staff who also had the lowest rates of completing outcome measures. As part of a state government project aimed at consolidating ROM in clinical public mental health services (funded from the Australian Government's "Commonwealth Own Purpose Outlays"), project staff from one lead agency conducted semi-structured interviews with team leaders or managers of 53 of 60 individual teams within six agencies in Melbourne and the North-East of Victoria.²⁵ About seventy percent of team leaders reported that, to their knowledge, outcomes data were not used at all. Asked what was required by agencies for ROM to become self-sustaining, a quarter spoke of embedding outcome measures into routine clinical processes and another quarter mentioned training in the use of the measures. Other issues mentioned frequently were leadership, resources, information technology, and improving the current form of the standard reports that were available to them.

Our review of the literature and our own work suggest that the concerns that mental health workers express in relation to ROM can be grouped into a number of domains, namely:

- information technology (ie, access to computers, network response time, computer literacy);
- instruments (psychometric properties, relevance, superficiality);
- time burden;
- suspicion of management or government motives; and
- competence and confidence in using ROM data.

This non-exclusive list represents a combination of realistic limitations and emotive and atti-

tudinal resistances. The balance between these is not always clear. For example, in the survey of team leaders described above, no relationship was found between the reporting of information technology problems and the frequency with which outcomes data were collected, suggesting that good technology, while clearly beneficial, is not essential for collection. Similarly, allegations of a possibly unacceptable level of reliability of a core instrument such as the Health of the Nation Outcome Scales (HoNOS)²⁶ are sometimes misplaced. Firstly, they make no parallel criticisms of unstandardised assessments, which are known to be notoriously unreliable.²⁷ Secondly, they mistake reliability as being a property of a test, when it is in fact a property of data obtained by the test.²⁸ Thus, rather than asking if the HoNOS is reliable, the more appropriate question is — Is it capable of providing reliable results? Thirdly, they overlook published evidence showing that acceptable levels of reliability can be attained when properly trained clinicians use the instrument carefully.

Resistance is a common reaction to innovation, which ROM certainly is. It is likely that, with the passage of time, it will be perceived as less innovative, particularly by new staff who were not present in the era when it was introduced. To the extent that ROM is implemented successfully and becomes part of the normal clinical landscape, and if consumers and carers and their representatives continue to press for their involvement in the process, compliance and routine use may grow.

We identify the following current themes and challenges. Firstly, the early years having been largely devoted to training the workforce in the instruments and the collection protocol, many staff now seek further training and guidance in how to use the results clinically. This requires the development of practical tools for them to turn their data into information that is useful at the clinical interface. These are now beginning to emerge.⁷ Secondly, there is a continuing need for the identification and promotion of local champions and services where ROM is flourishing. In this regard, the general lack of enthusiasm of the psychiatric profession (although there are some

notable exceptions) is worrying, but there are anecdotal signs that this may be changing. Thirdly, there is an ongoing need to continue to refine information systems so that information can be delivered to the workplace in a suitable form (verbal, graphical and/or numerical, according to the preference of the recipient) in a timely fashion, which probably means virtually instantaneously.

Note

Further details and links relating to ROM in mental health can be found at <www.mhnocc.org>

Competing interests

The authors declare that they have no competing interests.

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