Outcome measures in assertive outreach: one team's journey towards a system of implementation

Mental health clinicians have a duty to provide quality health care. By providing evidence of the impact of their intervention and support, outcome measures demonstrate the effectiveness of collaborative work with clients. Danielle Hitch describes one team's efforts to develop a workable system of outcome measures, as a means of supporting good practice and fostering meaningful therapeutic relationships with clients.

One member of the team had been chosen to lead this project, and it was decided to develop the system as a team. It was hoped this approach would overcome resistance to any change and produce a system that was practical and realistic. The first team meeting focused on the general topic of outcome measures, and their place in clinical practice.

Why use outcome measures in assertive outreach? To begin with, the team wanted to think about their reasons for using outcome measures, so as to be mindful of their motivation throughout the process. At an organisational level, outcome measures fulfil several important functions. They have direct relevance to benchmarking the team's performance against standards to a point where they may be crucial in determining funding levels. The team also identified a role in supporting statutory duties, an example of which is the reporting of Health of the Nation Outcome Scales (HoNoS) data to the Department of Health.

To measure change over time, the team also wanted to use outcome measures at different points in the patient's journey through the service. They can be used to identify a need for further assessment and support, and also represent an ongoing review of the effectiveness of the interventions provided. To this end, the team wanted to use outcome measures as a means of offering feedback to other staff and clients and possibly to assist in the recognition of early signs of relapse. This goal of feeding back into the treatment process supported the team's therapeutic philosophy of engagement, by promoting collaborative working and lending credibility to subjective discussions on client progress. Ultimately, the team also hoped to use outcome measures to highlight clients' strengths and skills, and empower them to monitor their own progress.

What should the team be measuring? As there were obviously many good reasons for using outcome measures, the team then considered what they wanted to measure. In the first instance, the team was keen to consult with other assertive outreach teams about their own systems of outcome measures and contact was made via email through the Assertive Outreach Forum website. The Bexley Engagement Measure had been used initially by

<table>
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<th>Table 1. Good outcome measures should:</th>
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<td>- Be standardised (proven reliability and validity)</td>
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<td>- Be evidence based (backed by research and used by other assertive outreach teams)</td>
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<td>- Be sensitive (to changes)</td>
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<td>- Fit in (with service aims and needs)</td>
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<td>- Be flexible (generic and profession-specific, relevant to different groups)</td>
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<td>- Be user friendly (quick and engaging)</td>
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<td>- Be relevant (to both client and service)</td>
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These keywords are based on the subject headings from the British Nursing Index.
Table 2. Priorities for outcome measurement

- Quality of life
- Function (including social and activities of daily living)
- Medication (including side effects, sexual dysfunction, attitudes and compliance)
- Symptoms (including severity and physical health)
- Risk
- Dual diagnosis issues
- Engagement

The meetings, a number of outcome measures had been collected by various team members and these were now linked to the appropriate sections of the NSF. Many sections of the NSF reflect outcomes that are measured on service and organisational levels, so in this case it was decided to focus only on those related to direct clinical care.

After discussions which included contributions from nurses, social workers, occupational therapists, and support workers, the areas shown in Table 2 were identified.

The staff member in charge of the project short listed 25 outcome measures addressing these dimensions, and in the second meeting asked the team to rate them on a scale of one to ten for relevance to assertive outreach, user friendliness and sensitivity. These were allocated randomly to team members to encourage them to become familiar with those they had not used before, and the meeting setting encouraged critical discussion. From these scores, several measures were clearly identified as being the most appropriate to their dimension. The medication, symptoms and dual diagnosis issues dimensions threw up a number of candidates. These measures were distributed to every member of the team, who then voted on which they felt was the most appropriate for each dimension (Figure 1).

Why were these outcome measures chosen?

**HoNoS**

The HoNoS is a standardised assessment originating from the Royal College of Psychiatrists’ Research Unit (www.rcpsych.ac.uk/cru/honoscales/what.htm). Its use is recommended by the National Service Framework for mental health (for England), and results form part of the Mental Health Minimum Data Set (for England). This has led to HoNoS being the most widely used routine clinical outcome measure in English mental health services.

The 12 items in the HoNoS measure: (1) overactive, aggressive, disruptive or agitated behaviour, (2) non accidental self injury, (3) problem drinking or drug taking, (4) cognitive

one team, but ceased due to its lack of research base. The Engagement Measure was mentioned by others, and some teams have been using this in conjunction with contact records to produce statistics. The Camberwell Assessment of Need was also identified by some teams, while one team member noted the Life Skills Profile is in regular use by some teams in Australia. Bromley Assertive Outreach team is reported to have used a range of outcome measures as part of a research project, but it is unclear whether these are also used in a clinical context (http://www.dur.ac.uk/sass/casr/projects/?mode=project&id=29). Few of the teams reported using a concrete system of outcome measurement, so at present they appear to be used on a largely ad hoc basis.

Much of the outcome measure literature regarding assertive outreach focuses on fidelity to the model rather than clinical outcomes, and no practice examples of implementation were found. The team thought it was likely that others were in fact using outcome measures in a more systematic way, but information about this is not in the public domain.

By drawing on their professional experience and expertise, many members of the team had clear ideas about the features of ‘good’ outcome measures (Table 1).

The sections of the National Service Framework (NSF) relevant to assertive outreach teams (Department of Health (DH) 1999) and the benchmarks for *Essence of Care* (DH 2003) were considered for providing standard frameworks, and the NSF was found to be the most relevant. Prior to
Many of the scales that were assessed monitor a client’s use of alcohol, but the HoNoS scale also measures mood and anxiety.

Box 1. Implementation Plan

- All primary outcome measures will be used with every client on the assertive outreach team’s caseload.

- Care coordinators are responsible for these measures being completed on a regular basis.

- Care coordinators should seek the input of their multidisciplinary colleagues wherever possible to ensure a variety of perspectives are included.

- If clients are unwilling to complete CANSAS or DAI, this should be recorded. Client/carer ratings should be included wherever possible.

- Results of outcome measures will be included in summary of need documentation, apart from HoNoS which is recorded separately in the electronic case notes.

- Professionals referring their clients to the team will be asked to complete these outcome measures prior to presenting at the team meeting. The care coordinator will be available to assist with this as necessary.

- Care coordinators will update these outcome measures at the time of CPA review. This should therefore happen every three to six months. They should also be updated at times of major change (i.e. admission, discharge or life event).

- All outcome measures will also be updated prior to discharge from the assertive outreach team, as part of the transfer CPA.

- Supervisors will review these outcome measures at each session with the care coordinator, and remind/encourage their use as necessary.

- Once again, the team were impressed by the speed and ease of administration with this tool, and those who were unfamiliar with it found it easy to learn. As it has been developed specifically for use in the assertive outreach context, the team also felt it was particularly relevant to this setting and it addressed the practical aspects of engagement which staff feel are most immediate to their daily practice.

Camberwell Assessment of Need

The Camberwell Assessment of Need Short Appraisal Schedule (CANSAS) assesses the health and social needs of people with mental health problems (http://www.iop.kcl.ac.uk/opwervirtual/?path=/hsr/prism/can/adultcan/cansas/). The short version is intended for routine clinical use, and is rated on performance over the past month. There are 22 items in the CANSAS, which cover the following topics: (1) accommodation, (2) food, (3) looking after the home, (4) self care, (5) daytime activities, (6) physical health, (7) psychotic symptoms, (8) information, (9) psychological distress, (10) safety to self, (11) safety to others, (12) alcohol, (13) drugs, (14) company, (15) intimate relationships, (16) sexual expression, (17) child care, (18) basic education, (19) telephone, (20) transport, (21) money, and (22) benefits.

Scoring is based on whether any difficulties exist in each area, and whether clients are getting sufficient assistance to manage them. There are three possible responses: no need, met need and not known. This assessment can differentiate between current and pressing problems, and those that are ameliorated by help.

The team chose to use the short version of the scale, as members felt this was most likely to result in successful engagement for the client as it doesn’t take very long to complete. It overlaps with the HoNoS on several dimensions, but the team felt its need perspective and greater level of details produced clinically important information which reflect quality of life more effectively. The CANSAS also supports the team in becoming a needs-led service, and enables client and carer views to be recorded in a formal manner.

Drug Attitudes Inventory

The Drug Attitudes Inventory (DAI) is a standardised assessment developed to measure what clients thought about and experiences of psychiatric medication (http://www.psychia-
tryinpractice.com/AssessmentTool/DRUG-ATTITUDE-INVENTORYDAI10-DAI10.aspx?f1=3&i2=3. It has proven internal consistency, high test-retest reliability and a high correlation has been noted with medication compliance and treatment outcome. Versions of the Drug Attitudes Inventory are also available in several different languages, which could prove useful in more multicultural areas such as London.

There are 10 items on the short version of the Drug Attitudes Inventory (DAI-10), which are rated from the client’s perspective. These take the form of true and false questions, and are compared with the template of the results of a fully compliant client. From this a positive or negative score is compiled, which indicated the level of compliance or non-compliance.

When considering which outcome measure to use for medication issues, several other alternatives were available. The resulting discussion highlighted the different side-effect profiles of typical and atypical drugs and the fact that not all clients suffer side effects anyway. The DAI was therefore chosen for its focus on compliance, which is a treatment factor for all clients. The tool itself was thought to be minimally intrusive and very accessible to clients, and most of the team members were already familiar with its use.

Drugs and alcohol use screens

These two scales were developed to assist clinicians assess and monitor drug and alcohol use in people with severe mental illness (Drake et al 1990; McHugh et al 1995). The tools are based on clinician observations and six items are measured on each, based on stages of change and motivation. Both of these scales have a test–retest reliability of close to 100 per cent, and also score highly for inter-rater reliability.

The dual diagnosis specialist in the team initially presented a package of outcome measures, but noted that some of these were not specifically designed for clients with dual diagnosis. The fact that DUS and AUS were decisive in the team choosing them as primary outcome measures, along with their being based on the relatively familiar stages of change format. However, the team noted that the format of the tool was difficult to understand at times and requested further training in this tool before its implementation.

How could this system be implemented?

For simplification, and in recognition that the discarded outcome measures may still have clinical use, a system of categorisation was proposed. The HoNoS was identified as the only compulsory outcome measure, while those chosen by the team became known as the primary outcome measures. All the others that had been collected were designated as secondary outcome measures, which clinicians could use at their discretion to address issues pertinent to individual clients. The team agreed that such a system was useful in demonstrating which were to be applied universally without forgetting that other options also existed.

Throughout this process, team members often expressed the need for this system to be workable, and for the information gathered from the outcome measures to be used in a meaningful way that integrated with current systems. In common with all assertive outreach teams, staff are under considerable pressure from the workloads produced by this approach and were keen to not "bite off more than they could chew". This was a decisive factor in choosing HoNoS as the primary measure for symptoms, as this tool was already in regular use. Similarly, the decision to use the trust's risk assessment tools promoted integration with existing systems.

The timing of application was also discussed in some depth, and it was found that the natural milestones of the CPA process coincided with the recommended frequencies for many of the outcome measures. The following policy for implementing this system was therefore designed with all these factors in mind (see Box 1).

So will it work?

The team recognises that it is still early days, and that a review is scheduled to take place in from six to 12 months’ time will be the true test of the system's efficacy. However, at this point in its development several advantages and disadvantages have already been identified (see Box 2).

The decision to develop this system collaboratively with the team appears to have been a successful strategy, generating comments such as ‘I feel like I really understand it now’ and ‘Thanks for seeking our opinions’, which show a level of appreciation from clinicians.

Where do we go from here?

This system is only now being put into operation. The following steps are still to be undertaken to complete its implementation:

- South London and Maudsley NHS Trust has adopted an electronic records system called patient’s journey, which includes a section dedicated to assessments. The team have approached the information technology department about how this system can be linked to the CANSAS, DUS and AUS.

Box 2. Advantages and disadvantages of this system

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<th>Disadvantages</th>
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<tr>
<td>The entire team has had a chance to contribute to its development, with representations from all disciplines.</td>
<td>All the measures are relatively crude and give only a general idea of outcome.</td>
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<td>Two of the outcome measures can be client rated and one can also be carer rated. However, if service engagement is poor most can also be rated by staff.</td>
<td>It will add somewhat to existing caseloads, and there is a potential for outcome measures to be ‘forgotten’.</td>
</tr>
<tr>
<td>There is potential for the team to provide informal training in their use to referrers, disseminating this area of development.</td>
<td>Copyright issues may lead to them not being available for use on the patient journey electronic system.</td>
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- A trust-wide assertive outreach forum has been proposed to disseminate this system to other teams to promote standardisation.

- The deputy manager of the team will be responsible for overseeing and encouraging the continued use of this system, and will work in collaboration with the clinical governance department to produce regular reports of the outcomes.

- Some members of the team have indicated they would like further training in the use of these outcome measures, particularly for the CANSAS, DUS and AUS.

- The team hopes that by sharing its experience other assertive outreach teams may find their own relevant ways of implementing outcome measure and demonstrating their effectiveness. We owe it to ourselves and the carers and, most importantly, to the clients. 

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References


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