

Evaluating community care

Paul Clifford describes the work of the Society's Centre for Clinical Outcomes, Research and Effectiveness.

BARELY a week goes by without a highly-publicised incident involving an ex-psychiatric patient. The media headlines proclaim yet another failure of community care and serious incident inquiries blame inappropriate discharge from mental hospital, failure to detect risk and poor co-ordination of services. The story is so familiar that the average member of the public could be forgiven for thinking that mental health professionals spend the day with their feet up reading the newspapers, barely looking up as their patients wander off into the streets to assault an unfortunate relative or member of the public.

If the media representation is inaccurate, what is the reality? Are mental health services really failing to meet the needs of some of society's most vulnerable individuals? Or are they doing a valiant job in difficult circumstances? Unfortunately, no-one really knows. There is remarkably little information as to whether patients seen by mental health services get better, happier, sadder, madder or badder as a result of their treatment.

How to evaluate outcome

One reason for the lack of information is the practical difficulty in deciding upon and collecting the right type of data. This is illustrated by considering the differing emphases of the three major planks of national mental health policy, which are:

- *community care*, which is based upon the proposition that quality of life is enhanced if people can remain in the community rather than spend long periods in hospitals many miles from their homes;
- the *care programme approach*, which requires the clinician to undertake a comprehensive health, social and risk assessment, to nominate a key worker, to formulate an appropriate care plan and to communicate its contents to relevant parties, including the

- patient and General Practitioner; and
- the *Health of the Nation* which sets objectives for improving the 'health and social functioning' of people receiving mental health services.

Each of these policies suggests a different approach to evaluating outcome. The 'quality of life' emphasis of community care suggests that 'impact upon quality of life' should be the main focus of measurement. 'Quality of life' is a subjective concept and implies that outcome should be measured from the patient's point of view. In contrast, the care programme approach is procedural in emphasis: the immediate 'outcome' should therefore be that certain things have been done and that the patient is aware that they have been done. Finally, the *Health of the Nation* focuses on 'improvements in health and social functioning', suggesting the use of more objective clinician-based measures of change in health and social status.

In order to evaluate mental health services accurately, all three perspectives need to be represented. In fact, a modern outcome system needs to meet all the criteria shown in Table 1.

This is the challenge that CORE has taken up in its Outcomes Initiative.

Taking the initiative

CORE is The British Psychological Society's Centre for Clinical Outcomes, Research and Effectiveness. It was established in late 1995 with a grant from the Department of Health and is based at University College, London with the main aim of promoting 'clinical effectiveness' in the NHS through the development of tools such as clinical guidelines and outcome measures.

In November 1997, CORE announced its Outcomes Initiative*, designed to answer for the first time basic questions about the impact of mental health services upon their users. In order to do this a battery has been developed, the 'Core Assessment & Outcomes Package', which captures all three perspectives on evaluation described above. The battery includes:

- a 'Core Assessment' which looks at objective changes in the patient such as recovery from illness and improvements in daily functioning;
- a brief questionnaire called 'Your Treatment and Care' which examines the extent to which assessment and treatment have been carried out appropriately; and
- a self-report questionnaire 'How Are

Multi-axial	measuring outcome along health, social and functional dimensions
Multi-perspective	investigating outcome from both clinician and user perspectives
Multi-functional	-serving multiple purposes (e.g. assessment and measurement)
Multi-disciplinary	acceptable and usable by all members of a multidisciplinary team
Multi-agency	effective as a form of communication between health and social agencies
Multi-site	to establish norms and enable 'benchmarking' comparisons to be made

Table 1: The 6Ms of a modern outcome system

You?' which uses everyday language to ask the patient to describe the subjective impact of treatment on his or her daily life and experience.

The project aims to collect high quality data on samples of patients drawn from services around the UK. The results will provide for the first time an in-depth picture of how mental health services really work — where they help, where they do not, and therefore where improvements can best be targeted so as to have a measurable and demonstrable impact on patients.

Early results will not be available until the end of 1998, but perhaps most significant to date has been the reaction of mental health practitioners and managers to the initiative. The response has been remarkable: at the time of writing it is anticipated that at least 30 services will be involved by the middle of 1998. It seems that the mental health professions themselves are beginning to recognize that information on outcomes needs to be part of modern clinical practice and service planning. If so, the sensational headlines could soon be replaced by a

more considered debate about how best to improve mental health services to produce the maximum benefit for patients.

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