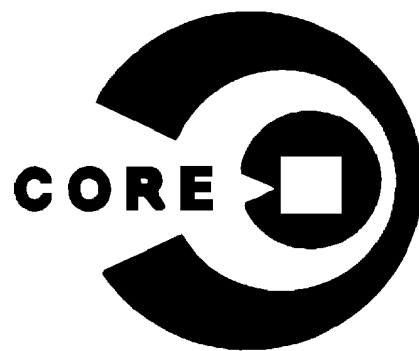


# **Outcome Assessment in Routine Clinical Practice in Psychosocial Services**

**David Sperlinger**



**Measuring Outcomes in Routine Clinical  
Practice: Paper 1**

*Outcome Assessment in Routine Clinical Practice* was written by Dr David Sperlinger on behalf of the British Psychological Society's Centre for Outcomes, Research and Effectiveness.

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Division of Clinical Psychology, 2002**

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## 1. Introduction

It is fundamental to the relationship between a user of a service and a clinician that the user should derive some benefit from that relationship. But how can it be determined whether benefit has occurred and how might one go about trying to define or measure such benefits? These are key challenges facing psychosocial services that want to develop systems for the routine monitoring of outcomes.

This paper is the first of a series to be produced by the Centre for Outcomes, Research and Effectiveness (CORE), which aim to provide evidence-based, practical advice on what measures might be used and about their implementation in clinical practice. (The paper has been produced in collaboration with the Division of Clinical Psychology, but will be of relevance to all applied psychologists working in clinical settings.) These papers will concentrate on issues relevant to outcome measures in routine clinical practice. They will not address the use of such measures in formal psychotherapy outcome research studies, which raises rather different (if related) issues when compared with their use in routine practice.

A distinctive aspect of the papers will be their focus on relevance to the National Health Service (NHS), in terms of, for example, the availability of UK norms and a concentration on measures currently being used in NHS services. Future papers will concentrate on specific measures or groups of measures. These measures will be examined in relation to specific disorders or problem areas or in terms of their relevance for particular user groups. The process for producing these reports is outlined in Section 5 below. Most of the existing literature on outcome measures focuses on symptoms of mental illness in adults of working age (and, to a much lesser extent, children). The literature with other groups or problems is sparse. In these latter areas, CORE will review what is available and make recommendations for the development of measures or databases where no adequate ones currently exist.

Many diverse definitions of the term “outcome” have been proposed. Berger (1996) provides a helpful outline of some of the issues and problems with such definitions. For the work to be undertaken here the following definition will be used:

The assessment, during or after having received services, of behaviour, states or adjustment, which are significantly related to the reasons for the person having sought care.

One key element of this definition is its emphasis on the reasons for seeking care. If help were sought for tackling a specific phobia then the kind of outcome measure that was relevant would be very different than if one was trying to evaluate outcomes in a forensic situation, where one might be dealing with a disabled, heterogeneous population with long-standing difficulties. Similarly, there will be very different issues involved in trying to evaluate the outcome of a request for help in supporting a group of staff deal with a traumatic incident. These are all situations where the evaluation of psychosocial interventions may be important. It is also important to recognise, as Berger (1996: 23) has pointed out, that

the outcomes of psychological interventions are the amalgam of a complex of factors and that attempts to assess such outcomes need to take account of the complexity.

Related to this, there is also a need to address the role that the measurement process and instruments themselves have on what ultimately constitutes the outcome data.

This complexity means that it is vital to be clear about the purpose for which the information about outcome is being collected and from whose perspective (user, clinician, carer, service commissioner, etc.). The answers to these questions will be major determinants of the measures utilised and how the measurements are undertaken. If the collection of such information is to be something more than an additional irritating and burdensome task for those involved, then the process must lead to the production of information that is useful, relevant and meaningful. This will require that there is a system for ensuring that data collected are interpreted and made sense of and this, in turn, will generally require that there is some form of comparative data against which the particular results can be evaluated.

It is important to differentiate measures of user satisfaction from other outcome measures. As Ruggeri (1996) notes, in her helpful review, satisfaction is a complement of, rather than a substitute for, measurement of other outcome variables. In particular, measures of user satisfaction tend to look at the way a service is provided rather than the clinical outcome, and there may not be a direct relationship between measures of satisfaction and outcome. In addition, compared to other kinds of outcome that are usually measured by standardised scales, satisfaction measures are sometimes tailored to specific service configurations. Nevertheless, measures of user satisfaction provide one very important tool in assessing the quality of services, which can provide information about outcome that is not tapped by other sources of information.

This paper focuses on three central questions that services and clinicians need to consider in relation to outcome measures:

- Why measure outcomes?
- How should outcome measures be implemented in clinical practice?
- What criteria should inform the selection of outcome measures for a particular service?

## 2. Why measure outcomes?

Current government policy puts high-quality care at the centre of its programme for reforming the NHS. The quality assurance framework outlined in *A First Class Service* provides the structure for achieving this (Department of Health, 1998). It includes, for example, the setting up of the National Institute of Clinical Excellence (NICE) and the Commission for Health Improvement (CHI). One important element of this strategy is the need to provide services that are of demonstrated effectiveness and this has now resulted, for example, in the production of a guideline on treatment choice in psychological therapies (Department of Health, 2001). Adequate information about service performance is also an essential element in the review and development of services. Initial reviews of services by CHI, however, led its Director to comment on “the general poverty in adequate measures of clinical outcomes” (Health Service Journal, 2000).

In addition to these political imperatives, there are also ethical and professional imperatives for psychologists and other staff to ensure that the services that they provide for users are, in fact, meeting user needs and being delivered in the most effective and appropriate manner. There is an increasing demand for the development of systems to ensure that clinicians are providing high quality and effective treatments. The measurement of clinical performance (including outcome) is likely to be central to meeting this demand. In this context, providing practitioners with regular feedback on the outcome of their work may well become part of regular personal development reviews of their practice.

Many of the difficulties found in trying to measure clinical outcomes in psychosocial therapies will be equally applicable to physical treatments. However, there are also some issues that are particularly problematic in relation to psychosocial treatments. For example, the changes aimed at in a psychosocial intervention may be indirect – that is they are designed to result in changes in the user through changes in the system in which the user is embedded. In this situation the intervention may not directly involve contact between the user and a clinician (e.g. where the clinician is working with staff in a residential service). The further that the services to be evaluated differ from an outpatient/adult mental health model, the more varied the kinds of “outcomes” it may be appropriate to consider.

The specific outcome measures to be used by particular services or clinicians will be dependent on the purpose for which they are required. Outcome measures are not an end in themselves, but a tool to enable clinicians and others to reflect on their work and to facilitate the improvement of the services provided to users. Examples of potential uses for outcome measures include:

- To compare outcomes between similar services (e.g. psychological therapy services provided to outpatients as part of a Community Mental Health Team or services for people with learning difficulties; counselling services in primary care; family therapy services for children) in different areas.

- To compare outcomes between individual clinicians working in the same service, in order to see if they are achieving comparable results.
- To compare outcomes between different user groups within the same service; for example, is the service achieving better outcomes for users with depression than those with anxiety or with white users than with those from ethnic minority groups?
- To help individual clinicians answer the question of whether a user that they are currently seeing is responding to the treatment they are being offered; (see, for example, Howard et al. [1996]). Lambert et al. (2001) found that providing therapists with feedback on patient change affected patient progress and the number of sessions attended.
- To provide feedback to a service about the course of response (recovery or deterioration) of those receiving help.
- As a pointer to the need for further investigation or action as part of a quality improvement process.
- To contribute to performance monitoring and audit of a service.
- To contribute to the quality evaluation of individual clinicians' practice, as part of continuing professional development and performance review.
- To evaluate the extent to which measured change in a user is clinically significant – i.e. change that makes a difference to the everyday lives of users and is not just statistically significant (see Jacobson and Truax, 1991; Kazdin, 1999).
- To provide information for the development of practice-based evidence, to help to build up a picture of the effectiveness of various therapeutic approaches with the range and diversity of problems found in routine clinical practice. For a discussion of these issues see, for example, Barkham and Mellor Clark (2000).



### **3. Implementing routine outcome assessment**

A crucial step in implementing routine outcome assessments is to get all those involved (clinicians, users, managers etc.) to acknowledge the importance of their use and to actually get them used in practice. In other words, the use of outcome measures needs to be implemented in a systematic way, which takes account of all stages of the process (from the decision about the reasons for collecting outcome measures through data collection to the dissemination of the results) and which recognises that what is required is a culture shift to seeing outcome measurement as an inherent part of clinical practice. Milne, Reichelt and Wood (2001) is one of the few reports which describes a clear and carefully thought out implementation project to introduce an outcome measure in routine clinical practice. Additionally, the Division of Clinical Psychology's Children and Young People's Special Interest Group (SIG) has produced a paper which outlines some minimum standards for psychologists working with children in relation to evaluating outcomes (Wolpert, Wilkinson and Fuggle, 2001).

There are several key decision areas in relation to implementation that need to be addressed.

#### *Deciding why the information will be collected*

As has been emphasised above, the crucial first step in the implementation process is to get clear agreement amongst all those involved about why there is a need to collect outcome data. What are the questions to which the service and clinicians want the data to provide answers? Unless the purpose of collecting the data is clear and agreed beforehand, then any findings are likely to be seen as irrelevant and there is unlikely to be a commitment to using the data that is collected and analysed.

#### *Deciding what information to collect*

A careful balance needs to be struck between collecting all information that might be relevant or of potential interest and what can realistically be managed in a particular situation given the resources (in terms of time, personnel, costs etc.). Clear decisions need to be made at an early stage about which outcomes are of particular interest and which measures will best reflect those outcomes. One factor to consider, in order to encourage clinician involvement in the process, is whether the measures selected also add value to day-to-day service provision by providing relevant data for clinical decision-making. It will facilitate this process if practitioners are encouraged to see that thinking about outcomes from the outset can help to ensure that interventions are delivered in a focused way and will help them keep in mind what the therapy is attempting to achieve.

#### *Deciding how the information will be collected*

Considerable thought needs to be given to the systems for administering the measures in practice, as this will have a significant bearing on the extent and quality of

the data obtained. For example, if the measure is to be completed by the service user, issues that will need to be considered include:

- How will users be sampled? Will all users entering the service be asked to complete the measure or only a subsample? If the latter, how will the sample be selected and by whom?
- When will the measure be given? At what stages of the therapeutic process will it be expected that measures will be completed (e.g. preassessment, assessment, during treatment, at the end of treatment, follow-up)?
- Who will arrange for the forms to be given out and collected? Will this be done by an administrator or by the clinicians themselves?
- What information will be supplied to users about the purpose of collecting the data and the uses to which any results obtained might be put? What issues are raised by the proposed process in relation to user confidentiality and consent? In the study by Stedman et al. (1997) focus groups of users who had completed outcome measures reported that issues about confidentiality and anonymity were among the key concerns that were raised.

Similar issues (about sampling, timing, administrative arrangements, etc.) will need to be considered where the person completing the outcome measure is not a user but a relative or clinician, in order that the information is collected and utilised in an optimum manner. In particular, the concerns of staff about the additional demands on their time from involvement in an outcomes assessment project need to be seriously addressed; see, for example, the issues raised by staff in four teams being asked to use the Health of the Nation Outcome Scales in Milne et al. (2001).

### *Maintaining and monitoring outcome assessment systems*

It is relatively simple to start collecting outcome data. It is extremely difficult to continue to collect data in a systematic and comprehensive manner on an on-going basis. Many studies have reported relatively high levels of completion of forms by users at the time of assessment, but these rates drop off dramatically as treatment progresses and at follow-up (see, for example, Stedman et al., 1997). There is also evidence, from a study of one mental health service in Australia, that staff may have quite negative attitudes towards measuring outcomes (Walter, Cleary and Rey, 1998). It will be important to consider such potential difficulties when planning the development of a system of outcome measurement.

It is also important to recognise that there are no easy solutions to these problems. There are, however, several steps that services can take in order to minimise some of the potential difficulties. These include :

- Identify potential barriers in the service to implementation (for example, resistance from professionals or users) and develop strategies as to how concerns may be addressed and overcome.

- Identify the education and training needs of all those involved in implementing and using results from the outcome assessment system (e.g. system administrators, users, carers, clinicians, managers, service commissioners). Make sure everyone involved understands the processes involved and their rationale. Have available a clear manual outlining the procedures involved.
- Look for ways of providing benefits to clinicians from the process to encourage them to participate fully in the measurement process.
- Where possible, implement a trial of the measures to be used and the procedures to be followed. Listen to the feedback from those involved and make appropriate changes, which take these comments into account.
- Introduce systems for monitoring operational problems with the process of data collection and for making appropriate adjustments where necessary.

#### *Analysing, interpreting and using the data*

Effective systems for collecting outcome data will be rendered meaningless unless there are also robust methods for ensuring that the data are used to answer the questions that the service wanted addressed in the first place. This means ensuring that the data that are collected are analysed, interpreted and made use of within the service. Areas that it would be useful for services to address to ensure that data will be well used include:

- Deciding how and when the data will be analysed and by whom.
- Identifying if a computerised scoring and profiling system is available.
- Ensuring that the data are compared with existing benchmarking data, either from within the service or from comparable services.
- Identifying who will own the data and the results and how they will be used.
- Developing systems to provide feedback about the results to clinicians and others.
- Creating processes to ensure that the information obtained is used to inform understanding of the service and, on the basis of the findings, to review what changes may need to be made in service delivery or in the process of outcome assessment.

## **4. Criteria for informing the selection of outcome measures**

There are an enormous number and variety of clinical outcome measures in current use in clinical practice and research, particularly in relation to adult mental health. One study found that in published studies of psychotherapy outcome over a five-year period, 1430 separate measures were used, 851 of these being used only in one study (Froyd, Lambert and Froyd, 1996). Whilst in the UK, it has been noted that four recently published trials assessing counselling in primary care did not share a single measure in common (King et al., 2000). In the face of this bewildering diversity, clinicians need some clear pointers about issues that they should consider when selecting measures for their particular service.

First, it is crucial to be clear about the purpose of collecting the data and which particular aspects of the service are of interest in relation to this particular purpose. For example, if the purpose is to look at the effectiveness of a service in relation to other similar services, then it will be vital to use an instrument that is being used by other such services and where benchmarking data are available. If the purpose is to audit particular aspects of a service, then the measure selected will need to address the relevant aspects (e.g. user satisfaction, symptomatic improvement, social integration, quality of life). In other words, the content of the measure needs to be appropriate to the purpose for which data is being collected.

Second, bearing in mind the agreed purpose, it needs to be decided which participants to involve in the outcome assessment process. There is considerable evidence that outcome evaluations may vary significantly between different groups (e.g. users and clinicians) (see the discussion of these issues in Lambert and Hill, 1994). The selection of whom to obtain information from needs to be driven by the decision about which perspectives on outcome are particularly crucial to the agreed purpose.

Third, the measures should “show respect for the complexity of psychological interventions and outcomes” (Berger, 1996: 36). Berger proposes a model in which outcome is a function of a number of variables to do with the individual, the condition that has to be dealt with, the treatment characteristics and the life and care context of the user. Attempts to assess outcomes will need to take account of this complexity.

Fourth, will the results from the outcome measures be able to be presented in a form that will support clinical decision-making and communication? For example, will the results help inform decisions about whether a user needs services or what kinds of services might be needed? Even if the primary purpose is to obtain information to assist in service planning, it may be sensible to select measures that are also beneficial to clinicians and users as part of the clinical process, in order to increase involvement in the whole outcome assessment process.

Fifth, if the measures are to be used across a range of services and thus provide the basis for benchmarking activity, then it is crucial that the measures used are compatible with a range of clinical theories and practices, rather than being relevant to only one theoretical approach.

Sixth, services need to bear in mind that it is inevitable that no system of outcome measurement will ever be able to capture the full complexity of the issues to be addressed. Any system will have its flaws or areas of weakness. The options, therefore, are either not to try to measure outcomes at all or to implement the use of some measures, whilst taking into account the limitations of the information that they can provide.

In addition to these broad criteria, there are some more specific criteria relevant to evaluating particular measures that may be of importance. A very helpful review of the criteria for selecting patient-based outcome measures can be found in Fitzpatrick et al. (1998). Criteria that it would be useful to consider are that measures should:

- Be easy to use in clinical practice. This would include, for example, the measures being: easy to teach clinicians how to use, being acceptable to users in terms of brevity and clarity of wording, and understandable to non-professionals when results are fed back.
- Have good psychometric properties - such as evidence of reliability and validity - and be sensitive to detecting changes over time that are relevant to users and carers.
- Reflect issues that are important to users in relation to the content of the measures and cover the most important problem areas for the population concerned.
- Have relevant population norms and databases available, to enable comparisons to be made between the findings for the particular clinician or service and appropriate other services
- Be able to be used cost effectively on a routine basis in a typical clinical situation, without undue burden to users or staff. Fitzpatrick et al. (1998), refer to this as the “feasibility” of measures; see also the discussion of these issues by Slade, Thornicroft and Glover (1999), who emphasise that feasibility is not a fixed property of a measure but is very much context-dependent. Stedman et al. (1997) conducted one of the few studies to use a qualitative methodology to ask users and clinicians their views about the feasibility of outcome measures that they were evaluating.

## **5. Process for producing further CORE outcome assessment papers**

CORE intends to produce a series of papers looking at outcome assessment in relation to specific areas of clinical practice. The process will be overseen by a development group, made up of a range of applied psychologists and other professionals, who will set the programme of work and review all reports before they are finalised. The papers will be available as short leaflets and will also be available through the CORE website. These papers will be produced by small expert topic groups, which will all use a common methodology and approach in their evaluations. The topic groups will consist of experts from the relevant areas being reviewed. The key steps the groups will follow in producing the reports are:

- Identify relevant measures to be evaluated through literature reviews and consultations with appropriate experts in the field.
- Establish the availability of relevant information (norms, reliability, validity etc.) in relation to each of the measures.
- Implement a systematic evaluation of the different measures. Some of the key issues that will be addressed include:
  - the domains sampled by the measures (e.g. symptoms, behaviour, cognitions);
  - type of measurement involved (e.g. self-report, clinician rated);
  - psychometric properties of the measure;
  - ease of use and efficiency in a clinical setting;
  - relevance to clinical needs;
  - the suitability of the measures for use in audit and evaluation;
  - sensitivity to change;
  - availability of UK norms, differentiating clinical and non-clinical populations;
  - cost.
- Identify measures that best meet the agreed criteria.
- Address issues involved in the utilisation of the data, including data analysis, interpretation and use of the data for audit or benchmarking purposes.
- Identify issues that require further development work to enhance the use of outcome measures in the particular area (e.g. the creation of national or other major outcome databases).

The resulting papers will review the major measures in particular areas of clinical practice. They will outline the key features of the measures and how they perform in relation to the agreed criteria. The reports will then evaluate the strengths and weaknesses of the measures and suggest which measures may be particularly useful in routine clinical practice, whilst recognising that there will always be indi-

vidual circumstances which impact on the decisions of local services about which particular measure to use.

It is planned that the first areas to be looked at might include generic measures for use in outpatient or community adult mental health services, measures for use in substance abuse services, measures for evaluating psychological services for people with dementia, measures for use with people with learning disabilities, and outcomes measures for children. Some initial evaluation of outcome measures for children has already been undertaken by the Children and Young People's SIG (Wolpert et al., 2001).

## 6. Annotated bibliography of useful references on outcome assessment

- Andrews, G., et al. (1994) *The measurement of consumer outcome in mental health*. Sydney: Clinical Research Unit for Anxiety Disorders  
*A detailed and thorough review of the then existing measures in adult mental health covering five dimensions (symptoms, disability, quality of life, burden on carers and satisfaction), which formed the basis for the study by Stedman et al. (1997).*
- Berger, M. (1996) *Outcomes and Effectiveness in Clinical Psychology Practice*. Leicester: British Psychological Society  
*A comprehensive and clear outline of the key practical and methodological issues related to outcomes and effectiveness in the NHS. Provides a helpful conceptual framework for looking at the outcomes of psychological interventions, as well addressing some of the practical implications of the model for services.*
- Clifford, P. (1998) M is for outcome. *Journal of Mental Health*, 7, 19-24  
*Identifies some main features of outcomes systems in the NHS and outlines the CORE outcomes initiative.*
- Donabedian, A. (1992) The role of outcomes in quality assessment and assurance. *Quality Review Bulletin*, 18, 356-360  
*A key paper outlining the crucial distinction between structure, process and outcome and the role of outcome measurement in the process of quality assurance.*
- Fitzpatrick, R., et al. (1998) Evaluating patient-based outcome measures for use in clinical trials. *Health Technology Assessment*, 2, 14  
*Provides a helpful outline of the major criteria to consider in selecting an outcome measure. Aimed at those undertaking clinical research but of relevance in a practice setting.*
- Huxley, P. (1998) Outcomes management in mental health. *Journal of Mental Health*, 7, 273-283  
*A paper which focuses particularly on some of the wider issues in implementing systems for the collection of outcomes data, not only the selection of appropriate measures.*
- Maruish, M. (ed.) (1994) *The use of psychological testing for treatment planning and outcome assessment*. Hillsdale, NJ: Lawrence Erlbaum  
*Outlines some general issues in relation to outcome assessment, as well as having a series of specific chapters reviewing individual outcome measures for both adults and children and adolescents.*
- Slade, M., et al. (1999) The feasibility of routine outcome measures in mental health. *Social Psychiatry and Psychiatric Epidemiology*, 34, 243-249  
*Describes the concept of feasibility in outcome measurement - i.e. whether a measure is suitable for routine use in clinical settings - and how it can be maximised.*



Stedman, T., et al. (1999) *Measuring consumer outcomes in mental health*. Canberra: Department of Health and Family Services

*An outstanding Australian study which investigated six outcome measures, not only in terms of their effectiveness as measures of change, but also examining their feasibility and acceptability in routine practice. It used quantitative and qualitative methods to elicit the views of service providers and consumers/users about the measures.*

Wolpert, M., Wilkinson, I., and Fuggle, P. (2001) *Minimum standards for evaluating outcome in clinical practice*. Leicester: British Psychological Society (DCP Children & Young People SIG)

*Outlines some standards that it proposes all clinical psychologists working with children should meet in relation to evaluating outcome. It also provides guidance about factors to consider in selecting measures for evaluating outcomes in clinical practice and gives a brief evaluation of some outcome measures in current use with children.*

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# Working in Teams

## A report by the Division of Clinical Psychology of The British Psychological Society

This document is intended primarily for clinical psychologists employed within health services. It is hoped that it will be of interest and relevance to a wider readership in the NHS, including managers and other clinical professions. It is divided into three parts.

### **Part 1: Professional responsibility and accountability**

- Separates professional responsibilities from those assumed as an employee and examines the accountability relationships that pertain to each kind.
- Clarifies the legal and contractual issues that underpin the responsibilities of healthcare practitioners.
- Examines related key issues such as negligence, consent, confidentiality and the liability of employing organisations within the law.

### **Part 2: Team working**

- Describes various modes of team working in multidisciplinary services.
- Identifies a care co-ordination role that may be shared among team members.
- Examines the concepts of medical responsibility and ultimate clinical responsibility.
- Clarifies the constraints within which authority and professional autonomy operates.
- Explores issues concerning confidentiality and consent in a multidisciplinary multi-agency context.
- Provides guidelines on the achievement of effective team working for an unambiguous role for particular disciplines.

### **Part 3: What to do if...**

- Describes a number of scenarios involving questions of responsibility and accountability.

### **The appendices provide:**

- A list of documents with which psychologists working as health care practitioners should familiarise themselves.
- Questions for managers, planners and team members to consider in the organisation and operation of teams.

*Working in Teams* costs £10 to DCP members and £20 to others. To order, please send a cheque payable to *Division of Clinical Psychology* to The British Psychological Society, St Andrews House, 48 Princess Road East, Leicester LE1 7DR. **For credit card orders call 0116 252 9551.**



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