

**DEVELOPING AN OUTCOMES BASED APPROACH  
IN SERVICES FOR CHILDREN**

**BY**

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## CONTENTS

	<b>Page</b>
<b>What Outcomes Are</b>	<b>3-4</b>
<b>Some Further Terminology</b>	<b>4</b>
<b>Outcomes Based Accountability</b>	<b>5-6</b>
<b>The Need for Evidence</b>	<b>7-8</b>
<b>Examples of Evidence Based Practice</b>	<b>9-10</b>
<b>Measuring Outcomes - Designing an Assessment Model</b>	<b>11-13</b>
<b>Using the 'Spider Diagram' to Show Progress Towards Outcomes</b>	<b>13-15</b>
<b>Difficulties in Measuring Outcomes</b>	<b>16</b>
<b>SMART Outcome Indicators</b>	<b>16-17</b>
<b>Equality Outcomes</b>	<b>17</b>
<b>Wider Difficulties in an Outcomes Approach - Keeping the Focus</b>	<b>18</b>
<b>Resistance to Change and Persecutory Anxieties</b>	<b>19-20</b>
<b>Involving the Service User</b>	<b>21</b>
<b>Potential Benefits and Value of Developing an Outcomes Approach</b>	<b>22-23</b>
<b>Building Outcomes Evaluation Capacity - The Need for Training</b>	<b>24</b>
<b>Conclusion</b>	<b>25</b>
<b>References</b>	<b>26-29</b>

## WHAT OUTCOMES ARE

Many organizations are familiar with describing what they do and who they work with. But you also need to describe the changes, benefits, learning or other effects that happen as a result of your work. These are your **outcomes**.

Outcomes are the changes, benefits, learning or other effects that happen as a result of your work. They can be wanted or unwanted, expected or unexpected. It is important to collect information in a way that tells you about intended and unintended outcomes. We aim to achieve outcomes that can be identified by the service user as positive.

Willis (2001, p.139) reminds us of the statement, which the Department of Health initiatives of the 1990's were founded upon,

Social care services are likely to be most effective when they are orientated towards outcomes: concerned with, designed, provided and evaluated in terms of the results experienced by the people for whom they are intended (SSI 1993: 9).

Stewart (1998) supports this point of view, "Services are only of value if they are of value to those for whom they are provided" (p.44).

Making the connection between Systematic Practice and an Outcomes based approach, Thompson (2008, p.3) summarises three key aspect of this approach,

- What are you going to achieve?
- How are you going to achieve it?
- How will you know when it is achieved?

Friedman (2005) outlines a clear way of evaluating our work using this grid

**Program Performance Measures**

	Quantity	Quality
Input Effort	<b>How much service did we deliver?</b>	<b>How well did we deliver it?</b>
Output Effect	<b>How much change / effect did we produce?</b>	<b>What quality of change / effect did we produce?</b>

How much we delivered is easy to quantify and how well is also not too difficult. For example, we delivered 10 therapy sessions, following all of the professional standards. The next two quadrants can be more challenging to evaluate – how many people benefited from our service and what was the quality of their benefit. In an outcomes model we are primarily concerned with these last two quadrants, whereas in a process model we may be more focussed on the first two.

## **SOME FURTHER TERMINOLOGY**

### **Intermediate outcomes**

Steps along the way towards the end outcomes. They are often smaller changes that need to happen before the final, desired outcome can be reached.

### **What outcomes are not**

The term 'outcomes' is often confused with other terms used during project planning. Outcomes are most often confused with 'inputs', 'outputs' and 'impact'.

**Inputs** are all the resources you put into the project to enable you to deliver your outputs. Inputs may be human, material or financial, or can be expressed as time.

**Outputs** are all the products and services you deliver as part of your work. Examples of outputs are: training courses, support sessions and publications.

Whereas an outcome is the change occurring as a direct result of project outputs, **impact** is the effect of a project at a higher or broader level, in the longer term, after a range of outcomes has been achieved. It often describes change in a wider user group than the original target, and many organizations may play a part in achieving impact. It is more difficult to assess this level of change within the lifetime of a short project.

### **Outcome indicators**

Pieces of information that indicate whether expected outcomes have occurred. They can be qualitative or quantitative. It is essential to choose the right outcome indicators and focus on the most important. For example, if the desired outcome is improved health an indicator might be that the patient reports feeling better or they have required less treatment for illness.

## OUTCOMES BASED ACCOUNTABILITY

### Background

The current focus in British social policy on outcomes or results has been informed by the work of Mark Friedman (2005) in the United States. Mark and colleagues visited the UK in March 2000 to discuss their experience of applying a **“results based” or “outcomes based” approach** to planning services for children, young people and families. The publication that applied this thinking to services in the UK was influential in determining the outcomes framework that underpins Every Child Matters (ECM) and the 2004 Children Act (Pugh, G. 2008).

Since that time staff in around 120 local authorities and a number of voluntary organizations have attended events on Outcomes Based Accountability (OBA) run by the Improvement and Development Agency. OBA has also featured strongly in fieldwork with over 100 local authorities for the Narrowing the Gap project and is informing the work of the newly established Centre for Excellence and Outcomes in Children and Young People's Services (C4EO) based at the National Children's Bureau.

OBA is a conceptual approach to planning services and assessing their performance that focuses attention on the results – or outcomes – that the services are intended to achieve. It is also seen as much more than a tool for planning effective services. It can become a way of securing strategic and cultural change: moving organizations away from a focus on 'efficiency' and 'process' as the arbiters of value in their services, and towards **making better outcomes the primary purpose** of their organization and its employees.

Further distinguishing features of the approach are: the use of simple and clear language; the collection and use of relevant data; the involvement of stakeholders, including service users and the wider community in achieving better outcomes.

Seven key questions are identified that organizations should routinely ask themselves; questions that can be as useful for staff supervision as they can for monthly or quarterly monitoring:

1. Who are our users?
2. How can we measure if our users are better off?
3. How can we measure if we are delivering services well?
4. How are we doing on the most important of these measures?
5. Who are the partners that have a role to play in doing better?
6. What works to do better, including no-cost and low-cost ideas?
7. What do we propose to do?

In conclusion, the OBA approach can provide a useful framework, or set of questions, to help organizations work collaboratively to ensure that they are planning effectively and to **know whether they are making a difference** to the lives of their service users.

Since ECM there has been a shift towards outcomes based commissioning. This is designed to,

...shift the focus from activities to results, from how a programme operates to the good it accomplishes.

*Plantz, Greenway and Hendricks 1999*

Methods that are evidenced to work are favoured over ones that look good on paper but provide little evidence of success.

## THE NEED FOR EVIDENCE

Despite this shift towards outcomes the vast majority of research studies in the UK on Looked after Children have been carried out for the purposes of generating knowledge, having been initiated either by policy makers or academics.

The dearth of evaluation-type research is surprising in light of the emphasis that has been placed upon evidence-based practice. Although there has been some criticism of the principle of evidence-based practice (Webb, 2001), and debate over its feasibility (Barrett, 2003) and even meaning (Mullen, Shlonsky, Bledoe and Bellamy, 2005), it is still remarkable that there has not been more of an effort in the area of LAC to evaluate what has happened to children who are being cared for and what impact this care may have had upon them in the short- to long-term (Gallagher, B., 2009).

As we move into the outcomes culture the next phase of development will be towards meaningful evidencing of outcomes. It is clear that the independent validation of evidence based outcomes is likely to become a requirement of commissioning – the Centre for Excellence and Outcomes in Children and Young People's Services in the UK (C4EO) have already begun the process of asking providers for evidence that can be validated.

Currently there is little evidence as to what actually works in enabling positive outcomes for Looked after Children. The strongest evidence is that children who leave care with educational qualifications do better in the long term than those with few or no qualifications (Hannon, et al, 2010).

For the majority of Looked after Children a focus on improving education outcomes would seem to make sense. However, for those children at the more extreme end of the spectrum requiring highly specialized placements, achieving well at school on its own is not likely to justify the significant investment required for such a placement, as much of the cost is not directly linked to education. As Thompson (2008, p2) argues,

An emphasis on outcomes linked to the notion of value for money is clearly part of this development: how can we justify expenditure without clarity about whether we have achieved our aims – that is, produced the desired outcomes?

Therefore these services will need to evidence how approaches focussed on improving a child's overall emotional well-being and state of mental health actually make a difference in these areas in the short and long term.

To achieve this independent validation is needed in the following 3 areas,

- How well does our approach enable children to achieve the desired outcomes?
- What is the method of measurement and how reliable is this?
- How do short term outcomes correlate with long term outcomes for these children?

In a paper titled, 'Avoiding the fate of the Dodo bird: the challenge of evidence-based practice', referring to Parry and Richardson (1996, p.43), Loewenthal and Winter (2006) argue that the same challenge faces all treatment interventions.

It is unacceptable.....to continue to provide therapies which decline to subject themselves to research evaluation. Practitioners and researchers alike must accept the challenge of evidence-based practice, one result of which is that treatments which are shown to be ineffective are discontinued.

One argument against the emphasis on empirical evidence based studies is that it will lead to an overly prescriptive approach. However, Winter argues,

If the results of an outcome study will only be considered if the therapy studied is manualized, then we should manualize, being mindful that a treatment manual need not be written in the prescriptive style of *The Complete Psychotherapy Treatment Planner* but rather in terms of more superordinate principles guiding the therapist's choice of alternative courses of action (p. 43).

He continues,

To distance ourselves from demands for empirical validation is, in my view, similar to Kelly's (1961) description of the form of suicide to which he referred to as a dedicated act, in which death is chosen in preference to an anticipated relinquishing of some core belief.

And he concludes that the Dodo bird will be our favoured model of therapy and as a result our potential clients will be denied an approach that is able to combine humanity with effectiveness.

## EXAMPLES OF EVIDENCE BASED PRACTICE

### **The Anna Freud Centre's approach to evidence based practice**

([www.annafreudcentre.org](http://www.annafreudcentre.org))

One area of research which child psychotherapy and psychoanalysis has very much needed to engage with is the 'evidence-based medicine' approach to the evaluation of treatment outcomes and cost-effectiveness. This area of scientific work has become extremely important to healthcare policy and planning, and we have for two decades accepted the challenge to test our belief that a psychoanalytic approach, just like other clinical approaches, can be shown to be effective in the treatment of a variety of children's emotional and developmental problems.

Carrying out such research on an intensive, long-term treatment, which aims to achieve change across personality and development, not just in particular symptoms, is particularly difficult and expensive, and was in the past unwelcome to many psychoanalytic practitioners. We are very proud that members of the directorial team and others at the Centre have led the way in attempts to demonstrate the effectiveness of intensive psychoanalytic psychotherapy, using a variety of methodologies from qualitative and narrative approaches, through single-case experimental designs to full-scale randomized controlled trials (RCTs).

Whilst recognizing the limitations and challenges of an evidence based approach the Anna Freud Centre states that their Directorial Team – has accepted that the demand for evidence of effectiveness is legitimate and potentially facilitates improved practice, and better targeting of scarce resources. They have been encouraging and helping psychoanalysts and child psychotherapists to undertake outcome research despite its methodological challenges and the traditional antagonism towards empirical research in our field.

### **Child Trauma Academy (CTA) Neurosequential Model of Therapeutics (Houston, Texas) [www.childtrauma.org](http://www.childtrauma.org)**

Working with Dr. Perry and the Child Trauma Academy, Dr. Gaskill developed our current version of the NMT-informed therapeutic preschool. Independent research by Dr. Sharon Barfield at the University of Kansas had documented the efficacy of this approach with high-risk children (CTA website).

On this basis The Child Trauma Academy has developed an extensive programme of on-line training and supervision.

Also from USA there is,

**Multidimensional Treatment Foster Care in England programme**

Multidimensional Treatment Foster Care has been developed and evaluated in the USA at the Oregon Social Learning Center as a cost-effective alternative to residential treatment for adolescents with complex needs and challenging behaviour, including offending behaviour. The Department for Children, Schools and Families in the UK has funded two substantial programmes based on this approach.

In these examples, many years of practice and research were required to reach the point of evidence with independent validity. The foundation for evidence is first of all consistent practice.

The process of independent research encourages a culture of enquiry; openness to critique and learning that is also supportive of reflective practice. This is also likely to lead to many other benefits, such as improvement of practice in terms of both effectiveness and cost. A validated treatment programme as shown by the MTFC programme can be adapted for work with different groups of traumatized children, in different settings and in different countries.

## MEASURING OUTCOMES

Before we can begin to measure outcomes, they must be clearly defined and relevant to the service user. There must be a clear understanding of what needs to be done to help the service user achieve the outcomes. There needs to be a plan based on this understanding and there needs to be a reliable way of measuring progress towards the outcomes. As Thompson (p.7) argues, 'If we are to have an outcome-based approach, then this places considerable emphasis on high-quality assessment'.

The Ofsted report (2009) makes the following points in its summary of its national inspections,

Good assessment, which also addresses a child's emotional and physical needs, is critical to achieving the right package of support. Inspections of children's homes, fostering services and joint area reviews have found too much inconsistency in the quality of assessments of the needs of looked after children. Assessments that describe the history and experiences of the child well can fall short on analysis of the impact of key events such as loss, trauma and separation of the child's well-being, capacity for forming trusting relationships or on their perception of the world around them. In outstanding authorities, assessments are comprehensive in content and analysis and provide a proper foundation for planning the individual care of the child (p.89).

And,

Comprehensive assessments, clear arrangements for how support can be accessed, strong communications between mental health professionals and care staff, and consultation with young people about their treatment are some of the factors that underpin the most successful provision of mental health services for looked after children (p.89).

A well designed assessment tool and process is a useful way of measuring progress. The tool and process can also be designed to maximize other potential benefits.

For example in work with traumatized children at SACCS the assessment process (Tomlinson and Philpot, 2007) helped the team to:

- Think about children together providing the child with the experience of being thought about in a positive and caring way.
- Understand children better – which enables us to respond more effectively to him.
- Integrate our work between the different professional disciplines - so that everyone is working together, consistently and in a focused way to achieve the same aim – models similar to this have been referred to elsewhere by Cant (2002) as 'Joined up Psychotherapy' or by Woods (2003) as 'Multi-Systemic Therapy'. It is

not a question of which therapeutic approach is the best, but of how the different professional disciplines can combine to achieve the most positive outcomes for the child.

- Develop a shared language and approach - very valuable when working in multi-disciplinary teams.
- Evaluate our approaches – what works and what does not.
- Clarify what we need to put in place to achieve these outcomes.

Two important points by Ward (2004) on the subject of assessment,

1. You can have assessment without treatment but you certainly can't have treatment without assessment.
2. What matters most... is that the whole team is engaged both in the process of assessment and in the process of treatment.

An assessment process needs to embrace these potential benefits, but also be a reliable indicator of progress as well as being practical to administer. Prior and Glaser (2006) talk about 'clinical usefulness', which they explain as: a summary of how useful the assessment might be in a clinical setting, based on what has been said about its established reliability and validity, and an assessment of the ease with which it can be administered (p.88). Prior and Glaser go on to say that this assessment of usefulness takes account of the time and resources needed to train and administer the assessment and what comes out of it.

In the draft consultation on the framework for assessment, the Department of Health and Department for Education and Employment (1999) say that 'good tools cannot substitute for good practice, but good practice and good tools together can achieve excellence' (p.66). What is needed, then, is an intelligent approach, which embraces both knowledge and the ability to use it to best effect.

### **Designing an Assessment Model**

This section does not attempt to go into great detail on an assessment model, but aims to illustrate how it is possible to design a clear way of showing progress towards outcomes. To do this I will refer to a model developed at SACCS (Walsh and Tomlinson, 2006), a UK organization whose mission is to deliver recovery for traumatized children.

Assessments need to measure and evidence where a person is in their progress towards desired outcomes. The assessment process needs to be thorough,

People who are tempted to 'skimp' on assessment and try to move swiftly on to service provision or other forms of help are taking a very significant risk. If we are not clear about the situations we are engaging with, the goals we are aiming for and what needs to be done to achieve them, then we risk becoming involved in

complex situations without being adequately equipped to deal with them (Thompson, p.7).

Assessment can be both quantitative and qualitative. Where subjective evaluation is made, for example, by responding to a question about a child's emotional development a simple scoring system can help to make the assessment more objective.

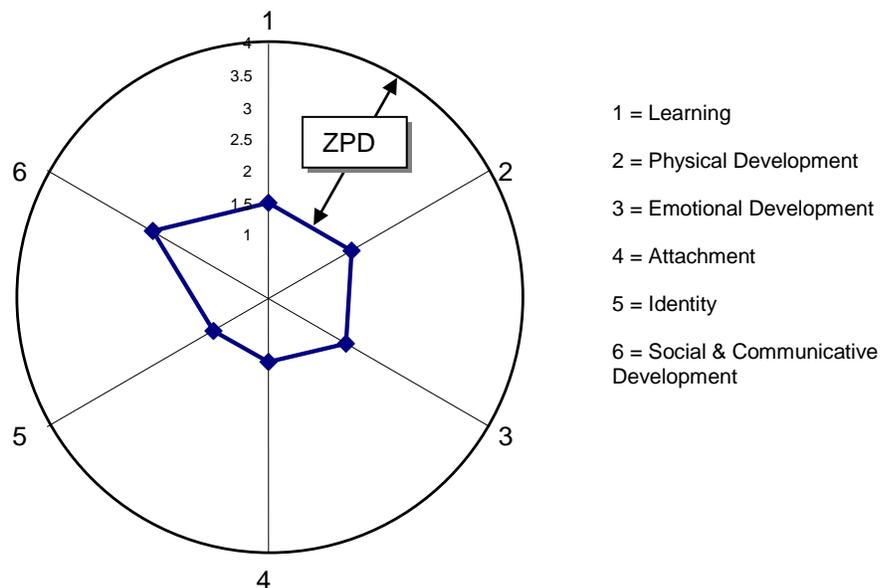
At SACCS the child is scored in comparison to what we would expect of a healthy child of similar age.

- 1** = Severe concerns; poor functioning in this area
- 2** = Substantial concerns; some signs of progress but a range of aspects to address
- 3** = Moderate concerns; one or two aspects to address
- 4** = Positive functioning in this area, possibly some minor concerns

The meaning behind these scores is further elaborated to provide more detailed guidance on what would equate to each of these levels of functioning (see Tomlinson and Philpot, 2007).

### Using the 'Spider Diagram' to Show Progress Towards Outcomes

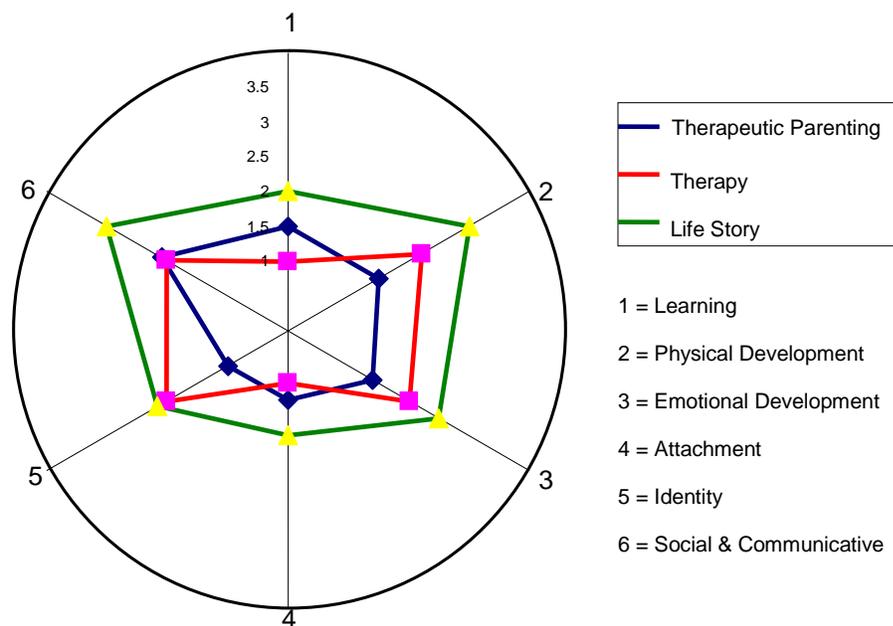
To help get a picture snapshot of the child and her development a spider diagram is used, sometimes also called a radar diagram.



Six developmental outcome areas are represented by the six axes. The child's score is plotted along each axis and the points are joined together to create a shape within the circle. This is done by taking the average score (between one and four), from the series of questions under each area. For example, the average score of the four questions under learning, might be 1.5 and this will be plotted on axis one. The points on the six

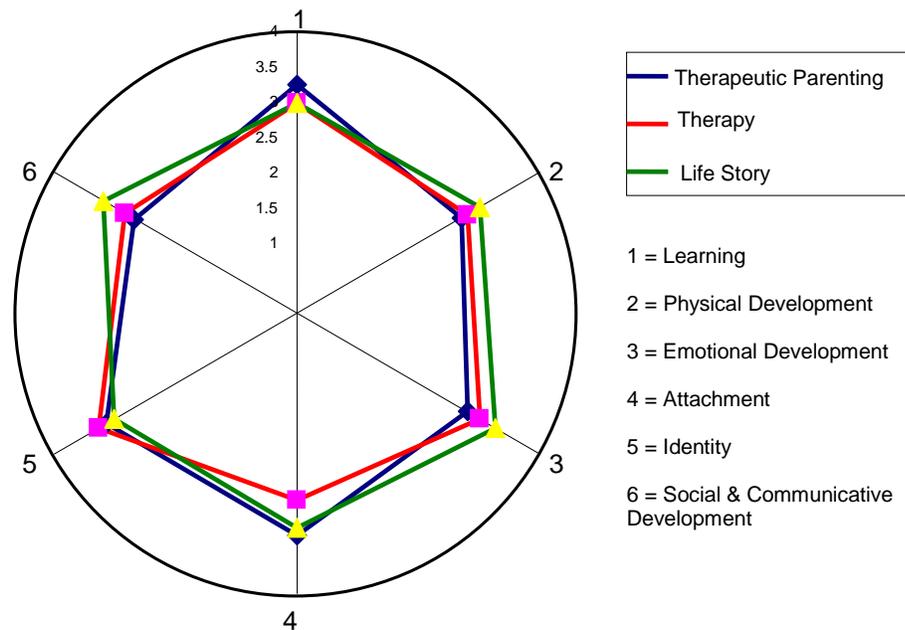
axes are joined together creating a shape representing the child's current stage of development. When we were developing our model and looking at different ways of visually representing the child's progress, the spider diagram was by far the most popular. I think this is partly because it symbolically captures the sense of the healthy child and the small or damaged child within. This could be seen as the small 'ego core' of the child as it grows over time, towards a 'well rounded child'. The outer circumference represents where a child with 'normal' or healthy development could be and the shape of the assessed child shows where the gaps are and how far there is to go. The greater the gap between the circumference and the inner shape the greater the therapeutic support the child will need. This gap is similar to Vygotsky's (1978) concept of the '**Zone of Proximal Development**' (ZPD), or, how the child is able to function on her own compared to how she could function with the input of others (Mooney, 2000). The support necessary to enable the child to move from where she is now to where she could be, Vygotsky termed 'scaffolding'. In our context this is where the therapeutic work takes place (Tomlinson and Philpot, 2007).

An initial assessment of a child by three different professional disciplines. Each discipline assesses the child independently and then compares their assessments.



As we can see, everyone sees a child who is extremely damaged in his development and who has huge needs. However, there are differences in the 3 pictures. We often see this with such a child – a child that Winnicott (1962) may have called 'Unintegrated', or Solomon and George (1999), a child with 'Disorganised Attachment'. He will be different things to different people at different times, compliant one minute and chaotic the next.

## Assessment two years later on the same child



This data suggests that the child is making good progress. The zone of proximal development is smaller; he needs less input to function to his true potential. There are still areas of difficulty and underlying fragility. We also see that the child's behaviour is more consistent, at different times, with different people in different situations. He is becoming integrated and his attachments are more secure. However, recovery is not a cure but a life long journey. As Dockar-Drysdale (p.50) has said, "I really want to jettison the concept of 'cure' at once, and replace this by 'evolvment'."

The aim is to clarify the areas where a child needs more help and support in order to progress their recovery. When considering a child's progress we should recognise that growth is not always linear. A traumatized child finding containment, warmth, safety and positive caring may need to regress in order to progress. Similarly, a child may 'take two steps forward and one back'. Recovery is not a cure but a life long journey.

## DIFFICULTIES IN MEASURING OUTCOMES

As discussed, it is often easier to measure inputs, processes and outputs than outcomes. Measuring outcomes requires a degree of user involvement and there will be resource implication to this. In a study on Routine Outcome Measurement (ROM) in UK Child and Adolescent Mental Health Services, Johnston and Gowers (2005), found that less than 30% of services carried out ROM and cite resource issues as the main obstacle.

The difficulty in measuring outcomes can contribute to the lack of focus on outcomes. For example, in work with children there may be a considerable gap between service delivery and the appropriate time to measure the outcomes. Willis (2001 p.146) argues that,

The problem with not trying to measure outcomes is that we are left with defining and measuring what is more readily measurable, the quality of the inputs, processes and outputs.

He continues,

...the danger is that managers and practitioners will spend considerable resources in measuring and seeking to improve the quality of inputs, processes or outputs that are either unimportant or possibly counterproductive to the realization of outcomes, culminating in an over-emphasis on procedural adherence at the expense of benefits for the users.

So on the one hand an outcomes based approach will put a demand on resources but on the other there may be less wastage by reducing unnecessary activity. It is important to keep in mind that the process is a means to an end, rather than end in itself.

Willis (2001 p.153) defines three broad outcomes categories – safety, happiness, development and suggests that the intended outcomes should be measured using SMART outcome indicators.

- **Specific** – people (children, parents, commissioners, practitioners, managers, etc) know what it means in practice
- **Measurable** – people know if it has been achieved, how do we measure outcomes – how reliable is this?

What is the evidence of how progress in the short term translates in the long term? Rose (1997) in his book on the outcomes of therapeutic work with troubled adolescents, describes how perceived progress within the therapeutic environment may not be sustained once the young person has moved on from that environment.

- **Achievable** – is everything in place to ensure that the outcomes are achievable. In the USA social care organizations are evaluated under four areas – Programme, Governance, Finance and Administration. Having an effective program is only one part of being an effective service. The organization also needs to demonstrate effectiveness in the other three areas if it is to receive funding.
- **Relevant** – How do we know the outcomes matter to children and young people?

If the outcomes are clearly linked to the fundamental human needs of safety, happiness and development then there can be little doubt as to whether the outcomes matter. We know that achievement of these outcomes should bode well for the child's future, though, the child may neither fully understand the significance of the outcomes, nor be willing to acknowledge whether the outcomes matter to them.

- **Time limited** – How often will we measure progress and how will we know these time periods are reliable. As already discussed, it is also not clear whether short-term measurements are a reliable indicator of long term outcomes.

The aim is to produce outcomes that are desired, achievable and measurable - DAM outcomes! (Institute of Public Care, 2006)

### **Equality Outcomes**

When measuring outcomes it is important that we measure equality outcomes, in other words to measure whether the outcomes are achieved equally by different groups receiving the same service, e.g. different gender and ethnic groups.

Every effort is made to understand and cater for individual needs, especially in terms of gender and cultural differences. However, we do not know that each child actually receives a service that is equal in quality in terms of achieving outcomes.

Whilst having the clear intent to achieve positive outcomes equally for all groups, if this assumption is not tested the outcomes for some groups could be subject to underlying discriminatory factors and/or a lack of understanding about their specific needs.

## WIDER DIFFICULTIES IN AN OUTCOME APPROACH

### Keeping the Focus

The focus of the service can easily shift from the desired outcome, to the outputs, processes, or inputs. Willis (2001) argues that this is exactly what has happened in Social Care,

the major focus of quality initiatives over the past decade has not been on defining how these outcomes might be evaluated in practice, but on standards and measures of inputs, processes and outputs (p.140).

and he cites a study by Shortell et al (2000) that 'was unable to find any link between a quality and culture and patient benefit' (Halladay and Bero 2000: 45). This is similar to the finding by Warner (1992) that there is no proven link between training and positive outcomes in Children's homes – a positive correlation was only found with leadership and clarity of purpose.

Some critics of Outcomes Base Approaches argue that a focus on outcomes detracts from the importance of high quality processes. Thompson (p.4) argues that a healthy balance is required,

I regard prioritising process over outcomes as in itself an oversimplification of a very complex situation. A focus on process that takes little or no account of outcomes can be a major waste of time and resources. What point is there in having a good process if there are no clear outcomes to justify that process and the resources invested in it? Similarly, a narrow focus on outcomes that does not take account of the importance of processes would be a very one-sided and unhelpful approach.

He also makes the point that clarity of outcomes will improve the quality of our work,

It has to be recognised that a large proportion of social work practice takes place within significant time constraints due to pressures of work. However, it would be a very serious and costly mistake to assume that, because of this, time invested in establishing clarity and focus is a luxury that we cannot afford. I would argue that unfocused practice is likely to lead to more mistakes, lower levels of trust and rapport and lower levels of worker morale and job satisfaction, thereby risking higher levels of complaints, dissatisfaction and ineffectiveness – all very costly matters in terms of use of time (p.6).

It is essential that we always keep in mind that all of our work, for example, training, supervision, assessment, consultancy, quality assurance is only of any use if it contributes to the delivery of the desired outcomes.

### **Resistance to Change and Persecutory Anxieties**

This section refers to 'Setting up clinical audit in a psychodynamic psychotherapy service: a pilot study' (Adelman et al, 2003). It highlights some of the challenges in moving towards an outcomes based approach.

With the increasing emphasis on clinical governance in health care provision, all NHS and other human services are finding themselves in the position of having to justify their work using standardised outcome measures.

Traditionally, the psychodynamic psychotherapies have been criticized for their lack of an evidence base and the services for failing to promote a culture of systematic evaluation, including that of clinical audit. This could be due in part to the reluctance of therapists to be involved in a process that could potentially affect the transference relationship with their patients. In addition, the outcome of such therapies is relatively difficult to measure. However, if such services are to continue to operate and receive funding in the modern culture, which emphasizes accountability and transparency, they will have to develop such systems of evaluation to justify their practice.

A variety of emotional pressures and anxieties give rise to taken-for-granted routines of the service and mitigate against changing these. It is the return of these feared elements in the work which constitutes the greatest threat embodied in evaluation...the element of appraisal increases this sense of threat. Any system of evaluation can all too easily come to feel like an accusation of inadequacy (Leiper, 1994, 201).

On the other hand: the current fashion for quality assurance can be viewed with some suspicion as an inappropriate attempt to objectify difficult choices about values and priorities, and to dispense with inevitable conflicts and uncertainties by hiding behind the appearance of scientific method (Leiper, 201).

Thus, senior staff may be uncomfortable with a process that they see to be politically necessary but of dubious clinical value, and that they know is going to add a burden to already overstretched staff. Clinical audit lends itself well to quantitative data such as length of waiting lists or type of therapy offered; it is less easy to apply to complex areas such as 'psychic change' or quality of relationships. However, such views are open to challenge; increasingly, the NHS requires accountability from its staff, much as insurance-funded treatments do in other countries, and complexity is no defence against the requirement for data. The *International Psychoanalytic Association Research Conference (2002)* had outcomes as its topic, 'What Works?', which is an acknowledgement of the widespread and pragmatic need for these measures.

In addition, the emotional burden of working with psychotherapy patients should not be underestimated. Trainees may find it hard to tolerate even staying in the same room for 50 minutes with a patient who stirs up feelings of helplessness, guilt, irritation, frustration, boredom and despair. 'Forgetting' to complete the additional tasks (of

evaluation) may, in part, be an unconscious enactment of 'hate in the countertransference' (Winnicott, 1975). They can then unconsciously experience the increased demands for openness and accountability as an envious attack on the privacy and autonomy of psychotherapy practice, with the result that they unconsciously resist the reasonable expectations that ordinary monitoring and measures of outcome be applied.

Psychotherapy has been seen as a soft target for cost cutting, whether by freezing posts or abolishing whole services. Psychotherapists may be forgiven for feeling that the audit system may be advocated more with the hidden agenda of dismantling their service than of really seeking to improve it. Menzies-Lyth (1990), among others, has written about institutional defences against anxiety, and psychotherapists are not immune. However understandable, resistance to change as a collective response to the anxiety mobilized is not ultimately an option.

Developing an outcomes based approach to the point where it becomes accepted and routine will take time. Marks claims that, 'It takes a clinical unit at least a year to implement outcome measurement to the point where clinicians do it as a routine...Implementation of any audit imposes a way of working and values implicit in the measures chosen and rated' (Marks, 1998: 283).

**INVOLVING THE SERVICE USER**

It is not always straightforward to determine who the user is for whom the outcomes are intended, as there can be many stakeholders involved. Willis (2001 p.140) refers to Parker et al (1991) who “defined five groups of stakeholders in relation to child care (the public; managers and elected members; professional staff; family members; and individual children)”.

In the case of services for children, is the user the child, the parents, or the local authority? While we might expect an adult to define the service they would like and what they expect from it, asking a child to do this can be at odds with the normal process of child development. Parents might listen to their children, but they would assume responsibility for decisions about the child’s best interest. The exact nature of this varies in practice and law according to the child’s age and understanding.

I would suggest that the model should be one of including the children as much as possible, in stating their concerns, wishes, likes and dislikes but the responsibility for defining what the outcomes of the service should be lays with the parents and/or local authority.

They should hold the service provider to account in delivering the agreed outcomes. The following point made by Willis (2001), can be seen as particularly relevant to children, ‘Users may feel dissatisfied because the service was imposed on them, even though it might have a beneficial outcome’ (p.143). However, the focus on issues of choice for the user, or being involved, should not detract from determining whether the user has actually benefited from the service.

## Potential Benefits and Value of Developing an Outcomes Approach

- a. **The primary benefit that underpins all further benefits will be improved outcomes for the service user** - a focus on outcomes should mean a better service for the user. It is possible to deliver the volumes of service required in the manner agreed and at the right time to high quality standards but still not achieve the desired outcomes.
- b. The development of a coherent model, which will unify the organizations practice and further distinguish the organization's model.
- c. Improvements in the organization's understanding of an outcomes based approach and alignment between the organization's activity and outcomes. Information on your outcomes can help make your work more effective, by helping you identify what works well and what you might change or improve.
- d. Help you use your limited resources most efficiently to meet your users' needs. A clear focus on outcomes can inform the organization's strategic decision making on how to use its resources, where to make investments and where to make cut backs. How does every aspect of the organization's activity best support positive outcomes?
- e. A shared understanding of the organization's outcomes can greatly improve the team's sense of purpose. It is also highly motivating for employees and service users to see clear evidence of the outcomes of their work. Overall outcomes can link into personal targets and appraisal systems e.g. what are you doing to achieve the outcomes the organization is required to meet?
- f. A coherent model will support long term sustainability of the organization as it will become embedded, providing continuity and consistency through any period of organization change.
- g. The model, with all supporting processes and materials, will also strengthen the organization brand – for example, each child's case review can be provided with a clearly recognizable and distinct report based on outcomes achieved by the child.
- h. A consistent model used across the organization will be more efficient in terms of administrative systems, also strengthening the brand by the use of consistent paperwork, etc.
- i. Existing routine systems such as quality assurance and case work records etc, can also be used as a source for assessment and outcomes information. You may be able to use methods of outcome monitoring as an integral part of your routine work. Therefore adding meaning to the already established systems. Also, focusing on the information you need to collect, rather than on what has always been collected, could reduce the time spent on monitoring.

- j. A large organization is in an excellent position to evidence the outcomes of its work as large amounts of data will be available for analysis. A consistent approach with a large group of users is ideal for academic research and publication.
- k. A well designed outcomes approach can provide opportunities for user involvement in their own development as well as the wider organization.
- l. The process of assessment and planning will strengthen the professional networks by everyone being involved in the same processes and speaking the same language.
- m. Improvements in relationships with referrers/funders by providing clearer information on outcomes. This should lead to improvements in customer retention and the development of new customers. For both funder and provider it encourages a knowledge driven approach to practice. Both sides need to know and understand the rationale behind each outcome and to identify methods of practice that can achieve demonstrable results.
- n. An increase in the organization's value as a company by developing its intellectual property. One of the ways of boosting this may be through publication.
- o. Once established the process of assessment, outcome evaluation and planning will lead to clear identification of the best and most effective practice, and hence contribute to the culture of continuous improvement. This helps to demonstrate that your organization is a learning organization.

**BUILDING OUTCOMES EVALUATION CAPACITY - The Need for Training**

If organizations are going to move genuinely towards an Outcomes Based Approach a significant degree of training will be necessary. This is clearly outlined by Philliber Research Associates (2010) <http://www.philliberresearch.com/>, a USA organization who carry out evaluation research and deliver outcomes training.

Those who fund social and human service agencies have recognized the utility of outcome-based accountability to monitor the effectiveness of their efforts. Funders routinely ask grantees to measure their outcomes and document their results. These data are essential to separating effective from ineffective programs. Moreover, knowledge of best practices grows from evidence-based conclusions. Many agencies, however, have difficulty responding to demands for outcome accountability. Their staff members have generally received most of their training in counselling, social work, or a myriad of other disciplines, but only rarely do they have more than cursory training in evaluation. Many are 'number averse'. While they often want to know about the results of their efforts, they may be sceptical, frightened, or even hostile toward evaluation. The paperwork that may accompany gathering data is viewed as onerous and as an 'add-on' to the job.

Many funders have tried to increase the capacity of their grantees and programs to produce evaluation results. However, this task is often approached in an unrealistic way, imagining that a workshop on evaluation will be sufficient. Even when agencies are given extensive training in evaluation, they often still fail to actually implement any meaningful data collection or analysis.

Another popular feature of Outcome-based Accountability is its capacity to bring staff and outside stakeholders together in a process where they can work constructively to plan better outcomes, irrespective of seniority. Initial momentum will, however, risk being lost without a wider, long-term training strategy and frequent reiteration of the approach.

**CONCLUSION**

An outcomes-based approach encourages us all to focus on the difference that we make and not just the inputs or processes over which we have control. It is right that we should be judged by tangible improvements in the things that matter. Successfully achieving and sustaining outcomes goes hand in hand with embedding a culture of continuous improvement.

Rudy Gonzales, Director of The Lighthouse Foundation in Australia, captures the importance of this development work, and the global development of outcomes based approaches,

I agree that there is a need for an outcomes focus, we can see the benefits of the approach in our young people, but how do we demonstrate it to government? This is one of the challenges we are facing. It would be great to get some feedback about how you measure the success of the therapeutic programs? We have survived without any government funding for 18 years, but we are now in discussions with government about funding. The need to demonstrate these outcomes is vital.

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