

Editorial Commentary: Routine outcomes monitoring as part of children and young people's Improving Access to Psychological Therapies (CYP IAPT) – improving care or unhelpful burden?

Miranda Wolpert^{1,2}, Andrew J.B. Fugard^{1,2}, Jessica Deighton¹ & Anke Görzig¹

¹Child and Adolescent Mental Health Services Evidence Based Practice Unit (CAMHS EBP), University College London and Anna Freud Centre, 21 Maresfield Gardens, London, NW3 5SD, UK. E-mail: Miranda.Wolpert@annafreud.org

²CAMHS Outcomes Research Consortium (CORC), London, UK

The Improving Access to Psychological Therapies (IAPT) programme introduced in 2006 aimed to provide new mental health services offering evidence-based psychological treatment for adults suffering from depression and anxiety rather than just offering them medication, which traditionally had been the only treatment widely available (see Clark, 2011 for a recent review of the approach).

In 2011, the programme was extended to other groups including children and young people (CYP). The CYP IAPT project (see <http://www.iapt.nhs.uk/cyp-iapt/>) was conceived differently from adult IAPT in that it set out to improve the quality of care in existing (rather than new) services, whether in health, social care, education or the third sector. Existing staff at IAPT sites are trained in key evidence-based treatments, initially Cognitive Behavioural Therapy and Parent Training programmes, extending in the second year to Family Therapy and Interpersonal Psychotherapy. The programme aspires to service transformation, which is to include the implementation of session-by-session routine outcome monitoring (ROM), not only with those clinicians who have been provided with IAPT training. The challenges and opportunities provided by the introduction of intensive ROM will be considered here.

A range of patient reported outcome measures are to be completed by parents, young people or both as judged relevant by their consulting clinician (see <http://www.iapt.nhs.uk/cyp-iapt/routine-outcome-monitoring-as-part-of-iapt/>). These include both idiographic and standardised measures drawing on learning from the CAMHS Outcomes Research Consortium (CORC), Adult IAPT and the experience of international colleagues (Clark et al., 2008; Weisz et al., 2011; Wolpert et al., 2012). At assessment, families are asked to complete in-depth measures to help plan the intervention; agree key goals; and the clinician records problem descriptions and contextual information, for example, about the family situation. At each meeting thereafter, problem-specific measures are used to record symptom change, progress towards the goals is reviewed and the users' experience of the meeting is captured. Finally at set review periods, the initial assessment measures are repeated along with a service satisfaction questionnaire.

The hope is that these measures will help improve care in three complementary ways. First, feedback from

the measures will be used to inform direct clinical work, by discussing the results directly with families and also in review in supervision (Law, 2012). There is evidence that the very act of feeding back information about user-report symptoms/function and satisfaction to clinicians improves outcomes (Bickman, Kelley, Breda, Andrade, & Riemer, 2011), especially for cases which are "not-on-track" (e.g. Lambert & Shimokawa, 2011). Second, the data will be reviewed nationally every quarter to monitor the consistency of care across the United Kingdom. This will look in particular at recovery and reliable change rates for the brief session-by-session symptom-specific measures. Finally, each year the data will be modelled to produce UK intervention norms, taking into consideration moderators of outcomes such as case complexity. This information can then be fed back into the in-session feedback process, for instance, to improve detection of unusually slow recovery.

The approach is not without challenges. Compromises had to be made in choosing measures, which could both inform practice in an individualistic way with the family being seen, but also be general enough to allow national evaluation of the effectiveness of interventions provided. This had to be balanced with the need to minimise burden on families, clinicians and staff involved in implementing ROM at the service. Thus, measure reliability had to be balanced against questionnaire length; specificity of problems had to be balanced against sufficient generality. It remains to be seen if these compromises will prove problematic for the quality of information for either clinical use or evaluation.

There is strong emphasis in the development of this approach on the need for measurement to be directly meaningful to clinical practice. The approach cannot work, and may even be harmful, if the measures are introduced as a top-down bureaucratic exercise. A range of support tools are being developed to help clinicians implement these measures as part of clinically meaningful conversations and develop a stance of curiosity towards what information they might provide (Law, 2012). However, this also requires an open-minded approach by clinicians and a culture shift for some. Whilst there is evidence of service users support and demand for this approach (Badham & Young Minds, 2011), there is evidence of both service user and clinician concern that if not used

sensitively these could actually have a negative effect on clinical interactions (Moran et al., 2011).

Services are being provided with a range of free software solutions to enable data collection, and guidance on interpretation of the measures, but there will still be some burden of data entry and collation for already overstretched services. It may be that the utility of the feedback will go some way to offset the sense of burden, but this remains to be seen. Whether commissioners and others will rise to the challenge of supporting this aspect may prove crucial to the success or otherwise of such intensive ROM use.

Many aspects of this approach are new and whilst we draw on experience from earlier pilots of session-by-session monitoring in CAMHS both in the United Kingdom (e.g. the CYP IAPT pilot in Bury; see Bala & Maguire, 2011) and abroad, and from Adult IAPT, there is likely to be much for us to learn. The approach will be reviewed in July 2012 in light of the lessons learned. Time will tell whether the approach helps to improve the care children and young people receive, but we are cautiously optimistic.

Acknowledgements

The first three authors took part in the CYP IAPT Outcomes and Evaluation Group (OEG) which devised the approach to outcome measurement for CYP IAPT, which was chaired by the first author. We wish to acknowledge and thank the many people who gave generously their time and expertise in developing this approach. For a list of members of the OEG: <http://www.iapt.nhs.uk/silo/files/rom-dec11-03.pdf>.

This article was invited by the Editors of *Child and Adolescent Mental Health*. The authors have declared no additional competing or potential conflicts of interest to those disclosed above.

References

Badham, B., & Young Minds (March 2011). Talking about Talking Therapies: Thinking and planning about how to make good and accessible talking therapies available to

children and young people. Available from <http://www.iapt.nhs.uk/silo/files/talking-about-talking-therapies.pdf> See also the blog at <http://cypipt.posterous.com/> [last accessed 13 June 2012].

- Bala, P., & Maguire, C. (2011). Improving access to psychological therapies for children and young people. In W. Yule & O. Udwin (Eds.), *Increasing access to CAMHS* (pp. 35–44). London: Association for Child and Adolescent Mental Health.
- Bickman, L., Kelley, S.D., Breda, C., de Andrade, A.R., & Riemer, M. (2011). Effects of routine feedback to clinicians on mental health outcomes of youths: Results of a randomized trial. *Psychiatric Services*, *62*, 1423–1429.
- Clark, D.M. (2011). Implementing NICE guidelines for the psychological treatment of depression and anxiety disorders: The IAPT experience. *International Review of Psychiatry*, *23*, 375–384.
- Clark, D.M., Fairburn, C.G., & Wessely, S. (2008). Psychological treatment outcomes in routine NHS services: A commentary on Stiles et al. (2007). *Psychological Medicine*, *38*, 629–634.
- Lambert, M.J., & Shimokawa, K. (2011). Collecting client feedback. *Psychotherapy*, *48*, 72–79.
- Law, D. (Ed). 2012. A practical guide to using service user feedback & outcome tools to inform clinical practice in child & adolescent mental health. some initial guidance from the children and young peoples' Improving access to psychological therapies outcomes-oriented practice (CO-OP) group. Version 1.3, Feb 2012. London: IAPT-NHS. Available from <http://www.iapt.nhs.uk/silo/files/a-practical-guide-to-using-service-user-feedback-outcome-tools-.pdf> [last accessed 30 May 2012].
- Moran, P., Kelesidi, K., Guglani, S., Davidson, S., & Ford, T. (2011). What do parents and carers think about routine outcome measures and their use? A focus group study of CAMHS attenders. *Clinical Child Psychology and Psychiatry*, *17*, 65–79.
- Weisz, J.R., Chorpita, B.F., Frye, A., Ng, M.Y., Lau, N., Bearman, S.K., ... & Research Network on Youth Mental Health. (2011). Youth top problems: Using idiographic, consumer-guided assessment to identify treatment needs and to track change during psychotherapy. *Journal of Consulting and Clinical Psychology*, *79*, 369–380.
- Wolpert, M., Ford, T., Law, D., Trustam, E., Deighton, J., Flannery, H., & Fugard, A.J.B. (2012). Patient reported outcomes in child and adolescent mental health services (CAMHS): Use of idiographic and standardized measures. *Journal of Mental Health*, *21*, 165–173.