Routine Outcome Measurement in CAMHS

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Many Child and Adolescent Mental Health Services (CAMHS) in the UK routinely evaluate change in a service user's presenting difficulties, functioning and progress towards their goals over the course of treatment. Most often, this is by using questionnaires, filled in by young people and/or their parents and/or the therapist. This is known as Routine Outcome Monitoring (ROM). The benefits of ROM are that this regular feedback on progress makes it easier to spot when therapy is not having the desired effects, so that the therapist can adapt or change the intervention accordingly. This means therapy can be as effective and efficient as possible, which is good for both the patient as an individual and for resource use in the healthcare service as an organisation.

Despite the benefits of ROM, therapists have some concerns about ROM, and there are also some practical barriers to doing ROMs in clinical practice. Our study took place in a network of CAMHS in an urban area, following a service-level mandate to use ROM. We aimed to explore therapists' experiences of the use of ROM within this context.

Twenty CAMHS staff completed a survey around the time of the mandate being introduced, and again 6 months later. The survey was designed to look at how their use of and attitudes towards ROM changed over this 6 month period (quantitative data), and to find out more about what got in the way of using ROMs in practice (qualitative data).

The ROMs that were most frequently used measured symptoms of anxiety and depression, the Revised Children's Anxiety and Depression Scale (RCADS). This was used by 70% of the participants. The other ROMs that were frequently used were a goal-based outcome measure (55%) and a session rating scale (55%) which is used at the end of each session to get feedback about how the service user experienced the therapist and the session work. ROMs which track specific symptoms and ROMS that capture functioning were used less often (20%).

Therapists tended to be more positive than negative about using ROMs. Many therapists thought that ROMs could be valuable for therapists, particularly if used meaningfully in sessions, and could encourage mutual feedback within therapy. Importantly, those therapists who held more positive attitudes towards ROM used ROM more. We found that over the 6 month period, therapists did begin to use ROMs more. However, their attitudes towards ROM did not change. That is, therapists did not become more positive or negative about using ROM as a result of doing it more. The most likely explanation for using ROMs more appears to be the mandate to do so from management.

Negative attitudes to using ROMs which were endorsed by therapists included; that it does not fit for more complex cases and that is another task to do within the context of time-limited, time pressured therapy sessions. Barriers to using ROMs included therapists' concerns about the potential misuse of this data, for example, as an index of service performance when they are intended to be, goal based and person specific and not necessarily

meaningful, when aggregated across service users, without taking context into account. Other barriers included a lack of technological support for inputting and sharing the data, as well as the additional workload burden that ROMs create. Therapists noted that there are some situations in which ROMs don't seem appropriate, like in crisis work.

There are some limitations to our study which should be borne in mind when considering the meaning of the findings. Specifically, a total of 60 therapists were contacted about the study, and only 20 of these participated. It may be that those who chose to take part had particular views about ROM. Over half of our participants were Clinical Psychologists, who may have particular views of ROM due to their training, which aren't necessarily consistent with the views of those with other professional backgrounds. This study also took place in one geographical area and in one mental healthcare provider organisation (although across a number of CAMHS teams in this area).

It is important to know that simply using ROM does not necessarily change how therapists view ROMs. Identifying the barriers to using ROMs from the therapists' perspective can help services to support implementation by problem-solving. It will be useful if future studies establish whether these findings apply to other CAMHS, and more explicitly identify what facilitates using ROMs.

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