

# The meaningful use of routine outcome monitoring in a low intensity service for children and young people with anxiety disorders and depression



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Anxiety and Depression in Young people (AnDY) Research Clinic

<http://andyresearchclinic.com>

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# Overview

- Rationale for low-intensity (LI) services for children and young people (C/YP) with anxiety disorders and depression
- Anxiety and Depression in Youth (AnDY) Research Clinic
  - Current project
  - Structure and organisation
  - The first 6 months
- The importance of ROMS
- How we meaningfully integrate ROMS into the service

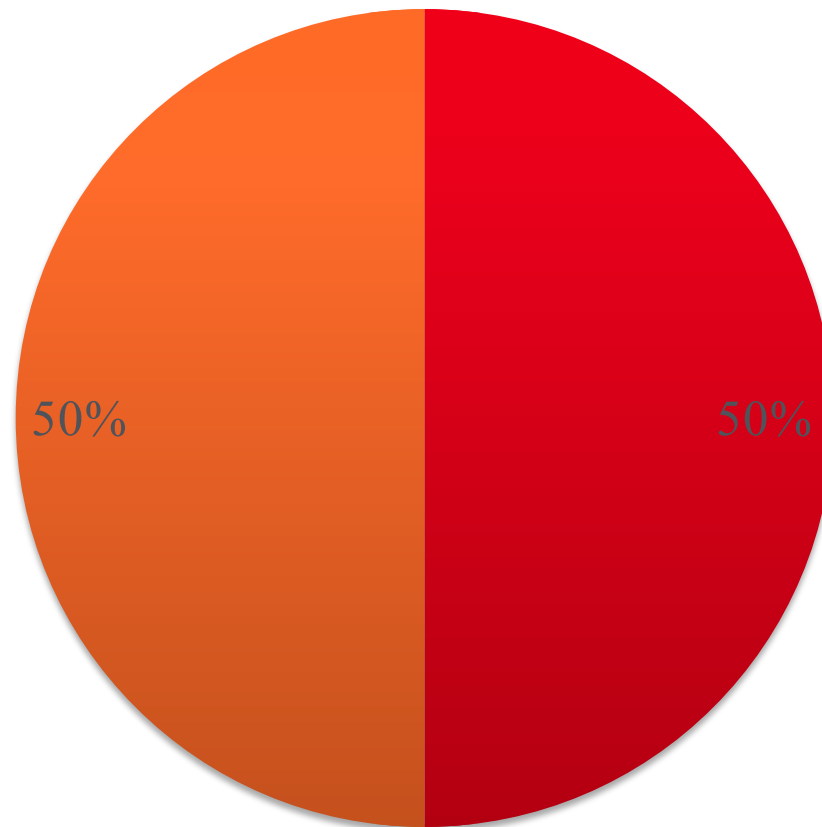


# Thanks to

- Ray Percy, Clinical Lead at AnDY Clinic, University of Reading
- Hannah Whitney, Director of CBT Programmes, Charlie Waller Institute, University of Reading

# The need for LI services

By the age of 15

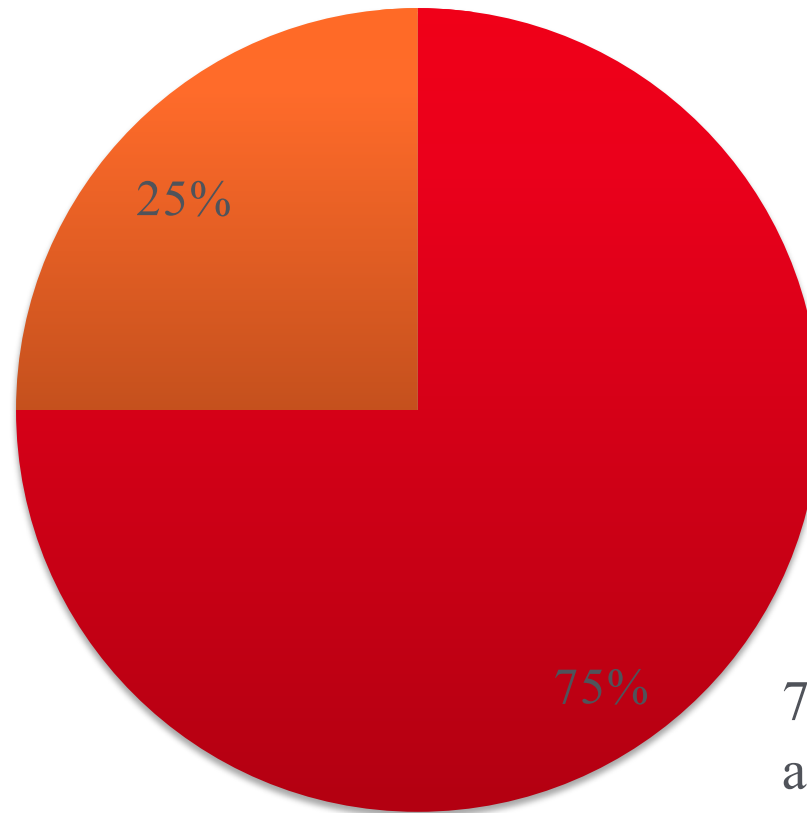


50% of mental illness in adult life (excluding dementia) has started

Murphy & Fonagy (2012)

# The need for LI services

By the age of 18



75% of mental illness in adult life (excluding dementia) has started

Murphy & Fonagy (2012)

# Anxiety and depression is common

Around 3.3% of C/YP have an anxiety disorder

Around 0.9% of C/YP have depression

(Green et al., 2005)

# Barriers to accessing support

- < 25% – 35% of C/YP with a diagnosable mental health condition access support (Green et al., 2005).
- Few C/YP who do access support receive an evidence-based intervention (Stallard et al., 2007)
- Pressures on conventional services mean that often only the most unwell C/YP are seen
- Those with mild-moderate anxiety disorders and depression *who are known to respond well to evidence-based psychological treatments* face long waits

# LI services for adults

- LI model successfully implemented by adult IAPT programme
  - Around 1.4m referrals in 2015-16
  - 81% seen within 6 weeks and 96% seen within 18 weeks
  - More than 0.5m people completed a course of treatment (typically a brief, LI intervention for anxiety and depression)
  - Recovery rates in excess of 46%, approaching those of RCTs that informed NICE recommendations
  - 62% showed reliable improvement in anxiety and depression symptoms

(NHS Digital, 2016)



# AnDY Research Clinic: Background

- AnDY Research Unit in School of Psychology and Clinical Language Sciences at University of Reading
- Committed to improving the understanding and treatment of anxiety and depression in C/YP
- Opened as a University-run research clinic in Nov. 2016
- Partly funded through local NHS Clinical Commissioning Group



# AnDY Research Clinic: Current project

- Over half way through a 12-month pilot project
  - Evaluate the feasibility and efficacy of the service
- Adopted the principles of the C/YP IAPT programme
  1. Meaningful service user participation
  2. Timely access to evidence-based interventions
  3. Collaboration between service users and primary, secondary, and specialist services
  4. Clinically-relevant session-by-session outcome monitoring used to select, guide, and evaluate treatment intervention through IAPTUS CYP



# AnDY Research Clinic: Aims

To Reduce:

- Cost of treatment - by reducing the number who need to be referred to higher intensity services
- Amount of time C/YP wait for an assessment and evidence-based psychological intervention

# AnDY Research Clinic: Aims

## To Increase:

- Number of C/YP being offered an evidence-based psychological intervention

## To Improve:

- Outcomes
- Experience of mental health services
- Understanding and treatment through recruitment into **clinically relevant research**

# Structure and Organisation

- Qualified staff (<5 WTE)
  - Clinic director (0.2 WTE)
  - Clinical lead (1.0 WTE)
  - 6x Research Clinical Psychologists (1.4 WTE total)
  - 1x Clinical Psychologist (0.4)
  - 1x senior PWP (0.4)
  - 2x PWPs (0.8 WTE total)
- Novice practitioners under close supervision (<6 WTE)
  - 6x undergraduate/postgraduate/doctoral assessors (2.0 WTE total)
  - 4x trainee CYP PWPs (3.2 WTE)

## Host service for C/YP IAPT PWP trainees

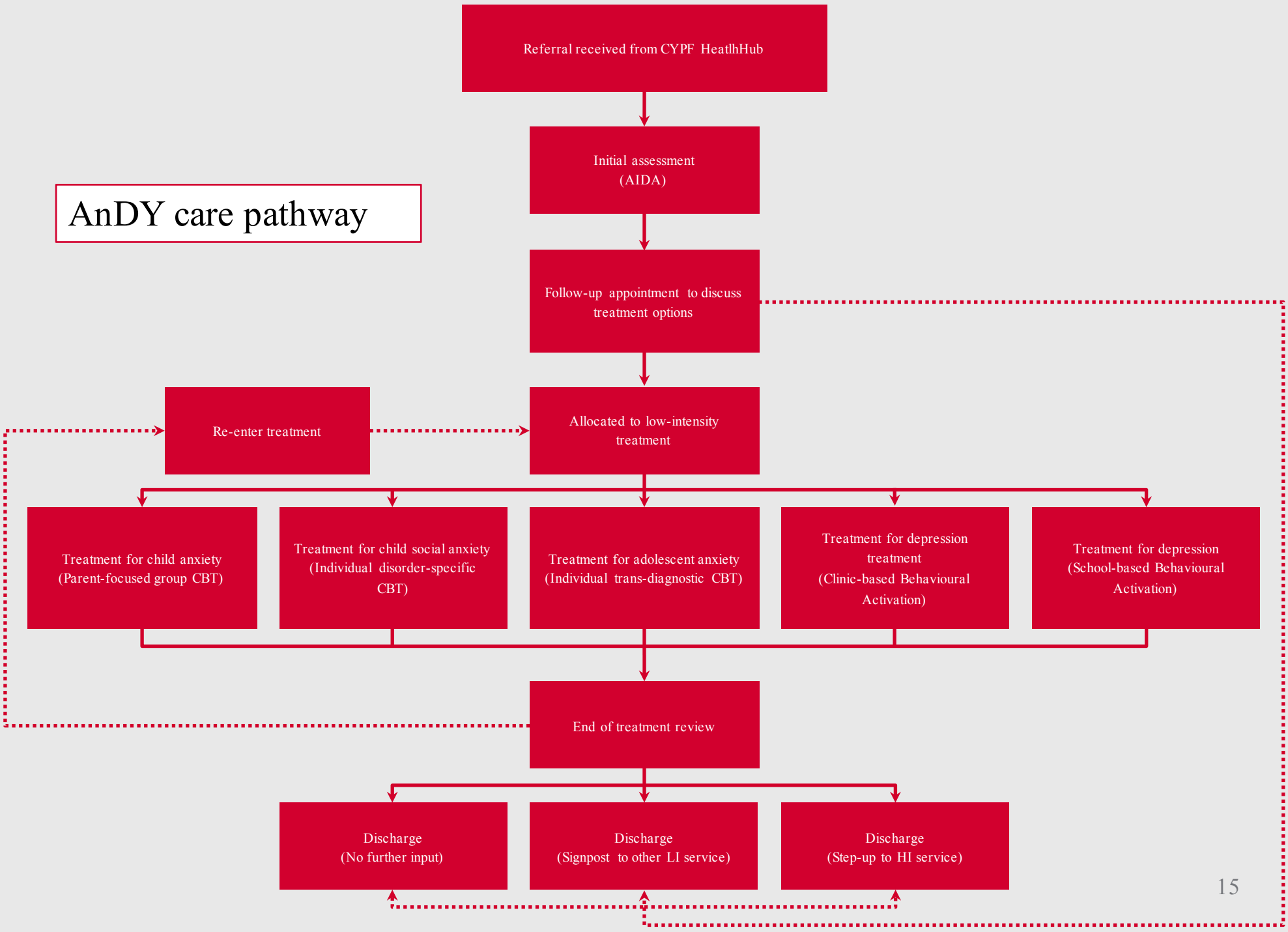
- 4 trainees
- Recruited to train for 1 year with salaries paid by Health Education England
- Carrying out assessments and delivering LI interventions
- Funding also covers supervision requirements
- Training by Charlie Waller Institute at UoR



*Charlie***Waller**  
INSTITUTE

Evidence-Based Psychological Treatment

# AnDY care pathway



# Why use ROMS?

- Improves treatment outcomes for clients; evidence-based practice
- Our clients want us to
- To develop our skills as clinicians
- To provide better service provisions that are targeted to the needs of our client populations
- Commissioning – the need to show that what we are doing is helping clients
- 90% national target for closed treatment cases and paired measure data



# Evidence for use of ROMS

- **Research suggests that we as clinicians are not good at accurately detecting client deterioration (Hatfield et al., 2010)**
- This study compared progress notes with systematic feedback on client progress (ROMs)
- Therapists noted deterioration in only 21% of cases that were worse than at the start of therapy

# Evidence for use of ROMS

- **ROMs can significantly help us detect and therefore respond to deterioration (Lambert, 2007)**
- Feedback to clinicians on whether the client was progressing in the direction expected (based on predicted trajectories)
- Reduced drop-out and led to better outcomes
- No advice given to clinicians on how to use the feedback; it was up the clinician's judgment on how to make use of the knowledge
- Particularly important for those not on track (NOT)

# Evidence for use of ROMS

Bickman et al. (2011)

- Large RCT (28 sites in 10 states) ‘real world CAMHS’
- Feedback weekly or every three months
- Faster improvement with weekly feedback
- Even better if clinicians looked at the feedback!

# Self-assessment bias

- 25% of mental health professionals viewed their skill to be at the 90th percentile when compared to their peers
- Most thought they were above average
- None viewed themselves as below average
- Clinicians tended to *overestimate* their rates of client improvement, and *underestimate* their rates of client deterioration
- Using session by session measures keeps us grounded, and improves our performance and outcomes

Walfish, S, McAlister, B., O'Donnell, P., & Lambert, M.J. (2012). An Investigation of Self-assessment Bias in Mental Health Providers. *Psychological Reports: Volume 110, Issue, pp639-644.*

## But I already ask my clients for feedback...



- Research has shown that clinicians are poor at gauging their client's experience of the alliance and they need to request more formal real time alliance feedback
- Clinicians **THINK** they ask more often than they do
- Plus, and more importantly, since the data says it's the client's point of view that is most predictive of outcome, you don't want to leave it up to the therapist to decide **WHEN** to ask

Norcross, J.C. (2010). The therapeutic relationship. In B.L. Duncan, S.D. Miller, B.E. Wampold, & M.A. Hubble (Eds.), *The heart and soul of change 2nd ed.: Delivering what works in therapy* (pp.113-141). Washington, D.C.: American Psychological Association.

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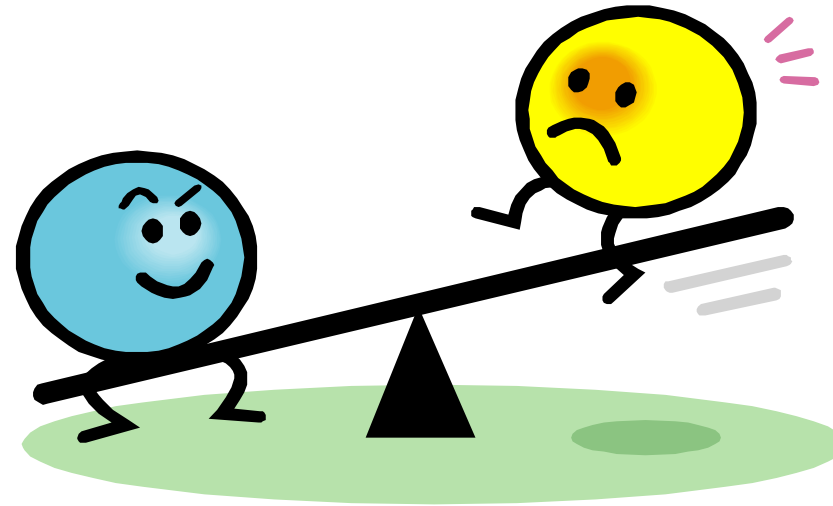
# For ROMS to work

Clinicians need to:

- Have knowledge, understanding and be familiar with measures
- See them as valuable and a good “fit”
- Be supported to use them by colleagues/manager
- Be in an organisation that prioritises measures
- Make time for use in session and interpretation
- Have the measures readily available

(Duncan & Murray, 2012; Hall et al., 2014)

# Service vs. Therapeutic Need



**SERVICE EVALUATION**

**CLINICAL MEANINGFULNESS**



**SDQ**

**ORS/CORS**

**RCADS**

**CGAS**

**Current View Tool**

**Goals**

**Symptom rating scales**

**Session rating scales**

**CHI-ESQ**

# Using Session by Session ROMs

At the follow-up assessment and beginning of treatment:

- Give feedback to C/YP (and families) around assessment measures
- Use the measures to inform our formulation, to establish shared goals, and to plan the intervention
- Use any other baseline measures as appropriate
- Select which measures to use session by session



# Session by Session ROMs

Tracking progress throughout therapy:

- Measure of functioning (ORS)
- Symptom trackers (RCADS + disorder-specific)
- Goal progress (Goal Progress Chart)
- Session rating scale (SRS)

# The first 9 months: Intervention

- 186 cases identified as suitable via triage assessment
  - 165 (89%) consented to a referral to AnDY (suggesting service is acceptable)
- Of the 110 C/YP who had completed an assessment by September 2017:
  - 94 (85%) offered and accepted a LI intervention for anxiety disorder or depression (average wait = 50 calendar days from date of triage and 30 calendar days from date of assessment)
  - 16 (15%) not suitable (e.g., needed to be stepped-up to high-intensity services)
- Encouraging early outcome data immediately post-treatment
  - 100% reported improvement in anxiety and depression symptoms at post treatment
  - 80% in sub-clinical range on RCADS A&D scale
  - No cases stepped-up to high-intensity services after treatment

# The first 9 months: Feedback

- Encouraging service user feedback
    - 87% of parents/caregivers
    - 70% of C/YP
- gave overall scores of 36/40 or above on the Session Rating Scale (SRS)



# The first 9 months: Summary

- Good progress towards initial aims
  - Now exceeding targets set by CCG – and we want to go further
  - Provided assessments and interventions in a timely manner – and we want to do better
  - Early data suggests interventions are likely to be cost effective (i.e., few stepped-up after treatment)
  - Well-received by C/YP
  - Meeting C/YP IAPT requirements for routine outcome measurement
  - Increased recruitment to clinically-relevant research
- Challenges
  - Limited resources (esp. clinic-only staff)
  - Uncertainty of CCG funding – makes planning very difficult

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# Thank you for listening

- Questions?