ROM – the Dutch perspective

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Where do we come from?

• 2008 – Start of ROMCKAP (Routine Outcome Monitoring Consortium Child and Adolescent Psychiatry) by 16 CAMH institutes – inspired by CORC!

• Mission:
  • Improve care by systematically measuring relevant characteristics before, during and after care
  • By providing feed back at three levels:
    • Individual (client & therapist)
    • Institutional (management)
    • Supra-institutional (CAMHS)
Where do we come from?

- 2009 – Start of national ROM-initiative for mental health in general
- Coalition of professional associations with health insurance companies
- National standard for assessing three domains:
  - Level of psychopathology
  - Functioning in daily life
  - Quality of life
- ROM to provide feed back for improving care, but also to be used by health insurance companies for *benchmarking*
- Health insurance companies reinforce participation through budgetary consequences
Lessons learned in initial phase

• Gross underestimation of logistic support needed within institutions
• Gross underestimation of level of difficulty of ICT
• Budgetary consequences improved participation but polarized field
• Stereotypes:
  • Professionals: ROM data are irrelevant for treatment, don’t represent quality of care, and are therefore not fit for benchmarking
  • Health insurance companies: Mental health professionals are not willing to take responsibility for quality and account for it
Zooming in on CAMH

• Minimal dataset:
  • Level of psychopathology: SDQ or ASEBA (CBCL, YSR, TRF)
  • Functioning in daily life: HoNOSCA
  • Quality of life: Kidscreen-27

• Specific problems in CAMH:
  • Enormous heterogeneity of population (from infants to young adults)
  • Enormous heterogeneity of problems (from oppositional behaviour to schizophrenia)
  • Multiple informants (parents, child, teacher)
  • Being embedded in broader services (welfare, pediatrics) and education
Zooming in on CAMH

• Comparibility at a meta-level asks for generic instruments
• Generic instruments are limited in measuring the heterogeneous population and problems in CAMH
• In developing ROM for CAMH one has to accept that important domains (e.g. Infant Mental health) and services (e.g. Consultation; Assertive Community treatment) can not yet be included
Where are we now?

2015:

- Yearly ± 145,000 DRG’s are provided by ± 140 institutes for CAMH to the Mental Health Benchmark Foundation
- In 2014 34% of the children in CAMH are covered for at least one of three domains (usually Level of psychopathology)
- Now that data are being collected, research has started
- In this phase mainly restricted to investigating their reliability and validity
- But there have been inspiring pilot studies, showing the potential of ROM
Where are we now?

2015:

• The CAMH field is divided.
  • Many professionals see ROM (= benchmark) as yet another useless bureaucratic practice, keeping them from doing what they are for: treating young people.
  • Some professionals have experienced the potential of systematic feedback on treatment, especially at the individual client-therapist level. They notice it improves their work.
Where are we now?

2015 is also the year in which:

• CAMHS are no longer covered by the Health Insurance Act (in contrast to adult MHS), but by a new Youth Act

• The Youth Act places CAMHS under the responsibility of the municipalities, as part of an integrated youth care

• Municipalities are obliged to verify whether service providers systematically assess three performance indicators: 1. Goal realization; 2. Drop out; 3. Client satisfaction
Where are we now?

• There is no telling yet how municipalities (we have over 390) will implement this
• Neither do we know to what extent the current ROM-practice can be integrated in the parameters set by the Youth Act
• Within the field covered by the Youth Act, CAMH is far ahead in the development of useful ROM and performance indicators
• Our Knowledge Centre for Child and Adolescent Psychiatry and our Association for Mental Health have a double duty:
  • Contribute to a meaningful assessment of performance indicators
  • Don’t let the knowledge gathered in eight years of CAMH ROM disappear
Where are we going to?

• Explore the combination of generic and specific measures for subgroups
• Explore Feedback Informed Treatment (e.g. ORS-SRS)
• Explore combining ROM with clinical support tools
  • e.g. informing therapist on non-specific factors, such as motivation, working relationship and social support in daily life
What makes this important?

• The effectiveness of CAMHS has to become more visible to stakeholders and society in general

• Some form of systematic assessment is essential in the continuing process of improving CAHMS
Questions (later...)

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