Tamsin Ford, Unversity of Exeter
'How do we know that we have made a difference?'
Responses to participant questions from theCORC International Conference 2016

Do you feel including societal, political and economical climates are currently taken into consideration when measuring CYP outcomes?

Tamsin: This is the context that individual commissioning groups, services and clinics need to consider when thinking about their outcomes or any change in their outcomes. I think that we all need to educate those who push for single summary measures and ignore important contextual issues that such a reductionist approach is meaningless and to encourage people to embrace the complexity of multiple measures (including those about context) from multiple informants – some with quantitative but not .

Can the AVS be applied to non-UK samples?

Tamsin: It has not been tested with non-UK samples, however the SDQ functions reasonably similarly across different populations internationally – so it could be tested against a trial that used the SDQ at two time points with the impact sample to see how it functioned – then we would have an idea – without that, it could still be used (with clinical or targeted intervention samples as that is what it is calibrated to do) with caution.

Clients seen for 1st assessment do a SDQ but then start treatment after 6-12 months. What ROM do you suggest to use at Time 2? SDQFU or RMQ?

Tamsin: I would be inclined to repeat the SDQ baseline at the beginning of treatment, but the follow up version would be OK. The only difference is the time scale over which you report – there may be conditions or clinics in which the ordinary SDQ makes more sense (a six month perspective) than a briefer one month perspective as with the follow up. The latter is shorter as many CAMHS interventions last less than six months and we want know how they are functioning AFTER rather than during treatment. For most children, these two before treatment starts will not vary substantially – but they might at follow up.

What's the rationale for the 4-8 month window needed between T1 and T2 on the PSDQ to generate the added value score?

Tamsin: This was the time scale between the baseline and follow up measurements in the epidemiological study from which the AVS is derived. The timing was based on data from a previous clinical study and the literature that suggested that vast majority of CAMHS service episodes were shorter than 6 months of active treatment.

The evidence is compelling for regular review of ROMS and feedback tools but how do we best counter resistance arising from clinician anxiety?

Tamsin: Discussion, airing the anxieties, sharing experience and emphasising that few services are universally dreadful or excellent – also keeping funding away from the measurement of outcomes.

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Wolfgang Lutz, University of Trier
'When, Why and How do Patients Change in Psychological Treatment'
Responses to participant questions from the CORC International Conference 2016

How did you decide on two focuses for intervention/archetypes (not in Jungian sense), ie problem solving vs motivation?

Wolfgang: It was just the clinical experience in what could be helpful in our outpatient setting.

What is the software you use for outcome measure data being collected on a touch screen?

Wolfgang: PsychEQ (http://www.psychoware.de/psychoeq/). My team and our software students added some tools. We got some funding from the German Research Foundation to make those tools more user friendly and accessible for other institutions ((it will take about another two years until we can make it available to everybody, it will be free).

Do you think that the willingness to be evaluated as a clinician & the expectation to have your treatment evaluated is culturally dependent?

Wolgang: No, not in the sense of a culture in a country or area. But definitively it is related to the openness to research in the culture of an institution (clinic, outpatient center etc.) or the preferred treatment approach in a specific environment (the distribution of psychological treatments as well as treatment length varies enormous between different service systems and countries).

What is the computer software which allows for caseload monitoring and allocation/looking at 'successful treatments' per clinician?

Wolfgang: PsychEQ, as before

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Bertine Lahuis, Karakter
Fritz Boer, University of Amsterdam
'ROM: The Dutch Perspective'
Responses to participant questions from the CORC International Conference 2016

What was the rationale for shifting funding from insurance to local municipalities in the Netherlands?

Bertine/ Fritz: It's a political issue. For years there was discussion on the organisation of mental healthcare for youth. For different political reasons (money, statements, personal reasons) most parties choose to bring everything regarding psychological help, including psychiatry, to the local government. There is also a general shift in thinking about healthcare (more local, not everything should be taken from the perspective of care / cure, but should be more part of life in general). Although decentralisation as a different perspective is interesting, the financial link on a local scale is a huge problem for specialized care because it is organized on a larger scale. Major amounts of money go to administration now (millions).

Do outcome measures in Netherlands help with gaining funding from local municipalities?

Bertine/ Fritz: Not at the moment. In the past we were obliged to do routine outcome measurement and if we didn't there was a financial penalty. It will probably develop with the local governments in the same way

What approaches do you take when improvement plateaus? Use other data? Discuss with CYP?

Bertine/ Fritz: In the pilots the graph is shown to them, discussed and used as an explanation for why continuing the treatment is probably not effective. It helps with SDM. However, this is all very premature. Hopefully there's more to say about this in the future.

Rather than showing stakeholders and society numbers for effectiveness, should we not change people's perspectives on how it looks ?

Bertine/ Fritz: The risk of figures and numbers is that there is the wrong interpretation of it. 'No help necessary any more' ; 'it didn't help' - this is in many situations an incorrect interpretation. The added value is the conversation that follows between patient and professional. What happened to make the line drop? Is there something going on in your life? What does it mean that we are not making any progression anymore: are we stabilised, or do we need to shift the focus? Am I still the right therapist; are we working well together etc. So, it helps the quality of the treatment, it helps the working alliance between patient and professional and it helps the professional in learning to become a better therapist. So, the value of the numbers and figures should be the conversation / feedback.

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Duncan Law, Anna Freud National Centre for Children and Families
Julian Edbrooke-Childs, Anna Freud National Centre for Children and Families
'Training to support the use of outcome measures and feedback tools in child mental health services'
Responses to participant questions from the CORC International Conference 2016

Has the training been delivered to traditionally psychoanalytically trained clinicians? How was it received?

Duncan/ Julian: The training has been delivered to a number of child psychotherapists and was well received - very creative in their thinking about how to integrate with ways of working.

What progress is being made in embedding ROMs in the clinical training, supervision and culture of psychiatry?

Duncan/ Julian: some services really welcome this for their psychiatry colleagues - we have run training for just psychiatrists in some trusts which works well (not full UPROMISE) . I would love to see ROMs as part of all core mental health training.

Would love to hear more about how we can work on clinician's attitudes and beliefs about ROMS.

Duncan/ Julian: get them to have a go and try out the tools and see for themselves

Why do outcome measures have to be formalised in a questionnaire rather than form part of the session in conversation with the client? Research evidence shows it is the written questionnaires that give an additional edge on clinical conversations - hypothesis is that this opens up more channels of communication to CYP .

Duncan/ Julian: Only a very few clinicians seem to have the ability to get good insight into therapeutic alliance and potential drop out without written feedback - see the work of Lambert, Bickman, Millar etc...

As we learnt that infrastructure/funding/reality impacts quality and use of data: is there training for top managements of trusts planned?

Duncan/ Julian: We deliver this aspect through the managers and leaderships trying as part of CYP IAPT - also often senior mangers sit in on the UPROMISE training.

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Fiona Pienaar and Mick Atkinson, Place2Be
Implementing Routine Outcome Measures in a charity-delivered counselling service
Responses to participant questions from the CORC International Conference 2016

How do you evidence improvement for the notable minority of children being referred showing no difficulties from SDQ?

- We calculate the % who improved by at least one point on the Total Difficulties (TD) score (so have started in the 'no difficulties' range)
- We look at change in the subscales (some children who are in the 'normal range' on TD nevertheless are 'abnormal' on a sub-scale)
- We use reliable change as this applies to more children in the sample than only those who are 'abnormal' at baseline
- We use the impact supplement to demonstrate whether teachers or
- parents have seen an improvement overall and whether there is an
- improvement for children whose difficulties impacted on their
- classroom learning, home life, friendships etc.

Could you explain on why specifically it's helpful for you to be members of CORC?

- CORC in itself is a good thing, a useful point of contact and place to go for outcome measures when we are looking into options
- Our main use for CORC is to have our service 'benchmarked' or compared to other service providers. This has its limitations but there is no other centrally collated source of outcomes from counselling for CYP that we are awaare of and, as we do not do a comparison group in our school , this is an invaluable comparison for us.
- As members we are able to access members forums, conferences and the implementers forum

How have Place2Be put SDQ onto tablets? What system are you using? And did that require copyright permissions?

We have a bespoke case management system built for us by a software provider, Pulsion Technology. One of our requirements when selecting a software provider was the development of questionnaires on mobile devices/ tables. We did require a license by the license holders of the SDQ.

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Fiona Pienaar and Mick Atkinson, Place2Be
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Responses to participant questions from the CORC International Conference 2016

Would Place2Be recommend use of goal setting for younger children (under 11) as opposed to more questionnaire based ROMs?

We are about to do a small pilot with Barry Duncan (PCOMS) and Mick Cooper (Roehampton) - 6 schools (3 as controls) trialing the PCOMS - and if successful, and funding is available, we may be part of a much bigger project. I would say that traditionally one can experience resistance from counsellors and psychotherapists to utilising ROM's, but at Place2Be we work hard to change that attitude. Our counsellors in the field receive training, tablets, feedback in the form of annual reports and reports on pilots from our Research and Evaluation team. They also have the ability to generate reports from our bespoke case management system for their schools (for Head Teachers, other Senior Staff, Governors and interested parties). Discussion about evaluation, data, research and so on takes place in training at central, team and area meetings and in supervision. At the moment we are doing pre, post and mid-point data collection across all 1:1 counselling. WHether we eventually move to session by session evaluation or not is something that does come up for discussion generally and at out Research Advisory Group (RAG). We do use adapted goal setting for CYP.

There is a majority of boys being initially referred, do you find they accept the support or put a guard up in the UK?

- Observations are that although most of the children and young people we work with 1:1 are males who are referred by school staff, parents of Place2Be staff, they are less likely to self-refer to our self-referral Place2Talk service - more girls do so than boys. This may suggest some 'put up a guard'.
- I don't have any evidence that boys necessarily put up a guard but we could look at a) comparing Did Not Attend (DNA) rates of boys vs. girls and b) looking at reasons for ending to see if boys are more likely to choose to end counselling than girls - unfortunately we don't have this analysis already to share.

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