LEARNING TO MAXIMISE RECOVERY & REDUCE SERVICE COSTS

Using routine measurement and feedback technologies for treating common mental health problems

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THE ROUTINE MEASUREMENT IMPERATIVE

NHS policy has given mental health services a consistent message that routine outcome measurement is critical for the local and national development of high quality patient care. However, the simple introduction of questionnaires for routine administration is not enough to develop effective and efficient services. In psychological therapies, typically, less than half of all patients referred for therapy complete pre and post-treatment outcome questionnaires. This compromises the production of reliable clinical effectiveness profiles due largely to early treatment termination – a phenomenon not uncommon across treatment compliance studies. Such attrition, severely limits the potential to learn how to improve recovery rates and thereby maximise the return on national and local NHS investment. Not surprisingly, recent national policy initiatives such as Improving Access to Psychological Therapies (IAPT) have placed a premium on mandating every session measurement. Thus in theory, if a patient is required to complete a questionnaire every time they attend a therapy session, then irrespective of whether they terminate their treatment early, it's assumed an outcome questionnaire will have been collected to profile patient benefits at their chosen point of self-discharge. Currently, detailed data collation profiles for national IAPT services are still being developed so it's too early to know if the laudable 90% measured outcome targets have been achieved. In the absence of such data, this article draws on our parallel experiences of introducing routine measurement, shares some of the challenges we've encountered, and most importantly, offers the solutions we've gained from those proactively working towards mastering the art of routine outcome measurement, to improve recovery rates and reduce costs locally.

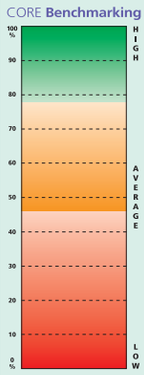
ROUTINE MEASUREMENT IN PRACTICE

In our experience, the demands of administering questionnaires at every session appear to be not uncommonly perceived to compromise the all important focus on building and maintaining a therapeutic relationship. This leads many clinicians/practitioners to experience routine measurement as an inconvenience they'd rather avoid where possible. For a service to master routine measurement, we've found there's a range of critical feedback resources that seem to help facilitate early success. In short, by developing measurement benchmarks and then helping services introduce them, we've learned that there are a variety of different ways to organise, deliver and manage routine measurement – and that some clearly produce swifter success than others. In a context in which there is a still a paucity of support resources for introducing routine measurement, it seems vital to us that policy makers, academic researchers and technologists work collaboratively with service providers, learning how they make measurement imperatives work locally, identifying demonstrable best measurement practice, documenting it for national training programmes and standardising it across measurement and support technologies.

In the challenge vignettes herein, we highlight some of the most frequently encountered antagonism to routine measurement voiced by GPs, Lo-intensity IAPT workers, Counsellors, CPNs, Psychologists, Psychotherapists and others. We offer these vignettes as a vehicle for profiling some of the creative solutions that service providers and users have helped develop to contribute to the growing national agenda to maximise recovery rates and reduce service costs for common mental health problems.

"I'm a clinician, I see no relevance to measurement either to me or my patients. It's something I have to do to simply get out of the way."

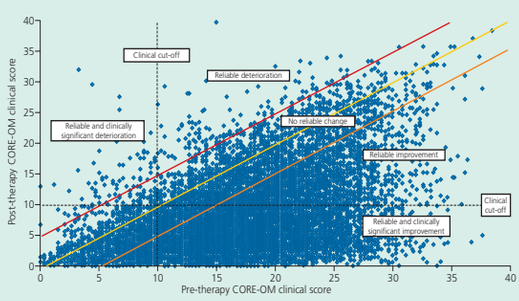
Invest time in acquiring and practising the new skill of utilising measurement as an integral part of patient care, explore with patients their questionnaire responses, experiment with different questionnaires where possible, and chart client progress in order to discuss it with patients being willing to refer to colleagues when change profiles are static or inappropriately negative.



"For years I've filled in outcome questionnaires. I never get to see my own results, so I find it difficult to maintain motivation to ask my clients to routinely fill them in."

Implement instant access self-appraisal benchmarking that helps you benchmark your clinical performance profile relative to the anonymised profiles for both your local peers and national comparators. Reflect on your personal contribution to key service quality performance indicators such as measured outcome rates, routine data quality, waiting times, un-attended sessions ratios, unplanned client-initiated therapy termination and clinical recovery or (statistical) improvement rates.

"As a PCT, we're most interested to know when treatments are not working, be they anti-depressants, prescribed books or exercise, computerised CBT, or one-to-one therapy."



CORE-OM data from a sample of NHS primary care psychological therapy services overwhelmingly demonstrate reliable and clinically significant improvement in clients following psychological therapy (data from the 2005 CORE NRD).

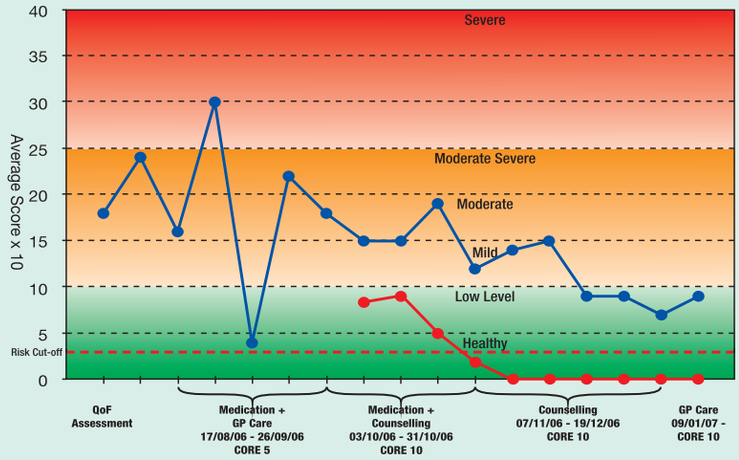
Create automated scatter plots that summarise up-to-date clinical progress profiles for all patients and quickly identify those that are demonstrably benefiting (bottom right), those that are clinically static (between diagonal tramlines), and those that are clinically deteriorating (top left) within treatments.

"As a manger responsible for over fifty clinical staff, my time is very limited and I am under great pressure. How can I ever analyse and assimilate all the practitioners' data in a way that will help my service deliver the best care possible?"

Develop automated signalling systems that alert you and your clinical staff to patients that may need closer attention. These may be patients at risk of suicide, self harm, or potentially being harmful to others. They may be patients who are showing no demonstrable clinical progress and who may be suitable for special case management, peer support or supportive supervision. Equally they may be patients showing inconsistent attendance histories who require careful follow-up, referral, or where necessary discharging to help manage the inefficiency of further unattended appointments.

We change outcomes!

- ✔ Challenging Mediocrity
- ✔ Promoting Excellence
- ✔ Increasing Transparency
- ✔ Hastening Recovery
- ✔ Improving Safety
- ✔ Reducing Costs



CORE Net progress tracking offers feedback to both GP and patient on improvement and recovery. The blue line displays the psychological distress score. The red line represents the risk score based on the patient's response to the question 'I made plans to end my life'. The dotted red line represents the clinical cut-off for risk.

CORE Information Management Systems is the leading provider of outcome measurement services in the UK. We specialise in using unique measurement technology to improve service delivery and accountability at individual, management and organisational levels. We offer a comprehensive range of software, support and consultancy on outcomes management for a range of major UK measures including CORE, PHQ9, GAD7 and others. Our national research database of anonymised data enables us to benchmark services to compare quality and facilitate clinical and strategic development. Growing through a consultancy tradition, CORE IMS tailors solutions to suit individual services.

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