Oxford Academic Health Science Network

Anxiety and Depression Network

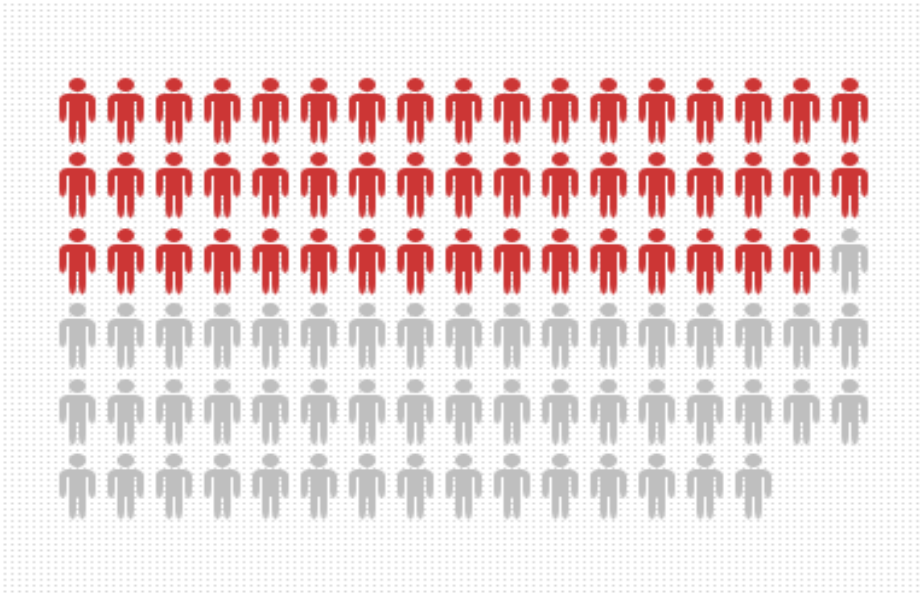
The importance of, and hurdles to, collecting outcome data in CAMHs

21st October 2015

Impact of Child and Adolescent Mental Health Problem

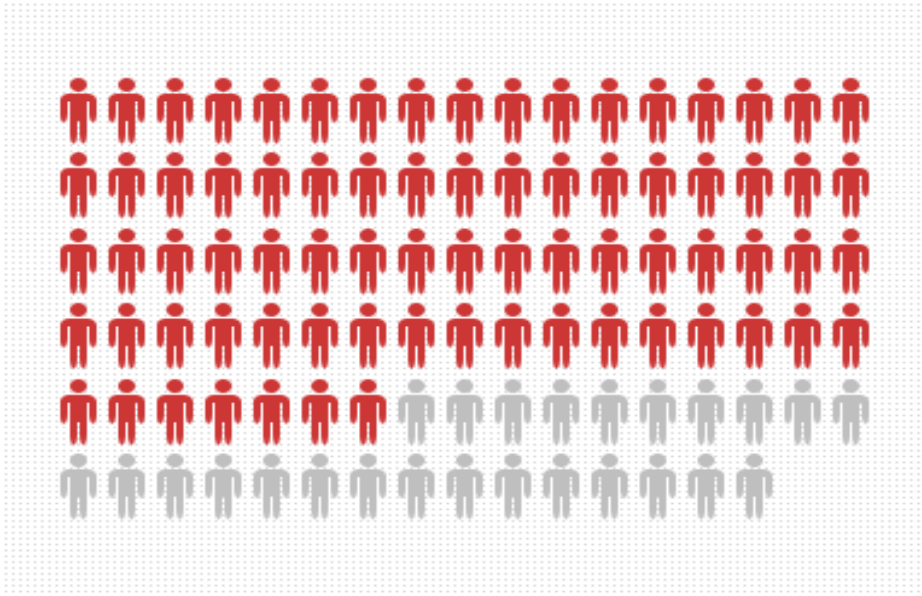
At Age 14

50% OF LIFETIME MENTAL ILLNESS (EXCLUDING DEMENTIA) STARTS BY AGE 14



By Mid Twenties

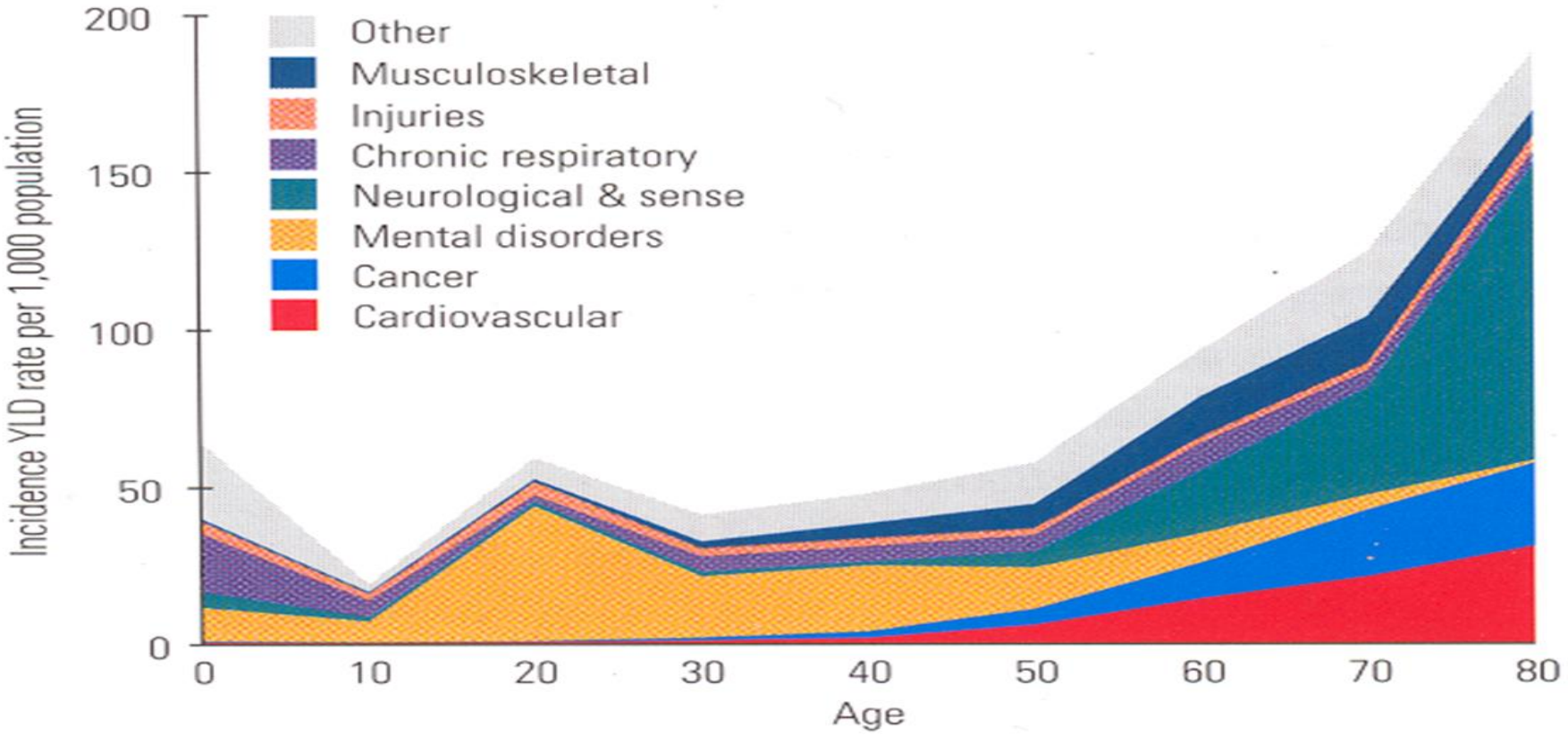
75% OF LIFETIME MENTAL ILLNESS (EXCLUDING DEMENTIA) STARTS BY MID TWENTIES



Mental health problems are the greatest health problem faced by children and young people

NHS England

Figure 6 Incident YLD Rates per 1,000 Population by Age and Broad Disease Grouping, Victoria 1996



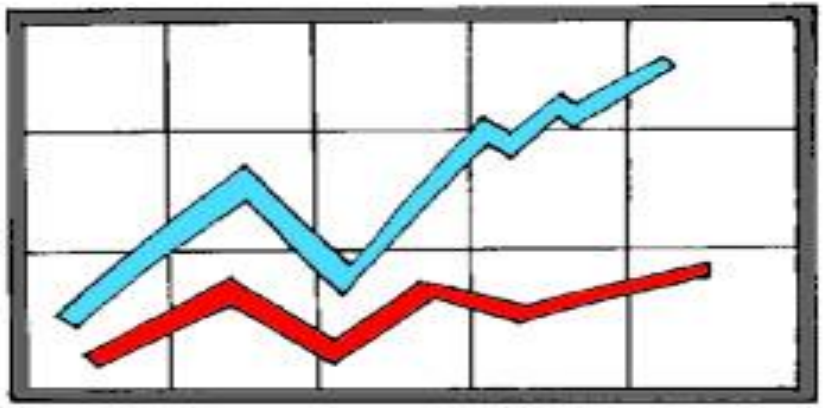
Prof Pat McGorry

NICE Recommended Therapies for Children & Young People

Disorder	Mild			Moderate			Severe		
DEPRESSION	Group CBT	CBT	ST	CBT	IPT	FT	CBT	IPT	FT
DEPRESSION(2nd line)	WW	G-SH	CBT / ST	CBT / IPT / FT	+	FLX	CBT / IPT / FT	+	FLX
CONDUCT DISORDER Children <12 years	Non-MC	PT		PT			PT		
CONDUCT DISORDER Children >12 years	PT			FT	PT		PT	CBT	MST
ADHD	WW	PT		PT			PT	+	MED
PANIC DISORDER	CBT			CBT			CBT		
GAD	CBT			CBT			CBT		
SOCIAL PHOBIA	CBT			CBT			CBT		
PTSD (NICE #26)	CBT- TF			CBT-TF			CBT-TF		
OCD (CG #31)	Psych-ED			CBT (ERP)			CBT (ERP)		
ANOREXIA NERVOSA	CBT	IPT	FT	CBT	IPT	FT	CBT	IPT	FT
AN Continued…	CAT	FPT		CAT	FPT		CAT	FPT	
BULIMIA NERVOSA	CBT-BN	IPT		CBT-BN	IPT		CBT-BN	IPT	
BINGE EATING DISORDER	CBT-BED			CBT-BED			CBT-BED		

With permission P Fonagy

Training in Evidence Based Practice



Research evidence

+

Patient preferences and values

+

Clinician observations

=

Quantifiable results

Utility for clinicians

Acceptable to recipients

Frueh et al (2012) Evidence-Based Practice in Adult Mental Health. Handbook of Evidence-Based Practice in Clinical Psychology. Published online.

CYP IAPT Service Transformation Programme

Began in April 2011 to **transform** *existing* CAMHs:

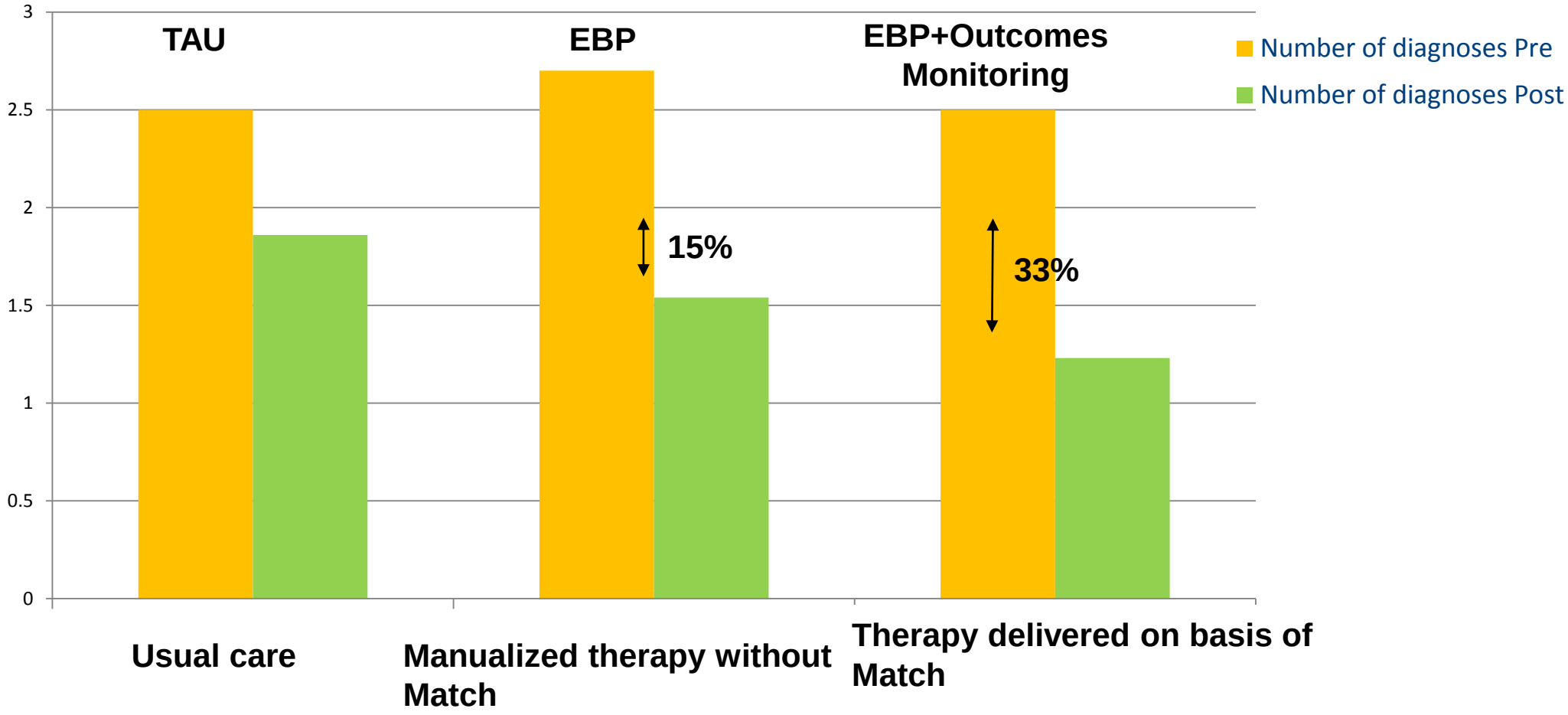
- Improve collaborative practice with children, young people and families
- Embed evidence based practice (EBP) as recommended by NICE in
  - CBT for anxiety disorders and depression
  - Parenting training (age 3-10)
  - Systemic Family Practice for conduct disorder (over 10s), depression and self-harm, and eating disorders
  - Interpersonal Psychotherapy for adolescents (IPT-A) for depression
  - Competency based curriculum using Roth and Pilling CAMHS competencies

CYP IAPT Service Transformation Programme

- Using routine outcomes monitoring
  - To guide therapist and supervisor
  - To help client monitor and understand how treatment is progressing
  - Across ALL cases and professions
- Empowering service users to take control of their care, establish treatment goals, choose treatment approaches and take opportunities to improve their own health
- Improving access to evidence-based therapies
- Introducing evidence-based organisation of care

WHY DO WE NEED ROMS IN CHILD AND ADOLESCENT MENTAL HEALTH SERVICES?

Measurement for a purpose: Guiding treatment to better outcomes



Weisz et al. (2012). Testing standard and modular designs for psychotherapy treating depression, anxiety, and conduct problems in youth: a randomized effectiveness trial. *Archives of General Psychiatry, 69*(3), 274-282. With permission from Peter Fonagy

Routine Outcome Monitoring – what do young people say?

"I don't mind doing it. It's a chance to say if there is something you'd rather be talking about or to say how well you think it's going."

"Really helpful because I can think about it as well, I can think I am not quite there but see there is room for improvement. If I'm not in a good mood my score can go down by 1 or 0.5, and vice versa but that's okay. I would find it hard to say in person how I feel but writing it down is an easier option. It helps me see I can do it and see my progress."

"It's easier to keep track and it can show you that you are making progress. It's proof that you are getting better"

Using routine outcome measures – how does it help?

- **Clinical practice**

  'staff are reporting that ROM is helping them prioritise need'.

  'Goal based measures [are] *helpful in maintaining client's focus and motivation'.*

  Using ROM in supervision *'encourages reflective practise'.*

Westminster: Interviews with young people showed *'they like filling in the questionnaires most of the time and one young person said it was the first time someone had asked me what I thought'*

- **Service development**

Bromley: *'They* [ROM and YP, parents feedback] *are providing us with information we can utilise in our discussions with commissioners about what we do, what works, gaps in provision and what service users experience.'*

Current levels of paired ROMS - CYP IAPT sites

Nationally collected data

- Nationally ranges from 29% to 83%
- Locally (OAHSN 5 patches) from 27.1% to 88.9%
- Huge variability & imprecise data

Locally collected data

- 27.2% to 64.2%

Our (modest) aim – to increase reporting by 10% in each CAMHs

Challenges with implementing and using outcome measures routinely

1. **IT issues** – progress with testing electronic systems and tackling functionality problems to improve the use of measures in real-time on tablets.

2. **Time** – use of measures in the clinical sessions; practical difficulties managing the paper work or filming; data duplication.

3. **Complexity of cases** – selecting the most clinically appropriate measure.

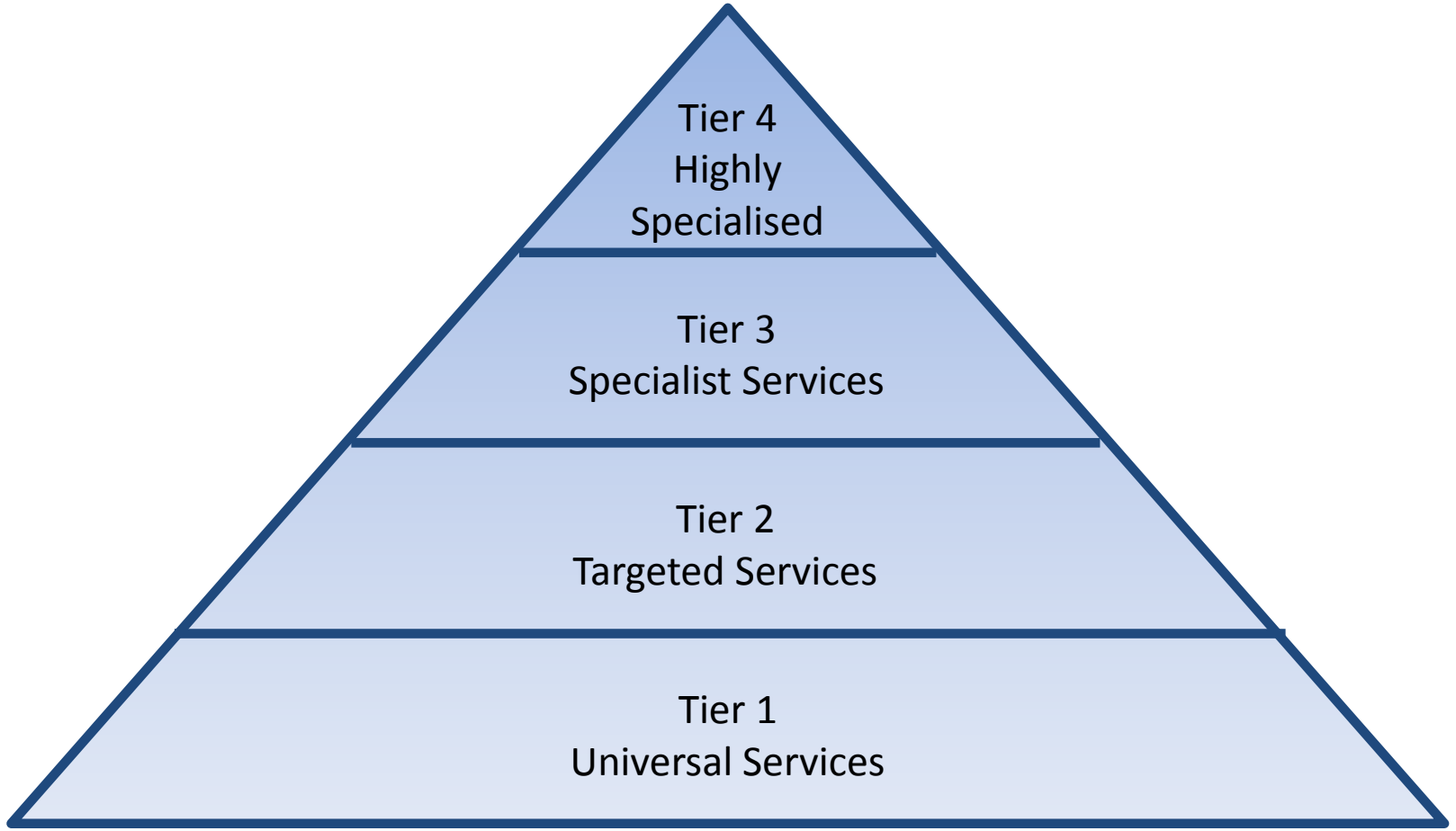
4. **Culturally appropriate measures –** difficulties selecting the most appropriate tool and using measures when working with interpreters.

5. **Staff concerns about how the data may be interpreted and if it is meaningful**

BARRIERS TO ROMS IN CHILD AND ADOLESCENT MENTAL HEALTH SERVICES

Current service provision: a snapshot

Child and Adolescent Mental Health (CAMHS) Tiers



iapt
Improving Access to Psychological Therapies

NHS England

Which Agency Commissions What?

	Service Type	Responsible Commissioning Agency			
		School	Local Authority	CCG	NHS England
Universal Services (Tier 1)	GPs practice staff				
	School nurses				
	Health Visitors				*Moving to LA*
	Social workers				
	Youth workers				
	Teachers				
Targeted (Tier 2)	Outreach into schools by CAMHS				
	School counsellors				
	Educational Psychologists				
	Community based counselling				
	YOT Health workers				
	Parenting Programmes			*In specialist CAMHS*	
Specialist (Tier 3)	Looked after children/adoption			*In specialist CAMHS*	
	Specialist CAMHS (T3) community		*Social workers/Ed psych /MST*		
Specialist (Tier 3/4)	Specialist Outreach services to prevent admission/speed discharge		*Social workers*	*In some areas commissioned locally*	In some areas Specialist Commissioning
Highly Specialist (Tier 4)	In patient or regional specialist community e.g. deaf CAMHS				

Darker shade reflects most likely responsible commissioner; Lighter indicates variation based on local agreements

The CAMHs caseload

Common mental health problems e.g. anxiety disorders, depression

Developmental disorders – ADHD, ASD etc.

Eating disorders

Severe, long term problems e.g. psychosis

Substance misuse problems

Conduct / behaviour problems

Self harm, unstable mood

Gender identity

Refugees and asylum seekers

Looked after children

Children with chronic physical health problems

‘Family problems’

Bullying

Bereavement

Neuropsychological assessments

Anxiety and depression pathway – Berkshire CAMHs

- Review of 100 consecutive cases
- At assessment suicide risk in 85%
- 50% did not meet diagnostic criteria for major depressive disorder and thus did not make criteria for treatment (34% have no diagnosis)
- Most anxiety & depression is likely seen in Tier 2 (thresholds raised)
- Parental involvement in assessment and treatment routine
- Multidisciplinary case management the norm (e.g. with any medication is required)
- When does an episode of treatment end?

What ROMs & from whom?

	Child / Young Person	Parent / Carer	Practitioner
Assessment / Choice	*SDQ S11-17 *RCADS HoNOSCA (13-18)	*SDQ P2-4 *SDQ P4-17 *RCADS-P HoNOSCA-P	HoNOSCA CGAS **Current View
Ongoing / Partnership:			
Goals	Goal Progress Chart	Goal Progress Chart	
Global	*ORS (13+) *CORS (6-12) YCORS (-5) *SWEMWBS (12+) *RMQ 11-17 (SDQ S11-17 Impact)	*ORS *RMQ 4-17 (SDQ P4-17 Impact) *Kessler-10	
Family Context	*Describe Your Family - SCORE-15	*Describe Your Family - SCORE-15	
Problem trackers / symptom trackers	*How are things - low mood RCADS *How are things - anxious away from home RCADS *How are things - anxious in social situations RCADS *How are things - anxious generally RCADS *How are things - compelled to do or think things RCADS *How are things - panic* RCADS *How are things - disturbed by traumatic event (CRIES) *How are things - Me and My School (MaMS) *How are things - PHQ9	*How are things - low mood RCADS-P *How are things - anxious away from home RCADS-P *How are things - anxious in social situations RCADS-P *How are things - anxious generally RCADS-P *How are things - compelled to do or think things RCADS-P *How are things - panic RCADS-P How are things - behavioural difficulties (ODDp) SLDOM (3-16) BPSES	

What ROMS & from whom?

symptom trackers	*How are things - anxious away from home RCADS *How are things - anxious in social situations RCADS *How are things - anxious generally RCADS *How are things - compelled to do or think things RCADS *How are things - panic* RCADS *How are things - disturbed by traumatic event (CRIES) *How are things - Me and My School (MaMS) *How are things - PHQ9 *How are things - GAD7 *How are things - EDE-A (12-14) *How are things - EDE-Q *YP-CORE *CORE-10	*How are things - anxious away from home RCADS-P *How are things - anxious in social situations RCADS-P *How are things - anxious generally RCADS-P *How are things - compelled to do or think things RCADS-P *How are things - panic RCADS-P How are things - behavioural difficulties (ODDp) SLDOM (3-16) BPSES	
Session Feedback	SRS (13+) CSRS (6-12) GSRS CGSRS YCSRS How was this meeting? SFQ	SRS How was this meeting? SFQ	
Review / Close	*SDQ S11-17FU *RCADS CHI ESQ (9-11) CHI ESQ (12-18) HoNOSCA (13-18)	*SDQ P2-4 FU *SDQ P4-17 FU *RCADS-P CHi ESQ (P) HoNOSCA-P	HoNOSCA CGAS **Current View

Notes

The missing ROMS

Children with neurodevelopmental disorders? Does it make sense to measure outcomes? If so what would these be?

Children who are not discharged from CAMHs – ie. do not have a discrete episode of care – e.g. depression CBT + medication is not discharged after CBT; ASD & anxiety, ADHD and conduct problems.

Severe and enduring mental health problems – mania, hallucinations

Assessment only services

etc

Comparing parent and child ROMS

- Mean YP MFQ score = 37.9
- Mean parent MFQ score = 25.48

- Mean YP RCADs score 17.46
- Mean parent RCADs score 12.86

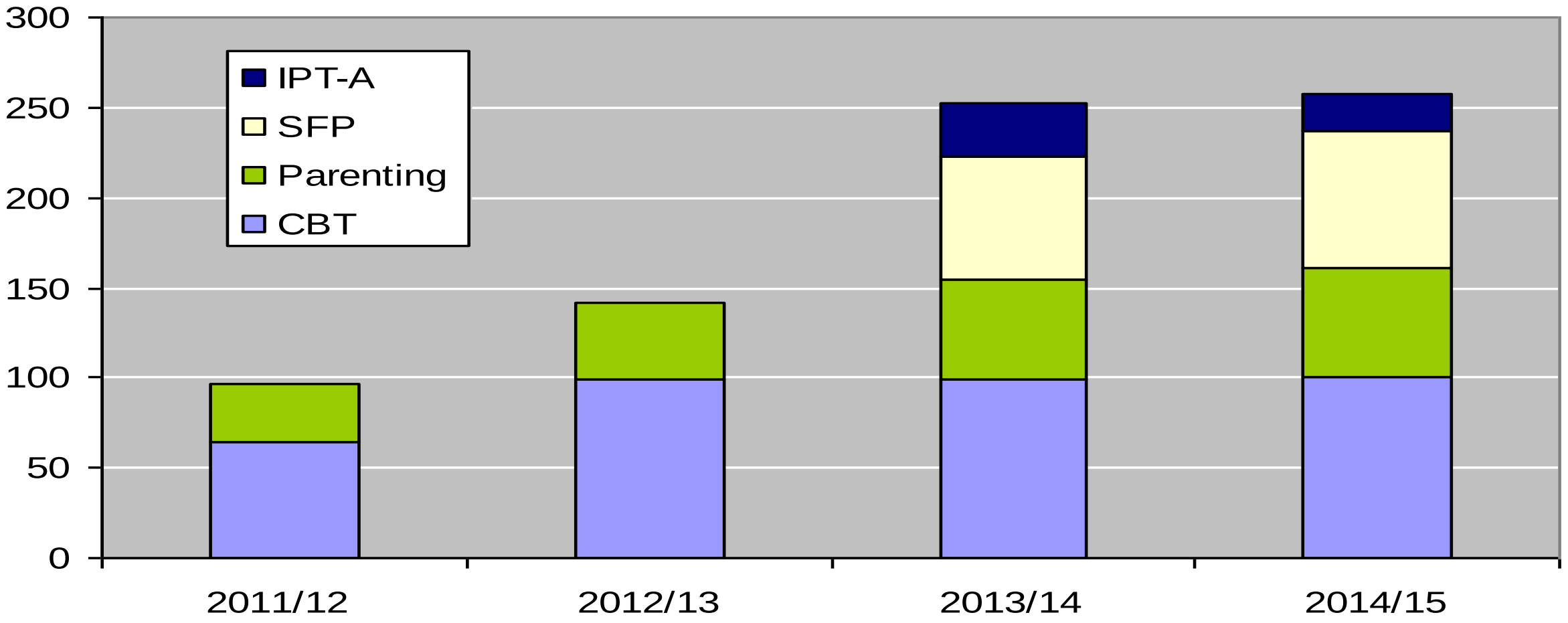
The ‘reach’ of CYP IAPT’ - Trainee numbers 2011-12

2011/12	Trainee therapist	Supervisor	Service lead
CBT	64	19	
Parenting	33	11	
Totals	**97**	**30**	**35**
Completed	*80 (83%)*	*28 (93%)*	*30 (85%)*
Did not complete	*17*	*2*	*5*

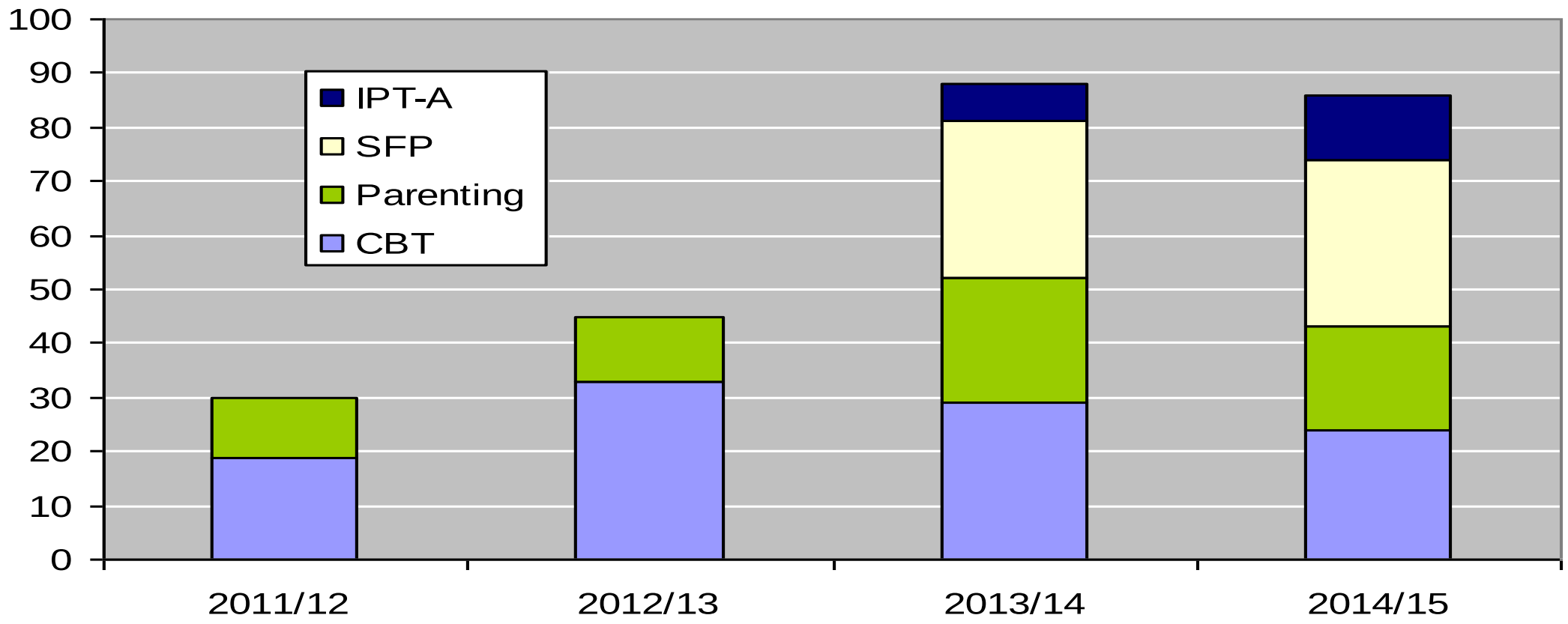
Trainee numbers 2014-15

2014/15	Trainee therapist	Supervisor	Service lead
CBT	100	24	
Parenting	61	19	
SFP (ED)	18	9	
SFP (Dep and CD)	58	22	
IPT-A	21	12	
EEBP	114		
Totals	**372**	**86**	**51**

Therapist trainee numbers by modality across 4 years of CYP IAPT



Trained supervisor numbers by modality across 4 years of CYP IAPT



Our priorities

We need a reliable baseline to measure change - To establish an accurate database for paired ROMs collected in our patch

We need expertise to overcome multiple difficulties –

- Build collaboration between OAHSN data managers
- Identify key barriers to using ROMS (technical, knowledge, resources)
- Share best practice and local solutions
- Develop local implementation plans to overcome these

Increase the collection of paired outcome data across CAMHs

THANK YOU

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