An investigation into the implementation of CYP-IAPT Routine Outcome Measures in their first year of integration into child psychotherapy practice

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Abstract

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This thesis examines the impact on child and adolescent psychotherapists within CAMHS of the introduction of routine outcome measures (ROMs) associated with the Children and Young People's Improving access to Psychological Therapies programme (CYP-IAPT). All CAMHS therapists working within a particular NHS mental health Trust[1] were required to trial CYP-IAPT ROMs as part of their everyday clinical practice from October 2013-September 2014. During this period considerable freedom was allowed as to which of the measures each therapist used and at what frequency.

In order to assess the impact of CYP-IAPT ROMs on child psychotherapy, I conducted semi-structured interviews with eight psychotherapists within a particular CAMHS partnership within one NHS Trust. Each statement was coded and grouped according to whether it related to initial (generic) assessment, goal setting / monitoring, monitoring on-going progress, therapeutic alliance, or to issues concerning how data might be used or interpreted by managers and commissioners.

Analysis of interviews revealed greatest concern about session-by

[1] This Trust has been anonymised throughout the thesis in order to protect confidentiality

session ROMs, as these are felt to impact most significantly on psychotherapy; therapists felt that session-by-session ROMs do not take account of negative transference relationships, they are overly repetitive and used to reward / punish the therapist. Measures used at assessment and review were viewed as most compatible with psychotherapy, although often experienced as excessively time consuming. The Goal Based Outcome Measure was generally experienced as compatible with psychotherapy so long as goals are formed collaboratively between therapist and young person. There was considerable anxiety about how data may be (mis)used and (mis)interpreted by managers and commissioners, for example to end treatment prematurely, trigger change of therapist in the face of negative ROMs data, or to damage psychotherapy. Use of ROMs for short term and generic work was experienced as less intrusive and contentious.

Declaration of originality and permissions:

I hereby declare that the contents of this thesis are entirely my own work; other sources of information have been cited throughout. Any work, published or unpublished which I have quoted or to which I have made reference are referenced in the body of the thesis and listed in full in the bibliography.

This project has received ethics clearance from UEL and permission to conduct the study has also been given from the NHS Trust in which this study took place.

Contents

Abbreviations:

CAMHS: Child and adolescent mental health service

CBT: Cognitive behavioural therapy

CGAS: The Children's Global Assessment Scale

CORC: CAMHS Outcomes Research Consortium

CORS: Child outcome rating scale

CSRS: Child session rating scale

CYP-IAPT: Children and young people's improving access to psychological therapies

DBT: Dialectical behavioural therapy

GBM: Goal based measure

IAPT: Improving access to psychological therapies

ORS: Outcome rating scale

PBR: Payment by results

PROMS: Patient-reported routine outcome measures

RCADS: The Revised Child anxiety and depression scale

RCT: Randomised control trial

ROMS: Routine outcome measures

SDQ: Strengths and Difficulties questionnaire

SRS: Session Rating Scale

STMs: Symptom tracking measures

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Chapter One: Introduction

This thesis examines the impact on child and adolescent psychotherapy within CAMHS of the introduction of routine outcome measures (ROMs) associated with the Children and Young People's Improving access to Psychological Therapies programme (CYP-IAPT) during the first year of the pilot, from September 2013 until September 2014.[2] It aims to establish strengths and weaknesses of each of these measures in relation to child and adolescent psychotherapy; it considers how these ROMs are used in practice by psychotherapists and how they might be used most effectively (or least intrusively). The study also addresses psychotherapists' views about the use that managers and commissioners might make of CYP-IAPT ROMs data. The study uses semi-structured interviews with eight child and adolescent psychotherapists and seeks to identify and explore issues which interest or concern child psychotherapists regarding use of the CYP-IAPT ROMs.

This chapter focuses on:

1) History and background of clinical audit and ROMs, and of IAPT and CYP-IAPT in particular

a) History of ROMs

b) History of IAPT

c) ROMs in Child and Adolescent Psychotherapy

2) Benefits that CYP-IAPT ROMs are intended to provide and questions that arise concerning these

3) Intentions of this study

[2] This Trust has been anonymised throughout to protect confidentiality.

1) History and background of clinical audit and ROMs, and of IAPT and CYP-IAPT in particular

a) History of ROMS

For as long as there has been healthcare there have been studies, however informal, to evaluate its effectiveness. There has always been an interest in how many patients live or die under different treatments, and medicine has evolved accordingly, embracing treatments which can be proven to be of benefit and, generally, rejecting those for which there is less evidence or negative evidence. Over the years clinical trials have become more comprehensive and scientific, evaluating ever-larger sets of data and complex variables in order to understand the effectiveness of different treatments. By the mid-twentieth century, the gold standard for such research had become the Randomised Control Trial (RCT), in which a treatment group is compared against a control group in a "blind" trial, with patients randomly assigned either to treatment or to a control group and with neither patient nor clinician knowing who is in each group.

Systematic research into effectiveness of mental health treatments followed some way behind that of physical health, due perhaps to the relative difficulty of assessing changes in states of mind. Studies in mental health outcomes are complicated by many variables within any diagnosis, including co-morbidity, learning difficulties, social factors, environment, drug use and prenatal factors, such that systematically analysing improvement in the mental health of a specific patient group presents enormous challenges. Even

apparently straightforward diagnoses such as “depression” or “anxiety” differ hugely in their manifestation in each individual. Clinicians necessarily rely far more on patient reporting of symptoms than, say, with a broken leg. The number of treatment variables is also likely to be higher than with many physical health conditions; these will include differences in type of therapy offered, the exact working practice of each therapist, number of sessions offered, frequency of sessions, training undertaken by the therapist and so on. Nevertheless, increasingly during the late twentieth and early twenty-first centuries there has been a proliferation of mental health research trials, including RCTs, operating under strict controls to isolate individual variables. Where a RCT is not possible – for example, when it is impossible for patients and clinicians to be “blind” as to which treatment is being provided – modifications to this method have been made. It would not be ethical to allocate some patients in need of psychological support to a “no treatment” control group, however it is possible, for example, to compare “treatment as usual within CAMHS” to weekly psychotherapy, or to compare psychotherapy, CBT and treatment as usual, as in the recent IMPACT study (Goodyer et al, 2011). Urwin (2007, p.135) notes that one difficulty of RCTs is that the population studied has to be “pure”, i.e. suffering from one recognizable condition without other conditions and without other treatment variables which might influence outcome; this makes these studies very different from the population treated at CAMHS, where it is more common to have multiple diagnoses and multiple complex contextual factors. Urwin notes: “…it is fair to say that the ‘purer’ the study in traditional scientific terms, the less relevant it becomes for making predictions about individual patients, with the multiple problems and complex family backgrounds that they are likely to bring

with them" (ibid, p.135).

One reason for the surge of interest in clinical trials for mental health treatments has been the need to be more accountable for NHS services. The culture in which mental health professionals are working has changed beyond measure. As far back as 1996 Walborn notes:

> At one time, therapists had the luxury of needing only devotion and faith to testify regarding the efficacy of counselling and psychotherapy. However, the honeymoon is over; times have changed…policy makers are demanding accountability; and third-party payers want results. (p.17)

Similarly, Pearsall (1997, p.17) notes: "We cannot afford any treatment that lacks a sound theoretical base, a replicable methodology, and a measurable outcome", while Jenkins et al. (2010, p.316) highlight the need to direct the limited resources most efficiently to where they can do the most good. Outcome studies are needed in order better to understand the merits of each mental health treatment in relation to each patient group and the many complex variables which might affect patient progress.

Mental health clinicians are therefore now often required to be researchers, feeding data into studies so that outcomes of work under usual clinical conditions (rather than laboratory studies) can be measured. Psychologists in particular have embraced quantitative research, and have embedded necessary skills to interpret data and carry out research within their training. In recent years numerous new treatments have emerged which are "evidence-based", i.e. proven to be of benefit by strictly controlled trials. These

treatments are generally short-term and goal-based, with measures in place to monitor progress. Examples include Cognitive behavioural therapy (CBT) and Dialectical Behaviour Therapy (DBT). Treatment is structured and focused on improvement of symptoms, and patients report progress using one or more outcome measure. ROMs data is used to help motivate the patient to continue, to demonstrate to the patient how well they are progressing or as evidence that treatment has reached its goals and therefore is ready to end. In theory, patients benefit from the increased evidence base and monitoring of treatment, as they are better placed to make choices about clinical care and also to assess whether or not their own care is effective. Increased monitoring of outcomes in theory also benefits clinical managers; care pathways become clearer and it is more evident who can and cannot be helped by each type of treatment. Managers become better able to allocate patients to specific treatments based on ROMs evidence. Patients who are not improving can be identified more quickly and steered towards alternative treatments.

Alongside the growth in mental health research there has necessarily been a proliferation of mental health assessment tools necessary to conduct this research. For adults these include the Beck depression inventory (1961), The Brief Psychiatric rating Scale (BPRS) (1962), HoNOS (1996) and the CORE outcome measure (1998). While these frameworks are intended to screen patients for specific categories of mental health issues, they can also be repeated during or at end of treatment, and therefore can also be used as outcome measures.

Outcome measures for children and adolescents and resultant studies

have followed just behind those for adults. Commonly used tools have included The Adolescent Well-being scale (Birleson, 1980), the Children's Global Assessment Scale (CGAS) (Schaffer et al, 1983), The Strengths and Difficulties Questionnaire (SDQ) (1997), HoNOSCA (HoNOS for children and adolescents) (1998), Connors (1998) and The Revised Child anxiety and depression scale (RCADS) (2000). Since 2004 CORC (CAMHS Outcomes Research Consortium) has been gathering outcomes data for children and young people; as of 2015 CORC hold information on 260,000 separate treatment episodes (CORC, 2015). CORC's aim is: "…to foster the effective and routine use of outcome measures in work with children and young people (and their families and carers) who experience mental health and emotional wellbeing difficulties" (ibid). The CORC measures are SDQ (Strengths and Difficulties Questionnaire), GBO (Goal based outcome measure), HoNOSCA (Health of the Nation Scale for Children and Adolescents) and CHI-ESQ (Experience of Service questionnaire). From 2011 CORC also included the CYP-IAPT outcome measures, which will be discussed individually later in this chapter and analysed in detail in subsequent chapters.

Despite CORC's influence, until recently levels of completion of ROMs within CAMHS have been low - Johnston and Gower (2005) reveal that in 2005 less than 30% of CAMHS teams were using any ROMs at all while Timini (2015, p.59) puts current ROMs use at around 10-25%. Hall et al. (2013) cite two audits of CAMHS teams who were routinely using ROMs in 2011 and 2012-2013; in the first audit they found that measures were only used more than once for an individual patient 30% of the time, while this had risen to 60% by the second audit. However, this still means that by 2013-2014 even in those

CAMHS teams that were routinely using ROMs, ROMs were not used to *monitor progress* in 40% of cases. CORC's current stated aim is that 90% of all young people seen in CAMHS should complete ROMs (excluding goal-based measures) on at least two occasions during their treatment (90% data completeness note, 2015); goal-based measures are excluded since they are individualised rather than standardised normative measures, a difference discussed further in Chapter Two.

Assessing children's mental health provides specific challenges (see, for example, Wolpert et al., 2014, p.272). It can be hard to separate progress as a result of clinical treatment from that associated with ordinary developmental changes; additionally, the child's environment is likely to be more influential than that of an adult, making it harder to isolate individual mental health difficulties from environmental and social situation. Furthermore, children are likely to be less reliable observers of their own states of mind and the impact of their symptoms, and might be expected to both over and under report their difficulties for reasons including the wish to please, misunderstanding, fear of reprisals, inability to differentiate on a sliding scale, lack of awareness of states of mind and multiple other factors. The youngest or most chaotic patients may have little concept that they are even receiving therapy and still less their reasons for treatment. Outcome measures for children and young people therefore tend to include patient reported outcome measures (PROMs) along with ROMs completed by parents / carers, teachers or therapist. Adolescents in particular are well known for their propensity to drop out of treatment before its conclusion, thus making "before and after" studies problematic.

b) History of IAPT

Out of a culture of increased accountability and evidence-based treatments came adult IAPT (Improving Access to Psychological Therapies). This followed from Layard et al. (2006), advocating that [adult] depression and anxiety could be well treated using talking therapies, and that this would have economic benefits. In 2006 two pilot sites were set up, and IAPT was subsequently extended nationwide. The aim was to widen access to talking therapies, and the budget for this in the NHS tripled (Evans, 2013). Short-term manualised treatments are offered, including CBT, internet-based treatments, self-help skills, groups and psycho-educational courses. These services are offered by clinicians who have undertaken a one-year focused training on a specific IAPT manualised treatment. Prior to IAPT, adult mental health services were receiving feedback on about 30% of treatments offered, but within IAPT every session is monitored. This produces evidence for both service users and fund holders regarding exactly how many people are getting better, and how this correlates to number of sessions and type of treatment given. Evidence shows that service users like giving such regular feedback (Evans 2013b).

IAPT for children and young people (CYP-IAPT) followed, and was in the pilot stage between September 2013 and September 2014. Unlike adult IAPT, services for children and adolescents are provided through existing CAMHS services. The aim is to offer treatment to more patients by adding additional CYP-IAPT treatments which are manualised and short-term. These CYP-IAPT specific treatments are therefore able to be offered more cheaply and to more young people, and are intended frequently to be the first intervention offered, in

order that more expensive and generally longer-term treatments in CAMHS can be reserved for those most in need. The integration of CYP-IAPT within CAMHS means that in addition to gathering data from these new CYP-IAPT treatments, *all* treatments within the designated CAMHS services are required to use the CYP-IAPT outcome measures. This is in order to improve the monitoring of all treatments that young people receive and to improve the allocation of young people to the most effective and cost-effective CAMHS treatment. The effectiveness of all CAMHS treatment will easily be able to be compared in terms of effectiveness and cost. CYP-IAPT also has as part of its ethos a view that progress in treatment is improved when ROMs are used to track progress and therapeutic alliance.

The specific CYP-IAPT ROMS used by the Trust during the pilot are all available from the Child Outcomes Research Consortium website (www.corc.uk.net/resources/measures/child/)

- Strengths and difficulties questionnaire (SDQ)
- Revised Child and Adolescent Anxiety and Depression Scale (RCADS) and sections from RCADS used as Symptom Tracking Measures (STMs)
- Current View Tool
- (Child) Session rating scale (SRS / CSRS)
- Goal Based Outcome Measure (GBO)
- (Child) Outcome Rating Scale (ORS / CORS / YCORS)

Relative benefits, challenges and pitfalls of each of these tools will be considered throughout this study, alongside ways that psychotherapists are

finding (or not) to make these ROMs compatible with psychotherapy.

c) ROMs in child and adolescent psychotherapy

For many years psychotherapy has been underrepresented in mental health outcome studies, leaving it with a relatively small evidence base in comparison to other treatments, particularly CBT. There has been a tendency for psychotherapists to feel that they do not need outcome studies in order to prove the effectiveness of their treatment and also to feel that their treatment cannot easily be measured using quantitative methods. In general until very recently there has been very little tracking of patient progress as it takes place in psychotherapy, and in particular there has been reluctance to involve patients in tracking and documenting their progress. By not fully embracing the collection of quantitative data during treatment psychotherapists have risked marginalisation within the NHS, since other professions have been quick to evidence their effectiveness in this way.

One reason for this is that the goals and desired outcomes in psychotherapy, as well as the process involved, are distinctive and significantly different to many other treatments. Traditionally in psychoanalytic psychotherapy – as will be discussed further in the literature review - there are not conscious goals to be held in mind and evaluated. Psychotherapy does not focus primarily on symptoms, which might be relatively straightforward to measure, but instead on unconscious processes and states, of which symptoms are only the most obvious manifestation. Psychotherapy aims to help the patient come to a fuller understanding of their internal world and how this

impacts on their external world, and by so doing symptoms are relieved. This work may feel difficult to quantify, with eventual progress emerging out of many sessions of experiencing "not knowing" and without an agenda or plan for the work as a whole or for individual sessions. This might make it harder to assess "progress" compared to treatments with clear agendas, goals or targets.

In addition, therapists make use of the "transference" relationship, i.e. the relationship which is projected onto them by the patient, which might reflect the child's positive or negative past relationships and wider (or imagined) relationships; the therapist becomes accustomed to noting in what role they are being cast by the child, and using this to make sense of how the child sees themselves in relation to the world and to others around them. The therapist is aware that the role in which they are cast may be very different to their actual presence in the room; a therapist, for example, who is warm and welcoming may be perceived as cold and hostile, a therapist who is available week after week may be seen as rejecting or unavailable. In addition, expression of negative feelings are welcomed in psychotherapy, there is not an expectation that the patient should be polite or that patient or therapist should try to focus on the positives. A session is not felt to be "good" if the patient leaves feeling positive or less good if the patient leaves feeling upset or angry. These aspects of psychotherapy are essential to understand in relation to how child psychotherapists might view the introduction of ROMs differently to therapists from other professional backgrounds.

The various core features of psychotherapy – including use of the transference relationship, welcoming of negative emotions, work with

unconscious processes, not focusing primarily on symptoms and not following an agenda in sessions - will be discussed further in Chapter Two in relation to the relevant literature. In order to understand the views expressed by therapists in this current study it will be important to understand which aspects of psychotherapy might be cited as evidence as to why ROMs sit differently within psychotherapy to other treatments; in other words, where ROMs use is felt to be antithetical to psychotherapy in particular (above other mental health treatments) it is crucial to understand the features of psychotherapy which might make this the case.

Within the profession of child and adolescent psychotherapy there has therefore been a tendency to rely on ways of reporting and demonstrating change or progress which are embedded in each relationship with each individual patient rather than reliant on processing large amounts of numerical data; progress becomes evident through observation of the multitude of tiny changes in how the patient relates to the therapist, as well as changes in patients' dreams, sudden shifts in awareness and changes in the therapist's countertransference relationship with the patient. For example, change might be observed when a patient lowers their hood or dares to open their box of toys for the first time. Child psychotherapists have tended to document how progress takes place through single case studies, where one patient's changes over time are documented and analysed in detail. Arguably the essence of this treatment is not well conveyed by asking the patient or therapist standardised and simplified questions about their state of mind or treatment as therapy progresses, since the nature of the work is so individual and unpredictable. Furthermore, some psychotherapists have argued that imposing patient-

reported outcome measures on treatment disrupts the course of the treatment, making the work too symptom or goal focused, rather than allowing the work to unfold according to whatever the patient consciously or unconsciously brings to each session. These arguments and the relevant literature in this area will be considered in Chapter Two.

2) Benefits that CYP-IAPT ROMs are intended to provide and questions that arise concerning these

The CYP-IAPT ROMs guidelines state that there are many advantages to incorporating ROMs into CAMHS treatments. For example, the measures are claimed to reduce dropout, lead to better outcomes more quickly, ensure that there are no gaps in areas covered at assessment or review and quickly highlight any deterioration in a patient's symptoms (Fleming et al., 2014, p.69). This study aims to identify whether or not these advantages apply equally to psychotherapy as to other CAMHS treatments, or whether there are such important differences in treatment method that some or all of these tools might be incompatible with psychotherapy. It will also consider how best to integrate these measures into psychotherapy, including which tools are most compatible, how frequently they should be used and for which treatment groups they are most suitable. This study will also consider whether there is any conflicting evidence which might challenge the positive account of ROMs cited by CYP-IAPT.

The stated advantages of using ROMs are embedded throughout the CYP-IAPT 2014 guidelines (Law and Wolpert (eds.), 2014), and can be summarised

as follows:[3]

a) The CYP-IAPT ROMs use will provide more accurate and consistent baseline assessments of all young people entering CAMHS (Law, 2014c, p.47)
b) CYP-IAPT ROMs will ensure accurate tracking of young people's progress in CAMHS treatments (Troupp et al., 2014, p.89)
c) Monitoring progress and the therapeutic alliance improves outcomes (Law et al., 2014, p.143)
d) CYP-IAPT ROMs make young active participants in their treatment plan (Law et al., 2014, p.143)
e) CYP-IAPT ROMs will facilitate more effective screening of patients and allocation to the most effective treatments, therefore will be of benefit to managers and commissioners (Troupp et al., 2014, p.88)

In addition, another potential benefit to ROMs use which is not stated in CYP-IAPT literature might be:

f) Psychotherapy in particular needs to develop a stronger evidence base, which the CYP-IAPT ROMs data will provide

a) The CYP-IAPT ROMs use will provide more accurate and consistent

[3] Page references given offer one example of each stated advantage of CYP-IAPT ROMs, however each advantage listed here can be found throughout the guidelines in multiple places. Two core documents set out the aims and methods for implementing CYP-IAPT ROMs; references to these will be referred to in the body of the text as either the "2012 guidelines" or the "2014 guidelines". This is to aid clarity throughout the thesis when making reference to either of these core documents, so that it is clear that this is information coming from CYP-IAPT rather than from other sources. The 2012 guidelines do not attribute any section individually by an author, so references after a quotation will refer to "Law et al., 2012". When quoting from the 2014 guidelines individual chapter authors will be cited.

baseline assessment of all young people entering CAMHS

Two main tools are used at initial assessment by CYP-IAPT – these are the SDQ (Strengths and Difficulties Questionnaire) and RCADS (Revised Child and Adolescent Depression Scale) (appendices 2 and 3); these are repeated at six-monthly intervals (reviews) and at the end of each treatment. Both these tools have proven validity and reliability and a long history of use; this means that the data can immediately be compared to other research trials using these measures, including tracking the prevalence of certain mental health difficulties by subset of the population such as socioeconomic status or ethnicity. They ask a broad range of screening questions, which will be discussed in detail in Chapter Two. Both SDQ and RCADS are useful for charting progress of individual children and young people and also of cohorts of patients who have similar presenting symptoms, in order to assess the effectiveness of different treatment options. They are the most detailed of the CYP-IAPT ROMs and therefore able to provide the most comprehensive data.

In addition to RCADS and SDQ, the therapist completes the Current View Tool (CVT) at initial assessment. This captures a snapshot of the difficulties with which a young person arrives at CAMHS and of their current life circumstances, such as whether they are Looked After, a young carer or have difficulties accessing essential services. At the point of conducting this study, data from the CVT was being monitored to identify “clusters” of symptom severity, with each CAMHS clinic’s funding intended to be determined by how many young people they see in each of the treatment clusters, with more severe clusters receiving most funding. This will be discussed in detail in Chapter Five. The CVT is intended to be updated whenever the child’s external situation /

presenting difficulties show significant change.

This study will reflect on how psychotherapists view use of these ROMs at initial assessment stage, focusing both on how useful these tools are in identifying underlying difficulties and also on how they are being used most effectively and least intrusively in practice by psychotherapists. It will also consider the potential impact on children and young people of completing these measures during their first CAMHS contact, and will consider how therapists feel that use of these tools impacts on other ways of gathering information and building a first relationship with a young person.

b) CYP-IAPT ROMs will ensure accurate tracking of young people's progress in CAMHS treatments

One obvious benefit of CYP-IAPT ROMs use is that the ROMs function to track progress in therapy and to make explicit both when there has been significant progress and when there has not, allowing the therapist and patient to make treatment decisions accordingly. Progress data may be gathered by repeating assessment tools (SDQ, RCADS) periodically throughout treatment. Progress can also be assessed by each patient (or, for younger children, parents / carers) setting goals at start of treatment using the GBO and monitoring progress towards these throughout treatment. This tool will be discussed in detail in Chapter Five. Another ROM intended for use to track progress is the (C)ORS. This measure looks at the period of time between the previous and current sessions and asks young people to mark on a sliding scale

from low to high indicating how they have been feeling under four headings, covering feelings, relationships with family, social settings (e.g. school, work, friendships) and a general score indicating overall wellbeing.

All CYP-IAPT ROMs offer one version to be filled out by parents and carers and another by the child / young person; this means that there is potentially the benefit of triangulation between the parent / carer's perception of progress and that of the young person and therapist. This is important as studies show that adolescents tend to under-report their difficulties (see for example Doran, 2013, p25), and are likely to be perceived differently in different places (e.g. home and school), while the youngest or most chaotic children might be expected to be unreliable reporters of progress. Differences in ROMs feedback from different sources might help therapists identify more precisely which areas will need to be discussed when a young person and parent / carer are together (e.g. during assessment, reviews or as part of family or dyadic work). The 2014 CYP-IAPT guidelines stresses that it is "important to remember that all data are flawed and there is a need to triangulate data from a variety of sources" (Fleming et al., 2014, p.71). This would include not only different versions of ROMs as discussed above, but also other data sources, such as discussions with teachers or social workers or a gathering of previous reports.

This study will examine whether interviewees feel that ROMs add usefully to the sum of information about a young person's progress and whether ROMs progress data is considered alongside other data or is felt to replace it. It will consider which tools for monitoring progress are most valued, how frequently they are being used and how accurate psychotherapists perceive

them to be as barometers of progress. It will consider to what extent these measures of progress are felt to sit well alongside psychotherapy or are felt to intrude into sessions or distort the nature of treatment. In addition it will reflect on how these tools might be used in ways other than to report progress, for example to reward or punish the therapist, to prolong or cut short treatment and so on. It will also reflect on whether there is any difficulty in measuring progress with specific patient groups.

The concept of "progress" itself will also be considered, since there is an assumption built into CYP-IAPT ROMs that some changes are "good" and represent "progress", which may or may not accord with psychotherapists' views. This study will invite open responses from psychotherapists about whether or not they feel these ROMs (or ROMs in general) to be nuanced enough to take enough account of various aspects of what "progress" means.

c) Monitoring progress / the therapeutic alliance improves outcomes

CYP-IAPT asserts that use of ROMs has direct clinical benefit, and that patients make more progress when ROMs are used. The 2012 guidelines state: "…effective clinical monitoring systems can lead to more effective and efficient interventions" (Law et al., 2012, p.14). When young people (and their parents / carers) are aware of how they are progressing and in which areas this adds motivation, it adds clarity to the work, enables the therapist and patient to target areas where more help is needed and overall will help young people to get better more quickly. Evidence also shows that clinicians are not good at recognising patient decline without explicit feedback from patients (for example Trauer, 2010, p.186). Providing regular ROMs feedback will therefore allow

clinicians to step in quickly when there is negative ROMs feedback about progress, and by so doing change treatment plan if needed or address concerns directly; this is also intended to reduce dropout which might occur when a patient feels misunderstood or feels their treatment to be somehow "getting it wrong". Literature regarding these claims will be examined in Chapter Two, and therapists' views and experiences of this will be considered throughout the thesis.

CYP-IAPT claims specifically that the act of monitoring the therapeutic alliance using the SRS improves outcomes and again offers evidence that clinicians are not good at gauging how good a relationship is between themselves and patient without specific feedback about this. Literature regarding therapeutic alliance will be considered in detail in Chapter Two, and therapists' experience of measuring the therapeutic alliance will be examined in Chapter Six. This study will examine whether psychotherapists agree that the SRS offers useful information about the therapeutic alliance and how they view guidelines that they should consider changing their therapeutic approach in response to patients' SRS feedback. This study will consider whether therapists report any concerns about use of SRS to monitor the therapeutic alliance and will look at the steps that psychotherapists take to integrate the SRS into each session in the least intrusive / most useful way.

d) CYP-IAPT ROMs make young active participants in their treatment plan

The use of CYP-IAPT ROMs fits into an NHS climate where increasingly "patient choice" is emphasised. The Department of Health's "National Service

Framework" (2004, p.7) states:

> As a minimum, all services evaluate outcome from the perspective of users (including where possible the referred child or young person themselves as well as key family members or carers) and providers of the service.

Gone are the days of being told: "This is the health treatment you need and this is where you get it"; now patients are viewed as active participants in their "care pathway." Thornicroft and Tansella (2010, p.xvi) note that mental health service users are now seen as experts in their own condition rather than passive subjects or objects of treatment.

CYP-IAPT promotes the view that young people are customers who are well placed both to determine the treatment which would be most helpful to them and to be able to say when the treatment they are receiving is not meeting their needs in some way. Young people have been asked to express "participation priorities", including indicating that they would like the chance to offer feedback about their sessions by using ROMs. MyApt, the CYP-IAPT young people's participation group, offers evidence that young people are requesting goal-based measures and clear tracking of progress and symptoms, alongside some role in evaluating benefits of the work and understanding what makes "good practice":

> We want there to be clarity and agreement about goals that we have helped set.
>
> We want to be clear about what we are getting and what we will get out of it and to be able to recognize good practice when they [sic] see

it. (MyApt, 2012)

The 2014 guidelines state: “Young service users, and carers, quite rightly, want their voice heard in intervention decisions, and therapy, and to collaborate in service development. They see the use of feedback and outcomes tools as an important aspect of this process” (Law, 2014a, p42).

As a result, CYP-IAPT makes extensive use of *patient reported* outcome measures (PROMs). The GBO, for example, actively involves the young person in agreeing goals in collaboration with the therapist, and so might be likely to improve a sense of investment in treatment and to promote a culture of shared aims and objectives rather than of being “done to.” This study will consider how psychotherapists in this study respond to giving patients greater say in their treatment plan and what the impact is of this on psychotherapy specifically.

Another intention of CYP-IAPT ROMs is that all feedback should be clear. The Data and Standards Task 2015 report, for example, quotes a young person:

> Graphs were updated weekly to show my levels of depression which I later found helpful as it showed me that gradually over time my level of depression and anxiety had reduced and I could see I had made progress. (p.13)

The intention within the Trust in which this present study takes place is for all ROMs feedback to be completed on iPads which can generate graphs to show young people clearly how they are progressing. In fact, implementation of iPads

was substantially delayed due to software difficulties and was due shortly to be implemented just as this study concluded.

e) CYP-IAPT ROMs will facilitate more effective screening of patients and allocation to the most effective treatments, therefore will be of benefit to managers and commissioners

The introduction of CYP-IAPT ROMs is a chance to measure all treatments offered by CAMHS and to use the data to get a clearer breakdown of specific benefits of each CAMHS treatment to each patient group. This should eventually facilitate more effective screening of cases so each case can be allocated to the most appropriate or helpful CAMHS discipline more quickly. Use of regular ROMs is intended, once data has been gathered and analysed, to help managers to determine optimum length and modality of treatment in terms of expenditure and benefit for each diagnosis and for each patient "cluster" (level of severity). Some studies show that patients who do not report improvement early on in therapy are unlikely to make progress over the whole course of therapy - see for example Howard et al. (1986), Lambert et al. (2001), Brown et al. (1999). Therefore, CYP-IAPT literature claims that early indicators or progress (or otherwise) help mangers to know if a particular treatment is going to be effective or not and therefore may trigger a change of approach to a more helpful intervention at an early stage in treatment.

This study will look at how psychotherapists view the possible impact of ROMs data being used by managers to influence or determine or care pathways for individual young people or for particular groups of young people. It will

consider whether or not psychotherapists have confidence that data will be viewed by their managers within any relevant contextual factors and with due regard to other sources of information, including the therapist's view and verbal feedback from those who know or work with the child / young person. It will consider the role of ROMs data in determining or changing care pathways, and to what extent this data is viewed as helpful in making decisions about individual care.

Commissioners are also likely to welcome added clarity regarding the type, cost and duration of the treatment needed, on average, for a young person in each "cluster" as this will, in theory, mean that the most effective services are commissioned which can best meet young people's needs. The 2014 guidelines state:

> Commissioners have increasingly been interested in receiving evidence that the services they commission provide good value and are effective, and supervisors and managers have encouraged clinicians to produce more objective information to evidence their practice. Measures are also helpful in guiding us to ensure the level of service provided matches with the severity of the client's problems. (Law, 2014a, p.44)

It is clear that CAMHS must demonstrate that each treatment offered is cost-effective and that treatments are targeted effectively. This study will consider whether the use of ROMs data by commissioners is experienced as supportive or harmful to psychotherapy as a profession. This would depend hugely on whether therapists think that these measures are likely to capture the positive

progress that they believe their patients make, and also whether they think data will be interpreted with enough awareness of the wider context and factors which influence ROMs scores. Confidence in how commissioners view data will also be affected by whether or not psychotherapists believe that commissioners understand the process of psychotherapy, particular the use of working in the negative transference which might be expected to generate lower (or more erratic) session-by-session ROMs data than treatment approaches aimed at, say, raising self-esteem or emphasizing positives. In order to have confidence that the measures will be able to tell the difference between surface-level and deeper changes psychotherapists would need to believe that measures have been designed fairly to assess the different impact that different types of treatment might have, with no bias towards cognitive treatments.

f) Psychotherapy in particular needs to develop a stronger evidence base, which the CYP-IAPT ROMs data will provide

Psychotherapists might have particular reasons to benefit from the generation of large amounts of data relating to progress, as this may help to address the previous relative scarcity of data compared to other professions within CAMHS. Data from the CYP-IAPT ROMs might be expected or hoped to show that on the whole psychotherapists are working with the most disturbed children who are nevertheless able to make good progress. Data could be used to justify the continuance of funding for psychotherapy, as a relatively expensive provision which is able to alleviate particularly complex or entrenched difficulties. It is also potentially in the profession's interests that psychotherapists develop their understanding of which presenting difficulties are

most likely to be helped by psychotherapy, in order to target resources most efficiently.

Whilst it may feel threatening to open up psychotherapeutic work to scrutiny from the outside in this way, it may be essential to if psychotherapy is to retain a place in the NHS. Wood (2010, p.256), writing about the resistance of many psychotherapists to engage in research, observes:

> …research might be the true "third", the uncomfortable different paradigm that psychotherapists wish to shun and expel that is seen as threatening to damage if not destroy the therapeutic 'nursing' couple. However, this is a "third" that brings a genuinely different perspective, that may challenge the cloistered exclusivity of psychoanalytic thinking and language, and that has the potential to offer a much more secure anchorage in the broader field of mental health and psychology.

Use of CYP-IAPT ROMs might help psychotherapists to recognise "red flags" in the data which might indicate that a different approach is needed; psychotherapy may not always be the most helpful treatment. This would allow psychotherapists to concentrate their efforts on patients where they can make greatest difference. Kazdin (2000, p.217) writes of the danger if psychotherapists fail to embrace systematic outcomes research which produces empirical data; individual case studies alone will not be enough to maintain the place of psychotherapy in the NHS. This study will consider whether or not psychotherapists in this study identify gathering empirical data as a priority and whether or not they feel that the CYP-IAPT ROMs will help with this

3) Intentions of this study

This study will seek to scrutinise the claims made by CYP-IAPT about its benefits in the light of the reported experience and perspective of interviewees, in order to assess the specific impact of these measures on psychotherapy. It will consider how psychotherapy might gain from use of these ROMs but also the specific issues concerning ROMs use which might apply specifically to psychotherapy.

In Chapter Two relevant literature will be examined in order to establish the evidence on which CYP-IAPT makes such strong claims as to the benefit of ROMs use and for these specific ROMs. Studies cited by CYP-IAPT will be considered alongside wider literature in this field, including literature relating specifically to psychotherapy. In Chapter Three, the methodology with which this study was conducted will be considered, including choices made in selecting research methods, reasons for these and processes involved. In addition the particular confounding factors which impacted on the implementation of this study will be considered. Chapter Three will also consider the extent to which the findings of the study might be in some respects generalizable to other CAMHS teams / psychotherapy services, and the specific and individual features of this particular team, such as demography and population served, training received and so on.

In Chapters Four to Six the specific ROMs used at different stages in the psychotherapy process will be examined, starting with initial (generic) assessment and moving through to goal-setting during the psychotherapy

assessment, monitoring goals throughout treatment and other ROMs used to track progress and monitor the therapeutic alliance. The differences between using ROMs in long-term psychotherapy and in short-term and generic work will be considered throughout, as will the differing impact of ROMs used at review and ROMs used every session. In Chapter Seven psychotherapists' views about how ROMs data might be used by managers and commissioners will be considered. In Chapter Eight the findings as a whole will be summarised and finally in Chapter Nine there will be a discussion of the findings alongside conclusions as to best practice for ROMs use in child psychotherapy.

The study will also reflect on the contextual factors which may have influenced the views of participants, such as the training received and the timing of the study, staff morale and specific pressures that staff were under at the time. There had been many changes in the working conditions of psychotherapists in this Trust over the three years prior to this study, changes which are highly relevant to understanding the reaction of therapists to the further changes inherent in implementing the CYP-IAPT ROMs. These will be discussed in detail in chapter three, and returned to in the final chapter. The training received by therapists is also highly relevant to understanding staff views, and will be discussed in chapter two (literature review) in relation to the specific CYP-IAPT literature which underpinned the training received.

This study seeks to identify ways forward for this group of psychotherapists in using the CYP-IAPT ROMs most helpfully, including frequency of use, choice of ROMs and how to implement ROMs into psychotherapy sessions or reviews. It is hoped that the findings will be

applicable more widely, in particular for psychotherapists working in other CAMHS teams which are more recently starting to use these measures for the first time or who are yet to do so. It is an intention of this present study to be part of the necessary thinking which needs to take place around the implementation of the CYP-IAPT ROMs into psychotherapy, in order that these ROMs can be embedded in as thoughtful and considered way as possible in order to be most helpful (and least intrusive) as possible to both therapists and patients.

Chapter Two: A brief Overview of literature

Brann (2010, p.108) notes: "Few studies examine the attitudes of CAMHS clinicians to any outcome measure in routine clinical settings". Most of the literature about the clinical impact of ROMs relates to adults, and generally relates to psychology or psychiatry. This chapter offers a broad overview of literature related to clinicians' or patients' experiences of using ROMs and the clinical impact / benefit (or limitations) of this, and will be considered under the following headings:

1) **Studies showing that ROMs use improves outcomes**
2) **Types of ROM**
3) **Criteria of effective ROMs**
4) **ROMs to measure therapeutic alliance**
5) **Resistance to ROMs**
6) **Measuring outcomes in psychoanalytic psychotherapy / child psychotherapy**
    a) **An overview**
    b) **Evidence-based therapies**
    c) **Significant Outcome Studies in psychoanalytic psychotherapy**
7) **The 2012 and 2014 CYP-IAPT Guidelines**
8) **Summary**

1) Studies showing that ROMs use improves outcomes

The 2012 and 2014 CYP-IAPT guidelines cite several key documents as evidence that ROMs use *improves outcomes* in mental health rather than

simply measures progress. One such text, Lambert et al. (2001), is a meta-analysis of studies investigating the impact of ROMs on psychotherapy, and is used by CYP-IAPT as evidence that there is decreased deterioration of symptoms and increased progress when ROMs are used, as therapists are better placed to change the course of treatment at an early stage. Lambert et al. (2001, p.166) note that ROMs data helps to identify "potential treatment failures" enabling clinicians to change treatment approach at an earlier stage and therefore reduce dropout and enhance progress". Their study showed that patients who had the opportunity to feed back to therapists using ROMs were offered more sessions and therefore made better overall progress than patients not given this opportunity to feed back (23% versus 16% achieving clinically significant change) (ibid., p.168). They further demonstrated that among patients making initial good progress, those using ROMs were offered fewer sessions than those making equally good progress but not using ROMs, thereby saving the service money by not wasting more sessions on clients who had already improved sufficiently. Lambert et al. (ibid, p.166) track the mechanisms which translate ROMs feedback into improved progress, noting that it allows clinicians to change approach and make different decisions regarding patient care.

CYP-IAPT also uses Bickman et al. (2011) as evidence of the effectiveness of ROMs in enhancing progress; Bickman et al conducted an RCT to test "the hypothesis that weekly feedback to clinicians improves the effectiveness of mental health treatment of youths living in community settings"; they studied 340 young people aged 11-18 in the USA, treated in their own homes by one of "cognitive-behavioral, integrative-eclectic, behavioral, family

systems, and play therapy" (Bickman et al., 2011, p.1424). They showed that:

> …youths (N=173) treated at sites where clinicians could receive weekly feedback improved faster than youths (N=167) treated at sites where clinicians did not receive weekly feedback. A dose-response analysis showed even stronger effects when clinicians viewed more feedback reports.

Data was collected using paper questionnaires during each young person's session and inputted into a computer, so that the resultant data showing trends of progress / decline could be used in the subsequent session. The computer-generated feedback drew attention to when a young person's symptom severity was in the top 25th percentile and also to evidence of reliable progress over time; a mechanism was included which allowed clinicians to feed back whether or not they agreed with the report (ibid, p.1424). The 2014 guidelines (Law, 2014a, p.14) use Bickman as evidence to assert:

> Simply put: using questionnaire based outcomes and feedback tools can help us do better therapy. However, the information from forms is only effective if it is used to feed back into the therapy and to make changes where helpful to keep things "on-track". Just monitoring without using the information to change the intervention is not effective.

Although Bickman is a promising study, the types of treatment offered are not a direct match for CAMHS treatments (and do not include psychotherapy), and the study did not cover treatment in clinics. Furthermore, Bickman et al. found that an immediate progress report which could be used at the next session was

an essential component in facilitating change, not simply the act of discussing ROMs feedback.

Miller et al. (2006) is also cited by CYP-IAPT as evidence that monitoring progress and therapeutic alliance improves outcomes. Miller et al. (2006, p.5) followed the course of therapy with 75 therapists and 6,424 patients over two years, using the SRS and ORS and conclude that:

> Recent studies have found that there are significant improvements in both retention and outcome when therapists receive formal, real-time feedback from clients regarding the process and outcome of therapy.

They note that: "…increases in SRS [alliance] scores over the course of treatment were associated with better outcomes" (ibid, p.13). Miller et al. also demonstrate that: "…providing formal, ongoing feedback to therapists regarding clients' experience of the alliance and progress in treatment resulted in significant improvements in both client retention and outcome" and "clients of therapists who failed to seek feedback regarding the alliance as assessed by the SRS were three times less likely to return for a second session and had significantly poorer outcomes" (ibid., p.14). However, the service examined by Miller et al. was short-term counseling by telephone (often only one or two sessions) and the client group was adults in employment who were receiving treatment as a corporate benefit. Reasons for seeking therapy included "employee assistance", "information and referral" and "executive coaching" (Miller et al., 2006, p.7), reasons not closely allied to psychotherapy or to CAMHS treatments. Therapists staffing the service were a mix of psychologists, social workers and marriage / family therapists. Furthermore,

Miller et al. conclude that because higher alliance scores (SRS) are associated with higher ORS scores (i.e. patient perception of how well things are going in different domains of life), this demonstrates that better therapeutic alliance is associated with better outcomes. However this does not take into account that patients who tend to give positive SRS scores might also simply be more positive in outlook generally and therefore give higher ORS scores. SRS scores were not triangulated with other measures of progress, such as decrease in time taken off work or perceived improvement by other family members. Miller et al. also note: "From the present data, it is not possible to determine whether feeling better leads to better alliances or better alliances result in feeling better (ibid, p.13-14).

In addition to the studies cited by CYP-IAPT as evidence for the benefits of ROMs, several other studies make similar assertions. Wood (2010) suggests that the use of ROMs can act as a helpful "third" which helps with triangulation of views and therefore lends greater objectivity to assessing progress. Lambert et al. (2005, p.165) survey four outcome studies and show that, from this data, when negative ROMs feedback from patients who had not made initial feedback is seen by clinicians progress rates increase from 21% to 35%-56%. They note the weaknesses of their study (ibid, p.168):

> …many of the patients whose therapists got feedback did not achieve clinically significant change by the time they left therapy, and many remained symptomatic (albeit better off than the controls) despite the feedback…this study provided no mechanism for monitoring whether and how clinicians changed treatment in

response to feedback…

They conclude that their research is hopeful, but that more research in this area is needed before links between measuring outcomes and improved progress can be understood.

Unsworth et al. (2011, p.78, p.71) interviewed NHS employees receiving counselling or psychotherapy and also their therapists; therapists said that they valued ROMs because they alert them to risks which they would not otherwise have known about, the scores were useful in supervision and the data helped them to determine how many more sessions would be needed. Although therapists reported initially being resistant to the measures, they became convinced that use of ROMs enhanced their assessments. They reported previously having relied on "gut feeling" while now they felt that this gut feeling could be validated and evidenced (ibid, p. 76). Both patients and therapists reported finding the visual feedback helpful. Whilst this is a useful comparison study to the present study, there are significant differences in treatment offered and patient group. Unsworth et al.'s therapists were offering short-term treatments of up to six sessions to adults in employment, and therapists included three psychotherapists (all trainees), five occupational therapists and two counsellors.

Whipple et al. (2003, p.59) carried out a study of 981 clients receiving psychotherapy under usual treatment conditions but randomly assigned either to a group completing ROMs or a group not doing so. They demonstrate that ROMs use in psychotherapy leads to improvement rates rising from 25% to 49%. They assert that: "…outcome is improved and treatment resources are

more efficiently allocated when feedback on client progress is provided to therapists". However, the clinicians involved in delivering "psychotherapy" were psychologists and trainee psychologists, and "psychotherapy" included CBT (50% of cases), psychodynamic-interpersonal (20%), humanistic-existential (20%), behavioural (2%) and other (8%) (ibid, p.60), with an average treatment length of 12 sessions; further investigation would be needed into whether or not there is correlation of findings with long-term psychoanalytic psychotherapy with children.

Troupp (2012) examines the impact on clinical practice of introducing goal-based outcome measures to child psychotherapy within CAMHS; she acknowledges that previous research in this area is "sparse" (p.1) and that there has been more interest in normative standardised measures than individualised ones such as GBOs. Her paper focuses particularly on how best to integrate goal-setting and goal-monitoring into child psychotherapy, with practical suggestions about the structure of goals and the most helpful processes in establishing goals. Her findings will be considered in chapter five alongside the experience by therapists in this present study of using GBOs. Emanuel et al. (2014) focus on the GBO within a hospital based CAMHS service. They discuss best practice for establishing and monitoring goals, and reflect on rare cases where use of the GBO is inadvisable. They find that use of the GBO clarifies the focus of treatment and enhances collaboration between the therapist, patient and parents / carers.

Baruch et al. (1995, p.259) conducted a longitudinal study over three years of work at The Brandon Centre where outcome measures were piloted and integrated into psychotherapy with 12-25 year olds. Therapists reported that

ROMs provided information which young people did not otherwise reveal at assessment. Baruch finds that outcome measures give a picture of clinical progress untainted by "the hopelessness that can be engendered by the troubled adolescent or…manic optimism which the therapist can use as a defence against hopelessness". Baruch and Vrouva return to the same service some years later to assess the impact of ROMs on treatment. They find that "young people who did not provide data at intake were more likely to have dropped out of treatment" (Baruch and Vrouva, 2010, p.30). They find that data collection rates improve when collected at regular intervals rather than at start and end of treatment.

Much research shows that mental health clinicians are poor at knowing how healthy or otherwise their patients are or how much they are progressing. Trauer (2010, p.186) notes: "Numerous studies attest to the low correlation between consumers' and service providers' assessments of illness severity and personal functioning". Lambert et al. (2005, p.173) note that: "clinical judgments are usually found to be inferior to actuarial methods across a wide variety of predictive tasks". Hannan et al. (2005) surveyed 48 therapists treating university students and asked them to predict which patients would get fully well, which would improve, which would stay the same and which deteriorate. Looking at the 40 patients in the study who deteriorated (as measured by the "Outcome Questionnaire"), patients' ROMs feedback had a far higher level of correlation with actual deterioration (31/40) than the therapists' predictions (1/40).

2) Types of ROM

Wiger and Solberg (2001) identify two broad groups of ROMs: normative and individual. In normative measures every patient is scored against the same statements as every other patient (such as SDQ, RCADS, (C)ORS, CVT) while individualised measures are tailored specifically to the needs and difficulties of each patient, such as the GBO. Normative measures may feel easier to introduce to a new patient since they do not require the patient to have any insight into their difficulties or any ability to discuss and explore these. However, questions cannot be tailored or altered to fit individuals as this would undermine their use for data comparison purposes. Wiger and Solberg (ibid, p.43) note that normative ROMs may be resisted by therapists: "…the more time-consuming and unrelated to specific treatment issues they are, the greater the therapist's dissatisfaction and noncompliance will be." Individualised measures have the advantage that they can be a closer fit to a young person's specific difficulties and so they are more likely to be welcomed by young people, however unlike normative measures their limitation is that there is no possibility of using the data for comparison with other young people, comparing against "norms", relating to a standardised norm or for comparing services (ibid, p.38).

An example of an individualised measure would be the GBO. Slade et al. (2010, p.75) point to the usefulness of GBOs in making personal and idiosyncratic aspects of change visible to others. They recognize that what matters is that the patient feels that there has been improvement and that their life is better as a result; this may feel more important to a patient than how they measure up against someone else's definition of a happy or successful life. They conclude: "More focus needs to be put on assessing and basing care on

the service user's perspective than on the staff perspective…and developing methods which recognize the uniqueness of individuals and their life goals….Therefore, evaluation of personally valued goals is central". Likewise, Wolpert et al. (2015, p.68) discuss GBOs as likely to be preferred by both patients and clinicians because they focus on the "particular concerns of the individual, [avoiding the] tick box exercise that both practitioners and service users are concerned about." Wiger and Solberg (2001, p.60) note the importance of using a combination of individualised and normative measures since it is important both to be sensitive to very individual concerns but also to allow for data comparison across groups and individuals.

Normative measures can be divided into those focusing on global functioning and others focusing on specific symptoms or diagnoses. Global assessment tools – such as SDQ - are likely to be most helpful at initial assessment in narrowing down presenting difficulties and ensuring that no area is left out - but might feel unwieldy if repeated too often and might feel unnecessary even at initial assessment to young people presenting with apparently very specific symptoms. Wiger and Solberg (2001, p.12) note the limitations of global measures as covering such a wide area that the information about any specific area is "vague". More focused measures such as symptom trackers (STMs) may feel less unwieldy but do not allow for the possibility of something unforeseen, for example when a young person has an underlying difficulty which translates itself into a new symptom e.g. shift from OCD to eating disorder. This would go unnoticed if only specific symptoms are tracked. Walborn (1996) points out that psychoanalytic thinkers tends to prefer global measures while cognitive behaviourists favour specific symptom based tools;

this is because psychoanalytic psychotherapists tend to think in terms of whole-person functioning rather than treating symptoms. Wiger and Solberg (2001, p.12), both psychologists, argue convincingly that multiple types of measure are needed, including global (infrequent) measures and specific (frequent) measures; however, they find that frequent specific measures provide a higher quality of feedback and are more useful in making decisions about on-going clinical care, such as to make a change to the treatment plan or to discontinue treatment.

3) Criteria of effective ROMs

Clearly it is important that whichever ROMs are chosen they feel useful, appropriate and well-chosen to both patient and therapist. Kabir and Wykes (2010, p.5) set out eight essential properties of successful outcome measures. These are: appropriateness, reliability, validity, responsiveness, precision, interpretability, acceptability and feasibility. These criteria will be considered throughout this thesis in relation to statements made by interviewees regarding CYP-IAPT measures. The most relevant to the specific focus of this study are likely to be acceptability – do patients and therapists believe in the worth of these tools, and are they prepared to use them? – and feasibility, are they practical to implement or intrusive to therapy? Kabir and Wykes note: “Despite our searches it has been difficult to discover many measures for which we are reasonably certain there is evidence that users value the outcomes they record” (ibid. p13). Brann (2010, p.109-110) notes: “Feasibility is the most demanding criterion”, and this will be a key aspect of the CYP-IAPT ROMs that will be

assessed throughout this present study.

Salvador-Carulla and Gonzalez-Caballero (2010, p.57) also spell out multiple criteria which make for effective ROMs; they consider whether or not tools are user-friendly, practical, efficient at gathering the required information and whether or not they are “meaningful for…recipients” including the patient, therapist and others who might view the data, such as patient’s family, managers and commissioners. They also consider whether, when tools are combined, there might be undue duplication of questions leading to decreased client and therapist satisfaction with the tools (ibid. p60-61). Miller et al. (2006) note that therapists resent using tools which take more than five minutes to complete, while Wiger and Solberg (2001, p.184) note that compliance rates increase when forms are kept short. They advise selecting a few tools which can perform more than one function, for example which provide both useful clinical data for the therapist / patient and also data for outcome monitoring by external agencies (ibid, p.185).

Use of a variety of tools enables more aspects of progress to be measured. Speer (1998, p.89) notes the need for both behavioural and emotional measures: “If one measures emotions alone, one might conclude that consumers improve quite rapidly; if one assesses only behavioural characteristics, we might conclude that change is a long-term process.” Speer (1998) and Lambert and Lambert (1999) both point to the importance of using multiple outcome measures since patients will improve in some areas and not so much in others. Wolpert et al. (2015, p.63) weigh up the benefits and limitations of each of SDQ, RCADS, C/ORS and GBO; they examine data from a range of studies related to each and conclude that they are best used in

combination. They also find that GBOs, C/ORS and RCADS have clinical utility while SDQ, C/ORS and RCADS gather useful data for comparison purposes.

In addition to potential benefits of using different types of measure, there is evidence that it is helpful to use ROMs which get the perspective of more than one person. This is particularly the case for children where the views of the therapist, parent / carer, teacher, social worker and other involved professionals may all offer very different perspectives. Brann (2010, p.106) observes: "…only including clinicians' perspectives tends to privilege symptoms…Parents' views are more likely to be biased towards family burden and externalizing symptoms, while children are likely to be more aware of internalizing symptoms". Trauer (2010, p.187) notes the importance of using ROMs to discover when there is a discrepancy of views, for example between child and parents; a child may have been keeping their true feelings to themselves or a parent might be invested in maintaining a view that their child is "attention seeking", for example. Wolpert et al. (2014, p.273) note that incorporating several perspectives was built into CORC measures from the outset, gathering the views of the child, carers and clinician as a minimum. They observe that while children are reliable reporters of their difficulties as a whole, parents tend to see the behavioural difficulties and clinicians are most reliable reporters of "complex symptomatology and functioning" (ibid p.273).

4) ROMs to measure therapeutic alliance

Measuring the "therapeutic alliance" is embedded into CYP-IAPT, on the basis that good alliance is key to good outcomes and that it cannot be assumed that the clinician knows how good / bad the alliance is without ROMs data.

CYP-IAPT's 2012 guidelines (Law et al., 2012, p.52) cite a study by Kelley et al. (2001) which offers evidence that monitoring the alliance between therapist and parent / carer improves treatment outcomes for young people. However, this study in fact only demonstrates the importance of keeping parents and carers informed about treatment, since they bring their child to therapy and could choose not to do so. It is misleading to use this study as justification for using the SRS, particularly for using the SRS with the patient; Kelley at al. make no claims about the benefits of ROMs to the therapeutic alliance, nor about use of ROMs every session, in fact they specifically draw attention to the lack of evidence in this area as a whole:

> A parent who has a strong TA [therapeutic alliance] with the therapist is likely to convey hope and other positive attitudes about treatment that may generally encourage the child's participation in treatment, which then in turn may influence youth outcomes….*however, rigorous empirical research has yet to be accomplished that could provide evidence of such effects.* (italics mine)

The CYP-IAPT 2014 guidelines mention in passing four other studies which assert the usefulness of session by session monitoring of alliance. They are Horvath and Symonds (1991), Martin et al., (2000), Wampold (2001) and Norcross (2010). Horvath and Symonds is a meta-analysis of 20 outcomes studies, which shows a small correlation between a reported good therapeutic alliance and positive treatment outcomes. However it does not look specifically at young people's therapy and only seven of the 20 studies involved psychodynamic approaches, nor is it clear if any of the studies involved long-

term therapy. Martin et al. (2000) makes no specific claims for session-by-session monitoring of alliance, and reports that patient-therapist alliance tends to remain consistent throughout treatment. This study might therefore point to the benefits of taking a snap-shot of the alliance at the start, but does not offer evidence for session-by-session monitoring. Wampold (2001) points to the correlation between a positive alliance and good treatment outcomes in a meta-analysis of studies, but again make no claims for session-by-session monitoring of the alliance nor does it look specifically at psychoanalytic psychotherapy. Norcross (2010) also makes no claims for session-by-session monitoring of alliance nor does it consider specifically either young people or psychoanalytic psychotherapy.

Looking at the body of evidence cited by CYP-IAPT in support of using SRS every session to monitor progress, it:

- relates only to adults and / or
- does not relate specifically to children and young people and / or
- does not relate to psychoanalytic psychotherapy or long term treatment

None of the studies cited by CYP-IAPT make any claims that session-by-session monitoring of the therapeutic alliance has any benefit.

In addition to studies specifically cited by CYP-IAPT, there are many other studies supporting the benefits of measuring the therapeutic alliance. Trauer (2010, p.7) writes: "…there is now considerable evidence that clinicians tend to consistently misread their consumers' wants, while confidently believing that they appreciate them accurately". Horvath and Luborksy (1993, p.563)

review research in this area and observe that alliance is a “pantheoretical factor” which accounts for progress in vastly different treatment types. Eubanks-Carter et al. (2010, p.74) cite seven studies as evidence that: “a strong alliance is a robust predictor of good outcome…weakened alliances are correlated with unilateral termination by the patient”. Several studies point out that while a positive alliance is correlated with good outcomes, a negative alliance at start of treatment is correlated with uncertain outcome (rather than negative outcome), for example Luborsky, 1996. However, Barber et al. (2010, p.40) observe that measures of “initial alliance” are often taken at the end of the first session, when the patient may have already felt the immediate relief of beginning treatment, and thus good alliance might be a result of good treatment rather than the other way round.

Karver et al. (2006, p.50) undertook a meta-analysis of 49 studies of therapeutic alliance and found a strong correlation between alliance level and outcome; their study furthermore attempted to break up “alliance” into specific component parts that might be more informative to therapists, such as “counsellor interpersonal skills”. Muran and Barber (2010) discuss what makes for a good alliance and how to improve this, and investigate reasons why the alliance may shift over the course of treatment. Luborsky (1976) finds that “good alliance” is different at start of treatment to later in the work, changing from a patient’s view of a helpful therapist to a sense of a shared struggle; he offers evidence that both types of “good alliance” are correlated with good progress. Several studies argue that therapeutic alliance is not just a predictor of good outcomes, it is a causative factor, for example: “alliance is a critical ingredient of change in diverse forms of therapy” (Safran and Muran, 2000,

p.243). Meissner (2010, p.243) asserts that for child patients, who are still forming their first relationships, and for the adolescents who are likely to walk away if not secure, a positive alliance is even more strongly related to good outcomes.

However, there is considerable dispute about whether "good alliance" is really a predictor of good outcomes, and certainly whether it is a causative or contributory factor. Barber et al. (2010, p.40) note that few studies examine how alliance and progress correlate *over time* and that those that do fail to show a clear correlation. They show that the relationship between alliance and progress is influenced by many variables such as patient expectation of treatment, for example Moras and Strupp (1982) show that patients who are hostile to the process before they start will get poorer outcomes. Kennedy and Midgley (2007, p.18) observe that any correlation between good alliance and good outcomes cannot be assumed to be causative: "…one cannot specify whether the alliance is the critical mechanism of change or merely a side-effect (or even a consequence) of good outcome." Patients whose alliance and outcome are poor may simply be those who had a worse preconception of treatment. Baldwin et al. (cited Fonagy 2010, p.36) carried out research which demonstrates that though therapists who are better at establishing a good therapeutic alliance have better patient outcomes, *within* each therapist's group of patients there is no difference in outcome between those patients who report the best or worst therapeutic alliance. It may be that therapists whose patients on the whole report a better alliance are also the better therapists, resulting in better outcomes. Measuring the alliance of each patient of a particular therapist may therefore provide no information which could be acted upon to identify "at

risk” patients, it might simply flag up therapists who are better or worse at developing good alliances with their patients.

Even if it could be proven that there was a causative relationship between good alliance and good outcome, more detailed information would be needed about specific components of a good alliance, the relation of each to outcomes and what behaviour or actions on the part of the therapist can influence these (for example Horvath and Luborsky, 1993, p.570). Ackerman and Hilsenroth (2003) find good alliance is rooted in therapists’ personal characteristics of: “being flexible, experienced, honest, respectful, trustworthy, confident, interested, alert, friendly, warm, and open” (cited Messer and Wolitsky, 2010, p.108). Horvath and Luborsky (1993, p.569) note that it is unclear how to train therapists to improve alliances with patients.

Specific issues emerge when considering the therapeutic alliance in psychoanalytic psychotherapy. This is not because the concept of the importance of a good therapeutic alliance is alien to psychoanalytic thinking. Freud (1913) highlighted the importance of having a positive “working alliance” with the therapist outside of the transference relationship while Anna Freud (1927, p.14) cultivated her child patients’ goodwill at treatment outset in order to “create a tie strong enough to sustain the later analysis”. More recently, Horvath and Luborsky (1993, p.561) write that psychotherapists should deliberately cultivate a positive alliance, because:

> …the ability of the intact portion of the client's conscious, reality-based self to develop a covenant with the "real" therapist makes it possible to undertake the task of healing.

Greenson (1967, p.102) describes a patient's "conscious and rational willingness to cooperate" so that even in the context of a hostile transference relationship the patient continues to attend.

Meissner (2010, p.234) sets out elements that constitute a successful therapeutic alliance within psychotherapy. These are the therapeutic framework, authority, responsibility, empathy, trust, autonomy, initiative, freedom, neutrality and abstinence, and certain ethical considerations. He highlights how the alliance changes as the therapeutic relationship progresses; it may begin as dependent, but over time the patient is more autonomous and able to challenge the analyst. Safran et al. note that the best outcomes were found when there had been a significant rupture in a good alliance and this had been repaired (Safran et al. 1990).

There are contradictory findings as to the relation between positive alliance and outcomes in psychotherapy, with studies such as Castonguay et al. 2006 showing a strong correlation while, for example, Puschner et al. (2008) shows no correlation. Stiles and Goldsmith (2010, p.47-54) cite ten studies which show that therapeutic alliance tends to increase over the course of psychotherapy, but also eight in which it does not; they discuss five studies showing a correlation between a linear improvement in alliance to better outcomes and five where this correlation is not present. They note a "failure of so much research to yield clear answers to what seem like basic questions in this area".

Messer and Wolitzky (2010, p.101) investigate why psychotherapists in particular might resist cultivating a "good alliance" and assert that is so as "not

to contaminate the field of observation" or disrupt the transference relationship. They trace a history of dispute within the psychoanalytic community about whether "therapeutic alliance" is a relevant concept. They find that the patient's overt co-operation has to be understood and interpreted in the transference, for example as a desire to be loved by the therapist as by a parent (ibid, p.102), a view shared by Brenner (1979). It is not evident in psychotherapy that a patient's overt co-operation is a sign that work is going well. Hatcher (2010, p.7) writes of therapeutic alliance in mental health care generally:

> When things go as expected and the patient is engaged and responsive, we know we are working well together.…Our work is on track. And we know the work is off-course when our patient seems to be losing interest, becomes silent or angry with us, or seems to feel misunderstood.

For psychotherapists this is far from evident; it can be a sign of progress when patients start to express and explore negative emotions towards the therapist, and within the transference relationship the therapist may well be cast in a number of negative roles; a patient who appears "engaged and responsive" may be showing superficial compliance which conceals underlying hostility. Meissner (2010, p.237) notes:

> One difficulty is that empirical assessments of alliance factors tend to interpret them in terms of conscious collaboration between patient and therapist…However, if the meaning of alliance is left in these simplistic terms as inadequately separated from a form of compliance, these findings might have more to do with a form of

misalliance more than alliance.

Stiles and Goldsmith (2010, p.56) note that alliance research has relied on a "drastic simplification" that does not separate out the real-life relationship, transference and therapeutic alliance. A question for this current study will therefore be whether or not the SRS tool for monitoring therapeutic alliance is sophisticated enough in both its design and in how its data is interpreted to take account of this complexity, or if it has been designed in line with the view of Hatcher (2010) that a surface appearance of co-operation is all that is needed to know that work is "on track".

5) Resistance to ROMs

Despite substantial evidence that clinicians are poor at spotting off-track therapies, many therapists resist ROMs use. Lambert et al. (2005, p.173) note:

> …clinicians do not see the value of frequent assessments based on standardized scales…possibly because they are confident in their ability to observe patient worsening accurately and provide an appropriate response.…

Unsworth et al. (2011, p.72), Brann (2010, p.109-110) and Wiger and Solberg (2001, p.11) all note how threatening it can be to therapists to have work scrutinized through ROMs data. Risq takes the view that (adult) IAPT ROMs actively act as malevolent "surveillance systems" (Risq, 2012, p.319) and that furthermore:

> …Deceiving oneself that there is no harm in using repeated and intrusive clinical measures simply because "that's what we've been

told to do" *when one actually believes otherwise* is potentially bad faith. This is…an essentially fraudulent solution.

Hatfield and Ogles (2003, p.489) surveyed 996 psychologists in the USA and found that 62.9% do not use ROMs, either for practical reasons (they take too long, impose paperwork or are a burden to clients) or because they are not seen as "helpful or relevant". Trauer (2010, p.259) notes that the requirement to complete ROMs with no additional time allocated to this is likely to result in "tokenistic compliance in order to minimise additional workload", a point also made by Wiger and Solberg, 2001, p.199. ROMs use may be experienced as an extra burden; Brann (2010, p.106) notes: "Many clinicians consider face-to-face clinical work to be the 'real' work, and resent intrusions into that activity". Trauer (2010, p.259) suggests that clinicians also fear data will be used unhelpfully to pit providers against each other to prove they have better / cheaper outcomes. Timini (2015, p.59) notes that ROMs return rates in CORC since 2004 have stayed at 10-25% and that no initiatives have managed to improved this low return rate, they speculate that ROMs data is not valued by front-line staff and conclude that the little data that *is* returned is unreliable since it has been submitted by such a low percentage of the workforce.

6) Measuring outcomes in psychoanalytic psychotherapy / child psychotherapy

a) An overview

Psychotherapists in particular have not generally been quick to embrace outcome studies or quantitative methods of evaluating progress. Wood (2010,

p.253) examines reasons why psychotherapists might be suspicious of the move towards trying to capture in numbers the complexity of what takes place in psychoanalytic psychotherapy:

> The notion of the unconscious is one distinguishing feature of the psychoanalytic model, yet that which is unconscious is not amenable to easy study or measurement, and empirical investigations which do not tap unconscious factors may be seen to neglect the essence of the work.

Interviewees in this present study make frequent reference to the core aims and processes of psychoanalytic psychotherapy which are essential to its functioning, in justifying their position in relation to ROMs use. In understanding interviewees' comments it is important to understand which aspects of psychoanalytic psychotherapy are considered essential (and perhaps specific) to this treatment and what impact ROMs use might have on these aspects and therefore on the method of treatment.

Unlike many other mental health treatments, the aims or intended outcomes of psychoanalytic psychotherapy (including child psychotherapy) are not usually conceptualised in terms of behavioural or symptom change alone and thus might seem to be harder to quantify than methods aimed at relieving symptoms. The changes that psychoanalytic psychotherapists are most interested in are changes to the "internal world", i.e. the patient's perception of themselves, of significant people in their lives and of the world around them; psychotherapists help their patients to allow what had previously been unthinkable or repressed (and therefore perhaps acted out in undesirable ways) to become conscious, able to be spoken about, and therefore less toxic.

When we look at literature by psychotherapists / psychoanalysts detailing the aims of successful psychoanalytic psychotherapy / psychoanalysis, both with children and with adults, the dominant view is that changes in psychotherapy may be harder to document than changes in other treatments, because the aims of psychotherapy are not symptom-focused. Nick Midgley, for example, writes:

> Measures of outcome are often very global and focus on symptoms, but this may overlook subtler – but possibly more significant – forms of change, such as those in one's internal state of mind. Such change, which psychodynamic treatments tend to focus on, is far harder to measure using standardised tools. (Midgley, 2009, p.77)

Midgley writes of the importance of capturing clinically significant change rather than merely statistically change, i.e. changes that impact on the patient's state of mind and which bring about lasting changes in wellbeing.

Robert Caper describes the aim of psychoanalysis as being "to assist the patient to integrate repressed or split-off parts of his personality" (Caper, 1999, p.21); he describes the therapist / analyst as a facilitator who creates the necessary conditions for the patient to recover, but who must resist any "urge to heal" – "only then can he be free to do psychoanalysis" (ibid p.31). Caper makes it clear that psychoanalysis (and psychoanalytic psychotherapy) involves creating the conditions where what has been repressed can become conscious and so less destructive, but that the actual use made of this is in the hands of the patient. He is clear that the aim of psychotherapy is not symptom change itself, but rather for the patient to gain greater understanding of their own

internal states, giving them more awareness of destructive states of mind and patterns of behaviour that result.

Paul Barrows sets out to define the aims of child psychotherapy. He writes:

> …one way of describing the "aim" of psychoanalytic therapy, [is] to state that it is concerned with making the unconscious conscious, in order to give patients more control over their lives. With greater awareness and insight into both the conscious *and* the unconscious factors determining their actions patients are better equipped to make their own decisions. Such an approach is clearly not targeted primarily at relieving particular symptoms but at effecting more profound, though less measurable, changes in overall psychic functioning. (Barrows, 2001, p.373)

Barrows outlines the way that excessive use of projective identification can leave an individual impoverished, because part of the self is felt to lie elsewhere – in others or in the world, but not in the self. One of the aims of psychotherapy, therefore, is to help the individual to become more integrated and to be able to accept back into the self those aspects which had previously been experienced as unacceptable, and which were therefore projected outwards into others. He writes of child psychotherapy:

> …the aim of psychoanalytic therapy then becomes that of helping to unravel these processes if and when they have led to the patient losing touch with an important area of their personality. Rather than

> setting out to target a particular symptom in order to remove it, the therapist has the intention of helping patients to reintegrate those aspects of themselves that have been disowned. The implicit aim is to restore to patients the full use of their own mental equipment and capacities, thus leaving them better equipped to deal with not only the current conflict or problem that has led to the referral, but also any future adversities….A decrease in symptoms would be an anticipated by-product of such an approach though not its overt target. (ibid p.374-375)

Because psychotherapy is not focused primarily on symptom change, any changes which the patient makes may not necessarily be closely related to initial "aims" or "goals" formulated at start of treatment; Barrows notes that even in cases where it is possible in advance to anticipate what symptom change might be desirable:

> At the same time, other benefits in terms of overall functioning might be expected to accrue, although they may not relate directly to the grounds for the original referral. (ibid p. 375)

This might make psychotherapy harder to measure than treatments where "progress" can be assumed straightforwardly to related to improvement of the symptoms identified as problematic at the start of treatment.

Another aspect of psychotherapy which will be frequently cited by therapists in the present study is the nature of psychoanalytic psychotherapy as a space without agenda, where patients are free to say (or play) whatever comes to mind; this concept is central to any literature outlining the core

features of psychoanalytic psychotherapy. Shedler (2010, p.100) writes: "…psychodynamic therapy encourages patients to speak freely about whatever is on their minds….their thoughts naturally range over many areas of mental life, including desires, fears, fantasies, dreams, and daydreams…."; similarly, Bott Spillius et al. (2011) write that patients in psychotherapy need to be free to say "what they think and feel, without censorship", and that the therapist should also not be focused on a goal, but instead "should avoid looking in the patient's material for what he hopes to find" (p.216). The Tavistock Psychoanalytic Psychotherapy patient information leaflet advises: "…there are no expectations, you are free to talk about whatever is on your mind", and it advises that therapists are "much less likely to ask questions or direct the conversation than other kinds of therapists" (Tavistock and Portman, 2016, p.4-5). It is important to understand this aspect of psychoanalytic psychotherapy, since it is through the patient's freedom to say whatever comes to mind that the psychotherapist begins to identify those thoughts, feelings and internal structures which might be unconscious and yet which are powerfully influencing the patient.

An additional feature of psychoanalytic psychotherapy which it is essential to understand is that this treatment is not aimed at making patients feel good in the short term, and might stir up powerful negative feelings; this aspect of psychotherapy is impressed upon new patients in a range of literature, for example the British Psychoanalytic Council website (2016): "The psychoanalytic therapist will seem less socially responsive and immediately reassuring than other therapists, who take more of a trainer or friend role" (BPC, 2016). The British Psychotherapy Foundation website advises patients that psychoanalytic psychotherapy "…can in itself be an emotionally disturbing and

sometimes painful process". Again, the Michigan Psychoanalytic Society website cautions prospective patients:

> Real lasting change does not come easy and is often accompanied by unexpected discomforts, diversions, and delays. For some, this means feelings of anxiety or depression or crying episodes which may make you worry that you are getting worse.

Reclaiming unwanted, troublesome aspects of the self is likely to be painful and turbulent, and might in the short term make the child feel hostility towards the therapist. Barrows notes:

> Given, however, that this process involves patients having to resume responsibility for aspects of their personality that, for powerful and compelling reasons, they have previously disowned and would prefer not to acknowledge, it is perhaps not surprising that this is met with resistance and that children may not always be keen on attending for their sessions. (ibid p.375)

Not only might psychotherapy make the patient feel worse in the short term, stirring up powerful negative feelings, it is a feature of psychotherapy that these aspects are actively named and thought about rather than avoided, and the therapist's role is not to reassure the patient. Dina Rosenbluth writes in the second edition of the *Association of Child Psychotherapists Bulletin*:

> The impetus to co-operate in treatment, the "therapeutic alliance", is fostered most effectively when the child gains the conviction that we understand him and are not afraid to put into words even the most

> violently hostile impulses and phantasies. If he feels that…we can understand and interpret and in that way make them more manageable for him, the impetus to co-operate fully in the treatment becomes thereby strengthened. (Rosenbluth 1961, p.72)

Psychotherapy does not shy away from both the therapist and patient being able to verbalise the most hostile and aggressive thoughts and feelings; in this way the patient begins to be able to know themselves more fully, and loses the need to repress or project outwards unwanted aspects of the self.

Another key difference between psychoanalytic psychotherapy and other treatments is the importance of the transference relationship. Again, this aspect of psychoanalytic psychotherapy is referred to throughout literature explaining the nature of this treatment; for example, Bott Spillius et al. (2011, p.216) describe transference as: "…unconscious expression of past and present experiences, relationships, thoughts, phantasies and feelings, both positive and negative, in relation to the analyst". This concept will be important for understanding how ROMs might fit within psychotherapy and what exactly it is that patients' ROMs scores might be expressing and reflecting. The concept of "negative transference" will be important to this present study, i.e. the negative projections into the therapist by the patient. This concept has always been important in child psychotherapy, for example E. M. Mason (1970, p.95) observes: "…the fantasies and irrational attitudes belonging to early object relationships are introduced into the relationship with the therapist…early relationships and attitudes are transferred to the therapist and current conflicts and attitudes are extended from the present to the treatment situation."

Hamish Canham (2004, p.144-145) writes that transference in child psychotherapy is the therapist's main way of understanding the child's internal world, through how the child treats the therapist (e.g. as a character from their past or wider life) and also in the feelings evoked in the therapist as a result, i.e. the therapist's counter-transference:

> …in order to understand our patients' internal worlds and the nature of their object relationships, defences etc. we have to experience them in the counter-transference, and in this way temporarily inhabit their world. Some measure of being pulled in is inevitable and even desirable.... one can catch oneself being pulled into something and use this as the basis for describing to the patient the nature, meaning and historical antecedents of what is happening now between the two participants.

It is essential for understanding the views of therapists in this present study that the aims and processes of psychotherapy as outlined by the writers discussed above are understood, as these underlie much of the debate around the type of outcome measures which might best / least fit with psychotherapy, and the reasons why psychotherapists might feel that their treatment needs to be considered differently to other CAMHS treatments in relation to ROMs use. The aspects of psychotherapy discussed above – particularly the use of the transference relationship, agenda-free space, encouragement to voice negative feelings and the lack of focus on symptoms, all combine to form a treatment which is arguably more complex to measure than treatments which do not share these features, and it is these features which will be referred to frequently by

therapists throughout this study.

b) Evidence-based therapies

The concept of "evidence-based practice" will be important in understanding the views of interviewees in this present study. On the surface it would be hard to argue with the view that treatments provided by CAMHS should be those with the most evidence of their effectiveness. The CAMHS Resource Directory for Commissioners (p.2) makes reference to the need to: "provide children and young people with mental health problems with swift access to evidence-based…services". The NICE guidelines are titled: "Improving health and social care through evidence-based guidance", placing the results of clinical trials using outcome measures at the centre of their recommendations about clinical care. CYP-IAPT's website (2016) also states its intended aim as:

> …improving access to evidence-based therapies by training existing CAMHS staff in targeted and specialist services in an agreed, standardised curriculum of NICE approved and best evidence-based therapies.

Clearly, being "evidence-based" lies at the heart of current mental health commissioning and recommendations for good practice.

Difficulties arise, however, when consideration is given to what constitutes "evidence" and whether measures which are appropriate for symptom-focused treatments are also the most useful measures for psychodynamic treatments. It is relatively easily to measure a treatment which

sets out to identify and improve specific symptoms. If psychodynamic treatments cannot be measured so simply, then it is likely that fewer outcome studies will be conducted and that they may therefore appear to have a less strong “evidence-base” than treatments which focus on symptom relief.

A. Pucci (2005), on The Association for Behavioural and Cognitive Therapies website, makes exactly this point:

> …cognitive-behavioral therapists believe that their explanation of human behavior (that "learned" behaviors and emotions are caused by one's thoughts) is correct. Rather than *assuming* that their theory is correct, they base this assumption on psychosomatic research that in fact proves that the assumption is indeed correct.

Pucci criticises approaches in which evidence of progress cannot be measured simply, i.e. approaches which are not manualised and symptom-focused, such as psychoanalytic psychotherapy:

> Many approaches to psychotherapy do not lend themselves well to being researched and proven effective because they either utilize techniques that are vague and difficult to repeat with consistency, or the approach attracts practitioners that are not very interested in testing the effectiveness of it.

Pucci claims that CBT is a superior treatment because its techniques are more precise / measurable, it is goal-based (and therefore measurable) and because CBT therapists are interested in research. He concludes that: “cognitive-behavioral therapists are not interested in techniques that "feel right" or "seem correct", but techniques that *are* effective”.

This view, i.e. that techniques such as CBT are better because "evidence-based", is interrogated by Shedler (2015b) on the website of *Psychology Today*:

> Academic researchers have usurped and appropriated the term "evidence based" to refer to a group of therapies conducted according to instruction manuals ("manualized" therapies). The other things these therapies have in common are that they are typically brief, highly scripted, and almost exclusively identified with CBT. The term "evidence-based therapy" is also, *de facto*, a code word for "not psychodynamic."

Shedler (2015a, p.47) asserts that daring to challenge *anything* about evidence-based therapy can be dangerous:

> Behind the "evidence-based" therapy movement lies what I will call the "master narrative"…[which] goes something like this: "In the dark ages, therapists practiced untested, unscientific therapy. Science shows that evidence based therapies are superior." This narrative has become a justification for all-out attacks on traditional (i.e., psychodynamic) therapy—that is, psychotherapy that fosters self-understanding and insight in the context of a meaningful, ongoing therapy relationship.

He accuses proponents of evidence-based therapies of "McCarthyism": "…it becomes difficult to have an intelligent conversation about what constitutes good therapy—to question claims for "evidence-based" therapy is to risk the accusation of being "anti-science" (ibid, p.48). He argues that the fact that

psychodynamic therapy has had fewer research studies, owing to the complexity of measuring this treatment, has been wrongly equated with it being less effective; under the laudable aim of supporting “evidence-based” practice the most easily-measurable and symptom-focused treatments – such as CBT - are in danger of being considered superior because they lend themselves more easily to research studies.

The use of the term “evidence-based” as a synonym for high quality treatments, without any awareness of the factors which might make some treatments more straightforward to measure than others, is a theme which will be highly relevant to understanding views expressed by some interviewees within this current study.

c) Significant Outcome Studies in psychoanalytic psychotherapy

Despite some of the difficulties in measuring psychoanalytic psychotherapy as discussed above, there has emerged a body of evidence in support of the effectiveness of this treatment. The Northern School of Child and Adolescent Psychotherapy website states:

> ...there is now enough research evidence to claim that psychodynamic therapy is an evidence-based treatment with effect sizes similar to or superior to those reported for other psychotherapies…it is encouraging that the benefits of psychodynamic therapy not only endure after therapy ends, but increase with time. This suggests that insights gained during psychodynamic therapy may equip patients with psychological skills that grow stronger with use. (Harvard Medical School, 2010)

One way to avoid either disrupting the treatment itself or reducing the treatment to over-simplified questions has been to carry out retrospective studies of patients' progress, most notably the Anna Freud Centre retrospective study (Fonagy and Target, 1996). Another way to avoid disruption to treatment has been to track therapists' perception of progress as the work takes place rather than asking the patient. For example, Boston and Lush (1994) studied children in care age 2-18 who had been referred to the Tavistock clinic, and used therapists' observations and ratings of change to assess progress. Therapists were asked to state their aims for each patient and the criteria against which they would know that their patient had progressed and thereafter to monitor the internal and external changes that took place against their original aims. However, this study relied entirely on therapist reporting of progress rather that patient reporting; this is significant since therapists tend to view progress very differently to their patients, as will be discussed in chapter two.

Midgley and Kennedy (2011, p.232) note that the results of research into child psychotherapy outcomes that *has* been conducted have not always been disseminated, conveying a false impression of an absence of research in this area. The Brandon Centre in London has been using patient reported ROMs (PROMs) to assess progress in psychotherapy for some years (Baruch, 1995). Exceptions to the general lack of interest in PROMs will be discussed throughout this study.

Several outcome studies have been conducted which demonstrate positive effects in psychotherapy. Shedler (2010) drew together the evidence of

several RCTs in order to establish that treatment effects of (adult) psychotherapy are at least equal to those of other treatments which are considered to be “evidence based”, such as CBT; furthermore Shedler offered evidence that patients who undertake psychotherapy often continue to improve after treatment ends, unlike other forms of treatment.

Trowell et al. (2007) carried out an RCT looking at the effects of individual psychotherapy and of family therapy on 72 patients aged 9-15 suffering from depression and receiving treatment for nine months. They showed that both treatments were equally effective at end of treatment at around 75% recovery and further that: “At follow up six months after treatment had ended, 100% of cases in the Individual Therapy group, and 81% of cases in the Family Therapy group were no longer clinically depressed”, an example of the “sleeper effect” whereby patients continue to improve after the end of their psychotherapy treatment (Trowell et al., 2007, p.157). Five different outcome measures were used, all administered at initial assessment, end of study and six months after the end of the study. Limitations of this study were the small treatment sample and lack of control group.

Urwin, C. (2007) carried out a study of 15 children undertaking psychotherapy over a year of treatment as usual. Parents and therapists completed HETA at the start of treatment, recording the hopes they had for treatment, and then returned to these hopes at the end of treatment. She finds that all 15 children registered either “change” or “significant change” at the end of the first year of treatment. Urwin balances a report based on data which shows numbers of children making progress with a detailed qualitative report on

the progress of just one child in the study; this allows for the very individual and specific to be balanced with an overview based on data. Urwin (2007, p.154) notes:

> For psychotherapists, a major anxiety about this approach must be that establishing expectations renders the therapeutic process too goal-orientated, cutting across the prerequisite to foster a therapeutic stance freed from pressure of "memory and desire", in the sense described by Bion (1970). It is partly to counteract this that we advocate keeping the HETA record in the filing cabinet rather than reviewing it frequently, and not scoring it with parents until the end of the first year.

She points to the value of such studies in communicating clearly to other professions what it is that psychotherapy can achieve, and also to the profession itself in clarifying the mechanisms involved in change.

Midgeley and Kennedy (1998) carried out an analysis of 34 studies into the effectiveness of child and adolescent psychotherapy, which included nine RCTs. As the majority of the trials included in their analysis were naturalistic, they generally involved patients each with multiple complex diagnoses; they therefore cannot be used as evidence for treatment guidelines which tend to present only studies isolating one particular presenting condition, such depression. They note a recent increase in research into the effectiveness of child and adolescent psychotherapy, but find that to date the mechanisms through which change takes place in child psychotherapy are little studied and little understood. They also note the need for studies looking at potential

adverse responses to child psychotherapy and triggers for drop-out from treatment. They conclude that child psychotherapy is: "…effective for a range of childhood disorders" and that while progress in psychotherapy is often slower than in other treatments its effects last longer and continue after treatment ends.

The Brandon Centre in London uses SDQ and RCADS at start and end of treatment and uses various other measures at intake, three and six months (YSR / YASR, and SOF / YABCL)[4]. Patients are tracked according to statistically reliable change, moves either out of (or into) the clinical population and progress is compared between internalising and externalising disorders. Measures have been chosen that have a good fit with psychotherapy, with no attempt at session-by-session monitoring (Brandon Centre annual report, 2013-2014, p.14). This example shows that it is possible for ROMs to be used in such a way that they provide useful and specific evidence about the impact of psychotherapy.

7) The 2012 and 2014 CYP-IAPT Guidelines

The first set of guidelines for the CYP-IAPT measures (Law et al., 2012) was published in 2012, and runs to 99 pages. This document sets out the guiding principles behind use of each of the measures and the rationale for the measures as a whole, and was not intended as a final statement: "This is a working document and we want your comments and feedback to improve and develop it" (p.99). The document invited comments and feedback about users' practical experience when using the CYP-IAPT ROMs, including the language to use when discussing the measures with young people and "tips for spotting

[4] Youth self report; young adult self report; teacher's report form; young adult behavior checklist

when things are off track" (p.99).

The 2012 guidelines are relatively prescriptive concerning how to use each measure and what to do if work is not progressing. They do not elaborate or discuss any exceptions or difficulties with following the guidelines, but instead contain clear and brief instructions. For example, they instruct clinicians as to which ROMs they should use, at what frequency and also the words they should use when explaining the ROMs to young people. Although the guide is at pains to explain that it is a starting point and that clinical judgment should always take first place, its instructions can be very definite, for example, in guidance on using the SRS:

> It is important to discuss any downturn on the SRS even when scores are above the cut-off. Any scores less than 9 on the four scales is an invitation for you to check out if you might have done or said something that did not sit well with them and / or how you can improve the sessions for that young person or family member. (p.55)

The 2012 guidelines also includes examples of language that the clinician can use when reflecting on why scores are not progressing, such as:

> These scores suggest that for the past few weeks I have not been getting things quite right for you? Can you help me understand what I need to do different to make these sessions fit better for you? (p.56)

The 2012 guidelines state unequivocally that good therapeutic alliance is essential for good progress in therapy, and that ROMs showing indications of poor alliance should be used as a basis for discussing changes in way of

working or even to trigger a change of clinician / therapeutic approach.

It will be important to this present study to consider the fit between this guidance (what to do, how to do it) and the way that child psychotherapists work, as this "fit" will form a central strand to the views of therapists' comments at interview. The 2012 guidelines contains positive quotes from a range of therapists about how helpful they have found these measures, but none of the quotes given are from child psychotherapists; for example a psychologist is quoted:

> The ORS/SRS measures fit incredibly well into the Cognitive Behaviour Therapy (CBT) model of working, allowing monitoring of progress in functioning in a measurable way, which is explicit to clients, and also enabling monitoring of the therapeutic alliance as part of the process of obtaining feedback from clients. (p.59)

An important question for this current study, therefore, will be how well do these measures fit with child psychotherapy as opposed to CBT, particularly in relation to those aspects discussed above such as use of transference relationship, lack of agenda and the bringing to the forefront of feelings and impulses which may be unwanted, uncomfortable, negative or aggressive. Child psychotherapists in this present study will make frequent reference to the content and directions contained in the 2012 guidelines, as these formed the basis of their training in the new measures. The 2014 guidelines had only recently come into use and were not yet disseminated into training.

The 2014 guidance (Law and Wolpert, eds.), in contrast to the earlier version, contains more discussion of the complexities of using these ROMs and

the possible exceptions. Running to 161 pages, it has additional sections including, most notably, a section about using ROMs in long-term therapies including child psychotherapy. The 2014 guidelines allow for more debate and for possible exceptions to the general rule; for example, while both versions assert that it is important to measure the therapeutic alliance because this is linked to better outcomes (2012 guidelines, p.52, 2014 guidelines, p.143), the 2014 guidelines also include the statement: "…there has been recent research to suggest that the earlier belief that therapeutic alliance strongly predicts outcome is not founded in evidence, and that many factors interact" (2014 guidelines, p.82).

The inclusion in the 2014 CYP-IAPT ROMs guidelines of a section on the use of ROMs for long-term treatment is an acknowledgement that, for psychotherapy in particular, there are complex factors to consider in ROMs implementation. The authors acknowledge that there will be some young people where exceptions need to be made and where specific ROMs should not be used or where they should be delayed (Troupp et al. pp.87-92) Unlike the 2012 CYP-IAPT ROMs guidelines, the 2014 guidelines accept the difficulty of completing RCADS with some young people at initial assessment and suggest that this should not be an absolute requirement:

> There may be occasions when using the RCADS…may be considered clinically inappropriate. For example, if a client is very distressed, asking them to complete a 47-item questionnaire might be overwhelming or have a negative impact on the development of a therapeutic alliance. (Trickey, 2014, p.117)

In addition, the preface to the 2014 ROMs guidelines states:

> All these measures are flawed; some are more flawed than others for given tasks. They should be used as a start to thinking, as guides for hypotheses or debate and need to be seen within the whole clinical picture.…In interpreting what responses and scores on these measures mean professionals must use their expertise and judgment. (Wolpert and Law, 2014, p.5)

It appears from these more recent guidelines, that use of ROMs may not in practice be quite as prescriptive as the initial training and literature suggested.

The differences between the two version of the guidelines are highly significant to this present study since the interviewees in this study made references to statements within the 2012 version, while none made reference to the later guidelines and these had not been in place long enough to be reflected in the training received. This means that to some extent interviewees may be basing their views of the CYP-IAPT ROMs on a set of guidelines which had already been superseded.

9) Summary:

This chapter has necessarily offered a brief overview of the relevant literature, much of which will be returned to throughout the thesis and in particular in the final chapter in relation to the findings of this present study. Clearly there is disagreement regarding aspects of ROMs implementation. This includes the usefulness of ROMs to clinical practice and to psychotherapy

specifically. It also includes the relevance or otherwise of a “good alliance” to mental health treatments and to psychotherapy specifically; even if this concept is relevant there is debate about how this can effectively be measured or what to do if a particular patient’s alliance is found to be poor. The evidence in favour of ROMs use cited by CYP-IAPT relates almost entirely to studies of adults and to modalities of work other than psychotherapy, and even in these studies findings are often equivocal.

Whilst there have been numerous outcome studies within mental health care, and a growing number in psychotherapy, there are very few studies examining how ROMs use is experienced by the therapist or patient, and little research at all into how ROMs use might impact on long term child and adolescent psychotherapy. It is vital that more is understood about the impact of introducing ROMs into psychotherapy sessions, as there is a risk that the act of measuring could significantly change the very thing being measured. More needs to be understood about what it is that each type of ROM can and cannot measure, how each is most helpfully used by psychotherapists, how ROMs use might impact on progress (either positively or negatively) and, where this is the case, about the mechanisms involved. More needs to be understood about the impact on the patient when ROMs are handed out at the end of a psychotherapy session or at review, and how much this depends on the type or ROMs or how the therapist introduces it. More needs to be understood about the specific nature of psychotherapy in relation to ROMs use, and whether there are specific aspects of technique that make certain ROMs more or less appropriate. In addition, thought needs to be given as to whether ROMs data from psychotherapy needs to be viewed differently to the data for other

treatments due to the different context in which it is gathered.

Finally, whether or not ROMs in general are experienced as helpful to child psychotherapy, questions need to be asked about the impact specifically of the CYP-IAPT ROMs, and the appropriateness or otherwise of each of these as tools to measure the work of psychotherapy. The remainder of this study seeks to begin to explore these areas in relation to interview responses from eight psychotherapists trialling the new CYP-IAPT outcome measures.

Chapter Three: Methodology

In planning this methodology my starting point was King and Horrock's 2010 guidance on using semi-structured interviews; this included an overview of how to select participants, ethics in qualitative interviewing, how to frame questions effectively (and without bias) and methods of recording and transcribing. Legard, Keegan and Ward (2003) was instrumental in helping me to frame specific interview questions and to think about how best to structure the interviews so as to ensure consistency and minimise bias whilst also drawing out the fullest possible answers from interviewees. Mason (1996) helped me to think about the value of interview data and to conceptualise this data as constructed narrative that is influenced by the position of being the interviewer / interviewee. Decisions that I made about choice of methodology will be considered in detail under the following headings:

1) **Setting up the study:**
    a) **Rationale for choosing research question**
    b) **The Trust as part of the CYP-IAPT pilot**
    c) **Population interviewed**
    d) **Rationale for using semi-structured interviews**
2) **Conducting the study:**
    a) **Ethics**
    b) **Steps taken to minimise bias**
    c) **Location and length of interviews**
3) **Analysing and managing data**
4) **Final thoughts**

1) Setting up the study:

a) Rationale for choosing research question

In framing my research question I was mindful of the guidance in Ritchie and Lewis (2003, p.48), who highlight the need for research to be clear and focused, not overly abstract, relevant and useful, contributing to existing research "with the potential to make an original contribution or to fill a gap" and of interest to the researcher. I selected CYP-IAPT outcome measures as my research area because of my fortunate position to be working in a CAMHS partnership that formed part of an NHS Trust participating in the first year of the CYP-IAPT pilot; I was aware of the huge implications to working practice that this entailed, particularly the impact of ROMs being required of *all* CAMHS clinicians rather than only those choosing to undertake training in the CYP-IAPT manualised treatments. I was aware of CYP-IAPT's stated intention to roll out to all CAMHS clinics in England, and that therefore issues encountered in this pilot were potentially of more general relevance. I was particularly interested in the impact on child and adolescent psychotherapy, since I was aware that ROMs use had not been part of standard practice for psychotherapists in my CAMHS partnership and that this therefore represented a significant departure.

At the time of starting this study I was in the final stages of my clinical training in child and adolescent psychotherapy and therefore I felt well placed to consider how CYP-IAPT ROMs would fit within psychotherapy, both ideologically and practically. I was aware that as participants in the CYP-IAPT pilot we had the opportunity to feed back into the consultation process, and

therefore that my own study had the potential to impact on exactly how (and which) measures would be used. In initial discussions with other psychotherapists within my CAMHS partnership it was clear that introduction of the CYP-IAPT ROMs was an area of interest as it had huge ramifications as to how they work and how the value of their work is measured, both as individuals and as a profession.

I was aware that there were many ways in which the introduction of CYP-IAPT might impact on child psychotherapists, for example that some might choose to train in one of the manualised treatments and that the constitution of teams might change in favour of CYP-IAPT trained colleagues offering shorter and cheaper treatments; however, in order to keep the scope of this study within manageable limits I decided to limit my enquiry to the impact of the CYP-IAPT ROMs on child psychotherapy.

b) The Trust as part of the CYP-IAPT pilot

The NHS Trust in which I was working covers a large geographical area and has several[5] sub-regions (CAMHS partnerships), each with their own management structures; my study took part in one of these CAMHS partnerships. The Trust was part of one of first three "learning collaboratives" in the CYP-IAPT pilot; by the time of completing this study there were five learning collaboratives together covering 60% of CAMHS clinics in England. Each learning collaborative included between eight and twenty-eight CAMHS partnerships.

In my own CAMHS partnership, there were nine psychotherapists spread

[5] Details unspecific in order to protect anonymity of the Trust.

over five community CAMHS clinics. All nine reported to one lead psychotherapist. The area covered is predominantly rural, with several small towns and one larger town and the population is predominantly white British. Psychotherapists work with young people aged 0-18; there is very little access to specialist services, therefore CAMHS treats a wide range of mental health difficulties including eating disorders and psychosis, it serves a wide range of groups including looked after children and children with learning difficulties, and offers a wide range of treatment approaches including groups, parent-infant work, individual therapy and brief interventions. Each community CAMHS team in this partnership is multidisciplinary, comprising psychotherapist(s), psychologist(s), family therapist(s), (senior) mental health practitioner(s) and the CYP-IAPT practitioners who were, at the time, undertaking training. There is one in-patient unit, in which there are no psychotherapists. The clinical lead for each professional group had undertaken the CYP-IAPT managers' training, and these leads were therefore instrumental in implementing ROMs across the partnership; this included the clinical lead for child psychotherapy.

The Trust had been subject to major upheavals over the previous three years. This included the amalgamation and relocation of some CAMHS teams, new IT systems and requirements, new administrative requirements and a change to the management structure. Of the eight participants in this study, three had previously been members of disbanded teams and another one had been relocated.

All expect one psychotherapist in this present study had been working within the Trust prior to the changes. The previous Trust had kept paper

records, while the new Trust had made the move to “paper free” administration. A new management level had been created to manage out of hours services, with all CAMHS workers at band six and below (which affected one psychotherapist in this study) required to offer 24 hour emergency care on a rota basis. All staff at bands six and above were now required to be on “duty” on a rata basis; this including taking duty calls from GPs, schools, families and young people, making crisis visits to hospitals, seeing urgent referrals and screening new referrals for urgency; these were all new demands for this staff group. All expect one psychotherapist in the study were carrying out a mix of generic CAMHS work with specialist psychotherapy provision, while previously their work had been predominantly specialist psychotherapy provision.

The Trust conducted a consultation about voluntary redundancies, which one psychotherapist (not part of this present study) had chosen to accept; this necessarily impacted on the wider team of psychotherapists. The Trust had raised the possibility of compulsory redundancies and had explained to all staff that there was a significant deficit and that significant savings were needed in staff costs. Trainee child psychotherapists in the Trust were finding it difficult or impossible to find permanent specialist posts in this Trust, and so were forced to either take lower banded posts, move away from the area or take temporary posts; this affected two therapists in the present study.

Assessments for new CAMHS patients had changed in order to include much more detailed paperwork, with a lengthy document covering areas such as risk, family history, drugs use, medication and so on. While these were not new areas to consider in an assessment, the amount of paperwork had

massively increased. In addition, following each assessment CAMHS staff were expected to transfer the data from their paper forms to the computer system, and then to monitor and update data regularly. Data was available to team managers, who were now more easily able to identify cases where a particular piece of paperwork was missing or where a review was late, and to follow this up through regular emails to the whole team about task completion rates. Teams were ranked against each other according to who had successfully entered the most data on time or successfully completed the most reviews on time. There was an expectation that the task of entering data take precedence over other tasks, as this was the basis on which team and individual performance would be judged.

These changes are relevant to the current study as they help to explain the generally low morale of CAMHS workers in this particular Trust at the time of the study. In addition to the changes introduced by the new Trust, the CYP-IAPT initiative carried the risk of being experienced as yet another change to working practice which had been determined without the consultation or agreement of individual members of staff and which required a significant amount of additional staff time to administer. In addition, there was some overlap between the types of demands made by the Trust already and now by CYP-IAPT, such as the increased emphasis on data and monitoring and the increased use of paperwork. This present study therefore carried a risk that therapists' feelings about the existing increase in paperwork and data monitoring required by this Trusy might be expressed through the opportunity to be interviewed about the CYP-IAPT data monitoring and paperwork. It was therefore necessary, as far as possible, to try to ascertain which of their views

might related to increased paperwork / data analysis in general, and which related specifically to the CYP-IAPT ROMs, and to be aware that in some cases views about both might have become intertwined in participants' comments.

c) Population interviewed

Participants in this study were selected on the criteria of being qualified child psychotherapists employed by this CAMHS partnership. Participation was voluntary, and from a pool of a possible nine psychotherapists, eight chose to participate. Participants worked at bands 7, 8a or 8c and covered a range of post-qualification experience:

- Less than a year: 1 participant
- 1-5 years: 2 participants
- 5-10 years: 1 participant
- 10+ years: 4 participants

Therapists had trained at four different training institutions and had a variety of pre-training career experiences. Participants therefore might reasonably be expected to "represent a variety of positions in relation to the research topic" (King and Horrocks, 2010, p.29).

One psychotherapist had undertaken the year-long CYP-IAPT managers' training, three had attended an optional one-day CYP-IAPT ROMs training and all but one had attended two hour-long group trainings organised by the clinical lead for psychotherapy. This had been an opportunity to look at the measures for the first time and discuss the pros and cons of using them. One

psychotherapist had not attended any CYP-IAPT ROMs training.

Although in all cases the interviewees were more experienced psychotherapists than myself, I felt that this did not impact unduly on interviewees' willingness to engage with the study or the seriousness with which they engaged; this is because I was well known to the group and also because they expressed an investment and interest in my research project. I discussed the nature of the project with the group as a whole and allowed several weeks for questions / clarifications before asking for participants. I gave each participant a summary of the nature of the research (appendix 2a) and sought consent (appendix 2b). I also gained consent from each of their teams and from the Trust's research department.

All CAMHS teams involved had already been using SDQ and RCADS with new patients for three years prior to the implementation of CYP-IAPT. However, these measures were sent out by administrators and not repeated at review or end of treatment, nor were they routinely discussed as part of the initial assessment; none of the therapists in this study reported making any use of any ROMs data prior to CYP-IAPT. Three therapists had previously used HETA (Hopes and Expectations for Treatment Approach). One therapist had a background in psychotherapy research and considered themselves familiar with outcome measures in general.

d) Rationale for using semi-structured interviews

I chose to use semi-structured interviews in order to enable a "fairer and fuller representation of the interviewees' perspectives" (Mason, 1996, p.66) than a more structured approach such as questionnaire / survey or highly structured interview. I chose individual rather than group interviews in order that each

participant could speak freely and without fear of judgment by others. I was aiming for the freedom and flexibility to explore as outlined by Legard, Keegan and Ward (2003, p.141):

> An initial response is often at a fairly "surface" level: the interviewer will use follow-up questions to obtain a deeper and fuller understanding of the participants' meaning. The in-depth format also permits the researcher to explore fully all the factors that underpin participants' answers: reasons, feelings, opinions and beliefs.

I therefore chose to use a series of "starter" questions (appendix 3) which were the same in all cases but which allowed interviewees to depart in directions of their choice, which I then followed with further prompts. My rationale for asking each participant identical starter questions was to try to minimise bias by avoiding any presumptions about participants' perspective. Initial questions were followed by supplementary questions (prompts and probes) reflecting the interests of the interviewee. I used probes to help participants expand on their views, offer clarification / examples or explain their reasoning. I asked specific prompt questions when initial replies were brief or partial, in order to elicit further detail.

Interview questions were worded to avoid leading participants in a particular direction so that themes arising were identifiable as being preoccupations of the interviewees rather than of myself, as discussed in Mason, 1996, p.198. I was therefore able to give more weight to commonality of theme or opinion, knowing that this had been offered spontaneously rather than sought out specifically. All questions were deliberately simple in order to

ensure clarity. My responses were as neutral as possible in order not to imply that I either agreed or disagreed with a response, so that respondents could continue to express opinions freely. Five interview questions concerned opinions / values, three concerned experience / behavior and one concerned background / demographics (categories of question as identified by King and Horrocks, 2010, p37). Question 9, regarding training school, was added to the list part-way through when it became apparent that this might be a relevant factor influencing participants' views; I subsequently asked the earlier participants to supply this piece of information. Interview questions were discussed in supervision prior to conducting the first interview, in order to have external validation that questions were appropriate and were not leading participants in a particular direction.

Prior to each interview I took care to put interviewees at ease by having a general chat and answering any questions about what we were about to do. I made no notes during the interviews in order better to listen to therapists' responses and to make sure that therapists felt heard. Interviewees were aware that I was not interested in *how* a point was made (e.g. use of hesitation and repetition). Where participants were anxious about being recorded this was explicitly discussed in advance. My first two questions were: "How would you describe the impact on your work as a child psychotherapist of starting to use the ROMs?" and "How does the use of the ROMs impact on your work as a psychotherapist?" These questions were intended to be sufficiently general that interviewees could respond in any way they chose, briefly or at length, enabling me to get a snap-shop of their perspective and the strength of feeling.

The next question was: “Looking at each type of ROM individually, what were the issues?” I showed each therapist a copy of each ROM and allowed them time to look at it and offer general comments, before I asked specific questions for each ROM. For each ROM I asked initial questions:

- What feedback can you give me about each individual question?
- When in the session did you use this ROM?
- How frequently did you use this ROM?
- Did you get any specific comments or reaction from children and young people about anything to do with this ROM?
- What were the benefits and concerns of using each ROM?

When a therapist was not already using a particular ROM then these questions were asked hypothetically, for example: “When in the session would you see yourself using this ROM?” When a therapist was unfamiliar with a particular ROM I asked a general question about whether or not they thought it looked useful and whether there were any particular reasons why they had not used this ROM. I allowed participants to depart from these questions in whichever way they wished.

The next question was: “How did you find using each type of ROM with different kinds of patient?”, breaking this down into age-groups and patient groups. This was included because I had anticipated that there might be strong views about using ROMs with particular patient groups. My next question was: “Did you have instances of the ROMs being used by the patient for other purposes than as an attempt to provide objective feedback?” This question was intended to elicit both examples of creative / helpful uses of ROMs as (for

example) to reward or punish the therapist. I also asked: “Did any young people refuse to participate? What reasons were given?”

In order to elicit examples of good practice that might point towards the most helpful ways to integrate these measures into child psychotherapy I asked: “What strategies and methods did you develop for using the ROMs?” This included sub-questions regarding frequency, processes for setting / revising goals, processes for identifying / tracking symptoms and whether therapists discuss ROMs data with patients. I also asked where and when the measures are competed, as I anticipated that each therapist might have worked out a different solution to this. I asked: “Do you have any thoughts on how data may be used by managers / commissioners?” again worded to allow positive and negative reflections. I ended by asking about training schools and, finally, for any additional comments or any views on the ROMs that had not already been voiced. I had intended to interview all participants twice, at the start of the pilot (before familiarity with the measures) and at the end. However, the start of my study was delayed due to systemic difficulties in gaining ethics approval, unrelated to my own study, so no interviews could be conducted until half way through the year. I therefore made the decision to carry out just one interview, as by this stage I expected therapists already to be familiar with these measures.

2) Conducting the study:

a) Ethics

Kvale (2007, p.8) writes:

> Ethical issues permeate interview research. The knowledge produced depends on the social relationship of the interviewer and interviewee, which again rests on the interviewer's ability to create a stage where the subject is free and safe to talk of private events for later public use.

Interviews carried risks of participants expressing a view that is critical of the Trust / individuals or revealing that they are not following Trust guidelines on ROMs use, either of which could generate uncertainty about possible repercussions. In ensuring that this study followed high ethical interviewing standards I drew on the guidance in King and Horrocks (2010) p105-124; participants were aware that all information would be held securely and would be anonymised, also that only their spoken responses would be regarded as data, not any other detail which I might already know or believe to be true. No interviews were carried out until the research proposal had been cleared by both the UEL ethics committee and by the Trust's research department. All participants had the right to withdraw at any time. Confidentiality was maintained throughout, including after the end of the study.

All interviews were recorded on two digital recorders, and data was stored securely; all transcripts were anonymised at point of transcription. No additional person was involved in transcription. In the final thesis I chose not to

use pseudonyms to link together the views of each participant, as with only eight participants who all know each other well, it might be possible for participants to work out the identity of an individual by linking separate statements together. This had drawbacks, as it could have been useful to look at the pattern of responses for each interviewee as well as across the group, however the threat to anonymity was too great. I omitted any reference to any particular therapist's role, even where potentially relevant, if there was any risk that this compromised anonymity. When a quote might have compromised anonymity it was omitted. This unfortunately had to include a document published by the Trust a few years prior to the implementation of CYP-IAPT ROMs which included views about ROMs which would have been highly relevant to this study, but which necessarily identified the Trust.

b) Steps taken to minimise bias

I considered issues of personal reflexivity as discussed by King and Horrocks (2010, p.125-141), i.e. the impact that my own role, beliefs and perceptions might have on how I conduct interviews or my interpretation of data. I was already known to all of the psychotherapists, as my role at the time was a trainee psychotherapist within the same CAMHS partnership and I therefore regularly participated in group meetings and trainings with the psychotherapists. Three of the therapists worked in the same CAMHS clinic as myself and one was my clinical supervisor. In the interviews I did not make any references to any previous discussions about ROMs and took care not to make assumptions about any particular therapist's point of view. In the ROMs group training I had myself voiced neither strongly positive or negative views, so interviewees would not have had reason to make assumptions about my own perspective.

I was aware that the position of being an interviewee is not a neutral one and might lead to answers that are more polarised, particularly if a subject wishes their own views to be well represented in the final report. In addition some subjects would feel more comfortable in an interview and being audio recorded than others. Subjects might also feel that there is an onus to hold a clear position and might wish to minimise the appearance of inconsistencies or ambivalence. I was mindful of discrepancies between stated views and actual practice, for example if an interviewee asserted that they welcomed a particular measure yet had chosen not to use it. I was also aware that interviewees might be using interviews to express views which they found difficult to express in other contexts. I found Mason (1996, pp. 62-83) helpful in allowing me to unpick such epistemological issues concerning data gathered at interview and its strengths and limitations. I had in mind that:

> Any theoretical framework carries with it a number of assumptions about the nature of the data, what they represent in terms of the "the world", "reality", and so forth. (Braun and Clarke, 2006, p.81)

I was aware that it was unrealistic to suppose that nothing about the context, my own role or participants' roles, the setting or relationships between individual participants, especially in terms of hierarchy, might influence the views expressed. I was aware that however much I tried to safeguard against this, "researchers cannot free themselves of their theoretical and epistemological commitments, and data are not coded in an epistemological vacuum (ibid, p.84). I therefore took reasonable steps to approach the material objectively but with the knowledge that my own background and experiences of ROMs and my

various relationships to interviewees must play a part in the data gathered.

c) Location and length of interviews

Each interviewee was asked at which CAMHS clinic they would like their interview to be conducted. Interviews were not interrupted and could not be overheard, and each interviewee was asked to set aside up to 90 minutes in order not to feel under pressure to rush. Interview rooms were comfortable and the surrounding environment was without distraction. I interviewed a maximum of two therapists per day, to allow myself sufficient time to process responses and to be able to respond freshly to each interviewee. I allowed a minimum of half an hour between interviews. Interview length ranged from 28 minutes to one hour and 25 minutes, dependent on how much each interviewee wished to say.

3) Analysing and managing data

Interviews were transcribed verbatim. Since I was not interested in *how* the statements were made, for example intonation, length of pauses and so on, these features have not been transcribed. I was aware that decisions such as how to punctuate each transcript were not neutral in that they might imply different inferences, and I was careful to return to the original recording for clarification in cases where exact meaning was uncertain from my transcription.

The methodology used to analyse interview responses falls under the broad heading of thematic analysis, using an inductive approach to arrive at eventual themes. Braun and Clarke (2006, p.83) write:

> In this approach, if the data have been collected specifically for the research (e.g. via interview or focus group), the themes identified

> may bear little relation to the specific questions that were asked of the participants. They would also not be driven by the researcher's theoretical interest in the area or topic. Inductive analysis is therefore a process of coding the data without trying to fit it into a preexisting coding frame, or the researcher's analytic preconceptions.

Initially statements were sorted into groups according to whether or not they were broadly supportive of or critical of ROMs and then subdivided by the aspect of ROMs or reason given. This resulted in multiple grids summarising perceived strengths of ROMs / concerns, subdivided by each type of ROM (for an example of such an early work in progress, see appendix 4). I was therefore able to identify emergent themes based on the numbers of therapists making a particular point rather than, for example, a particularly persuasive point made by one therapist or my own preconceptions. Issues were subsequently grouped together into wider categories when it became clear that they shared a pattern of identified concerns / benefits, for example reasons given for finding ROMs at initial assessment cumbersome (amount of time they take, amount of paperwork, duplication of questions and so on) were grouped together.

Use of these grids allowed me easily to identify areas where several therapists expressed a view. However, I did not adhere to rigid rules that, say, I would only follow up a particular theme if more than four therapists expressed a view on it, as this felt unnecessarily rigid. Clearly there were some areas where particular therapists had a more informed view than others, for example three of the therapists had attended the Trust's training on CYP-IAPT, and therefore had more specific knowledge about how the measures were to be used than the other therapists, so when a particular issue was identified by two or more of

these therapists this was highlighted as a possible theme. In taking this flexible approach to the number of therapists required in order to establish a "theme" I follow guidance in Braun and Clarke (2006), p.82 to "retain some flexibility…rigid rules really do not work." The analysis of material in order to identify themes was a very active process, and I bore in mind guidance by Legard, Braun and Clarke (2006, p.80) that themes do not "emerge", they are actively identified.

Next I experimented with the overarching groupings; my first attempt at this produced categories of various concerns about ROMs and advantages of their use, however I found that grouping material in this way generated much overlap between themes. I therefore experimented with grouping material into stages of the psychotherapy process, from generic assessment through psychotherapy assessment and ongoing work. Where statements related to more than one stage of work they were placed in more than one section. This worked better as it was evident that thoughts about using ROMs at, say, initial assessment were very different to their thoughts about using ROMs to review progress at reviews, and these in turn were different to thoughts about monitoring therapeutic alliance every session. New codes / categories were added as the process evolved and all transcripts were revisited to identify any further instances of such categories.

The eventual coding structure formed a tree pattern, with overall headings being the stage of psychotherapy treatment, divided into statements that are broadly supportive / not supportive and subdivided into reasons for holding this view. For example, statements relating to the assessment process (A) were divided into positive or negative statements (P/N) and further into

specific reasons why as follows:

Positives:

i) provides broad overview of range of presenting difficulties (things can't be overlooked) - APO

ii) ensures consistency - APC

iii) Offers triangulation of viewpoint - APT

iv) not too intrusive – API

v) Other positive – APS

Negatives:

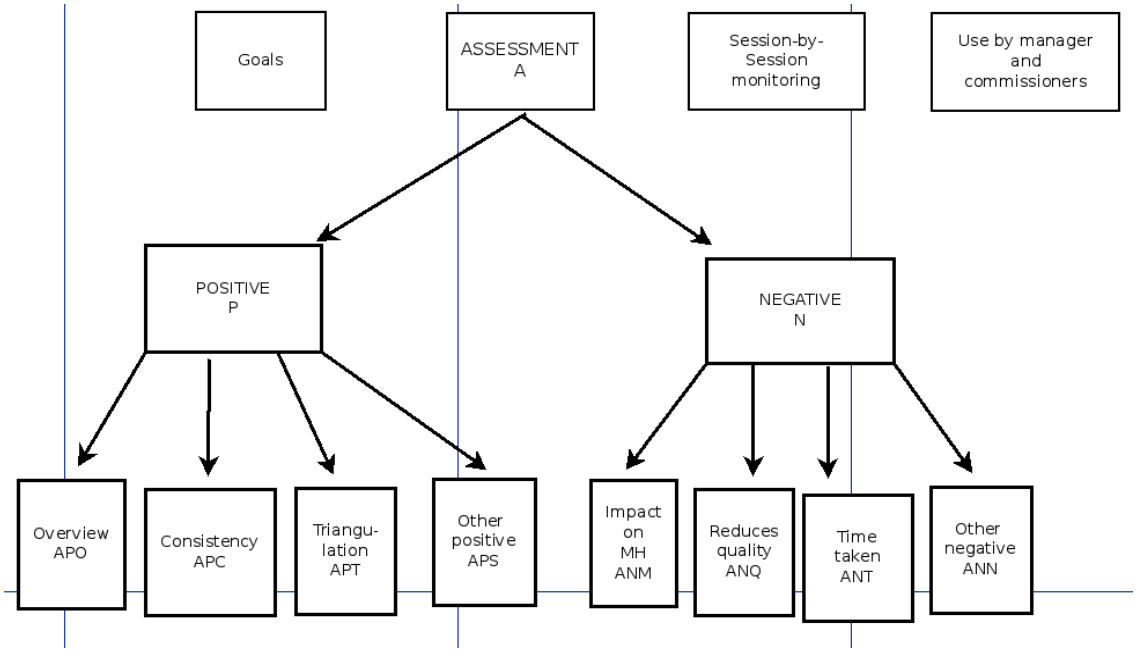
i) Negative impact on young people's mental health of so much measuring - ANM

ii) Negative impact on the quality of the assessment / too impersonal - ANQ

iii) Takes too much time – ANT

iv) Other negative - ANN

A further group of comments were coded as neither positive nor negative; these included good-practice suggestions for ROMs use and questions raised by psychotherapists. These were coded "?" statements. An example of the skeleton "tree" for the assessment stage, before further broken up into finer sub-levels, was:



The same process was followed to group statements for each stage of treatment. Finally statements relating to hopes and fears around how managers and commissioners might use or view the data were grouped together and subdivided into each particular concern or hope expressed. Statements relating to an overview of ROMs received separate coding. Many comments were given dual coding, for example statements about how managers might use assessment data. There were several adjustments to this structure as work proceeded. Each stage in the development of grouping statements by theme and organising into chapters has been preserved, in order that "the processes of exploration…be documented and retrievable" (Coffey and Atkinson, 1996, p.191). In treating the data in this way I held in mind the guidance contained in Spencer, Ritchie and O'Connor (2003, p.210):

> It is essential that the analytic ideas and concepts that are developed are rooted within the data, rather than simply superimposed. To achieve this, the method needs to provide a structure that allows emergent ideas, concepts and patterns to be captured and revisited.

As a result of this process, the following over-arching themes were identified:

- Use of ROMs at initial assessment and reviews
- Use of ROMs to set and monitor treatment goals
- The impact of using ROMs during regular long-term psychotherapy, particularly when used every session
- How CYP-IAPT ROMs data might be used by supervisors, managers and commissioners

My final stage in data analysis was to speculate on reasons behind particular clusters of opinion, i.e. to go beyond the data itself and attempt to understand possible explanations for this. When considering the data in this way I took into account background and contextual features which might influence therapists' views. I also related my findings to other studies and to wider literature, in order to attempt critically to interrogate my own data.

In the final stages of work on this thesis I checked all of my themes back against both the summary grids and the original audio recordings and transcripts, to ensure both that each therapist's view was fairly reflected and that I could provide evidence for any assertion made (for example regarding the number of therapists holding a particular view). Original material was screened again to ensure that no data had been omitted from consideration. I carried out tests for accuracy, taking a sample of quotations which appeared in the final report and checking these against original audio recordings.

b) Verification of findings

In the end stages of writing the thesis, stakeholder checks were carried

out to ascertain the extent to which participants felt that the research findings reflected their views. A summary of findings (appendix 5) was discussed by the group during two meetings with the lead psychotherapist (June 6th and June 15th 2015). Feedback from this meeting was that therapists agreed that their views were reflected in the summary. I carried out individual informal discussions with four participating therapists in order to gauge their view of the final thesis and whether or not they felt it reflected their own views, and in all cases they confirmed that it did.

4) Final thoughts:

The process of organising material into a coherent narrative was a journey of discovery, and involved numerous reshuffling of codes and of my written material in order to arrive at a structure which I felt made logical sense in terms of the reader's experience, avoided excess repetition and was demonstrably and clearly derived from interview data. All decisions made regarding which material to include and exclude are compromises, and the wealth of data gathered means much is inevitably left out of the final thesis. I was aware of the richness of interview data which could only be sampled, meaning that many often passionately argued statements regarding ROMs use did not make it into the final text of the thesis. However, I trust that, using the methods described above, I have fairly represented each participant's view and also given a fair balance to all of the different perspectives discussed.

Chapter Four: Use of ROMs at initial assessment and reviews

The first of the CYP-IAPT outcome measures to be introduced in this Trust were those used at initial (generic) assessment – RCADS and SDQ, both normative measures using standardised questions. All patients who are new to CAMHS are assessed using RCADS and SDQ. The purpose is to gain a clearer picture of the nature of the young person's difficulties and also to provide a baseline against which progress can later be measured. They are intended to ensure that CAMHS assessments have a level of consistency, regardless of the professional background or particular experience of the assessing clinician and regardless of the willingness or otherwise of the patient and their parents / carers to enter into discussion. By asking the same questions to all young people, regardless of presenting difficulty, these tools pick up on any supplementary difficulties that may not be evident in the CAMHS referral or which a young person might find it hard to name. At the point of conducting interviews all but one psychotherapist had been using RCADS and SDQ for a minimum of seven months. This chapter will consider ROMs at initial assessment under the following headings:

1) **Overview of SDQ and RCADS**
2) **Benefits of SDQ and RCADS at initial assessment**
3) **Concerns about ROMs use at initial assessment**
4) **Summary and Discussion**

1) Overview of SDQ and RCADS

SDQ has the advantage of asking about both the strengths and weeaknesses of a young person and Moran et al. (2011, p.75) report that young people find SDQ "easy to understand". Brann (2010, p.109) cites evidence that SDQ is "easy to complete" and provides useful clinical information. Children aged 11-17 complete a version of the SDQ themselves, as do their parents / carers, while for under 11s only the parents complete the measure. The SDQ also exists in a version for teachers, though this has not been included in the CYP-IAPT resource pack. As well as providing a total score relating to severity of overall difficulty, the SDQ gives individual scores for:

- emotional symptoms
- conduct problems
- hyperactivity/inattention
- peer relationship problems
- prosocial behavior

There are 25 questions about symptoms followed by five additional questions relating to the impact of the symptoms on everyday life. The resulting data can be analysed by hand or by computer, providing clear summaries about both specific areas of difficulty and overall symptom severity. Both Individual symptoms and overall difficulty are banded into non-clinical, clinical and borderline scores, allowing for easy identification of areas of difficulty. The SDQ is a trusted tool with a long history of use and proven validity and reliablity.

Wolpert et al. (2015, p.64) note the large amount of peer-reviewed literature regarding the validity and consistency of the SDQ, incuding its abilty to discriminate between clinical and non-clinical populations and to predict which young people are likely to experience most difficulties in their day to day lives. There are well over 500 peer-reviewed studies in which the SDQ has been used.

The second tool used at initial assessment is RCADS, which focuses in detail on anxiety and depression and is inteded for use with children age 6-18. In the 2012 guidelines Trickey (2012, p.39) cites several studies demonstrating the internal consistency and validity of RCADS, and argue that: “RCADS’ ability to help inform diagnoses, track clinical change, and further delineate between anxiety and depression disorders shows its strong utility in both clinical and research contexts”.

RCADS comes in the form of a full tool for use at assessment, reviews and end of treatment, which has 47 questions and a version for parents as well as one for young people. In addition RCADS can be broken down into “symptom trackers” (STMs) which can be used following an initial assessment, and which contain only those questions related to areas that have already been identified as problem areas, such as questions only relating to anxiety. This means that a close eye can be kept on areas of difficulty without necessarily repeating the whole tool. The full RCADS produces results broken down into the following areas:

- Separation anxiety
- Social phobia
- Generalised anxiety
- Panic

- Obsessive compulsive
- Total anxiety
- Low mood
- Total anxiety and low mood (sometimes known as “internalising”)

(Trickey, 2012, p.116)

The related STMs are titled:

- Depression and low mood
- Anxious away from home (separation anxiety)
- Anxious in social situations (social anxiety or phobia)
- Anxious generally (Generalised anxiety)
- Compelled to do or think things (OCD)
- Panic
- Disturbed by traumatic events (PTSD)
- Behavioural Difficulties
- PHQ9 (Additional depression screening tool)
- GAD7 (Additional Generalized Anxiety Disorder screening tool)

RCADS has the benefit of breaking down “anxiety” or “depression” into specific components which can distinguish between apparantly similar presentations, thus allowing a much more precise screening. The 2014 CYP-IAPT ROMs guidelines offers an example of a young person who appears upon referral to have a low mood, but RCADS flags up a possibility that low mood is a result of OCD symtoms: “Such alternative possibilities can be raised with the young person as hypotheses with a view to seeking their opinion”

(Trickey, 2014, p.117). Wolpert et al. (2015, p.68) highlight the different benefits that SDQ and RCADS in terms of data value, pointing out that RCADS may be best able to capture change while SDQ is better able to capture an individual's relation to the population norm.

Although all clinicians are using SDQ and RCADS at assessment, the way in which they are presented to patients is different across the five clinics and also depending on the preference of each therapist. In some clinics both measures are completed with the young person / family during the first CAMHS appointment, as part of the generic assessment; in others the SDQ is sent out by post while RCADS is completed with the therapist and family / young person together at assessment; in some clinics both are sent out by post while others ask patients to arrive early to complete ROMs in the waiting room. In cases where RCADS is completed during the assessment appointment, some clinicians favoured doing this with the young person alone, and others completed this with parents / carers also present. Wiger and Solberg (2001, p.187) observe that completing assessment tools with the young person and therapist together (rather than at home or in the waiting room) also enhances return rates.

2) Benefits of SDQ and RCADS at initial assessment

Seven of the eight psychotherapists interviewed felt that RCADS and SDQ together could be a good starting point for assessment, including those therapists who also expressed reservations about the impact of their use. Those therapists who had strong reservations about the use of ROMs in general found RCADS and SDQ at initial assessment least problematic. For

example, one of the therapists with the strongest reservations about ROMs in general said of RCADS and SDQ: "It gives you an impression of whether it's a depression kind of thing or a hyperactive kind of thing or whatever…" and it "gives you a snap shot of diagnostic criteria." Seven psychotherapists felt that RCADS and SDQ help to start a conversation, with five specifically expressing a view that use of RCADS and SDQ at initial assessment is helpful in alerting the therapist to issues that might not otherwise have been identified so quickly. Four therapists specifically named obsessional compulsive disorder (OCD) as an area that they might not necessarily have asked about at assessment without prompting from specific ROMs statements, which include:

> I have to keep checking that I have done things right (light the switch is off, or the door is locked)
>
> I have to do some things over and over again (like washing my hands, cleaning or putting things in a certain order)

One therapist drew attention to questions about physical states, and felt that this is an area that they would not have addressed without the ROMs questions. On the SDQ these are:

> Restless, overactive, cannot stay still for long
>
> Often complains of headaches, stomach-aches or sickness

Similarly, on RCADS statements include:

> When I have a problem, my heart beats really fast

I suddenly start to tremble or shake when there is no reason for this

One therapist recounted asking a physical-states question of a young person who replied: “I have that all the time”; the therapist reflected: “It brought something out that I think otherwise she wouldn’t have talked about and I wouldn’t have asked either.” Use of RCADS / SDQ might therefore be particularly helpful for psychotherapists in addressing areas where psychotherapy is less commonly involved (such as OCD, where patients within this Trust are usually assigned to psychologists) and areas where a particular presentation is less common. One therapist said of RCADS: “That very quickly hones into where the difficult areas are and what I need to be questioning about, what I need to be thinking about, it often highlights to me things I wouldn’t otherwise be thinking about and the rest of the session is more productive because I have the data from the RCADS in my mind.”

All of the therapists who had used ROMs at an initial assessment reported that young people seemed relieved to answer specific questions as this removes some of the anxiety about not being able to explain their difficulties. Young people may feel that their problems have been somewhat normalised by the fact that there is already a question asking about a particular area of difficulty, therefore it cannot be something so unique or bizarre that it will shock the therapist. Wolpert et al. (2015, p.68) assert that RCADS helps structure discussions between patient and clinician and provides additional information in addition to what is gained through discussion.

RCADS and SDQ were felt to supplement existing assessment strategies rather than replace them; a typical comments were:

> "I think it can help to give you more information than just your assessment alone….."

> "It usually matches up to what you think from your assessment, what your impression is, but there are some things you might not have picked up as being a problem."

> "They are useful as an adjunct, to have there with everything else …if people come to rely on them as the be all and end all then that's not really helpful."

This is a recurring theme throughout discussion of the usefulness of the CYP-IAPT ROMs; in isolation each tool can be said to have weaknesses, but viewed as part of a package of measures including clinical assessment as usual, they provide additional information and a different perspective which adds to the information available.

One perceived benefit of using ROMs at initial assessment, as voiced by five psychotherapists, is that this allows the views of the parents / carers and child / young person to be thought about together and compared at assessment, offering triangulation of perspective. A typical comment was:

> Where they can be clinically useful straight away without collecting any statistics is when you are comparing – comparing the child and the parent …about seeing how different people are reading each other and how the child behaves relative to the relationships.

Triangulation of perspective might point to difficulties in communication between parent / carer and child, or to an over or under estimation of the difficulties by either the child or their carer. It might reveal a tendency of a parent to downplay and minimise their child's distress, or to a child who seems unaware of the level of difficulties they are experiencing. Discrepancies in scores might indicate a need for some joint work before individual work can commence, or might indicate that issues are not about a young person's individual mental health but are rooted in a relationship difficulty. While differences in perspective might emerge in any case, ROMS use at assessment means that these differences are evident at a glance and allow the therapist to focus in very quickly on areas of discrepancy and to reflect with the family on possible reasons for the discrepancy. The Royal College of Psychiatrists studied the reliability of the SDQ as completed by parents / carers, young people and teachers and observed that:

> Overall, parents and teachers provide information of roughly equal predictive value, although their relative value depends on the type of disorder. Thus information from parents is slightly more useful for detecting emotional disorders while information from teachers is slightly more useful for detecting conduct and hyperactivity

> disorders…. For emotional disorders, self-report data are about as useful as teacher data, but less useful than parent data. (Goodman et al., 2000, p.538)

It is therefore vital that the data from the patient's assessment ROMs is not considered in isolation but in the context of all of the data received from a wide range of sources, including reports from teachers or social workers, to get the broadest possible understanding of the potential difficulties, as there might be very different reports from the patient, their family and the professionals involve.

3) Concerns about ROMs use at initial assessment One concern raised about ROMs use at initial assessment was the risk that they prevent the therapist from having real emotional contact with the young person and with the pain and distress that has brought a young person into the clinic. Five psychotherapists felt that for this reason ROMs have the potential to be actively harmful to a meaningful relationship between therapist and patient because they form a barrier of standardised questions which require standardised answers; this might prevent both the patient and therapist from having any genuine emotional experience. Two expressed a view that very difficult areas of emotional experience which have highly complex answers are approached as if they should be quick and simple to answer. An example was given of the question "other people my age generally like me" where the true answer may be complex and potentially distressing, and might open up a lifetime of difficulties - but the patient is required to answer simple "never", "sometimes", "often" or "always" (RCADS). This therapist felt that if patients were allowed to talk freely, the nature of the difficulties would emerge without

young people being required to give simplified answers to complex and emotive questions. Their view, which one other therapist also voiced, was that when a young person talks freely about an issue, such as their friendships, they can be in touch with the emotional impact of this, as can the therapist; it becomes a live and shared emotional experience in the room, which tells the therapist far more about the specificity of what it is really like, for example, to feel friendless, to feel ridiculed or to feel different from peers.

Four interviewees expressed concern that with the arrival of the requirement to complete RCADS and SDQ at initial assessment this left very little time available for a more open and free exploration of a young person's internal world. One therapist drew attention to the amount of overlap between SDQ and RCADS, thus potentially wasting valuable assessment time by duplicating questions. Such duplication could also give the young person and family the impression that the therapist has not listened to their first answers or that they are asking questions mindlessly. Duplicating questions takes up time that could otherwise be used for a more individualised approach, so might lead to less being understood about the young person. One therapist cited a young person complaining about the number of questions they had been asked, and this therapist agreed: "There are so many questions, there's 47 questions – when you have this and the other questionnaire that's too much in an assessment." Another therapist expressed a view that young people are flooded with a raft of general questions, rather than having enough space to explore the specific reasons that have brought them to CAMHS. They cited parents of a young person with an eating disorder complaining that the ROMs questions were not allowing them to talk about the specific difficulties that had

brought the family to CAMHS. One therapist commented: “It’s taking more time away [from thinking space] and far less reflection, it takes much longer and it’s harder work to have a really good long assessment process where you’re using [ROMs]….”

Three therapists felt that the initial assessment has now become such a rush, due to the ROMs requirement, that this reduces the quality of assessment. One commented: “It’s about getting through [lots of ROMs] and I think young people will pick that up, as I would as an adult.” In their view this detracts from forming a relationship with the young person and from a more open and thorough exploration of what has brought a young person to CAMHS. They felt that excessive paperwork – particularly at this crucial first contact - interferes with a meeting of minds: “I think that if you feel that that young person is wanting to make an engagement and that it’s not going to be helpful to use a piece of paper then therapists shouldn’t be forced to do it.” Another commented:

> If you are trying to make an engagement with somebody, for some people a piece of paper is not helpful…it feels that you are not actually getting *them,* you’re not making eye contact, you’re not listening to them…If I feel that then I wouldn’t use it in the very first appointment.

It may be that the reason that ROMS use during initial assessment feels onerous to some psychotherapists in this study is because at the time of conducting interviews they were still in the early stages of implementing these tools and therefore their use did not yet feel embedded. Furthermore, the requirement to use ROMs at assessment followed rapidly behind the

introduction of other required paperwork, all of which must be completed at first contact and the exact requirements of which had changed several times. At the time of interviews all clinicians were expected to complete the following at a first contact:

SDQ and RCADS (when not sent out in advance)

Current view tool (after the assessment)

Consent to share information form

Care plan

Consent to allow CYP-IAPT data to be anonymously analysed

Risk assessment

Drugs / alcohol assessment (CRAFFT)

Core assessment (lengthy document including background history, family history, presenting problem, physical health, mental health, etc.)

One therapist observed: “The expectation is that we use the whole lot in the first assessment session, and I don’t think that’s clinically appropriate in all cases.” This therapist described patients who might take much longer than this to engage at all, and families where the presenting issue is so pressing or where distress is so high that paperwork has to take a back seat. Four therapists felt that very little time is left for discussion, either of the answers given to the ROMs questions or of wider issues that might help them to form a relationship with the young person and their parents / carers. At present, in this pilot stage, these

therapists felt there was some leeway not to complete all the paperwork at first meeting; however they expressed an anxiety that once these ROMs are fully embedded then this requirement will be more strictly enforced. Two therapists reported that they would not have time to offer more than one appointment to each new patient and therefore had no choice but to complete all of the measures at first contact.

Sending RCADS and SDQ out in advance does not necessarily help with this problem. Not all patients and parents / carers will complete the measures in advance if they are received by post, so this cannot be relied on. One therapist pointed out that when the measures *are* completed in advance: "Some people don't want to go through it again…maybe for some families they just want to tick the boxes and that's it, and that's not clinically meaningful." This therapist observed that when the measures are sent out in advance it is also harder to know if a response is really that of the young person, or if they have been steered towards particular answers. This might happen, for example, when parents feel that only the most extreme of answers will result in their child being accepted for treatment, or when a parent has a very different perspective to the young person and exerts pressure on the young person to agree. In addition, if ROMs are completed in advance then answers are not fresh in the young person's mind and might feel far removed from how the young person is currently feeling. One therapist raised the concern that sending out the ROMs in advance may face children / young people with difficult questions in an environment where it does not feel safe or to answer them: "Particularly questions about death and things like that, a child where there's lots of suicidal acting out or thoughts around - I'm not sure about

opening something up that might have a sense of something uncontained about it prior to seeing them." One clinic in this CAMHS partnership usually asks for the measures to be completed just before the first appointment, in the waiting room. However: "Families can be late for their appointments because they are spending so long completing them." Another disadvantage might be that families are potentially discussing sensitive questions in front of other children and families. This is particularly true of children and young people who cannot read or write and therefore must express their answers verbally. Being asked these questions in public might distort the answers given.

All five therapists who reported that either RCADS, SDQ or both are usually completed outside of the session also stated that they rarely or never look at the responses received. One therapist reported that the data is available, but that they would never look at it as they wish to start from where the chid is now, not how they might have been a week or two previously when they completed the ROMs. Four therapists said that there is no time to look at ROMs responses that have been sent out in advance:

> "Often I don't even get the data that comes back from it."

> "It's hard if they come with it done if I haven't got time to look at it before…"

> "It's there on RIO [computer system] but we are so stretched for time that it's hard to look…in an ideal world before you see someone it would be on the system, or not even on the system you'd see it

> before you see your patient, but mainly we see these after the initial assessment and to be honest with SDQs I don't even look at it unless someone is challenging our – you know, what is the difficulty here, and you want to get a better picture - but that would be very rare and I don't think I've ever done that…"

Two therapists reported routinely completing RCADS with the patient during the initial assessment appointment. One stated that this process is very informative, not just because of the answers given but because the therapist can observe *how* they are given. Some questions open up fruitful discussion, questions that are hard to answer are immediately identifiable as potentially sensitive areas. One therapist commented that it is essential that ROMs answers are discussed together in order to be clear what exactly the young person's responses mean, for example if a young person has misunderstood a question: "I think it's important that you can look at them and check these things out." Another commented:

> Sometimes when I'm using [RCADS] a young person says "I don't really understand what is meant by the question" and that can be quite a good thing, that we can have a conversation about what is actually meant.

One therapist who reports using the ROMs successfully in assessments divides the 90 minute session up into:

1) Family complete SDQ in advance; this is used as a benchmark in

terms of data collection but not discussed in the assessment.

2) General chat with whole family – get to know something about the young person and what has brought them to CAMHS. Explore family history and complete core assessment overview / history.

3) Meet with young person alone to complete RCADS, send parents out to complete their own RCADS. Use this time with young person to explore their answers further. Complete risk assessment. Complete CRAFFT tool (alcohol consumption) if relevant. Decide what to feedback to family.

4) Meet with young person, parents / carers together. Sum up presenting difficulties. Compare parent / carer RCADS to young person's RCADS and discuss differences / similarities. Agree on plan for next stage in CAMHS referral – usually to discuss further with team. Discuss safety plan if needed. Gather the required signatures.

This therapist asserts that while completing RCADS takes time, this is offset by the fact that it enables the therapist and young person to get to the specific nature of difficulties more quickly, so discussion is more focused and it is more evident as to what the appropriate treatment plan should be. Less time is spent by this therapist on the other core assessment paperwork, such as genogram, though a family and personal history is still taken.

4) Summary and Discussion

Psychotherapists in CAMHS have for many years undertaken work outside of their specialism, which includes generic assessments of patients new to CAMHS. This work may feel very different to psychotherapy itself, in

that it focuses on gathering information and carrying out risk assessments in order that the young person can be allocated to a particular CAMHS treatment. It would not be surprising, therefore, if use of ROMs at initial assessment raised fewer concerns for psychotherapists than use of ROMs in long-term psychotherapy, where the method of working is very different.

However, even at initial assessment psychotherapists have previously been relatively free to conduct a conversation with a young person and parents / carers however they chose, which might include a very open space where the young person can talk freely about whatever they wish and where the psychotherapist is equally free to use the tools of their trade to understand the communication; this might include paying attention to how words are used (not just which words are spoken), common patterns and themes, omissions, relationship between patient and parents / carers, how a young person responds to the therapist's comments and so on. Psychotherapists have been free to use their intuition and clinical judgment to follow tangents and also to ask questions which they might feel shed light on a difficulty, such as to ask if the patient has had any dreams which they can remember or to see which areas a patient talks about when given the free space to talk about whatever they want. There has been little previous requirement to follow any particular format, so different professions and individual clinicians were free to carry out initial assessments in whichever way felt most helpful. It is therefore unsurprising that use of RCADs and SDQ at initial assessment would be experienced as a major change to working practice for psychotherapists.

Interviewees' comments flag up the importance of not allowing the use of ROMs to make the first appointment so full of bureaucracy or such a rush that

this forms a young person's negative first impression of CAMHS. The question then arises as to whether it is possible both to compete the required ROMs at initial assessment and also to have a meaningful contact where there can be a genuine meeting of minds.

On the whole, use of RCADS and SDQ at initial assessment was less contentious than use of any of the other CYP-IAPT outcome measures. This may be because they are not taking place in the context of psychotherapy, and therefore issues such as impact on the transference relationship, imposition of an agenda on an agenda-less space and so on did not arise. Seven therapists identified at least one clinical benefit of RCADS and SDQ at initial assessment, five cited the way they triangulate different points of view, five pointed to their benefit in initiating a conversation and five said that it helps identify underlying issues more quickly. Other gains from use of these ROMs at initial assessment included the ability to identify issues which might not otherwise have been noted, the importance of offering consistency of assessment experience and the need to offer comprehensive screening. In addition, use of RCADS and SDQ at initial assessment offer an objective benchmark against which later progress can be measured and which also allows for comparison between patients and patient groups; this will be discussed further in Chapter Six in the context of ROMs to monitor progress.

Concerns expressed around use of RCADS / SDQ at initial assessment were mostly around feasibility, i.e. whether it is possible to ask so many questions without this resulting in a less personalised and meaningful initial contact. Therapists are concerned that the initial assessment can become

impersonal, as the therapist concentrates on completing the paperwork in the required time, rather than getting to know a young person in a live emotional contact. The flip-side for a rigorous and comprehensive screening process at initial assessment was felt to be a loss of spontaneity and reduced space in which the therapist can find out anything meaningful about the patient's internal world and emotional state.

There is clearly a training need to allow therapists to share their experience of using ROMs during the initial assessment, to help each to find a way of managing this that is practical and which feels satisfactory both to the therapist undertaking it and to the patient. Two therapists reported managing this balance successfully, and felt that they were able to have a meaningful first contact whilst using these tools, rather than having to abandon this due to pressure of paperwork. Clearly it will always feel more possible to complete all the necessary assessment tools with some families and young people than with others, and therefore there may be cases where clinical judgment will need to override the requirement to complete these ROMs at first contact. Therapists need to feel empowered to justify a decision not to carry out (or to postpone) these measures with a particular patient for clinical reasons, and it might benefit the psychotherapist group to discuss scenarios when this would be advisable.

One important factor in how a young person experiences these ROMs at first CAMHS contact may be the therapist's own attitude towards the measures. If they are introduced in a way that implies that they are an annoying intrusion into the "real" work then they are unlikely to lead to fruitful

discussion. The therapist needs to be prepared to answer questions about the measures, for example to be able to explain why they are asking lots of questions that may seem very similar to each other. Therapists need to be prepared for what they will say to those parents who feel that questions are ignoring specific difficulties which have brought their child to CAMHS, or to those young people who struggle to commit themselves to a response or who find particular questions difficult. Therapists need to know in advance how they intend to structure the session so as to accommodate the ROMs, for example whether they intend to offer adolescents a time without parents / carers to complete RCADS / SDQ, and how they intend to bring together the parents' / carers' measures with those of the child or young person.

Trickey, in the 2014 revised guidelines, stresses the importance of seeing RCADS as a collaborative tool, a springboard for discussion with the young person and their parents / carers rather than an alternative to discussion. In addition, he stresses that ROMs do not replace the therapist's clinical judgment: "Clients that are concerned or frustrated can be re-assured that the scores are just a small part of the information on which your assessment is based" (Tricky, 2014, p.118). Seen as just one tool in the psychotherapist's assessment toolkit, RCADS and SDQ are on the whole perceived as less controversial than any of the other CYP-IAPT outcome measures.

Chapter Five: Use of ROMs to set and monitor treatment goals

Following initial assessment, ROMs are next used to establish "goals" for treatment using the Goal Based Outcome Measure (GBO); for psychotherapists this will take place either during the psychotherapy assessment or within the first few sessions of any generic / short-term work. This is an example of an individualised measure, whereby goals are individually tailored, and the purpose is clinical benefit rather than data analysis or comparison. The therapist is expected to establish two or three goals with the child, young person or parents / carers, which will be reviewed regularly throughout treatment. The GBO is an attempt to be clear about the purpose of the work from the outset and to track progress in a transparent way. Two therapists interviewed had not yet used the GBO, the remaining six had tried with at least some patients.

The CYP-IAPT 2012 guidelines assert that the GBO is helpful because:

> …it gives a different perspective to clinical outcome measures and can measure different sorts of change that might not always be captured using only behavioural or symptom based outcome measures.

In the 2014 guidelines Law and Bradley (2014, p.130-131) state the advantages of using GBOs as being good face validity, individuality, the fact that they are reportedly liked by young people and by clinicians and that they help young people to know which areas they need to work on; in addition: "Preliminary analysis of the CORC data suggests that goal setting may lead to higher rates of retention and perceived satisfaction…."

This chapter will consider the process and purpose of setting goals as

follows:

1) **Overview**
2) **Is the concept of a "goal" too directive for psychotherapy?**
3) **Do goals have to be externally focused?**
4) **Are all young people capable of setting appropriate goals?**
5) **Benefits of using the GBO to monitor on-going work**
6) **Concerns about use of the GBO to monitor on-going work**
7) **Summary and Discussion**

1) Overview

The setting of goals is intended to ensure that, from the outset, there is clarity about the purpose and task of treatment. The GBO attempts to ascertain what a young person would like to feel different and how the young person, their parents / carers and therapist would recognise that they have made progress. The process of discussing and naming potential goals highlights when there might be a lack of clarity about purpose of treatment or where there might be a discrepancy in the wishes of a young person and their parents / carers. One therapist described how discussing goals had been helpful:

> Helping parents to see the child did have a goal and bringing this to the parents' attention…helped the child to get really good results, whereas the parent might have had a different goal and it wouldn't have worked.

Five of the six psychotherapists who have used this measure expressed a view

that setting goals gives therapist and patient a clearer grasp of what they are jointly wishing to achieve, for example:

> "It focuses the mind a little bit about what it is we want out of therapy."
>
> "For me it has helped make the work that I'm trying to do a bit more explicit…and for the young person as well…"
>
> "There's a little more focus on what are we trying to do and why."

This is particularly important for psychotherapy within this Trust where even "long-term" work is usually limited to a year and where short-term interventions may be as little as six to twelve sessions. Six therapists expressed the view that it is essential that there is some agreement as to what it is that the patient, their parents/ carers and the therapist might reasonably hope for from treatment. If it is not possible to articulate what desired changes might look like at the start of work, then an extended assessment might be indicated. Law (2013, p.10) points out that although setting goals might be more familiar in models of work such as CBT, "…hopefully any therapeutic process starts with a joint understanding of what the goals of the intervention are (the destination) before the therapy (the vehicle to get you there) begins".

One of the advantages of the GBO is that it is a subjective measure, intended primarily to benefit clinical work rather than primarily as a data-gathering exercise. Law (2013, p.11) was involved in developing the GBO, and describes his rationale: "My interest in developing a goals based measure was my belief that the most important measure of change is that which children,

young people and their families have chosen to make themselves". Goals may be more or less long / short-term, more or less challenging and may be modified or changed throughout the work. The GBO, therefore, has the potential to be less rigid than other outcome measures because it does not use standardised questions or statements.

2) Is the concept of a "goal" too directive for psychotherapy?

Four therapists expressed a view that having a "goal" in mind fits more easily with cognitive treatments or with short-term psychotherapy and generic work than with long-term psychoanalytic psychotherapy. For these therapists the word "goals" feels too concrete, cognitive or external to fit comfortably with the work of psychotherapy, for example:

> "I think I don't like the word 'goal'. I think: 'What are your hopes for treatment?' would be better, because for some of them it never feels like they are going to reach that goal, and is that their fault or my fault?"

> "I think 'goals' is the wrong word, it's really not helpful."

Four therapists expressed a view that measuring progress towards "goals" would imply that progress throughout treatment is linear and that the end point can be in sight the outset, which they did not feel accurately describes psychotherapy. They pointed out that psychotherapy is patient-led and each session follows whatever comes into the patient's mind rather than having an

agenda.

3) Do goals have to be externally focused?

Five therapists expressed a view that the GBO exists in order to monitor external changes, in contrast to the work of psychotherapy which is about internal changes. One therapist commented:

> We are measuring things on external signs of progress – that does worry me…that does concern me, that some of the measures focus on that, not all of them, but obviously the goal based one.

Whereas CBT, for example, might consider a goal to be for a young person to stop self-harming, a psychotherapist would be more likely to want to explore the underlying reasons for self-harm which might remain in place even after this symptom has stopped, and might, if left untreated, lead to the formation of a new symptom. While psychotherapists are likely to regard changes such as stopping self-harm as positive indicators, they are unlikely to see this as the "goal" of treatment, but rather bench-marks that *might* reflect underlying internal change. Symptoms can be the gateway to get a young person into CAMHS – but they are not necessarily the focus of the work once a young person starts psychotherapy. For this reason, a "goal" to reduce the presenting symptoms was felt by psychotherapists to have the potential to distort their work and to place an unhelpful emphasis on something that might turn out to be incidental.

Two therapists expressed a view that parents tend to express

externally facing concrete goals for their children, such as for their child to stop hurting others or themselves, start eating a wider range of foods, and so on. These might be different from changes that young people or children themselves might wish for. For example:

> I think if a parent or carer had a very strong opinion about it being the child's behaviour that's uppermost, and that they think it's nothing to do with their own circumstances or their own part to play then I'll lay off setting goals as it can become very behavioural.

When parents do have "behaviour change" goals in mind it might be possible to work together on what the accompanying internal change might look like. For example, "You want your child to get into fewer fights with others…how would she need to feel about herself and about others in order for that to happen?" This could lead to fruitful discussions about what it is that is causing their child to behave in particular ways, and might open the way to thinking about internal change.

4) Are all young people capable of setting appropriate goals?

Seven of the eight psychotherapists were concerned that setting goals can be too difficult for some young people. Three made the point that as a profession they tend to see the most complex and chaotic young people who might be least expected to know or be able to articulate their own goals. Therapists expressed a view that psychotherapy is often the chosen treatment for young people who are non-verbal, chaotic or have psychotic or borderline

symptoms. There was anxiety in the group that goal setting is a skill which requires insight and an ability to step outside of immediate feelings; two therapists made the point that young people who possess this ability are unlikely to be referred for psychotherapy in the first place. Seven therapists were concerned that by asking young people to set goals they may be facing some with an impossible task and therefore getting treatment off to a poor start. One gave an example of a young person with borderline personality disorder who "looked at me like I came from outer space" when the idea of goals was introduced. Other comments included:

> "The way now where you come in and everybody agrees what the problem is and everyone decides what the goals are, well I think that's brilliant if you can do it, but not everyone can do it…so whether the system says 'well we don't bother working with the people who can't do it', well I'm not very happy with that… those would be the ones where no treatment other than psychotherapy could possibly work…"

> "If you put it in front of someone and they can't set a goal …how does that leave them? I think that's probably a bit of an issue, does that mean they've failed, and how does that compound the feeling of not wanting to come out of their shell?"

One therapist described a sixteen year old girl for whom "everything felt wrong" and she had not been able to articulate any kind of goal - "It felt too overwhelming for her to extract something manageable".

Those therapists who expressed a concern that not all young people

have the capacity to know and to name goals independently shared a belief that CYP-IAPT *requires* patients to do this. This may be because the 2012 guidelines suggests an appropriate conversation starter with a young person concerning goals to be:

> "So, from what you have told me so far, what would you say your main goals are from coming to this service? If we were to work together in a very helpful way, what things would you hope to be different in the future, when we agree to stop meeting, from how things are now?"

The experience of seven of the psychotherapists was that many (or all) of their patients would not be able to answer this kind of question. This is a point also made by Troupp (2013, p.22):

> We may hope that we sound respectful and collaborative in asking some variant of "what do you want?", but patients know that they have not come to the mental health equivalent of the sandwich shop. They want their therapists to inspire confidence.

Those therapists who reported having had any success with the GBO found it most useful when goal-setting is collaborative between young person and therapist, with goals emerging naturally out of the psychotherapy assessment; one commented:

> In the assessment we would normally anyway formulate some of the areas that are the main areas of concern and these would be my key areas on the care plan so that feels quite straightforward… and then

after coming back and reviewing those.

Two therapists described having arrived at a collaborative way of establishing goals by accident, having initially made the mistake of following the CYP-IAPT guidelines by asking a young person directly for their goals. One reported:

> My most extreme reaction with one looked after child was that she found it an extremely intrusive process to set the goals… I reflected with the child and carer that I did think it was intrusive and we should have started more slowly. It helped to say I'd made a mistake and we had rushed things.

Another therapist described having asked an adolescent girl to name her goals, but she had been unable to. They had therefore left the goal-setting process aside and proceeded with the psychotherapy assessment:

> The difficulty for the girl was she didn't know really, she found the process [of goal setting] very difficult and we got to the goal because she was just talking early on about what she wanted and I said to her "this is actually your goal" which is she wanted to be more her own person inside and out….she wouldn't have been able to verbalise that if I hadn't extracted it from the conversation…but she did agree with it as a goal.

This therapist felt that "extracting" the goal from the conversation was not what is expected by CYP-IAPT. However, the process this therapist described was

having been able to attune to the patient's difficulties and their desire for change and having been able to draw this out and articulate it as a goal. This is exactly the process that Troupp recommends (Troupp, 2012, p.23):

> I propose that goal-setting is kept at the back of the therapist's mind until the time is right to mention it, be that in the first, second or third session. The first task, as ever, is to begin to build the foundations of the working alliance and contain the anxiety of the family members. This requires the old familiar skills of listening to the various stories and narratives, asking clarifying questions, and pulling things together, while offering the beginning of a relationship and the hope that things can get better. Goals can emerge and be formulated at any time and in the middle of these kinds of conversations.

The task for the therapist then, is not to *set* a goal (or aim), but to draw it out from the assessment, discuss this with the young person (and possibly also parents / carers), refine it and – eventually – to record it on the GBO. The resulting goal / aim is likely to be something that was not in the patient's mind at the outset. One therapist described discussing goals at the end of the psychotherapy assessment:

> I would very often try to summarise what a child or young person has brought…and the parent / carer / adopter and their view, and then try to wonder about the goals. So having reflected back what I've heard, but also trying to keep it open and check there isn't anything else that hasn't been said…[it might take several sessions] for them to really

mean something.

Of course even when the therapist draws out underlying goals from the patient's assessment in this way, it is possible that the patient will reject the suggested goal or express a different one, which might be perverse or unachievable. Not all patients want to get better or be in touch with the reality of how things are, while some have unachievable goals. One therapist gave an example of a young person saying that their goal was to be dead, and another patient having said their goal is not to have their disability any more. This therapist thought about how to work with an unachievable goal and how to find goals that might help:

> If your goal is, for instance, not to have your disability any more …we know that's not going to happen but we can help you to live with the distress of your condition…

Four therapists gave an example of an anorexic patient with a goal only to be thinner, an example also used by Law and Bradley (2014, p.133) in the ROMs guidelines, who advise:

> By understanding what is hidden behind an initially stated goal, it is usually possible to find some point of overlap to agree goals and begin a collaborative intervention. It is often helpful to ask,
>
> *"What would you hope to be different if you lost the 10kgs?"*
>
> This gives the young person the opportunity to talk about their hopes,

> "I would hope I'd feel more confident if I was thinner" or "I would feel I had achieved something". This then opens the door to negotiating goals that both therapist and service user can agree to work together on: building confidence, being successful.

Law suggests that one way of helping a young person to set a goal where this is proving difficult is to ask them to think of three "wishes" that they would like, if they could have a miracle (Law, 2013, p.16). One therapist used this model and found it unhelpful, telling me about a child whose "three wishes" were:

> Go back to mummy and daddy
>
> Start my life again so that I wouldn't be so bad so that mummy and daddy wouldn't throw me out or treat me badly
>
> Have an Xbox

This therapist felt that asking about wishes faced this child from the outset with the impossibility of having the things they most wished for, leaving both child and therapist stuck. One solution might be to explore whether this is a child who also wants to feel better about their life as it is at the moment, perhaps this child believes that nothing can ever feel good again after such a catastrophic loss. Their two-part goal might therefore look something like:

> To feel better about how things are in my life now; to talk in therapy about what it's like to be in foster care.

The desire for an Xbox might also be explored. Perhaps it represents being like

other children, or a way to switch off from thinking about difficulties. Or, perhaps the Xbox is just an Xbox, and this opens up a fruitful conversation about what it is that therapy can and cannot deliver. It seems helpful to be clear from the outset that therapy is not aiming to achieve the unachievable. Law (2013, p.24) writes:

> Such shared decision making helps strengthen the overlap between what the service user wants and what the therapist is able to provide; this is where the therapeutic alliance is likely to be strongest.

One therapist described working from the patient's statement of an overly general aim towards considering more specific changes that would accompany this:

> One young person I see, nearly 15, wanted to feel happier. In the process of assessment…I said to her, 'What would feeling happy look like?'…She started to talk about her difficulties with friendship…from there emerged an idea she'd like to feel more confident approaching someone for the first time, so I think it emerges organically with some patients…but with some…I think it's much harder to come up with that….

Another therapist advised a similar process:

> ...it's something about thinking: "Is it an achievable goal? Is it a small enough step that we are asking people to make?" and "Is there a way of telling how you've achieved it?" As well, "How would you know?" It's easy to set a goal that is a bit more specific…an example would

> be rather than “I want to be less angry”…would it not be better to think about: “I’m having less arguments at home”?

In some cases initial goal(s) may need to be purely related to engagement in psychotherapy. Troupp et al. (2014, p.90) write

> If setting goals is a challenge, the first set of goals may need to be focused on building trust in the therapeutic relationship, as basic trust is often very fragile with this group of children and young people. This kind of goal should be revised at reviews so that the therapeutic relationship itself does not remain the primary goal of therapy in the long-term.

A two-part goal might therefore be framed something like: “To trust that this is a safe place to be; to stay in the room for longer”. Some young people may not be able to subscribe to a goal at all if, for example, they are engaging in therapy only to please their parents and have no aspirations for themselves. By discussing goals from the outset discrepancies between the parents’ / carers’ or therapist’s hopes and those of a young person become apparent. It might take time before there are the beginnings of a therapeutic alliance which might indicate that a young person is genuinely consenting to treatment and therefore might have their own aims for their therapy. One therapist described this process:

> I have come across quite a few young girls who have massive issues with opening up so I would link that with trust and work together with

> the young person to think about their difficulties with trusting people…and we would then devote the goal around beginning to trust enough to begin opening up in the session… this feels like a goal that would be beneficial to the therapeutic process because the goal is about opening up and trusting in therapy… so early on in therapy I might use that kind of engagement goal.

Emanuel et al. (2014, p.178) find that GBOs are appropriate for most, but not all, psychotherapy cases. They find no correlation between severity of difficulty and patients' ability to make use of the GBO:

> Some of our patients with eating disorders, for instance, were very severe cases and yet engaged in the aim-setting exercise readily. In our view, aim-setting is more usually abandoned if the patient's level of fragmentation or disintegration is too high; if the patient does not yet have the ability to put words to feelings….Clinical judgement must, of course, be used in introducing any outcome measure.

They suggest that for some patients the use of the GBO might be delayed until the patient is more stable or they are better able to put feelings into words. For this reasons there needs not to be an absolute requirement to introduce a goal by a particular point in treatment. There will always be a small number of patients who cannot bear (or are unable) to hold any idea of a goal in mind, even if it is largely formulated by the therapist or even if the goal relates to engagement in psychotherapy. These might be particularly chaotic, borderline or psychotic young people or those who arrive at CAMHS feeling utterly without

hope. Perhaps for these young people it would be possible to frame this early in the work as the *therapist's* aim or goal, conveying a view that they therapist is able to hold onto hope for change even when a young person cannot. A final example of a patient who might struggle to have any goals in mind, would be a patient who feels such high anxiety about succeeding or failing that the existence of a goal makes them feel that they cannot achieve it. Emanuel et al. (2014, p.178) cite an example:

> One teenage patient, Sophie, for instance, could not identify any aims for her therapy because the very idea of this made her fear that she would fail to fulfil them. In this case, careful thinking about the distinction between treatment "goals" and "aims" was not sufficient to help her to feel less persecuted about the idea.

This interviewee felt strongly that for those young people who already feel a failure, the existence of any target might feel hugely threatening, another benchmark which they fear they will not hit. Some might be helped by an initial goal that is eminently achievable, such as "I will just get myself here each week", but for others any goal might need to be postponed until the young person feels more secure within the psychotherapy setting.

5) Benefits of using the GBO to monitor on-going work

Despite seven out of eight therapists reporting some difficulty in setting goals, once these have been set four therapists felt that the GBO is generally a helpful tool for monitoring progress while another expressed a mix of positive

and negative views. A typical comment from the four therapists who reported finding the GBO a helpful barometer of progress was:

> I suppose the difficulty is with this ROM…finding a goal that is achievable, appropriate and will work with therapy is a challenge …but once I find them then it works well…

The sole purpose of the GBO is its clinical usefulness, i.e. the impact it can have on the course of treatment as it progresses, and therapists highlighted its utility in drawing attention to specific areas of progress and to how each of the patient, therapist and parents / carers view progress. One interviewee observed: "The research was very scary in terms of the gap between how a therapist thought things were going and how the patient thought things were going...so that is pretty salutary stuff." As discussed in Chapter Two, research consistently shows that therapists tend to overestimate progress in comparison to the view of the patient or parents / carers. One therapist highlighted how helpful it is to be able to compare views of progress and refer to the GBO as evidence:

> You might have one parent who thinks the work is going really well, or you might have a young person who thinks the work is going really well but the parents don't, so it just helps to clarify

Three therapists recognised that the GBO can be useful when a young person holds a view that nothing has changed and yet has made good progress; the therapist can use the data to show that the young person has reported changes over time. Change in psychotherapy can be slow and

therefore hard to notice, but looking at a graph showing progress over several months can help a young person to be aware that things are progressing. One therapist discussed: "that scenario where you *feel* you are not achieving your goals but you *are*…The young person might find it hard to see the goals are being achieved because of where they are at in their therapy…." It can be helpful to have the GBO to keep some level of contact with external reality. Another therapist commented:

> It helps people realise really what has changed…sometimes people…forget how awful it all was when they started, when things are still difficult but they've also changed. You do get comments like "I'd forgotten how bad it was" and "I hadn't realised that all those things had improved".

Of course simply showing young people their progress on a graph is not necessarily going to convince a young person that they have made progress. One therapist pointed out:

> It's very complex isn't it, if they feel that I'm not hearing them say that [nothing has improved] then that's not going to be helpful but …saying "Yes, there's these dips but actually things have changed – you may not have reached the goal of nirvana *but*…" [can be helpful].

Where there is conflict between the patient's feelings about progress and the GBO data, or between the therapist's and patient's views of progress, then the therapist needs to approach this with the same sensitivity and thoughtfulness that they would approach any other patient material. The ordinary work of psychotherapy would involve taking seriously the patient's view that "nothing

has changed" and thinking about what lies behind this view, whilst *also* examining whether this view reflects reality. It cannot be assumed that all young people wish to make (or to report) progress; it might feel safer to retain the current symptoms or there may be a fear that if progress is made (or if it is reported) then the patient will be discharged before they are ready (see for example Moran et al., 2011, p.75).

The GBO is a springboard for discussion about progress, it is not the final word on this. Used thoughtfully it provides a way to think about which areas are progressing and which are not, and whether the aims set out at start of treatment remain current. An advantage of the GBO is that its subjectivity creates flexibility and this may mean, if goals are set thoughtfully, a closer fit to a young person's progress than ROMs where young people score themselves against predetermined statements. Goals can be small steps where progress is more likely to be observable, in contrast to the other CYP-IAPT ROMs where the measures cannot be broken down into smaller parts.

6) Concerns about use of the GBO to monitor on-going work

Three therapists felt that the GBO is unhelpful for monitoring progress, and one expressed ambivalence; issues of the appropriateness of the measure as well as its feasibility were voiced. The main concern was that a conscious focus on "getting better" is a distraction in long-term psychotherapy. Two therapists cited Bion's "without memory or desire" (Bion, 1970) as an important principle; it is unhelpful for therapists / patients to be fixated on "progress", "getting better" or "symptom change" as this obstructs a free ranging attention to whatever a young person may consciously or unconsciously bring to the room.

This is particularly felt to be a risk if the GBO is used too frequently in long-term psychotherapy, while it was felt to be less of a risk when the GBO is used at reviews or in short-term or generic work.

Four therapists expressed concern that use of the GBO may feel like imposing an agenda for each session and might suggest to the patient that the therapist is only interested in hearing about positive changes in specific areas. Observations included:

> "People think, 'So that's what the problems are and now I've got to get better', and there may be pressure on them [the patient] as well as the therapist."

> "That concerns me slightly, that there's a focus on progress."

> "We can look at whether the graph goes up or down or whatever, so progress is immediately centre stage…"

Therapists voiced a fear that the GBO risks introducing measures of success or failure to therapy sessions. This may particularly be a risk with monitoring goals that are internal to therapy, for example for a young person to try to speak, in the room or voice negative feelings. These sorts of goals might suggest that a session can be judged as more / less successful accordingly. This would be immediately at odds with a view that the therapist is there to understand and reflect on whatever the patient communicates and however they communicate it without judging a session or behaviour as good or bad. For example, a target for a silent patient to be able to put some feelings into words risks implying that their silence is not good enough and that it is viewed as behaviour to be modified rather than material to explore. Therapists identified a risk that failure

to achieve goals devalues the work that patients have done, which might be considerable but be outside the areas identified as goals. One therapist described how in a recent review a young person said that she had made no progress with her anxiety or depression – but in discussion it emerged that in fact she was able to engage with others better, listen and take in critical comments, communicate more clearly, and had fewer arguments: "We actually realised she had changed quite a bit but I don't think that would have necessarily been captured if we had set a goal at the beginning." This therapist felt that by asking an open question at review, such as "What has changed?" then *all* change can be noticed, whereas selecting desired areas of change in advance caries the risk that changes *do* take place but not in the areas identified as goals. It is important then, that it is made clear to patients and their families that the GBO is just one way of finding out about change, and that it needs to be used alongside a free-ranging discussion about what else may have changed.

Three therapists expressed a view that the GBO can be demotivating if used every session. One reported:

> I have one boy and he struggles with an eating problem and he just says, "It's like rubbing my face in it" so I said, "Let's just not do it…".

There is a risk that young people will feel they have failed if their goals are not met, regardless of any other progress they make or insights they have. One therapist commented:

> I don't find this [ROM] so useful at all… if you've got a depressed adolescent they will basically just keep scoring zero and then they

> feel rubbish… and I've actually decided not to pull this out every session and discuss it with them.

Scoring zero every session might suggest that a very large goal has been set at the outset, and might point to the need to break this up into much smaller parts, or it might suggest a patient who is really not yet really to notice any changes at all. This therapist's response also flags up the inadvisability of using the GBO every session in long-term psychotherapy, when it is reasonable to expect that changes are slow and that drawing attention to goals too frequently will indeed be an unhelpful distraction and likely to be demotivating. With any goal there must be a risk that there will not be any recorded progress on the GBO, and therapists will need to consider how to use the GBO with young people in these cases. Law (2013, p.19) advises:

> …in such cases it may be helpful to move away from goal focused talk to "un-stick" the problem before moving on. The goal might always be in the mind of the therapist but not always the direct focus in the room.

Another concern expressed about the GBO was that scores have potential to be misused, such as to reward or punish the therapist, to try to maintain a place at CAMHS or as a bid to be discharged. One therapist discussed the example of a young person using the GBO weekly:

> Because he was a very compliant young man…he looked at it and thought what I ought to do is put it….what he dutifully did was put it at 3 or 4 and then put it half a scale better each time because that's what he thought he ought to do.

The majority of concerns expressed regarding the GBO related to a fear that this measure will be required to be used too frequently, possibly every session. The impact of using session-by-session ROMs will be considered as a separate issue in Chapter Four. The only examples given of successful use of the GBO every session were taken from short-term and generic work where maintaining a clear and specific focus is part of the work; an example might be a brief intervention with a parent and infant where the presenting problem is that the infant will only eat a very limited range of foods, or where a child has difficulties separating from parents. Therapists are not always working in classic long-term psychotherapy, but often in a more applied and overtly goal-focused way, and work might include targets (such as to try eating carrots) or integrating strategies with more reflective thinking. In this kind of work therapists can hope for more rapid change in relation to specific goals, and none of the therapists raised it as a concern to use the GBO frequently for this kind of work. One reported:

> I particularly like this with my dyadic work which I'm concerned can sometimes drift…this stops drift, it focuses you on what you're working on.

However, seven therapists expressed a view that having a conscious goal in mind *every session* during long-term psychoanalytic psychotherapy is likely to be detrimental to the work, and all felt the GBO in long-term psychotherapy is most helpful when used at reviews or termly, or "infrequently". Comments included:

> "It's just an intuitive exercise as to when I would review the goals…sometimes at a CPA [care programme] review or when something has gone backwards or has progressed…If there was an idea that we'd have to review this every session then it wouldn't be good, but it's fine as it is."

> "If you link it back to goals from time to time that's good, but not too often as it has to emerge and [for] unconscious material to come out means that we would not try – in psychotherapy – to be overly directive or controlling otherwise, that completely sabotages the point of it, so it's a fine balance."

> "I don't find session by session goals helpful…I prefer to use them on a broader, more termly basis, that fits better I think with my work."

> "I would feel concerned about using it session by session because of the strong focus on progression …and I think that isn't helpful for psychotherapy."

Too frequent use of the GBO was felt to place pressure on a young person to focus consciously on their progress in particular areas only, distorting the focus of psychotherapy and inhibiting the expression and exploration of negative feelings. Furthermore, measuring progress every session would suggest that a therapist might be expecting or wanting to see this, an unrealistic view that might increase a sense of failure. The 2014 ROMs guidelines acknowledges the potential difficulty in tracking symptoms every session:

> …it seems that directing the child or young person's attention to their symptoms at every session could be experienced by them as irksome and too narrow a focus. Again, we suggest that guidance be amended to allow for frequent rather than session-by-session symptom tracking. (Troupp et al., 2014, p.89)

7) Summary and Discussion

A number of concerns were raised in interviews about how to establish goals at the start of long-term psychotherapy. One fear expressed was that goals are external markers and therefore are at odds with the focus on the internal world that is central to psychotherapy. However, although psychotherapy might tend to be more concerned with the internal world than with the external world of behaviour and symptoms, it nevertheless does need to find some way to stay in touch with these. Troupp (2013, p.23) points out: "moments of insight need to be harnessed to real-life experience so that they can be recognised outside the consulting room. Children and young people, perhaps more than adults, need particular 'scaffolding' from the therapist to make such links". If psychotherapy ignores the child's external world altogether this would be extremely unhelpful, the child does not exist in a therapy-bubble divorced from external reality and the need to function at school and at home. Furthermore some external behaviour, such as self-harm, carry risk, and it is vital that the therapist does keep track of when a child's external functioning presents a danger to themselves or to others.

The GBO has the potential to be used to monitor both internal and

external goals / aims. There is no requirement that goals must be symptom related or externally facing, but equally no requirement that they relate only to internal states. The challenge is to establish goals which represent genuine changes in the young person's state of mind and which also indicate a more successful adaptation in the external world. Troupp suggests:

> Patients can be encouraged to divide the goal into two: the first part of the goal about feeling differently; the second part contains an example of how the patient might behave differently. In other words, there is a goal for internal change, followed an example of behavioural change. So the goal for internal change can be followed by the question, "And how would that look in practice?" A behavioural goal can be followed by the question, "And how would you need to feel to be able to do that?'" (ibid, p.25)

She offers an example of a two-part goal: "Feel more confidence with my friends…be able to go for a sleepover." This recognises that attending a sleepover is one example of the sort of change that might be noticed if a young person felt more confident with their peer group; it is not the only example, and might turn out to be incidental – but it helps to keep the focus of psychotherapy connected to the child's external life.

Another type of goal might also be considered, which focuses on how the young person and therapist interact in therapy rather than changes in the young person's wider life. An example might be a goal to dare to voice negative or angry feelings. The "internal change" component to this goal might be "to start

to believe I don't have to protect others from my angry feelings all the time" or "to believe that people might accept me even if I'm not always perfect". The therapist might draw attention to when a young person has indeed been able to do this in a session, and the GBO might be used as a barometer to record how well this is going.

Another concern expressed was that the word "goal" was felt to imply linear progress towards a target that is consciously held in mind during each psychotherapy session. Therapists felt that not all young people are capable of setting goals, and when they do set goals these might be too vague or perverse to be helpful. Emanuel et al. (2014, pp.171-172) write:

> For psychoanalytic psychotherapists, the use of the term "goals" can imply… working consciously towards achieving the goals within each session….Psychoanalytic psychotherapists seek to hold in mind Bion's (1970) injunction to eschew memory and desire so as not to be saturated with the memory of the goals set for the treatment.

They suggest that the word "aim" might be more helpful, as this can relate to the desired "overarching attainments" rather than something to be held consciously in mind during treatment (ibid, pp.171-172). An "aim" might feel more appropriate for capturing what it is at the start of work that the parents / carers or young person wish to be different. Being able to articulate or agree an aim means that the patient has an investment in their treatment, they are not being imposed upon. It implies that there is at least some desire for change, even if this is not the whole story.

Several examples were given by interviewees of goals being established successfully, or where therapists had learnt from mistakes in using the GBO in unhelpful ways, and many examples were given of finding more helpful goals. The GBO was being used most successfully when all goals are formulated collaboratively with the patient and therapist / family, and emerge over time. It might be helpful to use goals which combine an element of internal change with an element of behavioural change. Those therapists using the GBO successfully viewed the process of setting goals with the young person or parents / carers as an important part of the therapy, helping to clarify the purpose of the work and to be realistic about what may be achievable. For some therapists the word “goal” felt too directive, and “aims” or “hopes” was preferred.

Positive features identified of using the GBO to track progress in psychotherapy were firstly that the GBO can draw attention to areas of change that might not otherwise be noticed and so can be a good motivator. The GBO can highlight differences in perception of progress, such as between therapist and patient or patient and parents / carers. However there were also concerns regarding the use of the GBO to monitor progress, including that they may risk too great a focus on good and bad behaviour rather than internal change or understanding the meaning of behaviour. A fear was expressed that the GBO focuses too much on conscious progress, which might distort the process of psychotherapy and limit the area of focus. If used too frequently or if goals are too challenging then the GBO could reinforce a sense of failure

Concerns expressed by psychotherapists related primarily to using the

GBO too frequently in long-term psychotherapy, such that conscious goals disrupt the free-flow of therapy and impose an agenda. When used in long-term psychotherapy therapists find it more helpful to use the measure infrequently and intuitively or at review. However, in short-term work and generic / applied work, it can be helpful to review goals more frequently. Overall the GBO was seen as helpful so long as therapists retain their freedom to use the measure as frequently as they see fit and only with those patients who are able to hold a goal in mind and where this might add something useful to existing ways of keeping track of progress. It was felt to be unhelpful if therapists feel under pressure to come up with goals that are experienced by both patient and therapist as artificial and contrived, and where goals do not naturally emerge it seems more helpful to leave this process on hold until the aims of the work are genuinely clearer.

Another concerns therapists' expressed was the use of the GBO to reward or please the therapist. One way to reduce the likelihood of scores being used in this way might be to choose carefully which sessions and at what point in the session the GBO is used. Use of GBO at reviews may for many patients be the most neutral time to step back and try to think about progress as a whole with less intrusion from the immediate feelings stirred up in a session. In addition, data from the GBO needs to be taken as just one indicator of change (or lack of change), in conjunction with other ROMs, verbal report from the patient and their family and discussions with other professionals such as teacher or social worker. A therapist might place more emphasis on the way that the GBO has highlighted a particular patient's need to please or to comply than on the actual scores given in cases where it is evident that the measure is

being used in an overly compliant way.

Of all of the CYP-IAPT ROMs, the GBO is the *most* adaptable and individualised; this might make it easier than the other ROMs to use it in such a way that young people do not feel compared, ranked or judged. Whatever goal the child or young person and therapist overtly agree to, it is still possible that the young person may – consciously or unconsciously – have a different goal in mind. For example, a young person with an eating disorder might agree to a goal that is in the area of daring to eat some "banned" foods while in fact having a conscious or unconscious goal of remaining the same weight or losing further weight. Psychotherapists would be aware that a consciously stated intention is not the whole story, and that there may be a whole raft of goals in a patient's mind that take many months or years even to become conscious.

Chapter Six: The impact of using ROMs during regular long-term psychotherapy, particularly when used every session

This chapter looks at the specific issues which concern the use of ROMs during psychotherapy to monitor progress. This applies particularly to the SRS, which is intended to be used every session, but also to any of the ROMs when used during each individual psychotherapy session rather than at review. This chapter will focus on:

1) **Benefits of the SRS as a tool to monitor therapeutic alliance**
2) **Concerns raised about use of the SRS as a tool to monitor the therapeutic alliance**
3) **(C)ORS and STMs**
4) **The impact of using *any* ROM within psychotherapy sessions in long-term treatment (rather than used at review), particularly when used *every* session**
5) **Which patient groups are these ROMs best used (or avoided) with?**
6) **Summary and Discussion**

1) Benefits of the SRS to monitor on-going work

The Session Rating Scale (SRS) is intended to be used every session to monitor the therapeutic alliance. Law et al. (2014, p.144) describe the four areas of the therapeutic alliance which the SRS sets out to monitor:

- Respect and understanding
- Relevance of the goals and topics

- Client-practitioner fit
- Overall alliance.

The SRS exists in three versions. SRS1 uses a sliding scale to cover "relationship", "goals and topic", "approach or method" and "overall". The first statement asks if the patient felt heard, understood and respected. The second asks if they talked about what they wanted to, the third asks if the therapist's approach was a good fit and the final question asks if there was "something missing in the session today". The patient can place a mark anywhere along the line between negative and positive responses.

SRS2 requires the patient to give a score out of four against these statements

a) did you understand what was said?

b) did you feel listened to?

c) did you talk about what you wanted to?

d) did it give you ideas for the future?

Statement d has been modified for psychotherapists in this Trust to "Did the meeting help you to think or feel differently in any way", since the original statement was considered by the lead psychotherapists to be a particularly bad fit for their work; psychotherapy is not strategy-based, and therefore does not seek to send young people away every session with ideas to try at home in the way that CBT or DBT might aim to. Young people must choose from "not at all", "only a little", "somewhat", "quite a bit" and "totally" against each question. CSRS is aimed at younger children and uses a sliding scale between a frowning face up to a smiley face with the statements:

a) Did not always listen to me / listened to me
b) What we talked about today was [not really] that important to me
c) I [did not] like what we did today
d) I wish we could do something different / I hope we do the same kinds of things next time

The intended purpose of the SRS is for immediate patient feedback about alliance to influence the course of the therapy, with clinicians changing the way they work (or even changing worker) in response to feedback, thereby improving progress and reducing dropout from treatment. Law et al. (2014, p.143) state in the CYP-IAPT guidelines that therapeutic alliance is one of the best predictors of good outcome, noting that: “Evidence regarding alliances contribution to outcome is reflected in more than 1,000 studies”. At the point of conducting the interviews, the SRS had been used by six therapists, with one having subsequently abandoned its use; the remaining two had not yet used this measure. One therapist expressed only positive views of this tool, three were ambivalent and four expressed overwhelmingly negative views of this tool.

The SRS has been introduced in response to a body of research claiming to show that a good therapeutic alliance is key to successful outcomes in therapy, as discussed in Chapter Two, and furthermore that therapists are not good at knowing how strong the alliance is without this specific and regular feedback. It allows the patient to offer feedback to the therapist without having to verbalise this directly, and allows the therapist and patient subsequently to discuss why a patient might be feeling a particular way about the session or about the therapist’s input. One psychotherapist felt: “It’s all about collaboration

and the relationship, and that feels to me the most helpful thing to be measuring and working on, and we also know that that's probably the key to…success in therapy…." Use of the SRS is recommended for use every session in long-term psychotherapy by Troupp et al. (2014, p.88) in the CYP-IAPT ROMs guidelines:

> In the limited experience thus far, it has been found to be a valuable source of information about how the session was received by the client, what was felt to be valuable and what could not be talked about. The SRS has identified important topics for further discussion, allowing as it does an impromptu "review" of the difficulties and strengths of the session.

Five therapists expressed a preference for either of the sliding scales – (SRS1 or CSRS) over SRS2, one expressed no preference and two preferred SRS2. One commented: "The sliding scale's quite good because you can just put a dash on a line and do not feel constrained… it also pays attention to the fact that it's a continuum and not discrete categories." The sliding scales have the advantage of allowing for subtle shifts and for the young person not to have to choose between rigid answers. One therapist commented that it is impossible for someone to "totally" listen to you, and highly unlikely that they do not at all in any way listen, therefore SRS2 is inviting misleading responses.

Three therapists said that they tend to use CSRS (smiley face version) rather than SRS1 with all ages of patient; although this measure has been designed for younger children, therapists reported that the questions are a better fit for psychotherapy than the SRS1 questions. In particular, the CSRS asks whether "what we did today" was "important" which is different to whether

the patient talked about what they "wanted to". Patients may "want to" talk about issues which are in fact distractions away from what is important, or they may be ambivalent about talking about their difficulties. However, young people can sometimes recognise what is important to talk about and separate this out from what they "want" to talk about.

Therapists using the CSRS reported that wording of the individual questions is less important than offering young people the chance to give a snapshot of how they experienced the session:

> At first I found it odd to focus on "what I did today I did or didn't like" and therefore "I wish we could do something different", as if it's about *doing* something…but actually how children, young people and myself seem to interpret that is that it's just the general feeling of the session rather than anything active so that became fine whereas I found it odd to begin with.

Therapists who valued this measure drew attention to the way it can be used to let the therapist know something that they would not otherwise have known. An example given from family or dyadic work was: "It would be useful to look at when the child has liked the session but the parent or carer thought it was a waste of time…the different perspectives and what the reasons for that might be…", so triangulation may be a helpful feature of the SRS. This comment related to short-term work with a family; it is in short-term work or in the early stages of long-term work that the therapist has least knowledge of a young person or their parents / carers and so may be least able to pick up on signals that a session has been experienced as unhelpful.

The SRS is intended to be used as a springboard for discussion; it might flag up, for example, situations where a patient has a different expectation of the purpose of therapy than the therapist, for example when parents view the work as purely about getting advice and strategies rather than understanding the intersection of the child's internal and external worlds; it might also draw attention to situations when young people see the work as focusing *only* on specific presenting difficulties (such as self-harm) rather than being more wide-ranging. Negative SRS feedback may point to the need for the therapist to clarify why they work the way they do, for example why they do not give lots of reassurance; on occasion SRS feedback might lead a therapist to plan that in subsequent sessions they will approach things a bit differently, for example in parent work to leave more time for discussing practical ways to address a child's difficulties. The therapist who found this tool most helpful related all examples to family or dyadic brief work with pre-latency children; in this context they described the SRS being used to make sure that the balance of thinking together, practical advice or strategies, discussion of family background and so on is most helpful to the family and that everyone involved is clear about the rationale for the treatment.

Another benefit noted by the four therapists who felt broadly positive or ambivalent about this measure was that the answers revealed children and young people's levels of insight about the therapy that they had not anticipated. One therapist reported:

> I have been struck by young children's ability to say they didn't like [the session] and that the approach wasn't good and there was something missing but [that] we worked just on what they needed to

> work on - so that's really interested me, that a child has a capacity to see that it might not be easy but they are working on it….

Two therapists who viewed this measure positively stated that the SRS provides information that they would not necessarily have known without it.

Among the four therapists who felt either positive or ambivalent about this measure there was a consensus that the questions asked are largely appropriate. For example:

> "It's helpful to know if the young person felt listened to, if they felt their problems were taken seriously, did they feel that they had some help? And that can mean different things to different people …hopefully that's not too much of an intrusion into the psychotherapy space…"

> "It's interesting about: 'Did you understand the things said in the meeting'….I'd hope that I would pick up when they haven't understand or they would give me that feedback, but I don't think you can always take that for granted."

For these four therapists, the SRS provides a safety net for when young people (or parents / carers) are not able to express negative feelings about therapy in any other way. This is likely to be more of a risk in the early stages of therapy or in brief therapy and generic work than in long-term established psychotherapy, and all of the examples given were of short term work / early stages of work.

Another helpful feature of the SRS which two therapists commented

on that it signals to the child, young person or parent / carer that their perspective matters:

> "The little ones that I've used it with have really liked it, and engaged with it, and I think they've really valued being asked and being part of the process…they probably aren't used to that very much, being asked and valued."

> "They really love it…It starts getting them thinking about their experience in a really positive way especially if they can draw and do what they like...if you encourage them to answer in whatever way they like…"

The SRS has the potential to help young people feel more like active participants who are consulted about their experience of treatment, and less like they are being "done to".

2) Concerns raised about use of the SRS to monitor the therapeutic alliance

More concerns were raised about use of the SRS than about any of the other tools. The specific nature of the concerns was consistent across the four therapists who expressed predominantly negative views of the ROM and also across the three therapists who expressed ambivalence about the SRS. One objection raised by seven therapists was that the SRS tends towards simplification and narrowing down rather than opening thought up in the way that psychotherapy usually aims to do:

> If you've got them structured, smiley faces and so on, they doubtless *could* use them, and little children are very prone to thinking "I am better than you", "You are crap" and "I'm crap" and things like this, they are not good at seeing the complications of life and this is pushing them further and further to simplicities which they tend to like anyway and is not helpful for their maturity.

Another therapist commented of latency age children in particular:

> They are particularly - you know – "Let's work out who's top and who's bottom, who's got the most goals, who's failed, who's done the most skips in the play ground" and so on…8-12, latency years, so much about competition, about seeing who's good and who's bad …they are used to it, they'd probably take to it like ducks to water, they'd probably like it, it fits into what they are like, but we want them to mature, don't we want them to move beyond black and white thinking?

One potential difficulty with the simplification inherent in the SRS is that it takes no account of the conflict between conscious and unconscious agendas. For example, a young person may have a conscious agenda to discuss particular issues but an unconscious agenda that is entirely different, such as to attack or compete with the therapist. It cannot be assumed that talking about what the patient consciously "wants" to is always most helpful for their therapy, it is frequently the case that the therapist will challenge the patient's conscious agenda. It is also often the case that at the start of treatment young people

might think that they “know” which issues are important to talk about, i.e. the symptoms which brought them to CAMHS and it can take considerable time for a patient to be able to voice a thought that feels “random”. Yet sticking only to those areas assumed to be “relevant” is restrictive and stops the patient from freely expressing whatever comes to mind, which might allow access to unconscious conflicts. Paradoxically, therefore, in the early stages of work young people may be more likely to score the session highly on the SRS as they are talking about what they “want” to or about what is “important”; later in the work when it is to be hoped that there can be more risk-taking and venturing into areas of the unknown, it may be harder to know whether or not these areas will turn out to be “important”, and the discomfort involved in taking risks of not-knowing may generate more negative SRS feedback. Therapists may frequently depart from the conscious content of what a patient says to comment instead on the way that words are being used, or the tone of voice or gestures which conflict with the manifest content, or a slip of the tongue and so on. Within psychotherapy powerful feelings (positive and negative), however apparently irrational or unrelated to context, are not unfortunate side effects to be discouraged or ignored – they are the essence of the work.

More than any other outcome measure, the SRS was felt to be rigid and simplistic, unable to capture what actually takes place in a session: all therapists expressed at least some doubts about the value / meaning of the data. This tool cannot capture the ebbs and flows of the session, where a young person might move between love or hate for the therapist and feel understood one moment and not at all the next. It does not take account of when a young person comes in the room consciously believing they “want” to

talk about one topic while their behaviour, dreams or slips of the tongue reveal a quite different agenda or issue. It does not take account of ambivalence, or of when a young person feels one way with the adult part of themselves, perhaps listened-to and understood, and yet feels completely differently in an infantile part of themselves, perhaps humiliated and not at all understood. Young people can often describe these complexities, but the SRS makes an assumption that feelings are uniform and straightforward. One therapist commented:

> It becomes 'Are you a good therapist or a bad therapist'…. Or a 'good' or a 'bad' patient….are you saying the right things? And you are getting into the dichotomies again which I think is not helpful.

A specific concern expressed by three therapists about use of the SRS in long-term psychoanalytic psychotherapy was that it ignores the transference relationship. The patient may explore (and experience) feelings that have arisen in their other relationships – such as being abandoned or unwanted – in the relationship with their therapist. A psychotherapist invites projections into themselves where they can be thought about and understood, for example the child of a depressed parent may view the therapist as equally unavailable to them; by so doing the child communicates that it expects its objects to be unresponsive. The psychotherapist does not ask "is this a fair judgment of me and of the work" but rather "why does this child need to see me in this way? What does this tell me about their object relations?". One therapist observed:

> Where's the transference [in consideration]? If someone is in a place where they feel that everyone is having a go at them and the world's

> my enemy then of course they are going to be marking you down because that's the nature of the difficulty, isn't it? And it seems to be naive to think [otherwise]....that's what young people do....

It is particularly likely that the SRS will become embroiled in the transference relationship compared to the other CYP-IAPT ROMs since it asks about the *relationship* between patient and therapist rather than about symptoms or goals. Additionally, patients are expected to give scores at the end of a session where they are still immersed in the transference relationship and when feelings of abandonment are most likely to be running high. This is different to giving scores during a review, when there may be the possibility of somewhat greater distance and objectivity from the immediacy of powerful feelings generated in the patient-therapist relationship. In the 2014 CYP-IAPT guidelines Trickey (2014, p.63) cautions the therapist using the SRS: "[Be wary of] taking the feedback at face value, for example feedback about not being listened to might actually be a communication about not being heard in other relationships….". Also in the revised guidelines, Troupp et al. (2014, pp.88-89) warn against taking SRS scoring at face value specifically in long-term psychotherapy, due to feedback relating to the transference relationship.

Seven therapists expressed a concern that the SRS is likely to be used by children to either reward or punish the therapist, and this is particularly a risk because the SRS is asking specifically about the relationship – which may easily be interpreted as "how good was the therapist?". Some children will have a strong investment in rewarding the therapist to make sure they are left with good thoughts about the patient, while others may want to punish the therapist for ending the session or for stirring up such strong feelings. One therapist

commented: “I think its very difficult for them not to feel that they are passing a comment on their therapist and that this would be experienced either as a reward or a punishment…..” Another commented that the SRS will be used to “get at you”, to punish the therapist if the session has been difficult: “So how accurate it is, I’m really not sure about”. Comments included:

> “It’s hard to know really how much sense [they made of it] or how much they were doing something they thought I wanted them to fill in…in the sense of giving a score that they wanted me, in a way, to be happy with….”

> “They might be eager to please so there could be bias, you might not get an honest representation of how they are feeling… or if they had a particularly difficult session…they might take it out on you in terms of feedback on the ROMs and stuff, that needs to be taken account of, it’s not necessarily objective because there’s so many subjective things going on.”

One psychotherapist described a video show in training where, at the end of the session, the SRS is completed. The video depicts a young person able to think honestly about strengths and weaknesses of the session while the therapist takes these on board as an accurate reflection of how useful (or otherwise) the session has been, and agrees to make changes accordingly. One psychotherapist commented:

> If you had a patient who was that articulate, they wouldn't be in CAMHS.... and I thought that was really unfair and that people’s

> faces were showing it, they were thinking...[the young people I see] are very troubled so this was just like an extraordinary bit of propaganda.... that kind of thing doesn't happen.

Another psychotherapist observed: "The psychologist that was running the training…she was saying: 'Yes and if they mark the session a bit down I like to ask "how could I have got it better" '…an idea that if we get it right then we are going to cure them…it [ignores the] inside dynamics…."

Four therapists expressed the view that the SRS actively encourages mindless response in the context of long-term psychotherapy because it is almost impossible to respond to this tool in a thoughtful way when faced with the same over simplified questions session after session. Comments included:

> "It just became part of the routine of the session – we will fill the form in and I will do the same lines where I've always done them."

> "In terms of meaning I'm not sure how much meaning you can gain from it really."

> "Some of them always give me top marks."

> "[If] a child's got very perfectionist beliefs they might feel duty bound to give you a good score each time; that reflects some of my experience of doing it that I get nothing but perfects, and I just wonder how true that really is. I know some sessions really haven't felt like that sometimes, so I wonder what difference that makes to a therapeutic relationship, that you're putting that scrutiny on them I suppose."

Four therapists reported months on end of identical scores. One of these therapists reported initially attempting to explore with the young person what their scores might mean, but after months of identical scores the therapist stopped discussing this as they felt there was nothing new to say. Two therapists gave examples of young people giving the lowest scores uniformly throughout the work, and two of universally high scores. Another therapist reported a young person stating that they will deliberately give only random scores on the SRS as a protest at being asked to use this measure.

The 2012 guidelines do seem to hold an assumption that SRS feedback is objective and therefore should be acted upon, if need be, to change the course of treatment. They advise the therapist to say to the young person:

> "Ok, it seems that I could be doing better. I am grateful for you being honest and giving me a chance to try to make some changes. What could I do different next time to make things better for you?" (Law 2012, p.57)

The three therapists who had attended the CYP-IAPT ROMs training all discussed this guidance specifically, all stating that low SRS feedback does *not* necessarily imply that the therapist should do anything different.

> In fact [in training they told us] you just say to the young person: "It's alright, it's not about you, it's about me getting it right for you", without an idea of this stamping on the dynamics, it's just stamping on the young person in my view.

The dynamics that this might "stamp on" would be the need for the young

person to be able to express negative feelings towards the therapist and for this to be part of the work, not necessarily an indication that there is something "wrong".

3) (C)ORS and STMs

Another tool intended for use every session is the (C)ORS, which asks for scores on a sliding scale indicating how the young person is getting on in various areas of their life. For young people age 13 and over these:

i) Individually (Personal well-being)

ii) Interpersonally (Family, close-relationships)

iii) Socially (Work, school, friendships)

iv) Overall (General sense of well-being)

For children age 6-12 headings are similar but phrased in simple language. for example the first area is: "Me (how am I doing)" and for very young children there is just one area: "How things are going for you" and a choice of three facial expressions to colour in (☺,😐, ☹) and also a blank face where a child can insert any facial expression they wish.

All but two of therapists interviewed for this study reported that they were completely unfamiliar with the (C)ORS, while one therapist had used this measure once and the remaining therapist was familiar with ORS but had decided to use SRS instead, as they felt it was excessive to use two measures during or after every session. One therapist, examining ORS for the first time during interview, commented that they would not use (C)ORS unless forced to do so because "it narrows things down"; they felt that used every session (or even at all) ORS puts young people under enormous pressure to "get better"

quickly, which feels particularly unachievable given the highly complex young people with entrenched difficulties who are referred to CAMHS:

> I would feel concerned partly that they think they feel they have to have improved in a way, and that they might have failed if they haven't, or that they feel they are wasting my time or CAMHS's time if nothing's changing, or they feel very despondent like I'm expecting it and they haven't been able to do that, so I'm thinking about the pressure it puts people under….

Symptom Tracking Measures (STMs) were also almost entirely disregarded by therapists in this present study. One therapist had used one on one occasion and found it to be somewhat helpful. Others had either chosen not to use STMs or were unfamiliar with them. The STMs take RCADS questions from just one area (e.g. anxiety) and ask only these repeat questions. They might be used every session, or less frequently and are intended to be helpful in monitoring specific symptoms. This might account for the lack of interest in this measure by psychotherapists, whose long-term work is not focussed primarily on symptoms but on the development of the child / young person as a whole; a psychotherapist may feel that it would be particularly unhelpful to keep directing their patients' attention to specific symptoms.

There may, however, be a risk that if a wide range of CYP-IAPT ROMs are not used, then this places undue weight on the few tools that are used. As discussed in Chapter Two, the advantage of using a wide range of tools is that each assesses something different; for example, CORS assesses functioning in everyday life, SRS assesses alliance while SDQ assesses global functioning

and the STMs track symptoms. Without a range of tools being used then the patient and therapist are potentially missing sources of information which complete an overall picture, and they are over relying on just one or two types of information.

4) The impact of using *any* ROM within psychotherapy sessions in long-term treatment (rather than used at review), particularly when used *every* session

Use of ROMs during psychotherapy sessions in long-term psychotherapy produced far more concerns than use of measures either at assessment, review or end of treatment, with seven therapists voicing at least some concern about the impact of *any* session-by-session ROMs use. At the time of conducting interviews there was no absolute requirement for ROMs use every session, this having been delayed due to problems with the iPad software needed to make this practical. However, therapists reported being told at training that this requirement would soon follow, with a minimum of one standardised measure for tracking progress (ORS / CORS or STMs) required every session, in addition to any use of the GBM.

Therapists expressed concerns that:

a) ROMs imposes an agenda on the session

b) Use of ROMs involves bringing in additional materials to the psychotherapy session, which is unhelpful

a) ROMs imposes an agenda on the session

Therapists raised concerns that use of ROMs every session risks imposing an agenda on the session. Firstly, this means that there is less time in the session for psychotherapy as some of the time has been diverted to ROMs. In order to minimise intrusion of ROMs into session time, two therapists said that they tell the patient after fifty minutes that the session has ended and that now it is time to complete ROMs, so additional time is offered for the ROMs; these therapists thereby indicate that one way of working or relating has finished and that they are now asking the child to access their functioning cognitive capacities to perform a separate task. One therapist allocates an addition two extra minutes after the session for ROMs while the other adds an additional five minutes. The rationale given for extending the session was in order to minimise intrusion:

> I've thought about is as we're required to do it [as therapists] so I haven't really wanted to do it in their time.

The remaining six therapists include the ROMs within the normal session time (or intend to do so); this was justified for practical reasons, since the therapist will normally have another patient waiting. Two said they would spend five minutes on ROMs, the rest all would spend less, with one therapist saying they spend just a few seconds. Only one therapist said that they are fully integrating the ROMs into the session and discussing them as a part of the session, spending around ten minutes doing so. Three therapists gave the young person the choice either to take ROMs home or complete them in the waiting room if

they prefer. Another therapist has not used session-by-session ROMs yet but expressed a view that the waiting room would be the best place to complete them in order to keep them separate from the session itself.

Seven psychotherapists expressed a fear that use of any ROMs during regular psychotherapy sessions could be intrusive, with four explicitly stating that ROMs use brings an agenda to sessions, contrary to the principle in psychotherapy that there should not be an agenda:

> "That's where it's really difficult for psychotherapy – you set it up in such a way that people come in with what they want to discuss– if you set it up with an agenda it doesn't quite fit."

> "As child psychotherapists our job is to see what the child brings to the session. If we bring something to the session we are altering completely our job and our work."

> "I'd only do it if it was compulsory as I wouldn't want to be bringing extra things into the session and be setting the agenda, I'd like them to feel it's their space and just come in the way they want to come in."

> "The therapist is introducing something into the session…it might stop the patient bringing something which they might have brought if that wasn't there, so you are setting an agenda of sorts."

As the therapist makes no other specific requirements of their patient, the fact that ROMs are required may make it appear to patients that these specific questions are very important to the therapist, and may colour young people's views about what it is that they are supposed to be doing in their session:

> I've no doubt it sets up trains of thoughts in the minds of the …young people – about what it is that you're doing and why you are asking these questions and not another set of questions - why that question and do other people get the same question and would you ask them in this way or at would you ask them at this point in the session and things like that – and I think…it must have an impact about whose agenda it's meeting really.

Six interviewees stated that by using ROMs *every session* psychotherapists are linking sessions unhelpfully to a culture of assessment, progress and benchmarks, for example: "We traumatise children" by insisting on grading and evaluating every area of their life". Another commented:

> Weighing up and measuring children is not good for their mental health and this is again doing that kind of thing…let's keep them out of this as long as possible, they get it all the time at school, why do it here?

This therapist felt that not only is scoring and grading unhelpful, it might be part of the reason why a child's mental health has declined in the first place. This would link to the recent study by Fink et al. (2015, p.504) who note that the increase in girls' emotional difficulties since 2009 might be related in part to increased "school performance pressure" with constant monitoring of grades and comparison against other students.

Six therapists were concerned that asking for scores at the end of a

session if a patient is emotionally distressed may be particularly insensitive and unreasonable. One therapist commented: "It's hard to do something that would feel routine if they are particularly upset or emotional in whatever way" and another: "If something is stirred up for them you might not at that point want to be faced with a ROM." Two therapists said that they would miss out ROMs if a patient had had a particularly emotional session. One reported that they always leave time after the ROMs for final thoughts:

> As long as there's enough time to say goodbye properly and a chance for other thoughts and feelings to come up… so it's not at the *very* end…that would be tricky…

b) Use of ROMs involves bringing in additional materials to the psychotherapy session, which is unhelpful

All eight psychotherapists expressed concern about introducing either paper copies of ROMs or iPads to psychotherapy sessions, when previously they would only have brought the child's therapy box into the room, or for older children and adolescents often no materials at all. This was felt to be a significant change to their method of working and there was a fear that ROMs are being introduced without any thought about how their physical presence in the room might impact on psychotherapy. One concern was that psychotherapists must necessarily divert some of their attention during the session onto keeping these resources safe, thereby withdrawing some of their attention from the child:

> "I guess you'd have to keep track of it as well…they could get ripped

during a session by…some angry patient."

"I wouldn't feel comfortable going into a room with all the forms particularly with some disturbed patients the ROMs would just get ripped up I think."

Five therapists raised a concern that by bringing an iPad into the session they must necessarily impose boundaries around its use; children cannot, for example, immerse it in water, throw it or stand on it, they cannot spend the whole session trying to access other apps or data. This makes it fundamentally different to the other materials that therapists provide such as glue, play doh or paints – toys chosen specifically because of their open-ended use. Therapists commented:

"They might very well be thrown through the window or something , who knows."

"I suppose there's the question, what if someone threw an iPad against the wall rather than turning a piece of paper into an aeroplane…then what would happen? And whose responsibility it is…"

"I'm slightly nervous about having an iPad in the room with certain children but I guess I won't use it for those."

> "There's just a bit of an issue when you've got a playroom that's covered in sand and paint and glue and water...that's going to be a little bit of a challenge, having somewhere safe to keep it...."

> "I think for some they would think hey, something to break or something to mess around on…I can see it just causing extra hassle really in the session."

> "I don't think I want to be in charge of iPads in sessions as well and be responsible for looking after that when you're trying to [engage in psychotherapy]…Thinking about some cases I've had, child psychotherapy cases where you're just trying to keep them safe in the room and keep them in the room, you don't want to worry about iPads as well so I have reservations...."

In addition, three therapists expressed a concern about young people trying to access other data or applications on the iPad, such as:

> I suggest that the naughty little boy type will immediately try to find other things to do on it – we've been assured that they cannot and it's locked but they will then spend some time trying to do this and they will get frustrated and fed up and it's not going to be good.

There was also a concern about what it means to a patient when the therapist brings an electronic gadget into a psychotherapy session. Excessive use of games consoles and electronic gadgets or phones are sometimes seen

by therapists as unhelpful in children's lives in that they can operate as a kind of unthinking psychic retreat and therapists are frequently in the position of working with parents to limit children's use of electronic equipment. Psychotherapy has always been a space apart from this, where the relationship with the therapist is primary and where the tools available are ones that encourage creative engagement. Therapists steer away from battery-operated toys that entertain with music, sound or movement, encouraging children to make use of their own ideas instead and not seeking to entertain or distract. There is therefore a need to think carefully about the impact on psychotherapy of introducing an object that may seem exciting and may have associations of mindless games or entertainment. One therapist observed:

> There may be young people who don't have an iPad at home because they are expensive electronic bits of equipment and what is that going to feel like and obviously it can be spoken about so that sort of ok-ish, but it's really complicated

This therapist felt that a child will naturally see the iPad as belonging to the therapist, and as something that the therapist values. There may be fantasies that the therapist is attracted to this piece of equipment. There also remains *no* space where a young person can altogether leave technology behind and be entirely free to think about the role of technology in their life without distraction. For some young people there may be an addiction to technology, a difficulty in leaving home without it, a struggle not to use their phone during sessions – and for this group, the presence of the iPad in the room may be highly distracting.

Use of the iPad, rather than paper, was also felt to impact on ways a

child might respond to the ROMs. For example, one therapist described how children using the paper forms typically draw on them, alter the wording or respond in pictures; they felt that use of the iPads necessarily means that the *only* way of responding is to select one of a range of prescribed answers. This therapist commented:

> It's a pity about the questionnaires being on the iPad, as the drawing on them and changing the words seems to be very important…so that seems to be a stumbling block, that would be a loss…

All eight therapists felt that given the choice between iPads or paper versions of the SRS, the paper versions are less intrusive. This was despite the fact that the majority felt that the iPads would reduce administration time. Comments included:

> I just feel reluctant to be taking iPads into sessions. It's just again, an intrusion into the session, but maybe I'm a bit of a dinosaur now…

An additional fear was that therapists themselves might struggle to use the technology, which would also be an intrusion into the session:

> "I'm also crap with technical things, if think I'll probably do it wrong or something, I feel very insecure about it."

> "One touch of your finger and things appear or disappear and it can happen so quickly, I think it worries me a little bit about using it correctly...then you have to make sure you get the right ones, stuff like that...it may take a little bit longer and in the situation it may make

it a little bit more awkward."

Therapists reported that the Trust's training on ROMs stated that young people like to use technology and that they want to see data represented in this way through the automated generation of graphs and tables. Evidence supporting this view includes Truman et al. (2003, p.9), who found that completing the SDQ electronically was more motivating and interesting to young people than a paper version. They conclude that the computerized version of the SDQ was more reliable and had better user-satisfaction than paper versions. Similarly, Hall et al. (2014, p.113) argue:

> Research has shown that electronic measures encourage people to answer more honestly… improve the effectiveness of the assessment…and offer the opportunity to present items in a "user friendly" manner, which has been identified as a key point in improving their use in practice.

In addition, as discussed in Chapter Two, those studies which link between ROMS use and enhanced progress, had access to facilities for data analysis which enabled the data to be converted *by the next session* into useful graphs and charts which made areas of progress (or lack of it) clear and which could flag up any data of concern. In contrast, therapists in this current study had no such rapid feedback from their ROMs data (as ROMs were completed on paper and might be submitted for analysis weeks later, months later or not at all). It may be that concerns related to the iPad reflect resistance to change more than actual difficulties in incorporating this new tool, and that once immediate data analysis and summaries are possible then this could be perceived by therapists

as clinically beneficial; it will be helpful for therapists to review the use of the iPad once it has been trialled in order to establish how it is used most helpfully and if there is any shared good practice that can make it more easily integrated.

5) Which patient groups are these ROMs best used (or avoided) with?

Seven psychotherapists expressed a view that adolescents are likely to find ROMs easy to access; reasons given were that adolescents feel more of an investment in their own treatment than do younger children, they are more likely to have chosen (or at least agreed) to come to CAMHS and are more likely to have some understanding of the difficulties that they would like to work on. This makes it more likely that they will be able to engage in those ROMs which help to define why they are coming to therapy and which help to review progress. Comments included:

> "Very insecure adolescents may like it as it gives them a feeling they are getting somewhere."
>
> "Adolescents might engage better with this…because you're asking something of them and it's involving them, more interactive, so I can see it working quite well with adolescents."
>
> "It's been particularly valuable for the adolescents that I've seen to have something focused."
>
> "They take it very seriously, thinking about the questions very thoughtfully."

> "Generally it's helpful and they value them…they like to be part of the process."

> "Some of them do quite like the concreteness of it, it can give a kind of framework."

> "A reasonably functioning adolescent is coming because they want to change rather than everyone around them wants them to change so this is more likely to be suitable."

For younger children there was generally more concern about ROMs use; a typical comment was: "Would they see the point or would it be more bureaucracy for them?" and: "It depends on whether they have a conscious awareness of why they are coming". Six therapists expressed a concern that latency aged children are so well defended that they are unlikely to be able to use ROMs helpfully, tending towards using them to reward or punish rather than inform, or using them further to strengthen black and white thinking. Only two therapists reported finding ROMs helpful or straightforward to use with under 8s, with most comments reflecting how complex this is:

> I've got three under sevens, one who couldn't go anywhere near it, that would be hopeless, the other two it's just a very complicated dynamic, whether they want to give up their symptoms or not…it's hard to know whether presenting them with that [ROMs] would hook into that part of them that would like to get better…

In the 2014 guidelines Troupp et al. (2014 p.90) comment that not all younger children will be able to access ROMs:

> Many children seen in longer-term therapy have severe difficulty in ordering their thoughts and are not able to reflect on themselves or on others. They may also have conduct disorders which lead them to see any such request as provocative and reason for further acting out. Outcome monitoring with this group of children and young people may therefore at times be contraindicated.

In these cases use of ROMs with parents / carers might be a more helpful alternative.

Only two therapists stated that they would attempt to use at least one ROM with *all* patients, with the other six feeling that there would be exceptions:

> "I've no idea what PD [personality disordered] adolescents would make of it, whether they would enjoy being as florid as possible".

> "With some patients I don't use them. I have a patient who is quite emotionally unwell and who regresses much of the time and I don't use them with her…When I began she was too unwell and she might have eaten them… I have nothing in the room that could be put into her mouth."

There was no objection to ROMs use with parents / carers:

> "I think they liked the opportunity to feed back in not a direct way but in a way that can get taken up quite gently, if they are feeling stuck or things aren't happening…"

> "We should be empowering parents and helping parents and making

them feel comfortable and listened to and understood…"

"Some parents and carers might prefer to see something concrete and yes, …in actual fact I think sometimes …it would be better to rely more on the parents and carers than on the little ones."

ROMs data was also felt to be helpful to demonstrate change to parents / carers, giving them a chance to stand back and take stock, to notice changes which have been gradual. Several therapists cited parents saying at review that nothing has changed, yet changing their mind in the face of ROMs data showing them their child's starting point and what has changed since then.

7) Summary and Discussion

a) Issues of measuring the alliance

As discussed in Chapter Two (literature review), there is in fact no consensus that good alliance is a causative factor in good outcomes, and some dispute about whether or not it is even predictive of good outcome; furthermore there is no evidence that session-by-session monitoring of the alliance is beneficial, nor is there evidence that therapists can be trained or supported to improve their patient alliances in general or in relation to specific patients. It is unclear what exactly the correlation between good alliance and good outcomes that has sometimes been observed actually means; it might, for example, merely reflect the fact that some therapists are better at their work than others and their patients score them more highly on both alliance and outcome. Research in this area is conflictual. Unlike the earlier 2012 guidelines which were very clear about the benefits of measuring the alliance, the 2014

guidelines are somewhat more equivocal, providing both evidence for the benefits of this but also statements such as this by Troupp et al. (2014, p.89):

> …there has been recent research to suggest that the earlier belief that therapeutic alliance strongly predicts outcome is not founded in evidence, and that many factors interact. (Troupp et al, 2014, p.89)

This takes into account that the relation between good outcomes and good alliance might be complex; for example, very early gains for the patient (good "outcomes") may lead to the patient giving a high score for alliance, rather than "good alliance" being a causative factor in good outcomes. It is perhaps then not at all surprising that therapists in this current study are not rushing to embrace the SRS, since they on the whole find it to be intrusive in the context of long-term psychotherapy and since there is not at present any conclusive evidence that it is of clinical benefit to monitor the alliance.

Even if there were to be future research which could demonstrate convincingly both that a good therapeutic alliance is a causative factor in good outcomes, and monitoring the therapeutic alliance every session was proven to keep the alliance on track and therefore contributed to good outcomes, it would still need to be proven that the SRS is the right tool for the job. However, as yet, there is no research into the effectiveness of the SRS in capturing the state of the therapeutic alliance or its pivotal role in keeping the alliance on track. In terms of long-term psychotherapy the overwhelming feeling was that this tool is not sophisticated enough to keep track of the subtleties of the shifting alliance as the questions are simplistic and do not capture the depth of the relationship nor its changeableness, not does it take account of the influence of the

transference relationship nor of the patient's need or desire to please / reward / punish the therapist.

Careful thought will need to be given by the psychotherapists about the most helpful ways to incorporate ROMs into regular sessions. Completing the ROMs in the waiting room might jeopardise confidentiality as some children – particularly non-readers – may need to give answers aloud. Also, it might not be helpful to ask a particularly distressed patient to return to the public area of the waiting room to complete ROMs. If ROMs are completed in the waiting room after the session it would also entirely defeat the intended purpose of making sure that problems are discussed immediately with the therapist in order to reduce the likelihood of drop-out. If session length is to be extended to accommodate ROMs, this also has implications for room bookings and for the number of patients that a therapist can see in a day. It would be helpful for the psychotherapist group to discuss together their experience of the least intrusive and most supportive way to accommodate ROMs into individual sessions, as each therapist seemed individually to be struggling with this dilemma.

b) **General issues of using outcome measures every session**

The benefit of measuring outcomes during regular on-going psychotherapy sessions lies in helping to promote a collaborative relationship where the young person (or parent / carer) is able regularly to feed back on their experience and to be actively involved in monitoring progress. For short-term / generic work / family and dyadic work / parent work therapists voiced no

difficulty with using ROMs every session and as a part of the session. In this kind of work there is usually already a more explicit agenda, which already often involves an active monitoring of aims and symptoms, and where the therapist may already be more directive. The relationship with the therapist in brief work is likely to be less intense, and the therapist is unlikely to be working directly in the transference relationships or interpreting from their countertransference in the same way as long-term psychotherapy. It is also more common in brief work to have parents / carers or other family members involved in sessions, so use of the GBM has the advantage of offering triangulation of viewpoint. Within brief interventions, the primary strength of session-by-session monitoring is making therapy more collaborative and providing feedback which the therapist might not otherwise have known.

There were no examples given of session-by-session ROMs being used helpfully in long-term psychotherapy, and six examples of session-by-session ROMs used mindlessly or pointlessly in long-term work. SRS questions were felt to be too prescriptive and limited to have value in long-term psychotherapy, as the questions do not take account of the complexity of the work, the nature of the transference relationship or the particular difficulty in stepping back at the end of an intense session in order to make any kind of objective comment about how the session has been experienced. Typical comments were:

> "If I was doing something short and focused I wouldn't see anything wrong with using it every session; I think if you were doing longer term work, the more difficult and maybe more intensive I'm not necessarily sure how much valuable information it would give you…"

> "I'd feel more comfortable using it in generic work where you are more likely to be working with conscious processes and less with the unconscious"

When used during regular sessions in long-term psychotherapy, seven therapists felt that ROMs will be used to reward, punish or placate the therapist, will reflect how a patient felt at the moment of ending a session, or will reflect the patient's transference relationship with the therapist. Simplistic standardised questions were viewed as fundamentally at odds with the psychotherapy, where all communication and behaviour is material to reflect on and where both therapist and patient can hope to be taken by surprise. While it seems helpful to have in mind questions like "how are we working together?" (the alliance) and "how are things going at home / school / therapy?" (goals and symptom tracking), these questions do not seem useful when repeated every session in long-term work, and indeed become repetitive and intrusive. The time taken to complete the ROMs if used during psychotherapy sessions rather than at review was also experienced as intrusive, and the introduction of iPads to ordinary sessions was also a concern to the group.

Therapists reported that in training they had been told that session-by-session ROMs use ensures that there will always be "end data" for every patient leaving treatment, even if they leave prematurely or unexpectedly, as the final session's data can considered to be a marker of how far they have progressed. Yet this only makes sense if progress is assumed to be linear with each session building neatly upon previous progress, a view that does not sit well with psychotherapy. It also ignores the possibility that if a patient ends therapy

prematurely their decision to leave might be related to a final session which was particularly difficult, with ROMs data likely to reflect this. Final ROMs data cannot be assumed to be an accurate indication of how far work has progressed.

Another concern about using any measures during regular psychotherapy sessions is that this changes the nature of the work. Session-by-session ROMs risk imposing an agenda onto the session, implying that some behaviour is good / bad, that progress is hoped for every time or that there are conscious goals to be held in mind each session; three therapists cited Bion's caution against the therapist's "excess desire" interfering with the process of psychotherapy. Five therapists felt that grading and judging every session has potential to impact negatively on young people's mental health as it connects psychotherapy to a culture of success and failure and a target-driven society. While it may be helpful to step back occasionally and take stock of where the work is going and how the young person experiences sessions, doing this too frequently risks changing the very thing that is being measured. It risks implying that a good session is one where the patient scores highly against the ROMs questions, where they like the therapist, feel happy, where they make progress towards goals or report symptom improvement. This leaves no room for the importance of negative or hostile feelings to emerge and to be treated as equally welcome and valid. A typical comment was:

> I think they look awful to use in a classic psychotherapy session…because instead of concentrating on how you and your patient is getting on and what that is like, we are again putting it into boxes and thinking about one thing or another. It's directive and it's

> putting constraints on free association…this is not free association, this is not doing psychotherapy…much more formalised, concrete, results driven, boxes – everything that is against the creativity of psychotherapy…you wouldn't be doing psychotherapy, you'd be doing something else, it's just not what we are trained to do.

Another therapist felt that using ROMs in individual sessions risks offering young people a way to avoid the struggle to put feelings into words, since they are offered simple tick boxes to communicate:

> I can't imagine trying [ROMs] with a silent patient….their silence is their way of communicating with the world, they are making a statement out of their silence, their silence is a rejection of the world and communicating with anyone in it…to do this is saying you are not communicating anything in your silence, it's saying we will do this, we will sneakily go round the corners and try and get you to say something even though you have made a statement about who you are and why you are. And we are not taking that on board in its own standards.

Risq (2012b, p.21) notes that overemphasis on ROMs changes the nature of treatment offered:

> …the invisible, *reparative* aspects of psychological care – the emotional contract between patient and therapist – are deemed invalid where they do not directly contribute to the measurable output of a service…notions of "playing tick-box games"…suggest that

> performance measurement systems may actually be “fatal remedies” (Sieber, 1981) whose unintended consequences undermine the very activity they seek to assess and quantify.

The 2014 guidelines acknowledges that session-by-session measures are new to psychotherapy and that psychotherapists are still in the early stages of trialling these. It urges therapists to be curious about their meaning but to “remember they are only one piece of information”. There needs to be careful thought and discussion about the impact of these measures on long-term psychotherapy, and if the consensus is that they are actively unhelpful then a case may need to be made to CYP-IAPT as to why this is so. If session-by-session monitoring is to be an absolute requirement then there will need to be careful planning about how to use the measures least intrusively. This will include considering at what stage in each session they should be produced, how the iPad is introduced, and how repeating the same questions each time can be thought about with the patient. It is unlikely to be helpful for therapists to express a variant of: “This is pointless and unhelpful but we have to do it so let’s get it over quickly”.

Chapter Seven: What thoughts do psychotherapists express about how CYP-IAPT ROMs data might be used by supervisors, managers and commissioners?

The psychotherapists were each asked the question: “Do you have any thoughts about how the CYP-IAPT ROMs data might be used by managers or commissioners?” In response, five of the eight therapists voiced only concerns and anxieties, one therapist voiced predominantly concerns and anxieties and the remaining two therapists stated that they had no particular concerns. The concerns expressed fell into two broad groups: three therapists felt that there may be a negative impact on individual patients if ROMs data is used in any way to determine or alter patient treatment while six therapists expressed concerns about how the ROMs data might be interpreted by commissioners in a way that makes psychotherapy appear to be poor value for money and which therefore has a negative impact on psychotherapy provision within CAMHS. The only positive thoughts about how ROMs data might be used by managers and commissioners were passing comments by two therapists that the ROMs data might help psychotherapy to develop a firmer evidence base.

This chapter will consider the following areas:

1) **Concerns about how data might be used to influence the treatment offered to individual patients**
2) **Concerns about how ROMs data might be interpreted by commissioners**
3) **Summary and Discussion**

1) Concerns about how data might be used to influence the treatment offered to individual patients

It is notable that while only three therapists in the group had so far attended the Trust's training on CYP-IAPT ROMs, all three expressed concern about the impact on individual patients of how ROMs data may be used, citing this training as evidence. They voiced a fear that managers and supervisors might over rely on ROMs data to inform treatment plans for individual young people; their training instructed them that ROMs data will be used to show that a particular approach for a patient isn't "working" which will in turn trigger a change of approach or change of clinician. They reported that they had been told at training that ROMs data should be brought into supervision and line management meetings in order to have external "hard proof" of the progress (or otherwise) of patients. One therapist commented: "I think that this information will be used to fuel a CAMHS service that does not take into account the unconscious and it will be looking at things in a very external way."

The training attended by the three therapists was disseminating information contained in the 2012 CYP-IAPT ROMs guidelines. These guidelines advise that if (C)ORS measures show no progress after three sessions then the therapist should say to the young person and carer:

> "The scores have not gone up, what are your hunches about why that is? These scores indicate we might need to try to do something quite different as you don't seem to be benefitting. What are your thoughts about that? What do you think we need to do differently to increase the chances of this line moving in an upward trend?" (Law, 2012,

p.57)

The guidelines advise that the patient's care plan might be changed at this point either to bring in other members of the family, or to involve the wider network around a child or young person in a different way. There is an assumption embedded in the use of ROMs for supervision that there *should* be a measurable progress in the first three sessions, and that patients should be aware of this and be reporting it accurately. There is furthermore an expectation that a young person might know what would need to change in their therapy in order for scores to go up, i.e. that they can stand outside their therapy and offer helpful guidance to their therapist.

Much of the early stage of psychotherapy can be about "charting the territory" (Meltzer 1992, p.105) in order to find out how things are in the patient's internal world, before any change can reasonably be expected. Although some young people might feel immediate relief just to be offered therapy and to find a receptive therapist, this is not necessarily the case, and would in any case not necessarily mean that ROMs scores would show improvement. It is not necessarily a good sign if a young person very quickly asserts that they feel improved, since this might indicate over-compliance or a desire to be discharged quickly. Certainly therapists would not be taking reports of rapid improvement at face value without careful exploration. The concept of "flight into health" is relevant here[6], whereby a patient rapidly pronounces themselves better before the work has had time to get underway, as a defense against

[6] W. Frick, 1999, p.58 notes: "Although its origin remains a mystery, the term *flight into health* has been part of the psychotherapeutic lexicon for more than half a century. Historically, the term has been used as an interpretative label, suggesting that patients who responded "too quickly" to therapeutic intervention were actually engaging in escape tactics."

knowing what is really going on. Over simplistic interpretation of ROMs data would have no way of distinguishing this from genuine progress and pressure of cases on waiting lists could make it tempting to discharge in this situation. One therapist commented on the culture of over-reliance on ROMs data: “There’s something about trying to get people through the door, prove that you’ve seen them, prove from some of these [ROMS] that things are better without there being a deeper listening and understanding….” Another commented that it takes so long to get into CAMHS that it would be very surprising if patients showed genuine rapid recovery in psychotherapy, and if their data showed this, “I would be quite suspicious”.

The ROMs 2012 guidelines advises that if there is no progress on the ORS / CORS after five or six sessions then additional services should be considered, including referral to other agencies, while if there is no upward trend after eight to ten sessions:

> …discuss with the client and carer about whether they need to see someone else such as another clinician with a different approach, and/or a higher level of care.
>
> [say] To the young person and / or carer: I am wondering if I might not be the best person to help with this problem. Would it be useful for me to go over different types of therapies and clinicians we have and maybe what one of them has to offer might be a better fit with you than what I can offer? (Law D., 2012, pp.57-58)

In addition, in the face of poor SRS (therapeutic alliance) feedback after three sessions therapists are advised:

> Check out that the approach is fitting and whether you need to adjust, or change to another approach.
>
> If there is a rupture in the alliance that you don't seem able to overcome, consider referring to a colleague. (Law 2012, p.57)

This is despite evidence, as discussed in Chapter Two (Safran, Crocker, et al. 1990), that the most positive outcomes of all occur in psychotherapy when there has been a rupture to the alliance which has been worked through and repaired; it would be impossible to know after just three sessions whether or not such a repair might be possible. Comments from the three therapists who had attended training included:

> "I went to a [training] day and they said that if the ROM isn't showing improvement after five sessions then they would be thinking about changing the clinician…that would feel quite concerning."

> "From what I've seen the first response is often to change [how you work] and not think about it and I don't think that's helpful …it's not whether the tool is good or not it's about how it's used and whether it's used to engage, or actually, sometimes I think more often, to avoid something quite difficult which needs probably needs to be addressed."

There is a fear that CAMHS teams might be in a position of replacing thoughtful case discussion with too much emphasis on ROMs data, and as a result make decisions more "easily" but in a less thoughtful and helpful way:

> “I'm really worried about the use of [ROMs] in supervision because we had input on that [in training] so you look and no progress and the supervisor gives you advice on how to change the way you are working to improve things ... I'm not ever ruling that out but that is quite naive I think really because the whole point about supervision is untangling some of that stuff really and helping the young person to develop whatever it is they need to develop. But it's marks on the page...”

> “If the patient says ‘I don’t feel heard’ or ‘The therapist approach isn’t a good fit for me’ that this can result in a swift action like changing therapist or wildly changing technique or approach…rather than try to understand what it is that they don’t like or what it is that doesn’t fit and that might be part of what the young person’s difficulties are and what they are bringing….”

Therapists pointed out that they would not usually respond so reactively in response to patient’s verbal comments during therapy; a patient might say “I don’t want to come back” or “I hate you”, and these would be thought about as part of the work. Therapists would consider whether the patient might be conveying that therapy feels frightening, or whether the therapist has been positioned in the role of someone cruel or abandoning; they would also think about whether the patient is testing out the therapist’s ability to cope with negative feedback, or whether the young person is taking helpful steps towards expressing angry and hostile feelings which had previously been unable to be voiced. This would include projecting feelings of rejection which may be looking

for a home or to be contained and named. The therapist's response would not be automatically to conclude that the young person is not benefitting from therapy, without a lot of other evidence.

One therapist cited an adolescent girl who had therapy for several years, who consistently gave only negative verbal feedback about the treatment, complaining about the treatment, the therapist and her own lack of progress - but who in fact made good progress and at the end of the therapy specifically thanked the therapist for not giving up in the face of her negative feedback. This patient had needed to test over and over again that she could not drive the therapist away, and she had needed the therapist to be thoughtful about these sorts of comments rather than take them at face value. The therapist explained that this young woman had "never said boo to a goose" before, she was withdrawn and overly complaint and it was absolutely essential to the work that she could take the risk to express negative views and have this accepted time after time, without driving the therapist away. This young person had previously internalised all her anger and negativity through self-harm, and it was the essence of the work to develop a capacity to express herself negatively towards others. By the end of her therapy this patient was able to direct her anger and aggression outwards where it belonged. Her therapist pointed out that had this patient been using the ROMs, no doubt she also would have given low scores with no "improvement", and it would have been unhelpful to have used this data to trigger a change in care plan.

There is a fear that the ROMs provide a buffer between clinicians and young people which facilitates a less thoughtful (and less painful) screening of

the needs of each young person and allocation of resources. Risq (2012a, p.324) writes that ROMs data in adult IAPT "operates as a social defence…that protects staff and managers from acknowledging and realistically managing the psychological distress, vulnerability and dependence of those referred to IAPT services." Three therapists expressed a concern that managers will not have time to reflect on *why* the data is the way it is for each patient and will be forced into making decisions based on data alone:

> "This whole belief that if you get it into tick boxes and you say that if its x then you do y it's a bit over simplistic…"

> "I think sometimes the data from them can be used in a very concrete way that spurs on some kind of action which is a bit premature, for instance like a child is clearly having difficulties yet somehow they have filled [the ROM] in that they are not having difficulties and because of pressures of caseloads and getting people out of the service there can be a desire to lighten the burden…"

> "I think there are lots of children and young people who are not seen because they haven't ticked the boxes or they've known how to fill something like that in and in actual fact they do need to be seen."

> "The worry would be that care packages are developed on the basis of ROMs, and [there should] be an element of it but it's much more complex."

Therapists are aware that the data which their teams are gathering is being inputted into a system designed to work out treatment "clusters" for young

people, arranged into four levels of complexity and severity in order to inform "payment by results" (appendix 1). There is a fear that ROMs are the start of an agenda to have simplistic formulae for treatment. One therapist commented:

> [CYP-IAPT ROMs] are trying to pin it down into little boxes, little areas, so that we can sort of work out for our own purposes which tend to be finance driven, how long somebody ought to be in therapy…you know if you have say ten sessions you have got so far…each person is so different and so unique, I cannot see how this can work.

The intention of "payment by results" is that funding will be allocated to each clinic based on the number of patients in each cluster, with patients in complex clusters funded at a higher rate to those placed into a cluster of less complex needs. This is not intended to mean that a particular patient in a particular cluster is *necessarily* limited only to the number of sessions deemed average for their cluster, however since funding is directly linked to each patient's cluster then it follows that as a whole each cluster must stick within the allocated number of sessions and that there is likely to be pressure on clinicians to stay within the budget for the correct cluster.

Which cluster a young person is placed into is likely to make a large difference to their care; the funding allocated for the lowest cluster is for just 1-6 sessions, 7-12 sessions for "core plus" cluster, which includes "mixed anxiety and depression", conduct disorders, PTSD and "a mix of conduct disorder and emotional difficulties". This rises to an allocation of 13-24 sessions for the "extended" cluster which are young people with "major impairment in functioning

at home, school or with peers" including OCD, major depression and comorbid ADHD and conduct disorder. It is only the "extended plus" cluster which offers enough sessions for long-term psychotherapy, with 25-215 sessions allocated to cover work with a mental health professional, liaison and review meetings, medication, "intensive outreach" or inpatient care. This cluster is intended to be a very small number of young people. Long-term psychotherapy is likely to require a minimum of once weekly sessions for a year, plus parent meetings and review meetings, possibly also appointments with psychiatrists and multi-agency work and therefore is likely only ever to be available to this small cluster. Those patients in the "extended plus" cluster are likely to be those scoring highly on both the number of symptoms, the level of difficulty the symptoms cause and also who fall into one or more of the groups identified by the Current View Tool (CVT):

1. Looked after child
2. Young carer status
3. Learning Difficulty
4. Serious physical health issues (including Chronic Fatigue)
5. Pervasive Developmental disorder (including autism and Asperger's)
6. Neurological issues such as tics or Tourette's
7. Current protection plan
8. Deemed "Child in Need" of social services input
9. Refugee or asylum seeker
10. Experience of war, torture or trafficking

Three therapists expressed a fear that the CVT will not accurately identify the most complex young people or those most in need of long-term work, since their cases do not neatly tick the “high risk” boxes, and might often be particularly stuck or entrenched patients where other treatments have failed:

> “What they have done, and I've noticed in our clinic particularly, and I assume it's elsewhere, is we try everything else first, all the short-term therapies are brought on board first and if nothing works then we will try the psychotherapists and we are the last posts and it may work or it may not.”

> “Quite often…by the time we get them in psychotherapy…things are so complex, so actually it takes a long time for things to change, if they can change, so I think sometimes we are getting cases where what's going on in the environment and in the family is so difficult that some of the changes are quite minimal or it takes quite a long time, and there's a bit of a fear that if that's the kind of cases we get then our results might not be that great whereas the very straightforward ones where CBT for example would ...or more solution focused fork would help, they don't come our way…”

> "Maybe there's not enough understanding at a higher level of just what it is we do and the nature of the patient that comes in."

It is not always clear at initial assessment if the presenting symptoms which have brought the patient to CAMHS are masking a more complex difficulty. The CVT measures some of the factors that might make a case more complex, but not all; two therapists observed:

> “Of course there's the Current View Tool as well that decides how complex a case actually is and how complex the situation is [and] in terms of thinking about payment by results and what works for whom that does help with the complexity of cases...but I have some reservations about that as well, because if I think anecdotally which cases I find where things do change, there's also correlation with the capacity of the parents to change and to think, which isn't necessarily reflected In how complex their whole life and their external situation is..."

> “I'm not sure that it [CVT] expresses the level and range of complexity of the cases we get, so that would be my concern, that context is everything.”

There is a fear that psychotherapists would normally see some of the most complex cases which may be most resistant to change, but that these will not necessarily be assigned to the highest cluster. There may therefore be pressure on psychotherapists to offer only brief interventions to patients allocated to the lower clusters, regardless of the actual severity of symptoms or complexity of the case.

2) Concerns about how ROMs data might be interpreted by commissioners

Six psychotherapists expressed a fear that ROMs data might be used as “evidence” that some treatments are more effective than others (or just as

effective but cheaper) and therefore ultimately as a reason to discontinue more expensive treatments, including psychotherapy. If the CVT is not accurate in capturing the most challenging cluster of young people, this may make psychotherapy appear to offer poor value in comparison to other treatments, since it might appear to take longer and cost more to help patients whose "cluster" is identical to those receiving cheaper treatments. There was also a concern that progress in psychotherapy may not be captured well by some ROMs, particularly session-by-session ROMs (ORS, CORS, SRS) as discussed in the previous chapter, and that therefore it may appear to be a less effective treatment than it is in reality**:**

> I have many concerns, funding implications are all because we are really facing massive cutbacks so it has to be shown that our therapies work....psychotherapy has long term effects and they are unquantifiable in quite the same way [as CBT]…and I think that managers and so on have huge difficulties in working out this.

No statement has been made by CYP-IAPT about how the data might be used in future to judge the effectiveness of different treatments or care pathways. This means that psychotherapists do not know which data might be used to judge effectiveness of different treatments, how comparisons might be made or which additional factors might be taken into account when assessing the data. Therapists therefore tended to assume that all data gathered might be used to judge the effectiveness of psychotherapy. The CYP-IAPT literature (2012 and 2014) makes little reference to how data will be analysed, instead focusing almost entirely on the clinical benefit to individual patients.

Therapists are wary that measures introduced apparently to help the therapist in their clinical work might subsequently be used to compare the impact of different professions. The GBO, for example, is described in the CYP-IAPT literature entirely in terms of clinical benefit. Yet Wolpert et al. 2015 (p.63, p.68) writes in a review of the CYP-IAPT measures that use of the GBO to assess performance cannot be ruled out: “More research is required around GBOs before their use for service evaluation can be determined” and “For GBOs, there is some evidence of possible use for overall measurement of outcomes”. These statements would seem to contradict another statement in the same document: “GBOs are *entirely* focused on clinical utility” (ibid. p.68; italics mine). The possibility that the GBO might be used to assess the performance of a team (or individual / profession) may raise alarm bells, since this might naturally steer clinicians towards setting only easily achievable goals rather than the most clinically helpful goals. Power (1998, p.29) makes the point that what may be *introduced* as a tool intended for clinical benefit or a “local learning process” can quickly become “a Trojan horse for the imposition of more far-reaching accountability and monitoring requirements”, and this was a fear expressed by six of the eight therapsits during interviews.

Five therapists expressed a fear that the ROMs used every session (CORS / ORS and SRS) are particularly crude tools and therefore most liable to result in mistaken conclusions at a higher level about how helpful a particular approach / clinician is:

> It’s a very simplistic way to interpret a very complex relationship so I would be concerned that it would be seen in a very simplistic way.

There is anxiety that the commissioners and data analysts will interpret a low score as meaning a poor session or poor outcome. This is felt to be a problem particularly related to psychotherapy: “We are not a feel-good approach”. Another commented:

> I guess there will be confusing spikes in the data depending where in the treatment the patient is, whether they are coming up to breaks for instance – I would be worried that they might focus too much on when things are not going so well because our approach is not so positive , its not like “hey lets get you better”...some of the goals and the distress, the underlying difficulties are so complex, my worry is that managers, commissions will only look at the data and not think about the actual person, the patient....

As discussed in the literature review, whereas other approaches may specifically seek to bolster self-esteem and might round off a session by emphasising the positives or the learning that has taken place, psychotherapy does not steer away from putting patients in touch with negative reactions and responses (for example Barrows, 2001, p.375).

Two therapists expressed a view that psychotherapy will help a young person see more clearly the areas of their life where they are having difficulty, which may result in low ROMs scores compared to more feel-good treatments. For example, a young person who tells their psychotherapist that no-one likes them may find themselves subsequently exploring what it is about themselves that feels so unlikable with this unlikableness taken seriously; this may be very different to other approaches which might emphasise the likable qualities of that

child or draw attention to those people who *do* appear to like that child. Whilst the psychotherapist might feel that the more longer lasting and significant change may come from facing up to the reality of unlikable parts of the self, this may result in lower ROMs scores. One therapist felt so concerned about the way that ROMs data might be seen simplistically by managers and commissioners that:

> I would be worried about me trying to sway towards being a bit more positive and not taking up the negative transference so much because of what it might provoke in terms of the [ROMs].

Two therapists expressed a fear that no-one would be looking into the longer-term effects of psychotherapy as compared to other treatments; they said that psychotherapy might appear to take longer and cost more for similar results, but you can only know the long-term results by asking about progress some time after therapy ends, since psychotherapy has a "sleeper effect" whereby patients tend to keep getting better after the end of treatment, and this is not true of other modalities (Trowell, 2002 and 2007). Comments included:

> I just think I'd want the managers to take into consideration that our results might be different but that's not to say the psychotherapy isn't working, and also things to be taken into account about the sleeper effect as well of therapy – although things are going better at the end of treatment, it might not be completely better, it might be just liveable with, but that's not to say it's not going to get better down the line – so follow ups would be good I think...

Four therapists stated that CYP-IAPT ROMs might be part of an agenda

deliberately aimed at replacing quality long-term treatment with brief (cheaper) forms of treatment by “proving” that cheaper treatments are as effective as more expensive ones. The ROMs are a product of CYP-IAPT, which is a mode of treatment based on short-term manualised treatments which can be delivered by non-specialists who have undertaken training of less than a year in their particular modality. This helps to meet government targets of offering treatment to a larger number of people more quickly (and more cheaply) than existing CAMHS specialisms offering their usual treatments. The ROMs have been designed with CYP-IAPT treatments in mind, to assess the efficacy of a way of working that is short-term, manualised and (often, but not always) based on a cognitive treatments. The fear expressed by half of the interviewees was that it might suit the government and commissioners if this cheaper way of working came out well in ROMs data analysis and if more expensive and longer-term treatments came out looking bad value in comparison. This would allow a replacement of expensive highly skilled clinicians with lower banded CYP-IAPT trained workers offering brief treatments. Cynicism about how ROMs might be deliberately manipulated for political gain came across strongly:

> “I'm a bit cynical ...it's going to be used to prove certain treatments work, whatever that means...”

> “Bion talks about the delusion of certainty. I think this information will be used to fuel a CAMHS service that doesn't take into account the unconscious and it will be looking a things in a very external way and I think that...it will be looked at in terms of what treatments "work" in an evidence base kind of way - that's the worst of what I feel about it,

> that as a psychotherapist we are really endangered as a species in this kind of world and I think it's driven by money."

Of course the flipside of this argument is that evidence from ROMs might be used to save psychotherapy as a profession within CAMHS rather that destroy it. Two therapists mentioned in passing that the ROMs will provide a large quantity of data, which might help to build an evidence base for psychotherapy; they felt that this might be useful in communicating the effectiveness of psychotherapy to managers or commissioners:

> "I would hope it would give a clearer picture of our work and the effectiveness of an intervention."

> "I think a lot of the data that's been gathered will show that we do good work and we are worth funding, I hope it would."

However the dominant feeling, expressed by six therapists, is that analysis of ROMs data will not help psychotherapy since these ROMs questions suit cognitive treatments more than psychotherapy and because data is likely to be interpreted too simplistically. There was no opposition to using ROMs in general to build a firmer evidence base, and the IMPACT study (Goodyer et al., 2011) was mentioned by one therapist as a good example of how ROMs might be used to show progress in long-term psychotherapy; however, the overall consensus was that data from the CYP-IAPT ROMs may be harmful to psychotherapy when interpreted by commissioners.

3) Summary and Discussion

One reason for the generally negative view of how ROMs might be used by managers and commissioners may be that this group of psychotherapists was not consulted about the prospect of ROMs implementation and five had not yet attended the Trust's training. The three therapists who had attended the Trust's training had been trained by a psychologist who might be expected to view (and explain) ROMs-use very differently to psychotherapists, due to the different nature of their work. This points to a training need for psychotherapists within the Trust to work as a group to consider how they might help managers and commissioners to understand and interpret data specifically in relation to psychotherapy patients. It might be helpful for psychotherapists to put themselves forwards to be involved in any future ROMs training, or to participate in working groups with managers and commissioners, in order that their perspective can be incorporated into how ROMs data is interpreted.

Points that psychotherapists might wish to convey to their managers would include an expectation that session by session ROMs may show negative feedback in psychotherapy, and that this does not indicate (necessarily) poor progress. It would not necessarily be desirable to see ROMs data improve in the first few sessions nor would low or declining scores necessarily be an indicator of poor progress; both need to be understood in the context of what these scores mean to the patient or how they are being used. ROMs data needs to be considered thoughtfully within the wider context of other indicators of progress, including reports from parents, schools, other professionals, the young person and therapist; used on its own it could be highly misleading, and

ROMs data alone should never be used to determine or change a care pathway. Some of the ROMs questions are not well suited to long-term psychoanalytic psychotherapy, so the results for these particular questions may be expected not to show “good” scores. When thinking about payment by results “clusters”, therapists will need to work with managers to explore the additional factors which might require a young person to have long-term psychotherapy which may not be reflected in the cluster to which that young person has been allocated based on CVT data.

Fears expressed around incorrect interpretation of the CYP-IAPT ROMs data were most strongly linked to session-by-session measures, i.e. the measures most felt by psychotherapists to be simplistic or at odds with how psychotherapy works. In fact, ORS and CORS have been almost entirely disregarded by psychotherapists in the first year of ROMs implementation, with therapists reporting that they either did not know about these tools or do not think that they fit psychotherapy. These were the tools most likely to be viewed by the psychotherapists as externally focused, simplistic and unable to capture the nature of change in psychotherapy. The onus is therefore on the psychotherapy group to make a case to managers / commissioners for judging the effectiveness of psychotherapy using data from RCADS / SDQ, or other measures used at reviews, rather than using data from session-by-session measures.

Another factor affecting the high level of anxiety about interpretation of ROMs data by mangers / commissioners seems to be the lack of clear information available to psychotherapists at the point of conducting interviews; it

was known that data would be gathered and analysed, and that this would be used both to determine individual treatments and at a broader level to inform commissioning, however seven of the eight therapists said that they were unsure of the details. As a result therapists' worst fears were expressed; six therapists conveyed a fear that the most subjective tools (such as GBO, SRS) or most simplistic tools (particularly the SRS) would be used to make judgments about how well a patient is progressing or about the effectiveness of psychotherapy as a treatment. At the point of conducting the interviews there was still a lot of confusion about the measures:

> "I know it is linked to payment by results as well, but exactly what that would mean I'm not quite sure."

> "We're doing this but I'm not really sure where it's going or how it's being used."

Another factor influencing the high level of concern may have been the financial situation in the Trust at the time of the interviews; there had already been voluntary redundancies and there were fears of compulsory redundancies. All therapists would be aware that in some neighbouring authorities psychotherapy has been removed completely, which might have added to a fear that an agenda might exist to use ROMs data to eradicate psychotherapy in order to save money.

The concern that ROMs data will be interpreted simplistically by managers and commissioners is addressed in the 2014 CYP-IAPT guidelines; this document takes on board, as the 2012 document does not, the risk of simplistic data interpretation leading to poor clinical or service-level decisions:

> We believe that there is a potential risk that inappropriately used outcomes and feedback forms, and data derived from them, may be unhelpful or even harmful. It is vital that the forms are used thoughtfully and with clinical judgement and embedded in well-supported, well-supervised environments to mitigate against the risk of harm.…we are at the start of a journey in using feedback and outcomes tools on this scale. (Law and Wolpert, 2014, pp.61-62)

The 2014 guidelines states that the supervisor should be asking the therapist questions which will help them to *understand and interpret* the ROMs data, to get beyond face-value (Karwatzski et al.,2014, pp.61-62).

The 2014 guidelines advise that the newness of these measures means that great care needs to be taken not to interpret data simplistically:

> The measures have not been used to collect session-by-session data in a systematic way before, therefore we do not know what a typical trajectory would look like and this presents challenges in thinking about what the information means. (ibid, p.63)

Clearly neither clinical nor service-level decisions should be based on apparent deviation from an optimal trajectory, since it cannot yet be known what this optimal trajectory would look like; ROMs data must, therefore, be treated with caution both at the level of individual care-pathways and when assessing the performance of a service or profession. Rao et al. (2009, p.36) consider the impact of implementing ROMs in an NHS psychological therapy service and caution:

> [It] requires sensitive and intelligent contextual interpretation of the data to account for complex change processes in psychological therapies. How data is contextualized and communicated is of paramount importance so as not to draw misinformed conclusions about the service effectiveness.

In the light of the findings of this study, it is recommended that psychotherapists ensure that their voice can continue to be heard in all the different stages in developing and implementing the payment by result “clusters” and the use of ROMs data in determining care pathways, in order to make sure that this data is not used simplistically and in ways harmful either to individual patients or to the provision of child psychotherapy.

Chapter Eight: Summary of Findings

In this chapter, the benefits and concerns of using each specific ROM at each stage of a young person's treatment by a psychotherapist at CAMHS (whether long-term psychotherapy or brief intervention) will be summarised. In addition, the perceived strengths and weaknesses of the CYP-IAPT ROMs as a whole as raised by psychotherapists at interview will be summarised. This will enable common themes to be drawn out, such as the impact of CYP-IAPT ROMs as a whole on young people's mental health. This chapter will be organised as follows:

1) **Summary of therapists' views of each ROM**
    a) **RCADS / SDQ**
    b) **GBO**
    c) **SRS**
2) **Positive reports of ROMs use as a whole**
3) **Concerns about ROMs use as a whole**
4) **Summary**

1) Summary of therapists' views of each ROM

a) RCADS and SDQ

On the whole RCADS and SDQ were felt to be compatible with the work that child psychotherapists do and were experienced as not particularly intrusive. This is both because ROMs were felt to confer greater benefit when

the patient is new to the clinic and also because ROMs are experienced as less intrusive when the primary tasks are information-gathering and risk-assessment rather than long-term psychotherapy itself. As SDQ and RCADS are not carried out during usual psychotherapy appointments, they do not risk intruding into the therapeutic relationship / process in the same way as measures intended for use during psychotherapy sessions. Therapists discussed the benefit that these tools bring in posing questions at initial assessment which might not otherwise be asked, particularly concerning OCD; in addition it was felt that such specific questions might enable young people to admit to feelings, symptoms and difficulties which might feel much more difficult to vocalise spontaneously. Several therapists felt that there could be a certain reassurance to the patient in seeing a symptom named in black and white, indicating that it is not unique to this particular patient and might therefore not be too shocking.

The objections to SDQ and RCADS concerned how long these ROMs take to complete and what, therefore, is lost from an initial assessment. This is perhaps particularly a concern while ROMs use still feels relatively unfamiliar, as therapists reported being overly preoccupied with how to manage their time in order to make sure that all paperwork is completed. Three therapists reported that ROMs and other paperwork together take up the vast majority of an assessment appointment, leaving little time for additional exploration of a young person's state of mind. There was a fear that therapists are judged according to whether or not they complete required paperwork rather than the quality of relationship formed or the meaningful dialogue which takes place at initial assessment.

An additional concern expressed was that asking young people so many questions at assessment is harmful to mental health, since it echoes a culture of constantly assessing and monitoring which is so prevalent in schools and which might be a contributory factor to the increase in young people's mental health difficulties. Therapists feared that young people might form negative impressions of therapists or of CAMHS as a result of excessive ROMs use; this might include a fear that therapists are not really interested in the patient as an individual or that therapists make judgments only based on ROMs data and not in a more thoughtful way. Possible ways of addressing these difficulties will be considered in the final chapter.

b) GBO:

The GBO was generally supported in principle so long as clinicians are free to use their clinical judgment regarding when not to use it and how often to use it. It was felt to be helpful in giving clarity to the aims of a piece of work, in making sure that expectations are not unrealistic and ensuring that there is agreement as to the purpose of the work. The GBO is helpful in allowing comparison of the young person and parents' / carers' / therapist's goals, and in facilitating discussion about possible initial disagreement about goals.

The GBO was also found to be useful in allowing goals to be focused on both internal and external changes, including the kinds of behaviour change that may follow from emotional change and the kinds of emotional change that might accompany changes in behaviour. The GBO was found to be helpful in allowing progress to be tracked, particularly as small changes over time can often

become taken from granted and it can be hard to hold the severity of the original difficulties in mind; used at review the GBO was felt to be an aid for showing how far a young person has progressed, especially if they (or their parents / carers) might not feel that much has changed. It also guards against "drift" in the work, whereby there are very few changes but this is never discussed; it provides a platform for reflecting on why this might be.

Anxieties about this measure included a concern that some young people are unable independently to name goals and that some young people cannot bear to have goals in mind as this carries so much risk of failure. Therapists also voiced a concern that use of the GBO might imply that some changes are more desirable than others, or that some behaviours are wanted in therapy while others are not. Several therapists were concerned that progress may be made, but not in the areas where goals were set, which might falsely give the impression that there has been no change and therefore demotivate the patient. Concerns were also expressed that the word "goal" is too directive for psychotherapy and implies conscious striving to achieve particular targets at the level of each individual session. Possible solutions for some of these concerns will be discussed in the final chapter.

c) SRS

Psychotherapists in this study on the whole expressed a view that the SRS is straightforward to use and can be a useful way to track the therapeutic alliance, so long as it is only use in brief interventions and generic work. In this context it could provide helpful data about the young person's perception of the

therapeutic alliance, and could facilitate a process of noting and discussing ruptures in the alliance at an early stage. One therapist noted the value in comparing parent / carer and child scores on the SRS, and in discussing these differences together; this might be particularly important in clarifying when a parent / carer is not clear about the purpose of their child's sessions or feels that they are not being offered the help, support or strategies which they had hoped for. One therapist felt that this measure is particularly valuable to very young children, who are not used to having their view explicitly taken into account in this way.

Feedback from attempts to use this tool every session for long-term weekly psychotherapy was that answers tended to be given thoughtlessly and were repetitive, and accordingly the SRS was given little attention or thought by both patient and therapist. Another concern expressed about the SRS in particular, but also relevant to any session-by-session ROM, was that the scores given may reflect a need to reward / punish / please / displease or interest the therapist, or to secure continuation (or discontinuation) of a service, rather than offering any accurate reflection of a young person's state of mind or view of the therapist / session or of their progress. It was also felt to be particularly susceptible to reflecting the nature of the transference relationship rather than offering an objective comment on the therapeutic alliance; coming at the end of the session it might often reflect a child's view that the therapist is rejecting or abandoning them, for example. Universally low scores might reflect a negative (but productive) transference relationship, rather than indicating that there is any problem in the work or the therapeutic alliance. No examples were given of this measure being helpful for use every session in long-term

psychotherapy.

1) Positive reports of ROMs use as a whole

All psychotherapists interviewed for this study identified at least some benefits of using the CYP-IAPT ROMs, even when perceived benefits were heavily outweighed by concerns. There was an acceptance that it can be helpful in principle to have data showing a baseline of when young people arrive at CAMHS and some data relating to progress which can be considered alongside the therapist's clinical judgment. The specific strengths of the CYP-IAPT ROMs as a whole identified in this study were:

a) As additional assessment tools (RCADS / SDQ) (7 therapists):

- To identify areas of potential difficulty that might not otherwise have been considered during assessment, e.g. questions about OCD (5 therapists)
- To bring together parent / carer and patient views, making it easier to spot discrepancies and areas of convergence (triangulation of viewpoint) (5 therapists)
- To provide a detailed baseline against which to gauge progress (5 therapists)
- To ensure a consistent assessment process (5 therapists)

b) As a way of establishing goals (GBO) (5 therapists)

- To ensure clarity and agreement from the start about the aims of a

piece of work; to make sure the stated goals are achievable and realistic (4 therapists)

c) To track progress (SDQ / RCADS / GBO / ORS / CORS) (5 therapists)

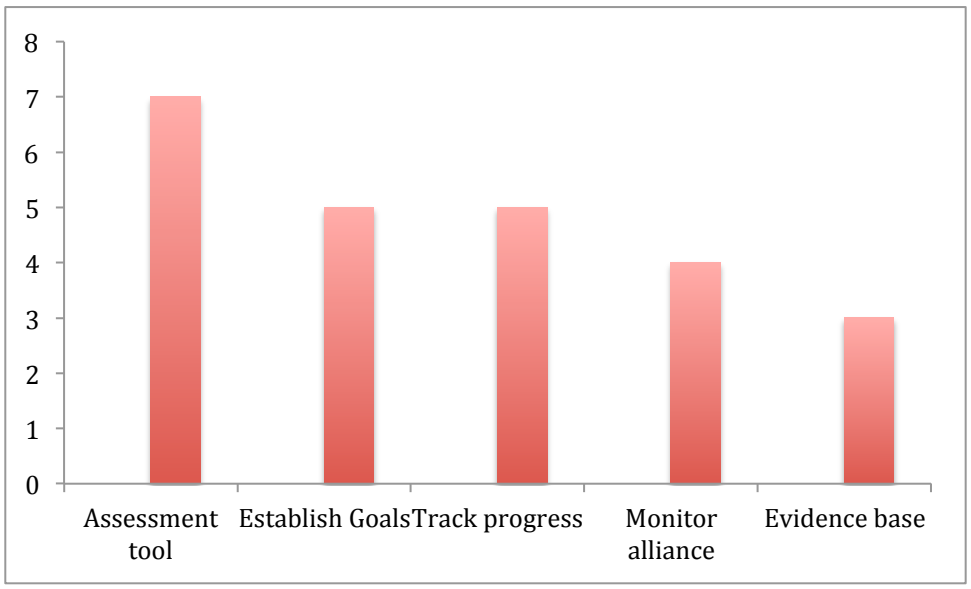
- A means of making sure that psychotherapy doesn't "drift" and maintains a clear purpose (4 therapists)
- A way of ensuring that progress is noticed by patient / therapist / parent or carer and of clearly demonstrating in which specific areas progress has taken place (5 therapists)
- A way of making the case for when further work might be needed, by demonstrating progress that has already taken place and identifying areas where further work is needed (2 therapists)

d) A means of monitoring the therapeutic alliance (SRS) (4 therapists)

- A quick way to check if the therapist's view of each session matched the young person's view; an opportunity to discuss any problems as they happen, thereby reducing drop-out (3 therapists)
- A means of monitoring the overall therapeutic alliance, leading to better outcomes (4 therapists)

e) A means of extending the evidence base for psychotherapy (3 therapists)

These perceived benefits can be summarised as follows:



Many examples of ROMs being used successfully were taken from brief interventions, and all of the examples of successful session-by-session monitoring related to brief interventions. Such interventions form a large part of therapists' caseload.

2) Concerns about ROMs use as a whole

The concerns raised by psychotherapists in this study about the implementation of the CYP-IAPT ROMs related to long-term psychotherapy and fell into the following groups:

a) Use of CYP-IAPT ROMs could be damaging to young people (8 therapists):

- ROMs may have a negative impact on young people's mental health, reinforcing a sense of failure when scores do not quickly "improve" and feeding into a culture of constant assessment (6 therapists)

- ROMs to monitor progress may make young people fear that if they show either too little or too great progress then they might be asked to leave the service; patients may feel under pressure to give the “right” answers to keep their place at CAMHS (3 therapists)

b) ROMs may impact negatively on how effectively psychotherapists can work (8 therapists):

- Use of ROMs at initial assessment may prevent psychotherapists from being as thoughtful and curious as they would otherwise be, as they constrict thinking and hinder free exploration (4 therapists)
- Session-by-session ROMs in long-term psychotherapy introduce formulaic questions and answers to psychotherapy sessions and conscious striving towards “goals”; this detracts from a fundamental tenet of psychoanalytic psychotherapy whereby the session can follow whatever comes into a patient’s mind (5 therapists)
- Session-by-session ROMs in long-term individual psychotherapy do not take into account the role a psychotherapist may be cast in in the transference relationship, nor the shifting nature of this throughout each session. There is an unrealistic expectation that a young person can set this relationship aside at the end of the session to provide an objective assessment of how they have found that session (5 therapists)
- Use of session-by-session ROMs takes away time from each

psychotherapy session without there being enough gain (4 therapists)

- CYP-IAPT ROMs give young people a distorted view of what they are supposed to be doing in therapy. If psychotherapists ask *every session* a variant of "are things better?" then young people may suppose that there *should* be measurable progress each session (4 therapists)
- An assumption that psychotherapy works with young people who necessarily want to "make progress" is incorrect, as it ignores the death instinct and masochistic tendencies, for example as particularly evident in eating disorders. There might be a lengthy period of psychotherapy where young people are motivated to try to keep things the same or to get worse (3 therapists)
- The presence of the iPad in the session may be a distraction and may have unhelpful associations, or it may be difficult to use and therefore take up a lot of time (8 therapists)

c) These ROMs will not necessarily capture the progress that young people make (8 therapists):

- These particular ROMs do not measure effectively the specific kinds of changes that take place in psychotherapy (7 therapists); they therefore will not help build a firmer evidence base (5 therapists)
- Some patients will be *unable* to offer an objective view of their own difficulties, of their progress or of what they would like to change

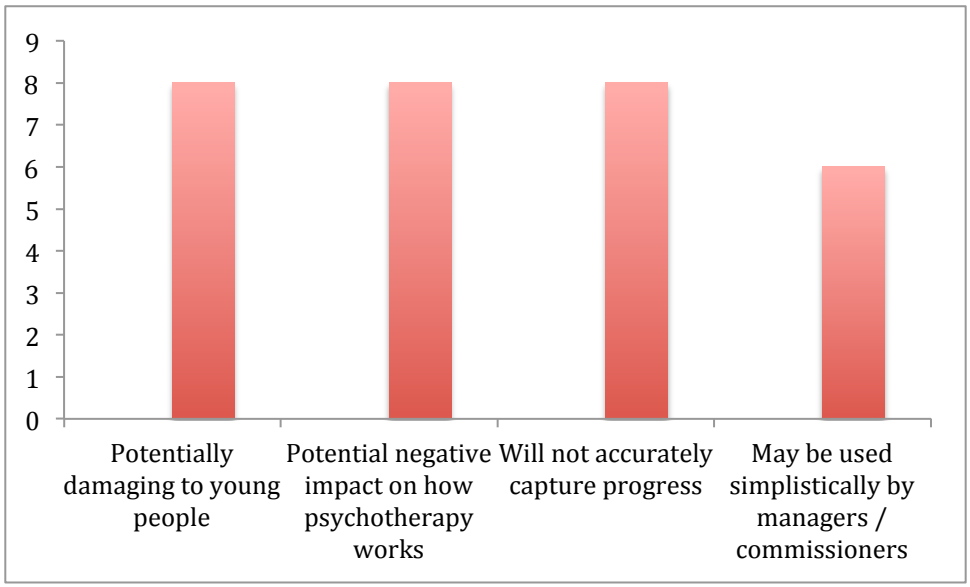
(7 therapists)

- Session-by-session ROM data may reflect the immediacy of the transference relationship rather than objective reality (7 therapists)

d) **ROMs data may be used simplistically by mangers / commissioners and may therefore damage young people's treatment (6 therapists):**

- Managers may be under pressure to make simplistic use of data to determine care pathways for each young person, or to end care early / change clinician / change therapeutic approach (4 therapists)
- Commissioners may use ROMs data to reduce (or eradicate) psychotherapy provision (6 therapists)

The major concerns about implementing the CYP-IAPT ROMs can be summarised:



No concerns were expressed about using ROMs as part of therapists' generic work or brief interventions. These were felt already to be goal-focused and based around targets and symptoms, and hence very different to long-term psychotherapy.

However, there were very high levels of concern about the impact of the CYP-IAPT ROMs on long-term psychoanalytic psychotherapy. A common thread connecting each of the individual concerns as discussed above is a concern that therapists' clinical judgment is being replaced by one-size-fits-all system, with a strong suspicion that the "one size" is psychology rather than psychotherapy. Comments included:

> "We are being forced into something and some of it is not very helpful...psychologists rule the world here I think."

> "I do notice whenever I go on training for ROMs, for example like using ROMs for supervision, a lot of the training is psychology led, and it just refers so much more to CBT and fits CBT, and we have to do all sorts of things to adjust it to make it work for us."

> "I think measures that make claims…to say that symptoms have gone down or patients are feeling less angry or their thought patterns have changed or something…are often treated as if they are the total story. "

Psychotherapists raised concerns that while psychoanalytic psychotherapy deals with the individual and with complexity, the CYP-IAPT ROMs deal with the general and simplified. Psychotherapists are trained to

think outside the box, to pay attention to the transference and countertransference, to deal with complex states of mind, to have as few preconceptions as possible – and there is a fear that the CYP-IAPT ROMs, particularly session-by-session ROMs, are conceptually at odds with this. There were multiple complaints of being told that they need to implement each type of ROM with every patient, regardless of their clinical judgment regarding this: “We need to be able to say that in this case it isn’t clinically meaningful and I’m not sure that we are able to do this.”

Two psychotherapists raised specific fears regarding the place of psychotherapy and psychotherapists within a culture of “evidence based practice”. They felt that it is impossible to challenge the dominant narrative that session by session ROMs use is helpful because to do so is to risk being seen as a mental health dinosaur with no place in the modern NHS. Their experience has been that there is no room for discussion about this, and they felt that CAMHS (and mental health care in general) is becoming a system where there is only one acceptable view of what constitutes “evidence”. One therapist observed:

> I feel very uncomfortable spending my day lying…I have to fill in [scores on ROMs] …is it this or this? But actually I would think it's neither of those, it's a bit of this and a bit of that, and every time you modify the data to put it in a box you then add up a whole series of slight departures from the truth and I think what do we end up with when we've added all of those up?

Two therapists expressed a view that CYP-IAPT ROMs have been deliberately designed to provide “evidence” that the cheaper, brief, manualised CYP-IAPT treatments are just as good (or better) at doing whatever it is that the CYP-IAPT ROMs measure, and that this will be used as justification for jettisoning treatments such as psychotherapy which deal with complexities and which therefore cost more money.

Therapists struggled in their interviews with issues concerning the difficulty of evidencing progress in psychotherapy; on the one hand they generally felt that the CYP-IAPT ROMs were either completely or somewhat inadequate for this task, on the other hand it was clear that there were no simple solutions as to what might be better:

> “In the world of psychotherapy which is slow and we are looking at the whole person and not bits and pieces, progress in one area may not be progress in others… and you need years to find out what the fallout is…. My feeling is that to look at the whole person is likely to be a deeper and more profound process and likely to be integrative in ways that a simple tick-box exercise cannot access.”

> “I would not do this work if I did not feel strongly that it does work, I would not do this work if I did not see that nearly all my patients make some differences and mature in some way that I felt was better for them. But these things are difficult to quantify. I have no solutions to this, I don't know what to say to managers except go and have therapy yourselves and work out what makes you feel better and

then put money behind us. But it is very hard and I do get that."

The interviewees were split between a pragmatic view of the ROMs, i.e. that they need to accept that these are a reality and find the best way to integrate them into their work regardless of qualms (two therapists), and on the other hand a view that the time has come to take a stand and that the ROMs represent a step too far in eroding the essential tenets of psychoanalytic psychotherapy (four therapists), with the remaining two expressing ambivalence. Four therapists voiced a fear that if psychotherapists do not take a stand now on behalf of the specific differences between their approach and other CAMHS approaches then psychotherapy will be so eroded that it no longer could be called psychotherapy at all – it becomes a target-driven, goal-centred brief intervention. One therapist commented that they had accepted ROMs implementation without thinking about what they might mean for psychotherapy:

> Maybe there's something a bit wrong about me that I would just go along with this experience [of trialling ROMs]…there doesn't seem to be time to think and reflect really about these questions….of their validity and usefulness…I haven't got time to think about that….

4) Summary

The predominant view of this particular group of psychotherapists in relation to the CYP-IAPT ROMs was that their overall impact is likely to be negative. There were significant exceptions to this negative view, particularly:

- SRS in brief interventions / generic work
- SDQ / RCADS use at initial assessment if more time can be allowed for this
- GBO so long as used infrequently and not required for every patient

However, on the whole, therapists voiced concern that these measures as a whole negatively impact on clinical judgment and will be used by managers and commissioners to replace thoughtful discussion and reflection. There was a fear that therapists will be required to use ROMs every session in long-term psychotherapy, thereby changing fundamentally the very process that is being measured. Therapists fear that these measures intrude on the process of psychotherapy and may have a negative impact on young people's mental health. In particular, the measures were felt to intrude upon psychotherapy as an agenda-free space, a space where negative and hostile feelings are likely to be expressed, where the transference relationship is central to the work and where symptoms are not the primary focus.

In the final section of this thesis, the findings from this study will be discussed and reflected upon, including discussion of factors which may have contributed to this generally negative picture. The limitations of this study will be noted, and suggestions for further research considered. The suggestions from various therapists about the most constructive uses of each measure, including practical suggestions for timing, framing of the measure and frequency of use will be compiled in order to arrive at a view of likely best practice for CYP-IAPT ROMs use.

Chapter 9: Conclusions, Limitations and Recommendations

This chapter will consider best practice for implementing the CYP-IAPT ROMs and will identify which of the ROMs seem most (or least) compatible with child and adolescent psychotherapy and the optimal frequency for their use. It will consider further research into the compatibility of ROMs with child psychotherapy which might help to address some of the unanswered questions within this study, and will look at the specific conditions of this particular study which may have influenced the findings.

This final chapter is organised as follows:

1) Specific conditions and limitations affecting this study

2) Recommendations for practice

- **a) Recommendations regarding specific ROMs**
  - **i. RCADS / SDQ**
  - **ii. GBO**
  - **iii. SRS**
  - **iv. CORS**
  - **v. The need for multiple measures**
- **b) Recommendations regarding CYP-IAPT ROMs in general**

3) Recommendations for further research

4) Conclusions

1) Specific conditions and limitations affecting this study

To some extent the fears and anxieties expressed by therapists in this study have been fuelled by the Trust's ROMs training, cited extensively by the three psychotherapists who had attended it, where statements were made which appeared to overvalue the importance of the ROMs and undervalue the importance of the therapist's clinical judgment; one trainer is reported to have made an assertion that if there is negative feedback on the SRS then the therapist should say "How am I getting it wrong for you?" and "How might I do things better?", making an assumption that the therapist *is* "getting it wrong" rather that there being numerous reasons why a young person might need to express a critical or negative view (and where it might be progress when they can do so). This view of therapy, i.e. that if the patient gives a low ROMs score then the therapist is "doing it wrong" is also present in the 2012 ROMs guidance, which formed the basis of therapists' understanding of how the ROMs should be used.

Another reason for a predominance of concerns about the ROMs rather than more positive views may have been the timing of this study early in the ROMs implementation, when only three clinicians had attended the Trust's training on CYP-IAPT ROMs; the group as a whole expressed confusion about how the data would be used and exactly what the requirements would be, especially frequency of use and degree to which they would or would not be allowed to use their own clinical judgment. There was a general view that therapists were being asked to implement something new without enough understanding of its purpose or of how to

use tools effectively, and this generated huge anxiety. Wolpert (2013, p.4) notes:

> The UK is in the process of a major experiment in terms of rolling out a new form of intervention – use of PROMS – but we are doing so currently without having trained people in their use. This is potentially extremely dangerous. If we replaced the word PROMs with "taking blood" we might be concerned to learn this was being widely mandated without clinicians knowing the answers to key questions such as: how best to safely interpret and report the data; how often to use in clinical practice; how best to introduce; how much change is enough and when not to use.

As discussed in chapter two, The implementation of the CYP-IAPT ROMs in this Trust also took place at a time when there had been cuts to CAMHS services and there was a threat of compulsory redundancies. ROMs implementation followed upon several years during which there had been substantial changes, adding to therapists' workload and impacting substantially on morale. Therapists had had to get used to a succession of changes to their day to day work, including the new task of taking "duty" (emergency or crisis) phone calls, hospital visits and crisis clinic appointments.

Since psychotherapists as a group had already had to make significant adjustments to their pattern of working – in some cases even a change of team or specialism – then the requirement to change yet again, by introducing ROMs to every psychotherapy session, may have been

experienced by some therapists as one step too far. This is likely to have contributed to the strength of negative views expressed in this present study, and it is possible that some of the negative statements relate not only to CYP-IAPT but also to the multitude of other changes which had been experienced. By offering therapists a chance to express their views about CYP-IAPT, when they had not been offered a similar opportunity to express their views about other changes, it is possible that their views on a range of issues were converged into a general sense of dissatisfaction.

Several of the changes which had already been introduced by the Trust may already have been experienced as detrimental to patient care or to the practice of psychotherapy. For example, while initial patient assessments had previously taken place with minimal paperwork, the Trust's "core assessment" document had been introduced, which was far more time consuming and necessarily resulted in less freedom for the therapist, patient or parent / carers to explore issues in whichever way they chose. While this had benefits in terms of the rigour and consistency of the assessment, it may not have felt a good fit to some psychotherapists. The introduction of the core assessment paperwork may have contributed to views about the CYP-IAPT ROMs being restrictive or impacting negatively on the freedom to think and explore freely.

Another change which had already been implemented by this Trust was the frequent monitoring of the "performance" of teams and staff members, in terms of whether or not particular administrative tasks were completed on time and entered into the computer as evidence of task

completion. I was witness to many formal and informal discussions within my own CAMHS team around the fact that the quality of the treatment itself was not monitored, but rather the swift completion of paperwork, creating an impression that administration was more important to the Trust than quality of therapists' contact with patients. Individual staff members were held to account for their ability to complete administrate tasks within a tight time frame, and a section of each team meeting was set aside for comparing this team's data to all of the neighbouring teams' data. This move had contributed to staff dissatisfaction, and is highly relevant to the present study since it relates to a perception that gathering data can be detrimental to patient care, can lead to an emphasis on unimportant or irrelevant targets and that managers may use the data in a critical way in order to target teams and individuals.

Therapists' hostility to the implementation of iPads may also have been connected to the "paper free" system introduced by the new Trust. While this clearly had many benefits, such as not having to decipher colleagues' handwriting, ease of access to documents, the ability to check records and so on, there had also been significant difficulties. Computers were shared with colleagues, and at peak times staff could experience a lack of available computers and therefore no possibility of adding to patient notes or checking them just before an appointment. At times the network failed altogether, leaving the whole team with no access to data. Previous paper records had to be requested and might take weeks to arrive, as they were not stored on site. For some staff who were less familiar with technology, the system of recoding notes and other information on the computer was

excessively time consuming. There were several major changes to the system, including one complete replacement with a different computerised system. It would not therefore be surprising if some views related to the Trust's use of technology might have been manifested in this present study in the unanimous view expressed that paper questionnaires would be preferable to use of iPads.

In this present study, several therapists also expressed a view that young people might feel judged or held to account dependent on the scores they provided on their ROMs. This also might be related to the way that individual therapists were indeed already being held to account for their own data inputted into the Trust's computer system, with their performance judged according to their ability to input data / carry out tasks required by the computer system. Both teams and individuals received reports from the Trust comparing their performance with others, and individuals' reports were used by managers as evidence for a need to improve. Any therapists who themselves had felt persecuted by the Trust's gathering of data regarding administrative targets may have concluded that young people might feel equally targeted and persecuted or criticised by the process of contributing to ROMs or of being presented with their own "performance" in the form of graphs and charts.

The specific conditions within this Trust at the time of interviews will necessarily have had an impact on findings, and are likely to have contributed to the generally negative view of ROMs and of ROMs implementation. It is a limitation of this study, therefore, that it took place

within only one service, rather than across a range of different CAMHS services who were participating in this pilot study.

Another factor affecting this particular study was the delay in issuing the ROMs software on iPads, meaning that all measures had to be carried out on paper. This led to unrealistic burdens of paperwork in order to administer the measures and process the data, and is likely to have affected therapists' willingness to trial these measures more extensively. More importantly it meant that none of the data could be fed back to young people / parents and carers within a reasonable timescale; it could take weeks or months to receive graphs showing patient progress on SDQ or RCADS, for example. This necessarily reduced the possible clinical utility of these measures; as discussed in the CYP-IAPT 2014 guidelines (Law, 2014a, p.14), ROMs are only of clinical benefit if the data can be fed back to patients in a timely way.

The original intention of this study had been to conduct two interviews with each therapist, one at the start of the year when therapists were unfamiliar with these measures and the second at the end of the year when therapists would be expected to be more familiar with the measures. This was not possible as a delay in ethics approval (related to administrative difficulties unconnected to my own particular study) postponed the start of interviews to six months into the pilot year. By this point all therapists were already trialing these measures, so I was unable to use two interviews to capture potential shifts in points of view. I therefore conducted just one mid-way interview with each therapist. This change was a loss to the study, as it

would be useful to note how therapists' views change over time and particularly whether or not initially negative views become modified over time.

2) Recommendations for practice

a) Recommendations regarding specific ROMs

There is no doubt that the requirement for all CAMHS clinicians to use the CYP-IAPT ROMs is pressing ahead, and that psychotherapists are therefore well past the point of being able to enter into a debate about *whether* or not ROMs should be used. Failure to engage with the CYP-IAPT ROMs is likely to leave psychotherapy isolated and vulnerable as a profession. Wood (2010, p.254) notes: "In the current climate, to refuse to embrace the agenda of evidence-based practice would be professional suicide". The most pressing questions for psychotherapists at this stage of ROMs implementation concern *which* of the tools are likely to fit best with they way psychotherapists work, *how* best to use each of these tools and what sorts of discussions need to happen with managers and commissioners to ensure that ROMs data is not misunderstood or used harmfully.

i. **RCADS / SDQ**

The two therapists who reported most clinical benefits from using RCADS and SDQ at initial assessment, felt that it was essential that these measures are completed with the therapist and young person together during the appointment,

rather than in advance or in the waiting area. By completing the measures together there can be discussion and clarification of the answers. The therapist can see *how* the measures are completed, *which questions* pose difficulty, and the therapist can be clear that the answers are the views of the young person (rather than undue parental influence). ROMs completed some weeks previously may feel to a young person to be irrelevant or inaccurate, and a young person may not wish to return to look at answers given at a different time. It is therefore a recommendation of this study that in order to maximise the clinical benefit of RCADS and SDQ they should be completed at assessment and review with the young person and therapist together; sufficient time must be allowed to make this practical and to avoid it feeling to both therapist and young person that this is a burdensome requirement which impacts negatively on the possibility for more open discussion.

It is also likely to be important that each therapist is able to articulate to patients and parents / carers why these particular ROMs questions are being asked and how they might be helpful. This will require all therapists to feel confident in their knowledge of these measures, confident in their ability to explain which areas each measure assesses and the purpose of using multiple measures, and able to summarise this in an age-appropriate and succinct way. Therapists will also need to be able to explain that ROMs are only one part of the initial assessment (or review) and not the whole basis on which decisions about care will be made. It is recommended that therapists receive sufficient training in order that they can communicate confidence in these measures to their patients and that they can answer questions about their use.

In a few cases, where ROMs are experienced by patients as particularly persecuting or hard to complete at initial assessment, it might be necessary to leave ROMs until later in treatment when a relationship with the young person has been formed. Therapists expressed a view that a failure to use all of the ROMs (and other paperwork) in the first appointment would be judged as a failure by management and that they would be held accountable for this, without any opportunity for discussion about the clinical reasons why measures were not used. It is therefore recommended that lead therapists are able to discuss with managers the types of presentation which might necessitate a delay in ROMs use, and that there is a mechanism for therapists to alert managers to these particular cases without fear of negative judgment of their work.

ii. GBO

Therapists' interviews revealed the hazards of attempting simply to ask young people to name their goals and then accepting these as the goals of the work. Instead, the findings of this study highlight the importance of allowing goals to emerge over the course of the psychotherapy assessment as the nature of the difficulties becomes clearer. By taking time to set goals this establishes from the start to the child and their parents / carers what psychotherapy is hoping to achieve, and ensures that unrealistic, unhelpful or unachievable goals can be identified at the outset. So, for example, it is helpful for parents / carers to know that psychotherapy is not trying to "fix" naughty behaviour and for a child to know that psychotherapy is not going to deliver an Xbox or return them to birth parents. It is also important to remember that those goals listed on the GBO are only the conscious goals, which does not rule out

the strong possibility of the existence of other unconscious goals for treatment, including goals that are perverse, unachievable or anti-life. Within the therapist group there were suggestions about how to formulate goals that are measurable and achievable as well as balanced between internal and external change.

Therapists using the GBO successfully found that it is most helpful to return to goals periodically, such as at reviews or key points in the work; it is not helpful for goals to be held consciously in mind and scored every session in long-term psychotherapy (but may be in short-term and generic work). This will guard against the risk that long-term psychotherapy becomes goal-oriented, thus distorting the essence of this work whereby the patient must be free to talk about (or play) whatever comes to mind. Clearly care must be taken that a young person does not see their goals as set in stone, or feel that they have somehow failed if a particular goal is not achieved. The GBO must always be seen as just one way of measuring what has changed, alongside all existing methods. There was acknowledgement that there may be some young people for whom the GBO is inappropriate, when their internal world is so chaotic that it is not yet possible to unpick any individual strand of this and for some psychotic or borderline young people where the existence of goals was felt to make no sense. It is recommended, therefore, that the guidelines about when goals should be recorded are flexible enough to allow for individual variation rather than an absolute requirement against which therapists' performance is judged.

iii) **SRS**

The recommendations of this study are that the SRS is not used during long-term psychotherapy; none of the eight therapists who participated in this

study found it to be useful when used in this way. It is not compatible with the complexity of the work of long-term psychotherapy, the questions are overly simplistic and its use is likely to be excessively repetitive. The tool was felt to be too limited to contribute to meaningful discussion.

This tool was found to be useful for brief and generic interventions, which make up a large part of the caseload of child psychotherapists. The sliding scale version of this tool was preferred, as it allows for more subtle shifts to be recorded.

iv) (C)ORS / STMs

Therapists in this study had almost entirely avoided use of the ORS / CORS and STMs. There is a training need for the group to become familiar with these tools and to assess whether or not they might be a helpful supplement (or alternative) to the SRS in getting a snap shot of “how things are”.

v) The need for multiple measures

There is a risk that if a wide range of CYP-IAPT ROMs are not used, for example, if (C)ORS is overlooked, then this places undue weight on the few tools that are used. As discussed in Chapter Two, the advantage of using a wide range of tools is that each assesses something different; for example, CORS assesses functioning in everyday life, SRS assesses alliance while SDQ assesses global functioning and the STMs track symptoms. Without a range of tools in place, the patient and therapist are potentially missing the value of

multiple perspectives which comes from using more than one type of measure. By using several measures from several different perspectives (patient, parent, therapist, teacher) it is possible to compensate for the potential unreliability of children and young people as observers of their own states of mind, and also to take more account of context of the assessment (e.g. home, school and clinic).

b) Recommendations regarding CYP-IAPT ROMs in general

Recent publications exploring patient reported ROMs use in mental health treatments indicate that understanding how best to use them is still in its early stages. For example, Wolpert et al. (2015, p.2) write:

> It may be important to be more explicit in roll out of PROMs nationally about how new an approach this is and how little is known about the psychometric properties, impact or indeed utility of many of the measures being used.

Given that use of ROMs within clinical sessions is such an under investigated, therapists will need to retain thoughtful, critical minds regarding their use. In particular, it is recommended that child psychotherapists familiarise themselves with exactly what research does and does not show about the CYP-IAPT outcome measures. This will enable them to challenge simplistic interpretations of evidence which might be used to drive forward ROMs implementation in an unthinking and inflexible way. For example, psychotherapists need to be aware that studies cited by CYP-IAPT as evidence of the clinical benefits of ROMs do not generally relate to psychotherapy, or to work with young people.

As discussed in the literature review, there is a discrepancy between the literature cited by CYP-IAPT in support of its outcome measured and the actual lack of clarity regarding some of this evidence, particularly regarding the value of monitoring the therapeutic alliance; it is therefore recommended that therapists critically interrogate claims made by CYP-IAPT in the light of their own clinical experience, and that where there is a discrepancy this can be discussed. The most obvious example would be CYP-IAPT's claims regarding the benefits of session-by-session monitoring of therapeutic alliance; inspection of their evidence shows that none of the studies that they cite in support of this measure actually relate to session-by-session monitoring. In addition, it is far from universally agreed that good therapeutic alliance is a causative factor in good outcomes, nor is it agreed what is meant by "good alliance", how best you would monitor this or what, if anything, can be done in any case to improve poor alliances. The 2014 guidelines do acknowledge: "…there has been recent research to suggest that the earlier belief that therapeutic alliance strongly predicts outcome is not founded in evidence, and that many factors interact…." (Troupp et al., 2014, p.89) This is a startling admission given the emphasis placed by CYP-IAPT on monitoring the alliance every session.

Psychotherapists need to be clear that session by session ROMs use is an experiment and that while they cannot assume in advance that it is unhelpful neither should they assume that these measures are benign and that their impact on clinical work (or on psychotherapy in particular) has already carefully been assessed. Psychotherapists will need to work as a group to monitor and assess the impact of these measures on long-term work and to make decisions as a group about which measures (if any) are helpfully used

every session over a long period. It will be recommended that psychotherapists' clinical judgment can be discussed with managers and that measures are not introduced when they would be clinically unhelpful.

Although the 2014 guidelines do contain numerous reassurances that clinical judgment must always come first (such as Wolpert and Law, 2014, p.5), this does not seem to have been communicated to psychotherapists who have attended the Trust's ROMs training; such reassurances might, in any case, feel at odds with guidance that clinicians must aim to complete ROMs in 100% of cases in order that a target of 90% can actually be achieved (Wolpert, 2014, p.20) as this leaves very little room for clinical judgment to come into play. It is recommended that each psychotherapist feels able – at every stage of the CYP-IAPT ROMs implementation - to have discussions with their clinical lead and managers in cases where they feel that use of specific ROMs or ROMs use with specific patients will be clinically detrimental, without feeling that to do so is to be labelled as anti-progress and standing in the way of evidence-based therapies.

3) Recommendations for further research

Further research in this area might help to clarify some unanswered questions. For example, the findings of this particular study may have significantly been influenced by the contextual factors as discussed above. In order to investigate further the generisabilty of the findings it would be useful to conduct a similar study with other teams, particularly:

a) Teams which have move beyond the initial stages of implementation, to investigate whether reservations about CYP-IAPT ROMs use in psychotherapy decreases over time

b) Teams which are relatively settled and where morale is relatively good at the point of introducing these measures

c) Teams where the members are not known in advance to the researcher

In addition, this study has highlighted that therapists are interested in the mechanisms of changes as well as measuring outcomes, and would like to know more about the factors that make psychotherapy different to other treatments and the impact of these factors. This could include carrying out investigations into the impact of the transference relationship, factors which might predict drop-out, the role of play or the use of the therapist's interpretations as determinants (or otherwise) of successful outcomes in psychotherapy.

Further research might, for example, make use of the "Anna Freud Session Rating Scale of Child and Adolescents", (Fonagy et al., 1993) which targets precisely the kinds of areas which psychotherapists in this present study identified as missing from the CYP-IAPT ROMs, including the impact of the transference relationship and the multiple layers of meaning in a child's play (Kennedy & Midgley 2007, p.16). Another tool which it might be helpful to consider would be the Child Psychotherapy Q-Sort (Schneider, 2004 & Schneider, Pruetzel-Thomas & Midgley, in press) which attempts to isolate specific aspects of psychotherapy treatment and their relation to outcomes.

There is an admission in the 2014 guidelines that little research has been done into the impact of session-by-session ROMs use during long term treatments in general. Troupp et al. (2014, p.90) write:

> Whilst children and young people have shown interest in using these measures in therapy, there is as yet no clear evidence as to what would be the impact of being asked to complete the measures very regularly over a long period of a year or more.

This is an area where urgent further research is needed, in order to find out if therapists' worst fears about the impact of these measures in long-term psychotherapy are founded.

4) Conclusions

At the point of conducting this study each therapist was making his or her own decision about which ROMs to use and the frequency, but it is likely that in the near future there will be a requirement for greater consistency. Psychotherapists will need to be able to state a clear position as to which measures are most helpful and what the frequency of use should be, and to be able to offer clear reasons why this is the case. It is therefore recommended that each therapist ensures that they are familiar with the strengths and limitations of each of the measures, as well as with best practice around how to use each measure most effectively. If therapists hold back from trialling each of the ROMs now then it is more likely that in the future they will be told how / when to use the ROMs and which ones to use, rather than being able to

contribute towards a discussion with managers at this still relatively early stage in ROMs implementation and find a solution which suits psychotherapists as a group.

As discussed in Chapter Two (literature review), there have been significant ammendments to the original 2012 CYP-IAPT guidelines, which mean that there may be more possibility of creative, thoughtful ROMs use than was feared by therapists interviewed for this present study, who were familiar only with the earlier 2012 guidelines. This includes an acknowledgement that these guidelines are only a "start to thinking" (2014 guidelines, p.117), there will be exceptions needed in some cases for long-term therapies (p.87-92), the measurement of therapeutic alliance may not be as helpful an indicator as previously supposed (p.82) and that the measures could have a negative and damaging impact on young people if used inflexibly (p.117).

Fonagy (2005a p.677) finds no good reason why psychotherapy cannot embrace quantitative measures; a "shift in epistemology on the part of psychoanalytic psychotherapists" is what is needed (ibid, p.677). He proposes: "…ending the splendid isolation of psychoanalysis" and "…adopting a scientific attitude that celebrates the value of the replication of observations rather than their uniqueness" (ibid, p.677). Fonagy lists the reasons why psychoanalysis needs to collect quantitative outcomes data: it will supplement psychotherapy's existing models, further the investigation into which treatments work best for which patients / mental health difficulties and provide a more solid evidence base for psychotherapy which can be more easily communicated outside the profession (Fonagy, 2005b).

It may be that anxiety about change and the newness of these measures and limitations of the training and guidelines has resulted in worst fears rather than hopes about ROMs use predominating. If the CYP-IAPT ROMs are allowed to be used flexibly, especially in terms of frequency, and if data is reflected upon intelligently in the context of other data and indicators of change, then ROMs might be seen as helpful additional tools among all the existing tools which psychotherapists use; they might add to the sum of what is known about a young person's state of mind, progress and relationship with the therapist. As with Bion's concept of multiple vertices (Bion, 1970b, p.83), there can be the capacity to hold more than one view in mind at once, in order to see an issue (or person) in a multi-dimensional way which might be less comfortable but ultimately closer to reality.

The overwhelming need is for this group of therapists to have the time and space necessary to reflect thoroughly on ways of measuring the impact of psychotherapy, and on the impact and utility of the CYP-IAPT ROMs in particular. The psychotherapists need the opportunity to think creatively about their implementation. Unsworth et al. (2011, p.71, p.79) conducted a study looking at the response of therapists to new outcome measures and found that: "therapists were initially anxious and resistant" but they "adapt 'creatively'"; they state that: "proper and ongoing training/support of therapists is necessary". Three therapists who were among the early adopters of the ROMs within the wider group expressed a view that they had previously been anxious about their use, but that now that they were using these some of their fears had proved to be unfounded:

“Think of it as some kind of experiment really and not be put off by it.”

“It is strange and uncomfortable to begin with but it very quickly becomes part of what is expected and an enjoyable part of the session, even if it’s all negative.”

“My advice would be just try it with a few that you feel would manage it because most of the anxiety is prior to people trying it. Once people try them it’s not as intrusive as people might expect.”

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Appendix 1: CAMHS Payment by Results (PbR) Project: Proposal for Piloting

(September 2012)

Clinically Meaningful Resource Group (CMRG): The higher the complexity the more likely the need for liaison consultation, inter-agency working and involvement of other professionals and potentially the more lengthy the case work	**Likely levels of:** Severity and types of presenting problems and complexity factors so far found or hypothesised to be most frequently associated with this cluster/CMRG	**Likely number of:** Face to face meetings within a care package(given only for indication of level of resource needed)	**Likely % caseload:** In generic non specialist CAMHS	**Likely resource use:** In generic non specialist CAMHS
CORE Complexity factors and comorbidity may indicate shift to CORE PLUS	Impact of mild-moderate difficulties in one or more areas at home, school or with peers • Common anxiety problems • Family issues	Around 1-6 meetings with a MH professional, plus liaison and review meetings	**50%**	**10%**
CORE PLUS Complexity factors and comorbidity may indicate shift to EXTENDED	Significant impact of difficulties at home, school or with peers • Mixed anxiety and depression • Conduct disorders (CD) • PTSD • Mixed CD and emotional Looked after child	Around 7-12 meetings with a MH professional, plus liaison and review meetings and possible medication	**25%**	**20%**

EXTENDED Complexity factors and comorbidity may indicate shift to EXTENDED PLUS	Major impairment in functioning at home, school or with peers • OCD • Major depression • Comorbid ADHD and CD Parental mental health issues	Around 13-24 meetings with a MH professional plus liaison and review meetings and possible medication	**15%**	**25%**
EXTENDED PLUS May need bespoke arrangements re specialist commissioning for small number of extremely high resource use CYP	Major impact on all aspects of life • Treatment-resistant OCD • Severe relationship difficulties and self-harm • Severe CD • Eating disorder • Psychosis • Bipolar disorder	Around 25-215 meetings with a MH professional, plus liaison and review meetings and possible medication, possible intensive outreach or inpatient work	**10%**	**45%**

Appendix 2a: Information for participants (*anonymised for inclusion in thesis)

University of East London

The Tavistock and Portman NHS Trust

University Research Ethics Committee

If you have any queries regarding the conduct of the programme in which you are being asked to participate, please contact:

Merlin Harries, Quality Assurance and Enhancement (QAE)

External and Strategic Development Service (ESDS)

University of East London, Docklands Campus, London E16 2RD

(Telephone: 020 8223 2009, Email: m.harries@uel.ac.uk).

The Principal Investigator(s)

Georgina Taylor

[address of CAMHS team]

Consent to Participate in a Research Study

The purpose of this letter is to provide you with the information that you need to consider in deciding whether to participate in this study.

Project Title

An investigation into the implementation of CYP-IAPT Routine Outcome Measures in their first year of integration into child psychotherapy practice

Project Description

The proposed study is an investigation of the impact of the introduction of Routine Outcome Measures (ROMs) on child psychotherapy provision in [geographical location], an area which forms part of a CYP-IAPT (children and young people's Improving Access to Psychological Therapies) pilot site in the first wave of its introduction. All of ROMs used by child psychotherapists in this period will be considered. The aim is to establish the strengths and weaknesses of these measures specifically in relation to child and adolescent psychotherapy. It will look at the possible impact on the therapeutic work of introducing these measures and also at whether or not these measures seem to tell us something useful about the outcomes of the work. The aim is to analyse the feedback from therapists and young people in order to identify common patterns, themes, concerns and strengths of these measures. I will also take a first look at the data returned, in order to identify areas where progress (or lack of it) has been measured by particular ROMs and what this data appears to indicate. My findings can directly feed back into the CYP-IAPT consultation process which is on-going. My study therefore offers child psychotherapists and young people the opportunity to have a voice within the implementation of the CYP-IAPT ROMs, and to shape the way in which they are implemented. This will be vital in terms of the wider roll-out of CYP-IAPT and the impact on child psychotherapy in CAMHS nationwide.

= I will be seeking to interview psychotherapists working in [geographical area] twice each during the course of the study. Each interview will last between 60 and 90 minutes and will be recorded. I will be analyzing your experience of specific types of ROM, specific questions within each ROM, your experience of using these ROMs with different ages and types of presentation

and the impact on the work (positive and negative) of the implementation of CYP-IAPT ROMs. I will also ask you if you can let me know during the year of any specific feedback and comments which you receive from young people regarding their view of the ROMs.

Confidentiality of the Data

Data will be stored and worked on at [name of CAMHS clinic] and at my home address. In both cases, data will be kept securely. All data included in the final study will be anonymised, including the identity of individual therapists and reports given relating to any young person's experience of using the ROMs. Once the program has been completed the interview data will be destroyed. Your consent will be sought if there is any request to use your interview data in any further study.

Location

[Name of area]

Disclaimer

You are not obliged to take part in this study, and are free to withdraw at any time during tests. Should you choose to withdraw from the programme you may do so without disadvantage to yourself and without any obligation to give a reason.

Appendix 2b) Consent form

UNIVERSITY OF EAST LONDON

Consent to Participate in an Experimental Programme Involving the Use of Human Participants

An investigation into the implementation of CYP-IAPT Routine Outcome Measures in their first year of integration into child psychotherapy practice

I have the read the information leaflet relating to the above programme of research in which I have been asked to participate and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what it being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researchers involved in the study will have access to the data. It has been explained to me what will happen once the experimental programme has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the programme at any time without disadvantage to myself and without being obliged to give any reason.

Participant's Name (BLOCK CAPITALS)

…….

Participant's Signature

……..

Investigator's Name (BLOCK CAPITALS) GEORGINA TAYLOR

Investigator's Signature

……

Date: …….

Appendix 3: Interview questions

1) **How would you describe the impact on your work as a child psychotherapist of starting to use the ROMs?**
2) **How does the use of the ROMs impact on your work as a psychotherapist?**
3) **Looking at each type of ROM individually, what were the issues?**
    - What feedback can you give me about each individual question?
    - When in the session did you use this ROM?
    - How frequently did you use this ROM?
    - Did you get any specific comments or reaction from children and young people about anything to do with this ROM?
    - What were the benefits & concerns of using each ROM?
4) **How did you find using each type of ROM with different kinds of patient?**
    - Very young children (under 7 years)
    - Children age 8-12
    - Adolescents
    - Parents and carers
    - Patients with learning difficulties
    - Silent patients
    - Children with behavioural issues
    - Any other particular group which emerges as relevant
5) **Did you have instances of the ROMs being used by the patient for other purposes than as an attempt to provide objective feedback?**

6) **Did any young people refuse to participate? What reasons were given?**

7) **What strategies and methods did you develop for using the ROMs?**
    - How often did you decide not to use them either for particular patients / in some sessions?
    - How did you go about setting and revising goals?
    - How did you identify and track symptoms?
    - When did you decide either to specifically bring in data completed by a patient or to exclude this from the sessions?
    - How did you go about asking specific questions / using specific ROMs in as unobtrusive way as possible
    - Did you extend the normal session time to accommodate the ROMs?
    - Did the young person ever complete the ROMs without you present, e.g. in the waiting room, and what was your reasoning about this?
    - Is there any advice on use of any of the ROMs that you can feed back for other therapists to consider?

8) **Do you have any thoughts on how data may be used by managers / commissioners?**

9) **(Participants' background):**
    - **Which training school did you attend?**
    - **How many years post-qualifying experience do you have?**
    - **Have you used ROMs in any other setting / any other ROMs?**

Appendix 4: Example of grid used early in study to record views of each therapist (a-h): highlighted areas show my areas of interest based on numbers of therapists falling into each group

	Benefits the clinical work					Offers greater CLARITY and FOCUS			
	Allows parent / child views of things to be compared and both thought about	**Helps start a conversation / allows something to be expressed**	**Allows issues to be identified which might not otherwise have been known so quickly**	**Allows a view from outside the therapy room – might give different picture**	**Tells you something about how patient feels about you and the work**	**Helps in initial screening to be clear about nature of problem**	**Offers clarity**	**Offers focus**	**useful review tool (shows progress clearly)**
GOAL	H				A		A B C E F	A	A B C
ORS / CORS		E H	H				H		
Session based		E D A	A C F H		F C A		B C		
RCADs / SDQ	B E G H E D	D F H C B	H (RCADS) E F G C	F		G F H	B G F H		F H
Current view									
ROMS in general	E B H F	D	B A H E D F	E B	C B	A B F	A B D F H C G E	A B D F H	F B
ANY or ALL ROMs	B E G H E D F B	C A D B F E H	G H E F B A D C	FE	F C B A	A B F G H	A B D F H C G E	A B D F H	A B C F H

Appendix 5:

Georgina Taylor:

SUMMARY of study into impact of CYP-IAPT outcome measures

Four of the therapists in this study expressed predominantly negative views about the CYP-IAPT ROMs, two expressed mixed or ambivalent views and two therapists were broadly positive although with some expressed reservations. Reasons for the high level of concern about the ROMs centred on their impact on long-term psychotherapy (rather than their use in generic or short-term work). Concerns included their perceived impact on patients' mental health, disruption to the therapeutic relationship, over-simplification, repetitive nature, incorrect assumptions about patients wanting in a straightforward way to make "progress" and emphasis on conscious progress and symptoms.

The ROMs training delivered by the Trust had not been well received by the three psychotherapists who had attended this, with it experienced as allied with CBT and offering unhelpful practice advice which did not relate to psychotherapy. Psychotherapists were strongly opposed to any requirement to use session-by-session ROMs in long-term psychotherapy, though these were felt to be useful or less intrusive in short-term and generic work. Fears that psychotherapists might be forced to change treatment plan or clinician based on poor-ROMs feedback added to lack of enthusiasm for these measures, and in addition there was a fear that these measures might be part of a wider plan to eradicate psychotherapy in the NHS by providing outcome measures which are by their design asking questions which strongly favour brief treatments and CBT.

Therapists on the whole expressed a view that ROMs can be used helpfully at initial assessment, with a reservation about the quantity of paperwork interfering with forming a more meaningful relationship. They also expressed a view that ROMs can be used helpfully in short term and generic work. RCADs and SDQ were felt to be generally helpful if used only at assessment and reviews and if therapists retain their autonomy to make judgments about particular young people or particular situations where they are felt to be unhelpful or excessive. The GPC (goal progress chart) was also felt to be helpful on the whole in establishing some shared aims for the treatment, so long as there is no obligation to set goals too soon and so long as the process is collaborative and emerges naturally from the psychotherapy assessment. The GPC was also felt to be helpful in tracking progress so long as this is not repeated too frequently (termly or at reviews was suggested to be most helpful) and so long as it can be discontinued if it is found to be demotivating or used in a perverse or unhelpful way. Two therapists cited the usefulness of ROMs in building a firmer evidence base for psychotherapy.

Appendix 6: Ethics Approval

Appendix 12

EXTERNAL AND STRATEGIC DEVELOPMENT SERVICES
uel.ac.uk/qa
Quality Assurance and Enhancement

28th November 2013

Dear Georgina

Project Title:	**An investigation into the implementation of CYP-IAPT Routine Outcome Measures in their first year of integration into child psychotherapy practice**
Researcher(s):	**Catrin Bradley**
Principal Investigator:	**Georgina Taylor**

I am writing to confirm that the application for the aforementioned proposed research study has received ethical approval by the University Research Ethics Committee (UREC).

Should any significant adverse events or considerable changes occur in connection with this research project that may consequently alter relevant ethical considerations, this must be reported immediately to UREC. Subsequent to such changes an Ethical Amendment Form should be completed and submitted to UREC.

Approved Research Site

I am pleased to confirm that the approval of the proposed research applies to the following research site.

Research Site	Principal Investigator / Local Collaborator
UEL Fieldwork	Catrin Bradley

Approved Documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
UREC Application Form	1.1	22nd November 2013
Participant Information Sheet	1.1	25th November 2013
Consent Form	1.1	25th November 2013
Interview Questions	1.0	9th October 2013

Approval is given on the understanding that the UEL Code of Good Practice in Research is adhered to.

Docklands Campus, University Way, London E16 2RD
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Email: r.carter@uel.ac.uk
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With the Committee's best wishes for the success of this project.

Yours sincerely,

Joanne Wood
University Research Ethics Committee (UREC)
Quality Assurance and Enhancement
Telephone: 0208-223-2678
Email: researchethics@uel.ac.uk