

The Canary in the Coalmine

...and other tales from the grumpy zone

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File it under the heading: 'stuff I already know'

- Routine outcome measurement has problems
 - Matching protocol to practice
 - Episode of care
 - Imperfect reliability
 - No carer measures in adult and aged
 - Insufficient resources
 - Limits analysis
 - Compromises
 - Brevity and comprehensiveness

But..., ...and in conclusion

- A number of concerns about Routine Outcome Measures are actually issues of clinical practice
- Routine Outcome Measures is simply
 - The warning system
 - The messenger
 - The sacrificial canary

...and you get to say this because?

- Community health
- Adult mental health
 - Inpatient and Community
- But primarily CAMHS
 - Eastern Health CAMHS and Routine Outcome Measures since 1997
- National Outcome Expert Group
- Trainer
- PhD
- Implementation committee for CAMHS, Adult, Aged and Specialist Mental Health
- Take Two

...what is it good for?

- "Outcomes measurement is of no use unless it is actually used" (Docherty & Streeter, 1996, p.17)
 - Only 13% of hospitals using an outcome system believed it improved quality of care (Lindner 1991)
 - Of 1400 plus instruments in studies 840 not used more than once (Ogles et al 1996)
 - Found over half clinicians not in favour even if it meant improved outcomes for clients (Walter et al 1998)
 - UK survey of psychiatrists
 - "the majority of psychiatrists do not use outcomes measures in their day-to-day practice" (Gilbody et al 2002)
 - Psychiatrists noted as less favourable in their attitudes than psychologists (Huffman 2004)
 - Less burden perceived by those who saw it as important
 - In USA, 92% had not used mandated OM for any aspects of their clinical practice (Garland et al 2003)

- Psycho-dynamically oriented staff worry it might constrain assessments (Manderson and McCune 2003)
- Increasing proportion using outcome measures (Hatfield and Ogles 2004)
 - 54 % compared with 23% using in CAMHS (Bickman et al. 2000)
 - More use by younger therapists
 - Client progress more important than external pressures
 - Those who spent more time providing therapy more likely to engage in outcome measurement
- Survey in UK
 - Objections resource rather than philosophical or scientific
 - Substantial use but many different instruments making it comparisons across services difficult (Johnston and Gowers 2005)
- Western QUATRO (Vic)
 - Clinicians believed clients didn't want it but majority clients supportive

So many issues, so little time...

- Not clinically useful
 - The content
 - The process (protocol timing)
 - Makes no sense clinically
 - Too subjective
 - Open to manipulation
 - Doesn't tell you anything
- No feedback
- Time consuming
- Just paperwork

The First Canary

- Aged Mental Health
 - Arose from the training context
 - Invitation to demonstrate the use of OM
 - Mostly aggregate uses
- I can see there might be some benefit for management in using some of this data but, seriously, its not clinically useful
 - Bring out your files
 - Curiosity and disparity
 - Probably not reliable
 - If this was my ...

The first canary indicates

- Communication between components of the system
- Respect for other professionals assessment
- Psychometrics as a defensive manoeuvre

The Second Canary

- CAMHS and Outcome Measures as a flag
 - Context of data integrity
 - e.g. no case manager, diagnosis missing, no recent contact, and...
 - Initial HoNOSCA score possibly too low (<10%ile)
 - Could be data entry problem
 - Devil is in the detail so lets check some files
 - Team leader finds
 - > Little correspondence between Assessment Report and initial HoNOSCA
 - > Little correspondence between initial HoNOSCA and subsequent review HoNOSCA by another staff member
 - But what can you do?

The second canary indicates

- Reservations about questioning clinicians about their practice by other clinicians and team leaders
 - Let alone being questioned by clients and parents
- What happens if a service treats outcome measures seriously?
 - Should errors be corrected
- Is there anything important about, functionally underplaying symptoms?

The Third Canary

- Adult and CAMHS training
 - Refresher Training during the transition to mandatory ROM
 - Its too subjective
 - It needs to have more specific criteria so that we are consistent
 - How do you know we don't just lie?
 - You should ask clients, not us

The third canary indicates

- Disingenuousness
 - Trust my
 - Formulation
 - Assessment
 - Diagnosis
 - Commitment to enact collaborative practice
 - But not my outcome assessment
- Avoidance
 - Clinicians less reservations about client measures compared with clinician measures (Callaly et al 2006)
 - Is it that clinicians are more accustomed to taking information than sharing their information?

The Fourth Canary

- Psychiatric nurse and mother reviewing primary school age boy
- Sharing clinician instrument with mum
- Response by colleagues
 - Outcomes constrain the richness of dialogue
 - Fundamentally at odds with therapy
 - What if the instruments do not agree
- Response by the nurse
 - Scary
 - Fear of losing the mum

The fourth canary indicates

- What focuses all our attention
 - All conversations can enter a homeostatic pattern and everyone tends to focus on the crisis
 - Recency and Severity
 - Scary to be transparent about what clinicians think
 - There are emotional issues at stake here
 - These are not just numbers

The Fifth Canary

- With huge demand, there is pressure to achieve throughput
- ROM and the throughput conspiracy
 - But when carer and client measures examined, a substantial proportion are being discharged with their problems still at a clinical level

SDQ Band at Assessment	SDQ Band at Discharge			Grand Total
	Close to average	Slightly raised	Substantial risk (Clinical)	
Close to average	28.2%	9.7%	4.9%	42.7%
Slightly raised	2.9%	1.00%	2.91%	6.8%
Substantial risk (Clinical)	29.1%	6.8%	14.6%	50.5%
Grand Total	60.2%	17.5%	22.3%	100%

The fifth canary indicates

- Again if we took outcomes seriously
 - How much is the service system interested in symptom reduction, improved functioning and better quality of life?
 - Where is the leadership and policy positions on the relative priority given to
 - waiting lists,
 - full inpatient units,
 - emergency departments
 - and discharging clients in the face of continuing symptoms, burden and distress

The Sixth Canary

- Adult training
 - Study of assessment practices
- Qualitative approach
 - I use HONOS as the assessment template
 - But it doesn't cover all the important areas and that is a huge problem with it providing good assessment material
- The protocol is stupid
 - Discharge community intake inpatient discharge inpatient intake community etc

The sixth canary indicates

- Sometimes the problem of a tool indicates
 - Lack of an underlying framework
 - Inconsistency in approaches
 - Were these intended to replace assessments?
- The division of in-patient and community
 - A system unable to shift from the 19th century to a person oriented approach
 - The key distinction remains hospital location or not
 - Service providers concern highlights the conceptual concrete at a funding level

Conclusion...

- This is not to deny problems with ROM
- Many concerns are about the system of care
- ROM should chirp away
 - Providing information
 - Informing discussion
 - Supplementing relationships
 - Provoking questions
- But when it is too awkward, the wish for it to be absent, to be silent is dangerous