Reply to Noom and Van Balkom: Monitoring Treatment Results of Psychiatric Patients: Do Different Objectives Need Different Designs and Implementations?

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We thank both Noom and Van Balkom for their extensive comments on our paper. There are several points on which we can agree with Noom. A smart organization of data collection can help the therapist and may prevent the creation of a burden to some extent. Ideally, practitioners should experience ROM as a clinical task. Ideally, monitoring results should be presented in such a way that they can be easily interpreted as feedback on a treatment. However, it is the question how these ideals can be realized. In our view, none of these issues can be considered as existing conditions for ROM.

Noom seems to read our contribution as an appeal against ROM. We must stress that our arguments are for the use of differentiated ROM methodology for different objectives, most specifically different measurement instruments and adapting the frequency of measurement to the objective concerned. We argue that the different objectives of ROM have different aggregation levels, most clearly when objectives are as different as evaluation of an individual therapy and evaluation of different psychiatric institutions. A measurement that is applied to a large variety of patients can hardly have specific relevance for all patients. To use the metaphor of Noom: a specific blood test is not equally relevant for every patient in a hospital. The use of global instruments, such as the Honos, does not provide specific information that can be directly applied as feedback to continue, change or stop a treatment of a patient. In our view, the therapists learns too little when a patient diagnosed with schizophrenia has less “cognitive problems” a year later, as measured by the Honos. On the other hand, these scores can be useful to evaluate the progress in the long run of a large variety of patients. We stress that the clinical relevance of measurements should be considered most closely, to prevent that ROM becomes less useful and relevant for the practitioners that have to supply the data. We argue for the use of patient and therapy specific instruments when individual therapies are concerned and to restrict the use of more global indicators to evaluations in which a large variety of patients is involved.

We have used the perspective of a single ROM study, which started with various objectives in mind and which at the end could only be seen as partially successful for one of the objectives, that is, the evaluation of the department but not as a feedback instrument for therapist and patient. As we describe the shortcomings of this study in detail, it should be clear that in our opinion improvements are possible and necessary. In our view, these improvements cannot be realized without the practitioners.

The core of our disagreement with Noom is the specificity of measurements. He argues that measures should always be specific and should provide accurate information for patient and therapist. In psychiatric institutions, patients are most different from each other and evaluation over a large variety of patients cannot be too specific. Measurements that are most relevant for one patient are not relevant for others. For instance, specific information about obsessive-compulsive behaviour is not strikingly relevant for patients with a manic-depressive disorder and vice versa. When the evaluation objective concerns a large variety of patients, global measures are useful. At the same time, global measures often lack in clinical relevance and are not easy to use as a specific feedback tool in an individual therapy.

Noom argues that actual data collection should be done by test assistants and data should be collected through the patient as much as possible. Our paper discusses the specific situation of ROM of patients with a serious mental illness. Some of these patients have paranoid characteristics. Often, ambulant patients are not easy to reach and lack to cooperate. Therapist and patient often differ about the definition of the problem and necessary interventions. Motivational problems concern both treatment and data collection. In this context, the usefulness of an assistant is limited and a good therapeutic relationship is necessary, both for motivating treatment and data collection. Certainly, a smart organization of the logistic process would be helpful. We agree with Noom that this should be considered direct from the start. But we are afraid that Noom overestimates the beneficial results and even the possibility of obtaining measures outside the therapeutic relationship.

Van Balkom raises the question whether the use of more specific, personalised assessments would solve the implementation problem. He extends the problem to non-adherence of professionals to new guidelines, including the use of measurement instruments, and points to the fact that non-adherence of professionals appears to be the rule rather than the exception. He suggests that improving clinical relevance of measurement instruments may be insufficient and a broader and further reaching implementation plan may be needed.

Actually, we agree with that point of view. Lambert (2007) has also pointed to this more general problem: clinicians seldom see the value of frequent assessments based on standardized scales. In our paper, we have

used the perspective of the professional and only hinted at the additional motivational problems of the professionals.

ROM can have a positive impact on diagnosis and monitoring of treatment, and on communication between patient and therapist. Specifically, ROM appears beneficial for patients who are not doing well in therapy (Carlier et al., 2012). But, contrary to their expectations, De Jong, van Sluis, Nugter, Heiser, & Spinhoven (2012) found no beneficial effect of feedback and there was no significant interaction between feedback and patients being not on track. Therapists who are more likely to trust their own opinion had patients with a slower rate of change than other therapists, whereas therapists who were more committed to use the feedback at the beginning of the study had patients who progressed faster. These results indicate that the attitudes of professionals play an important role.

When applying routine outcome monitoring, practitioners should feel confident when using measurements and should be able to educate patients about the relevance of the measurement as part of their treatment. Training to familiarize health care providers with the application of measurements may be part of an extended ROM implementation plan. In that respect, organizing team meetings may be helpful, as well as developing training aids and providing instruction material for patients. As ROM is there for the long run, it may be necessary to check repeatedly whether the implementation of ROM still works sufficiently or should be improved. However, we cannot see how this all can be accomplished when the measurements are not evidently useful for the practitioners and their patients.

Increasing the clinical relevance of measurements instruments so that they can be used more easily for evaluation within individual therapies is a starting point and not a complete solution. Too often, professionals consider the use of measurement instruments often as superfluous and inferior to their own clinical judgements. They overestimate their own objectivity and, in the long run, may overlook the adaptation of standards. The implementation of ROM and measurement instruments should be considered as an intervention on its own. When implementing ROM, the opinions of the professionals should be considered most closely, as they cannot be missed in the data collection process. Ensuring clinical relevance is a starting point, not a final solution. As ROM should be considered in the long run, continuous monitoring of the role of professionals for obtaining measurements is a necessary part of the process. Both usefulness and burden should be considered repeatedly and necessary improvements should be implemented with some urgency.

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