



A call for routine outcome monitoring in Iran

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Assessment is a crucial part of randomized clinical trials (RCTs) that give us evidences for decision making in clinical evidence-based practice. However, the process of evaluation does not end with results of a trial. Clinicians should use similar assessments to evaluate treatment modalities and to improve the quality of the care in routine practice. There has been a growing notice for feedback systems similar to assessment technology developed for RCTs. Such a system should not only evaluate the patient at the end of treatment, but also provide information on severity of pathology prior to treatment, as well as feedback on progress made in treatment.¹ Evaluations can involve both symptoms and (social) functioning.

Routine outcome monitoring (ROM) refers to the assessment of treatment outcome at regular intervals, setting up a feedback loop to improve the clinical process. A comprehensive ROM-assessment can be successful in several domains² and should meet the following criteria. The very first aim is to be positively effective in (i) clinical process by continually optimizing treatment decisions using repeated assessments. This feedback system can give accurate information about treatment progress¹ by systematic evaluation of patients' response during the treatment. Most importantly, it can pick up signals to identify patients that do not show a favorable response.³ This regular feedback could also improve the quality of

practice by professionals.⁴

From a (ii) managerial perspective, a comprehensive ROM provides an orderly appraisal for all patients receiving the care and yielding valuable information for managers to optimize strategic choices.⁵ Data are gathered by standard assessment tools which will be available for both professionals and patients to improve transparency and generate information for external (iii) accountability for parties, such as insurance companies and policy makers. An inclusive ROM takes account of all eligible patients and uses valid and proper instruments. ROM-data can add value to care-consumption data by giving insight in who is profiting from the care provided and who is not.² Finally, a good ROM should contribute to (iv) research by providing naturalistic "real-world" data about disorders, needs of care, and outcome.⁶

Hurdles are to be expected in the implementation of ROM. Standard tools leave little room for personal treatment aims. Monitoring and comprehensive assessment can be time consuming and very costly. The referral process -where patients are referred back and forth between primary, secondary, and tertiary care centers- challenges the continuity of the monitoring system; especially for those care systems that advocate general practitioners to provide low intensity care to eligible patients. Confidentiality might also be an issue. Clinician may criticize the

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process of ROM as a burden for patients.

In the field of somatic diseases like diabetes, there have been long standing monitoring initiatives such as Mayo Clinic Health System, which have shaped the daily clinical practice.⁷ For psychiatry, ROM has been implemented in several countries, but not all of them could overcome these difficulties. Pharmacotherapy Monitoring and Outcome Survey (PHAMOUS) is a good example of ROM that was started in 2006 to improve the quality of care for patients with psychotic disorders in the Northern Netherlands.⁸ PHAMOUS is focusing on disease management aiming to improve care for this vulnerable patient group. It has a secured ROM position in clinical practice ever since and supports the primary process of decision making.^{9,10} It provides useful

information for both healthcare planning and economics and has built a robust infrastructure for of research projects with different approaches. Similar projects are also successful for patients with anxiety and depression (De Beurs or Leiden).

Iran has already built an extensive health care network with several achievements, such as integration of mental health into the primary health care system.¹¹ This structure makes Iran a good candidate for successfully implementing ROM. Recently, an initiative started in East Azerbaijan province entitled Azeri Recent onset and Acute phase psychosis Survey (ARAS). This will be the first study in Iran using ROM structure. This approach can also be valuable for other diseases, outside psychiatry. Hopefully, such research efforts will have additive value to clinical practice.

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References

1. de Beurs E, den Hollander-Gijsman ME, van Rood YR, van der Wee NJ, Giltay EJ, van Noorden MS, et al. Routine outcome monitoring in the Netherlands: Practical experiences with a web-based strategy for the assessment of treatment outcome in clinical practice. *Clin Psychol Psychother* 2011; 18(1): 1-12. DOI: 10.1002/cpp.696
2. Delespaul PA. Routine outcome measurement in the Netherlands - A focus on benchmarking. *Int Rev Psychiatry* 2015; 27(4): 320-8. DOI: 10.3109/09540261.2015.1045408
3. Harmon C, Hawkins EJ, Lambert MJ, Slade K, Whipple JS. Improving outcomes for poorly responding clients: the use of clinical support tools and feedback to clients. *J Clin Psychol* 2005; 61(2): 175-85. DOI: 10.1002/jclp.20109
4. Jamtvedt G, Young JM, Kristoffersen DT, Thomson O'Brien MA, Oxman AD. Audit and feedback: effects on professional practice and health care outcomes. *Cochrane Database Syst Rev* 2003; (3): CD000259. DOI: 10.1002/14651858.CD000259
5. Knaup C, Koesters M, Schoefer D, Becker T, Puschner B. Effect of feedback of treatment outcome in specialist mental healthcare: meta-analysis. *Br J Psychiatry* 2009; 195(1): 15-22. DOI: 10.1192/bjp.bp.108.053967
6. van Noorden MS, Giltay EJ, den Hollander-Gijsman ME, van der Wee NJ, van Veen T, Zitman FG. Gender differences in clinical characteristics in a naturalistic sample of depressive outpatients: The Leiden Routine Outcome Monitoring Study. *J Affect Disord* 2010; 125(1-3): 116-23. DOI: 10.1016/j.jad.2009.12.007
7. Rady MY, Johnson DJ, Patel BM, Larson JS, Helmers RA. Influence of individual characteristics on outcome of glycemic control in intensive care unit patients with or without diabetes mellitus. *Mayo Clin Proc* 2005; 80(12): 1558-67. DOI: 10.4065/80.12.1558
8. Bartels-Velthuis AA, Visser E, Arends J, Pijnenborg GHM, Wunderink L, Jorg F, et al. Towards a comprehensive routine outcome monitoring program for people with psychotic disorders: The Pharmacotherapy Monitoring and Outcome Survey (PHAMOUS). *Schizophrenia Research* 2017. [Submitted].
9. Tasma M, Liemburg EJ, Kneegtering H, Delespaul PAEG, Boonstra A, Castelein S. Exploring the use of Routine Outcome Monitoring in the treatment of patients with a psychotic disorder. *Eur Psychiatry* 2017; 42: 89-94. DOI: 10.1016/j.eurpsy.2016.12.008 [doi]
10. Tasma M, Swart M, Wolters G, Liemburg E, Bruggeman R, Kneegtering H, et al. Do routine outcome monitoring results translate to clinical practice? A cross-sectional study in patients with a psychotic disorder. *BMC Psychiatry* 2016; 16: 107. DOI: 10.1186/s12888-016-0817-6
11. Yasamy MT, Shahmohammadi D, Bagheri Yazdi SA, Layeghi H, Bolhari J, Razzaghi EM, et al. Mental health in the Islamic Republic of Iran: Achievements and areas of need. *East Mediterr Health J* 2001; 7(3): 381-91.