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The Use of Routine Outcome Monitoring (ROM) Among the Psychotherapists of the Italian National Health Service

Jessica Lampis¹  | Guido Rocca²

¹Department of Pedagogy, Psychology, Philosophy, University of Cagliari, Cagliari, Italy | ²Italian National Health System, Cagliari, Italy

Correspondence: Jessica Lampis (jlampis@unica.it)

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ABSTRACT

Routine outcome monitoring (ROM) is one of the most important methodologies for evaluating client progress and improving the efficiency and quality of psychological assistance. Despite this, the culture of ROM use is struggling to establish itself in the Italian National Health System, shaping up as a sporadic and unevenly used practice. The main objective of the present study was to assess the frequency of use of different outcome monitoring measures and the attitudes toward ROM within psychological services of the Italian National Health System. The study involved 184 psychotherapist (75% female and 25% male) employed in the Italian Health System structures. Participants completed an anonymous questionnaire composed by *Outcome monitoring use* and *Attitudes to ROM*. The data reveal a general low-frequency in ROM use, with the exception of the symptom monitoring measures. In our sample, the variables that significantly affect the level of ROM use are psychological capability and physical and social opportunity. The present study provides some empirical evidence to reflect on the importance of increasing the use of ROM within psychological services and to promote interventions to improve clinicians' positive attitudes toward ROM.

1 | Introduction

Routine outcome measurement (also called outcome measurement) involves the measurement of clinically relevant indicators (severity of symptoms, functioning, etc.) at the beginning and end of treatment. This method is typically characterised by low-frequency measurements, with the main objective of evaluating the overall results of a service.

Routine outcome monitoring involves measuring clinically relevant indicators at frequent intervals throughout the course of treatment. It is characterised by frequent assessments, such as session-by-session measurements or at less frequent fixed intervals (Mütze et al. 2021). The goal is generally to use these measurements to inform treatment and aid clinical decision-making.

ROM and feedback is when outcome monitoring is integrated with messages to the therapist and/or patient to aid in clinical decision-making. Feedback helps therapists make informed decisions about treatment progress. More advanced feedback systems use statistical prediction models to compare a patient's treatment progress with data from previous patients.

The statement 'the use of routine outcome monitoring (ROM) represents the most significant advance in psychotherapy in the last 25 years' (Wampold 2015) is strongly supported by a substantial body of scientific evidence. Some authors include the monitoring of routine results among the methods that are effective in psychotherapy, listing it among the 13 demonstrably effective methods at the distal end of treatment (Hill and Norcross 2023). Among the most important factors, it is noted that the use of progress and outcome monitoring measures as a feedback tool improves the rate

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Summary

- Despite international literature strongly documenting the importance of routine outcome monitoring (ROM) in measuring client progress and improving the efficiency and quality of psychological assistance, this methodology continues to be poorly used in public health services.
- This study analysed the frequency of use of different outcome monitoring measures within the psychological services of the Italian Health System and assessed attitudes toward ROM.
- Recommendations for practice include the need to implement frequency in the use of ROM among psychologists working in the Italian National Health System through interventions aimed at improving levels of psychological capacity, motivation and physical and social opportunities.

of clinically significant change (CSC) of psychological treatment (Anker, Duncan, and Sparks 2009; Kraus et al. 2011). Equally important is the decrease in the risk of deterioration and drop-out (Shimokawa, Lambert, and Smart 2010).

When discussing ROM and feedback and its impact on outcomes, it is essential to also consider other significant variables involved in therapy, such as patient and therapist characteristics. de Jong et al. (2012) were among the first to study the relationship between feedback and therapist characteristics, demonstrating that NOT (Not on Track) patients had lower rates of change when their therapists relied on internal feedback rather than external feedback. When feedback was provided, patients of therapists with high self-efficacy improved more quickly. It thus emerged that outcomes were determined by a complex combination of patient characteristics, therapist characteristics and the use or nonuse of feedback. However, Bovendeerd et al. (2023) found no significant effects of therapist characteristics on outcomes. Nevertheless, it has been observed that therapists' high perceived validity of feedback significantly influences its use: the higher the perceived validity, the more likely therapists are to use it.

Recent research continues to confirm the importance of implementing this methodology in clinical practice (Barkham et al. 2023; Evans and Carlyle 2021; de Jong, Delgadillo, and Barkham 2023; Lutz et al. 2021). Of course, the research also highlights the limitations and necessary precautions in interpreting outcome data, noting discrepancies between outcomes assessed with symptom measures and other sources, known as paradoxical outcomes (Stänicke and McLeod 2021). Integrating ROM with other measurement tools, including idiographic, consensus-objective and alliance tools, allows for a better understanding of the actual results produced by psychological treatment (McLeod et al. 2024).

Another fundamental opportunity provided by ROM is the collection of data to document the effectiveness of the treatments provided. Many NHS services in the UK have had ROM-based activity assessments in place for some time, although some studies (Bruun 2023; Scott 2021; Martin et al. 2022) highlight doubts about the real consistency of the results obtained with

improving the project, access to psychological therapies. This need to collect outcome data routinely also concerns the Italian National Health Service, which, through the Essential Levels of Assistance (LEA) (Decreto del Presidente del Consiglio dei Ministri 2017), reiterates the indispensable use of care methods based on evidence and guided by adequacy criteria. The assessment can be carried out using measurement tools aimed at patients of different age groups and data collection systems disseminated free of charge internationally and translated into multiple languages, including Italian (Rocca and Carta 2017; Rocca 2018; Rocca and Piroddi 2019).

1.1 | The use of the ROM in Italy

Since 2010, the Italian Ministry of Health has established the National Outcomes Program (PNE) with the aim of systematically monitoring the outcomes of the NHS through 45 indicators (32 on performance and 13 on efficiency) of hospital and local services. However, none of these indicators pertain psychological interventions, other than quantifying how many psychotherapy sessions for how many patients.

Consequently, when outcome data are collected, the monitoring of intervention progress relies solely on the rare initiative of some psychology service directors attempting to use the data to improve assistance.

When discussing routine outcome measurement and monitoring of psychological treatments in the Italian NHS, the reference is to the pioneering activity of Francesco Reitano, at the Psychology Operative Unit n. 2 of the Provincial Health Services of Trento (Reitano 2002; Reitano and Soldà 2004). Reitano was, in fact, among the first Italian psychologists to propose the implementation of ROM in a public health service, collecting large quantities of data and engaging in the dissemination of procedures through which to introduce this method into psychology services. Starting from this experience, in 2005, Reitano coordinated, through the Italian Society of Psychology of Hospital and Territorial Services (SIPSOT), the first network of Italian psychology services, for the collection of outcome data on a national scale through the Italian version of the CORE-OM (Palmieri et al. 2009), one of the currently most widespread measurement tools in the panorama of Italian services. This work laid the foundation for the first research network among Italian psychology services, coordinated by SIPSOT, whose data were collected and processed (Rocca 2020) through the platform of the VETraPNetworK Project (Rocca and Carta 2007).

Despite the tools and their large-scale use within psychological services for years (Barkham et al. 1998), the diffusion of routine outcome monitoring (ROM) within the Italian NHS remains slow and uneven. Despite a culture favourable to the scientific method, a literate population and the ability to transmit information at unimaginable speeds, it can take up to two decades before new discoveries are integrated into clinical practice (Brownson et al. 2006).

The Report of the Task Force on monitoring outcomes and progress in psychotherapy of the Canadian Psychological Association (Tasca et al. 2019) highlighted how, despite the

ethical obligations to apply evidence-based procedures, most psychotherapists currently do not assess patient progress or outcomes (e.g., only 12% of Canadian psychologists use monitoring measures) (Ionita and Fitzpatrick 2014). This phenomenon is also present in Italy, making it essential to identify and address the reasons that hinder the development of clinical environments and the organisation of services.

Since the very beginning of ROM dissemination, much research has focused on the obstacles faced in the routine assessment of outcomes. Hatfield and Ogles (2004, 2007) identified various variables, classified as ‘practical’ and ‘philosophical’, that could fuel the resistance of clinicians toward ROM. The same authors also highlighted some possible strategies that could have facilitated the overcoming of some obstacles. They also proposed strategies to overcome these obstacles. Among these, it was crucial to make outcome evaluation user-friendly through specific tools and software. Equally important was the dissemination of the value of routine data collection, both process and outcome, highlighting their use for case formulation and treatment planning (Castonguay et al. 2010).

Another objective was to improve clinicians’ knowledge of the tools and to reassure them regarding the use of data in a manner that respects privacy.

One of the most widespread objections among clinicians is that ROM could interfere with the therapeutic alliance. However, there are no studies supporting this concern. On the contrary, Youn, Kraus, and Castonguay (2012) suggest that well-implemented outcome procedures are welcomed by clients and can actually enhance the therapeutic alliance. Detecting and communicating even slight improvements can reassure sceptical patients about the treatment and strengthen the therapeutic alliance (Youn, Kraus, and Castonguay 2012).

Additionally, research aimed at identifying ROM training processes that enhance clinicians’ perception of self-efficacy is a particularly interesting area of study (Edbrooke-Childs, Wolpert, and Deighton 2016).

1.2 | The Organisation of Psychology in the Italian NHS: The Psychology Services

In 1978, when the National Health Service (SSN) was established in Italy, territorial service teams often included only one psychologist and were usually managed by a medical manager. In recent years, different forms of organisation of services providing psychological services have begun to take hold in the SSN. This change has been driven by an ever-increasing demand for specialised psychological services and a greater sensitivity of patients and institutions toward psychological health needs. There are approximately 5000 psychologists working in the National Health Service (20% men, 80% women). Less than 30% work in hospitals, while the remaining 70% are in local services (Ministry of Health 2021). The average age of these psychologists is 53.2 years, with an average of 19.4 years of work experience. The number of psychologists in the NHS is seriously undersised compared to the standards established by Italian law.

Moreover, Italy has a highly developed national law recognising citizens’ right to health. It guarantees basic health care—‘Essential Levels of Care’ (LEA, DPCM 12.1.2017)—and acknowledges psychology’s fundamental role in various life stages (minors, adults and families), contexts (outpatient, consultatory, hospital, hospice and home) and service types (individual, couple, family and group). These principles highlight the significant clinical role of psychological services, emphasising the need for psychological interventions to cover prevention, treatment and rehabilitation functions across different healthcare contexts (hospitals and local health services). This should correspond to a unified hierarchical organisation for the different functions (Psychology Operational Unit) rather than being fragmented across various individual services.

However, unlike the United Kingdom, where the IAPT project proposed and implemented a uniform organisational model at the national level, in Italy, psychology services within its NHS have developed very heterogeneously across different geographical areas. In some regions, comprehensive services have existed for years, while in others, they are only partially available or have never been activated. The lack of a uniform model of management results in varied care procedures and different systems of recording data on performance. This deficiency therefore makes benchmarking impossible, seriously hindering the revision of organisational care criteria.

The advancement of evidence-based psychology has enabled numerous demonstrations of the effectiveness of psychological treatments to be included in a growing number of guidelines, recommendations and best practices. This process has been facilitated by the increased dissemination of practice-based evidence research methodologies in psychology services, introducing the routine assessment of psychological treatment outcomes in many operational settings. A culture of outcome assessment is slowly spreading as a fundamental tool for defining of care planning guidelines.

Indeed, the prime objective of any National Health Service is to evaluate the appropriateness of the services provided, the efficiency of resource management and the verification of equity in access to services. All these variables require constant monitoring of care activities through the use of appropriate measurement systems and procedures and a psychological organisation capable of implementing these procedures uniformly. The ‘matrix’ model (Table 1) represents the best form of integration between the management of the clinical function and that of professional resources. Each psychology service is in charge of managing all psychologists in each health company, in integration with other territorial and hospital health services through formal operational protocols across different areas of care.

1.3 | The Present Study

There is a paucity in studies conducted in Italy on routine outcome monitoring (ROM), and to the best of our knowledge, there is no published study surveying the frequency and attitude with respect to the use of ROM among the psychotherapists in the Italian NHS.

TABLE 1 | Psychological activities/health services integration matrix.

Main activity	Territorial services					Hospital services					
	Prevention	Maternal and infant area	Mental health services	Family counselling services	Addiction Services	Primary care/home care	Medicine area	Critical area	Surgical area	Emergency and Urgency	Office/staff management
Prevention	•	•	•	•	•	•	•	•	•	•	•
Psychodiagnosis (psychological evaluation)		•	•	•	•	•	•	•	•	•	•
Psychological support		•	•	•	•	•	•	•	•	•	•
Habilitation and rehabilitation		•	•	•	•	•	•	•	•	•	•
Psychotherapy		•	•	•	•	•	•	•	•	•	•
Psychological counselling	•	•	•	•	•	•	•	•	•	•	•
Psychology of organisations	•										
Training	•	•	•	•	•	•	•	•	•	•	•
Research	•	•	•	•	•	•	•	•	•	•	•
Quality	•										

Note: The sign (•) indicates the intersections between the main psychological activities provided in the NHS and the care functions of the various health services. The sign (§) indicates brief and/or focal psychotherapies provided in a hospital setting in continuity and connection with outpatient care. The organisational-training-quality activities are clearly transversal and involve all health services. The table highlights the specific competence of the Psychology Operational Unit in supporting programmes and interventions with high integration between the different healthcare functions. Guidelines for the psychological assistance provided by the complex organisational structures of psychology, territorial and hospital, of the NHS' revision 2009 (first draft 2003) by the Italian Society of Psychology of Hospital and Territorial Services (SIPST) in collaboration with the National ANCI Federsanita Bureau.

Our study represents a first step in bridging this gap, considering the use of ROM within the context of the public psychological services. Our main objective was to conduct an exploratory survey of the frequency of use of different outcome monitoring measures within the psychological services and to assess attitudes toward ROM. To achieve this objective, we specifically referenced a study conducted by Bear et al. (2021) and decided to consider the dimensions of the Capability, Opportunity and Behaviour Motivation Model (COM-B; Michie, van Stralen, and West 2011). The model is a useful reference for rigorously identifying the dimensions needed for service implementation and intervention design (Eccles et al. 2005; Nilsen 2015) and is a useful framework for mapping operational and attitude-related factors and how they can act as barriers and facilitators of ROM.

The COM-B model posits that any behaviour (B) is comprised of three essential components: Capability (C), Opportunity (O) and Motivation (M). For an individual to perform a specific behaviour, they must perceive themselves as both psychologically and physically capable (C), have access to the necessary social and physical resources (O) and possess a stronger desire or need to engage in that behaviour compared to alternative actions (M). Since these components interact dynamically, interventions must address one or more of these elements to achieve and sustain effective behavioural change. All three components influence behavioural change and are, in turn, influenced by it. For instance, targeting the opportunity component could encourage a psychotherapist who does not use ROMs to adopt them, perhaps by providing specific training within their service. If this therapist initially doubts their ability to use ROMs (capability) but participates in training programmes alongside colleagues, this could enhance their confidence and motivation. This suggests that the model operates interactively, implying that behavioural changes also impact the determinants of behaviour, thereby facilitating long-term modification. According to the model, modifying one or more of its components is essential for facilitating effective and enduring behavioural change. By improving perceived capabilities and opportunities, an individual's motivation to perform a specific behaviour can be influenced, promoting behavioural change. If these modifications are substantial, they will affect the determinants of behaviour, leading the individual to favour the new behaviour over competing alternatives, thus reinforcing long-term change. The COM-B model is central to the Behaviour Change Wheel (BCW)—a framework designed for developing behavioural change interventions. Behavioural objectives can be identified as a basis for interventions aimed at altering behaviour, such as implementing new practices or modifying existing ones (Atkins et al. 2017). Utilising the COM-B model to assess barriers and facilitators to ROM use provides a comprehensive and implementation-oriented framework for their adoption (Bear et al. 2021).

This is the first study conducted in Italy on these topics, and it has an eminently exploratory nature. Our aim is to capture a snapshot of a relatively new reality within the Italian National Health Service service. Our initial objective was to understand how often psychotherapists in the Italian NHS use routine outcome measures (ROMs) as part of their work. We then analysed the differences in ROM usage with respect to various socio-demographic variables such as age, gender, and the type

of service in which participants work. Finally, we examined the relationships between attitudes toward ROM use and the frequency of employing routine outcome and feedback monitoring in psychotherapists' work.

Referring to the results of Bear et al. (2021), we expected a positive correlation between the frequency of using outcome monitoring measures and various dimensions of attitudes toward ROMs (psychological capabilities, physical and social opportunities and motivation).

2 | Method

2.1 | Procedure

The study was conducted online via a survey distributed to consenting adults working as psychotherapists in the Italian Public Psychological Services. Data were collected through secure Google survey models, complemented by online advertisements sent by the authors via email and messages to the Italian Society of Psychology of Hospital and Territorial Services (SIPSOT) and Italian professional orders. SIPSOT is the only scientific society composed of psychologists (approximately 2.300 members) working in the National Health Service (SSN), both in hospital and territorial settings (recognised by Law 24/2017). Members were engaged through a link distributed via newsletter, which included the addresses of SSN psychology services. Additionally, the regional orders (21 across Italy) were involved by placing a link on their homepage. It was not possible to obtain the number of accesses to the link.

Organisations were asked to send the link to the questionnaire to their members. Thus, the study utilised a 'snowball' sampling method to recruit participants. Respondents provided consent to participate on the first page of the survey instrument. Participation was voluntary, and the information provided was anonymous and confidential. Participants provided digitally signed informed consent prior to the study.

The study observed all appropriate ethical guidelines and received approval to conduct the study from the institutional ethics board of the Department of Psychology at the first author's institution.

2.2 | Participants

A total of 207 questionnaires were collected; however, 23 were excluded due to missing socio-demographic information. The final sample comprised 184 psychotherapists (in the Italian Health System; psychotherapeutic treatments can only be provided by psychologists who specialise in psychotherapy), with 75% female and 25% male. The profession of psychologist and the practice of psychotherapy in Italy have been regulated since 1989 by law no. 56. The profession of psychologist is carried out after a 5-year degree course, 1 year of compulsory professional training and a qualification exam. The practice of psychotherapy is reserved for psychologists and physicians who have acquired the specialisation through accredited courses lasting at least 4 years. The contracts of the Italian NHS provide that only

psychologists are hired to provide psychological treatments and psychotherapy.

The participants' ages ranged from 29 to 68 years ($M = 49.98$ years).

Regarding the level of education, 3.3% held master's degrees, PhD degrees and clinical specialisation, while 93.7% held master's degrees and clinical specialisation. Geographically, more than half (54.9%) worked in northern Italy, 20.1% in central Italy and the remaining 25% in southern Italy, including the two major islands, Sicily and Sardinia. About 22.8% of psychotherapists worked in hospital services, while 77.2% were employed in community-based services. Of the total, 61.4% worked in psychology services (either hospital or community-based), while the remaining 39.6% were employed in other types of services. In terms of work seniority, 27.7% had been working for more than 30 years ($M = 34$ years), 39.1% had been working for between 16 and 29 years ($M = 22.5$ years) and 33.2% had been working for between 4 and 15 years ($M = 9.5$ years).

2.3 | Instruments

Individual and Demographic Characteristics. Participants were asked specific questions about their demographic and personal characteristics, including gender, age, professional role and occupational seniority.

Outcome Monitoring Use (Bear et al. 2021). Participants were asked questions relating to their outcome monitoring use (e.g., 'How often do you use outcome and feedback measures as part of your work?'). Responses were rated on a 3-point Likert scale (0 = never, 1 = sometimes, 2 = always).

Respondents were asked about the type of measures they used (General Coverage Measures, Symptom/Disorder-Specific Measures, Measures of Goals and Measures developed locally) and the metrics used to interpret the scores (Comparison with Normative Data, CSC and Reliable and Clinically Significant Change [RSCS]).

General Coverage Measures. This aims to encompass a broad spectrum of changes occurring in therapy, such as quality of life or well-being assessments.

Symptom/Disorder-Specific Measures. These are unidimensional, focusing on symptomatic areas such as anxiety or depression, or on other specific aspects not necessarily linked to a diagnosis, such as self-esteem or functioning in relationships.

Measures of Goals. Personalised goal setting, collaboratively agreed upon with professionals, is a key component of mental health work (Bickman et al. 2011; Bickman, Lyon, and Wolpert 2016; Carlier et al. 2012; Knaup et al. 2009). Goal tracking, alongside other outcome measures, aids in monitoring progress, while explicit goal setting motivates and engages service users, making them feel more involved in discussions about their care (Wolpert et al. 2014).

Locally Developed Measures. These measures may be employed when no existing measure adequately fits the evaluation needs,

such as when addressing very specific problems within a particular service. Although these measures can be useful, they often complicate comparisons with other services due to deviations from standard core outcome batteries used routinely in service settings. Criteria of generalizability, usability, language and psychometrics (GULP) should still be met.

Comparison with Normative Data. This involves data on the distribution of both clinical and nonclinical populations, not merely means and variances. A sample distribution wide enough to accurately reflect the non-Gaussian distribution is necessary, illustrating how rare high scores are in nonclinical samples and how rare low scores are in clinical samples.

CSC. This refers to a shift that moves an individual from a score indicative of a problematic or dysfunctional state to a score typical of the 'normal' population (Jacobson, Follette, and Revenstorf 1984; Christensen and Mendoza 1986; Jacobson and Truax 1991).

RCSC. This metric integrates CSC with reliable change (RC), which evaluates whether changes are unlikely due to measurement unreliability (Jacobson and Truax 1991; Evans, Margison, and Barkham 1998). Beyond achieving reliable and clinically significant improvements (RCSC), Jacobson's method permits a more detailed analysis of outcomes. It can identify patients who have improved in a clinically significant but unreliable manner, as well as those who have improved reliably but not significantly. Reliable detection of deterioration is also crucial.

Attitudes to ROM (Bear et al. 2021). Items were developed using the COM-B Model as the underlying framework. The content was based on the theoretical and empirical literature related to the implementation of ROM, as well as the experiences and learning of mental health services shared at Child Outcomes Research Consortium (CORC) workshops and learning events. Each item mapped on to one of the 'sources of behaviour' outlined in the COM-B Model (Michie, van Stralen, and West 2011). Subscale domains were psychological capability, opportunity (social/physical) and motivation.

Psychological capability refers to the possession of the knowledge, skills and abilities needed to enact a given behaviour (e.g., 'How well do you feel able to decide when outcome and feedback measures are appropriate to use and when they are not?'). *Opportunity* refers to external factors that make it possible to perform a given behaviour. It is divided into physical opportunity (opportunities provided by the environment such as time, place and resources) (e.g., 'How easy is it to access outcome and feedback measures in sessions with service users?') and social opportunity (opportunities provided by social factors such as cultural norms and social factors) (e.g., 'Analysed outcome and feedback data are shared with staff in an effective way'). *Motivation* refers to the internal processes that influence our decision-making and behaviours (e.g., 'Outcome and feedback measures help me decide when a different approach or professional is needed').

Items were rated on 4-point (psychological capability and physical opportunity scales) and 5-point (social opportunity and motivation scales) Likert scales, where higher scale scores

indicated more positive attitudes. The different dimensions were evaluated by averaging the sum of the items on each scale. The Italian version of the questionnaire was developed via back-translation procedures (Sousa and Rojjanasrirat 2011) to ensure semantic equivalence between the Italian and English versions. Initially, two experts fluent in English independently translated the questionnaire from English into Italian. The researchers then compared these forward translations with the original scale and reconciled any discrepancies. In the third step, the reconciled version of the questionnaire was back-translated into English by a bilingual researcher with expertise in ROM. Finally, the two English versions were compared to determine whether there were any differences in meaning and conceptual coherence between the English and Italian versions. Any identified differences were corrected. This process ensured both conceptual and linguistic equivalence (see Supporting Information S1 for the final version of the Italian translation and its English counterpart). The original version of the questionnaire (Bear et al. 2021) scales showed acceptable internal consistency: psychological capability (six items, $\alpha=0.88$), physical opportunity (three items, $\alpha=0.71$), social opportunity (five items, $\alpha=0.85$) and motivation (10 items, $\alpha=0.87$).

In the present sample, the internal consistency was $\alpha=0.90$ for the psychological capability score, $\alpha=0.73$ for the physical opportunity score, $\alpha=0.91$ for the social opportunity score and $\alpha=0.87$ for the motivation score (see Table 2 for descriptives).

2.4 | Data Analyses

Statistical analyses were performed using SPSS 20.

First, a frequency analysis was performed to determine the prevalence of outcome monitoring indicators used within psychology services among the sample. Next, chi-square analyses were conducted to assess whether the frequencies of usage levels (0 = never, 1 = sometimes, 2 = frequently) differed significantly for each outcome measure.

Chi-square analysis also used to explore whether the frequencies of usage levels of outcome measures differed significantly across various demographic variables, including age groups (1 = under 40, 2 = 41–53, 3 = over 53), gender groups (1 = male, 2 = female), occupational seniority groups (1 = over 30 years, 2 = between 16 and 29 years, 3 = between 4 and 15 years) and types of service settings (1 = hospital, 2 = territorial; 1 = unit embedded in a psychology service, 2 = unit not embedded in a psychology service).

TABLE 2 | Descriptives ($n = 184$).

	Min.	Max.	Mean	S.D.
Psychological capability	5	20	13.16	3.39
Physical opportunity	3	12	6.86	2.11
Social opportunity	5	25	13.8	4.95
Motivation	18	50	37.1	5.67

TABLE 3 | Frequencies (%) in using outcome measures ($n = 184$).

	General coverage measures	Symptom/disorder specific measures	Measures of goals	Measures developed locally	Comparison with normative data	Clinically significant change (CSC)	Reliable and clinically significant change (RCSC)
Never	46 (41.3%)	47 (25.5%)	132 (71.7%)	112 (60.9%)	83 (45.1%)	50 (27.2%)	115 (62.5%)
Sometimes	44 (23.9%)	86 (46.7%)	39 (21.2%)	49 (26.6%)	57 (31.0%)	73 (39.7%)	44 (23.9%)
Frequently	64 (34.8%)	51 (27.7%)	13 (7.1%)	23 (12.5%)	44 (23.9%)	61 (33.2%)	25 (13.6%)
χ^2 test	$(\chi^2 = 8.52, df = 2, p < 0.01)$	$(\chi^2 = 15.0, df = 2, p < 0.001)$	$(\chi^2 = 128, df = 2, p < 0.001)$	$(\chi^2 = 68.3, df = 2, p < 0.001)$	$(\chi^2 = 12.9, df = 2, p < 0.01)$	$(\chi^2 = 4.32, df = 2, p < 0.05)$	$(\chi^2 = 73.4, df = 2, p < 0.001)$

Pearson's product-moment correlation coefficients were employed to analyse the relationships between attitudes toward ROM (encompassing psychological capability, physical opportunity, social opportunity and motivation) and the actual use of outcome measures in clinical practice (0 = never, 1 = sometimes, 2 = always).

3 | Results

3.1 | The Use of Routine Outcome Monitoring

The frequency analysis and chi-square results indicate that the use of routine outcome measures (ROM) is generally limited. Certain measures, such as Measures of Goals and Measures Developed Locally, are particularly underutilised, while others, including, General Coverage Measures and Symptom/Disorder Specific Measures, are more commonly used. Chi-square results revealed that the frequencies of usage levels for each outcome measure differed significantly. Detailed findings are summarised in Table 3.

In our sample, 59% of respondents reported using General Coverage Measures ('sometimes' = 24%, 'frequently' = 35%). This suggests a developing culture of comparability in outcome data between health services and psychotherapy research (Froyd, Lambert, and Froyd 1996; Barkham et al. 1998). Nevertheless, the fact that 41% of respondents never use these tools indicates a need for increased awareness and training on this methodology among NHS psychologists.

The use of symptom/disorder-specific measures is notably higher ('sometimes' = 47%; 'frequently' = 28%). This suggests a common practice of combining these measures with general ones, reflecting a focus on specific problems that may be challenging to compare across services. The frequent use of these specific measures highlights the challenge of standardising outcome data collection for specific issues.

Measures of Goals were identified as the least utilised tool in our sample, with 72% of participants reporting they never use them and only 7% using them frequently. This finding is significant because personalised goal setting is a crucial component of effective mental health work (Bickman et al. 2011; Bickman, Lyon, and Wolpert 2016; Carlier et al. 2012; Knaup et al. 2009). Goal tracking, along with other outcome measures, helps monitor progress, while explicit goal setting can motivate and engage service users (Wolpert et al. 2014). However, limitations in involving clients in treatment, especially those with severe mental disorders, may impact the practical application of goal setting (Hamann et al. 2009; Seale et al. 2006). It remains unclear whether the 72% of participants who never use goal measures do so due to clinical or operational reasons or due to a lack of awareness of the benefits these tools offer.

Similarly, measures developed locally are infrequently used, with 61% of respondents reporting they do not use such tools. This could indicate an awareness of the challenges these measures pose in comparing outcome data across different health-care contexts.

Approximately 45% of participants reported never using Measures of Comparison with Normative Data, although 31% use them 'sometimes' and 24% 'frequently'. The fact that nearly half of the participants do not use these measures is concerning, as it suggests that many may be using tools lacking robust measurement standards (Barkham et al. 1998). Alternatively, this may reflect a reliance on idiographic measures without normative reference values.

CSC is reported to be relatively common, with 73% of participants using it ('sometimes' = 40%; 'frequently' = 33%). However, its application is not yet universal as a fundamental parameter in evaluating treatment outcomes.

Finally, RCSC is among the least frequently used measures, with 63% of clinicians reporting they 'never' use it and only 13.6% using it 'frequently'. This suggests a significant gap in skills and a lack of appreciation for these tools in evaluating the effectiveness and limitations of psychological services provided by the NHS.

3.2 | Frequencies of Levels of Use of Outcome Measures Respect to Age, Gender, Occupational Seniority and the Kind of Service in Which One Works

A chi-square analysis was also conducted to explore whether the frequencies of levels of use of outcome measures significantly differ with respect to age, gender, professional seniority and the type of service. This analysis revealed several significant findings. Table 4 presents the frequencies and standardised residuals from these results.

With respect to gender, the χ^2 test revealed significant differences between males and females in the levels of use of symptom/disorder-specific measures ($\chi^2 = 8.16$, $df = 2$, $p < 0.01$). Standardised residuals indicated that the frequency of use of these measures is higher among females.

The χ^2 test also revealed a significant, though not large, difference between different age groups (1 = under 40, 2 = 41–53, 3 = over 53) in the level of use of symptom/disorder-specific measures ($\chi^2 = 9.99$, $df = 4$, $p < 0.05$). From the analysis of standardised residuals, it appears that this measure is frequently used, particularly among professionals under the age of 41. Conversely, individuals over 53 years old emerge as the category that uses it the least frequently. Psychotherapists aged 41–53 years most often report using this measure 'occasionally'.

Regarding professional seniority, instead, the data revealed that the use of Measures of Goals is significantly higher among psychotherapists with more years of experience, while younger professionals report the lowest levels of use ($\chi^2 = 10.69$, $df = 4$, $p < 0.05$).

With respect to the type of service in which participants work, the data revealed that the use of Measures of Goals is significantly higher among psychotherapists working in

TABLE 4 | Frequencies and standardised residuals for levels of use of outcome measures respect to age, gender and the kind of service.

			Symptom/disorder-specific measures			
			Never	Sometimes	Frequently	Total
Gender	Female	Frequencies	28	70	40	138
		Standardised residual	-1.2	0.7	0.3	
	Male	Frequencies	19	16	11	46
		Standardised residual	2.1	-1.2	-0.5	
Total			47	86	51	184
			Symptom/disorder-specific measures			Total
			Never	Sometimes	Frequently	
Age	Under 41	Frequencies	10	10	13	33
		Standardised residual	0.5	-1.4	1.3	
	41-53	Frequencies	13	44	21	78
		Standardised residual	-1.6	1.2	-0.1	
	Over 53	Frequencies	24	32	17	73
		Standardised residual	1.2	-0.4	-0.7	
Total			47	86	51	184
			Measures of goals			Total
			Never	Sometimes	Frequently	
Professional seniority	over 30 years	Frequencies	32	13	5	50
		Standardised residual	-0.6	0.7	0.8	
	16-29 years	Frequencies	46	20	6	72
		Standardised residual	-0.8	1.2	0.4	
	4-15 years	Frequencies	53	6	2	61
		Standardised residual	1.4	-1.9	-1.1	
Total			131	39	13	183
			Measures of goals			Total
			Never	Sometimes	Frequently	
Service	Hospital	Frequencies	22	14	6	42
		Standardised residual	-1.5	1.7	1.8	
	Community	Frequencies	110	25	7	142
		Standardised residual	0.8	-0.9	-1.0	
Total			132	39	13	184
			Clinical cutoffs			Total
			Never	Sometimes	Frequently	
Service	Hospital	Frequencies	7	14	21	42
		Standardised residual	-1.3	-0.7	1.9	
	Community	Frequencies	43	59	40	142
		Standardised residual	0.7	0.4	-1.0	
Total			50	73	61	184
			General coverage measures			Total
			Never	Sometimes	Frequently	
Psychology service	Yes	Frequencies	36	30	47	113
		Standardised residual	-1.6	0.6	1.2	
	No	Frequencies	40	14	17	71
		Standardised residual	2.0	-0.7	-1.5	
Total			76	44	64	184

hospital-based services compared to those in community-based services ($\chi^2 = 10.64$, $df = 2$, $p < 0.01$). A similar trend was observed for the frequency of use of clinical cutoffs ($\chi^2 = 7.42$, $df = 2$, $p < 0.01$).

Finally, those working within an operational unit/psychology service use General Coverage Measures more frequently than those who do not work in such services ($\chi^2 = 11.08$, $df = 2$, $p < 0.01$).

3.3 | Correlations Between Attitude With Respect to ROM Use and Frequency of Using Routine Outcome and Feedback Monitoring

The correlation matrix allows for the identification of three sub-matrices (see Table 5): the 7x7 triangular matrix of correlations between the frequency of using routine outcomes, the 4x4 triangular matrix of scores on attitude scales with respect to ROM, and the 7x4 rectangular matrix of relationships between attitude with respect to ROM use and the frequency of using routine outcome measures and feedback monitoring.

In the 7x7 triangular matrix containing correlations among the frequency of using routine outcome measures, the correlation between Measures of Goals and Measures Developed Locally is relatively high ($r = 0.45$), as is the correlation between Measures of Goals and RSCS ($r = 0.47$). The correlation between CSC and RCSC is also fairly high ($r = 0.47$). High correlations are observed between measures of Comparison with Normative Data and RCSC ($r = 0.51$) and measures of CSC ($r = 0.61$).

In the 4x4 triangular matrix that containing correlations among the dimensions of Attitude with Respect to ROM, the highest correlation is between Physical Opportunity and Social Opportunity ($r = 0.57$). A strong correlation is also found between Physical Opportunity and Psychological Capability ($r = 0.50$).

In the 7x4 rectangular matrix that includes correlations between attitude with respect to ROM use and the frequency of using routine outcome measures and feedback monitoring, correlations between Measures Developed Locally and Psychological Capability ($r = 0.39$), Physical Opportunity ($r = 0.38$) and Social Opportunity ($r = 0.41$) are relatively high. The correlation between Measures of Comparison with Normative Data and Psychological Capability ($r = 0.39$) is also quite high, as is the correlation between Measures of RCSC and Psychological Capability ($r = 0.41$). The highest value is observed for the correlation between Measures of RCSC and Physical Opportunity ($r = 0.46$).

These values suggest that a higher likelihood of using locally developed outcome measures is associated with working in contexts where there are greater physical and, notably, social opportunities and simultaneously feeling that one possesses the knowledge, skills and abilities needed to enact specific behaviours. Similarly, increased use of metrics to interpret scores, particularly RCSC, is associated with the perception of working in a context with greater opportunities such as time, place and resources and the perception of having the knowledge, skills and abilities necessary to implement specific behaviours.

TABLE 5 | Correlations between attitude with respect to ROM use and frequency of using routine outcome and feedback monitoring ($n = 184$).

	1	2	3	4	5	6	7	8	9	10	11
1- General coverage measures	1	0.276**	0.218**	0.117	0.175*	0.272**	0.382**	0.233**	0.348**	0.269**	0.275**
2- Symptom/disorder specific measures		1	0.338**	0.210**	0.240**	0.325**	0.330**	0.275**	0.275**	0.214**	0.172*
3- Measures of goals			1	0.448**	0.409**	0.244**	0.468**	0.323**	0.307**	0.359**	0.250**
4- Measures developed locally				1	0.422**	0.311**	0.420**	0.387**	0.382**	0.412**	0.196**
5- Comparison with normative data					1	0.606**	0.515**	0.393**	0.326**	0.243**	0.196**
6- Clinically significant change						1	0.470**	0.335**	0.319**	0.224**	0.214**
7- Reliable and clinically significant change							1	0.408**	0.459**	0.299**	0.279**
8- Psychological capability								1	0.500**	0.363**	0.427**
9- Physical opportunity									1	0.566**	0.361**
10- Social opportunity										1	0.193**
11- Motivation											1

* $p < 0.05$, ** $p < 0.01$.

4 | Discussion

The data from our study highlight several important considerations regarding the use of routine outcome measures (ROM) within the Italian National Health Service (NHS). Overall, ROM utilisation remains limited, particularly for Measures of Goals, Measures Developed Locally, and RCSC, while General Coverage Measures and Symptom/Disorder-Specific Measures are more commonly used. This pattern aligns with prior research (Ionita and Fitzpatrick 2014), indicating significant potential to increase ROM adoption across the NHS. The higher prevalence of symptom-focused ROMs suggests that clinicians tend to prioritise symptom detection over comprehensive assessments that include patient resources, potentially leading to interpretive biases (Lambert 2010) when excluding statistical measures of change (Jacobson and Truax 1991).

The underutilisation of goal-setting measures in our sample is consistent with previous studies (Cooper and Law 2018; Norcross 2011), despite strong evidence supporting the link between goal consensus and improved therapeutic outcomes (Tryon, Birch, and Verkuilen 2018). This indicates a critical need for greater awareness and training on the importance of goal setting in therapy. Enhancing clinicians' understanding of the value of goal setting may improve its application in practice, thereby contributing to better patient outcomes.

Although some ROMs are used more frequently, there is a notable gap in the consistent application of others, particularly in goal setting. Bridging these gaps could lead to a more holistic evaluation of treatment outcomes within the NHS.

We found that Symptom/Disorder-Specific Measures are used more frequently by female therapists, in line with studies that highlight gender differences in therapeutic approaches (de Jong et al. 2012). Younger psychotherapists (under 41) are also more likely to use these measures, while those over 53 years old use them the least. This could be attributed to younger professionals receiving more recent training that emphasises ROM utility, whereas older clinicians may harbour reservations, viewing these tools as interfering with the therapeutic process (Boswell et al. 2015). Further research is needed to confirm these hypotheses and explore their implications.

It is also worth noting that the latest recommendations from the Italian Ministry of University and Research (Ministero Università e Ricerca Scientifica 2020) do not include references to learning tools and methodologies for measuring outcomes and monitoring treatment progress nor to their systematic use in supervision processes.

Interestingly, more experienced psychotherapists tend to use Measures of Goals more frequently, potentially reflecting a deeper understanding of the limitations of nomothetic measures in capturing the specific problems or goals that are of greatest importance to individual clients or particular groups of clients and a preference for idiographic approaches (Jacob et al. 2018). Problem-focused and goal-focused measures are two primary types of outcome assessment tools. Problem-focused measures ask clients to identify and rate the extent of issues they wish to address, while goal-focused measures

allow clients to set and evaluate their own therapeutic goals. This client-directed approach accommodates diverse value systems and definitions of treatment success (Jacob et al. 2018). More experienced clinicians may favour this client-centred approach, as it more accurately reflects the individualised processes of change pertinent to each client (Edbrooke-Childs et al. 2015). This preference is supported by research showing that clients with similar diagnoses may have varied therapeutic goals (Holtforth and Grawe 2002).

Our data indicate that psychotherapists in hospital-based services use Measures of Goals significantly more often than their counterparts in community-based services. This trend is also observed in the frequency of using clinical cutoffs. In inpatient mental health settings, where behaviour change is a key component of treatment plans, goal setting plays a critical role in identifying and achieving specific behavioural changes (Bailey 2019). The NICE guidelines (2017) advocate for SMART (Specific, Measurable, Achievable, Relevant, Time-bound) goals to enhance treatment planning and outcomes.

Additionally, psychotherapists working in operational units or psychology services utilise General Coverage Measures more frequently. This suggests that a structured organisational setup supports the effective implementation of requirements set by Local Education Authorities (LEAs). Such organisational frameworks, inspired by the IAPT model of the English NHS, foster accountability and improve the evaluation of clinical interventions. Recent Italian legislation (Law No. 176/2020) reinforces this by mandating the integration of psychological activities within NHS organisations into a unified corporate function.

The correlations between attitudes toward ROM use and the frequency of using routine outcome measures reveal that the use of locally developed Measures is linked to Psychological Capability, Physical Opportunity, and Social Opportunity. Psychological Capability is also associated with Measures of Comparison with Normative Data and RCSC, while Physical Opportunity correlates with the use of RCSC measures.

These findings suggest that the use of locally developed measures is more likely in contexts with ample physical and social opportunities and where individuals feel confident in their knowledge and skills. Similarly, the use of RCSC measures is associated with greater contextual opportunities and perceived capabilities.

This underscores the importance of Psychological Capability in determining the application of outcome measures and highlights the need for further analysis of how physical and social opportunities influence the use of local measures. Organisational culture and climate play a significant role, indicating that effective service organisation is crucial for implementing local tools, despite challenges such as limited comparability and psychometric limitations (Evans and Carlyle 2021).

4.1 | Limitations and Future Directions

Certain limitations of the study should be highlighted. First, the sample size and the nonprobability sampling method warrant caution in interpreting the findings. Our sample

represents less than 5% (3.7%) of the target Italian population, making it a relatively unrepresentative sample, despite its tendency to reflect certain socio-demographic characteristics of the population, such as gender (75% female vs. 80% in the target population), average age (50 years in our sample vs. 53 years in the population), years of service (22 years in our sample vs. 19.4 years in the population) and predominant employment in local services (77% vs. 70% in the population). The lack of representativeness of our data may also be related to motivational biases among participants. Those with strong opinions for or against ROMs (in any form) might be more motivated to participate than those who do not view ROMs as particularly important, potentially increasing the variance in attitudinal variables.

The interpretability of the correlation matrix, also, is limited by the small number of therapists using some measures, which may introduce bias. Some measures are not widely used by a significant number of therapists. For example, out of a total of 184 therapists, 132 do not use measures of goals, 112 do not use locally developed measures and 115 do not use RCSC measures (Table 3). These data warrant caution in generalising results that include such measures.

To improve the generalizability of the results, further studies should involve larger samples, employ alternative statistical techniques capable of accounting for the varying intensity of ROM usage and explore, through specifically designed questions, both the biases related to greater sensitivity and knowledge of ROMs, as well as those associated with overly positive or negative attitudes toward them, and those connected to their limited use. The data are cross-sectional, limiting the study's ability to explore potential increases in the use of routine outcome measures (ROMs) compared to the past or to examine changes over time in the associations between the investigated variables. Regarding the latter, future prospective and longitudinal studies are needed to explore potential changes in these associations and the strength of these relationships over time.

To address the increase in ROM usage compared to the past, one approach could be to include questions in the questionnaire with both retrospective and prospective value. This would allow investigation into whether participants have previously reflected on ROMs (e.g., through involvement in a similar survey) and whether they believe there will be greater attention to ROMs in the future.

A further limitation is that we relied solely on self-report data. It is thought that responses to questions about professional issues, such as psychological capability or motivation, can be influenced by cognitive biases such as idealisation and social desirability bias. This could be addressed through qualitative research and the administration of semistructured interviews for providing data that are more accurate.

Moreover, an interesting avenue for further research would be to reflect on the moderating or mediating role of variables, such as previous training on ROM, and positive and negative feelings toward ROM.

4.2 | Practical Implications

Our study highlights that, despite various studies emphasising the importance of routine outcome monitoring (ROM) for tracking client progress and enhancing the quality of psychological services, ROM practices remain underutilised within the Italian National Health Service (NHS).

The observed lack of consistency in ROM use is partly due to organisational variability within Italian NHS psychology services, including disparate training paths and the absence of standardised protocols for routine monitoring. This lack of uniformity may hinder the widespread adoption of ROM practices.

According to the COM-B Model, capabilities and opportunities influence motivation, which in turn affects behaviour change. Therefore, addressing gaps in perceived capabilities and opportunities is essential for motivating and implementing ROM practices effectively. Improving these factors could lead to increased ROM adoption and subsequently reinforce positive perceptions of ROM.

To address these issues, we recommend a series of strategic actions. Firstly, we advocate for the enhancement of training. This involves implementing comprehensive training programmes for psychologists, starting from university education and extending through psychotherapeutic training and clinical supervision. Such initiatives would address existing gaps in the knowledge and application of routine outcome monitoring (ROM), which currently contribute to its underutilisation in clinical practice.

Secondly, we propose the standardisation of procedures. This includes the development and dissemination of clear guidelines and protocols for ROM use within the NHS. Establishing uniform procedures and organisational standards is essential to ensure consistency across various clinical settings.

Finally, we recommend advancing cultural and regulatory acceptance. It is crucial to promote the cultural integration and regulatory endorsement of ROM. The recent publication of the 'Guidelines for the Psychology Function in the NHS' (Ministry of Health 2022) marks a significant advancement by providing standardised criteria for psychological services and establishing basic standards for ROM utilisation and effectiveness data collection.

By addressing these recommendations, we aim to bridge the identified gaps and foster a more systematic and effective use of ROM across the Italian NHS. This approach is crucial for improving service quality and achieving better patient outcomes.

5 | Conclusions

While international evidence underscores the importance of ROMs, their integration into Italian clinical practice remains limited. Further research is crucial to understand the barriers to ROM implementation and to develop strategies for overcoming these challenges. Building a culture of data-driven practice could significantly enhance the quality of psychological care within the NHS.

Author Contributions

Conceptualisation: J.L. and G.R. Data curation: G.R. Formal analysis: J.L. Methodology: J.L. Writing – original draft preparation: J.L. and G.R. Supervision of the entire work: J.L. and G.R. Writing – review and editing: J.L. and G.R.

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Ethics Statement

The study followed all relevant ethical guidelines. All procedures performed were in accordance with the ethical standards of the institutional research committee and with the 1964 Helsinki Declaration and its later amendments (or comparable ethical standards).

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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