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REVIEW

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Routine outcome monitoring (ROM) and feedback in university student counselling and mental health services: Considerations for practitioners and service leads

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Abstract

Aim: Routine outcome monitoring (ROM), including the use of feedback, has become a much vaunted method in psychological therapies but is little used in university/college counselling and mental health services, perhaps because its adoption raises questions for many practitioners and service leaders. There is a need for both clinical- and research-based statements to clarify the reasoning and rationale for ROM. This paper aims to present and respond to common challenges of and reservations about using ROM in student counselling and/or mental health services.

Method: The article poses 15 questions and issues about the adoption of ROM drawn from the literature on this topic and further refined by practitioner- and researcher-members of a consortium comprising service leads, practitioners, and researchers working in the field of student counselling in the UK. The questions address nine themes: (1) the purpose and yield of ROM; (2) the burden of measurement; (3) the impact on clients and process of therapy; (4) consistency with therapeutic theory; (5) client groups and settings; (6) concern from practitioners; (7) equality, diversity, and inclusion; (8) implementation; and (9) relationship with the paradigm of practice-based evidence.

Findings: Responses to each of the 15 questions are provided from a methodological, evidence-based, and clinical perspective.

Conclusions: The responses provide practitioners with the necessary information to enable them to make informed decisions as to the value, or otherwise, of adopting ROM, including feedback, in the delivery of counselling interventions, and generating evidence created from clinical practice.

KEYWORDS
higher education, implementation, psychological therapies, repeated measurement, routine outcome monitoring (ROM), sessional measurement, student counselling, student mental health

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1 | INTRODUCTION

Routine outcome monitoring (ROM), including the use of feedback, has recently become a significant feature in the delivery of psychological therapies and has generated a considerable body of literature comprising randomised controlled trials (e.g., Delgadillo et al., 2018), meta-analyses (e.g., De Jong et al., 2021), reviews (e.g., Barkham et al., 2023a, 2023b) and practitioner-oriented texts (De Jong et al., 2023). The yield of such research has shown an overall advantage to clients in the region of 8% above and beyond the standard effects of therapy when practitioners have adopted ROM (Barkham et al., 2023a, 2023b; De Jong et al., 2021). And yet this procedure is not as widely adopted in practice as might be supposed if practice is to be informed by research evidence (Barkham & Lambert, 2021; Boswell et al., 2015). This situation is even more evident in the field of university student counselling and mental health services, which can, at times, appear tangential to mainstream efforts in evaluating and monitoring client outcomes (Broglia et al., 2018).

Specific features characterise the context and delivery of student counselling, including changing student demographics (e.g., widening participation); developmental factors (e.g., transition from adolescence to adulthood); leaving home (associated homesickness and lack of belonging; Gopalan & Brady, 2019); needing to perform at their highest level academically (Karaman et al., 2019); impact of social media (Baltaci, 2019); and high prevalence of social anxiety (Luan et al., 2022). The therapeutic models adopted in university counselling are varied and will invariably be short-term working within the constraints of semesters and the finite duration of university courses (Mair, 2015). In this context, the purpose of this article is to focus on arguments in support of student services adopting ROM as one component in fostering the adoption of evidence-based practices in routine settings that have the potential to improve the outcomes for students in receipt of counselling or mental health services.

Routine outcome monitoring has been defined as "the implementation of standardized measures, usually on a session-to-session basis, to guide clinical decision-making, monitor treatment progress, and indicate when treatment adjustment is needed" (Pinner & Kivlighan, 2018, p. 248). It has been recommended by the American Psychological Association (APA, 2006) as well as other organisations in the United States (e.g., The Joint Commission, 2018) and in Europe (The Roadmap for Mental Health Research; Emmelkamp et al., 2014). In addition, measuring treatment outcomes in specific contexts in a number of countries has become a requirement (e.g., Australia: Burgess et al., 2015; Canada: Tasca et al., 2019; and Norway: Knapstad et al., 2018).

In England, session-by-session measurement is a hallmark of the NHS Talking Therapies for Anxiety and Depression programme, previously known as the Improving Access to Psychological Therapies (IAPT) programme (Clark, 2018). However, while considerable resources have been invested in NHS settings, support and strategic development of sessional measures and ROM

Implications for Practice

- Routine outcome monitoring provides a process tool for therapists to provide feedback to their clients and be able to adapt the course of counselling for those who are not making the gains that might have been expected.
- There are several tools/software, but the principles of ROM can be achieved with a combination of low-tech support and informed clinical acumen.
- Building a culture for feedback helps to support and address the challenges of implementing ROM and has the potential to support universities to move towards offering data-informed mental health services for their students.

Implication for Policy

- Routine outcome monitoring can play a dual role in enhancing the session-by-session delivery of university student counselling and/or mental health services as well as providing a robust evidence-base to underpin embedded services by assisting in securing their status as a specialist support service for addressing the increasing mental health issues experienced by students.

in the field of UK university student counselling has been more limited. Broglia et al. (2018) reported that "[F]ew [Higher Education] services administered measures every session representing only 8% of small, 23% of medium and 11% of large HE services" (p. 448).

In response to this agenda, a central tenet of this article is that implementing only pre- and post-counselling/intervention measures is neither sufficient nor efficient in terms of collecting reliable data.[1] For example, Connell et al. (2008) found that 31.5% of clients in a sample of students attending university counselling across seven institutions did not have linked outcome data, a percentage that is likely to be an underestimation due to other data also being excluded. Notwithstanding the increasing policy levers, in the absence of any mandated call to use sessional measures in university counselling and mental health services, it will remain a challenge for services to progress this agenda (Broglia et al., 2021). However, there is an increasing body of literature that may provide supporting arguments to enable service leaders and individual practitioners to give the adoption of sessional measures greater consideration.

There have also been recent political and contextual developments that will increasingly require the adoption of outcome measures to ensure that services are able to respond to students'

[1]Although the term "data" is formally plural, we have adopted the increasingly accepted view of the term as a mass noun and therefore refer to data collectively as "data is" but "data points are."

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fast-changing needs. Publication of *The University Mental Health Charter* (Hughes & Spanner, 2019) emphasised the need to demonstrate the evidence base for the mental health interventions offered to students and ensure that appropriate resources are allocated to such services. This evidence is key in reassuring students seeking support from services that they trust to be effective (Priestley et al., 2022) and for recognising the value of in-house support services with accredited practitioners who are highly skilled at working with students (Harrison & Gordon, 2021).

Accordingly, the aim of this article is to address questions that individual practitioners and university support services and leading personnel may raise about ROM and feedback. The intention is to provide these stakeholders with evidence from the available literature supporting the adoption of session-by-session outcome measurement and feedback as a route towards securing a better evidence base for university student mental health services (Barkham et al., 2019).

2 | METHOD

As a framing device, we adopted the method employed by Waskow (1975) some 50 years ago when proposing the adoption of a core outcome battery, an attempt to identify a small number of outcome measures from which practitioners would select and thereby deliver a more focussed evidence-base derived from an agreed class of bona fide measures. To underpin the task, Waskow generated a fantasied dialogue between a researcher and consultant regarding the issues involved in developing and adopting a core outcome battery. In adopting this device for the current article, we derived an initial listing of 10 questions and concerns (Appendix S1) arising from academic outputs relating to the use of sessional outcome measures (Barkham et al., 2023a, 2023b) and a practitioner text (De Jong et al., 2023). This listing was circulated to all members of the Student Counselling Outcomes Research and Evaluation (SCORE) consortium comprising heads of services, experienced practitioners, policy makers, and academic researchers. The SCORE group is supported by the British Association for Counselling and Psychotherapy (BACP), but the group functions independently. The SCORE members contributed feedback on the initial 10 questions in the light of their experience, and the list was revised to arrive at 15 questions set out in Table 1. The dialogue comprising this article addresses the 15 questions and responses taking a clinical/therapeutic perspective and evidence from the research literature. The 15 questions have been framed under nine themes as follows: (1) the purpose and yield of ROM; (2) the burden of measurement; (3) the impact on clients and counselling process; (4) consistency with therapeutic theory; (5) client groups and settings; (6) concern from practitioners; (7) equality, diversity, and inclusion; (8) implementation; and (9) relationship with practice-based evidence.

While the origins of this project arose from a focus on university student counselling in the UK (SCORE; https://score-consortium.sites.sheffield.ac.uk/), the issues themselves transcend that specific setting and geographical location and the responses are generally applicable to most psychological therapy settings. Similarly, there will be national differences, but the principles of ROM and feedback remain relatively constant. The article focusses primarily on presenting the case for adopting ROM and is a starting point—a primer—for any person working in the field of student counselling, or psychological therapies more generally, who is considering the challenges of adopting ROM.

3 | ROUTINE OUTCOME MONITORING (ROM) AND FEEDBACK: QUESTIONS AND RESPONSES

3.1 | Theme: The purpose and yield of ROM

3.1.1 | Question 1: I have years of experience as a counsellor and can tell how a client is doing, so why should I use outcome measures at all?

First, as practitioners, it is crucial that we have the necessary knowledge to determine whether a client is improving, stable, or deteriorating, as how we proceed in a session will likely depend on that assessment. Clinical experience is undoubtedly a crucial component and while practitioner experience accumulates with passing years, there is evidence that their associated client outcomes do not necessarily also increase and in fact, if anything, slightly decrease over time (Goldberg et al., 2016).

Second, the argument that experience is a totally reliable basis for clinical judgements is vulnerable. Going back over 70 years, a seminal text noted that statistical models (i.e., those derived from data) were more accurate than clinical judgements (Meehl, 1954). Such a view was endorsed in a meta-analysis that found statistical models to be 13% more reliable than clinical judgements (Ægisdóttir et al., 2006).

Third, therapists have been found to overestimate their effectiveness in studies carried out in both the United States (Walfish et al., 2012) and the UK (Parker & Waller, 2015). And in a classic study carried out in a university counselling centre, practitioners were only able to predict one correct occurrence of client deterioration out of an actual deterioration in 40 clients. In contrast, using empirical classification methods identified all negative outcomes in a larger sample (Hannan et al., 2005).

The collective evidence indicates that practitioners' abilities to identify change, particularly deterioration in clients, can benefit from the use of data (Lambert, 2010). Importantly, biases are present in many decision-making scenarios involving people in general and in clinical decision-making in particular (Marsh et al., 2018). And such biases are not specific to the field of mental health but to medical decision-making in general (Saposnik et al., 2016). Unfortunately, there is little effort in clinical training or experience that mitigates such biases.

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TABLE 1 Final agreed list of questions, concerns, and related themes.

No.	Questions	Themes
1	I have years of experience as a therapist and can tell how a client is doing in therapy, so why should I use outcome measures at all?	The purpose and yield of ROM
2	I already use pre–post measures—why should I change to using sessional measures?	
3	How do I make the most of using ROM for a client I am seeing?	
4	Using pre–post measures is challenging enough—but using them every session would just feel too much of a burden for us and our clients.	The burden of measurement
5	We don't have the administrative support to handle sessional measures.	
6	We'll end up with so much data we won't know what to do with it all.	
7	What do clients think about completing a measure at every session and will they get fed up with it? And having clients fill in a measure at every session is going to dominate the therapy and will interfere with the process.	The impact of measurement on clients and the process of therapy
8	How do we know that the client is being honest when they complete the form? Or what if the client exaggerates their responses to be seen more quickly?	
9	I've heard that using ROM has a negative impact on the therapeutic alliance.	
10	What if I practice a model of counselling or therapy, such as person-centred or psychodynamic therapy, where using a measure at every session doesn't sit as naturally as perhaps with other models of therapy?	Being consistent with therapeutic theory
11	Does a student population and setting impact on decisions regarding which measures to adopt?	Special populations and settings
12	I am worried that outcome measures will be used to measure therapists' effectiveness.	Concern from practitioners
13	What can outcome measures do for clients from marginalised backgrounds?	Equality, diversity, and inclusion
14	If I did decide to adopt ROM, what are the main obstacles to implementing it? There are many measures available—how do you know which ones to use?	Implementation
15	Finally, how might I use ROM to contribute to the evidence base for psychotherapy? I'm a practitioner, not a researcher, it's not my responsibility/I don't have the skillset or time to engage with practice-based research.	Impact on and contribution to practice-based evidence

3.1.2 | Question 2: I already use pre–post measures—why should I change to using sessional measures?

First, collecting only pre- and post-counselling data provides incomplete information for the service, and data is therefore likely to be biased in that it only includes data from those clients who complete counselling. Incomplete data arises from the fact that the design is totally dependent on clients filling in the end of counselling measure. Unfortunately, many clients end counselling unilaterally and do not complete a final measure. They may or may not have improved, and we simply do not know. While data from clients completing an outcome measure at the end of counselling can be used to determine rates of improvement (Evans et al., 1998; Jacobson & Truax, 1991), pre- and post-designs have been reported as yielding return rates of approximately 38% (Clark et al., 2018).

Collecting only pre- and post-measures is akin to earlier psychological therapy trials that based their analyses on "*completer*" samples comprising only those clients who completed therapy and provided end-point data. Such analyses are no longer deemed to be appropriate and have been replaced with an *intent-to-treat* (ITT) analysis in which data from *all* clients with pretherapy data would be included; that is, once randomised (in a trial), a client's data will be included regardless of whether they remain in counselling (de Beurs et al., 2011). Translating this approach to university counselling and mental health services requires data to be collected from every client regularly, preferably at every attended session, so that there will always be a "final" datum point regardless of how or when counselling is terminated. This approach provides a more comprehensive and informative evidence base for the service and ongoing information for the practitioner. Having "complete" data on all clients means we can explore whether (and why) certain clients are more likely to drop out, and strive to develop inclusive services that reduce the likelihood of them doing so.

Second, while pre- and post-measurement can evaluate an episode of counselling (providing there is data at the end-point), ROM informs services about *all* clients as well as providing individual practitioners with information about the current state of the client and also about the *process* of counselling and the episode itself. Moreover, embedding ROM within a university clinic becomes a key component in adopting the principles and procedures of a learning health system, where the generation of evidence (i.e., data) is a "by-product of care delivery" and the application of that evidence is "to support continuous improvement, evidence-based care delivery, and population management" (Guise et al., 2018, p. 2237).

Crucially, session-by-session data is addressed within the context of a "collaborative conversation" between the client and the

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practitioner (Faija et al., 2022). This approach locates ROM as an integral part of building a good working alliance. Having repeated data available across time provides a record of how change occurs and can flag up signs of deterioration during counselling and, crucially, information that enables a practitioner to redirect the course of counselling if it appears not to be progressing as expected (Lutz et al., 2022). The failure to view ROM data as being an integral part of the process of therapy is a crucial oversight in the light of evidence showing that using ROM yields, on average, better client outcomes (De Jong et al., 2021).

3.1.3 | Question 3: So, how do I make the most of using ROM for a client I am seeing?

Following on from the previous response, ROM is a continual process in which data is collected ongoingly (routinely), is integrated into the practice of counselling and provides the practitioner with information on a client's progress, or lack thereof, and enables them to feedback data to the client within the context of a therapeutic conversation (Barkham et al., 2023b). Routine outcome monitoring is a key component that enables the practitioner to respond appropriately in a session should data alert the practitioner that progress has stalled. There are software packages that provide such information (see Appendix S1 for references), but the focus here is to explain the purposes of such packages so that practitioners gain an understanding of them and can mimic their procedures without necessarily adopting a software system.

A key principle is the notion of *nearest neighbours* (Lutz et al., 2005). The idea derives from avalanche predictions whereby meteorologists predict the daily probability of an avalanche by sampling, say, the 50 days in their archive data set that most closely approximate key weather variables on the day in question. This data then provides probabilities of the likelihood of an avalanche on the targeted day. Such a procedure directly translates to designing data sets from which it is possible to sample, say, the 20 most similar presenting clients and see what course of change over counselling is modelled using their data, and this provides the basis for determining whether the progress of a specific current client is progressing satisfactorily (termed "on-track") or not (termed "not-on-track") (Lambert & Shimokawa, 2011). While a practitioner may have in their mind many similar clients to the one they are focussing on, it is clear to see how a data-informed system could provide more reliable information in providing the expected trajectory of improvement.

In terms of clinical practice, sessional data provides information that aids the process of counselling, particularly concerning deterioration and failure to progress as might be anticipated (De Jong et al., 2023). The simplest signal would be whether data showed a deterioration in a client's state, which was equivalent to the reliable change index (RCI) of the measure used. The RCI can be easily calculated for any bona fide outcome measure and represents the amount of change required to exclude measurement error (i.e., the inherent unreliability of a specific measure) as being a plausible explanation for the difference in scores (for further details, see Evans et al., 1998). But what if a client's score doesn't change at all? Even so, a feedback system may provide an alert flag because similar clients may well have shown improvement by that particular session but not an earlier one, and this is what a practitioner needs to know: namely, is a client improving to a similar extent within the same time period compared with other clients who presented with similar problems or severity? This is employing the approach of data-informed therapy (Lutz et al., 2022).

If the outcome data from the current client is considered to be "not on track," the task of the therapist is to consider the possible explanations as to why a particular client's data lies outside the expected treatment response of their nearest neighbours. At this juncture, the practitioner needs to draw on their clinical understanding together with the research literature to generate hypotheses as to what is creating the obstacle that can then be offered to the client within the therapeutic conversation as a possible explanation for counselling not progressing as well as expected. Crucially, these exchanges are presented within the adopted theoretical model, and any adjustments in the direction of counselling discussed and agreed with the client (for fuller details, see De Jong et al., 2023).

Well-developed ROM systems have incorporated additional measures that can be administered at a key point to help determine the areas where obstacles to change may be occurring. These measures are referred to as clinical support tools (CSTs) and have been found to be a key component of more effective feedback systems (De Jong et al., 2021). They can, of course, also be used by any practitioner as a stand-alone measure to help understand the process of therapy with a client.

3.2 | Theme: The burden of measurement

3.2.1 | Question 4: Using pre–post measures is challenging enough—but using them every session would just feel too much of a burden for us and our clients

First, it is important *not* to presume that ROM will be a burden for clients as there is evidence that they support the use of measures provided they see practitioners using the information (Thew et al., 2015). And for practitioners, having a positive attitude towards the use of ROM is related to it being a success (Rye et al., 2019).

Second, rather than viewing measures as an additional burden, it is crucial that ROM is viewed as an integral part of the therapeutic process, and this view needs to be conveyed from the very start of counselling. A key point for clients is to receive a clear rationale for completing a measure at each session (Brooks Holliday et al., 2021). And the rationale needs to focus on enabling the best treatment decisions for the client: the rationale is not to evaluate the service—the client is at the centre of the rationale for ROM.

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However, there will be occasions when a client refuses to take part in ROM, and it might appear that the best line is acceptance of such a decision, largely based on the line in research that clinical need is a priority over the needs of research. But this would miss the key axiom that ROM is an integral part of clinical practice: it is not research. Hence, when considered from a therapeutic stance, the client is communicating something about their state and the task of counselling is to try and enable a sense of mutual understanding about their reluctance. This is similar to clients who deliberately miss out completing items in a measure—the value of missing data. No client can be cajoled into completing an item or measure, but the concern can be shared in session and its meaning better understood. Alternatively, another modality may take the approach of suggesting trying to complete the measure for one session to see whether the client is able to experience how it might benefit them. Either way, there is potential therapeutic material that can be utilised between the client and practitioner.

3.2.2 | Question 5: We don't have the administrative support to handle sessional measures

Administrative support is undeniably a constant issue and may be more challenging to secure in smaller, less well-resourced services. However, a number of points counter resigning to this view. First, relying on only pre- and postmeasures is a false economy for determining the effectiveness of clients' outcomes as the return rate at post-therapy is unlikely to exceed 50%. Second, pre- and post-therapy alone does not provide practitioners with any information about the process of change during the course of therapy. Third, attempting an intermittent approach (e.g., once every 4 weeks) creates administrative uncertainty in relation to missed appointments, holidays, etc. Fourth, when the evidence is that for many clients, a disproportionate extent of change occurs early on, then it is logical to capture this change more frequently through session-by-session measurement, especially where therapy is short-term such as in the university context. Evidence from university counselling supports the view that greater benefit is achieved by weekly sessions (Erekson et al., 2022).

3.2.3 | Question 6: We'll end up with so much data we won't know what to do with it all

Fearing having too much data is an understandable concern, but it is perhaps fuelled by a misconception regarding the amount of data ROM requires in order to be informative. A key principle is to distinguish between assessment and ROM. The purpose of the former is to collect a working profile of the client in order to aid decisions about the type of intervention to be delivered. In contrast, the purpose of ROM is to gain, via a brief outcome measure, a snapshot of a client's ongoing psychological status in response to the intervention offered. Keeping this key distinction in mind will help contain the task of ROM.

3.3 | Theme: The impact of measurement on clients and the process of counselling

3.3.1 | Question 7: What do clients think about completing a measure at every session and will they get fed up with it? And having clients fill in a measure at every session is going to dominate the counselling and will interfere with the process

Regarding clients' views of ROM, there are positive but also questioning views. Research reports that clients generally support monitoring outcomes during therapy (see reanalysis of data from Lutz et al., 2011, as reported in Castonguay et al., 2013). But qualitative data has also revealed clients' doubts about completing measures when their providers either did not look at or make use of the information (Talib et al., 2018). Four meta themes have been identified by clients regarding ROM (Solstad et al., 2019): (1) questioning the motives for adopting ROM (i.e., suspicion that ROM was being used to determine service effectiveness rather than used for clients' benefit); (2) the dominance of symptom focus (i.e., the need to broaden out to include other domains of experience such as social functioning that better reflect the complexity of clients' lives); (3) the need to provide a rationale, engaging with clients and explaining how data will be used; and (4) the need to develop a collaborative practice in which ROM becomes a clinical process tool to direct and deepen the therapeutic dialogue (Faija et al., 2022).

In terms of dominating the session, the aim is to make clear that data is central to the purpose of therapy and counselling and that the information is actionable (i.e., the data will be used in the session). There is an overall level—total score—that can be commented on by the therapist and an invitation for the client to respond: "It looks like things are continuing to go well.... Is that how it feels to you?" This is especially important when managing risk and handling conversations about risk items, which clients may feel uncomfortable discussing.

But the focus can also be on specific items that show a worsening and provide a route into a discussion between the therapist and client. For example, the contrasts in item scores between the current and previous session can be captured very simply using Excel plots and shared with the client (Cross et al., 2015). With a little ingenuity, data can always be made to be interesting. But the key message is: "This is the way we work here. We use the data you bring to help us decide how we are doing and to signal any changes in direction that might be helpful to you."

3.3.2 | Question 8: How do we know that the client is being honest when they complete the form? Or what if the client exaggerates their responses to be seen more quickly?

First, it is important to recognise that people can generate false data, particularly if they think that it will secure them a quicker route to

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access help. Equally, some clients will score a measure in a way that they think will please their practitioner. In response to both scenarios, practitioners need to become experts in any measure they use and build skills that will enable them to discern when someone is generating a false score. With experience, noticeable patterns of scores will become familiar and outlying scores will become apparent, while false scores are likely to be inconsistent with any clinical presentation.

Second, notwithstanding deliberate attempts to falsify an outcome score, it is important to recognise that all measurement contains an element of error—measurement is not perfect. What a practitioner is looking for are patterns in the data, both within the same time interval and across time (De Jong et al., 2023), and this practice is congruent with the information therapists work with daily when with their clients (Broglia & Knowles, 2020).

3.3.3 | Question 9: I've heard that using ROM has a negative impact on the therapeutic alliance

It is probably easiest to address this concern from a clinical perspective as it is understandable that any practitioner does not wish to engage in a procedure that they feel will jeopardise their relationship with their client. Three points are worth noting. First, ROM is more likely to be successfully implemented if the practitioner has a positive view towards it (Rye et al., 2019). Second, a key aim of ROM is to ensure that it is integrated into the delivery of counselling from the beginning. Hence, ROM is best presented as a quality component of counselling that will assist in clinical decision-making. And third, evidence suggests that the alliance mediates the impact of ROM on yielding better outcomes, although it is not known in which direction causality works (i.e., better alliance leading to better outcomes or vice versa; Brattland et al., 2019). And in a recent systematic review and meta-analysis of clients' and therapists' experiences of using ROM data in sessions, more than half the studies (17/31) referred to ROM data enhancing the therapeutic alliance in terms of facilitating communication (Låver et al., 2023; see also Unsworth et al., 2012). The use of data was deemed especially important in the early sessions.

3.4 | Theme: Being consistent with therapeutic theory

3.4.1 | Question 10: What if I practice a model of counselling or therapy, such as person-centred or psychodynamic therapy, where using a measure at every session doesn't sit as naturally as perhaps with other models of therapy or counselling?

In the current climate of evidence-based practice, as well as that of practice-based evidence, it is important that theoretical models of therapy are able to adapt and accommodate emerging evidence. Given the evidence that ROM can, on average, yield approximately an 8% advantage, why would a practitioner practicing *any* model of therapy not want to employ an additional approach that yielded such a gain for the average client above and beyond the general effectiveness of therapy? If the purpose of ROM is to be able to adapt and modify therapy in light of client data, then the therapist needs to have sufficient flexibility in terms of clinical options and skills to be able to adapt within the therapy model accordingly.

It may appear initially that ROM fits more easily within some theoretical models (e.g., cognitive behavioural therapy) than others (e.g., person-centred or psychodynamic therapy), and such challenges have been acknowledged (Aafjes-Van Doorn & Meisel, 2022). But all therapeutic models have strategies that enable the therapist to focus on and work with clients' feelings and emotions in the here and now in the session such that reactions to the use of ROM becomes part of the therapeutic material. It is similar to responses to recording a therapy session—the responses of the client become part of the therapeutic process with which both client and therapist can work.

3.5 | Theme: Special populations and settings

3.5.1 | Question 11: Does a student population and setting impact decisions regarding which measures to adopt?

While ROM can be applied across many settings, there is a subtle difference when considering student counselling and mental health services. For example, the population is likely to be younger, more digitally oriented, and issues and interventions more focussed around a period of transition. There are key issues specific to the university and college context such as students' sense of belonging, academic thriving and employability (Pedler et al., 2022; Tan et al., 2023). It is also a population where outcome measures have been specifically developed—The Counseling Centre Assessment of Psychological Symptoms (CCAPS-62; Broglia et al., 2017; Locke et al., 2011), the Counselling Impact on Academic Outcomes (CIAO; Scruggs et al., 2023)—or adapted—the General Population-Clinical Outcomes in Routine Evaluation (GP-CORE; Sinclair et al., 2005). See Appendix S1 for more information on outcome measures. Using measures that tap into students' unique needs is important to ensure that their fast-changing needs are met, identify opportunities for service development, and demonstrate how university services contribute to students thriving at university (McKenzie et al., 2015).

Within the university context, evidence from an RCT has shown that students who present with anxiety achieve greater clinical improvements when they receive feedback from ROM compared with no feedback (Murphy et al., 2012), which is noteworthy given the global concerns surrounding student anxiety (Liyanage et al., 2021).

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3.6 | Theme: Concern from practitioners

3.6.1 | Question 12: I am worried that outcome measures will be used to measure our effectiveness

The primary purpose of ROM is to ensure that the direction of therapy is working best for the client and, if necessary, adjusted accordingly. But collected data can subsequently be used for a number of purposes, including evaluating the effectiveness of services, identifying training needs for practitioners, and upholding the accreditation requirements of therapists being research-informed (British Association for Behaviour and Cognitive Psychotherapies, n.d.; British Association for Counselling and Psychotherapy, 2020). But we live in a climate where data is at a premium and where data needs to be used respectfully to maximum benefit for all. So, practitioners of all persuasions need to be open to the collection and consideration of data and what it tells us about our own practice. Indeed, there is a line of argument that ROM can extend information to practitioners about their own practice beyond self-reflection and appraisal (e.g., Pinner & Kivlighan, 2018).

There is considerable and consistent research showing a wide range in the effectiveness of practitioners (Johns et al., 2019), and some therapists consistently yield client outcomes that are twice as effective as others (Saxon & Barkham, 2012). Against this background, there is a view that therapists should be monitoring their own outcomes and be learning from such data. Equally, managers have a responsibility to ensure that therapists and counsellors in their clinic or organisation are working as effectively as can be expected given the client population. And if such data can help identify training needs or be used to better match clients and counsellors, then there are likely gains to be achieved.

Concerns arise where a focus on therapists' performance becomes the driving rationale for using outcome data. Hence, the issue is about *how* data is used. A central thread in this article is that the use of ROM is first and foremost aimed at delivering an enhanced experience for students in terms of better meeting and responding to their needs within the context of university or college counselling. Using data at a service level is a secondary function.

3.7 | Theme: Equality, diversity, and inclusion

3.7.1 | Question 13: What can outcome measures do for clients from marginalised backgrounds?

Universities and colleges are faced with unique hurdles and a growing divide in the accessibility of mental health care and services for their students. For instance, financial barriers disproportionately affect women, sexual/gender minorities, and Black or Hispanic students, whereas younger male undergraduates grapple with notable privacy/stigma concerns and older students encounter practical obstacles (Horwitz et al., 2020). Disparities have also emerged among student groups concerning their clinical severity of need and treatment outcomes. Examples include increased mental health complications for American Indian/Alaskan Native students and treatment rates for Asian, Black, and Latinx students either at or below the lowest recovery rate observed for White students (Lipson et al., 2022). Given the disparities in students' support-seeking behaviours and recovery rates, it becomes crucial to recognise potential differences between groups, such as their treatment preferences and service utilisation methods. A pivotal aspect of this understanding involves grasping students' encounters and inclinations towards using routine outcome measures.

A growing body of work highlights the benefits of developing culturally sensitive approaches to psychotherapy with sexual and gender minority clients as well as LGBT+ affirmative training (Pepping et al., 2018). Adaptions have also been made to clinical measures used via cross-validation for a different culture or a full translation into other languages (see Appendix S1 for examples). Adapting student care pathways and interventions to address unique challenges is imperative, supported by evidence showing that routine psychological therapy from national services may not yield the same recovery levels as the general population (Barnett et al., 2022). This recognition has had a global impact on diverse service networks, with initiatives including those that have transformed student mental health care through stakeholder engagement and service mapping to tailor interventions, enable early case identification, and promote early engagement (e.g., Vallianatos et al., 2019).

Stakeholder engagement and network development within university and college settings have also led to significant improvements in mental health literacy, service coordination and ultimately adapting policies and communications to cater to the needs of under-represented and marginalised students (e.g., Cao et al., 2021; Ecclestone et al., 2023). Notwithstanding the challenges associated with the application or potential adaptation of measures when working with students, there is value in using existing measures with marginalised clients as a starting point for using ROM as they allow comparisons with centre norms and can highlight subgroups of clients who require further attention (e.g., Eid, 2022). Furthermore, with the growing accessibility of ROM data from marginalised student groups, the potential to comprehend their progression through and outcomes from psychological therapies also expands. This, in turn, aids in fostering the creation of tailored interventions to enhance outcomes not only for these students but also for all within the student body.

3.8 | Theme: Implementation

3.8.1 | Question 14: If I did decide to adopt ROM, what are the main obstacles to implementing it? For example, there are many measures available—how do you know which ones to use?

Routine outcome monitoring likely works best when it is located within a culture that is accepting of outcome measurement and is

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committed to data-informed approaches to psychological therapies. While the literature on the benefits of ROM has yielded both positive and null findings, the literature is almost unanimous in identifying implementation as the main barrier for successful ROM, with obstacles grouped into three main categories: (1) the people, (2) organisational aspects, and (3) systems (Lewis et al., 2019; Van Wert et al., 2021). Unlike most therapeutic methods, ROM is dependent on a climate of organisational support, referred to as a "culture for feedback" (Bertolino & Miller, 2012). Cultural and philosophical issues are potentially greater obstacles to implementation (Boswell et al., 2015).

Commonly reported barriers include ease of accessing and using ROM systems, guidance on selecting outcome measures, and organisational accountability (Van Wert et al., 2021). Mackrill and Sørensen (2020) identified a wide range of factors comprising leadership, interorganisational factors, feedback culture, implementation team, coordinators and champions, supervision, training, measures and generating a language for ROM use in clinical practice. Rye et al. (2019) reported that holding more positive attitudes regarding the adoption of ROM predicted greater use of standardised instruments.

Limitations centred on ROM being seen as too narrowly focussed, not suitable for clients presenting with multiple problems and hindering the relationship between client and therapist. Such concerns predicted poorer uptake of standardised measures. Therapists with a higher commitment to client feedback also had a higher probability of using feedback and those therapists were more effective with not-on-track clients (De Jong et al., 2021). Similarly, therapists' satisfaction with ROM systems and use of feedback information tend to predict the magnitude of feedback effects (Lutz et al., 2015). Many authors have described strategies for improving implementation (e.g., Bear et al., 2022; Mellor-Clark et al., 2016) and for choosing a measure that suits your intention (Broglia et al., 2022 and Appendix S1). Simmonds-Buckley et al. (2023) have also conducted a systematic review of clinical outcome measures and identified 26 bona fide measures that can be used in practice, together with an overview of their psychometric properties (see Appendix S1 for key measures).

3.9 | Theme: Impact on and contribution to practice-based evidence

3.9.1 | Question 15: Finally, how might I use ROM to contribute to the evidence base for counselling? I'm a practitioner, not a researcher, it's not my responsibility and I don't have the skillset or time to engage with practice-based research

The response to this final question provides the opportunity to locate ROM within the paradigm of practice-based evidence. While session-by-session data can be used to direct and redirect within session activity, the data can also be used as an exemplar within practice-based evidence by building data sets that are not only nested (clients within therapists) but also include repeated data points over time for individual clients. This leads to a stepped change in how we collect, look at, analyse, and understand data in routine practice. Indeed, as an exemplar for implementing ROM within the paradigm of practice-based evidence in a university psychotherapy service, Valdiviezo-Oña et al. (2023) set out a practical vision of what can be possible. The effort of co-ordinating and securing common data sets with all the necessary governance agreements is a task that should be pursued and supported in order to provide a rich data source to inform service development decisions and that will yield evidence from practice to complement findings from trial methodology. The combination of both paradigms will provide the best-balanced evidence for psychological therapies as delivered in the real world.

4 | CONCLUSIONS

This article is a resource for university and college counsellors/practitioners and service leads who are wanting to understand the arguments in favour of adopting ROM in place of pre- and post-assessments. The argument rests on ROM being an evidence-based process tool that can enhance the effectiveness of psychological therapies and provide a more comprehensive data set to therapists (and services) to deliver data-informed interventions in the field of student counselling. Although there are challenges in implementing ROM, the present article is an attempt to persuade all those concerned with the delivery of counselling and therapy that adopting ROM is both feasible and beneficial and can play a significant role in securing the evidence base for embedded university and college counselling and mental health services.

AUTHOR CONTRIBUTIONS

Michael Barkham: Conceptualization; writing – original draft; writing – review and editing; investigation. **Emma Broglia:** Conceptualization; writing – original draft; writing – review and editing; investigation.

CONFLICT OF INTEREST STATEMENT

MB was a codeveloper of the CORE-OM and CORE-10, both of which have been used in ROM-related activities, but receives no financial gain from its use. MB is a co-author of a text on Routine Outcome Monitoring and Feedback but receives no royalties. Both MB and EB are members of the Student Counselling Outcomes Research and Evaluation (SCORE) consortium that promotes the use of ROM but have no financial interests in its activities.

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Additional supporting information can be found online in the Supporting Information section at the end of this article.

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