



Illustrating routine outcomes monitoring at different points in a patient's journey: Inpatient then daypatient treatment of a patient with depressive and borderline symptoms

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Abstract

Routine outcomes monitoring (ROM), combined with a psychotherapeutic intervention, can improve outcomes by assisting therapists in supporting patients who are off track to achieve a better treatment endpoint. While many ROM systems are suitable for particular clinical contexts, psychotherapy delivered in a hospital setting presents unique challenges. People can be treated as inpatients and daypatients, and psychotherapy may be delivered in multiple formats (e.g., closed and open groups; group and individual). The present case study will illustrate the adaptation of ROM to this environment with an 18-year-old woman with Borderline Personality Disorder. The patient was successfully treated with Dialectical Behavior Therapy as both an inpatient and daypatient. The case demonstrates the use of ROM systems and illustrate they are sufficiently flexible to accommodate these complexities of routine care.

KEYWORDS

borderline personality disorder, dialectical behavior therapy, feedback, psychotherapy, routine outcomes monitoring

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Individuals with borderline personality disorder (BPD) experience instability in their relationships, emotions, sense of identity, and behaviors. Aside from the difficulties faced by the individuals, there is an array of challenges for treatment teams. Therapists may have preconceived notions about BPD patients. They may perceive that BPD patients to be hard to treat, due to the severity of symptoms. Therapists may consider the patients hard to engage, due to the instability in relationships and identity. Patients may be expected not adhere with treatment plans and timelines, due to their instability in emotions and the relationship with the therapist. Facing what can be a chaotic therapeutic challenge, therapists may burnout or engage in iatrogenic behaviors themselves (Levy et al., 2018). These challenges have been acknowledged and proactively responded within treatments such as dialectical behavior therapy (DBT) by the inclusion of peer-support sessions. Nonetheless, a complementary approach, that has the potential to assist both patient and therapist identify when symptom improvement is not on track or when risks of adverse outcomes (such as drop-out or self-harm), is the adoption of routine outcomes monitoring (ROM; Davis et al., 2006; de Jong et al., 2021; Delgado et al., 2017) into DBT.

ROM is a transdiagnostic technique that supplements treatment, by regularly collecting problem-relevant data (e.g., symptoms and wellbeing scores) and feeding those results back to both patient and/or therapist in a manner that can guide therapy. Being able to track a patient's current emotional state against past ratings or against those of similar individuals undergoing treatment, the process of ROM provides a focal point for a discussion of the patient's emotional experiences. ROM benefits clinical practice by identifying patients who are "not on track" and open up a conversation enabling staff and patient to work collaboratively towards a positive outcome (de Jong et al., 2021; Delgado et al., 2018). Thus, while ROM is transdiagnostic, it aligns well with the core of DBT.

ROM aligns with DBT because within a DBT framework, there is a tension created by a seeming paradox created by the patient's need for validation of current distress while simultaneously acknowledging the desirability of positive change. This dialectic, between acceptance and change, is one of the core dialectics that are a focus for resolution in DBT. For the therapist, it means that the dialogue will alternate between statements and actions that convey acceptance of the patient in the moment and attempts to work towards change. That is, the therapist conveys does not communicate acceptance, but imply change is desired; rather, the therapist accepts and works towards change aligned with the patient's values.

Within BPD, the use of ROM provides a platform for ongoing conversations that focus on the dialectical dilemma of acceptance with change. For both patient and therapist, the scores themselves can provide an externalized characterization of the dialectic. For example, while different ROM systems present data in various ways, common elements are that the patient's scores across a series of measurement occasions are depicted as a time series. This presentation allows an idiographic interpretation where the patient's present scores are presented against past scores. The presentation of the scores invites interpretation without a necessary prescription. The patient and therapist can discuss questions such as: Have symptoms changed? If so, what underlies the stability or instability? What does an increase or decrease in wellbeing mean to you? By foregrounding the symptoms and wellbeing, it provides validation and opens a dialogue around the implications.

In addition to the self-comparison, ROM permits normative comparisons. Presentation of the data can provide data to support consideration of how the level and manner to change compares with similar patients. The normative feedback can be in the form of a "traffic light" feedback where the patient's actual scores are overlaid on a colored banding indicative of the clinical significance categories of recovered (blue), improved (green), no change (amber), and deteriorated (red; Ronk et al., 2012). Other normative feedback systems compare scores against an expected trajectory of change, where the expected time course in symptoms and well being is empirically derived from similar patients undergoing similar interventions. The present paper will illustrate both approaches but viewed through a DBT lens. Both methods foreground the patient's actual progress relative to a normative expectation. When a patient is "not on track," the dialectical dilemma is presented starkly and an uncomfortable tension that calls for a resolution is evident. Patient and therapist do not use this tension punitively to motivate guilt or shame. Instead, it creates a space to discuss questions such as: Why is progress going as it is? What does it mean that the responses

reflect instability while the expected trajectory appears to imply steady progress? What is unique about this particular journey that we need to understand?

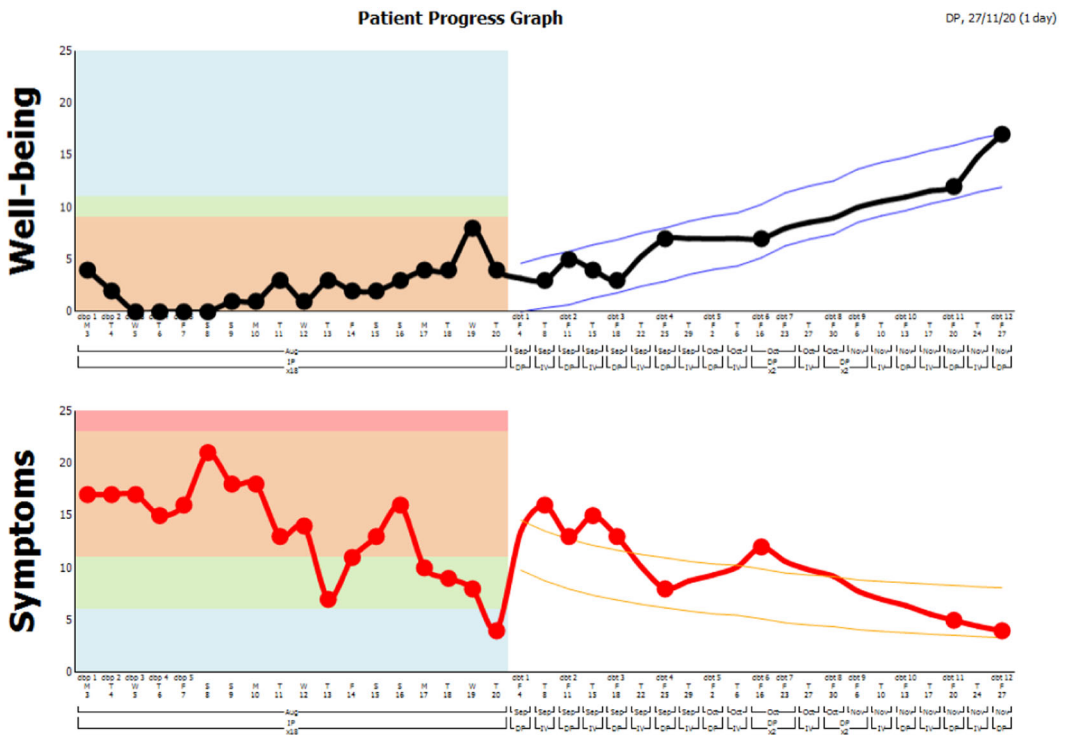
Each of these two methods of feedback move a dialectical dilemma between acceptance and change into center stage. In so doing it aligns with the suggested response from Tusiani-Eng and Yeomans (2018) to the stigma BPD patients may experience. They recommend that priority is given to validating each patient's experience. In addition to validating the severity of symptoms, there is potential clinical value in validating any improvements that the patient describes. Resolution of this dialectic is a key element of DBT and the use of ROM feedback explicitly places one view of the patient's current and past experiences in a form that is amenable for discussion.

The present paper will outline how ROM was used in one clinic while working with one individual with BPD receiving DBT-informed treatment. The aim is to illustrate the benefits of using the ROM in fostering a discussion of the dialectical dilemma between acceptance and change, rather than the technical details of how DBT is applied. We will open by describing the ROM system we have developed that is flexible enough to accommodate the complexities demanded by treating patients with BPD.

Perth Clinic began patient progress monitoring and feedback in our closed psychotherapy group programs (e.g., Newnham et al., 2010a). As an acute psychiatric hospital, we wanted a briefer measure than was mostly available in outpatient and daypatient settings (e.g., Andrews & Page, 2005; Lambert et al., 2001) and one that could be eventually adapted for inpatient care. That is, most systems asked patients to describe symptoms over a period of weeks, yet in some instances inpatient care could be completed in periods of days. The World Health Organization's 5-item Well Being Index (WHO-5; Bech et al., 2018; Newnham et al., 2010b) was chosen as a brief measure suitable for daily closed groups. The WHO-5 asks patients to rate the frequency over the last day that they have felt cheerful and in good spirits, felt calm and relaxed, felt active and vigorous, felt fresh and rested, and that their daily life has been filled with things that interest them. It was paired with the 5-item Distress Index (DI-5) (Dyer et al., 2014), a DI-5 to assess these symptoms. The DI-5 instrument asks patients to report "Over the last day..." to rate the frequency that they have, felt anxious, felt depressed, felt that worthless, had thoughts about killing self, and felt that they are not coping. Questionnaire choices range from 0 (*at no time*) to 5 (*all of the time*). Importantly in the context of BPD, the DI-5's Suicide Question (SQ) allows monitoring of the patients' suicidality. A trajectory of expected recovery was first overlaid on the graph of the daypatient's actual total wellbeing and symptom scores to show on-track and off-track daily changes (Hooke et al., 2018; see Figure 1).

However, many of our DBT patients move in and out of both open and closed psychotherapy groups as well as between inpatient and daypatient care. This movement of patients means that a single trajectory of improvement (typically used in daypatient settings; Delgado et al., 2018) did not translate well to this more complex context where the same patient can enroll in many different groups or treatment programs. Furthermore, as open groups can be offered during an inpatient admission (for which the duration is not known ahead of time) and they themselves do not comprise a fixed number of sessions, it is not possible to predict how long a person expects to be receiving this treatment. This means that an a priori trajectory of improvement proved unsuitable and even one based on the typical patient, proved of little use to the patients who remained in hospital longer than the average person. Hence, a more tailored and nuanced system was required. Therefore, for an inpatient admission we adopted a ROM feedback system that included four ranges, shown in the left hand side of the graphs (see Figure 1). The "Healthy range" (light blue color); the "Improving Range" (green in color); the "Unchanged Range" (orange in color); and the "Deteriorated Range" (red in color).

The scores from the ROM system are displayed via the intranet as illustrated in Figure 2 and accessible at any time by staff to share with patients. The screen shot illustrates the data available to therapists during a DBT group that is available on their mobile device and can be shared with patients. Staff need to log in to the tablet device, but this is a regular action as this is the method for staff to record each patient's attendance at (or premature departure from) treatment. For each patient, the Wellbeing/Symptom column allows therapists to review the symptom and wellbeing graphs (illustrated in Figure 1). For ease of access, the numbers are the Wellbeing (WHO-5) and symptoms (DI-5) scores. The color coding of red signals a person is off track



The charts plot your progress over time - please consult your treatment team for more information.

FIGURE 1 Routine outcome monitoring graph during an inpatient (left hand side) and daypatient (right hand side) admission. WHO-5 Wellbeing scores are in the top panel and DI-5 symptom scores are in the lower panel. WHO-5, World Health Organization's 5-item Well Being Index (WHO-5)

(relative to the expected trajectory of improvement) and blue is on track. The SQ is the question about suicide, which again is color-coded and allows staff to respond to any previously undetected thoughts of suicide. The orange bar graphs quickly show how much the patient is using the skills, and how this has affected their perceived Emotion Regulation and Distress Tolerance so that therapists can monitor the processes of therapy as well as the outcomes (of wellbeing and symptoms).

1 | CASE ILLUSTRATION

1.1 | Presenting problem and client description

Tracey was an 18-year-old female who presented with a history of depression, BPD including emotional instability and self-harm. Her progress through treatment is illustrated in Figure 1 and her admission and discharge scores are displayed in Figure 3. The use of ROM will be discussed in the context of the two phases of treatment in which an inpatient admission was followed by daypatient treatment. The inpatient admission involved the routine hospital care, plus the provision of a brief 5-day DBT module (described in Seow et al., 2022), and followed by attendance at a mood management psychotherapy group. After discharge, Tracey participated in a 12-week daypatient DBT program that comprised group and individual therapy (see Seow et al., 2022).

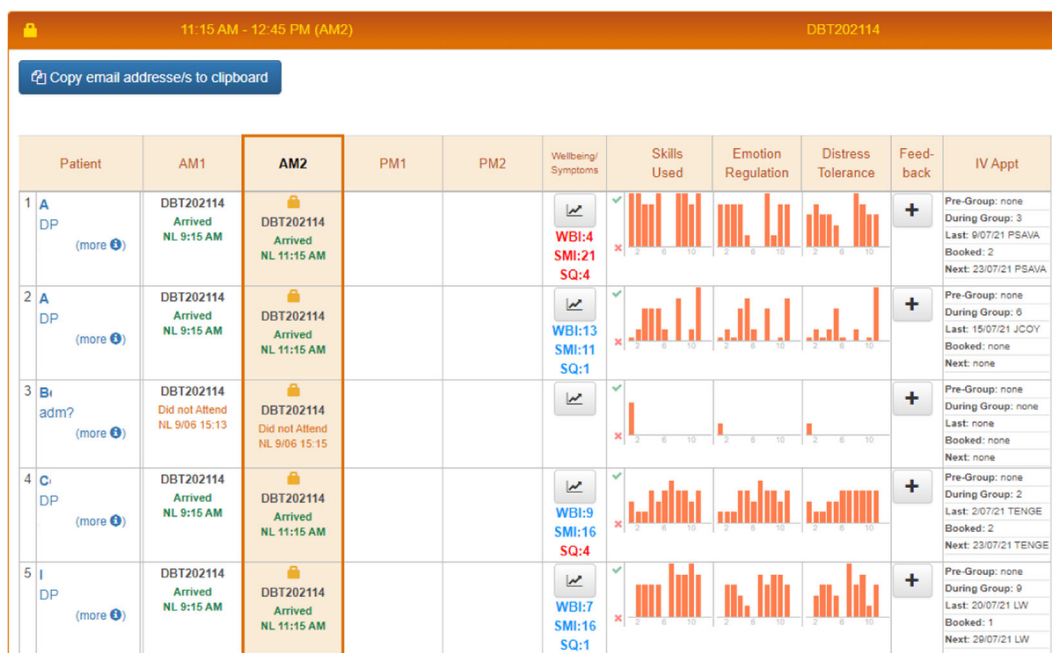


FIGURE 2 Screen shot of typical feedback screen available to DBT therapists to discuss treatment progress with patients in the closed psychotherapy groups. DBT, dialectical behavior therapy.

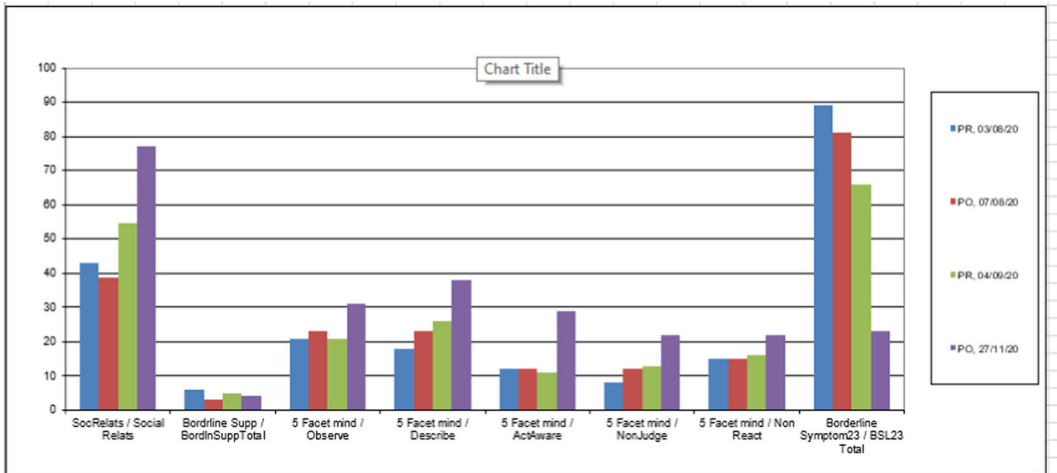
1.2 | Case formulation at inpatient phase of treatment

Tracey was referred with a history of depression and BPD. Her contact with the service involved an initial inpatient phase followed by a period of daypatient care. Therefore, the case formulations and treatment descriptions are divided accordingly.

Consistent with her presentation she demonstrated including emotional instability and episodes of self-harm (see Figure 1). Tracey reported her impulsive self-harm was usually precipitated by self-loathing thoughts, particularly fusion to the belief that she is a bad person. A collaborative engagement with the inpatient care team enabled Tracey to identify three key goals for her admission: reducing self-harm, improving her routine, and stabilizing her mood. To address these identified goals a treatment program was embarked upon that prioritized the self-harm, by encouraging Tracey to start her inpatient admission by participating in, and completing, a 1-week dialectical behavior therapy (DBT) Primer program (see Seow et al., 2022 for details). The goals of improved routine and mood stabilization were further addressed in a mood management program, described below.

1.3 | Course of inpatient treatment

Observing the graph depicting her progress through Tracey presented to hospital with a high symptom measure (17/25) and a low wellbeing measure (4/25); both of which were in the clinical range of the DI-5 (Dyer et al., 2014) and the WHO-5 Wellbeing Index (Newnham et al., 2010a). Whilst her symptom scores on the DI-5 fluctuated throughout her admission, her WHO-5 Wellbeing scores showed smaller changes, dropping within the first 2 days of being an inpatient, but increasing steadily in the second week. The DI-5 symptom scores showed spikes that were consistent with times when Tracey reported to staff that she was struggling and these provided a good opportunity to have a shared conversation about these fluctuations.



19-Jul-2021

Social Relations

Calculated as a % indicating the % of satisfaction in Social relationships out of 100%

BorderlineSupp.

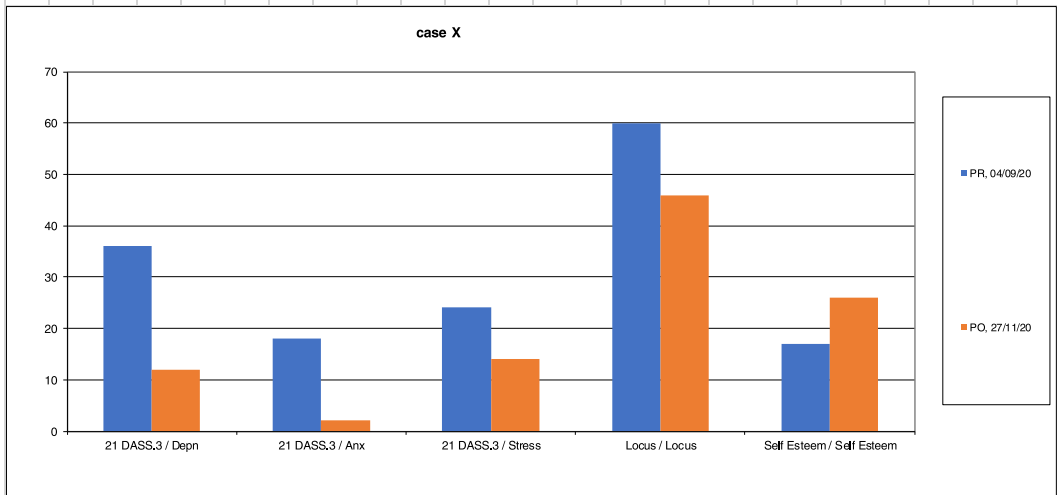
Measures impulsivity of behaviour. Higher score indicates higher levels of impulsive behaviour over the past week.

5 Facet Mindfulness

Observing, Describing, Acting with Awareness, Non reactivity to inner experience and non judgement. Higher scores suggest greater psychological wellbeing. Each Facet is out of 40 except 'non reactivity' which is out of 35.

Borderline Symptoms

Rates characteristics of the Borderline personality structure. Highest score is 92, indicating a greater symptom level.



7-Jul-2021

DASS - Depression

Measure of Depression

0 - 9 Normal
10 - 13 Mild
14 - 20 Moderate
21 - 27 Severe
28 + Extremely Severe

DASS - Anxiety

Measure of Anxiety

0 - 7 Normal
8 - 9 Mild
10 - 14 Moderate
15 - 19 Severe
20 + Extremely Severe

DASS - Stress

Measure of Stress

0 - 14 Normal
15 - 18 Mild
19 - 25 Moderate
26 - 33 Severe
34 + Extremely Severe

Locus

Measure of Locus of Control

Belief in your own ability to manage your feelings/future versus out of control. Maximum negative score = 85
A decrease in scores is an increase in your belief in yourself and your ability to cope.

Self Esteem

Measure of Self Esteem

An increase in your score is an increase in your self esteem. Maximum positive score = 40

FIGURE 3 The symptom profiles, as available to staff and patient, at admission and discharge from the inpatient and daypatient periods of care. Top panel is Depression Anxiety Stress Scale, Locus of Control, and Rosenberg Self-Esteem scores, and the bottom panel is the borderline symptoms and 5-facet mindfulness scores.

At the clinic patients are encouraged to complete their daily questionnaires in the morning before beginning the group psychotherapy, allowing the therapist to obtain accessible self-report daily feedback of patients' symptoms and wellbeing on the day. Patients are encouraged to complete the questionnaires upon admission to the hospital. The admitting nurse will introduce the patient to the tablet device available in the patient's room. The device provides a mechanism for the completion of the daily questionnaires, but it is part of a platform to help each patient organize all facets of their admission. Since it is a platform for ordering meals, a calendar of events, a collaborative record of ISOBAR (i.e., Identify Situation, Observations, Background, Agreed Plan, and Readback) at nursing handover, locating treatment programs and rooms, information about their treatment team, and helpful links and resources (e.g., relaxation exercises), it is a device that is regularly used by patients during each day. The daily feedback of symptoms and wellbeing is especially beneficial in an open group format as it enables the facilitator to prioritize patients accordingly.

The first therapy session of each day begins with a check-in that usually involves patients reflecting on their symptoms, wellbeing, and seeking support in addressing challenging situations. The group facilitator may highlight changes in the patient's symptoms and wellbeing, to encourage reflective practice and increase insight into the impact of patients' actions on their experiences. It provides an opportunity to review the scores on the SQ of the DI-5.

Ideally, patients inform staff directly of changes in their suicidal ideation or urges, but the self-report measure provides another mechanism for patients to provide this information. Importantly in the context of suicidal thoughts, patients are encouraged to be mindful of the potential impact of disclosure of increased suicidal urges on other group members. Furthermore, patients may be unfamiliar with other group members, thus altering their comfort in sharing vulnerable thoughts in the group setting. The facilitator checks patients' recorded rating for suicidality and this permits a complete and more detailed follow-up post group for patients rating their urge at 3/5 or higher. Some patients in the acute hospital have reported that their verbal self-report is dependent on their rapport with the staff supporting them on the day. Therefore, when these changes are reported and tracked on the system, they prompt the therapist and other staff members to follow up with the patient.

In addition to the potential for daily check-ins, the symptom and wellbeing progress graphs are printed out for each patient every Friday and they are invited to discuss their progress with the group as a way of reflecting on progress, learning from setbacks, and planning for the week ahead. Some patients have expressed appreciation for the visual representation of their mental health journey, as it allows them to reflect mindfully on their week. Patients have also indicated that the graph validates their difficulties if their symptoms are higher on the scale. In the mood and anxiety management group, the graph is commonly used to reflect on factors that may have influenced positive and negative changes in symptoms and wellbeing. The aim of this is to reinforce more helpful behaviors that are value or goal-focused and to understand the negative impact of unhelpful behaviors.

Therapists use their clinical judgment to decide how best to use the ROM feedback and adapt it to the patient or group. At a clinic level, the feedback principle adopted was that the data are the patient's and so should be shared, but clinical staff have a duty to care to manage the patient's welfare. Following this principle, patients cannot access their graphs from their own tablets, but they do so in collaboration with the therapist or nurse. Staff initiate discussions about the graphs as a routine part of care and patients can request to talk about the graphs as well. In the context of closed group treatment programs, staff are prompted to discuss the ROM graphs at the end of each week. This feedback is incorporated into a reflection on progress and planning for the weekend (where patients may often be engaging more with family and friends). During daypatient treatment, staff and patients can initiate discussions, but typically they will wait until 2–3 sessions have passed or when something clinically noteworthy has happened (e.g., self-harm, a rapid increase or decrease in symptoms or wellbeing).

Feedback in a group context involves some additional complexity. Patients may not wish to share their progress and therapists do not insist on disclosure. That being said, therapists will regularly review each group member's progress before a session and seek permission from a particular member to begin sharing with the group. For instance, a therapist might notice that a person's symptoms have risen since the last session, but the patient has

been finding some treatment techniques have been helpful or unhelpful. The review of the individual patient is then used as a prompt for a group discussion (e.g., sharing about similar experiences to assist with validation, discussing different ways that patients have managed similar situations with varying degrees of success). The therapist's management of the first patient to discuss is key in setting a tone for the session. Therapists strive to validate the experiences and to be accepting of all actions. That is, both improvements and setbacks provide opportunities for learning. Responding with therapeutic genuineness and openness to all accounts creates a supportive context of sharing and more reluctant patients tend to warm to the activity.

In the current clinical context the patient completed the relevant questionnaires and the resulting scores were available for discussion in group and individual sessions (obviously, only if patients were willing to share and discuss). From a DBT perspective the ROM feedback allowed therapists to validate each patient experience. In the present instance, the scores during the inpatient stay (left had side of Figure 1) provided a vehicle to validate Tracey's experience. Tracey's symptoms had fluctuations (15–17/25) during her time in the DBT Primer group, however, her wellbeing index dropped completely (0/25).

Thus, the depiction of the scores provided a foundation for therapists to share the observation that symptoms were fluctuating. Such a pattern is not atypical in DBT, but the scores reflect the emotional instability and allow therapists to validate this experience. Notwithstanding, for most of the inpatient admission and during the DBT-Primer program, the symptoms and wellbeing were in the amber (or unchanged) range. The boundaries of the unchanged category are set by the patient's initial score and from a DBT perspective that both communicates acceptance by validating that this is where the patient's symptoms are and we understand that there will be fluctuations around that. However, the implicit message conveyed by the red (deteriorated), green (improved), and blue (healthy) ranges points to the opportunity for change, captured in the dialectical dilemma. The presentation of these data can be used by therapists as they routinely frame these dialectics for each patient.

In the present case, it was possible to validate Tracey's experience by noting that a decline in the WHO-5 wellbeing index is not uncommon among new inpatients perhaps among new patients perhaps reflecting challenges in adapting to the environment of a hospital. In so doing, therapists were able to validate the experience and to convey that a patient's "normal" journey is not one is a linear increase in wellbeing. Likewise, the relative stability of symptoms in the first week was consistent with Tracey's presentation as emotionally restricted and being distracted by her own thoughts through most group sessions. She reported being caught in ruminative thoughts, which precipitated an increase in her symptoms towards the end of the week and this is reflected in her progress graphs. The depiction of these symptoms both validated Tracey's experience and provided a platform for discussion of how her inner experiences translated into her emotional experiences.

Tracey's symptom measure at its highest point (21/25) at the end of her first week as an inpatient. Again, this is not an uncommon observation among patients who are now beginning to confront challenging problems, but feel able to do so with the protection of hospital care to support them. Her vulnerability was heightened by her interpretation of comments from a staff member as perceived criticism, which prompted her thoughts of being a "bad person" and hence increased her self-harm urges on this day. Tracey, however, at the time, denied self-harm urges with staff. In this context, it is valuable to note that the symptom (DI-5) index provided a fruitful avenue to engage conversations about the patient's feelings. Tracey reported attempts to manage her self-harm urges using grounding and distraction were not sufficient, as her self-loathing thoughts intensified, ultimately leading to an incident of self-harm. Her symptoms following this incident dropped slightly (18/25), and she took steps to ensure her safety and was supported by nursing staff.

These discussions around self harm speak to another common dialectical dilemma focused on during DBT, namely competing wishes to live and die. The DI-5 asks patients to describe the frequency wish which they have thoughts about the action of killing themselves. Endorsements of this item provide a platform for therapists to invite a discussion about what it means to both wish to live and to die. These are not bipolar opposites, but potentially simultaneous motivations associated with an ambivalence. These items allowed a conversation around self-harm that will be described in more detail later.

After completion of the closed DBT program to begin to provide the skills to address self-harm, Tracey moved to an open psychotherapy group. The mood and anxiety management group is an acute program for inpatients presenting with symptoms of depression and anxiety. The open group aims to teach patients skills to manage acute symptoms. The group consists of 6–10 patients per group and runs for 3 h across two sessions on weekdays. The first session is used to check-in with each patient to learn more about their experiences and increase their reflective practice. The second session is focused on cognitive-behaviour therapy-informed skills training.

In the mood management group, Tracey shared her experiences of invalidation and expressed her anger towards those that misunderstood her. She reflected on the impact of her experiences on her self-esteem. Tracey participated well in discussions and activities aimed to improve insight into factors impacting on her depression, including value-based living and self-compassion. She was encouraged to practice these strategies to work towards her goals.

Tracey reported an improvement in her mood towards the end of the first week, consistent with her symptom measure, which had dropped significantly (6/25). Tracey was engaging well with the group process and participating in discussions thoughtfully. At this stage, Tracey reported she felt ready for discharge from the hospital.

Following this, Tracey reflected on her experiences with invalidation within past challenging relationships, at which stage a spike is seen on the symptom measure. Tracey reported self-harm at the peak of this spike (16/25) precipitated by self-loathing thoughts, feelings of loneliness and emptiness, following an evening out with family. Tracey reflected on her self-harm, identifying she commonly feels this way, “when good things are happening.” Tracey reported guilt following her self-harm incident, stemming from her belief of being a bad person. Tracey completed a chain analysis with the group facilitator the following week. This was used as a tool to understand her vulnerabilities, validate her distress and reduce Tracey's increasing feelings of guilt.

The spike in symptoms is further explainable by the anxiety Tracey experienced concerning discharge, a common concern for inpatients. In light of these concerns, Tracey's planned discharge was delayed to permit additional support with discharge planning. Her symptoms gradually improved following this additional structured planning.

Tracey's symptoms were in the healthy range (3/25) on the day she discharged. She reported she felt confident about going home, following an extra week in the group exploring strategies such as value-based goals, boundary setting and cognitive distortions. Her wellbeing index remained unchanged (4/25) from admission and for this reason daypatient care was provided to assist both the consolidation of the recent gains, but also with a view to broadening the impact of treatment.

A presentation of the scores to this point reflected the journey of improvement (chiefly in symptoms), but also validated that Tracey's experience of wellbeing had shifted little during her inpatient stay. Hence, there was an agreement about continuing to engage with therapy.

1.4 | Case formulation for daypatient phase of treatment

Tracey began a 12-week DBT program that involved weekly group therapy sessions accompanied by individual sessions (see Seow et al., 2022). At the commencement of the DBT program, Tracey already possessed remarkable insight regarding her personal struggles. She described an over-reliance on external validation and profound sensitivity to criticism. She reported she struggled to define herself as her illness dominated her sense of identity. Tracey reflected that she strived to be perceived as “good” by others in recent years and noted strong ambivalence regarding her current occupations and choices, including those in which she was externally perceived to be excelling. Tracey also noted numerous friendships formed throughout her adolescence in which she did not perceive herself to be authentically known by others.

Tracey identified goals for the DBT skills program, including managing self-harm behavior, suicidal thoughts, emotional dysregulation and persistent feelings of emptiness and worthlessness.

1.5 | Course of daypatient treatment

At the commencement of the program, her symptom measure had increased in severity (15/25), and the wellbeing measure had declined (3/25) following her discharge from the hospital 2 weeks prior. At this stage in her treatment, Tracey recognized her increase in symptoms and decline in wellbeing stemming from difficulty adjusting to her everyday life. Tracey's self-harm behaviors were often tied to perceived success and failure, as well as her anxieties regarding both outcomes. Unfortunately, Tracey indicated the only part of herself she was familiar with was the part of herself that "deserved to feel pain." Thus, in addition to being encouraged to implement DBT skills and strategies, Tracey was also encouraged to take a self-compassionate attitude towards herself in DBT skills coaching sessions.

Tracey's expressed sense of hopelessness and shame represented barriers to using DBT skills in the initial stages of therapy. In the first week of DBT, Tracey's self-harm behaviors relapsed. While she did not self-harm the following week, her skills use was minimal. She was tasked with assessing the pros and cons of using DBT skills compared with not using skills. At this stage, the wellbeing index enabled access to a concrete representation of Tracey's decline since her discharge from the hospital. As treatment progressed, Tracey completed diary cards more readily, and her skills use increased. In addition to reviewing the wellbeing and symptom measures with her group and individual therapists, she retrospectively described the process of completing the daily wellbeing questionnaire as "a helpful way to check in with yourself." She suggested it facilitated an opportunity to mindfully acknowledge aspects of her mood and coping that she had previously ignored. Nonetheless, she identified that she tended to self-harm at 2-week intervals due her to fear of "getting better." She reported that her maladaptive coping strategies enabled her to remain in her "comfort zone."

As Tracey struggled with her resistance to recovery, she was noted to be highly sensitive to the group therapy environment and the behaviors of her peers. The wellbeing index's SQ score enables group members struggling with increased suicide risk to be identified and offered support outside of the group. While Tracey's SQ score was consistently low (0–1/5) throughout the program, Tracey did become actively suicidal during a group session in response to her peers' dysphoric mood and hopelessness. On this day, Tracey did not complete the wellbeing questionnaire or approach the group therapist to manage this sudden increase in distress and suicidality. Instead, Tracey self-harmed during a short break between group sessions. She returned to the group, reported that self-soothing exercises helped reduce her distress and went home with minimal suicidal urges. When reviewing her diary cards at her next individual session Tracey noted this event and with the support of her therapist was able to reflect on its significance. At the next group session, Tracey was able to articulate more fully the sense of hopelessness she had felt regarding her own future wellbeing as she listened to her peers. She noted that, as a young adult, she felt overwhelmed by the prospect of her difficulties dominating her adult life. At the same time, she felt unsure of her own capacity to succeed in a personally meaningful way and to enjoy her success.

Tracey's symptom measure and wellbeing index at this time show an increase in symptoms and a reduction in wellbeing, which may be partly attributed to her shame and discomfort in acknowledging her recent behavior. However, following this acknowledgment in group and individual therapy sessions, Tracey consolidated her need to work on "being ok with being ok." Tracey's symptom measure and reported distress diminished, and the wellbeing measure improved consistently, as she cultivated greater acceptance of her emotions, opportunities, and of herself as a worthy individual. Tracey's engagement in learning and practising mindfulness skills appeared to provide a sound foundation for her to reconnect with her physical self. She commented on her self-harm behavior's past role to "feel" and to "release" emotions. During the program, she explored opportunities to implement skills as an alternative to self-harm. Between skills sessions, Tracey reported high levels of active practice, regular meditation and mindful activities. She reflected an affinity with natural environments and commented that she could often cultivate present moment awareness and connection with positive experiences whilst bushwalking. Tracey also noted the benefit of adjusting her body temperature to assist her in regulating emotions, particularly during times of increased distress. Tracey explored distress tolerance strategies, including active distraction, sensory soothing and

radical acceptance. Tracey reflected on building her understanding and acceptance of emotions, particularly exploring the “feeling behind the urge” associated with her self-destructive behavior and striving to self-validate more effectively.

Within group sessions, Tracey shared her opinions more confidently as the course progressed. Her contributions appeared highly valued by her peers, who further validated her right to assert herself with others and forge her own path. Tracey also invited her parents to attend a group supporter's session with her. Tracey's parents expressed pride in their daughter, her abilities and her motivations, as well as acknowledging their own confusion and anxieties regarding her illness and difficulties. This appeared to further benefit Tracey, who described increased willingness towards constructive and effective communication with her family in the latter parts of the program and greater awareness of their efforts to support her. Tracey also noted starting a new relationship in which she reported feeling more authentically known and accepted by her partner.

Tracey retrospectively commented that the wellbeing index was especially beneficial during the DBT program because it was “linked with my day to day life.” This was particularly evident when Tracey was upset by her family's concern due to her reduced academic striving compared to high school. She recognized her wellbeing had substantially improved relative to this time in her life and felt angered that her supporters disagreed with her perspective. Tracey's trajectory on the wellbeing index enabled the therapist to affirm Tracey's perspective strongly. The manner in which Tracey responded to relapse after a prolonged period of zero self-harm was an additional key milestone. As the program's conclusion approached, she recognized she relapsed and self-harmed to manage anxiety and dread stemming from uncertainty about her future. While disheartened, Tracey indicated the incident reinforced rather than diminished her desire to abstain from self-harm. At the conclusion of the group program, Tracey reflected positively on her progress towards her personal goals and expressed a sense of hopefulness regarding her future. She reported an intention to continue to practice the DBT skills she had learned and outlined plans to seek support in her local community. Tracey also explored strategies for managing crises and stated she felt confident accessing further professional support if necessary. She retrospectively commented that the outcome graphs provided in the program's final session were particularly helpful for her as they provided a means to show to herself and others reward for the work she had been undertaking in therapy.

2 | CLINICAL PRACTICES AND SUMMARY

The case outlined, highlighted a variety of values that ROM can play in terms of treatment. First, the care provided to the patient involved a multidisciplinary team with different staff providing care at the same time and within the different group programs. The use of a common ROM system means that staff can have a shared language when monitoring progress and discussing progress both among themselves and with patients. For each staff member and in each circumstance, the data provide one element in the decision-making progress and they will be enriched with the other clinical information available.

Second, the ROM highlights that the value of any system is only as good as the quality of the data. The patient's completion of the questionnaires was higher in the daily structure of the inpatient admission compared to the weekly daypatient care. The more complete data set allowed staff to more closely monitor the self-harm risk reflected in the SQ (Kyron et al., 2018; Restifo et al., 2015), but this was harder in the daypatient setting when the data were not always available. Thus, the limitations must be acknowledged, but it also highlights that despite the absence of the scores, the clinical care is still provided and therapists need to seek the information in routine ways in clinical sessions.

Third, our intention was to outline the application of one ROM system to one particular patient. Thus, we are not intending that the learnings are generalizable to all systems and all patients. Although ROM systems tend to share some common features, it is unlikely that the implementation of them all is identical or even ideal. For instance, we recorded symptoms daily, but there are good reasons why more frequent (e.g., hourly) might be more

appropriate for some occasions. The emotional instability in BPD is one area where the more frequent approaches (i.e., Ecological Momentary Assessment) may prove beneficial. It will be useful to see how these methodologies translate into routine practice and the added benefits to outcomes.

Finally, looking at the entire progress of the patient through treatment, it is clear that the use of ROM captured two important messages. It was clear that the inpatient admission served an important function in reducing acute symptoms, but the treatment journey was not complete as wellbeing remained low. The transition to daypatient care and the subsequent value of this in consolidating the gains and extending them to improve wellbeing (while avoiding additional inpatient admissions), highlights the provision of multidisciplinary care in different formats working together in a coordinated manner to achieve a good outcome. Without these measures it would be harder to demonstrate the value of the substantial progress made by this patient, to herself, to the hospital staff, and to funding agencies. All these interested parties share a common goal that was achieved in the present case – an appropriate and coordinated care provided in an efficient and timely manner that allows a person to return to a good level of functioning. The use of ROM within this service allowed staff and the patient to monitor the progress towards this shared goal.

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Data sharing is not applicable to this article as no new data were created or analyzed in this study.

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