MEASURES TO PROVIDE PRACTICE-BASED EVIDENCE (PBE)

Introduction

The basic principle behind PBE is that therapy and supervision will prove more responsive and effective if psychologists are able to keep closely attuned to the experiences of their clients. Hence the employment of user-friendly brief measures for monitoring client progress is central to the PBE approach – as an aide not an alternative to holding so-called meta-conversations with clients (i.e. “how do we think things are going?”)

This brief document directs both trainees and their supervisors to suitable resources that will support the PBE training initiative adopted by the three Yorkshire clinical psychology programmes at the Universities of Hull, Leeds and Sheffield. The measures recommended have been selected to meet three basic criteria:

- They are freely available
- They are scientifically credible
- They are suitable for use in the NHS context

IAPT

Although the Improving Access to Psychological Therapies (IAPT) initiative was sold in its original format as an exercise in Evidence-Based Practice intended to deliver scientifically proven treatment packages to adults with common mental health disorders, it has also always contained a commitment to careful monitoring of client progress and data-based supervision of practice.

The IAPT service for adult clients (initially for those of working age) makes a number of helpful measures freely available via its website (http://www.iapt.nhs.uk/silo/files/iapt-data-handbook-appendicies-v2.pdf). These include brief measures that are suitable for sessional administration (the PHQ-9 to monitor depressed mood and the GAD-7 to monitor levels of anxiety). There are longer instruments designed to support the treatment of specific psychological problems such as obsessional compulsive disorder (the 42 item OCI) and PTSD (the 22 item revised Impact of Events Scale). These and other measures are freely available to download from the IAPT website. Scoring criteria are included.

In 2012 the IAPT service for Children and Young People was launched with an even more pronounced commitment to routine outcome monitoring as a core element of its treatment strategy. The CYP IAPT website, like its adult counterpart, provides a range of freely available measures designed to be used with young people and their families, but also offers some very practical advice for how the idea of regular monitoring of progress might be best presented to clients and how this information can subsequently be used in therapy and supervision (http://www.iapt.nhs.uk/cyp-iapt/routine-outcome-monitoring-as-part-of-iapt). A truly compendious resource pack of over 130 pages (http://www.iapt.nhs.uk/silo/files/childrenandyoungpeoplesiapttrackingoutcomesresourcepack-v132.pdf) includes details of measures for use by both young people themselves and their parents. In addition to the symptom-focused instruments that dominate the adult IAPT repertoire of tests the CYP IAPT resource pack includes both generic measures of psychological functioning (such as the Strengths and Difficulties questionnaire) and an attractively straightforward ideographic measure (the Goal Progress Chart) that allows therapists and their clients to devise a simple way of monitoring how well they are meeting the unique expectations of individual young people. The resource pack includes variations of measures adapted to particular developmental levels too. All in all this is a truly excellent
facility which will have something to offer all child clinical psychologists. Again the material is all freely available and full details of scoring criteria are included.

ORS/SRS

Sample copies of the Outcome Rating Scale (ORS) and Session Rating Scale (SRS) are provided within the CYP IAPT resource pack but individual practitioners must register with the measures’ developers to gain permission to use the instruments (see details later in the paper). Neither the ORS nor the SRS have been developed specifically for working with young people. Indeed the bulk of published research using the measures has been undertaken with adults. The format of both instruments is similar and very simple to score and administer. Clients are asked to rate how well they feel they are functioning (ORS) and their experience of therapy (SRS) by placing a mark on a 10 cm line. The developers of these measures Scott Miller and Barry Duncan had in mind that they would be used in concert as an integral part of what they termed a Client Directed Outcome Informed (CDOI) approach to psychotherapy. The two measures can be freely downloaded from the websites of both Scott Miller (http://scottdmiller.com/?q=node/6) and Barry Duncan (https://heartandsoulofchange.com/content/measures/login.php) along with details of scoring procedures. A number of variations of the two scales have been developed (e.g. for use in groups) and Miller’s website also includes the LASS scale for monitoring the supervisory alliance produced by Nigel Wainwright in Leeds!

CORE

The CORE project has been the UK “brand leader” in the practice-based evidence field for over a decade. The initial CORE-OM measure was developed as a generic tool to help monitor clinical outcomes across a range of NHS mental health services. It has proved highly successful and there now exists a substantial research literature supporting its use. However the 34 item original scale is not well suited to collecting sessional feedback and a number of shorter alternatives have subsequently been developed (such as the CORE-10 and CORE-5). The CORE researchers have also produced variants that have been designed with particular clinical populations in mind (the YP-CORE for young persons and the LD-CORE for individuals with learning disabilities) both of which are brief enough to be used for repeated administration. The CORE website (http://www.coreims.co.uk/index.html) also includes a short questionnaire assessing the therapeutic alliance (the ARM-5) which is an abbreviated version of the Agnew Relationship Measure. The CORE-Net web-based service supports the inclusion of a number of other instruments (both normative and ideographic) that are suitable for monitoring clients’ progress and experience but it is only the paper versions that are available for free download. However like the ORS/SRS system individual users must first register and agree to abide by copyright restrictions.

The Warwick Edinburgh Mental Well-being Scale (WEMWBS)

Another UK based initiative has been the development of the WEMWBS by researchers based at the universities of Warwick and Edinburgh. The WEMWBS has been explicitly designed to measure mental well-being rather than psychopathology. In contrast the CORE measures are predominantly symptom focused and questionnaires such as the PHQ-9 and GAD-7 only enquire about particular subsets of symptoms. The original 14 item questionnaire has been supplemented by a shorter 7 item
version so the WEMWBS is well-suited for collecting sessional feedback and may prove especially useful in non-medical settings such as work-based counselling services. The psychometric qualities of the instrument are detailed in a freely available article (Tennant et al (2007) The Warwick-Edinburgh Mental Well-being Scale (WEMWBS): development and UK validation. Health and Quality of Life Outcomes 5, 63) and full details of the scoring of both the 14 and 7 item variants can be accessed via the NHS Scotland website (http://www.healthscotland.com/understanding/popupulation/Measuring-positive-mental-health.aspx).

**Other measures**

Two further local initiatives illustrate the drive to produce sessional feedback measures that are tailored to the specific needs of particular client groups or therapy interventions.

Nigel Beail in Sheffield has developed two versions of his Psychological Well-Being Scale (one self-report and one completed by carers) for use in LD services. Nigel is very happy that we should pilot this recently developed measure on the three training courses so interested supervisors and trainees should contact him directly for further information (Nigel.Beail@swyt.nhs.uk).

Peter Stratton and colleagues from Leeds have developed the SCORE (a systemic parallel to the original CORE-OM measure) a questionnaire that aims to track changes at a family rather than individual level. A 15 item version has been produced that is especially suitable for sessional use (http://www.aft.org.uk/SpringboardWebApp/userfiles/aft/file/Members/UsingSCORE(Jan2012).pdf). Like the Beail measures the different SCORE variants are at an interesting stage of development and trainees should contact Peter Stratton if they wish to help in collecting further standardisation data (email p.m.stratton@ntlworld.com).

**And the rest...**

This is not an exhaustive list of available measures. It noticeably does not include some of the best researched US measures such as OQ-45 questionnaire developed and used by Michael Lambert and his colleagues at Brigham Young University. This is primarily because the instruments have US normative data and/or are not freely available to UK users. However those students and supervisors who wish to read more about research in the field of practice-based evidence should peruse the reading list at the end of this document.

This is also not intended to be a definitive statement of policy from the three courses. We are very open to suggestions about other ways of collecting feedback from clients (both qualitative and quantitative) and in particular to ideas about tracking outcomes in psychological interventions other than direct therapy such as consultation and training.

**Copyright**

Although all the measures listed in this paper are freely available to our trainees and their supervisors some, such as the CORE and SRS/ORS, require that individual users register with the parent organisation and sign a copyright agreement. It will probably be most practical if all trainees on the three courses take these actions during their induction at the University. They can then show their supervisors what to do! It is important to note that there will be restraints on computerised use of some measures but paper versions can be used with impunity and kept in patient files if necessary. There are therefore no restrictions on photocopying these measures for the use of individual therapists. However this freedom does not apply to other copyrighted test material unless the host...
Trust has got a site licence to permit such copying (e.g. the Child Psychology Portfolio compiled by Irene Sclare and published by NFER Nelson). Indeed our trainees should be explicitly warned against illicit photocopying of copyrighted test material.

**Choice of measures**

Although there is a growing body of evidence that the collection of practice-based evidence has definite advantages for both clients and trainees there is as yet scant understanding of quite how this outcome is achieved. There is certainly no empirical basis on which we might recommend the use of one measure over another. So the choice of what will work best for whom is a matter of local determination. However we strongly recommend that patient preference should play a prominent role in that decision.

David Green
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**Reading List**

