Therapists’ and clients’ perceptions of using CORE-Net and ARM-5 in the NHS

by

Gisela Carvalho Chan Unsworth

THESIS
Submitted for the degree of Doctor of Clinical Practice

PART ONE
Research Project
Overview of Integration of Knowledge, Research and Practice
Academic Paper Submitted

Faculty of Health and Medical Sciences
Division of Health and Social Care
University of Surrey

September 2009
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Statement of Originality

This thesis and the work to which it refers are the results of my own efforts. Any ideas, data, images or text resulting from the work of others (whether published or unpublished) are fully identified as such within the work and attributed to their originator in the reference/bibliography or in footnotes. This thesis has not been submitted in whole or in part for any other academic degree or professional qualification.

Name......Gisela Unsworth.............

Date......September 2009......
Dedication

To my loving husband David who was the sole person living with me throughout the four year doctoral programme and who has been so amazing throughout. He was always encouraging and helpful and continued to love me unconditionally even through the last few months towards the submission deadline when I was unable to give him much quality time and at times may have been impossible to live with due to effects of accumulative exhaustion.
Acknowledgements

First of all I would like to express appreciation to both my supervisors at Surrey University, Professor Helen Cowie and Dr Anita Green who supported me to get to the end. Special thanks are due to Dr Samual Thayalan, Occupational Health Physician who as Consultant in my department was the first one to encourage me to study at doctorate level and acted as Collaborative Supervisor and for this I will always be grateful. I am also deeply appreciative of the therapists who participated in the study and my own team especially who I know found the research very challenging but nonetheless were willing to participate with particular thanks to Kate Peters who since the completion of the study has given me regular and immense encouragement and support to finish and Lynn Barnes for her 'practical expertise'. Particular mention needs to be made to my fellow Doctorate of Clinical Practice students who have encouraged one another not to give up and especially to Denise Thomas who was the first one in our year to submit her thesis on time and who has been an inspiration to us. Dr John Mellor Clark, Tony Jordan, Barry McInnes and all the therapists on the international online forum of "heroicagencieslist", deserve a mention as they have inspired me in many ways. I am most grateful for the support of the NHS Trust who employs me for allowing me to undertake this research project and for which I will always be appreciative. Last but not least, the following quote describes my work with clients whom I am indebted to for inspiring me in this project:

"Treat people as if they are what they can be and you help them to become who they're capable of being." Goethe
Abstract

Title: Therapists' and clients' perceptions of using CORE-Net and ARM-5 in the NHS

Objective

This qualitative study elicited the perceptions of both psychological therapists and their clients in the use of Clinical Outcomes in Routine Evaluation (CORE-Net) where instant visual feedback was given on a computer screen and the combined use of an alliance measure (Agnew Relationship Measure, ARM-5) at each therapy session for session tracking. It elicited how therapists view its potential value in supervision and their suggestions for improving training in it.

Design/Setting/Participants/Outcomes

A purposive sample of convenience was used with therapists in a primary care counselling setting (PCC) who are the longest users of CORE-Net in the UK and an employee counselling service (OH) in the NHS just beginning to use CORE-Net and ARM-5 with their clients. Data were collected using focus groups, interviews and diaries. All data were analysed using a general inductive approach except the therapist diaries which were analysed using conventional content analysis.

Results/Conclusions

The study identified six overarching themes: 1) therapists were initially anxious and resistant; 2) therapists adapt 'creatively'; 3) outcome measures help the client/therapist relationship; 4) clients perceive visual measures as helpful; 5) CORE scores inform supervision; and 6) proper and ongoing training/support of therapists is necessary. The implementation of routine outcome measurement for session tracking is a challenge but can be made easier with proper training and supervision of therapists. Clients appear happier than their therapists when routine outcome measurement is used.

Key words

Agnew Relationship Measure, CORE-Net, practice based evidence, qualitative study, routine outcome measurement
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<td>CDOI</td>
<td>Client-Directed Outcome Informed</td>
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<td>CORE</td>
<td>Clinical Outcomes in Routine Evaluation</td>
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<td>CORE-OM</td>
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<td>DoH</td>
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<td>EBP</td>
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<td>National Institute of Clinical Excellence</td>
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<td>Occupational Health</td>
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<td>OM</td>
<td>Outcome Measurement</td>
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<td>Psychological Well Being Service</td>
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CHAPTER ONE

Introduction
CHAPTER 1

1.1 Introduction to the Study
This thesis has six chapters. Chapter One (Introduction) describes the topic of research, the background and context of the problem, and the rationale for the research project. Chapter Two (Review of the Literature), provides a review of the literature relating to the topic. Chapter Three (Methodology and Methods) describes the aims and design of the study with a methodological literature review, participant selection and characteristics, the research procedures, data preparation and analysis. Chapter Four (Therapists Interviews, Focus Groups and Clients' Interviews) and Chapter Five (Therapists' Diaries and Supervision Sessions and David's Interview) contain the findings of the data analysis. Chapter Six (Discussion and Conclusions) includes a discussion of the implications of the findings.

1.2 Introduction to Chapter One
This introductory chapter introduces the topic of the research and provides the necessary background and context for the study. The rationale for the current study and the framework for the research are discussed. This chapter also includes some background on topics of particular relevance to the study and concludes with a brief summary of the chapter.

1.3 Background and Context to the Study
I am a practicing integrative psychotherapist delivering a comprehensive Psychological Well Being Service (PWBS) for employees in the public health care sector in the UK. My role includes responsibility for the broader remit of organisational stress management but the bulk of my work is the provision of individual counselling that requires quality evaluation of the intervention and
comes into the area of outcome measurement and management. In January 2005, I began a Doctorate of Clinical Practice and this research project. The research involves the provision of psychological therapy with routine outcome measurement within the researcher's own clinical setting, an occupational health department, and a primary care counselling setting on the south coast of England.

1.4 Rationale for the Current Research

I trained as an integrative psychotherapist before I knew about Evidence Based Practice (EPB). Instinctively, I chose to be 'integrative' as opposed to adhering to one particular theoretical model because I felt they all had something to offer and I did not want to narrow my scope of practice. My training as an integrative psychotherapist parallels my subsequent choice of empirical enquiry, my rationale for the methods of data collection and analysis used in this study, and my choice of a flexible design.

My preference in terms of what I consider valid methods of empirical inquiry is 'methodological pluralism' (Goss & Mearns 1997) as I see value in both the quantitative and qualitative paradigms of research. Cooper and McLeod (2007) discussed a pluralistic framework for counselling and psychotherapy. They suggest that therapists can have a trans-theoretical approach to their work which allows three main domains, namely, goals, tasks and methods to bring together different models of change, distress and therapeutic practice. They emphasise a 'collaborative approach to therapy' that holds the 'client's view on what is helpful and not helpful in therapy as valid as the therapists' (p11). A collaborative relationship between therapist and client is advocated to help identify the tasks and methods that may help the client achieve their goals. This requires a therapist to engage in dialogue at each stage so that the client is directly relating to the therapist as they negotiate their way into laying a foundation for further engagement with each other. My philosophy of science is developing and is best described as closely aligned to a new paradigm of science that embraces the Levinas' ethics first approach.
Drury (2006:184) speaks of “not relying on any one model, for no model is superior in generating new beginnings to troubling situations, but we can be aware of many”. The idea is to enhance “withness-talk” and the tools that can help us to do this with our clients in therapy are those that provide feedback about the clients’ progress and our therapeutic alliance as it is this feedback that allows us to alter the process in therapy.

In my journey over the past four years of the doctoral programme I have embraced the Client Directed Outcome Informed (CDOI) practice as described by Duncan et al. (2004) which encourages primary accountability for the therapist to the client. Patient progress in psychotherapy and the emerging new paradigm for evaluating psychotherapy research, client-focused research, is concerned with monitoring an individual’s progress over the course of therapy (i.e. session tracking) and providing this information to the practitioner, supervisor or case manager so that changes can be made during the course of therapy to produce a different outcome before the last session (especially if the client is failing to improve early on in therapy) (Howard et al. 1996). Extensive work by Duncan et al. (2000, 2003) on Client Directed/Focused Outcome Informed (CDOI) clinical work attempts to answer the question “Is this treatment working for this client?” If it is not, can we find out during therapy and change the course of treatment before it is concluded to improve outcomes? (www.talkingcure.com). In the USA, work by Lambert et al. (2005) discuss an emerging method for providing clinicians with timely feedback on treatment effectiveness using sophisticated computer software that can signal alarms for deteriorating clients and assist therapists with Clinical Support Tools (CST) to try to improve the rest of therapy for a successful outcome. In this study, for the Occupational Health therapists, therapists will be using both an outcome measure (CORE-Net) for session tracking and also an alliance measure (ARM-5) at each session (both described later in this chapter).

The theoretical framework of introducing outcome measurement routinely into my service and which underpins this study concerns measurement relevant to psychotherapy and its evidence
base. This study is carried out in a naturalistic setting and the research evidence it contributes to forms part of one of the current modern paradigms of evidence called Practice Based Evidence (PBE). This study supports a model of professional self-management (practice-based evidence) which is widely applicable in psychiatry and medicine (Margison et al. 2000). The purpose of this study is to answer the overarching research question: How do therapists and clients perceive and experience CORE-Net and ARM-5 in the National Health Service (NHS)? This study had three specific aims related to the research question:

1. To elicit the perceptions of therapists (both experienced and trainees) and clients in relation to their use of a system of continuous monitoring of their therapy via a feedback system that includes regular outcome measuring (CORE-Net) and therapeutic alliance measure (ARM-5);

2. To elicit the perception of therapists in utilising feedback information in supervision; and

3. To elicit the perception of therapists with regard to the training elements required in the process of implementation of this type of routine measurement in clinical practice.

1.5 U.K. Population Psychological Needs and the Political Context

As a practitioner working within the NHS, I am influenced by the UK political context as well as clinical governance issues, the need for quality evaluation of any therapeutic interventions and organisational accountability to the hospital where I work. Due to the current climate of the DoH (2004) recommendations and Lord Layard's (2005) call for more therapists in line with requests from the British public for help with mental health issues, and in conjunction with clinical governance and the pressures of the reality of cash strapped NHS, treatments that are effective and of shortest duration as possible are encouraged to be researched in the many areas of clinical work. These key factors comprise the rationale for the current research and are summarised in Figure 1:1
1.6 Clinical Governance in the NHS

The National Institute of Clinical Excellence (NICE) guidelines on Clinical Audit (NICE 2002) highlight the significant shifts in society's attitude to quality in healthcare, which has led to the introduction of clinical governance in the NHS. Our chosen audit system is CORE (Clinical Outcomes in Routine Evaluation) System (2002), which was developed following government policy, and specifically in 1996 in reference to a review of NHS psychotherapy services in England (Parry 1996) and followed by other policies relating to mental health and the delivery of psychological therapies (DOH 1999, 2001; HCC 2005; Layard 2005; NIHME 2005).

1.7 Interventions Need Quality Evaluation

These psychological Interventions need good quality evaluation and systems need to be in place to gather this data. Some research shows how feedback gathered via data routinely collected can enhance practice so as to improve outcomes (Lucock et al. 2003). It is therefore important to
audit psychological service provision to clients to evaluate the areas for improvement in clinical practice

1.8 Organisational Accountability

The organisation always wants best practice and efficient services through service development based on EBP and PBE. This research project will contribute to general knowledge about clients' or users' perceptions and experiences of psychological therapy services and the therapists who use CORE-Net (outcome measure) and ARM-5 (alliance measure) to deliver these services. The combined use of outcome measurement with an alliance measure has the potential to improve the collaborative relationship by either improving outcome or deciding earlier that they would benefit from seeing another therapist.

My research simultaneously gathered anonymous quantitative data which is routinely donated to the UK national benchmarking network for CORE users, and will ultimately be donated to Leeds University and COREIMS Ltd for any future studies that may look at substantiating the claims of some international studies (Lambert et al. 2003) or validation studies of ARM-5. No published qualitative studies were found up to September 2009 on the use of CORE-Net (web-based version of the CORE system) in delivering psychological therapy, so this will be the first qualitative study using CORE-Net with a combined use of an alliance measure (ARM-5) in routine practice. A description of CORE and ARM-5 is necessary to set the scene for this study.

1.9 What is CORE?

The chosen outcome measure for this research project is CORE (Clinical Outcomes in Routine Evaluation) System (2002). It has CORE-OM 34-item (Appendix 1), a self-report outcome measure that is used by many therapists in the UK, mainly at the beginning and end of therapy when clients are asked to fill out the measures. The therapists also fill out additional contextual forms for additional key management data (Barkham et al. 1998).
CORE-OM is a UK based outcome measure that is standardised and has internal and external validity (Barkham & Mellor-Clark 2000). Data can be managed with a

Figure 1.2 Key Benefits of Measuring Outcomes


Level 1: Measurement
Helps people who use services and practitioners measure change over time and reflect on the effectiveness of care provided. This will help inform discussion about treatment and care and informs service improvement.

Level 2: Monitoring
Helps Commissioners assess needs and inform the allocation of resources across services.

Level 3: Service & Treatment Management
Helps policymakers identify what types of services/treatments have been most effective for specific different groups of people.

Level 4: Benchmarking
Enables all stakeholders to compare services and treatments at a local and national level. **(CORE is at this level)**.
sophisticated software system called CORE-PC that is embedded within a unique systems approach (Evans et al. 2002; Jacobson et al. 1984; Jacobson & Truax 1991; Lunnen et al. 1998). The principle of practitioner involvement in the development of CORE system for quality evaluation was seen as important if practitioners are expected to both implement and utilise evaluation tools in their routine practice (Mellor-Clark et al. 1999). Practitioners’ views are considered critical to ensure that PBE is developed and the use of CORE System is a ‘bottom up’ approach whereby therapists are engaged at a practice level in outcome measurement (Barkham & Mellor Clark 2000). This principle contributes to service improvements as their ‘voice’ is paramount to giving clinical feedback on such monitoring systems. Current government guidelines are encouraging outcome measurement routinely in mental health services but they are not yet requiring it as mandatory practice (NIMHE 2005). It would therefore be both politically appropriate and have a strong practical implication for service enhancement. This research attempts to contribute to the PBE research of bridging the gap between research/practice and researcher/practitioner.

The CORE Outcome Measure (CORE-OM) captures information across 4 main sub-groups: well-being, social functioning and problems/symptoms, risk to self and risk to others. CORE-OM is designed to measure a pan-theoretical ‘core’ of clients’ global distress, including subjective well-being, commonly experienced problems or symptoms, and life/social functioning. The main purpose of the tool is to offer a global level of distress which is expressed as the average mean score of the 34 items that can be compared with clinical thresholds before and after therapy to help determine clinical and reliable change. To enhance client intake, the Therapy Assessment Form (Appendix 2) collects important contextual information including patient/client support; previous/concurrent attendance for psychological therapy; medication; and a categorisation system to record presenting difficulties, their impact on day-to-day functioning and any associated risk. The form additionally collects data on clinical governance and service
performance assessment items that profile the accessibility and appropriateness of service provision. These include patient/client demographics, waiting times, and the suitability of referral. To contextualise the outcomes of therapy, The End of Therapy Form (Appendix 3) collects profile information that includes therapy length, type of intervention, modality, and frequency. To enhance the development of service quality, the form also collects data on critical discharge audit items that profile the effectiveness and efficiency of service provision. These include problem and risk review, therapy benefits, session attendance rates, and therapy ending (i.e., planned or unplanned).

The most recent and exciting development is CORE-Net which became available in 2006. It is a web-based, paperless system that encourages a more dynamic form of collaborative interactions with clients when they visually see their progress charts on screen at each session.

CORE-Net first became available on a pilot basis in January 2006, and a focus group in this study was made up of a group of the initial therapists involved in the trial of the pilot. The CORE-Net system allows therapists to input all data without using a data entry clerk, and once competent, the therapist is able to effortlessly have access to ‘live data’ without a time delay for real time analysis of data. The direct input of forms onto the screen provides instant feedback via visual colour graphs that display client progress and thus allow both therapist and client to chart progress by session tracking (Appendix 4).

Both the therapist and the client can look at the answers that were inputted to see how the client is progressing by seeing which issues scored high, since these are flagged with darker shades of pink or red (Appendix 5). Therefore, both therapist and client can actively consider these issues in therapy.
The software allows entry, storage and reporting of data gathered from the full set of CORE forms (Outcome Measure – OM, Therapist Assessment Form – TAF, End of Therapy form – EOT) including the shorter versions of CORE-5, CORE-10 and CORE-18 forms A and B (Appendix 6, Appendix 7, Appendix 8, Appendix 9). In addition, for the specialist area of workplace counselling there are several additional contextual forms that capture additional data, e.g., number of sick days (Appendix 10, Appendix 11).

1.10 The History of CORE and the PWBS

The PWBS has been using CORE for six years. In more recent times, our service started to routinely discuss the pre and post therapy outcome scores actively with clients. There was more dialogical use of CORE with the client so that it was no longer to be just a sophisticated quality evaluation system. A keen interest was taken in the individual therapy outcomes of each client. Our service had never routinely used an alliance measure but we were ready to use ARM-5 for this study as a first pilot site for ARM-5.

1.11 Agnew Relationship Measure (ARM-5)

The Agnew Relationship Measure (ARM-5) is (Appendix 12) comprised of 5 items reduced from a 12 item ARM-SF (Stiles et al. 2003) which is a shortened form of the original ARM with 28 items (Agnew-Davies et al. 1998). There is an easy scoring sheet to facilitate therapists' scoring of the client's scale (Appendix 13). ARM consists of two parallel forms rated by both clients and therapists using a seven-point scale anchored 'strongly disagree' to 'strongly agree'. Instructions on the client scale read, "Thinking about today's meeting, please can you indicate how strongly you agreed or disagreed with each statement by circling the appropriate number". Both the client and therapist will know what they are measuring on the client's scale and discussed in the session but the therapist's scale of how he or she views the alliance with his or her client will not be used for the purposes of this study. The ARM-SF has demonstrated very
high correlations with the 28-item version (Stiles et al. 2003) and assesses four domains of the therapeutic relationship:

1. Bond, which concerns the friendliness, acceptance, understanding and support, e.g., "I feel friendly towards my therapist".
2. Partnership, concerning working jointly towards therapeutic goals, e.g., "My therapist and I agree about how to work together".
3. Confidence, optimism and respect for the therapist's professional competence, e.g., "I have confidence in my therapist and his/her techniques".
4. Openness, the client's felt freedom to disclose, without fear of embarrassment, e.g., "I feel I can express my thoughts and feelings to my therapist".

Chapter Two will consider more information on ARM-5 and the therapeutic alliance.

1.12 Summary

Various influences on the researcher's clinical practice such as the UK political context for effective psychological interventions that need quality evaluation, together with organisational accountability and clinical governance requirements provide the context for the research project. Although the start of routine outcome measurement in the researcher's team is located within the quantitative paradigm of PBE, this research project has a qualitative design. This research will attempt to answer the question, "How do therapists and clients perceive and experience CORE-Net and ARM-5 in the NHS?" Specifically, this study collected qualitative data from both therapists and clients involved in therapy which included the use of outcome and alliance measures routinely alongside computer technology. A description was given of CORE/CORE-Net as a self rating outcome measure and ARM-5 as an alliance measure. Chapter 2 will provide a review of the current literature relevant to this study. Chapter 3 will provide the specific details.
of the research design. Chapters 4 and 5 will present the findings of the data. Chapter 6 will include the discussion, conclusions and recommendations.
CHAPTER TWO

Review of the Literature
CHAPTER 2

2.1 Introduction
The chapter will consider my search strategy and the main literature relevant to the study leading to the research questions. My journey began with a specific interest in the role of Occupational Health or workplace counsellors/psychotherapists and their effectiveness in the individual client work. In particular, I searched for evidence as to whether these interventions are effective. After the first year of study I narrowed the focus to psychological therapy and outcome measurement research in psychotherapy.

2.2 Search Strategy
The following literature search terms were used:

Evidence based practice, patient-focused research, psychotherapy outcomes, the effectiveness of psychotherapy, therapeutic alliance/relationship, alliance measures, quality evaluation, practice based evidence, CORE-PC, benchmarking, performance assessment, practice research networks, routine outcome measurement, service quality improvement, reliable and clinical significant change, feedback in psychotherapy

This narrowed the literature search to finding evidence of the efficacy and effectiveness (CORE research comes into this area) of psychotherapy and leading to the work of client-directed, outcome-informed clinical work using computer software that allows instant feedback.
(sometimes referred to as Clinical Support Tools – CST) for incorporation into the ‘here and now’ of the therapy session or session tracking.

The following exploration starts with the literature that I was most familiar in my role as a workplace counsellor and as an NHS employee. I then explored the other areas under the broad overarching theme of psychotherapy research, namely: Efficacy, Process, Outcome and Effectiveness Research, Bridging the Gap Between Research/Practice and Researcher/Practitioner, U.K. Political Context of the Evaluation of Psychological Therapies, the Development of CORE in the U.K. and Practice Based Evidence (PBE) in Routine Practice, Measuring Recovery and Improvement, Validity, Reliability and Sensitivity, Client Directed Outcome Informed (CDOI) and patient focused research and Routine Outcome Measurement (ROM). See Figure 2:1

2.3 U.K. Psychological Treatment Needs and Provision

One in six adults of working age suffers from a mental health problem and for every 100 patients who consult their General Practitioner about such problems, 91 will be treated in primary care (DoH 1999). Historically, however, mental health services in the NHS have suffered from lack of investment and failure to provide access for treatment which has been reflected in the rising numbers of mentally ill people on incapacity benefit. For employees in distress this means they could be waiting for months to receive assistance via primary care and specialist mental health services. The growing number of psychological therapy provided by Employee Assistance Programmes (EAPs) and internal counselling for staff in the NHS has eased the situation in more recent years. Such therapy needs to be delivered in a timely, effective and confidential
manner and needs to have accountability both to the users and to the organisation in terms of clinical governance (DoH 1997) and according to government guidelines (DoH 2004).

Traditional counselling services are well established in UK general practice, with between one third and one half of practices offering on-site counselling (Mellor-Clark 2001). In 2001, 76% of PCTs offered a counselling service (www.primhe.org). A Cochrane review of seven randomised controlled trials of counselling concluded that it was popular with patients and associated with modest improvement in outcomes in the short-term compared to 'usual care', but provided no additional advantages in the long term (Bower & Rowland 2003).
A recent and comprehensive systematic study of the research evidence specifically relating to workplace counselling was carried out by McLeod (2008) and revealed that counselling in the workplace could also reduce levels of sickness and absence by up to 60% in as little as three to eight sessions of counselling.

The effectiveness of workplace counselling compares favourably with outcome studies carried out in other settings in terms of the range of effect sizes reported (Lambert & Bergin 1994).

It is important to go back in history to review the historical development of psychotherapy/counselling research per se to understand the development of the various outcome measurement tools and to see how it leads to the new generation effectiveness research paradigm where CORE and practice based evidence sits.

2.4 Efficacy, Process, Outcome and Effectiveness Research

Psychotherapy research is said to have evolved through various generations. The first generation of research that was conducted until the mid-1980s focused on efficacy, "Does Psychotherapy Work?" (Smith et al. 1980). This question crystallised earlier in a controversial article published by Eysenk (1952) who concluded based on an early review of 24 studies that there was no research evidence to support the effectiveness of psychotherapy compared to groups not receiving therapy and that psychoanalysis was less effective than no treatment. Numerous psychologists like Bergin (1971) strongly criticized Eysenk's argument, which led to a dramatic increase of interest in scientific investigations of psychotherapy (Bergin & Lambert 1978). The second generation of research was concerned with how therapy works and the therapeutic alliance (Bordin 1979; Gaston 1990; Horvath & Symonds 1991). The third generation of research focuses on finding evidence based practice and is currently where UK psychological therapy research stands, whereby works by Roth and Fonagy (1996) emphasise the EBP paradigm.
An important focus of some research papers is on the dose-effect relationship in psychotherapy and understanding that the amount of therapeutic benefit is positively associated with amount of treatment (Lueger 1988; Lueger et al. 2001; Orlinsky & Howard 1986) and thus contributes to the understanding of optimum treatment lengths of therapy. Perhaps the fourth or new generation of research involves therapist effects that produce differential outcome effects based on the initial work of Lambert et al. (2001a, 2001b, 2002). This work that is being undertaken may be termed "patient-based research", "quality management" and "outcome management" (Lambert 2001). Luborsky et al. (1997) described a study that focused on finding the contribution of psychotherapists to the outcome of treatment and concluded that the important differences in improvement could not be explained by the differences in patient background or severity but rather that the safest basis for choosing therapists for research studies or clinical purposes is their "work sample" record of efficacy with their previous caseloads. Miller et al. (2004) acknowledge that although the empirically validated, integrative and evidence-based practice movements share in the belief that specific therapeutic ingredients, once isolated and delivered in reliable and consistent fashion, will work to improve outcome, the research and clinical experience indicates otherwise. They propose that the best hope for integration of the field is a focus on the common goal of change and the use of outcome to inform the clinical process as significant improvements in client retention and outcome have been shown where therapists have feedback on the client's experience of the alliance and progress in treatment. This therefore puts the emphasis rather than on evidence-based practice, that therapists tailor their work through practice-based evidence.

Wampold (1997; 2001) and others (Luborsky et al. 1986; Crits-Cristoph et al. 1991; Crits & Mintz 1991; Elkin 1999; Wampold & Serlin 2000; Huppert et al. 2001; Okiishi et al. 2003; Kim et al. 2006) argue that researchers have ignored the individual therapist as a source of variance and this published research makes use of Hierarchical Linear Modelling (HLM), pointing to the
conclusion that the clinician accounts for much more of the variance in psychotherapy outcomes than treatment method per se. The person of the therapist is necessary to delivery of the treatment and personal characteristics of the therapist modify the effect of the treatment. Factors contributing to therapists effects may include elements clinical skill and knowledge as well as personality traits. In a study of psychiatrist effects in the psychopharmacological treatment of depression, both psychiatrists and treatments contributed to outcomes in the treatment of depression (McKay et al. 2006). However, given that psychiatrists were responsible for more of the variance in outcomes, it can be concluded that effective treatment psychiatrists can, in fact, augment the effects of the active ingredients of anti-depressant medications as well as placebo.

In summary, the major research conclusions to date on psychotherapy can be summarised as follows: Different therapies produce similar results — Bergin and Garfield (1994) emphasise that although there are only a few exceptions, overall there is massive evidence that psychotherapeutic techniques do not have specific effects, yet there is tremendous resistance to accepting this finding as being a legitimate one. Roth and Fonagy (1996) note that when considering head-to-head comparisons among treatments differing in the strengths of their respective evidential support, there appear to be surprisingly modest differences. For most disorders there is little evidence beyond the paradoxical 'Dodo bird verdict' of equivalent outcomes from very different treatment methods (Luborsky et al. 2002). In a UK effectiveness study, (Stiles et al. 2008), comparing the effectiveness of cognitive-behavioural, person-centred and psychodynamic therapies in UK primary-care routine practice, the theoretically different approaches tended to have equivalent outcomes. They acknowledge caution in interpreting the results because of limited treatment specification, non-random assignment and incomplete data. In a commentary on this study Clark et al. (2008), they criticise the study mentioning the above aforementioned points and add that there was no evidence that the treatments were appropriately delivered and add that much higher rates of completion are needed if the public are to have information about the effectiveness of routine outcome monitoring. They suggest
clinicians giving out simple outcome measures at every session. A more recent randomized clinical trial in a naturalistic setting undertaken in Norway showed stunning results of using client feedback to improve couple therapy outcomes (Anker et al. 2009). Progress and alliance information was given to both clients and therapists during couple therapy at every session. Results show that couples in the feedback condition demonstrated significantly greater improvement than those in the Treatment As Usual (TAU) condition at post treatment, achieving nearly four times the rate of clinically significant change, and maintained a significant advantage on the primary measure at six-month follow-up while attaining a significantly lower rate of separation or divorce. They concluded that the time has arrived for routine tracking of client progress due to the mounting evidence of feedback effects with different measures and populations.

The client's resources are paramount — Orlinsky et al. (1994) speaks of the quality of the patient's participation in therapy as standing out as the most important determinant of outcome. Tallman and Bohart (1999) concluded that research data point to the inevitable conclusion that the primary agent of change is the client. In other words, 70% of why therapy works goes to the client and 30% to the therapist. On the whole, there is very little difference between therapists that is based on their training or experience, suggesting that specialised expertise on the part of the therapist is not a major contributor to effectiveness. Cooper (2008) provided a summary of research findings and their implications for practice and concluded in his review of the literature that "professional development through training, supervision and experience have some relationship to therapeutic outcomes, although the size of the effect tends to be small, and paraprofessionals seem to have as good outcomes as professionals" (Cooper 2008:96).

In my study, a practice based paradigm as a theoretical framework is used which complements evidence based practice. The two key components central to this paradigm are effectiveness (i.e., the generalisability of results across particular services and settings) and practice (i.e., the
analysis of results within a service), both of which allow practitioners to enhance the quality of
the intervention. This encourages ownership of the research activity whereby they strive to
innovate and generate solutions to local service delivery issues. An understanding of why the
ARM-5 was used as an alliance measure in conjunction with CORE-Net for this study is
discussed next.

2.4.1 The Therapeutic Relationship

Glass and Arnkoff (2000) summarised several studies in relation to consumers' perspectives on
helpful and hindering factors in mental health treatment which included the context of the
treatment, therapy relationship, issues addressed/interventions and help outside the mental
health system. Particularly interesting were their observations of the various facets of the
therapy relationship which included:

- therapist's ability to accept clients' frames of reference and experience as valid
- the importance of the therapist's knowing and communicating their own limitations and responsibilities
- a collaborative relationship that deemphasises the power imbalance and work together to deal with stuck points and exploring options and part of this partnership may centre around the ability of the therapist to see their clients as a whole person with a unique history and many skills, strengths, and abilities as opposed to seeing only the deficits and symptoms inherent in the 'patient' role
- Therapist's believing in and communicating an expectation of success. For example, the positive expectation that it is possible to have a fulfilling life, and not just be a perpetual patient is vitally important (Glass & Arnkoff, 2000: 1468-9)

This paper was quite meaningful to me as a new researcher in the way that I personally view the therapeutic relationship and the collaborative nature of the equal partnership with the client as
therapist. I wanted to use an alliance measure and to advocate its use in my team within our journeys with clients, in a way that incorporated the aforementioned findings.

Elvins & Green (2008) gave an excellent empirical review of the conceptualization and measurement of the therapeutic alliance. The concept was proposed by Hill and Knox (2009), that if therapists and clients process their therapeutic relationship (i.e. directly address in the here and now feelings about each other and about the inevitable problems that emerge in the therapy relationship), feelings will be expressed and accepted, problems will be resolved, the relationship enhanced and clients will transfer their learning to other relationships outside of therapy.

The choice of an alliance measure for my research project stemmed from hearing through the CORE National Database network, that a research team needed a pilot site for the use of ARM-5 and its validation. Prior to this I was going to use the Session Rating Scale (SRS) validated in the USA (Miller et al. 2003). The decision was then made to use a British measure with CORE which is validated. Horvath (2005) listed several elements of the therapy relationship: the alliance, cohesion, empathy, goal consensus and collaboration, positive regard, congruence, feedback, repair of alliance ruptures, self-disclosure, counter transference (management of) and relational interpretation. These elements were implicit in my psychotherapy training and that of many therapists.

2.4.2 Alliance measures

Stiles et al. 1994 gathered client’s evaluations of their sessions using the Session Impact Scales – 16 items (SIS), the Session Evaluation Questionnaire – 27 items (SEQ) and a Hindering Impacts Index. Both were questionnaires were given at the end of each session and returned to clinic administrators before the client left the clinic. Clients were informed that their therapist would not see their ratings until after therapy was completed to prevent the impact measures
from becoming a channel for client-therapist information. Thus in this study the purpose was not to engage client-therapist in a direct dialogue of how they found the session they just had. One of the issues the study did highlight was that the Hindering Impacts Index was that the ability for clients to flag for rare problematic sessions or relationships could be extremely valuable, for example, as a way to identify difficult sessions for intensive qualitative study or for feedback in training or supervision. I wanted the use of my chosen measure ARM-5 to be presented to the client in a way that elicited any problematic areas in the relationship and I wanted to train the therapists on my team to have a culture of learning and openness with clients so that feedback from the clients could inform clinical practice.

2.4.3 The ARM measures
As was already mentioned in Chapter 1 section 11.1, the Agnew Relationship Measure (ARM; Agnew-Davies et al. 1998) is a self-report measure designed to assess the client-therapist alliance. Much has been written about the client-therapist alliance in the psychotherapy process (Clarkin & Levy, 2004; Constantino et al. 2002, Horvath & Bedi, 2002; Martin et al. 2000; Orlinsky et al. 1994, Safran & Muran, 1998). Agnew-Davies et al. 1998, described the original 28-item ARM as being developed using a mixed conceptual-empirical strategy to encompass scale content that was considered important in the alliance across a variety of theoretical orientations. The classic alliance dimensions of client-therapist bond, agreement on tasks, and agreement on goals as described by Bordin (1979) are included and the last two fold into a partnership dimension. Additional dimensions in the scale are confidence, openness and client initiative where confidence is described by Hatcher & Barens (1996) and Hatcher (1999) as a particularly strong predictor of positive outcome. Marmar et al. (1989) describe openness as the felt freedom to disclose and reveal personal material without fear of censure or embarrassment and initiative items concern the client's taking responsibility for the direction of therapy.
The reduced 12-item version (ARM-12), has been used to study online reporting of alliance and internet therapy (Reynolds & Stiles, 2007; Reynolds et al. 2006) and sudden gains in cognitive behavioural therapy (Hardy et al. 2005). Advantages of ARM to other alliance measures (Elvin & Green, 2008) include the incorporation of content areas drawn from multiple sources and in simple language that is applicable to most therapeutic approaches and parallel forms are developed for both the therapists and their clients (Agnew-Davies et al. 1998). It shows strong convergent validity with the Working Alliance Inventory (WAI; Horvath & Greenberg, 1986, 1989) which is the most widely used alliance measure (Stiles et al. 2002). ARM also assesses the relationship dimensions that are not measured by WAI but described elsewhere in the alliance literature (the confidence and openness scales; Stiles et al. 2002) and has substantial correlations with gains in therapy (Stiles et al. 1998). This is consistent with repeated suggestions that a strong client-therapist alliance is the strongest known process predictor of psychotherapy outcome which thus supports the measure's construct validity (Horvath & Bedi, 2002; Martin et al. 2000; Orlinsky et al. 1994, 2002).

There are many reasons for the development of the two shorter versions of ARM-12 and also ARM-5 which include the acknowledgement of the differences between their use in clinical research trials and in routine practice. The majority of alliance measures have been designed for research and theoretical purposes rather than everyday use by therapists (Duncan et al. 2003). The ARM-12 and ARM-5 were meant to reduce the burden on clients and therapists but the two have different intended uses. ARM -12 was for use in research studies to be a close proxy to the original and retain a similar factor structure assessing the identified components of the alliance. However, for ARM-5, it was to be used as a very short index of the core alliance construct and practical for busy practice settings to function as a clinical decision tool in case tracking.

ARM-5 was designed with an eye toward the growing evidence that feedback to practitioners on their clients' progress results in improved outcomes, particularly for clients who have a poor
initial response to treatment (Lambert et al. 2001b; 2003; 2005). A paper has recently been submitted for publication by Cahill et al. 2009 indicating that the two short forms (ARM-5 and ARM-12) have acceptable psychometric properties and that they are converged with each other and with the full ARM. For the ARM-12, the results of previous research were used together with conceptual considerations to select 3 items to represent each of four ARM subscales: Bond, Partnership, Confidence and Openness. For the ARM-5, item-analytic principles were used to select 5 items to represent overall alliance. In all three ARM forms, client and therapist versions were constructed to contain parallel items. Data was drawn to assess reliability and validity from three UK trials of brief therapy for depression.

2.5 Bridging the Gap Between Research/Practice and Researcher/Practitioner

In contrast with clinical trials research, effectiveness research aims to understand how clients change in the context of how therapy is practiced in day to day clinical settings (e.g. Seligman 1995). Howard et al. (1996) introduced 'patient-focused' research as a new paradigm for evaluating psychotherapy which is aimed at monitoring an individual patient's progress over the course of therapy. Careful consideration has been given to the practical issues in this research study in terms of it being conducted by a sole researcher with limited resources available and combining this with the overriding theoretical framework of the importance of the external validity as a prime consideration in routine practice to engage therapists more actively in using routine outcome management for enhancing client outcomes.

The DoH (1996) policy review highlighted a wide gap between research on psychological therapies and its everyday practice. However, this gap can be closed if therapists' routinely collect data from clients and this data is donated to a National Practice Research Network (PRN) (Audin et al. 2001). This allows benchmarking of like-for-like services which becomes a powerful research tool as data from thousands of clients accumulates in the database (Mellor-Clark et al. 2001). One such national database (CORE) began in 1996 or 1997 with the collaboration of
work between COREIMS LTD (CORE Information Management Systems) and Psychological Therapies Research Centre (PTRC) at Leeds University and is now the largest database set in the UK and second to USA internationally for psychological therapies (Barkham et al. 2006a, 2006b).

2.6 U.K. Political Context of the Evaluation of Psychological Therapies

The UK government has stepped up its agenda for routine outcome measurement. In Improving Access to Psychological Therapies (IAPT) (IAPT 2008:7), the government emphasised the principles and benefits of outcome measurement with the primary purpose of 'improving people's experience and benefits from the service and is part of ongoing, collaborative service evaluation, with feedback from patients at its heart'. One of the benefits mentioned is that people can chart their progress towards recovery. By doing this they can then see at what point their psychometric score falls within the normal range and can thus set their own goals for therapy. Feedback is given on an ongoing as to whether it is working and which elements are helpful or unhelpful. CORE is one such system which will be considered next in its historical development in the UK.

2.7 Development of CORE in the U.K. and Practice Based Evidence (PBE)

The early ideas of selecting a core battery for outcome researchers was discussed in the 1970s by Waskow and Parloff (1975) and later reasons as to why the idea had not been taken on board discussed by Barkham et al. (1998). However, by the mid 1990s a text by Strupp et al. (1997) spurred activity in the UK for the development of a core outcome measure that could be adopted by both practitioners and researchers (Barkham et al. 1998). In 1998 CORE Outcome Measure (CORE-OM) was launched followed by the CORE-system in 1999 and the CORE-PC first version in 2001. By 2003, CORE performance Indicators for Primary Care Counselling services in the NHS were developed and an updated version of CORE-PC was released in 2004, and then the web-based software called CORE-Net was released in 2006. CORE
research uses the practice based evidence paradigm (PBE) (Barkham & Mellor-Clarke 2000; Barkham et al. 1998).

CORE is a valuable audit tool as it contributes to a very large standardised data sets from which benchmark data can be derived (Barkham et al. 2001; Evans et al. 2003). This kind of data enables the capacity to set and assess performance with like-for-like services that allows for the development of a National Research Database. The development of an evolving common CORE methodology related to the paradigm of quality evaluation is underway to potentially help identify, share and develop excellence in psychological therapy and counselling services (Mellor-Clark et al. 2006).

2.8 Measuring Recovery and Improvement, Validity, Reliability and Sensitivity

A useful framework for adopting a standard definition of clinically significant change is provided by Jacobson et al. (1984) and Jacobson and Truax (1991), called the reliable change index (RCI), which establishes whether the change shown by a client is reliable. Any outcome measure used needs to show that it provides a valid measure of an individual's level of psychological distress and the score provided needs to reliably differentiate between those who are troubled and those who are within the normal range. The evidence for CORE suggests that it does (Evans et al. 2002). This paper presented psychometric data on reliability, validity and sensitivity to change for the CORE-OM (Clinical Outcomes in Routine Evaluation-Outcome Measure). Results show internal and good test-retest reliability (0.75-0.95) as was convergent validity with seven other instruments, with large differences between clinical and non-clinical population samples and good sensitivity to change. Test-retest stability were excellent at (0.87-9.1) on all items bar risk. The CORE-OM is a reliable and valid instrument with good sensitivity to change and acceptable in a wide range of practice settings. CORE system allows practitioners to estimate the level of clinical change and clarify whether that change can be relied on (Evans et al. 1998, 2002). This is also explained as clinical cut-offs that are indicative of
membership of non-clinical and clinical populations. The CORE methodology scores highly in ease of use and external validity. Over the years since it was first developed, CORE outcome measures are generating scientifically important findings concerning therapeutic change in clinically representative settings. The CORE methodology scores highly in ease of use and external validity. Its demonstrated overlap with other measures brings non-empirical factors into play for those choosing between CORE and other comparable measures. In addition, CORE may need to be complemented by domain-specific measures to do justice to complex clinical situations. It is acknowledged that CORE is not a substitute for clinical judgement.

2.9 Client Directed Outcome Informed (CDOI) and patient focused research

The aim of client/patient-focused research (e.g., Howard et al. 1996; Lambert 2001b) is to predict the course of individual client's progress in psychotherapy (e.g., decreased in symptom intensity) on the basis of their initial characteristics. Lambert et al. (2003) and Lutz (2002a; 2002b) discuss the predicted trajectory and its use for triage or comparison with client's actual progress as a basis for clinical decisions during treatment. The beneficial effects of simply giving therapists' feedback on their clients' progress relative to predicted trajectories have been demonstrated in studies (Finch et al. 2001; Lambert et al. 2003). The expected trajectories have been calculated from large clinical data sets drawn from this approach from practice research networks (Barkham et al. 2001; Borkovec et al. 2001) or from health insurance companies (Lyons et al. 1997; Newman & Tejeda 1996).

Some studies have found that clients at risk of a negative outcome were less likely to deteriorate and twice as likely to achieve a clinically significant change when their therapists had access to outcome and alliance information (Whipple et al. 2003) and client retention is improved (Miller et al. 2005). One study showed that written and graphic performance yields better results than verbally delivered feedback, which can actually reduce the effects of feedback (Kluger & DiNisi
In relation to CORE in the UK, some work has been primarily concerned with research of the national database for CORE and benchmarking of primarily primary care data as well as the development of CORE as a valid and reliable outcomes measurement tool (Barkham et al. 2001, 2005a, 2005b; Barkham & Mellor-Clark 2003). Several studies used sophisticated software with the use of comprehensive clinical support tools and decision trees for treatment (Brown & Jones 2005; Claiborn & Goodyear 2005; Haas et al. 2002; Hannan et al. 2005; Hanson & Lambert 2003; Harmon et al. 2005; Hawkins et al. 2004; Safran et al. 2002).

2.10 Issues related to the Implementation of Routine Outcome Measurement (ROM)

There are various issues in relation to the implementation of ROM which are critical to be considered as overcoming some of the barriers to implementation give the optimum opportunity for successfully embedding these measurement systems into routine clinical practice.

2.10.1 Job satisfaction and workplaces and change

Professional groups may experience stress as this commonly arises where one has little control (decision latitude) over one’s work (Karasek 1979). Whereas higher levels of decision latitude are associated with a greater sense of personal accomplishment and satisfaction (Jospeh & Conrad 1979). Thus those workers who experience high job demands, low decision latitude and low support at work are the most stressed (Karasek, 1979). Other studies show that those involved in mental health professions like mental health social workers, community based mental health staff and psychiatrists show moderate to high levels of stress, low morale and emotional exhaustion (Maslach et al. 1996; Maslach 2003; Prosser et al. 1996; Pajak et al. 2003; Priebe et al. 2005; Evans et al. 2006; Ogresta et al. 2008). Job dissatisfaction is thought to lead to high turnover, absenteeism and ‘burnout’. However burnout and dissatisfaction have been shown to be alleviated by clinical supervision (Newsome & Pillari 1991), praise from supervisors (Martine 1991), socialising with colleagues (Leiter 1991), clear role definition (House 1988) and opportunities for advancement (Martin 1991).
Within the human resources management literature, the introduction of major changes, including a greater focus on demonstrating better health outcomes, tends to be viewed as particularly difficult. Some have felt that change should be imposed by strong and controlling management (Etzioni 1975; Ordione 1979) or facilitated by eliciting the willing participation of all involved (Hertzberg 1966). Attempts to reconcile these two have included emphasising leadership rather than control or cooperation, and seeking to resolve the various perspectives on the current situation and the meaning of change through good communication (Ouchi 1981; Peters & Waterman 1982). Within the NHS in the UK various change models are advocated (Iles & Cranfield 2004; Iles & Sutherland 2001) and the Health and Safety Executive have undertaken research that promotes stress reduction via six management standards to be maintained by managers who demonstrate good management behaviours (Mackay et al. 2004; Cousins et al. 2004; Yarker et al. 2007, 2008).

Social psychological theories also shed light on the factors which facilitate and impede the introduction of innovations. Festinger (1957) discussed cognitive dissonance theory which holds that individuals try to maintain attitudes which are internally consistent. Rogers (2003) innovation diffusion theory is an attempt to identify the factors which facilitate the adoption of new practices. Certain factors of a proposed change are predicted to be associated with positive attitudes to the proposed change on the part of those involved such as, simplicity, reversibility, compatibility, flexibility and freedom from risk (Rogers 2003).

2.10.2 Possible frameworks of change and implementation for routine outcome measurement

Four key concepts of change/learning may inform the implementation of routine outcome management programmes. The first is described by Kubler Ross (1969), who originated the concept of the transition curve and studied the dynamics of personal change. This research was concerned with helping patients confront and come to terms with the trauma of terminal illness,
characterising seven stages through which individuals must pass before they may be considered to have "let go" of the past and adapted to their new circumstances. These stages are:

- **Denial/Shock** – (avoidance, confusion, fear, numbness, blame) conscious or unconscious refusal to accept the facts, information, reality relating to the situation concerned. A normal defence mechanism but some people can become locked in this stage when dealing with a traumatic change.

- **Anger** – (frustration, anxiety, irritation, embarrassment & shame) and can be manifested in different ways such as anger with themselves and/or others.

- **Depression & Detachment** – (overwhelmed, lack of energy, helplessness) acceptance with emotional detachment where one may feel sad, regret, fear, uncertainty and shows the person has begun to accept reality.

- **Dialogue and bargaining** – (reaching out to others, desire to tell one's story, struggle to find meaning to what has happened)

- **Acceptance** – (exploring options, a new plan in place) and may indicate some emotional detachment and objectivity.

The second concept is by Parker and Lewis (1980) who applied the concept of the transition curve to executive development. There are seven concepts as follows:

- **Immobilisation/shock** – a mismatch between the expectations versus the reality

- **Denial of change** – temporary retreat, false competence

- **Incompetence** – increased awareness and frustration

- **Acceptance of reality** – willing to 'let go'

- **Testing** – working out new ways to deal with new reality

- **Searching for meaning** – internalising the situation and trying to make sense of it and understand it

- **Integration** – leading to changing viewpoint and behaviours
The third concept is a well known model for the stages of change is the transtheoretical model (Prochaska & Velicer 1997), whereby six stages are referred to as follows:

- **Pre-contemplation** – not currently considering change (‘ignorance is bliss’) and at this stage it is important to validate lack of readiness, clarify: the decision is theirs, encourage re-evaluation of current behaviour, encourage self-exploration, not action and explain and personalise the risk.

- **Contemplation** – ambivalent about change (‘sitting on the fence’) and not considering change within the next month and there is a need here to validate the lack of readiness and again clarify that the decision is theirs, encourage evaluation of pros and cons of behaviour change and identify and promote new, positive outcome expectations.

- **Preparation** – some experiences with change and are trying to change (‘testing the waters’) and planning to act within a month. Help to identify and assist in problem solving re: obstacles, help identify social support, verify that they have underlying skills for behaviour change and encourage small initial steps.

- **Action** – practicing new behaviour for 3-6 months, focus on restructuring cues and necessary support, bolster self-efficacy for dealing with obstacles and combat feelings of loss and reiterate long-term benefits.

- **Maintenance** – continued commitment to sustaining new behaviour (post 6 months to 5 years), plan for follow up support, reinforce internal rewards, discuss coping relapse.

- **Relapse** – resumption of old behaviours (‘fall from grace’), evaluate trigger for relapse, reassess motivation and barriers and plan stronger coping strategies.

In addition to the above stages of change Prochaska & Velicer (1997) indicate that processes of change such as consciousness raising, dramatic relief, self-re-evaluation, environmental re-evaluation, self-liberation, social liberation, counter conditioning, stimulus control, contingency
management, decisional balance, self-efficacy, temptation are important consider. This is because processes of change are the covert and overt activities that people use to progress through the stages. A final model for consideration is a learning framework called 'conscious competence' learning model that the US Gordon Training International organisation has played a major role in defining it and promoting its use (Wikipedia [internet online]). This model has four stages:

- Unconscious incompetence – the individual understands nor knows how to do something, nor recognises the deficit, nor has a desire to address it.
- Conscious incompetence – though the individual does not understand or know how to do something, he or she does recognise the deficit, without yet addressing it.
- Conscious competence – the individual understands or knows how to do something. However, demonstrating the skill or knowledge requires a great deal of consciousness or concentration.
- Unconscious competence – the individual has had so much practice with a skill that it becomes "second nature" and can be performed easily (often without concentrating too deeply). He or she may or may not be able to teach it to others, depending upon how and when it was learned.

A possible fifth stage has been suggested as the "Conscious competence of unconscious competence". This describes a person's ability to recognise and develop unconscious competence in others. This could be seen as a key concept in how to train and disseminate information of new skills to therapists by those who have already learned those skills and practiced as opposed to the "top down" approach whereby often only theoretical knowledge is passed on without the competence to train others for clinical integration into their practice.

The above conceptual frameworks may be able to inform not only the team changes that take place within organisations for therapists to integrate outcome measurement routinely into their
practice but the very individual journeys of each therapist in making personal changes in themselves and their clinical practice in order to accommodate this new learning. In effect, there is a parallel process whereby therapists' clients are expected to make changes in therapy but also the therapists themselves are expected to learn how to integrate routine outcome measurement into their clinical practice for session tracking.

2.10.3 Challenges of implementation

In a brief review of outcomes management in mental health, (Huxley 1998), highlighted not only the selection of appropriate measures but a wider range of critical components. These include: gaining staff and patient co-operation, making data gathering simply, efficient and non-duplicative, expertise in analytic procedures, clinical utility, regular feedback mechanisms and comparable data bases for financial and client data. Additionally he advocated the principles of collecting clinically meaningful data, providing rapid feedback and including the user perspective.

Marks (1998) identified several obstacles to routine outcome measurement including: few agreed, simple and valid outcome criteria and lack of incentives to measure. He highlighted that rating outcomes may be reduced with computer technology but that it would take 'at least a year to implement outcome measurement to the point where clinicians do it as routine and regard it not as a non-clinical nuisance, but rather as being as much a part of clinical work as is an initial assessment interview' (Marks, 1998: 283). He emphasised that the regular tracking of patient outcome is beneficial and that barriers to its implementation can be reduced by the actions of individual clinicians and that other hurdles require actions by professional and governmental organisations. He concluded that patients will be more likely as a result to receive cost-effective treatment once clinicians are outcome measuring routinely and analysing outcomes and costs in routine care.
Slade et al. (1999) proposed the notion that if mental health care is to maximise outcomes, then more attention needs to be paid to the process of developing and facilitating the routine clinical use of measures. The measures themselves need to be feasible meaning brief, simple, relevant, acceptable, and available and to show value to the clinician as having more value than unstandardised assessment. They propose a framework for introducing these measures into routine practice based on the principles by Green and Eriksen (1988) for changing practice through predisposing clinicians by alerting them to a problem and possible solutions, enabling them to identify and remove barriers to change and finally to reinforce which involves maintaining changes through rewards, once they are in place.

Rock et al. (2001) discussed strategies that may facilitate the successful implementation of service-wide outcome measures in public mental health services. They concluded that a top down approach only has limited success whereas a bottom up approach whereby this makes optimum use of a small team of 'outcome experts' developing local clinical guidelines would increase the co-operation and participation of the wider clinical community and may be a more successful longer-term strategy (p43). In an editorial, Slade (2002) discussed routine outcome assessment in mental health services and emphasised the benefits for the patients as setting up the expectation of change and charting their process which can act as a motivator to re-evaluate the treatment plan where no improvement is evident. Such reflection he says 'has the potential to improve outcome, either directly (through changing the content of care) or as an effect modifier (by improving process issues' (p1341). When talking about implementation strategies he recommended collected data for minimal cost in time and effort to staff and patients and increasing access to and training in information technology with a focus overall on promoting and rewarding reflective practice, both at the treatment and the programme level.

In a study by Miller et al. (2003), which discussed a preliminary study of the reliability, validity and feasibility of the Outcome Rating Scale (4-item scale), showed 89% compliance of use from
therapists after twelve months compared to 25% for the original version (OQ-45.2) with many more items in a similar patient setting. The 25% compliance seems even more amazing given that although therapists were not mandated to utilize outcome measurement, they were part of an ongoing research team and compliance was expected and they all had close supervision and was provided support throughout the research project. Lambert and Hawkins (2004) recommend the use of brief outcome measures completed by patients at regularly throughout their therapy and the importance of these results to inform practice so that outcomes can be managed should their be a need assessed during the course of therapy for alternative interventions.

The practicality of implementing a feedback system in routine practice is a real challenge. One study shows that generally, clinicians do not see the value of frequent assessments based on standardised scales (Hatfield & Ogles 2004). This could be because they are confident in their ability to accurately observe if their patient deteriorates and their provision of an appropriate response to them. However, evidence suggests that psychotherapists are not alert to treatment failure (Hannan et al. 2005; Yalom & Lieberman 1971). It is possible that therapists' confidence in their own clinical judgements may stand as a barrier to the implementation of monitoring and feedback systems and that by monitoring therapists outcomes it inevitably makes their practice 'transparent' and that in itself may evoke evaluation anxiety and fears of losing control (Lambert 2007). Other challenges in implementation include the cooperation of therapists and the time that it would take before they can see the clinical utility of such feedback systems and the actual practical difficulties of adding monitoring activities to such busy practices.

Pirkis et al. (2005) reported on a study that involved the consultation of 123 stakeholders in Australia's public sector mental health services and the main highlights were that for routine outcome measurement to be possible it has to be supported by a co-ordinated, strategic approach and strong leadership alongside clinician commitment.
In a review of the literature and their own work, Trauer et al. (2006) suggested that the concerns that mental health workers expressed in relation to routine outcome measurement (ROM) were: information technology (access to computers, network response time, computer literacy), instruments (psychometric properties, relevance, superficiality), time burden, suspicion of management or government motives and competence and confidence in using ROM data. Bickman (2008) highlighted that just collecting data on an annual basis will not result in improvement so that measurement is not enough. He argued that establishing and sustaining such systems are difficult as real change in the real world is really hard but that the only way to learn about how to solve implementation problems is through continued implementation.

2.11 Client and therapist experiences of using questionnaires in therapy

Therapists tend to have more fears about anything that appears to interfere with the therapy sessions than their clients. They may view certain outcome measures like questionnaires either within the research context or not with clients or interviews as part of research as potentially 'intrusive' and 'frame breaking' to the therapeutic space which they perceive as having the potential to be damaging to the therapeutic relationship. A study reported by Llewellyn (1988) in which views of how psychological therapy were sought from both clients and therapists, revealed some positive findings. Given that at the end of each session Helpful Aspects of Therapy (HAT) forms were completed and at termination an additional questionnaire about their experience of therapy, the response rates were remarkable. Very useful data was gathered since there was a 95% response rate with 76% of clients and 78% of therapists reporting that therapy had been helpful. It appears in the aforementioned study that both therapists and clients were happy to participate in the research which may have been viewed as 'intrusive' since they were filling out forms at the end of every session but was not and had an excellent response rate.

Marshall et al. (2001) described the results of their primary study (Marshall et al. 1996), which assessed the subjective experience of being a participant in psychiatric research. A
questionnaire that assessed the positive and negative reactions of patients to three typical research methodologies (self-report questionnaires, structured diagnosis, interviews and tape-recording of sessions) was administered to 23 patients-therapist pairs in a long term psychodynamic psychotherapy and psychoanalysis setting. The results indicated that the questionnaires and interviews were slightly to moderately helpful to clients in promoting self-realisation and facilitating therapy and not at all to slightly intrusive and disruptive. Interestingly, the therapists significantly overestimated the negative effects and underestimated the positive benefits patients reported from participating in research. The findings also suggest that therapists' assessments of their patients' experience in research were, not surprisingly, influenced by their own attitudes. Thus the belief held among some therapists that research is necessarily intrusive and harmful was not supported by the data. This study also gives information about the use of self report questionnaires and how patients found these helpful in providing new insight about themselves and in facilitating therapy.

A recent study (Davy 2008) used a mixed methods methodology for the evaluation of the client experience. The setting was employee assistance counselling services and CORE pre and post self report measures were administered and this was linked to client statements of improvement and their accounts of therapy were connected with the phased model of progress measured by CORE. Clients were interviewed to gain their feelings about their counselling journey. Findings suggested that counselling is effective for enhancing well being and functioning and reducing symptoms/problem severity. The therapeutic relationship was found to be a significant factor in determining success of the process.

2.11.1 Clinical staff and attitudes towards outcome measurement

Several survey studies have been undertaken to evaluate therapists' attitudes to routine outcome measurements (Johnston & Gowers 2005; Milne et al. 2001; Smart et al. 2006; Walter et al. 1998). An excellent study by Callaly (2006) described responses elicited by interviews two
years after clinicians started to use routine outcome measurement. There were equal numbers of positive and negative observations from clinicians about the clinical value of the clinician-rated outcome measures, while more positive observations were made about the value of the consumer-rated outcome measure. The most frequent observation from clinicians in relation to making outcome measures more useful to them in clinical practice was that more training, particularly refresher training, is needed. In addition, clinicians indicated that more sophisticated support which assists them to understand the meaning and possible use of outcome measure ratings is required. None of the aforementioned studies, however, include the views of the recipients or patients by interview and none include diaries that the therapists fill out as they implement routine outcome measurement for the first time in their clinical practice.

Only the study by Smart et al. (2006) included an alliance measure routinely in a similar way to the current project but did not include the clients' views. Therapists felt the system provided improved understanding and/or conceptualisation of the client, improved client/therapist interaction and recognisable, quantifiable measure of change. Although overall positive comments, there were some concerns with the questionnaire: validity, or insufficient measurements, decreased morale, creation of competitiveness within the centre, worries that clients were being burdened by having to complete measure, fears that eventually may impact salary and advancement decisions, concerns about excessive resources being allocated to the system, distracted from the therapeutic process, research objectives become more important than therapeutic outcomes and one or two respondents had concerns that it promoted short-term therapy model. This study is most informative as it elicited views about training and supervision of such continuous monitoring systems. Therapists felt the continuous feedback system was good for tracking client progress, supporting conceptualization, monitoring specific items, informing termination decisions, tracking difficult cases, and assessing the therapeutic alliance. However, the use of the feedback system in supervision was not consistent. Some
supervisors and trainees apparently highly valued and utilised the feedback whereas some had never utilised feedback.

Staff varies greatly in their attitudes towards outcome measurement. Staff was surveyed from central Sydney mental health services who had taken part in a commonwealth-funded project that required them to rate patient outcome as one of the first studies to explore the attitudes of staff towards measuring outcome (Walter et al. 1998). Questionnaires were given to clinical staff three months after the completion of the project. The major concern expressed by respondents was that rating outcome was too time-consuming. More than half were not in favour of measuring outcome routinely even it meant providing a better service to patients. The conclusion of this study was that instruments for routine measuring need to be short and the battery of instruments to be kept to a minimum, attention needs to be given to the attitudes of staff 'so that measurements faithfully reflect a patient's clinical state, properly inform the treatment course and meaningfully influence resource allocation' (Walter et al. 1998: 114).

Another survey to assess mental health clinicians' knowledge of and attitudes to the health outcomes approach, their expectations as to its likely impact on them was reported by Crocker & Rissel (1998). The strongest and most consistent predictor of positive expectations of an increased focus on health outcomes was the extent to which staff thought they would be able to influence the way this approach would be applied to their workplace. The conclusions indicate that there are at least four opportunities to facilitate the introduction of a health outcomes approach to community mental health services: consultation/discussion with staff to address concerns about its implementation with a view to an increased ownership of such projects, practical education in the use of instruments, ongoing training workshops to allow for two-way interaction which implies the possibility of remedying unforeseen circumstances and lastly avoiding unnecessary complexity and inconvenience for staff bearing in mind that a high volume of paperwork is conducive to burnout.
Stein (1999) emphasised in an article about the usefulness of the Health of the Nation Outcome Scale, that completing rating scales that have an ulterior motive such as assisting the purchaser, or helping to gather national statistics would be to act on behalf of third parties. As such, it would therefore serve as an intrusion into the clinician-patient relationship and would not be tolerated except for a very brief period, for example in a research project. In assessing attitudes to outcome measurement in rural Western Australia, including the HoNOS, Samar et al. (2002) revealed the need for staff to be provided with reasons and incentives for incorporating outcome measurement into their routine practice, in addition to the provision of thorough and on-going training and support in time and resources from management.

Psychiatrists in the UK not using outcome measures was reported on by Gilbody et al. 2002. The problems and objections included: inability to capture the subtlety of multifaceted outcome, simplistic, pseudo-scientific, psychometrically suspect, use of scales detracts from the therapeutic relationship and little or no benefit to self or to patient care. However, they did feel that it was good that they could be completed by non-clinicians and that they could help to bring the multidisciplinary team together. In a study where therapists received scored assessment profiles for their clients, the vast majority reported that they did not use the scores in treatment planning or monitoring thus perceiving little clinical utility of outcome measurement (Garland et al. 2003). Many therapists felt that the feedback they received was not 'user friendly' and that even if they understood the feedback did not find the scores helpful in practice. They also indicated that they would be likely to use scores from outcome measures if the results were presented in a narrative as opposed to quantitative form.

A pilot study (Gardiner et al. 2003: 288) was carried out in a voluntary sector counselling agency over a seven month period to 'assess the feasibility of adopting a well-established system (CORE) designed to measure client outcomes'. The counsellors' experiences of using the CORE...
system were largely positive as they felt it was useful 'to assist with funding applications', 'to identify good practice', that it had stimulated reflection on their own role and practice, is valuable in assessing risk and helped clients focus more clearly on their reasons for attending counselling. The negative aspects were that they had not felt sufficiently informed about the project prior to its start and that they needed to have had someone on hand and available when implementing day to day practicalities of the evaluation who could answer immediate concerns and deal with their anxiety and uncertainty. Counsellors did not like the amount of paperwork and felt it was a burden that was a diversion from actual therapeutic work and that some clients through literacy difficulties were unable to complete the questionnaires with a few clients responding with a 'look of horror'.

In terms of clinical supervision, the overall response was that they seldom referred to it, it was viewed as 'not relevant', did not refer to it with regard to actual client work and did not impact on it in this area. Most counsellors felt the measures had very little impact on the therapeutic relationship. Conclusions indicate that the client questionnaire appears to be acceptable and comprehensible to almost all clients, heavy policing was needed to ensure maximum returns of the last session forms, data analysis/interpretation was difficult and time consuming and finally, that access to trained consultants or training staff specifically in this area may be advantageous as well as having someone who operates the evaluation system to be on hand to facilitate the collection and submission of data. The point is made that it takes a considerable amount of time for evaluation data to have any impact on counsellors' actual work with clients or what they discuss in supervision. Finally, there was evidence that using CORE system can help counsellors reflect on their own work, and that as they gain more experience with the system, they become more confident and competent and better able to deal with the interface between data collection and clinical practice.
Trauer et al. (2009a) aimed to assess the effect of feedback on the attitudes and practice of staff in Victoria, Australia since the introduction of outcome measurement in 2000. The opinions of usefulness differed greatly with the highest ratings found in admin staff and the lowest in medical staff. The high ratings of value among admin staff suggest that they perceive potential administrative value while the clinicians perceive less clinical value. The study concluded that there was a need to create more clinical value for those who complete the outcome measures by better reports, better IT support, so reporting is immediate and more emphasis in training in using outcome results.

A second study by Trauer et al. (2009b) looked at the effect of guidance in the use of outcome measures in clinical meetings. Therapists' trialled new forms of feedback within clinical review meetings to determine whether there was any effect on staff perception and clinical use of outcome measurement data. Staff indicated that they wanted more training in how to use the measures with consumers, more training in what the measures mean, staff found it useful to compare their individual consumer ratings with national averages, staff found the outcome measures provided a 'reality check' on consumers' symptoms and functioning especially with 'difficult' consumers and that congruence or divergence between consumer and provider rated measures became a focal point for dialogue.

2.11.2 The attitude of the therapist is important
A small study by Soderberg et al. (2005) investigated the reliability of the Global Assessment of Functioning (GAF) and analysed certain factors that affect measurement errors when the scale is used by regular psychiatric staff. One of the study's conclusions is that if raters are positively inclined to use rating instruments, then measurement errors are minimized and reliability is maximised. They suggest an increased motivation to perform good assessments may be through more systematic use of the results of GAF, for example, in annual results and giving
rewards to skilful raters. Another possibility is that raters who cannot learn to rate well should not be allowed to make clinical ratings. In a large study in Scotland (Hunter et al. 2009) showed the feasibility of collecting meaningful outcomes data in schizophrenia by using self-report measures in routine clinical practice in the NHS. The data was incorporated into patient care plans. Clinician engagement was shown to be important and was incorporated into training and educational sessions throughout the research so as to fundamentally emphasise the acceptance and engagement of clinicians in the routine use of outcomes data.

2.12 How therapists evaluate their own practice

The purpose of outcome research has been largely to demonstrate to society that therapy works and is a valuable professional activity. As such it has been able to inform health policy decisions. However, how do therapists actually view research that is published for them? A useful mail survey was carried out to examine the utilization of psychotherapy research by practicing psychotherapists and the perceived gap between psychotherapy research and practice (Morrow-Bradly & Elliot, 1986). The study showed that many therapists are sceptical about the findings of outcome studies, believing that they are based on an over-simplified view of what can happen in therapy. Therapists reported low rates of psychotherapy research utilization and stated that they gained their most useful information from experience with their client work. Behavioural and non-dynamic orientations as well as research production and consumption were modestly correlated with utilization. Therapists were critical of research that ignored the complex realities of the therapy situation but rather favoured research on typical populations and modes of treatment, especially if it described the treatment carefully and focussed on process outcome links, significant change events and the therapeutic alliance.

Lambert et al. (1992) recommended that outcomes be assessed in terms from as wide a range of perspectives as possible. However, a large focus since then has been more outcome studies that focus largely on client self-reports of symptomatic states such as anxiety and depression,
with fixed choice questionnaires (Froyd et al. 1996). The question is thus raised: If therapists do not readily utilise psychotherapy research how are they evaluating their own practice?

An excellent qualitative study by Daniel & McLeod (2006) set out to find out how person centred counsellors evaluate the effectiveness of their practice. Interviews with counsellors enabled them to talk candidly about the judgements they made around the success or otherwise of their work with clients. Evaluation for these counsellors seemed to be governed by what they were trying to achieve as person-centred counsellors and was an integral part of their counselling activity and very much embedded in the process of counselling itself, rather than comprising a separate activity. Counsellors talked about obtaining different types of information such as whether clients were satisfied with the therapy and used review sessions to elicit this, looking out for evidence of change with client's inner and outer world. The 'inner world' changes were in relation to whether the client had for example become more self accepting and the 'outer world' change may be if they had sorted say interpersonal issues out with friends, neighbours or relatives. Counsellors spoke of the counselling relationship and noting the quality of this throughout the counselling journey which was viewed as a 'joint thing' where both counsellor and client were learning. Counsellors felt that their own personal satisfaction with the work was very important and they needed to know if they client had got the best out of them as counsellors and to value the 'special moments' when they have been profoundly moved by a client's story. 'Weighing up the evidence' was an important theme for the counsellors in how they evaluated their practice. Counsellors expressed monitoring very closely both how they felt about the client and how they felt about their own performance as a counsellor.

Counsellors had a 'multi-faceted' process of 'weighing up' the evidence that they gathered and this included reviews with the client, supervision and discussion with colleagues. Counsellors were aware of other concepts of outcome and felt that formal evaluation was seen as a "scientific and quantitative activity involving data collection and analysis, which was regarded as
a difficult thing to do because of what some informants characterised as the 'subjective' nature of counselling" (Daniel & McLeod 2006: 247). Three further reasons to demonstrate their resistance to formal evaluation were that 1) it could conflict with their approach to counselling, 2) they did not feel it added much to the assessment and that their personal experience of the client was valued much more highly and finally, 3) the questionnaires would only tell them what they already knew and they would be astounded if there was anything they did not know. This study tells us that these counsellors engaged in a complex process of evaluation based on a range of different sources of evidence which they then 'weighed up' Evaluation for them was a continuous activity that was embedded in the counselling process itself rather than occurring at particular times. These counsellors although being aware that societal expectations in regard to formal evaluation was present, had resistance to formal evaluation and were confident in their own practice of evaluating the effectiveness of their work with clients.

Although, this study was with person centred counsellors, one could say that before formal evaluation became more embedded in many services is this not the way that most therapists would be evaluating their work with their clients? The converse may also be true, in that therapists that are trained in more recent times to only use formal evaluation may not have developed this complex art of evaluation without using questionnaires for formal evaluation which is often one dimensional. This study then also shows that therapists may possess a sensitivity to the complexity of outcome that is missing in much current research.

Although therapists may be able to evaluate their practice effectively some other studies do not agreed. Therapists and supervisors may have an overly optimistic view of client outcome and usually overestimate improvement and underestimating deterioration in relation to client self reports (Grove et al. 2000; Najavits & Strupp, 1994). In a study of 48 therapists who were asked to identify how many clients they felt over a three week period that they assessed would leave therapy having deteriorated, they said 3/550 clients whereas the algorithms accurately identified
77% (Hannan et al. 2005). These results may lead one to think that therapists and supervisors may not be allocating the appropriate attention to the most at risk cases without formal actuarial methods. This was remarkable given that the therapists were told in advance that 8% was the base rate for deterioration.

Love et al. 2007 discussed a cross-sectional study that looked at the relationship between twenty three mental health therapists' perceptions of treatments' impact and actual change in their six month therapy with foster children. Interestingly, only a single therapist on a single outcome variable negatively evaluated the efficacy of their practice and no correlation was found between the therapists' perceptions of clients' progress and actual child's outcomes. The conclusion was made that mental health therapists are unable to subjectively evaluation their own practice accurately. This study thus raised the critical issues of 'practice wisdom' that often guides treatment and a therapist's subjective feelings which may come into play when determining the effectiveness of their practice decisions. Without critically examining the client's goals and progress towards these, subjective appraisals can be fraught with bias and further complicated if the therapist's operating theory is not constructed to invite refutation or criticism. Some therapists may either assess their client's progress favourable or blame them for being 'unmotivated' or 'resistive', and therefore none of these assessments encourage the therapist to challenge the efficacy of the intervention. One way that therapists feel may help them to evaluate their practice is through the provision of regular clinical supervision.

2.12.1 The role of evaluating practice via clinical supervision

Two major review studies suggest there is little research evidence to support the claim that supervision contributes to therapy outcomes for clients (Kavanagh et al. 2002; Wheeler & Richards 2007). However, there have been other studies that would argue differently. Worthen & Lambert (2007), argue for supervision that includes regular monitoring of client outcome which increases the focus on clients not making the expected treatment progress according to
the monitoring of their outcome. Also included in the supervision would be the addition of assessment and problem solving strategies through clinical support tools for clients not making expected treatment progress. They concluded that by doing this counsellors and supervisors can enhance client outcomes and especially for those clients not making the expected progress and provided for enriched and focused supervision activities. A study by Isakson et al. (2002), recommended progress feedback to therapists in supervision by means of visual charts.

An initial exploration of using CORE data in counselling supervision within primary care was undertaken as an action research project and showed potential benefits and the capacity for potential positive impact on service delivery (McNaughton et al. 2006). The potential benefits were in relation to the provision of supervision providing a safe and supportive environment and by using CORE data within this context it was seen to:

"widen the lens of supervision, bringing issues into focus that might not otherwise present themselves, such as counsellor 'strengths/weaknesses, patterns of practice, training and continual professional issues and contextual issues'. Further opportunities were identified as a potential for 'regular review, meeting ethical obligations, reinforcing effective practice, learning and clinical development and providing evidence for the counselling profession"" (p.222).

However, in contrast, the consistent themes in relation to CORE data being explored with management were a sense of being 'monitored, held accountable, eliciting fear of evaluation, not being good enough, being exposed, getting the sack and of disempowerment' (p222). The challenges of using CORE in the supervisory process were numerous and common concerns highlighted were: 'reduced safety/trust, increased mistrust, decreased honesty/openness, reduced autonomy, disempowerment, permeable boundaries (that supervisory processes could leak into management processes), and also a potential for negative feedback to negatively impact on counsellors' self-efficacy and beliefs' (p222). As this was the introduction of a new process and a huge change to the service some resistance was present even though it was introduced as an action research project. The authors highlight another very critical point which
is the interpretation of CORE feedback and that this should not be viewed as absolute truth but in consideration meaningfully and not in isolation from other sources of evidence. They conclude by advocating a 'voluntary' rather than 'mandatory' use of CORE data in supervisory processes and 'promoting counsellor's understanding of their feedback, with an emphasis on using CORE as one of many useful sources of evidence in the development of meaning' (p224). Mothersole (2004) termed this process as 'metaphorically circling the data'.

Mothersole (2006) wrote about his doctoral thesis which was based on an action research project introducing CORE into his service and using it in supervision. He emphasised the promotion of a 'CORE friendly' culture as crucial to fostering a culture of openness and curiosity with some sense of ownership and investment in the gathering and of making sense of the data which as a process can take around 'three years or so' (p.180). The learning from the project included making sure that the information was accessible not just to himself as the manager but to each individual clinician so they could see their own data in comparison to those of the aggregated service figures and in relation to national benchmarking figures.

The performance appraisal template provided a CORE summary profile of key performance indicators such as level of DNAs, deterioration and clinical/reliable change percentages. A word of caution from the author is about the possibility of practitioners 'massaging the figures or outright cheating' and he goes onto say 'this is the uncomfortable reality that stems from a willingness really to seek to drive up overall quality' (p184). Again when considering clinical cut-off scores, Mothersole (2006) sees the need for a protocol so that practitioners are clear about their options for example, when a client is below clinical cut-off having the conversation with the client either to take them on for a reduced amount of sessions with a view to extension or to not take them on at all. This would minimise the risk that someone that someone might inappropriately be denied counselling. As a result of this practice he reports a mean reduction of
6 to 5 sessions since they began to look at intake scores below clinical cut-off and applying the protocol.

In a recent study (Crocket et al. 2009) where supervision practice was informed through research via a narrative enquiry, the stories suggest that there are therapeutic benefits in an ethic of transparency that provides for practices that overtly carry stories in both directions between counselling and supervision. They suggest some innovative ways of taking supervision forward which include: counsellors speaking more directly with clients about knowledge generated in supervision conversations, the possibility of a supervisor making a direct therapeutic contribution to client practice by making a recording of their session for the client to hear them 're-telling' of the 're-telling', and this might also include the supervisor responding to the client as 'outsider witness after viewing a tape of counselling' and either write a letter or make an electronic recording (p106).

2.13 The experience of qualified therapists when learning new skills or approaches

In an important study, Henry et al. (1993a) reported that when training therapists to adhere to a manualised psychodynamic model, this adversely affected the therapeutic relationship and increased the likelihood of therapist hostility towards their clients. A further study from the same data noted that those therapists who had prior experience of supervision were more reluctant to change their intervention style during training and those that strongly adhered to the model after training were therapists who had hostile and controlling introjects (Henry et al. 1993b). These therapists were largely responsible for the post-training increase in negative and complex interpersonal communications in client-therapist interaction patterns.

In a rich qualitative study by McKay et al. 2001, counsellors saw at least two clients during a three month period where they received supervision following training in the psychodynamic-interpersonal (PIT) model of therapy. Counsellors were interviewed about their experiences of
changing their practice. Themes indicated that learning a new model of therapy is a complex task for counsellors and evoked difficult feelings for them such as feeling at times 'uncertain, fearful, stressed, fearful and unable to perform when in sessions with their clients' to the point of 'getting in the way of the therapeutic process' as they 'missed aspects of what was going' on or even 'changed their interventions in order to avoid their own difficult feelings continuing' (p36). They learned and changed awareness as a result of learning the new model and identified ways through which they coped with the difficulties of applying the new model. Some of these ways were: 'surrounding oneself with support, from other counsellors and supervisors', 'accepting their own mistakes and had faith that things would change when they had more practice with the model'.

The implications from this study included the key role of supervision in addressing the difficult emotions in therapists when learning to apply a new model including discussion around the real possibility that adhering to the model strictly may have negative effects for the counsellor who may feel they are failing or cannot attend to their client. Thus a strict supervisor may invoke hostile introject and accompanying deterioration in interpersonal process as discussed by Henry et al. 1993b). In contrast to this, counsellors who avoid or circumvent parts of the model that they are less comfortable with and thus providing a less pure form of therapy may also be detrimental to outcome according to Luborsky et al. 1985.

Mackay et al. (2001) suggested it may be helpful for counsellors learning new models to try to 'absorb the spirit of the model' rather than to follow it 'slavishly' which of course involves counsellors seeing 'beyond the details of the model, to the underlying principles being suggested' (p38). In a later paper on this same study Guthrie et al. (2004), confirmed that after training, counsellors' adherence to the new model increased without affecting their basic counselling skills and so they can be trained to learn and deliver PIT effectively in primary care settings.
In another UK qualitative study by Richards et al. (2006) about developing a UK protocol for collaborative care in managing depression patients, some barriers to implementation were highlighted. Professionals interviewed which included GPs and mental health professionals, outlined potential problems with enthusiasm, resources and fitting into existing service configurations. This study is an excellent example of adapting the research findings into 'real practice'. There was an adaptation of certain elements of the original protocol in order to make it more acceptable both to the professionals and their patients. The interviews provided confirmation of the acceptability of telephone-delivered mix of medication, support and low intensity psychological support but the adaptation of the protocol involved an initial face-to-face appointment, and their training has paid attention to the nonspecific factors necessary to develop a therapeutic alliance as well as the knowledge and skills required for education and medication support. A final suggestion was made that, 'only by combining data from qualitative research with clinical outcomes can sufficiently detailed protocols be developed, which can feasibly be implemented and thereby contribute to improvements in health care delivery' (Richards et al. 2006: 305)

In a study with therapists who were part of an Employee Assistance Program (EAP), training of how to use the measures with clients on the telephone was given prior to the commencement of the study (Miller et al. 2006). The results were compelling and showed that not only did the treatment effect double as a result of using the brief measures but out of thousands of sessions of treatment provided during the course of the study only a handful of complaints were logged from clients regards the scales. Simultaneously the use of the scales by therapists to inform treatment was exceptionally high as compared to studies that have employed longer and more complicated measures (99% versus 25% at 1 year [Miller et al. 2003]). This informs us that routine use of the brief measures appear to be acceptable to both clients and therapists.
In a reflective paper by McInnes (2006), he described his experiences as service manager to a counselling service who used CORE pre and post measurement and the 'critical importance of winning practitioners' 'hearts and minds' and also ensuring data completeness and quality are highlighted as essential pre-requisites for ensuring practitioner commitment and subsequent utility of outcome measurement data' (p163). He recommended implementing performance measurement as a process of organisational change and wanting practitioners to feel that they want to 'do the right thing' as opposed to being seen to do 'the right thing'. He practically highlighted principle concerns and objections clinically from therapists about their views of outcome measurement as: it is reductionist and does not reflect the nuances of the therapeutic work, it is an intrusion into clinical work, anti-therapeutic, will add nothing and lack of experience and confidence in using with clients.

Concerns of the use of data include: performance management and judgements about competence and who will access data and how. The practical challenges were seen to be: time required for completion of measures by client and therapist and then to use it in client work, practitioner access to PCs and in house data installation and sharing protocols. He suggested sufficiently addressing the aforementioned concerns with therapists in the very early stages of implementation and engagement which also includes practical training and developing protocols and guidance. Then a focus on the data accumulation, the issues of data completeness and data quality to ensure accurate completion of forms by therapists. He highlighted the need to develop the use of outcome data and a performance culture so that all in the team alongside the manager could explore the data with 'a spirit of enquiry' (p173).

My study will consider the perceptions of both therapists and clients and the experience of the use of such technology in their therapy sessions and one group of therapists will be using an alliance measure (ARM-5) alongside session use of CORE-Net. As of 2008, no qualitative research studies on CORE-Net were found. The purpose of this study is to answer the
overarching research question: How do therapists and clients perceive and experience CORE-Net and ARM-5 in the NHS? This study had three specific aims related to the research question:

1. To elicit the perceptions of therapist (both experienced and trainees) and clients in relation to their use of a system of continuous monitoring of their therapy via a feedback system that includes regular outcome measuring (CORE-Net) and therapeutic alliance measure (ARM-5);
2. To elicit the perception of therapists in utilising feedback information in supervision; and
3. To elicit the perception of therapists with regard to the training elements required in the process of implementation of this type of routine measurement in clinical practice.

2.14 Summary

This chapter has provided a review of the essential literature relevant to this study. The field of research in relation to outcomes in psychotherapy research is dominated by quantitative research that has contributed both to the Evidence Based Practice (EBP) and Practice Based Evidence (PBE) research paradigms. The routine monitoring of clinical outcomes using both an outcome measure and an alliance measure falls into the area of PBE and is an extension of quality assurance action research which represents an effort to bridge the gap between research and practice while enhancing clinical outcomes before therapy with a client ends. It has been important to consider the literature that looks at the therapeutic relationship and alliance measures utilised to measure it as well as to reflect on the research of how therapists evaluated their own practice. It has been vital to include the literature on client and therapists experiences of using questionnaires in therapy and how experienced therapists feel about learning new skills or approaches. This leads to my study which includes interviewing one group of therapists and their clients on the experience of the use of routine outcome measurement using for session tracking and one group that had only used the outcome measure. I have attempted in this study to include the suggestions of research studies from my review of the literature into the implementation of routine outcome measurement in my own service.
CHAPTER THREE

Methodology and Methods
CHAPTER 3

3.1 Introduction
This chapter will begin with a brief outline explaining the rationale for the design of the study, followed by an outline of the context of the chosen methodology as contributing to existing research evidence on outcome measurement as a way of a reminder leading to the research question. It also will consider the design of the study, a description of the settings with participant details, procedures, methods of data collection and analysis and ethical considerations.

3.2 Rationale for the design of the study
As has been considered in the literature review in Chapter 2, most of the studies in the field of routine outcome measurement have been quantitative with far less on the client and therapist experience of routine outcome measurement. In my study, I used a purely qualitative paradigm that gathered rich data from various sources allowing data triangulation and a moment by moment account of therapists actual experience and 'felt sense' of adapting and integrating to routine outcome measurement with both CORE-Net and ARM-5. It also allowed the 'client's voice' to be heard as to what the impact was of such systems of continuous in their therapy experience.

I was able to include in the Occupational Health (OH) setting both client and therapist perspectives in interviewing and only used ARM-5 with this setting. My decision not to use ARM-5 and to interview clients within the Primary Care Counselling (PCC) setting was because of geographical logistics and resource constraints in achieving this with another service in a
different part of the country. This obviously presents as a limitation to the study in terms of comparability as the client’s voice is not heard in the same way as the OH setting and these therapists did not use the alliance measure, however, it does provide ‘rich’ data from the therapists perspective of being the longest users of CORE-Net in the UK.

3.3 Methodology

The study was influenced by using a ‘naturalistic’ method of enquiry or paradigm (Lincoln & Guba 1985). There are matching methodologies to theory and a piece of research can differ along a series of four independent dimensions (what is written in brackets is relevant to this study): the type of data elicited (perceptions, experiences, feelings, emotions), the techniques of data elicitation (interviews of both individual and focus groups, diaries), the type of design for monitoring change (interviewing of new users throughout the process and longer term users) and the treatment of data as qualitative (analysis of data using qualitative content analysis and a general inductive approach) (Breakwell & Rose 2000). The explanatory purpose of enquiry depends on the purpose of the research (Robson 2002). My study is an exploratory study as “it seeks to find out what is happening, particularly in little-understood situations, seeks new insights, asks questions, assesses phenomenon in new light, seeks to generate ideas and hypothesis for future research and the design is almost exclusively flexible” (Robson 2002:59). This seemed the best approach to this study since existing research in routine outcome measurement (ROM) is mainly quantitative and usually only gaining the views and attitudes of clinicians/therapists on ROM, therefore, using this method of enquiry would complement and add to existing studies by gaining an in-depth view of both therapists and their clients.

3.4 The Research Question and Aims

The purpose of this study was to answer the overarching research question: How do therapists and clients perceive and experience CORE-Net and ARM-5 in the NHS? This study had three specific aims related to the research question:
1. To elicit the perceptions of therapist (both experienced and trainees) and clients in relation to their use of a system of continuous monitoring of their therapy via a feedback system that includes regular outcome measuring (CORE-Net) and therapeutic alliance measure (ARM-5);

2. To elicit the perception of therapists in utilising feedback information in supervision; and

3. To elicit the perception of therapists with regard to the training elements required in the process of implementation of this type of routine measurement in clinical practice.

In order to achieve these aims several perspectives were sought. Both interviews and diaries were used in capturing these perspectives. However, only diaries were used by the Occupational Health setting therapists and only clients from this setting were interviewed. Also in the OH setting, the therapists used the alliance measure (ARM-5) with CORE-Net because as discussed in the review of the literature (Chapter Two) the alliance at the beginning of therapy is a good prognosticator of premature termination (Horvath & Luborsky 1993). The primary care counselling therapists who were the longest users of CORE-Net were interviewed precisely for their long term experience with it even though they had not used an alliance measure in their work.

3.5 Design of the Study

My study was a flexible design (Robson 2002) using mainly qualitative methods of data collection and analysis. Qualitative research within a natural setting seeks to understand specific behaviours and their subtle variations, and uses categories to describe and analyse the social phenomenon (Meadows 2003; Pope et al. 1999). This study included fundamental characteristics such as an evolving design, the presentation of multiple realities, the researcher as an instrument of data collection and a focus on participants' views. Chesney (2001) discusses the 'dilemmas of self' that is involved in the 'researcher-as-instrument' rather than relying on specialist tools and instruments. The involvement of the researcher and how involvement changed the researcher both as a therapist and as a team leader of other therapists, as a result of this research process, is discussed later in this Chapter and in the Discussion Chapter 6.

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Ahern (1999) discussed the need for reflexivity on the part of the researcher to identify areas of potential researcher bias.

3.6 Methods

In considering the approach for data collection in this study, it was important to understand the purpose, advantages and disadvantages of using interviews, focus groups and diaries, with respect to the researcher’s available time and resources. Table 3.1 summarises the three research aims and where the answers were identified in the data.

Semi structured interviews are widely used in flexible, qualitative designs and King (1994) suggests that they may be used where the focus of a study is on the meaning of particular phenomenon to the participants and where individual perceptions of processes within a social unit – such as a work-group, department or whole organisation – are to be studied using a series of interviews. I used both telephone and face-to-face one-to-one interviews in this study.

<table>
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<tr>
<th>(i) To elicit the perceptions of therapists (both experienced and trainees) and clients in relation to their use of a system of continuous monitoring of their therapy via a feedback system that includes regular outcome measuring (CORE-Net) and therapeutic alliance measure (ARM-5)</th>
<th>(ii) To elicit the perception of therapists in utilising feedback information in supervision</th>
<th>(iii) To elicit the perception of therapists with regard to the training elements required in the process of implementation of this type of routine measurement in clinical practice</th>
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<tbody>
<tr>
<td>2x Focus Groups (5 therapists in OH and 4 in PCC) (Appendix 14 &amp; Appendix 15: Q1-4 &amp; 7)</td>
<td>2x Focus Groups (Appendix 14 and Appendix 15: Q 5 &amp; 6)</td>
<td>2x Focus groups (Appendix 14 &amp; Appendix 15: Q 5 &amp; 6c)</td>
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<tr>
<td>7 x Interviews with non-CORE-Net users</td>
<td>7 x Interviews with non-CORE-Net Users</td>
<td>7 x interviews with non-CORE-Net users</td>
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The telephone interviews were used due to time and resources and the geographical logistics of travel to these participants being prohibitive. Interviews have the advantage of offering the possibility of modifying one’s line of enquiry, following up interesting responses and investigating underlying motives in a way that postal and other self-administered questionnaires cannot. Non-verbal cues may give messages to try to understand the verbal responses, which have the potential to provide rich and highly illuminating material. One challenge is the lack of standardisation, which inevitably raises concerns about reliability and biases, which are hard to rule out. Interviews require skilled interviewers to use closure skills which are time-consuming and require preparation prior to the interview. It is also very time-consuming to transcribe and complete data analysis.

From a critical realist perspective, focus groups have considerable potential to raise consciousness and empower participants (Johnson 1996). There are some advantages and challenges to using focus groups, according to Robinson (1999). Some advantages to using focus groups include  (a) collecting data from many people at the same time, (b) relatively

<table>
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<th>(telephone interviews) (Appendix 18: All prompts)</th>
<th>(Appendix 18: Prompts on general views of their team using CORE-Net and their own future use of CORE-Net)</th>
<th>(Appendix 18: Prompts on general views of their team using CORE-Net and their own future use of CORE-Net)</th>
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<tr>
<td>10 x Therapist Diaries (Appendix 19: Q1-8)</td>
<td>10 x Therapist Diaries (Appendix 19: Points to raise in supervision)</td>
<td>1 x David’s Interview (Appendix 16: Prompt on training aspects and future recommendations for the teams)</td>
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<td>28 x Therapist Supervision Interviews (face to face)</td>
<td>28 x Therapist Supervision Sessions</td>
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<td>1 x David’s interview – key (PCC) informant (face to face) (Prompts on comparison of two groups, client assessment, risk, triage, use of ARM-5 and failing clients)</td>
<td>1 x David’s interview (Appendix 16: Prompt on use of training aspects)</td>
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<tr>
<td>10 x Client Interviews (face to face) (Appendix 17: all prompts)</td>
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<td>374 (clients) x CORE-Net user satisfaction on screen questionnaire</td>
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inexpensive to set up, (c) natural quality controls occur whereby participants tend to provide checks and balances on each other and extreme views tend to be weeded out, and (d) participants are empowered to make comments which may be stimulated by the thoughts and comments of others in the group (including talking about difficult subjects as there is mutual support within the group and participants who are have difficulties such as being unable to read or write are not discriminated against). Robinson (1999) continues to highlight the challenges of focus groups which include, (a) the number of questions that can be covered in a reasonable time frame, (b) expert facilitation of the group process by the interviewer, (c) personality conflict within the group and domination of the discussion by certain individuals, (d) confidentiality within the group, and (e) the results cannot be generalised as they cannot be regarded as representative of the wider population.

Given the resources available in the study, and to accommodate time constraints in the real world setting of clinical practice, diaries were used to facilitate the therapists' thinking. Diaries were also used in the study to capture the processing of each therapist's views as they occurred and therefore have a temporal framework whereas the individual and focus group interviews were retrospective (more time would have elapsed between the experience and the interviewing).

The questions for all the one-to-one interviews (both telephone and face to face) and the focus groups were compiled from a particular survey study by Smart et al. (2006).

The last method of data collection used a feature already built into the computer software that asked clients each time they filled out a CORE-Net measure, how they felt about filling it in. The question asked “How did you feel about being asked to complete this questionnaire?” The options for the client to click from left to right are: Quite Happy, Didn't Mind, Don't know, Not Keen and Disliked it. Results of this questionnaire will be found in the Results section at the end of Chapter 4.
My research adopted a multi-modal approach to elicit a range of perspectives on the use of CORE-Net/ARM-5, to include therapists, the researcher and clients in two NHS settings, see Figure 3:1. Please note the Abbreviations used to shorten words like (I) for (Interview) and FG (Focus Group). Table 3-2 shows the main methods of data analysis and data collection used in this research study design.

Table 3-2 Methods of analysis and data collection

<table>
<thead>
<tr>
<th>Method of analysis</th>
<th>Theoretical basis</th>
<th>Method of data collection</th>
<th>Main authors</th>
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<tbody>
<tr>
<td>Conventional Content</td>
<td>Inductive category development -</td>
<td>OH Therapist Diaries</td>
<td>Hsie &amp; Shannon (2005)</td>
</tr>
<tr>
<td>Analysis</td>
<td>Mayring (2000); Kondracki &amp;</td>
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<td>Wellman (2002)</td>
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<tr>
<td>General Inductive</td>
<td>Inductive - Strauss &amp; Corbin (1990)</td>
<td>Interviews (face to face and telephone) and</td>
<td>Thomas (2003, 2006)</td>
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<td>Analysis</td>
<td></td>
<td>Focus Groups</td>
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Data were gathered from the following sources:

1. **Focus groups** with both OH and PCC therapists: the questions are semi-structured questions with probes (Appendix 14, Appendix 15).

2. **Interviews (face to face)** with individual clients: these questions were compiled in collaboration with feedback from current CORE-Net users (Appendix 17).

3. **Interviews (telephone)** with seven therapists from PCC: these questions were only slightly different than the questions used for the focus groups and were devised similarly. These therapists from PCC had not yet begun to use CORE-Net but were using CORE system (Appendix 18). Finally, one interview with a therapist from the PCC who was a current user and part of the PCC focus group was undertaken after the first two focus groups were completed. This last interview was in an unstructured format (Appendix 16).
with fixed choice questionnaires (Froyd et al. 1996). The question is thus raised: If therapists do not readily utilise psychotherapy research how are they evaluating their own practice?

An excellent qualitative study by Daniel & McLeod (2006) set out to find out how person centred counsellors evaluate the effectiveness of their practice. Interviews with counsellors enabled them to talk candidly about the judgements they made around the success or otherwise of their work with clients. Evaluation for these counsellors seemed to be governed by what they were trying to achieve as person-centred counsellors and was an integral part of their counselling activity and very much embedded in the process of counselling itself, rather than comprising a separate activity. Counsellors talked about obtaining different types of information such as whether clients were satisfied with the therapy and used review sessions to elicit this, looking out for evidence of change with client's inner and outer world. The 'inner world' changes were in relation to whether the client had for example become more self accepting and the 'outer world' change may be if they had sorted say interpersonal issues out with friends, neighbours or relatives. Counsellors spoke of the counselling relationship and noting the quality of this throughout the counselling journey which was viewed as a 'joint thing' where both counsellor and client were learning. Counsellors felt that their own personal satisfaction with the work was very important and they needed to know if they client had got the best out of them as counsellors and to value the 'special moments' when they have been profoundly moved by a client's story. 'Weighing up the evidence' was an important theme for the counsellors in how they evaluated their practice. Counsellors expressed monitoring very closely both how they felt about the client and how they felt about their own performance as a counsellor.

Counsellors had a 'multi-faceted' process of 'weighing up' the evidence that they gathered and this included reviews with the client, supervision and discussion with colleagues. Counsellors were aware of other concepts of outcome and felt that formal evaluation was seen as a "scientific and quantitative activity involving data collection and analysis, which was regarded as
a difficult thing to do because of what some informants characterised as the 'subjective' nature of counselling" (Daniel & McLeod 2006: 247). Three further reasons to demonstrate their resistance to formal evaluation were that 1) it could conflict with their approach to counselling, 2) they did not feel it added much to the assessment and that their personal experience of the client was valued much more highly and finally, 3) the questionnaires would only tell them what they already knew and they would be astounded if there was anything they did not know. This study tells us that these counsellors engaged in a complex process of evaluation based on a range of different sources of evidence which they then 'weighed up' Evaluation for them was a continuous activity that was embedded in the counselling process itself rather than occurring at particular times. These counsellors although being aware that societal expectations in regard to formal evaluation was present, had resistance to formal evaluation and were confident in their own practice of evaluating the effectiveness of their work with clients.

Although, this study was with person centred counsellors, one could say that before formal evaluation became more embedded in many services is this not the way that most therapists would be evaluating their work with their clients? The converse may also be true, in that therapists that are trained in more recent times to only use formal evaluation may not have developed this complex art of evaluation without using questionnaires for formal evaluation which is often one dimensional. This study then also shows that therapists may possess a sensitivity to the complexity of outcome that is missing in much current research.

Although therapists may be able to evaluate their practice effectively some other studies do not agreed. Therapists and supervisors may have an overly optimistic view of client outcome and usually overestimate improvement and underestimating deterioration in relation to client self reports (Grove et al. 2000; Najavits & Strupp, 1994). In a study of 48 therapists who were asked to identify how many clients they felt over a three week period that they assessed would leave therapy having deteriorated, they said 3/550 clients whereas the algorithms accurately identified
77% (Hannan et al. 2005). These results may lead one to think that therapists and supervisors may not be allocating the appropriate attention to the most at risk cases without formal actuarial methods. This was remarkable given that the therapists were told in advance that 8% was the base rate for deterioration.

Love et al. 2007 discussed a cross-sectional study that looked at the relationship between twenty three mental health therapists’ perceptions of treatments’ impact and actual change in their six month therapy with foster children. Interestingly, only a single therapist on a single outcome variable negatively evaluated the efficacy of their practice and no correlation was found between the therapists’ perceptions of clients’ progress and actual child’s outcomes. The conclusion was made that mental health therapists are unable to subjectively evaluation their own practice accurately. This study thus raised the critical issues of ‘practice wisdom’ that often guides treatment and a therapist’s subjective feelings which may come into play when determining the effectiveness of their practice decisions. Without critically examining the client’s goals and progress towards these, subjective appraisals can be fraught with bias and further complicated if the therapist’s operating theory is not constructed to invite refutation or criticism. Some therapists may either assess their client’s progress favourable or blame them for being ‘unmotivated’ or ‘resistive’, and therefore none of these assessments encourage the therapist to challenge the efficacy of the intervention. One way that therapists feel may help them to evaluate their practice is through the provision of regular clinical supervision.

2.12.1 The role of evaluating practice via clinical supervision

Two major review studies suggest there is little research evidence to support the claim that supervision contributes to therapy outcomes for clients (Kavanagh et al. 2002; Wheeler & Richards 2007). However, there have been other studies that would argue differently. Worthen & Lambert (2007), argue for supervision that includes regular monitoring of client outcome which increases the focus on clients not making the expected treatment progress according to
the monitoring of their outcome. Also included in the supervision would be the addition of assessment and problem solving strategies through clinical support tools for clients not making expected treatment progress. They concluded that by doing this counsellors and supervisors can enhance client outcomes and especially for those clients not making the expected progress and provided for enriched and focused supervision activities. A study by Isakson et al. (2002), recommended progress feedback to therapists in supervision by means of visual charts.

An initial exploration of using CORE data in counselling supervision within primary care was undertaken as an action research project and showed potential benefits and the capacity for potential positive impact on service delivery (McNaughton et al. 2006). The potential benefits were in relation to the provision of supervision providing a safe and supportive environment and by using CORE data within this context it was seen to:

"widen the lens of supervision, bringing issues into focus that might not otherwise present themselves, such as counsellor 'strengths/weaknesses, patterns of practice, training and continual professional issues and contextual issues'. Further opportunities were identified as a potential for 'regular review, meeting ethical obligations, reinforcing effective practice, learning and clinical development and providing evidence for the counselling profession'' (p.222).

However, in contrast, the consistent themes in relation to CORE data being explored with management were a sense of being 'monitored, held accountable, eliciting fear of evaluation, not being good enough, being exposed, getting the sack and of disempowerment' (p222). The challenges of using CORE in the supervisory process were numerous and common concerns highlighted were: 'reduced safety/trust, increased mistrust, decreased honesty/openness, reduced autonomy, disempowerment, permeable boundaries (that supervisory processes could leak into management processes), and also a potential for negative feedback to negatively impact on counsellors' self-efficacy and beliefs' (p222). As this was the introduction of a new process and a huge change to the service some resistance was present even though it was introduced as an action research project. The authors highlight another very critical point which
is the interpretation of CORE feedback and that this should not be viewed as absolute truth but in consideration meaningfully and not in isolation from other sources of evidence. They conclude by advocating a ‘voluntary’ rather than ‘mandatory’ use of CORE data in supervisory processes and ‘promoting counsellor’s understanding of their feedback, with an emphasis on using CORE as one of many useful sources of evidence in the development of meaning’ (p224). Mothersole (2004) termed this process as ‘metaphorically circling the data’.

Mothersole (2006) wrote about his doctoral thesis which was based on an action research project introducing CORE into his service and using it in supervision. He emphasised the promotion of a ‘CORE friendly’ culture as crucial to fostering a culture of openness and curiosity with some sense of ownership and investment in the gathering and of making sense of the data which as a process can take around ‘three years or so’ (p.180). The learning from the project included making sure that the information was accessible not just to himself as the manager but to each individual clinician so they could see their own data in comparison to those of the aggregated service figures and in relation to national benchmarking figures.

The performance appraisal template provided a CORE summary profile of key performance indicators such as level of DNAs, deterioration and clinical/reliable change percentages. A word of caution from the author is about the possibility of practitioners ‘massaging the figures or outright cheating’ and he goes onto say ‘this is the uncomfortable reality that stems from a willingness really to seek to drive up overall quality’ (p184). Again when considering clinical cut-off scores, Mothersole (2006) sees the need for a protocol so that practitioners are clear about their options for example, when a client is below clinical cut-off having the conversation with the client either to take them on for a reduced amount of sessions with a view to extension or to not take them on at all. This would minimise the risk that someone that someone might inappropriately be denied counselling. As a result of this practice he reports a mean reduction of
6 to 5 sessions since they began to look at intake scores below clinical cut-off and applying the protocol.

In a recent study (Crocket et al. 2009) where supervision practice was informed through research via a narrative enquiry, the stories suggest that there are therapeutic benefits in an ethic of transparency that provides for practices that overtly carry stories in both directions between counselling and supervision. They suggest some innovative ways of taking supervision forward which include: counsellors speaking more directly with clients about knowledge generated in supervision conversations, the possibility of a supervisor making a direct therapeutic contribution to client practice by making a recording of their session for the client to hear them 're-telling' of the 're-telling', and this might also include the supervisor responding to the client as 'outsider witness after viewing a tape of counselling' and either write a letter or make an electronic recording (p106).

2.13 The experience of qualified therapists when learning new skills or approaches

In an important study, Henry et al. (1993a) reported that when training therapists to adhere to a manualised psychodynamic model, this adversely affected the therapeutic relationship and increased the likelihood of therapist hostility towards their clients. A further study from the same data noted that those therapists who had prior experience of supervision were more reluctant to change their intervention style during training and those that strongly adhered to the model after training were therapists who had hostile and controlling introjects (Henry et al. 1993b). These therapists were largely responsible for the post-training increase in negative and complex interpersonal communications in client-therapist interaction patterns.

In a rich qualitative study by McKay et al. 2001, counsellors saw at least two clients during a three month period where they received supervision following training in the psychodynamic-interpersonal (PIT) model of therapy. Counsellors were interviewed about their experiences of
changing their practice. Themes indicated that learning a new model of therapy is a complex task for counsellors and evoked difficult feelings for them such as feeling at times 'uncertain, fearful, stressed, fearful and unable to perform when in sessions with the their clients' to the point of 'getting in the way of the therapeutic process' as they 'missed aspects of what was going' on or even 'changed their interventions in order to avoid their own difficult feelings continuing' (p36). They learned and changed awareness as a result of learning the new model and identified ways through which they coped with the difficulties of applying the new model. Some of these ways were: 'surrounding oneself with support, from other counsellors and supervisors', 'accepting their own mistakes and had faith that things would change when they had more practice with the model'.

The implications from this study included the key role of supervision in addressing the difficult emotions in therapists when learning to apply a new model including discussion around the real possibility that adhering to the model strictly may have negative effects for the counsellor who may feel they are failing or cannot attend to their client. Thus a strict supervisor may invoke hostile introject and accompanying deterioration in interpersonal process as discussed by Henry et al. 1993b). In contrast to this, counsellors who avoid or circumvent parts of the model that they are less comfortable with and thus providing a less pure form of therapy may also be detrimental to outcome according to Luborsky et al. 1985.

Mackay et al. (2001) suggested it may be helpful for counsellors learning new models to try to 'absorb the spirit of the model' rather than to follow it 'slavishly' which of course involves counsellors seeing 'beyond the details of the model, to the underlying principles being suggested' (p38). In a later paper on this same study Guthrie et al. (2004), confirmed that after training, counsellors' adherence to the new model increased without affecting their basic counselling skills and so they can be trained to learn and deliver PIT effectively in primary care settings.
In another UK qualitative study by Richards et al. (2006) about developing a UK protocol for collaborative care in managing depression patients, some barriers to implementation were highlighted. Professionals interviewed which included GPs and mental health professionals, outlined potential problems with enthusiasm, resources and fitting into existing service configurations. This study is an excellent example of adapting the research findings into 'real practice'. There was an adaptation of certain elements of the original protocol in order to make it more acceptable both to the professionals and their patients. The interviews provided confirmation of the acceptability of telephone-delivered mix of medication, support and low intensity psychological support but the adaptation of the protocol involved an initial face-to-face appointment, and their training has paid attention to the nonspecific factors necessary to develop a therapeutic alliance as well as the knowledge and skills required for education and medication support. A final suggestion was made that, 'only by combining data from qualitative research with clinical outcomes can sufficiently detailed protocols be developed, which can feasibly be implemented and thereby contribute to improvements in health care delivery' (Richards et al. 2006: 305).

In a study with therapists who were part of an Employee Assistance Program (EAP), training of how to use the measures with clients on the telephone was given prior to the commencement of the study (Miller et al. 2006). The results were compelling and showed that not only did the treatment effect double as a result of using the brief measures but out of thousands of sessions of treatment provided during the course of the study only a handful of complaints were logged from clients regards the scales. Simultaneously the use of the scales by therapists to inform treatment was exceptionally high as compared to studies that have employed longer and more complicated measures (99% versus 25% at 1 year [Miller et al. 2003]). This informs us that routine use of the brief measures appear to be acceptable to both clients and therapists.
In a reflective paper by McInnes (2006), he described his experiences as service manager to a counselling service who used CORE pre and post measurement and the 'critical importance of winning practitioners' 'hearts and minds' and also ensuring data completeness and quality are highlighted as essential pre-requisites for ensuring practitioner commitment and subsequent utility of outcome measurement data' (p163). He recommended implementing performance measurement as a process of organisational change and wanting practitioners to feel that they want to 'do the right thing' as opposed to being seen to do 'the right thing'. He practically highlighted principle concerns and objections clinically from therapists about their views of outcome measurement as: it is reductionist and does not reflect the nuances of the therapeutic work, it is an intrusion into clinical work, anti-therapeutic, will add nothing and lack of experience and confidence in using with clients.

Concerns of the use of data include: performance management and judgements about competence and who will access data and how. The practical challenges were seen to be: time required for completion of measures by client and therapist and then to use it in client work, practitioner access to PCs and in house data installation and sharing protocols. He suggested sufficiently addressing the aforementioned concerns with therapists in the very early stages of implementation and engagement which also includes practical training and developing protocols and guidance. Then a focus on the data accumulation, the issues of data completeness and data quality to ensure accurate completion of forms by therapists. He highlighted the need to develop the use of outcome data and a performance culture so that all in the team alongside the manager could explore the data with 'a spirit of enquiry' (p173).

My study will consider the perceptions of both therapists and clients and the experience of the use of such technology in their therapy sessions and one group of therapists will be using an alliance measure (ARM-5) alongside session use of CORE-Net. As of 2008, no qualitative research studies on CORE-Net were found. The purpose of this study is to answer the
overarching research question: How do therapists and clients perceive and experience CORE-Net and ARM-5 in the NHS? This study had three specific aims related to the research question:

1. To elicit the perceptions of therapist (both experienced and trainees) and clients in relation to their use of a system of continuous monitoring of their therapy via a feedback system that includes regular outcome measuring (CORE-Net) and therapeutic alliance measure (ARM-5);
2. To elicit the perception of therapists in utilising feedback information in supervision; and
3. To elicit the perception of therapists with regard to the training elements required in the process of implementation of this type of routine measurement in clinical practice.

2.14 Summary

This chapter has provided a review of the essential literature relevant to this study. The field of research in relation to outcomes in psychotherapy research is dominated by quantitative research that has contributed both to the Evidence Based Practice (EBP) and Practice Based Evidence (PBE) research paradigms. The routine monitoring of clinical outcomes using both an outcome measure and an alliance measure falls into the area of PBE and is an extension of quality assurance action research which represents an effort to bridge the gap between research and practice while enhancing clinical outcomes before therapy with a client ends. It has been important to consider the literature that looks at the therapeutic relationship and alliance measures utilised to measure it as well as to reflect on the research of how therapists evaluated their own practice. It has been vital to include the literature on client and therapists experiences of using questionnaires in therapy and how experienced therapists feel about learning new skills or approaches. This leads to my study which includes interviewing one group of therapists and their clients on the experience of the use of routine outcome measurement using for session tracking and one group that had only used the outcome measure. I have attempted in this study to include the suggestions of research studies from my review of the literature into the implementation of routine outcome measurement in my own service.
CHAPTER THREE

Methodology and Methods
CHAPTER 3

3.1 Introduction

This chapter will begin with a brief outline explaining the rationale for the design of the study, followed by an outline of the context of the chosen methodology as contributing to existing research evidence on outcome measurement as a way of a reminder leading to the research question. It also will consider the design of the study, a description of the settings with participant details, procedures, methods of data collection and analysis and ethical considerations.

3.2 Rationale for the design of the study

As has been considered in the literature review in Chapter 2, most of the studies in the field of routine outcome measurement have been quantitative with far less on the client and therapist experience of routine outcome measurement. In my study, I used a purely qualitative paradigm that gathered rich data from various sources allowing data triangulation and a moment by moment account of therapists actual experience and 'felt sense' of adapting and integrating to routine outcome measurement with both CORE-Net and ARM-5. It also allowed the 'client's voice' to be heard as to what the impact was of such systems of continuous in their therapy experience.

I was able to include in the Occupational Health (OH) setting both client and therapist perspectives in interviewing and only used ARM-5 with this setting. My decision not to use ARM-5 and to interview clients within the Primary Care Counselling (PCC) setting was because of geographical logistics and resource constraints in achieving this with another service in a
different part of the country. This obviously presents as a limitation to the study in terms of comparability as the client's voice is not heard in the same way as the OH setting and these therapists did not use the alliance measure, however, it does provide 'rich' data from the therapists perspective of being the longest users of CORE-Net in the UK.

3.3 Methodology

The study was influenced by using a 'naturalistic' method of enquiry or paradigm (Lincoln & Guba 1985). There are matching methodologies to theory and a piece of research can differ along a series of four independent dimensions (what is written in brackets is relevant to this study): the type of data elicited (perceptions, experiences, feelings, emotions), the techniques of data elicitation (interviews of both individual and focus groups, diaries), the type of design for monitoring change (interviewing of new users throughout the process and longer term users) and the treatment of data as qualitative (analysis of data using qualitative content analysis and a general inductive approach) (Breakwell & Rose 2000). The explanatory purpose of enquiry depends on the purpose of the research (Robson 2002). My study is an exploratory study as "it seeks to find out what is happening, particularly in little-understood situations, seeks new insights, asks questions, assesses phenomenon in new light, seeks to generate ideas and hypothesis for future research and the design is almost exclusively flexible" (Robson 2002:59). This seemed the best approach to this study since existing research in routine outcome measurement (ROM) is mainly quantitative and usually only gaining the views and attitudes of clinicians/therapists on ROM, therefore, using this method of enquiry would complement and add to existing studies by gaining an in-depth view of both therapists and their clients.

3.4 The Research Question and Aims

The purpose of this study was to answer the overarching research question: How do therapists and clients perceive and experience CORE-Net and ARM-5 in the NHS? This study had three specific aims related to the research question:
1. To elicit the perceptions of therapist (both experienced and trainees) and clients in relation to their use of a system of continuous monitoring of their therapy via a feedback system that includes regular outcome measuring (CORE-Net) and therapeutic alliance measure (ARM-5);
2. To elicit the perception of therapists in utilising feedback information in supervision; and
3. To elicit the perception of therapists with regard to the training elements required in the process of implementation of this type of routine measurement in clinical practice.

In order to achieve these aims several perspectives were sought. Both interviews and diaries were used in capturing these perspectives. However, only diaries were used by the Occupational Health setting therapists and only clients from this setting were interviewed. Also in the OH setting, the therapists used the alliance measure (ARM-5) with CORE-Net because as discussed in the review of the literature (Chapter Two) the alliance at the beginning of therapy is a good prognosticator of premature termination (Horvath & Luborsky 1993). The primary care counselling therapists who were the longest users of CORE-Net were interviewed precisely for their long term experience with it even though they had not used an alliance measure in their work.

3.5 Design of the Study

My study was a flexible design (Robson 2002) using mainly qualitative methods of data collection and analysis. Qualitative research within a natural setting seeks to understand specific behaviours and their subtle variations, and uses categories to describe and analyse the social phenomenon (Meadows 2003; Pope et al. 1999). This study included fundamental characteristics such as an evolving design, the presentation of multiple realities, the researcher as an instrument of data collection and a focus on participants' views. Chesney (2001) discusses the 'dilemmas of self' that is involved in the 'researcher-as-instrument' rather than relying on specialist tools and instruments. The involvement of the researcher and how involvement changed the researcher both as a therapist and as a team leader of other therapists, as a result of this research process, is discussed later in this Chapter and in the Discussion Chapter 6.
Ahern (1999) discussed the need for reflexivity on the part of the researcher to identify areas of potential researcher bias.

3.6 Methods

In considering the approach for data collection in this study, it was important to understand the purpose, advantages and disadvantages of using interviews, focus groups and diaries, with respect to the researcher's available time and resources. Table 3.1 summarises the three research aims and where the answers were identified in the data.

Semi structured interviews are widely used in flexible, qualitative designs and King (1994) suggests that they may be used where the focus of a study is on the meaning of particular phenomenon to the participants and where individual perceptions of processes within a social unit – such as a work-group, department or whole organisation – are to be studied using a series of interviews. I used both telephone and face-to-face one-to-one interviews in this study.

Table 3.1 Research aims and answers identified in the data

<table>
<thead>
<tr>
<th>(i) To elicit the perceptions of therapists (both experienced and trainees) and clients in relation to their use of a system of continuous monitoring of their therapy via a feedback system that includes regular outcome measuring (CORE-Net) and therapeutic alliance measure (ARM-5)</th>
<th>(ii) To elicit the perception of therapists in utilising feedback information in supervision</th>
<th>(iii) To elicit the perception of therapists with regard to the training elements required in the process of implementation of this type of routine measurement in clinical practice</th>
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<tbody>
<tr>
<td>2x Focus Groups (5 therapists in OH and 4 in PCC) (Appendix 14 &amp; Appendix 15: Q1-4 &amp; 7)</td>
<td>2x Focus Groups (Appendix 14 and Appendix 15: Q 5 &amp; 6)</td>
<td>2 x Focus groups (Appendix 14&amp; Appendix 15: Q 5 &amp; 6c)</td>
</tr>
<tr>
<td>7 x Interviews with non-CORE-Net users</td>
<td>7 x Interviews with non-CORE-Net Users</td>
<td>7 x Interviews with non-CORE-Net users</td>
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</table>
The telephone interviews were used due to time and resources and the geographical logistics of travel to these participants being prohibitive. Interviews have the advantage of offering the possibility of modifying one’s line of enquiry, following up interesting responses and investigating underlying motives in a way that postal and other self-administered questionnaires cannot. Non-verbal cues may give messages to try to understand the verbal responses, which have the potential to provide rich and highly illuminating material. One challenge is the lack of standardisation, which inevitably raises concerns about reliability and biases, which are hard to rule out. Interviews require skilled interviewers to use closure skills which are time-consuming and require preparation prior to the interview. It is also very time-consuming to transcribe and complete data analysis.

From a critical realist perspective, focus groups have considerable potential to raise consciousness and empower participants (Johnson 1996). There are some advantages and challenges to using focus groups, according to Robinson (1999). Some advantages to using focus groups include (a) collecting data from many people at the same time, (b) relatively

<table>
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<tr>
<th>(telephone interviews) (Appendix 18: All prompts)</th>
<th>(Appendix 18: Prompts on general views of their team using CORE-Net and their own future use of CORE-Net)</th>
<th>(Appendix 18: Prompts on general views of their team using CORE-Net and their own future use of CORE-Net)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 x Therapist Diaries (Appendix 19: Q1-8)</td>
<td>10 x Therapist Diaries (Appendix 19: Points to raise in supervision)</td>
<td>1 x David's interview (Appendix 16: Prompt on training aspects and future recommendations for the teams)</td>
</tr>
<tr>
<td>28 x Therapist Supervision Interviews (face to face)</td>
<td>28 x Therapist Supervision Sessions</td>
<td></td>
</tr>
<tr>
<td>1 x David's Interview – key (PCC) informant (face to face) (Prompts on comparison of two groups, client assessment, risk, triage, use of ARM-5 and failing clients)</td>
<td>1 x David's Interview (Appendix 16: Prompt on use of training aspects)</td>
<td></td>
</tr>
<tr>
<td>10 x Client Interviews (face to face) (Appendix 17: all prompts)</td>
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<tr>
<td>374 (clients) x CORE-Net user satisfaction on screen questionnaire</td>
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inexpensive to set up, (c) natural quality controls occur whereby participants tend to provide checks and balances on each other and extreme views tend to be weeded out, and (d) participants are empowered to make comments which may be stimulated by the thoughts and comments of others in the group (including talking about difficult subjects as there is mutual support within the group and participants who are have difficulties such as being unable to read or write are not discriminated against). Robinson (1999) continues to highlight the challenges of focus groups which include, (a) the number of questions that can be covered in a reasonable time frame, (b) expert facilitation of the group process by the interviewer, (c) personality conflict within the group and domination of the discussion by certain individuals, (d) confidentiality within the group, and (e) the results cannot be generalised as they cannot be regarded as representative of the wider population.

Given the resources available in the study, and to accommodate time constraints in the real world setting of clinical practice, diaries were used to facilitate the therapists' thinking. Diaries were also used in the study to capture the processing of each therapist's views as they occurred and therefore have a temporal framework whereas the individual and focus group interviews were retrospective (more time would have elapsed between the experience and the interviewing).

The questions for all the one-to-one interviews (both telephone and face to face) and the focus groups were compiled from a particular survey study by Smart et al. (2006).

The last method of data collection used a feature already built into the computer software that asked clients each time they filled out a CORE-Net measure, how they felt about filling it in. The question asked "How did you feel about being asked to complete this questionnaire?" The options for the client to click from left to right are: Quite Happy, Didn't Mind, Don't know, Not Keen and Disliked it. Results of this questionnaire will be found in the Results section at the end of Chapter 4.
My research adopted a multi-modal approach to elicit a range of perspectives on the use of CORE-Net/ARM-5, to include therapists, the researcher and clients in two NHS settings, see Figure 3:1. Please note the Abbreviations used to shorten words like (I) for (Interview) and FG (Focus Group). Table 3-2 shows the main methods of data analysis and data collection used in this research study design.

Table 3-2 Methods of analysis and data collection

<table>
<thead>
<tr>
<th>Method of analysis</th>
<th>Theoretical basis</th>
<th>Method of data collection</th>
<th>Main authors</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Inductive Analysis</td>
<td>Inductive – Strauss &amp; Corbin (1990)</td>
<td>Interviews (face to face and telephone) and Focus Groups</td>
<td>Thomas (2003, 2006)</td>
</tr>
</tbody>
</table>

Data were gathered from the following sources:

1. **Focus groups** with both OH and PCC therapists: the questions are semi-structured questions with probes (Appendix 14, Appendix 15).

2. **Interviews (face to face)** with individual clients: these questions were compiled in collaboration with feedback from current CORE-Net users (Appendix 17)

3. **Interviews (telephone)** with seven therapists from PCC: these questions were only slightly different than the questions used for the focus groups and were devised similarly. These therapists from PCC had not yet begun to use CORE-Net but were using CORE system (Appendix 18). Finally, one interview with a therapist from the PCC who was a current user and part of the PCC focus group was undertaken after the first two focus groups were completed. This last interview was in an unstructured format (Appendix 16).
4. **Therapists' process diaries** about their experience of using CORE-Net/ARM-5 with two clients they saw in this way: headings were compiled with feedback from current CORE-Net users and were designed to be brief but to assist therapists to reflect on the process of using the measures (Appendix 19)

5. **Therapist Supervision Sessions (face to face):** throughout the project the researcher recorded supervision sessions relating to the measures to gain a fuller picture of the reality of introducing these types of measures in routine clinical practice and potential impact on a service and its manager. All the entries were dated to give a temporal framework.

3.6.1 **Settings**

The first setting is a Primary Care Counselling service (PCC) where the NHS therapists had already been using CORE-Net for over a year and the second setting is the researcher's team in an acute hospital setting in an occupational health department in the NHS (OH) who already had plans for service development by being prepared to use CORE-Net within the time frame of the research programme but had not yet begun its use. The managers of both services are acquainted through the National CORE Benchmarking Database and Practice Research Network in the U.K.

3.6.2 **Organisational context for OH**

An acute district general hospital based approximately 12 miles from central London. The hospital supports some 320,000 people in the surrounding area. There are approximately 520 beds and the Trust directly employ some 2,600 staff with another 300 staff employed by contractors but working on behalf of the Trust. It provides a full range of diagnostic and treatment services and has a national reputation for innovative developments in healthcare, particularly in 'patient-focused' care, day surgery and maternity services.
The workplace counselling unit is part of a wider Psychological Well Being Service (PWBS) which is situated within the hospital grounds located in the occupational health department and provides counselling to both the staff employed by the Trust and the contractor staff as well as external organisations that it has service level agreements with. The service was set up in 1999.

The remit of the PWBS includes other workplace counselling activities such as health promotion, policy formulation and implementation, delivering training in stress management, mediation, coaching, and the promotion of the complementary therapies for relaxation. Referrals are received from other occupational health professionals, management, human resources and self referrals. These therapists have not used an alliance measure routinely in their practice until the start of the research but had used pre and post manual forms of CORE for at least six months prior to the start of the research project. The purpose for this group of therapists and clients to be interviewed was to capture their experience ‘live’ during the implementation of a service change from pre-post methodology to session tracking on screen and adding an alliance measure to the methodology. All individual counselling is delivered on the hospital site that all hospital employees’ work at which involves no travelling and two rooms are allocated for the therapists so that there are always two therapists on site. All employees from external contracts travel to the hospital site for their counselling.

The hospital has a strong culture of research and audit and this is no different for the occupational health department and the PWBS within it. The PWBS has been monitoring its performance by having a quality evaluation system from 2002 when it started using the pre-post measurement methodology with manual forms and has had a practice based research interest since 2005. The PWBS does not have a separate budget to occupational health and there are adequate funds for training and supervision. Training needs are identified in the annual PDR or if anything comes up during the year that staff want to attend at the suggestion of the manager. Therapists are exposed to research evidence of other professional groups on the occupational health teams and read research articles relating to occupational health in journals that their
nurse and medical doctors receive. Due to the nature of the service overall turnover is high. This is because the service is funded for 1.4 WTE and the rest of staff 1 WTE are made up of Masters/Doctoral students finishing their psychotherapy/counselling psychology training and are in honorary placements for 2 year contracts. The turnover for substantive staff however is very low. The Head of PWBS first heard about CORE through a regional NHS staff counsellor's forum in London also attended by the RCN who informed the group that they were using CORE. There was no requirement by the organisation for the counselling service to use any clinical measurement system at that time.

Clients are employees with the majority 96% being younger than 59 years of age and 72% from white ethnic background and 70% female. Clients are contacted within 48 hours and waiting times for their assessment and ongoing therapy are an average of 7 days. All data that was manually inputted was given to the audit department for analysis and any recommendations were actioned year on year. From 2004 with the introduction of CORE-PC the data was analysed by the head of service and any recommendations actioned. All annual reports were presented to the Board and policy and practice changed as a result of recommendations from each analysis.

3.6.3 Organisational context for PCC
The PCC setting is an NHS Foundation Trust with teaching status that provides specialist mental health, learning disability and substance misuse services.

The counselling unit has a service level agreement to provide counselling to the patients referred to them by the GPs in the local Primary Care Trust. The primary care counselling service (PCC) setting sees clients referred to them by the General Practitioners and more recently from Graduate Mental Health workers (GMH) for brief psychological interventions. These therapists do not use an alliance measure in their work routinely and therefore it was
decided not to ask them to begin to use one for the study as there would be no resources for the training and implementation support of such. There were five therapists who began to use CORE-Net eighteen months ago but only four were able to be interviewed as part of the focus group. The purpose for this group to be interviewed was to capture their experience as the longest users of CORE-Net in the UK. 80% of counselling is delivered on a ‘grace and favour’ basis within the GP surgeries which has always been a constant problem. 20% is delivered within the mental health Trust premises.

The counselling unit has a strong culture of audit and practice based evidence research from its inception in comparison to the culture of their organisation physical setting. The unit has a generous budget for training and supervision and training needs are identified in the annual Personal Development Review or if anything comes up during the year that staff want to attend as well as at the suggestion of the manager. Minimal turnover which is almost incalculable and below both national and their own Trust level. Staff reasons for leaving in recent years are due to retirement or relocation.

With the advent of GP commissioning the service was set up to provide psychological therapy in 2000 with the specific requirement that they use CORE system for measuring clinical outcomes. In 2002 the service began to use CORE-PC and then in 2005/6 they were the first therapists in the UK to trial the CORE-Net software. The area of the country which this service serves is characteristically an older white population with the median client being white 40 year old female. The service set no upper age limits to clients accessing the service so that they have around 20% of the clients seen who are 65 years and older. The wait time during from 2005 - 2007 went from 0 to 6-8 weeks. The head of the service undertook a doctorate degree which brought several changes to practice including: the development of a risk policy based on CORE clinical risk scores; therapist engagement with data and service engagement with data for outcome management.
3.6.4 Participants

An appropriate sample size for a qualitative study is one that adequately answers the research question (Marshall 1996). Creswell (1998) and Weiss (1994) discuss different strategies for selecting a sample of informants depending on the scope of the study, the amount of time that the researcher is willing and able to spend in data collection and finally the tradition of enquiry used for the project. Creswell (1998:119) refers to a typology of sampling strategies in qualitative enquiry and lists sixteen types of sampling of which 'criterion' includes all cases that meet some criterion which is useful for quality assurance. The sample of participants recruited for this study was a purposive sample in which the 'criterion' strategy allowed subjects to be selected because of some characteristic (Patton 1990). Purposive sampling emphasises the 'researcher's judgments as to typicality or interest 'which enables the researcher to satisfy the specific needs of the project by gaining the most meaningful information (Robson 2002:265).

Marshall (1996) emphasized that with a purposeful sample, the researcher actively selects the most productive sample to answer the research question which can include subjects with special expertise (key informant sample). This is often based on the researcher's practical knowledge of the research area and the available literature. Marshall (1996: 523) states "this is a more intellectual strategy than the simple demographic stratification of epidemiological studies, though age, gender and social class might be important variables". Therefore a sampling strategy that would generate rich data was essential to answer the research question and objectives. The research objectives thus required meaningful data to be gathered from experienced practitioners in CORE-Net methodology and those that had just started it's use who were required by their workplace to incorporate an alliance measure. As a practitioner in one of the organisations, I additionally had access to the therapists and clients in my own setting, for the new users, and, in the other setting, to the therapists who were the longest users of the methodology in the U.K. It thus made both practical and theoretical sense to use participants from both these NHS settings.
Figure 3.1 Research Study Design

Primary Care Counselling Service (PCC): CORE-net users for 12-18 months
Data collection April – December 2007

Occupational Health Counselling (OH): New CORE-net users
Data collection April – December 2007

A) Focus group (FG) with 4 long term CORE-Net users with researcher as facilitator (FG-PCC)
B) One to one telephone interviews (I): 7 non-CORE-Net users (I-PCC)
C) One to one face to face interview (I) with key informant (PCC) CORE-Net user (I-David)
D) Therapist Process diaries (TD): x 10 new CORE-Net users (TD-OH)
E) Therapist Supervision Sessions (SS): 28 x new CORE-Net & ARM-5 users (SS-OH)
F) Client interviews (I) face to face: x 10 (I-OH)
G) Focus group with 5 therapists facilitated by key informant PCC therapist (FG-OH)
The specific selection criteria for all therapists and clients from OH setting who participated were:

1. CORE-NET therapists must have PC and internet access at every session with clients;
2. All therapists must abide by the BACP Code of Ethics for professional practice and be members although not necessarily accredited i.e., they may be in training;
3. All therapists must be in post for the duration of the study;
4. All therapists must undertake at least 1.5 hours of clinical supervision of their practice monthly according to BACP ethical requirements;
5. Therapists provide a variety of theoretically guided treatments;
6. Clients in both settings include consecutive cases seen in routine practice regardless of patient diagnosis or combined conditions (rather than being disorder specific); and
7. The length of therapy is determined by both client and therapist but these services work with around 6-8 sessions per client.

3.6.5 Recruitment of therapists and clients

As both team leaders of the two different settings were acquainted via the CORE national benchmarking data network, communication was initiated by the (OH) team leader and a list of names of all the therapists on the (PCC) therapists was exchanged. The (OH) team leader had the (OH) setting therapists in place for this setting as they were in the same team.

Therapists were informed in advance that either their first or second client in the first half of the trial would be invited for interview and that again in the second half (approximately 4.5 months after start of the trial) the first or second client would be asked for interview. The team leader allocated all the referrals as per normal routine practice to each therapist as the client referral came in and would inform the therapist on allocation of the client that at assessment they were
to inform the client about being interviewed one month after they finished their therapy sessions by the team leader.

3.6.6 Therapists

Please see Table 3-3 for details of the PCC therapists. Additional Therapist Details was gathered via Appendix 23 for all therapists. Most of the therapists described themselves as having an "Integrative" theoretical orientation to their practice. The average age of therapists was 46 and there were 2 male and 2 female therapists. All barring one therapist had BACP/BPS or equivalent accreditation status. These three therapists had an average of 9 years post qualifying experience and all but one worked part-time hours with an average of 27.25 hours per week. Two therapists routinely use CORE information sheet and consent and all therapists give out a client satisfaction questionnaire at the conclusion of their episode of counselling with their clients. All therapists have access to broadband internet in their therapy room and have used CORE-Net online methodology (using it for most client sessions but not all) for an average of 1.6 years.

Table 3-3 Demographic details of 18 months CORE-Net Therapists in PCC Settings

<table>
<thead>
<tr>
<th></th>
<th>David</th>
<th>Aline</th>
<th>Bonita</th>
<th>Tom</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theoretical</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Orientation</strong></td>
<td></td>
<td>CBT</td>
<td>Integrative</td>
<td>Integrative</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td>49</td>
<td>50</td>
<td>36</td>
<td>49</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td>Male</td>
<td>Female</td>
<td>Female</td>
<td>Male</td>
</tr>
<tr>
<td><strong>Qualifications</strong></td>
<td>BACP</td>
<td>CPC</td>
<td>500+</td>
<td>BPS</td>
</tr>
<tr>
<td><strong>Post qualifying</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>hours/years</strong></td>
<td>3</td>
<td>10</td>
<td>0</td>
<td>14</td>
</tr>
<tr>
<td><strong>Part-time/full-</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>time hours</strong></td>
<td>Part-time</td>
<td>Part-time</td>
<td>Part-time</td>
<td>Full-time</td>
</tr>
<tr>
<td><strong>Actual</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Working hours</strong></td>
<td>17</td>
<td>30</td>
<td>27</td>
<td>35</td>
</tr>
<tr>
<td><strong>Use Consent</strong></td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>
An additional seven therapists who did not use CORE-Net but used CORE OM or CORE System (manually-filled out forms) were interviewed. The additional therapist details for these therapists who were Non CORE-Net users can be seen in Table 3-4 which have also been taken from the Additional Therapist Details (Appendix 23). Five out of seven therapists described their theoretical orientation in clinical practice as "Integrative" with another being "Person-Centred" and another "Structured/Brief". All therapists barring one were female and these therapists had an average age of 51.29. All were experienced therapists with BACP equivalent accreditation status with an average post qualifying time of 11.28 years. All worked part-time with an average of 20.21 hours per week. All except one routinely use CORE information and consent forms with their clients but all give their clients at the conclusion of the counselling episode a client satisfaction questionnaire. All had access to internet broadband in their therapy rooms and had used CORE pre-post methodology using manual paper forms for an average of 4.57 years.

<table>
<thead>
<tr>
<th>Use of satisfaction evaluation</th>
<th>David</th>
<th>Aline</th>
<th>Bonita</th>
<th>Tom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Access to internet/pc in room</th>
<th>Yes</th>
<th>Yes</th>
<th>Yes</th>
<th>Yes</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Time use CORE-Net</th>
<th>1.5</th>
<th>1.5</th>
<th>2</th>
<th>1.5</th>
</tr>
</thead>
</table>

Table 3-4 Demographic details of non CORE-Net Users in PCC Setting

<table>
<thead>
<tr>
<th>Theoretical Orientation</th>
<th>Samantha</th>
<th>Liticia</th>
<th>Donna</th>
<th>Denise</th>
<th>John</th>
<th>Tanya</th>
<th>Jackie</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Integrative (INT)</td>
<td>INT</td>
<td>INT</td>
<td>INT</td>
<td>Person Centred</td>
<td>INT</td>
<td>Structured /Brief</td>
</tr>
<tr>
<td>Age</td>
<td>54</td>
<td>62</td>
<td>49</td>
<td>48</td>
<td>60</td>
<td>49</td>
<td>37</td>
</tr>
<tr>
<td>Gender</td>
<td>Female</td>
<td>Female</td>
<td>Female</td>
<td>Female</td>
<td>Male</td>
<td>Female</td>
<td>Female</td>
</tr>
<tr>
<td>Qualifications</td>
<td>BACP</td>
<td>CPC</td>
<td>BACP</td>
<td>BACP</td>
<td>BACP/ CPC</td>
<td>BACP/UK CP</td>
<td></td>
</tr>
</tbody>
</table>

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The OH setting is in an occupational health setting within an acute district general hospital and provides psychological therapy to employees. The entire service including the researcher switched to the use of CORE-Net for the purposes of this study. ARM-5 was developed by Leeds University and was piloted for the first time in this study. ARM-5 was used because as research evidence (discussed in literature review Chapter 2) shows the combined routine use of both outcome and alliance measures improve clinical outcomes. The research focus was to capture the 'experience' of actually using both in routine practice and the 'reality' of such an implementation for both therapists and their clients. The demographic details of the FG-OH (6 months) can be found in Table 3-5.

Four out of five therapists described themselves as "Integrative" in theoretical orientation to their clinical practice. Their average age was 46.2 years and all were female. Two out of the six therapists were BACP accredited and the rest were on a two year placement having completed a basic counselling qualification but undertaking the completion of their studies for BACP/UKCP accreditation/registration. The two therapists that were BACP accredited had an average of 6.5 years post qualifying time. All therapists worked one day (8 hours) per week. All used CORE
information and consent forms routinely and all except one routinely asked their clients to fill out a satisfaction questionnaire at the completion of their counselling episode. All therapists had internet broadband connection in their therapy rooms and had an average experience time of 2.4 years of CORE pre-post methodology using manual paper forms.

Table 3-5 Demographic Details of 6 months CORE-Net Therapists in OH Setting

<table>
<thead>
<tr>
<th></th>
<th>Selaye</th>
<th>Tamsin</th>
<th>Sally</th>
<th>Jennifer</th>
<th>Phoebe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theoretical Orientation</td>
<td>Integrative</td>
<td>Psychodynamic</td>
<td>Integrative</td>
<td>Integrative</td>
<td>Integrative</td>
</tr>
<tr>
<td>Age</td>
<td>44</td>
<td>49</td>
<td>62</td>
<td>31</td>
<td>45</td>
</tr>
<tr>
<td>Gender</td>
<td>Female</td>
<td>Female</td>
<td>Female</td>
<td>Female</td>
<td>Female</td>
</tr>
<tr>
<td>Qualifications</td>
<td>300+</td>
<td>BACP</td>
<td>BACP/UKCP</td>
<td>350+</td>
<td>470+</td>
</tr>
<tr>
<td>Post qualifying hours</td>
<td>7</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Part-time/full-time hours</td>
<td>Part-time</td>
<td>Part-time</td>
<td>Part-time</td>
<td>Part-time</td>
<td>Part-time</td>
</tr>
<tr>
<td>Actual Working hours</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Use Consent</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Use of satisfaction evaluation</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Access to internet/pc in session</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Time use CORE-OM</td>
<td>0.75</td>
<td>5</td>
<td>4</td>
<td>1.25</td>
<td>1</td>
</tr>
</tbody>
</table>

3.6.7 Clients

In the PCC setting clients were not interviewed for the research study but the experience of the therapists was based on their seeing clients that were those referred to them via various methods of referral with in the primary care setting including via the GPs.
In the OH setting the clients were employees who came to the service via routine procedures that included self referral, direct management referral and referral from other professionals within the OH team, for example, nurses and doctors and from the Human Resources department. This client data was gathered via the CORE contextual forms Therapy Assessment Form (Appendix 2) routinely gathered for each client and verified in the interview data when they were asked if they had counselling before. Additionally this data was also verified via the Occupational Health software called "OPAS" used by the whole multi-disciplinary team in the Occupational Health department (admin, nurses, doctors) which is also an electronic diary system which has information from when they started employment with the Trust and were occupational health cleared for work containing their date of birth details for example as well as the dates of all episodes of care given through occupational health during their time of employment and what they were e.g. counselling, vaccination or management referral. Please see Table 3-6 for details of these OH clients (all names are pseudonyms).

Ten clients were recruited who were all female with an average age of 41.8. two had had counselling before with outcome measured used in their counselling episodes, four had also had previous counselling with outcome measurement used and four had not had counselling before. The range of issues that clients brought to therapy were: Relationship difficulties, alcohol abuse, bereavement, work issues, personal issues, medical health condition and depression.

<table>
<thead>
<tr>
<th>OH Client</th>
<th>Seen by this therapist</th>
<th>Age of client</th>
<th>Counselling before with OM</th>
<th>Counselling before without OM</th>
<th>Never had counselling before</th>
<th>Presenting Issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Katherine</td>
<td>Phoebe</td>
<td>39</td>
<td>X</td>
<td></td>
<td></td>
<td>Relationship &amp; alcohol abuse issues</td>
</tr>
<tr>
<td>Tabitha</td>
<td>Selaye</td>
<td>39</td>
<td>X</td>
<td></td>
<td></td>
<td>Bereavement</td>
</tr>
<tr>
<td>Belinda</td>
<td>Tamsin</td>
<td>41</td>
<td>X</td>
<td></td>
<td></td>
<td>Relationship difficulties</td>
</tr>
<tr>
<td>Bernadette</td>
<td>Tamsin</td>
<td>46</td>
<td>X</td>
<td></td>
<td></td>
<td>Relationship difficulties</td>
</tr>
<tr>
<td>OH Client</td>
<td>Seen by this therapist</td>
<td>Age of client</td>
<td>Counselling before with OM</td>
<td>Counselling before without OM</td>
<td>Never had counselling before</td>
<td>Presenting issue</td>
</tr>
<tr>
<td>-----------</td>
<td>------------------------</td>
<td>---------------</td>
<td>-----------------------------</td>
<td>-----------------------------</td>
<td>-----------------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Dorcas</td>
<td>Jennifer</td>
<td>37</td>
<td></td>
<td></td>
<td>x</td>
<td>Work issues</td>
</tr>
<tr>
<td>Charmaine</td>
<td>Sally</td>
<td>53</td>
<td></td>
<td>x</td>
<td></td>
<td>Bereavement</td>
</tr>
<tr>
<td>Sabrina</td>
<td>Selaye</td>
<td>57</td>
<td></td>
<td>x</td>
<td></td>
<td>Personal issues</td>
</tr>
<tr>
<td>Vanessa</td>
<td>Phoebe</td>
<td>38</td>
<td></td>
<td></td>
<td></td>
<td>Work issues</td>
</tr>
<tr>
<td>Amy</td>
<td>Jennifer</td>
<td>36</td>
<td></td>
<td></td>
<td>x</td>
<td>Medical condition</td>
</tr>
<tr>
<td>Chantelle</td>
<td>Sally</td>
<td>32</td>
<td></td>
<td></td>
<td>x</td>
<td>Depression</td>
</tr>
</tbody>
</table>

### 3.6.8 PCC Setting

PCC therapists were invited to participate with invitation letter, information sheet, consent form and additional therapist details requested (Appendix 20, Appendix 21, Appendix, 22) before they could participate. These formed the focus group from a Primary Care Counselling (PCC). The focus group consisted of five therapists, one of these was unable to attend on the day and Ethics approved for this therapist to be interviewed separately on the telephone but their data to be included as part of the focus group data. One to one telephone interviews were conducted with seven counsellors who did not use CORE-Net but did use CORE System (Appendix 18). A last one to one face-to-face interview (Appendix 18) was undertaken with one PCC current CORE-Net therapist and trainer at the end of the day when he had concluded his facilitation of the OH therapist focus group. The background to these therapists is that the CORE-Net users were asked to be part of the Beta development of the CORE-Net software since its inception and have had regular meetings with COREIMS Ltd so as to feedback the clinical usefulness of the software and to make suggestions for its improvement.

Demographic details of these four therapists were gathered and can been seen in Table 3-3.
3.6.9 **OH setting**

All OH therapists were invited by letter, given an information sheet, consent form and asked to fill out an additional therapist questionnaire (Appendix 23, Appendix 24, Appendix 25, and Appendix 26).

3.6.10 **Training of therapists and procedures**

The CORE-Net training was delivered with online tutorials and individual training sessions which demonstrated how to use it with visual illustrations and a verbal (audio) explanation of how to use the forms with clients. ARM-5 was explained in a face-to-face training delivered to each therapist consisting of one and half hours and delivered by the researcher (Appendix 27, Appendix 28, Appendix 29). The material for the online tutorials was taken essentially from principles of both the information of current users of CORE-Net, COREIMS Ltd and their advisors plus the work of Lambert (2001), Miller *et al.* (2005) and other studies on feedback to therapists and clients and how this can be used interactively (Castonguay & Beutler 2006; Miller & Rollnick 1991).

After the delivery of the training for CORE-Net and ARM-5, the researcher provided additional assistance and mentoring to all therapists as required throughout the study. All participating clients were asked for consent since they were part of the research study whereby *anonymous data* were stored and used for donation to national database, research purposes and service development improvements. It must be noted that all OH clients already gave routine consent for anonymous donation of their data for service improvement and national database benchmarking and research purposes. These forms continued to be used if clients indicated they did not want to be a part of the research study. All clients were given an information sheet and consent form before they were included in the trial (Appendix 30, Appendix 31). For each client, the therapists administered CORE-Net at the start of sessions and ARM-5 at the end of each
session. From commencement of the study the therapists were asked to write process diaries for the first two clients that they worked with using CORE-Net and ARM-5 with a pre-set inventory for their diary as a guide (Appendix 32). After they had used the system for four and a half months they were notified by the researcher which client they needed to ask at the end of therapy if they would like to be interviewed by the researcher within a month of ending their therapy. If they consented to this their contact details were passed onto the researcher to contact them after completion of their therapy. The one-to-one face-to-face interview with clients was for up to half an hour ideally conducted within one month of therapy ending (see Appendix 17).

The researcher conducted interviews. The selection of these clients has been described in section 3.5.3. The researcher also recorded supervision sessions with the therapists in OH. as they occurred ad hoc throughout the study period. Only the parts of the supervision session that were related to a discussion around the clinical scores and therapists feeling about this were recorded and transcribed.

A focus group was held with therapists after using CORE-Net and ARM-5 for six months. The therapists were invited to take part in a focus group to share their experiences with a PCC counsellor who was a current CORE-Net user as facilitator (Appendix 14).

3.6.11 Interviewing Environment

The interviews and focus groups were conducted in a quiet environment where interruptions and disturbances were kept to a minimum. Other environmental considerations such as lighting, temperature, size of room were conducive to make the participants and researcher feel as comfortable as possible. In the focus groups, the chairs were placed in a semi circle and in the individual interviews; the chairs were placed at right angles to each other. As part of the interviewing process, a digital recording device was used. The interviewees were made aware of
why the recorder was being used and of their rights to stop it at any point in the interview. The following dialogue took place prior to all interviews: "I'd like to tape record what you have to say so that I don't miss something that you say or inadvertently change your words somehow. So if you don't mind, I'd like to use the recorder. If at any time during the interview you would like to turn the tape recorder off, all you have to do is press this button on the recorder and it will stop or say please stop recording." A summary of the methods for data collection are shown in Table 3-7.

3.6.12 Secure Storage of Data and Confidentiality

The tapes were kept in a locked cupboard and the researcher was the only person with access to the key and they will be destroyed upon completion of the course. The recordings were anonymous before they were sent to the transcriber. Data kept on computers was anonymous. Any printed out or written matter like consent forms and Therapist demographic details as well as the allocation of fictitious names for client and therapists was kept locked in a metal fire-proof filing cabinet in the researcher's NHS place of employment. CORE-Net data is anonymous to those outside the service but identifiable to the team so that case management was made possible via supervision meetings during the study with OH setting therapists.

Table 3-7 Summary of Methods for Data Collection

<table>
<thead>
<tr>
<th>PCC setting:</th>
<th>Obtained only therapist consent as only therapists were interviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>(i) 1 x Focus group (semi-structured questions) with four therapists at the start of the data collection period who had used CORE-Net for the longest time in U.K. to ascertain their perceptions of using CORE-Net.</td>
<td></td>
</tr>
<tr>
<td>(ii) Undertook 7x one to one telephone interviews (semi-structured questions) with non CORE-Net users from the PCC setting. These therapists had been invited initially to participate and had declined and after the passage of 1.5 years were just about to commence their CORE-Net training.</td>
<td></td>
</tr>
<tr>
<td>(iii) 1x face-to-face interview undertaken by the researcher with one current PCC user and CORE-Net trainer who facilitated OH focus group (unstructured questions).</td>
<td></td>
</tr>
</tbody>
</table>
Obtained both therapist and client consent

(iv) Training delivered and began using CORE-Net and ARM-5 in routine practice. Simultaneously, started using therapists' process diary which was filled in a diary outline about the use of CORE-Net/ARM-5 with first 1st client and 2nd clients seen at the start of the trial period (5 x therapists x 2 = 10 process diary accounts)

(v) 28 x Therapists supervision sessions recorded during the study in the researcher’s team.

(vi) 10 x Face-to-face short interviews with clients within one month of ending counselling with one client selected for the process diary plus one more client after four and a half months of practice using CORE-Net/ARM-5 (10 x one-to-one interviews semi-structured questions)

(vii) After 6 months use of CORE-Net and ARM-5, these therapists were part of a focus group(semi-structured questions), facilitated by an external facilitator who was a therapist from the PCC service with a view to ascertaining their experience of using CORE-Net/ARM-5 with their clients (5x therapists).

(viii) CORE-Net had a built in question that came up on the screen asking the client about their view of filling in the questionnaires every time they filled it in on line (x 374 individual clients).

3.7 Ethical considerations

Richards and Schwartz (2002) discuss four special ethical issues arising in relation to qualitative health services research. First, researchers should consider treating informed therapist demographic details as well as the allocation of fictitious names for client and therapists was kept locked in a metal fire-proof filing cabinet in the researcher's NHS consent as a process rather than a one off event being aware that an interview may take on the mantle of a therapeutic encounter. Second, due to possible confusion with a therapeutically encounter, researchers need to ensure that information and support for participants are available when necessary. Third, anonymity of participants in published work needs to be ensured due to the nature of qualitative data and clues to participants' identities. Finally, the risk of misrepresentation can be minimised by ensuring the adequate training and supervision of researchers and encouraging reflexivity about the influence of researcher's personal and professional characteristics.
3.7.1 Consent

Therapist informed consent was sought for all therapists in both settings prior to the data collection period. Only client consent from the OH setting was requested. The total duration of the study was 20 months but the therapist data collection period was around 7 months which depended on ethics clearance. The research sent a letter to each therapist to invite participation. Consent from all therapists was gained based on BACP ethical guidelines for researching counselling and psychotherapy (Bond 2004). It was made clear to all participants that consent could be withdrawn at any stage of the research process even if they had given initial consent. Client consent from PCC setting was not needed as the therapists in the focus group and telephone interviews were only be interviewed themselves, not their clients.

3.7.2 Ethical Approval

Ethics consent was obtained simultaneously from both the researcher's local R&D Committee and COREC before it was submitted for ethical approval from the ethics subcommittee of the Institute of Health and Medical Sciences, University of Surrey, Guildford (Appendix 33, 34). The researcher was replaced with an external therapist to the NHS trust who acted as the interviewer. As the study is a requirement in part fulfilment of the Doctorate in Clinical Practice, the researcher had academic supervision throughout the programme.

The researcher conducted site visits in the second setting for the research at the Primary Care Counselling Service on another geographic location in the country for some of the data collection. Ethics approval was obtained for this organisation before the focus group could be undertaken (Appendix 35).

3.7.3 Risk

There was minimal risk to clients as those in the OH setting were interviewed by an experienced therapist and were able to access the service easily for support if they became distressed in any
way. No clients were interviewed in the PCC setting so there was no risk to clients. I only foresaw client reluctance to fill out repeated measures on screen due to questionnaire fatigue but this seemed unlikely based on studies by Lambert et al. (2001b) and Miller et al. (2005) and current CORE-Net users. I had considered the possibility that clients who had never used a computer mouse may feel a little anxious about learning how to do so. Therapists were trained so as to know how to support their clients in this respect, and a dummy screen for a practice run was provided if indicated.

3.7.4 Researcher involvement

Hammersley and Atkinson (1993) argued that there is an inevitable power imbalance in the research relationship, "even when the researcher has an intellectual and emotional commitment to the people being studied" (1993:274). Etherington (2001) discussed that a power imbalance may be exaggerated when a researcher is also a health professional. This was evident in my journal which is discussed in the following section on Researcher Reflexivity'. Holloway and Wheeler (1999) indicate that the participant may feel pressured to participate in research because of a sense of duty, or because they depend on the goodwill of their careers. Small (1998) indicated that although it is often assumed that a qualitative interview, which allows the participant to speak in their own terms, can be therapeutic, this feature can also potentially lead to exploitation and harm. If the interview becomes confused with a therapeutic encounter, a researcher may be tempted to ask sensitive questions inappropriately and participants in turn may divulge more information than they had anticipated when they consented to the study. Robinson and Thorne (1998) and Etherington (1996) indicate these sorts of problems are likely to arise when one person fulfils the dual roles of researcher and health professional, especially if they are directly involved in the care of the participant.

For the OH therapist participants the researcher was therefore very mindful of the relationship with them as colleague, team leader and researcher plus the potential researcher effects and
bias in their responses and reactions to me within the whole process of the research study. This will be further discussed in the Discussion Chapter 6.

3.8 Researcher Reflexivity

Qualitative research requires reflexivity on the part of the researcher. "Reflexivity requires an awareness of the researcher's contribution to the construction of meanings throughout the research process, and an acknowledgment of the impossibility of remaining 'outside of' one's subject matter while conducting research. Reflexivity then, urges us "to explore the ways in which a researcher's involvement with a particular study influences, acts upon and informs such research" (Nightingale & Cromby 1999).

Willig (2001: 10) describes two types of reflexivity: personal reflexivity and epistemological reflexivity. 'Personal reflexivity' involves reflecting upon the ways in which our own values, experiences, interests, beliefs, political commitments, wider aims in life and social identities have shaped the research. This includes thinking about how the research may have affected and possibly changed us both as people and as researchers. 'Epistemological reflexivity' requires us to engage with questions such as: How has the research question defined and limited what can be 'found'? How have the design of the study and the method of analysis 'constructed' the data and the findings? How could the research question have been investigated differently? To what extent would this have given rise to a different understanding of the phenomenon under investigation? This process encourages us to reflect upon the assumptions (about the world, about knowledge) that we have made in the course of the research, and it helps us to think about the implications of such assumptions for the research and its findings.

As a researcher, I need to reflect on the nature of my involvement in the research process, and the way this shapes its outcomes. Reflexivity is thus required throughout the research process – for instance, in trying to be aware of how my I formulate my research question, and the issues I highlight in my interview topic guide. Ahern (1999) encourages reflexivity to identify areas of
potential researcher bias. This helps the researcher to recognise feelings that may indicate a lack of neutrality which may include avoiding situations in which one might experience negative feelings, seeking out situations in which I will experience positive feelings. It is beneficial to clarify personal values systems and acknowledge areas in which you know you are subjective. Stiles (1993) indicated that by revealing rather than avoiding the investigator’s orientation and personal involvement in the research and by evaluating interpretations according to their impact on readers, both investigators and participants facilitate qualitative research to shift from the goal of quality control of objective truth of statements to understanding by people.

Elliot et al. (1999) encouraged qualitative researchers to embrace evolving guidelines for the publication of qualitative research studies that include: owning one’s perspective, situating the example, grounding in examples, providing credibility checks, coherence, accomplishing general vs. specific research tasks and resonating with the readers. This was in order that ‘qualitative researchers may exercise greater self-reflectiveness in their conduct and reporting of investigations’ (Elliot et al. 1999: 225). Morrow (2005) encourages the writing of a self-reflective journal from the inception to the completion in order that a record is kept of the researcher’s experiences, reactions, and emerging awareness of any assumptions or biases that come to the fore. Depending on the frame of the researcher these emerging self understandings can then be examined and set aside to a certain extent or consciously incorporated into the analysis. Chesney (2001: 131) spoke of ‘the relationship with self’ whilst carrying out her research as a white British midwife in a Pakistan setting interviewing participants of a different culture. She states, “initially, I judged that I was stealing time from the women and their families by conducting the research as it was for my own interest and benefit to obtain a doctoral degree”, (Chesney 2001: 132)

To this end I began the free hand writing of a self reflective research diary/journal and the journal was carried at most times during the trial period by me. This provided an audit trail of all the
decisions taken during the process and my emotional involvement and struggle throughout the implementation and analysis of the project. The journal was begun before the start of the trial date and data gathering time and includes the process of involving and liaising with the Trust's Information Technology (IT) team, losing one therapist after giving consent who had to leave suddenly due to family illness abroad and withdraw from the study as well as one of the existing team being in two minds as to whether to start or not having given consent and experiencing great anxiety about the process and it being against her own philosophy of delivering counselling. I was aware of my heightened sense of emotions like a 'roller coaster' as I was keen to get the project off on time.

The 'dilemma of the self' described by (Chesney 2001) and the imbalance of power that is exaggerated when one is both the researcher and health professional (Etherington, 2001) was highlighted through various incidents during the research project. In my journal I wrote about my feelings about the therapist who had previously given consent to participate but on the start date expressed the possibility of withdrawing from the study as was too anxious and it was against her philosophy of counselling:

My stomach just completely churned over and I felt immediately nauseous at the prospect of losing another therapist to the study. I found it really hard to step back from being an enthusiastic researcher/team leader and reassure the therapist that I wanted her to feel able to exercise her informed choice on the issue and that this was something that I would accept respectfully should that be her decision. She expressed anxiety at the thought of having to work in this way and I felt that I was also undergoing a parallel process of anxiety myself since I also had not used CORE-Net before. How can I do this? I feel anxious and I am supposed to be a team leader for the implementation and yet I am starting to have ambivalent feelings about the project.

Another occasion whilst interviewing a client, this client expressed really negative feedback about the therapist they saw and the whole process was clouded by this negativity. My journal reported the following:
I found it really hard with this client to try to bring her back to the questions and keep the discussion moving as she seemed 'stuck' on the negativity and she just 'kept filling' the interview with more and more negativity and I was torn between feeling that I knew everything she was saying about the counselling process was marred by the fact the therapist applied the Do Not Attend policy and openly had discussed with the client these issues. I knew it had been a negative experience for her and in many ways I felt helpless. At the end of the interview I knew I had to try to close it on a positive note for her to feel in the future should she have problems with a therapist to try to make contact sooner rather than later. I worry now that the other clients I am due to interview will all be such hard work to interview and to contain in the session.

As it turned out, this was a ‘deviant case’ but did disturb my thinking following the interview. I did get a sense at the end of this client interview that perhaps this had been more ‘therapeutic’ than the experience she had had with the therapist in that she was appreciative of the opportunity to discuss her negative experience and receive clarification from me of the change of therapist procedure that I discussed with her before the interview session ended should she wish to re-refer herself to the service in the future. When undertaking the analysis at times I felt overwhelmed by the sheer volume of words and trying to make sense of it and expressed it in this way:

This week I have been feeling really overwhelmed by the analysis. I am trying to unpick some of this and realise that I feel a huge sense of responsibility as a bearer of another’s experience and want to get it right. Even if I can do a good enough job I hope it will relieve some of my overwhelming feelings. I do feel I am changing through this experience and am starting to feel a lot more empathic towards the therapists including myself and the challenges of the changes in practice required in the CORE-Net methodology.

The journal describes my daily challenges and highs and lows, periods of intense anxiety by me as I was also starting to use CORE-Net for the first time myself and had a steep learning curve and then having to give leadership to the team as they also experienced anxiety and resistance both before starting and during the trial process. This process of writing reflexively was extremely important as it helped to process my emotions and the ongoing tension of being both researcher and team leader at the same time and feeling pulled in opposite directions many times. It helped me to get a better perspective at times when I was 'unable to see the wood for
the trees' by writing my thoughts and reflections which I realize that if I had not done so I would have been unable to undertake the research project and move from a 'lay novice to acceptable incompetent' (Lofland & Lofland 1995). Writing the journal enabled me to keep returning to re-read what I had written many times and then taking action based on what I had processed and made sense of for myself through the writing and reflecting process.

3.9 Data Analysis

"The trustworthiness or otherwise of findings from flexible, qualitative research is the subject of much debate. One problem is that identical circumstances cannot be re-created for the attempt to replicate" noted Robson (2002: 168). Lincoln and Guba (1985) prefer the terms credibility, transferability, dependability and confirmability. They go onto discuss three threats to the validity of flexible design research (pp294-301). Reactivity is the way in which the researcher's presence may interfere with the setting that forms the focus of the study and with the behaviour of the people involved. Researcher bias may occur when participants are either obstructive in withholding information or being compliant or performing to give the answers that they think the researcher may want. Researcher bias refers to what is brought in terms of preconceptions and assumptions which may in some way affect the way the researcher behaves in the research setting such as in terms of who is selected for the interview, the questions asked and the selection of data for reporting and analysis.

Padgett (1998) suggests some strategies for dealing with threats to validity which include prolonged involvement with data collection, triangulation of data, methods and theory; member checking by asking participants to comment on accuracy of transcripts and findings; negative case analysis and an audit trail of all the research such as raw data transcripts, research journal and details of coding and data analysis.
3.9.1 Specific Issues of Analysis in this research study

In the study, scores and the severity levels inputted into CORE-Net automatically appear on the screen. The data from ARM-5 was scored simply by the therapist after the client manually filled it out; the therapist returned it and flagged issues for discussion at the next session (since ARM-5 is completed at the end of a given session). With the resulting client scores of both CORE-Net and ARM-5, the aim was to look at the discussion with clients about the scores at each session. The purpose of this study is not to analyse CORE-Net or ARM-5 quantitatively but to ascertain the perceptions of its use in routine practice. The interviews and focus groups will capture this feature of the study. The interviews, focus groups and one-to-one interviews together with the process diaries of therapists and researcher were fully transcribed, comprising the raw data for qualitative analysis. They were transcribed as soon after the interview as possible. A transcriber was used but all data for interviews was anonymous before transcription. Once the data was transcribed, computer software (Nvivo 7, QSR International) helped manage the data for analysis. All data was loaded into Nvivo except the OH therapist diaries and OH therapist supervision session.

There are sequential common features to all forms of qualitative analysis. Miles and Huberman (1994) describe the need for codes to be obtained from the interviews, and added comments (memos) and then examining both for similarities, differences, themes or relationships which gradually leads to small generalisations that cover the consistencies discerned in the data and then linking these to a formalised body of knowledge in the form of constructs or theories.

Nvivo 7 software was used for data management and analysis as an opportunity to learn the software and save time in the long run. Creswell (1998: 155-6) considers some advantages of such a system by highlighting that they provide an organised single location storage system for all the material with quick access to the material without cutting and pasting; can handle large amounts of data quickly; they force detailed consideration of all text in the database on a line by
line basis and help the development of consistent coding schemes. Creswell (1985) mentioned time taken to learn it, difficulties in changing categories once established, and some programs imposing specific approaches to the data analysis as disadvantages. The greatest disadvantage that I personally found in its use was in the time and effort taken to be proficient with it and for myself I only managed to learn Nvivo 7's very basic functions.

3.9.2  Conventional Content Analysis for OH Therapist Diaries

The OH therapist diaries were set out with pre-set questions to facilitate easy and consistent request of information from the therapists after each session with their clients. The data from all diaries were analysed using Conventional Content Analysis which was chosen instead of Directed Content Analysis or Summative Content Analysis (Hsie & Shannon 2005). Conventional Content Analysis is where the researcher avoids using preconceived categories but rather immerses themselves in the data to allow new insights to emerge (Hsie & Shannon 2005). It was deemed that for the purposes of analysing the diaries of the therapists, Conventional Content Analysis was an appropriate method as it is generally used with a study design whose aims are to describe a phenomenon when existing theory or research literature on the phenomenon is limited. Directed Content Analysis was not used because the goal is to validate or extend conceptually a theoretical framework or theory where existing theory or research can help focus the research question and is a more structured process than Conventional Content Analysis approach (Hickey & Kipping 1996). Likewise, Summative Content Analysis was not used for data analysis as this would involve the text being approached as single words or in relation to particular content rather than approaching the data as a whole. This type of analysis of patterns leads to an interpretation of the contextual meaning of specific terms or content (Hsie & Shannon 2005).

Within the Conventional Content Analysis framework, Tesch (1990) describes reading all data initially repeatedly to achieve immersion and obtain a sense of the whole. Codes are then
derived when the data is read word for word by first highlighting the exact words from the text that appear to capture the key concepts or thoughts (Miles & Huberman 1994; Morgan 1993; Morse & Field 1995). Notes are then made of the researcher’s first impressions, thoughts and initial analysis and as this process continues labels for codes emerge that are reflective of more than one key thought which may become the initial coding scheme. The codes are then sorted into categories based on how different codes are related and linked and are used to organise and group codes into meaningful clusters (Coffey & Atkinson 1996; Patton 2002). Subcategories can be combined into smaller categories depending on their relationship and then definitions for each category, subcategory and code are developed alongside exemplars for each code and category that has been identified in the data. In the final write up of the study, the researcher may address relevant theories or other research findings in the discussion section (Hsie & Shannon 2005).

An advantage of the Conventional Content Analysis approach is that you can gain direct information from the study participants without preconceived categories or theoretical perspectives but rather is based on generating knowledge based on the participants’ unique perspectives and thus grounded in the actual data. There are two main challenges to this type of analysis that Hsie and Shannon (2005) mention:

1. It fails to develop a complete understanding of the context, thus failing to identify key categories which can result in findings that do not accurately represent the data and is described by Lincoln and Guba (1985) as credibility within the naturalistic paradigm of trustworthiness or internal validity within a paradigm of reliability and validity.

2. It can easily be confused with grounded theory methodology (Strauss & Corbin 1990) or phenomenology. Conventional content analysis is limited though both in theory development and description of the lived experience. This is likely because the sampling and analysis procedures make the theoretical relationship between the concepts difficult to infer from the findings.
3.9.3 General Inductive Analysis for the focus groups and interviews

The data from the interviews and focus groups was analysed inductively using a general inductive approach for qualitative data analysis (Thomas 2006). This approach was chosen because its purpose is to (a) condense extensive data into a brief summary format, (b) establish links between the research objectives and the findings from the data, and (c) develop a model or theory about the underlying structure of experiences or processes in the data (Thomas 2006). Although the outcomes of analysis may be indistinguishable from those derived from grounded theory approach, it is much more straightforward. There is no emphasis on learning new technical terms such as open coding and axial coding. Dr Thomas clearly describes an approach where data analysis is guided by the specific objectives and allows the research findings to emerge from the significant themes inherent in the raw data, without the restraints imposed by structured methodologies.

3.9.4 Process of Inductive Coding

To start the analysis process and begin inductive coding, the researcher closely read texts and considered multiple meanings inherent in the text and then identified text segments that contained meaning of units which were then labelled for a category into which the text segment was then assigned. The upper level or more general categories are likely to come from the evaluation aims and the lower level categories from in vivo coding. An initial description of meaning of a category and writing of memos about it and then linking this may be linked to other categories in various relationships like a network, causal sequence or a hierarchy of categories. There are several features of categories developed from coding which outline the outcome of an inductive analysis. Essentially, the text was labelled for categories whereby a word or short phrase may refer to the category, then a description of meaning of the category which includes key characteristics, scope and limitations followed by examples of text or data associated with a category that illustrates meanings, associations and perspectives associated with the category.
Links are then made with other categories based on commonalities in meanings between categories or assumed causal relationships and the category system may then be incorporated into a model, theory or framework which may be an open network, a temporal sequence, a causal network or none at all (Thomas 2006). The intended outcome of the process is to create between three and eight summary categories that capture the key aspects of the themes identified in the data (those most important given the research objectives). The General Inductive Approach is most similar to Grounded Theory but does not explicitly separate the coding process into open coding and axial coding, see Table 3-8. Researchers also typically limit their theory building to the presentation and description of the most important categories according to Thomas (2006).

Table 3-8 A comparison of General inductive Approach and Grounded Theory (Thomas 2006)

<table>
<thead>
<tr>
<th>Analytic strategies and questions</th>
<th>General Inductive approach</th>
<th>Grounded theory</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>What are the core meanings evident in the text, relevant to evaluation or research objectives?</td>
<td>To generate or discover theory using open and axial coding and theoretical sampling</td>
</tr>
<tr>
<td>Outcome of analysis</td>
<td>Themes or categories most relevant to research objectives identified</td>
<td>A theory that includes themes or categories</td>
</tr>
<tr>
<td>Presentation of findings</td>
<td>Description of most important themes</td>
<td>Description of theory that includes core themes</td>
</tr>
</tbody>
</table>

3.9.5 Validity and Rigour

Data was triangulated allowing for multiple perspectives from the participants in the form of interviews, diaries and focus groups data. Researcher bias can never be eliminated but a reflexive approach was taken as the researcher was mindful of the role played as both researcher and as team leader in the OH setting. Peer debriefing and support occurred regularly with colleagues in the National CORE Benchmarking Database and Practice Research Network in the U.K. This was undertaken by email or telephone or when the researcher met face to face with colleagues at conferences and other meetings. Member checking occurred at various
stages of the research. All transcripts were sent to all participants so that they could comment on their accuracy before they were loaded up into Nvivo 7 and analysis began and also a draft of the preliminary and final draft of the analysis. An email gave participants the opportunity to acknowledge successful receipt of the attachments and to feel free to make any comments or ask any questions. All acknowledged receipt of the information and two participants, one therapist and one client made additional comments that it was interesting information and a comment that it was accurate but there was no additional feedback from the rest of the participants. The researcher's academic supervisors checked for accuracy of the analysis of the data throughout. Thomas (2006) recommends coding consistency checks for assessing the trustworthiness of the data analysis such as independent parallel coding, clarity of the categories and stakeholder or member review. In the research study, as mentioned, only academic supervisor checks and member checked with participants for verification of transcripts and themes were undertaken due to resources and time. However, as most of the data is available in Nvivo 7 (including audio recordings) it may be possible in the future and after completion of this study to have inter-rater reliability checks undertaken. At the completion of the study a summary of the findings was sent to all participants.

3.10 Preparation of data for analysis and Procedure

All data sources were first automatically and manually coded using Nvivo 7, which will be described below except the Therapist Diaries (TD-OH) and supervision sessions (SS-OH). Both auto and manual coding was undertaken and transcribed externally due to time constraints using intelligent verbatim which excludes filler noises and irrelevant sounds, some punctuation, and does include colloquialisms. When transcripts were returned to me, I then read through all of them several times and listened to the recordings so that I could add the necessary punctuations (determined by pauses in the recordings and beginnings of new sentences). A list of each of the participants along with their associated recording identifiers is located in Appendix 36.
Five interview schedules were used to compile shortened category titles required for viewing as node titles in Nvivo 7. The complete interview schedules can be found in Appendix 14, Appendix 15, Appendix 16, Appendix 17, Appendix 18. After initial coding, the results were 44 categories and 225 subcategories containing coding (Appendix 37).

The Frequency Counts in Appendix 38 indicate the number of interviews with at least one comment coded to each node. After undertaking this coding, I found some initial evidence of the perceptions of clients and therapists with regard to Routine Outcome Measurement (ROM). I then constructed a model to depict these initial factors that may be influencing the therapists’ tendency to engage in ROM. A detailed description of this model and elicitation of the codes for each section of data analysed will be discussed in the relevant findings chapters Four and Five.

3.11 Analysis of both focus groups (OH and PCC)

Psychotherapists in the UK due to their general training background, often have an internal struggle with the concept aptly described by Hofmann & Weinberger (2007) of the “Art & Science of Psychotherapy” and how to integrate empirical evidence into their ‘intuitive, creative and artistic practice’. The elicitation of a metaphor for their use of CORE-Net was thus hopefully going to appeal to their ‘artistic/creative’ side in order to describe their process of what is essentially a quantitative method of outcome measurement.

An ice breaker question was given to each of the focus group members to think about in advance of the group with the purpose of facilitating the start of the focus group and setting the scene to get the participants to try to think of a metaphor that represented their use of CORE-Net. It could be a bird, a flower or any object. Mothersole (2005) in his research on the use of CORE informed my request for preparation of the metaphor as an ice breaker statement “They were asked to begin with a simple task of finding an association between CORE-Net and a bird/flower or other object. The purpose of this exercise was to initiate reflection in a way that
elicited implicit as well as explicit meanings. They were asked to then give a brief ‘because’ statement that linked their association with CORE-Net. The thinking behind this approach was to encourage creative associations that would engage people and lead to involved and informative discussion. A picture or metaphor is indeed worth a thousand words* (p194) (Italics changes are mine).

The metaphors were examined by the researcher and considered for their content and meaning. Memos were used throughout the analysis to assist in the analysis of the metaphors of both focus groups (see Appendix 39). After examining each of the 10 metaphors, five categories and subsequent subcategories were gleaned and reported in the findings Chapter Four.

3.12 Data Collection and analysis of the OH Therapist diaries

The five therapists completed diaries for the first two clients they saw using CORE-Net and ARM-5 in sessions. The diaries consisted of a set of questions designed to identify key themes and experiences around how they introduced, processed and felt about using CORE-Net and ARM-5 in sessions, as well as perceptions of client feelings and experiences (Appendix 19). In total, 10 client diaries were completed by five therapists. These diaries varied from assessment plus two sessions to assessment plus eight sessions. The amount written and the way the questions were interpreted varied significantly between therapists and this seemed to emphasise levels of engagement with the process. Details of the analysis and codes generated will be discussed in Chapter Five.

3.13 Data analysis of OH therapist supervision sessions

A General Inductive Approach as outlined by Thomas (2003) was used to analyse the transcripts of the interviews with the five OH therapists and has been described in sections 3.9.3 and 3.9.4 earlier in this chapter. A detailed discussion of how the themes were elicited for the therapist supervision sessions is described in Chapter Five.
3.14 Summary

This qualitative study sought to determine how therapists and clients perceive and experience CORE-Net and ARM-5. The primary data consisted of transcribed individual interviews with clients and therapists and focus group transcripts. Most of the data was initially coded and analysed with the assistance of NVivo 7 qualitative analysis software except the OH therapist diaries and supervision sessions. Ethical considerations such as consent were established and full confidentiality of data was maintained. Chapters 4 and 5 will present the data and the analyses and Chapter 6 will present the conclusions and recommendations for future study.
CHAPTER FOUR

Findings 1: Therapists Interviews, Focus Groups and Clients' Interviews
CHAPTER 4

4.1 Introduction

In this chapter, I commence with a description of the initial analysis and elicitation of themes for each group followed by their respective findings. Firstly, I present the findings for both the PCC (FG-PCC) and the OH focus (FG-OH) groups followed by the findings of the individual interviews with the non CORE-Net users (I-PCC) from the PCC setting. I conclude this section with the findings of the individual interviews with the clients seen in the OH setting (I-OH).

4.2 Analysis and elicitation of initial themes from the metaphors of both focus groups

Therapists were asked to give a metaphor that aptly described their use of CORE-Net (see Chapter 3 under section 3.9). The analysis of the 9 metaphors from both early and experienced users was undertaken initially as a collaborative process between the researcher and her academic supervisors and this was completed before the rest of the focus group data was undertaken. In the example of the metaphor analysis (Appendix 40), in the first example of the first part of Sally's (therapist – early user) metaphor of a rose, the section in red is split into two units of meaning as follows:

1st unit of meaning – "A rose is perfect and it has a lot of meaning as soon as you see it, it's about love, it's about appreciation, it's about a lot of things so the connotations are already there".

The first level of coding for the first unit of meaning is: perfect/love appreciation

The second level coding: The offer of a potential therapeutic relationship

The third level coding: CORE-Net has potential to help clients.
The second unit of meaning – "it immediately gives explains a lot of things that don't need to be said when you give the rose".

The first level coding: immediate and inherent meaning

The second level coding: the offer of a potential therapeutic relationship

The third level coding: CORE-Net has potential to help clients.

Each metaphor was analysed in the same way until they could all be summarized into five categories. These emerged as follows:

1. CORE-Net has potential to help clients:
   a) By offering therapeutic benefit through the therapeutic relationship in therapy;
   b) By pinning down risk;
   c) By allowing progress to be tracked visually; and
   d) By having instant access to results.

2. CORE-Net is technically and logistically difficult and painful to use due to:
   a) The physical requirement of having it in the room;
   b) The technology of inputting data; and
   c) Therapists' desire to have control/choice over its use or not use it at all.

3. There are difficult new skills for the therapist to learn—CORE-Net needs to be integrated into clinical practice.

4. CORE-Net gets in the way of therapeutic work with clients because it feels intrusive in the room and affects the therapeutic relationship.

5. CORE-Net offers a vision/overview that greatly enhances the therapists' insights and knowledge by:
   a) Offering an overview of the complex work;
   b) Allowing the therapist to be informed about the client's progress; and
   c) Providing instant access to results visually displayed on screen.
The five above categories were then used as an initial coding frame for the rest of the analysis of the focus groups. The literal texts were read closely and considered for the multiple meanings within. Each text was evaluated for text segments relevant to the categories. The category system was reviewed and refined throughout the process so that within each category subtopics were determined. An example of how the analysis of the metaphors was conducted can be found in Appendix 40.

After this initial coding of the metaphors and then both of the focus group data it was possible to see the factors that appeared to be affecting the perceptions of therapists in using Routine Outcome Measurement (ROM). These factors included certain influences such as ongoing supervision and support, initial training and support, perceptions of the benefits of using ROM, perceptions of the barriers of ROM, therapists' own views of Outcome Measurement (OM) and service requirements to use ROM and this can be seen in Figure 4:1.
Figure 4.1 Initial Factors that may influence therapists' engagement in ROM identified after initial Nvivo7 coding from I-PCC, FG-PCC and FG-OH
4.3 Findings of the Primary Care Counselling (PCC) Focus Group – (18 months)

The resulting main themes from the analysis of the PCC focus group are in Table 4-1 and then I will follow with the illustration of key quotes within each sub-theme. Please note that all participants' names are pseudonyms throughout both result chapters.

Table 4-1 Main themes from analysis of PCC Focus Group

| 1. Therapists are largely positive about CORE-Net use |
| 2. CORE-Net engages clients in conversations about their scores |
| 3. Therapists alerted to risk and treatment failure |
| 4. Therapists develop flexible use of the measures with clients |
| 5. Clinical supervision and continuous learning and training essential |

4.3.1 Therapists are largely positive about CORE-Net use (theme 1)

All therapists expressed that they liked using CORE-Net. They value the speed of online results, appreciate its difference to CORE manual system and through time have become more comfortable with its use. However, they also recalled the initial technological challenges and anxiety/irritation they experienced, which was not entirely gone from the group. However, when all were asked directly to rate their level of comfort with the use of CORE-Net, 1 being not comfortable and 10 being very comfortable, all rated between 8-10. This indicates a high level of feeling comfortable with the use of CORE-Net after 1.5 years use.

Speed is important

Therapists reflected on using CORE-Net initially when it was slower and its current use which was faster and reduced anxiety/irritation as a result. These views are captured in the following quote:
TH Aline: I've been on line for a month now, it has changed my practice I'm much less anxious about well not anxious but irritated I think by the intrusiveness of it because when it was very slow and it was the same with the paper version there would be some people who would do it in two seconds and then there'd be other people who 20 minutes later because carefully pondering over and with CORE-NET because it was so slow it would take you know I did count once it took 20 minutes....And it got in the way and I used to feel it was a bit of a drag really, whereas now with on-line it's a joy really.

Eliminates paperwork and ease of use

Therapists were able to see the differences when they only used paper forms which they still occasionally have to do but that this gives them double the work. They liked that CORE-Net eliminates paper work and does the calculations and is easy to use which is summarised in this quote:

TH Bonita: With it being online, really has changed....so yeah the speed makes all the difference... I would not want to go back to paper version, much more instantaneous.

TH Tom: I wouldn't want to revert back to a paper based system, I mean we'd have that as kind of back-up for times when the computer system isn't working but no I think it's a vast improvement, apart from anything else because it helps that, what I know I do all the time is misreading things, you know, it kind of flags it up for me so it lacks human error.

4.3.2 CORE-Net engages clients in conversations about their scores (theme 2)

A dominant theme within the group was the information that the visual screen gives to both therapist and client and the dialogue that comes from this with the client about their scores and progress. There was evidence from the discussion that this group of therapists are using CORE-Net clinically via their dialogical discussion with their clients.

Informative

Therapists agreed that using CORE-Net was informative to themselves and their clients and they demonstrated clinical utility of this by having a dialogical discussion with client about the
scores as is seen by the following quote:

TH Bonita: I think when the score comes up and we look at the graph and I talk about the balance and say if it's something like moderate or moderately severe, I say, I guess the computer is telling us that things are really quite difficult for you at the moment, does that fit for you and they say yes or no.

Reassures & engages client

Therapists discussed how CORE-Net engages the client and reassures them as they consider the scores with them once they see the visual representation on the screen.

TH Aline 1: For me it's also a nice way of reassuring the client that they're not going mad because most clients will fall within the mild, moderate and then there is severe, but of course severe is that high even with the high score they could have scored a 136 and they didn't. So there holding it together up to a point and I think you know it's, it's very reassuring to see the scale for the client.

TH Tom: You are saying which is like so you're declaring an improvement, let's really pin down what you've done differently, what's happening differently for you so that you really have that and you can always do the opposite you can think well so what would you need to change in order for this to be lower?

Discrepancies of CORE & your assessment

Therapists discussed the discrepancies of the CORE-Net score and how the client presents and were able to give suggestions as to why they thought there was discrepancies such each client being an individual as can be seen by the following quotes:

TH David: I think you have to be cautious about the cut-off because I mean you know making very black and white rules around above and below cut-off because I think you have to with the cut-off we're giving an individual might be different for another individual.

Measures helpful

Most therapists expressed that the measures were helpful to them and their clients in assessment and validation of their feelings as illustrated in the quote below:

TH Bonita: Whereas in the past we might have said you know I'm sitting here and I have this feeling that you've improved or you haven't improved, whereas this is kind of there you know, and it's a lovely excuse to actually validate
it on more than your perception.

Therapists raised that fact that the visual impact on clients was liked by them and was proof of progress or a validation of feedback to the client as can be seen by the following quote:

TH. David: I think the visuals are very important because it's back to this perspective thing, as I was saying that the metaphor at the beginning about helping you to give you vision, I think it helps you and the client to have a sense of where are they in the great scheme of things.

TH Aline: Yes, and evaluation and for the clients I think it's slightly objectifying something that feels very you know it lends a, it puts a view on it.

TH Tom: The feedback is very validating for the client.

CORE-Net as means to create change

The majority agreed that using CORE-Net engages the client and by flagging up high scoring items or risk items it enables the therapist to address and explore issues as well as alerting the therapist to change in the client. The following quotes help to illustrate this:

TH David: If risk is significant....that would probably then figure probably quite substantially in the dialogue that then follows. I know that whey they walk out the door at the end of the 50 minutes, I need to know how I'm going to assess that in terms of note taking or taking any action, you've got to ring someone, you can't just sort of leave it.

TH Tom: Once we begin to see change it's the difference and then if you've got it up on the screen you can say and be really curious, what is it that's made that difference and to operationalise it to actually talk it out loud, to really help the client to know what makes the difference.

Working with other GPs

Therapists agreed that the use of CORE-Net particularly at assessment helped them to focus on the issue of change and keeping track when there is no change and thus enabling decisions to be made earlier about either referring to the GP for referral to other services.

TH David: It does help to focus on the issue of change as being part of why we are here and to keep you on track about the point of the exercise and I think...
in instances where you are not getting any change. I can think of an elderly gentleman who was very stressed but I felt he had what I call social work issues. What he needed was support he was getting elderly, he was on the fringe of not being able to cope living on his own and I think he needed to be assessed with a view to going into supported care. I just referred him back to the GP and suggested they had a social work assessment of the person. So I think, it might alert you sooner than you otherwise to the fact that perhaps counselling isn’t necessarily the right intervention for the client at this time.

Figure 4:2 summarises some of the positives identified by the primary care counsellor’s focus group as identified in the data.

4.3.3 Therapists alerted to risk and treatment failure (Theme 3)

The group were in agreement that CORE-Net is useful in initial and continuing risk assessments of their client’s progress although they acknowledged that clients often misread questions on risk. Their discussion showed that they were able to integrate this information into their clinical practice.

Clients misread questions

Therapists agreed that it was important that as it seemed common for clients to misread questions on risk it was particularly important to check this out with them to make sure they did understand the question correctly. The following quotes represent this theme:

TH David:  Yeah, it pops up immediately as a red on the risk, when in actual fact they haven’t threatened anyone, but they have felt threatened and they’ve completely misread or misunderstood the question. There’s another one about optimism, a lot of people don’t understand the word optimism and therefore they misanswer the question.

Th. Bonita:  But that is a lovely example isn’t it that however scientific or rational we try to become, that the meaning of these questions will be very individual to each client because the meaning of if they feel they’re not taking care of their health, and then that’s very important isn’t it, because it would tell you that they’re maybe over worrying or there’s somebody who feels at odds with themselves.
Safeguard measure

All therapists valued CORE-Net as being a way to alert them and the client quite visually to risk and allowing that to inform them on how to proceed which always includes recording the risk. This theme is represented in the following quote:

TH David: The assessment thing for me, it's particularly keen on the risk side of it because I feel very strongly that by the end of the assessment you really have to have a very clear idea of is there any risk and if so what is it, what type of risk and how much of it is there, the how severe is it, and so I look at CORE-NET or and CORE generally as being a very useful tool in being able to help me get that information and then have it recorded so in the event that there is a significant risk issue there's some sort of recording of it.

4.3.4 Therapists develop flexible use of the measures with clients (Theme 4)

The group was in agreement of the need for therapists to be flexible in how they used the measures in the session with the client. The reasons given by therapists for this varied from having clients that are illiterate and too distressed to fill out the forms to the technology failing and feeling no need to measure since you feel you are already informed as to how they are feeling in that session. In processing the information together with the client they found that it informed them both about their work together and that particularly in the initial assessments, they were being alerted to risk in such an overt way on the screen which in turn assisted them in making decisions about early referral or seeking other support and assistance.

User Flexibility

Therapists recognised that need to be flexible in how the online measure is used if the technology fails or it is inappropriate to use the form if the client is too distressed and may want to take it away with them to fill out later or the client may be afraid of using the computer for whatever reason. This was expressed by the following therapist quote although most therapists made similar comments:
TH Aline: I had an elderly man this week, he was 74 and he just said I can't do this and I said oh don't worry, that's ok, we've got a paper version. So it's about the client really. It felt fine. But what I'm also discovering is actually sometimes people have reading difficulties or they're not confident in using the computer, we can also sit side by side and with a mouse you can just be clicking all the screens right in front of the client and you can just be reading them out the questions and clicking for them.

Introduce as part of the process

Most therapists expressed the need to present CORE-Net to the client as part of the process and not something separate and that although in the early days the technology got in the way of the process, they felt that through practicing they are more comfortable and introduce it in a non-threatening way. The following quotes illustrate some of these aspects:

TH Bonita: I actually now treat it as a matter of course. I would like to get an up-to-date picture of how you are and to do that would it be ok for you to fill in a questionnaire which asks all the relevant questions and it can form a basis for our discussion. The client usually inevitably says of course and then I say how are you with computers, is clicking ok, most of the time they say yes and that's that. I don't actually introduce CORE-NET as an issue, as a separate issue.

TH David: I just treat it as I do the CORE paperwork, it's like here's something that helps me to understand and help you and help us focus and all that sort of thing. Initially the technology kind of got in the way because it's a laptop with a screen and used to put it here and now I use it with the kind of the work internet so I ask people to go and sit over at the desk, but it's really just not an issue it's like this is part of what we do and just feels very, very easy.
Figure 4:2 Positives of CORE-Net for Primary Care Counselling Focus Group

- User flexibility needed
- Initially not appealing. But through practice becomes more integrated
- Conversation Enhancers
- Gives overview & insight into the work
- Triaging of Sessions
- Risk Assessment (a safeguard measure - SM)
- Speeds up Assessment
- Visual Tracking Of progress

FG - PCC POSITIVES
Frequency of use

The general opinion of the group was that they always used the measures pre and post therapy and when they needed to they would use a mid measure to check progress partway but not usually at every session. However, they did say that since they went onto Broadband internet they were probably using it more often due to the increased speed. They emphasised the importance of always bearing the individual client in mind and their individual needs and then deciding if they client was comfortable with it or not and if they were they tended to use it more frequently. The following quotes capture some of this consensus of the group:

TH Tom: I'm kind of very variable with it and there's something about the feel of how the work is going. It's like if I know the work is going well, I don't bother so much, if I know there's not a risk issue that I need to be concerned about I'm not going to bother so much, but if I've got that feeling if you know I'm really not sure what's going on here, then I guess I'd probably means I'm going to do it measure more often.

TH Bonita: I would say if I was doing six sessions I would probably manage first, last and maybe one in the middle because of how slow it was but now it's more like every other session I would say it's there when the client comes in and I just say, it's a bit of a ritual they come in and they kind of expect to sit at the computer and then we sit down and we might sort of obviously we look at the results and if it's higher or lower I might say, well it looks like it's been a difficult or a much better week let's go and talk about it you know, the speed makes all the difference.

Logistics of the room with computer

The general view of the group was that managing the logistics of the computer in the room was a challenge for them all at least initially when they had laptops and later to a PC in the room but that to a greater or lesser degree they individually worked at making it less intrusive upon the session which required adjustment on the part of the therapists. This concept is represented by the following quote:

TH David: I think I'm liking it more with it on the desk away from us in a strange way because sometimes, it did feel a little bit physically intrusive with the laptop there because obviously you have to think of your room layout but it
was kind of there between you and sometimes it's nice to by going away to the desk and then coming back from the desk, if you contain the computer bit to one side so you don't get too caught up in computers. It's sort of more contained I suppose which I think overall I prefer.

**Technicalities, varies by client and level of comfort using CORE-Net**

The group had mixed views on the ongoing challenges of the technicalities of using CORE-Net with some being irritated with it and others happier with it but that its use varied according to how the client presented as can be seen by the following quotes:

**TH. David:** I occasionally get a bit irritated if the internet connections slow and I'm sitting there sort of drumming my fingers thinking hurry up, but that's going to happen with anything so yeah I don't have a problem.

**Th. Bonita:** It's lovely you know in terms of the peoples psychological profile coming through where somebody who would blame themselves for example would score on certain items and it's already sort of tells you a story you know before you've even, you know, so it can be useful, but talking of times when I don't if somebody comes into the room and I can see something has happened you know they're on the verge of either bursting into tears or seem really, really low, I don't then say you know fill it in because to me that would just be really insensitive you know they need to sit down, they don't need bloody forms right now you know because they're obviously upset or something has happened and you can kind of know your sense of it.

**Treatment failure**

Therapists had some views about the question on 'treatment failure' in relation to them not feeling they had failed even if CORE-Net showed no improvement clinically and that it provides the opportunity to reflect on whether this is actually working for this client at this time. The following quote captures this thought:

**TH. Tom:** There's something about it that in an ideal world and I'm not claiming that I always do this, but you know helps me to have that conversation with the client about, I wonder if you're missing something here or if somehow you know some other way I'm kind of trying to help you isn't fitting with what you actually need and can we just have a look at that and if there's something that you need to tell me about how you need to be helped then let's address that and I guess that also begs the question about you know therapy itself might not be appropriate at this time, at all, or with me, or
you know there's any kind of number of permutations there but again I just think it helps highlight those things.

Most of the therapists had used other outcome measures but said they would not like to return to paper versions.

TH Aline: In the past I used BDI but not really consistently, and no I wouldn't want to go back at all to a paper version.

No improvement by Session 3 or 4, CORE-net alerts to treatment failure

Therapists were in agreement that this is a time to reflect and see if this is the right time for counselling for the client and if are the right counsellor for them as well as considering whether they need to be referred for longer term work as shown by the quotes below:

TH Tom:: It's a big challenge isn't it? It might be myself individually, I'm the wrong gender or just the wrong personality style for this person or whatever or now is not the right time or you know therapy isn't the right thing that they need now.

TH. Bonita: Well my understanding is rightly or wrongy that therapy could as a result of reading the results be more tailor made to the client in terms of identifying clients with whom change doesn't help, does not occur for some reason and then looking at why that change does not occur and looking at time factors as one of the possible variables here where perhaps some clients would respond better to a longer term approach if change is not happening quickly enough within the 6 sessions. That's my understanding of it.

Therapists agreed that CORE-Net scores may differ from reality and so checking it out with the client is important as well as an opportunity for the therapist to see if it is life for the client at that given moment.

TH David: I'm a bit cautious about this treatment failure phrase because there are lots of times when the distress level goes up or the score goes up and its actually highly relevant, it's what you would expect for the client in the context and sometimes I say to people when they're saying how their feeling got a high score, well what do you expect in the circumstances.
TH Bonita: It's an opportunity to ask the question, is it me or is it life?

Therapists expressed a common view of the helpfulness of being able to visually immediately identify the extreme scores by the colour of the drop downs on the severity rating of the scales which could be used dialogically with clients as can be seen by the following quotes:

TH Bonita: Yeah I look with the client, yeah and I sort of say to them what are we sort of looking for is the 3 and 4's because they would be signalling an area of difficulty, so let's read through them and I'm kind of composing a story as I go along through you know from the answers, you know, because that gives you some sort of even before they say anything.

TH Tom: It's just giving a kind of visual indication of some of what the person is saying and then maybe picking out some of the extremes as you were saying make a story out of it and so kind of a triangulation between me and the client and the CORE-Net or the screen roll.

4.3.5 Clinical supervision and continuous learning and training essential (Theme 5)

Therapists were clear about the benefits of the assistance they received as they were learning CORE-Net experientially through supervision and regular meetings and that a process of learning was inevitable but that this had led to benefits.

Additional resources helpful using CORE-Net

Therapists agreed that although initially there were challenges, through time they worked through these with both support from within the team and external via the helpline for CORE-Net and they were now largely positive about its' use. Therapists expressed that having meetings such as the focus group and having the time to talk about their clinical cases is helpful and that the resources they have had to date were adequate as can be seen by the following quotes:

TH. Aline: I think having conversations like this

TH Tom: Where we are now, really helpful to just focus in on about how do we now make sense of using it rather than just developing something.

TH David: Alex from CORE came down and said well this is a starting point see how you get on so now we've got something that's really very slick and there's quite a few bells and whistles starting to appear which are quite
interesting, quite fascinating.

Minimal training experience before starting the use of CORE-Net

The group remembered the training they had received at the start which was minimal but a positive experience and learned by trial and error and they had some suggestions as to what elements should be included in training and why they would recommend CORE-Net to others. The following quotes illustrate this:

TH David: We were experienced as counsellors, we were experienced in using CORE as a tool generally but in terms of taking it into the technological phase, I mean nobody could have done, it wasn't a training. It was Alex from CORE who came down and it was just by fumbling around and trial and error and it kind of edged forwards bit by bit from there.

They went on to give specific recommendations for the training to include a technical and the process part as well as simplification of the training as seen below:

TH David: I think that the training of CORE-NET for newcomers is in two parts, there's the technical bit of how you do it, how you click this and go from that screen to that screen blah, blah and then there's the how can you actually make it work for you in the purpose for why your there which is to do counselling and that bit is the final fascinating interesting bit and I think its different for every person.

The therapists expressed the importance of conveying in training of CORE-Net to new users, the vision, purpose and its integration in clinical practice. They were also mindful that gaining the therapist is important for it to be useful and for the client to feel comfortable with it as can be seen by the following quotes:

TH Bonita: Give some of the possibilities and the visions and the well I've tried it this way and this seems to help because you know when a clinician here sat with another clinician they go, oh well that's all right I could leave that, whereas if it's just like my manager tells me I've got to use it.

TH Aline: I think you know even on a really basic level about the assumptions of what this process is about, you know, and the fears you know what it might do to the process ... I think that any problems of using it to my mind
are a function of the counsellors’ problems or the clinician’s problems...Yeah, or if they feel you know I’ll do it but I think what I’m doing is really wrong... You know then you’re being apologetic to the client you know, and then of course the client will you know, pick up on it.

Therapists valued talking about CORE-Net in supervision and saw its potential for themselves and new therapists, although not all had supervision with colleagues who used CORE-Net and expressed the view that it would be useful to use in the training of new counsellors.

TH David: I think it has the potential to improve clinical practice quite substantially and it’s not just by looking at generalised figures but by looking at specific figures that the fact that the clinician can look at their own data, their own client and keep reflecting, that’s what we do we reflect we help others reflect and now we can reflect upon outcomes and that’s another part of the whole equation really.

TH Aline: It would be interesting to look at that data wouldn’t it that we have lower DNA rates than others since we’ve been using CORE-Net you know those kinds of things.

They also viewed CORE-Net as a useful tool in looking at both service’s and individual therapists’ performance for themselves and new therapists. This can be seen in the following quotes:

TH Aline: The other thing is, if you’re training and you are being trained with the idea of accountability as an idea, even that will change the way you work....You know, rather than, this very private process nobody knows quite you know...It’s about changing it on that level even if there’s an argument with the figures and everything else, it’s about introducing transparency as an idea even if it’s not.

TH David: I think it would be great value in both supervision and in training, training new clinicians.... I wonder whether the way how we can analyse the data will be more that just these ideas of clinical improvement of two scores and in relation to a cut-off once we’ve got multiple scores per individual. I think we may well better look at the profile of the scores and analyse that in more sophisticated ways ... ....... Yes, that will give you a measure of improvement even though they don’t go below cut-off say, so you actually start looking at the slope of the curve or something, that may show other ways of demonstrating effectiveness or of the therapy or the individual worker but I think that if you’ve got a lot of data for a given therapist then
you're getting a bit of a measure of how they are doing overall how
effective they are in general and that's I think more of service manager or
if it was a trainee it would be about supervisors or trainers view, as is this
person developing into this work in a way as it's going to go somewhere or
should I get out or failed or something like that.

A common theme from the group were around their reflections of the use of CORE-Net being
like a journey or learning curve that you learn and improve at and that the benefits of using
measures more frequently in session were to give more data for the therapist to learn from and
all agreed that more time in supervision groups for learning just with those using CORE-Net
would be beneficial to them.

TH. Aline: Wouldn't it be useful to have a supervision group around people that are
using CORE-Net and I'd love to be bringing more stuff that causes
dilemmas for me.

TH David: One of the old problems that existed with the CORE system where there
was a failure for therapists to complete measures, that isn't going to
happen with CORE-NET because you're intrinsically capturing measures
all the time so its going to overcome another problem very well and I think
it will engage clients. I think the benefit that will come to an individual
practice is that as time goes on and you see more cases and how they
turned, it will improve your ability back at the beginning which is the
assessment because I think the key to all of it is assessment and you start
asking when you've done 6 or 12 sessions and things haven't gone as you
might have hoped and you start to analyse why, probably the reasons for
that were identifiable very much nearer the beginning sessions 1, 2 and 3.
Self learning what has not worked and spotted that in those early
sessions, that's one of the things that will reduce wasted sessions.

The sub themes mentioned in total throughout the primary care counselling group who were the
longest users of CORE-Net specifically in relation to barriers to therapists using CORE-Net for
routinely for session tracking are summarised in Figure 4:3.

4.4 Summary of Focus Group in Primary Care Counselling (FG- PCC)

FG-PCC mentioned that the following may help the journey progress are: practice with dummy
clients on CORE-Net; settle client into session and be relaxed, enthusiastic and non-threatening,
explain clearly what they need to do and assure anonymity of data; user flexibility — allows therapist to adapt to client needs to use paper version or not and to use it or not if client too distressed; don't introduce CORE-Net as a separate issue but rather tell the client it is an 'up to date picture' of how they are doing' or say 'it is a shortcut way of doing an assessment' so speeds up assessment 'it is part of what we do' like we changed initially when we began to use the CORE manual forms. Therapists valued practicing on 'dummy clients' to make sure they knew what they were doing before they started with client work. It was also mentioned the importance of being very "enthusiastic" and "non-threatening" when introducing the measure to the client. Most therapists don't actually introduce CORE-Net as a 'separate issue', and they do not make assumptions that the elderly are not able to use computers.

Visual feedback "validates" the client experience and progress made session by session is liked by both therapists and clients. The dialogical use of CORE-Net as conversation enhancers was emphasised by most therapists as it 'prompts a lot of discussion, lots of dialogue...it kind of oils the wheels of the conversation of the whole process'.

There is however, the 'Danger of getting hung up with absolute scores' and the therapist needs to really get a sense of what is going on not just taking the scores at face value. Therapists like how it "Speeds up assessment" saving doing manual calculations of scores and asks many questions in just a few short minutes. Therapists liked being "Alerted sooner to risk" and client deterioration which enabled them to address it during the session as opposed to maybe only be alerted at the end of therapy. Through time it feels more "natural" and "integrated into clinical practice" and "less worrying about the minutia of inputting data" as they were initially so they felt more comfortable through practice and use.

They liked the "flexibility and bird's eye view" that CORE-Net gives which enables the therapist
to get an overview of various issues. Therapists felt that it was important to 'Slot it where it feels it flows' and so to use it in the session with each client organically. They appreciated the 'paperless' system, the validation of both change and validation of client's feelings, conversation enhancers between therapist and client, that it aids self awareness, promotes client engagement, empowerment and validates gut feelings.

4.5 Findings of Occupational Health (OH) Focus Group- (6 months)

These users were selected as they were about to embark on using CORE-Net routinely and also an alliance measure and the invaluable data that would come from this to capture the "immediacy" of the process with the client. Due to the differences in the timeframe and the possible contrast between the new users and the experiences users it was thus useful to include the experiences of both groups. The demographic details of these five therapists show that like the FG-PCC therapists, the majority of therapists follow an integrative theoretical orientation but whereas the FG-PCC therapists only had one trainee counsellor and most worked more than eight hours per week, the OH therapists all worked part-time with an average of 8 hours a week and over half of the therapists were trainees. The demographic details of these therapists can be found in Chapter 3, Table 3-5.
Clients often misread risk questions
Logistics of the computer in the room
Anxious about incorporating into clinical work
Discrepancies of how scores and how clients present
Not helpful to use in session if client too distressed
CORE-Net differs from reality when clients don't improve & are in crisis
Therapists may feel judged for their performance
Should be voluntary use not mandatory
FG - PCC Barriers
Table 4-2 shows the main findings from the analysis of the OH therapist's focus group data. The group had largely negative views of their experience to date and the data covered aspects of their practice in relation to the physical and practical use of CORE-Net and ARM-5 and their views on how they feel their clients responded to the measures being used in their sessions. I will only be presenting the themes from this group that are different from the PCC group which are themes 1) to 3) and 7) with illustrative quotes.

Table 4-2 Main Themes from Occupational Health focus group

| 1) Therapists initially anxious and resistant |
| 2) Therapists trust their own subjective measure |
| 3) The therapeutic relationship creates change not outcome measurement |
| 4) Therapists use the measures ‘creatively’ |
| 5) Therapists agree that CORE-Net alerts them to risk |
| 6) Therapists agree that clients like the visuals of CORE-Net |
| 7) Therapists do not like the use of ARM-5 |
| 8) Training/support and clinical supervision is helpful |

4.5.1 Therapists initially anxious and resistant (Theme 1)

This was the theme with the most sub-themes for this group. The sub-themes related to therapist resistance and the psychological and physical logistics of having a computer in the room for outcome measurement and its impact upon the therapy session. Therapists also discussed their fears of the process taking away therapist intuition and fear of being judged for their performance as therapists.

Therapist Resistance

Therapists tried to distance themselves from the process by saying it is for research when
introducing it to the client and hoping that the researcher/team leader had explained it all to the clients and also sent them information, so that all that was left for them to ask the client before commencing therapy was if they had any questions and this was expressed by the following quote:

TH Tamsin: I accept the researcher was doing research (Laughs) I don’t want to own it. So it was a lack of ownership, it was I already got a letter explaining all of that so I was disassociating myself, I know it’s not helpful but that’s the honest truth......And so it became, it belonged to her.

The protocol was for all therapists to use the measures at every session with the clients and mostly they did so except for when they forgot and one explanation given for this was that it was very much being caught up in the process of the client as expressed by this therapist:

TH Selaye: I’ve forgotten a couple of times and I’ve discussed in supervision the fact that the client I’ve forgot about doing it with a couple of times. That whole process of forgetting sort of reflected what was going on for her, it was very hard, however much I sat down at the beginning of the session, right, got to remember to do CORE NET, when would be a good time to do it, shall I do it now and she’d be off and it was just incredibly difficult to break into that.

A common concern for therapists was that once the scores came up they did not know what they meant or how to explore it with the client and that it felt and that somehow it did not ‘gel’ in the session.

TH Jennifer: I think I also haven’t considered using it part way through the session, I felt very much that it was something that I had to do and make sure came into the session, and was a bit worried that if I left it any longer I wouldn’t have time or it would get into processing it, it would be harder to bring in. I did find that after I had used it in an assessment session with a client, I had it up on the screen when they came in, and they, and the expectation was that they would just sit down and do it. I had several clients saying, oh do you want me to do this now, but I found it very hard in assessment sessions because I was asking them to do it as part of introducing it into the sessions and then, I then feeling just completely baffled about what to do, because I was just looking at the score and missing what they were saying, so it just didn’t, maybe I just didn’t find a way of kind of making it work, but I had the kind of scores and everything that was going on in front of me, and yet I was very aware that the client was stressed or had a
Intrusive/jarring in the session

Some therapists felt that discussing the scores in detail with the client could be experienced as 'jarring' if they were to look too deeply at the chart and the severity rating colours of the specific items as can be seen by the following quote:

TH Tamsin: I think for me it was more it was the jarring, I felt there was less flare, there was an interruption in the process for me that felt unhelpful and some clients were pleased to see the graph so perhaps that, perhaps that, well pleased to see the graph when it was going as you describe in that nice tidy way that felt affirming, if that's the right word, reassuring actually reassuring so I think yeah.

Impact of Technology

The logging back into the screen every time they client filled the questionnaire was seen as impacting on the logistics of the room (which for some of the therapists was a tiny room) as can be seen by these quotes:

TH Tamsin: But the impact of that for me was it was all this chair changing I couldn't be doing with that because the client would go there client, and then I would have to get up and I'm thinking .... Very jarring.

TH Jennifer: Almost with your back to them as well.

TH Selaye: And also difficult in such a small room doing all the shuffling around.

Demoralising to client

There was a sense from the group that with some clients who saw that they had an 'up and down graph', their sense from their clients was that the client felt responsible for not getting better when they saw their graph, and therapists where concerned about this as can be seen here:

TH Sally: I haven't had negative experiences with my clients except their sense of which I picked up from particularly one client who's graph has been going a little bit up and down of almost feeling responsible, that it's not working the way it should be working so I'm not getting better and trying to justify to me why it's not really, because this has happened, and this has
happened, and all that.... Yeah the client felt responsible and really this is about using so it's not really about my feelings it's about really how my clients felt.

Therapists described how it may demoralise clients and may not be helpful to them when they see their progress chart visually with the expectation of progress but the reality being different.

**TH Selaye:** Every week she was staying firmly in the moderate area and with a couple of blips of deterioration but she wasn't improving as she saw it, and she said 'I don't know what else to do, you know here I am, I'm doing all these things that I've decided that I need to do, it's not making a blind bit of difference' and I think she felt quite demoralised by the time it got to sort of session 5 or so and nothing as far as she could see was actually happening. ... I actually felt that she was working very hard both inside and outside the sessions and I actually felt a bit disappointed on her behalf that it wasn't sort of showing up that you know she was really doing that work, so in some senses having the graph not moving didn't help her, I think having the graph at the beginning was definitely helpful to her but after a while it wasn't helpful.

**Th. Sally:** I guess it worked very nicely when the graph did what it's expected to do, which is start up there and come down here and then it looked very nice and very neat. I think that when that happens it's a bit ... know why its going up and down, the client knows why its going up and down but then again the client is feeling like I'm being a nuisance here, I'm supposed to be getting better and I'm not getting better sort of thing and ....Or am I allowing myself to get better or is it my, you know, there is an element of that in it. I have a client who he's come quite up there and stayed there but it confirmed to him that his life is miserable and that's how it's going to be, so yes it gets messy when it doesn't do what they imagine it will do and what I imagine also it will do... I mean it fits in, in knowing what it's about but it doesn't fit in their expectation of I will start very high and will go very low because that's really what we're saying or you look quite stressed here, and hopefully you will while we are working together things will get better for you, and if that's not then happening then ok, although they know the reasons and we both know the reasons it still somehow jars with the expectations.

**Client automaticity**

The group expressed that after the assessment session, the client had the expectation that they would come in and start the session by doing the computer screen and so a sense of
'automaticity' would set in somehow. This was discussed with by the therapists in a neutral way and aptly described by this therapist:

TH Jennifer: I did find that after I had used it in an assessment session with a client I had it up on the screen when they came in, and they had the expectation. They would just sit down and do it. I had several clients saying oh do you want me to do this now.

Discrepancies in CORE-Net Scores

Most therapists described to some degree that there were discrepancies in how clients presented in the session to what the CORE-Net score was. For example, the client may understate how they are when they answer the questions. The reasons given for such discrepancies ranged from how the client reads and understands the questions to there perhaps being some longer term issues present. This is illustrated in the following quote:

TH Jennifer: There has at times been discrepancies between the CORE score and assessment of client and I wonder whether sometimes that is partly to do with how the clients read the questions, partly to do with the meaning that they give to them, and partly also to do with something about not being completely honest on them wanting to minimise or maybe not being in touch with how they actually feel about it or the emotional part of it that they read the question in a certain way, but actually the experience in the room with them which brings in the emotion and the way that their feeling can feel very different from my perspective and it sometimes shows on the score.

The complexity of the clinical work and how the scores could not capture in numbers what is really going on in the room was expressed by this therapist:

TH Jennifer: It was annoying because it wasn't reflecting the more complexities of what was actually happening in the room and it never would in the numbers.

Preferred the use of CORE paper versions

Therapists tended to prefer using CORE manual forms overall due to the intrusiveness of
CORE-Net and the frequency of using it sessionally and possibly the perception of the client in seeing it on paper they can see when it will end but on a screen each question just comes up one at a time. These issues are illustrated by the following quotes:

**TH Sally:** Yeah I agree that when it was at the first session and the last session it feels very different. I don't know whether you do that if you do that with CORE NET it would feel the same less intrusive, but also whether then if it ends up the last one being higher there wouldn't be doing what it's meant to be doing, which is looking at what's happening on a session basis. I don't know, but yes it makes a difference when it's not on an every session basis.

**TH Selaye:** I don't know whether there's sort of a difference of perception if you've got 34 questions written out in front of you and you know you have to go through all of those, I wonder if that's actually feels different from having one question popping up on screen and you're not entirely sure how long that is going to go on for.

**Fear of being judged**

Therapists felt that the graphs did not always present the perfect curve to improvement visually and that it was unrealistic to assume this for all clients and expressed aptly here:

**TH Sally:** Well these are the thorns to the rose I mean human beings are not predictable, there emotions are messy. What happens in peoples' lives is messy and that's exactly how its reflected and assuming that 6 sessions will do this perfect graph and make it go down and send them merry on there way, is unrealistic. It can happen, of course it can, but assuming this is all it is, I think it's unrealistic.

All agreed that they had a fear of being judged as therapists for their performance based on a set of scores as well as negatively affecting confidence in their work and provoking anxiety in them which can be seen by the following quotes:

**TH Sally:** I'm finding it very interesting that all these questions do not address the fact that this is also a measurement to check on their efficiency or of the therapist, and it is a fact that it is, and I'm finding all that is really saying, this is just for the client, this is just for the client but that's not true. This is about therapy, is working and whether it is working or not, and whether a particular therapist is working or not, and that is very important because that's really is quite present in the room, of course it is, and that is a question that's coming from there... It makes me more alert to possibly my work being judged and how it can be judged in such a wrong way.

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TH Tamsin: Ok interesting. Well I'm less confident in my work, so I guess I'm more anxious about the what I'm giving to the client so I guess for me at some level I'm just thinking this as I say I guess I thought Oh that's quite good that they've improved because that was lucky, you know, what I mean because I don't feel I'm giving them what, I don't feel my work is as good as it could be, because I'm using this and I take ownership for this I'm not finding it helpful I'm not using it well, therefore, I'm aware that my work is not as good and therefore, if my clients do improve I'm quite relieved for them and for me maybe going back to your comment so if my client isn't improving then I think yes perhaps that's because I'm not giving you a very good experience or maybe because you're not ready or whatever.

The dilemma that this may bring to the therapy room for the therapist was unanimously expressed by all that it is that all these scores or series of scores are very open to interpretation and therefore difficult to answer if treatment with a client has failed as the work they have done with the client may not feel like it was a failure.

TH Sally: But it actually, is actually, is the graph that defines failure or non failure as far as anybody else is assessing... And the events that happen in that client's life that may have caused that is not necessarily interpreted, explained on the graph.... But also the graph can be going very nicely and something new happens, they find out there husband is having an affair and it's up there and you're ending.

Taking away therapist intuition

The therapists felt they were already sensitive to outcomes and it depended on what the definition of outcomes was. The consensus was that CORE makes the work with the scores very concrete perhaps taking away the intuitive part of therapy and it is debatable as to whose outcomes matter. This is aptly illustrated by the following quotes:

TH Tamsin: Because for me the process creates the outcome, so it's absolutely all one really. I mean if it was a poor outcome I would be looking at the process and wondering why, rather than wondering about the outcome I'd be back in that place...... I think that question helps me clarify why I found it so difficult, is because for me it's the concreteness of CORE that is so difficult because for me you know, like in my supervision for instance, I might go with some concrete stuff and you know and obviously I want to get rid of all of that and understand what's going on unconsciously and intuitively, and so on to really inform me rather than staying with the concreteness, and it feels like a measure and yes there has to be a measure but I
suppose for me to achieve a good outcome I need to be able let go of the concreteness.

TH Sally: The process is about creating an outcome anyway; it may not end up being the right outcome ....... Yes what happened and you would through the process, because the outcome is also we are seeing how the work is going, so if the work is not going the way we think it needs to be going then that we would be looking at that, because that will inform the outcome.

TH Phoebe: I think for me I absolutely agree with you. I think it leads the client to what could be considered a good outcome rather than the client finding there own way that is ok for them.

4.5.2 Therapists trust their own subjective measure (Theme 2)

Therapists were not using CORE-Net scores to inform them how to proceed necessarily though in terms of whether to continue work with them or to discharge them. Therapists' felt quite strongly that the therapeutic relationship and their own subjective view is what informs the therapy process and informs their work over the information from COREN-Net and ARM-5 as can be seen by the following quotes:

TH Sally: What informs how I work is what's my relationship with the client, the progress of the work that I'm doing with the client.....

TH Phoebe: No, I'm informed and influenced by the relationship ...I use my own subjective measurement. Whatever CORE says I go on my own subjective measurement and whatever CORE says doesn't influence it but it can inform it in a sense that, if it's presenting well and I don't feel that to be so, then I'll look deeper at what my, what is actually in the room, but I won't make a decision on CORE.

The overwhelming sense from the group was that they already knew what was going on with the client and did not need the measures but that they may add another layer to the work if they were different to how the client presented. This is illustrated by the following quote:

TH Phoebe: I like your idea of the paper form being done outside of the session and I think that could be useful just if necessary to highlight or to talk about something and to show risk. I prefer not to use the computer in the
session, although if it needs to be done I would continue to use it as creatively as I can. They were helpful if they were different and then we could talk about it in some way but I think you, I could pick that up anyway, I didn't need the measures you know but it did give a different layer to what could be going on for the client in terms of them being more out of contact with their feelings possibly, than I first thought if the level was very low.

Therapists concurred that for them to view CORE NET to be a tool of change in and of itself it would have to be integrated more into their whole practice which is something they did not feel comfortable with.

TH Sally: I didn't feel it as a measure as it needs to create change... No that's not how I experienced it. I don't think that using the measure would change the outcome of my work with the client one way or the other, I don't think it. I think whatever the outcome of my work with the client would have been the same regardless of whether I used CORE NET or not.

TH Tamsin: I think I didn't use it, I didn't, I didn't incorporate it into my work adequately for it to, and I'm criticising myself in that, for it to be effective, because I don't think I want to work that way so you know I'm not saying you can't, I think I didn't allow it.

Fear of changing the way I work

They would see this as CORE-Net setting the agenda for the clients rather than the client's setting their own agenda and thus could change the way they work which they feared. The only factor they commented on that could possibly change their practice as a result of CORE-Net use, was the way it flags up risk but this would be allowing CORE-Net to set the agenda.

TH Jennifer: That's a very good valid point about risk in terms of change seeing it as a tool for change, I think for me personally it's not quite the way that I would like to work so I feel that in some ways it is asking me to change the way I work slightly to be able to fit it in, maybe to make it more focused, but I find it goes against, kind of the way that I work.

TH Selaye: I think I'd go along with that, and I'd sort of look at it from the point of view of feeling that going into great detail about for example, you scored very highly on this question, what's that all about, that seems to me to be imposing CORE-Net's agenda on the session, and isn't necessarily what I
would want to focus on and possibly not what the client would want to focus on either, and I take the point about the focus on risk being very useful but I can only see that the way it could be a means to create change is by really using CORE NET as the agenda for the session rather than having the clients work to the agenda.

4.5.3 Therapeutic relationship creates change not outcome measurement (Theme 3)

Therapists expressed firmly that it is the therapeutic relationship that creates the change and not the use of outcome measurement as can be seen by this quote:

TH Sally: What informs how I work is what's my relationship with the client, the progress of the work that I'm doing with the client.....

TH Jennifer: I think for me it's very difficult to separate the two because once it comes into the room, it's in there, so it's very difficult to say well is it changing the way that I work. I think it's not but obviously it's something that's then going to be in my head throughout the session. In terms of length of therapy and thinking about does it impact, either you know if someone is in the healthy range for a couple of weeks would I be considering ending, or if they're not would I consider you know, extending the sessions? I don't think I would use it as cut as that, I think I would be working more in the relationship with the client and exploring with them whether it's time to end or not to end.

4.5.4 Therapists use the measures "creatively" (Theme 4)

Therapists described different ways that they adapted 'organically/creatively' to have survival or coping strategies in incorporating the measures into their clinical work which were about the timing of when to use it in a session.

TH. Jennifer: There has been some scope for creativity.... ways of using it creatively.

TH Sally: I tend to once I have something to do, I do it to the best of my ability, so I did it to the best of my ability and there wasn't a hitch as such, but I never use it in terms of the way it should have been used maybe, and I'm not sure whether I should or shouldn't which is first thing when they walk in. I've always allowed it to happen when, within the session something occurs that feels like ok let's see if that is reflected in how it is on the graph, and in that it felt a little bit less intrusive and more like and not like this is what I need you to sort out before I even start talking to you.

TH Tamsin: I did the same sometimes I used it half way through, sometimes at the end and occasionally at the beginning but I tried to make it as organic as I
possibly could and sometimes it worked organically.

4.5.5 Therapists agree that CORE-Net alerts them to risk (Theme 5)
Therapists agreed that CORE-Net alerts them to risk and find this useful, although clients often misread certain risk items the therapists allow this to inform them about the client and have some dialogue about this with the client. These themes were similar to those already mentioned for the PCC focus group therapists.

4.5.6 Therapists agree that clients like the visuals of CORE-Net (Theme 6)
Therapists were able to see that the information from CORE-Net was able to inform their work with the clients who liked to see the visuals. These themes were similar to those already mentioned for the PCC focus group therapists.

4.5.7 Therapists do not like the use of ARM-5 (Theme 7)
There was a consensus of negativity for the use of ARM-5 particularly to the point of it feeling meaningless and given the choice would not use it again.

Meaningless
Therapists unanimously said they found using ARM-5 'meaningless', anxiety provoking and that it was difficult to even bring themselves to do it so they often forgot to do it as can be seen by the following quotes:

TH Sally: I don't like it at all, I mean CORE NET is one thing but ARM is another animal really and using it every session but then I think it was my client just don't even look, they don't even think. I think those who don't give the full marks are those who feel well it's my first experience I can't give the full marks because that should come next time or the time after which it does end up happening but I haven't had one that was major thing that explained that was anything really wrong in our relationship as such... And I think it's a joke if you say ok I'll hold the paper and I'll turn my face. I mean they know they're going to get out and you will be picking it up.

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TH Tamsin: And my anxiety, and I haven't, and my anxiety is, would that ever happen not because, not because they don't have a problem with me I'm sure, many have a problem with me but would they have the courage to say it, if they did, would they return? I find it very uncomfortable and embarrassing for them and for me. I often, I forget, I don't forget I just can't bring myself to do it.

When asked to rate how comfortable they felt in using CORE-Net and ARM-5 with 1 being 'Not at all' comfortable and 10 being 'Very comfortable', they all rated ARM-5 at 1 and CORE-Net as varying from 1-6.

Questions patronising

One or two therapists found the questions confusing for the client and patronising for them as a therapist as can be seen by the following quotes:

TH Sally: I think it's really a bit patronising because I think if any of our clients you know found out or felt they're really not getting what they want out of us, they're capable of making it very clear that by either not coming if they can't face saying I want somebody else, or by actually having the courage to go and say I'd like to change my therapist, which happens sometimes I'm sure. Must have happened so it's a bit patronising that we need them to sort of bit up there.

TH Jennifer: I just don't like the way the questions are phrased either, I think there's just something, it's just so awful about, what is it the question about the therapy, I believe my therapist's using her techniques ....

TH Tamsin: One client said to me how an earth do I know how (laughs) do it, I said well you don't have to answer it, she said I haven't got a clue how you feel about your techniques.

4.5.8 Training/support and clinical supervision is helpful (Theme 8)

Most therapists brought their clients to supervision and found it helpful. They were largely positive also about their initial training of CORE-Net and ARM-5 and acknowledged that for counsellors in training the reality of outcome measurement needs to be conveyed. The overall feeling was that training and support with regular supervision is necessary to support therapists in the use of CORE-Net and ARM-5.
TH Selaye: I think it’s definitely something I bring to supervision you know looking at the journey a client has been on and where they started and where they are now that they have ended therapy.

TH Jennifer: I think for me in terms of outcomes as well that I would discuss in supervision is maybe having to end because we’re doing short term work having to end before, or maybe I feel the outcome would be so it’s like what would my ideal outcome be for this client, what is the outcome that has come through the process if the length of time that we have been able to have and how to kind of resign the two, and if you know they’re ending because the short term work is ending and it’s not the ideal outcome then kind of dealing with that insufficiency as well.

CORE-Net for training counsellors

When asked about their views on CORE NET and its potential usefulness in supervision and training counsellors, there were mixed comments from not wanting to have outcome measurement but accepting its reality to it promoting a possible element of competition between therapists to reassuring the therapist that you are doing ok and to affecting therapist spontaneity as can be seen by the following quotes:

TH Tamsin: I know in the real world it has to be used so actually people do need to know how to use, but if I was in charge of the world, which clearly I’m not, I would just get rid of it!

TH Jennifer: I think from my perspective I can see where it’s kind of aiming and that we are trying to kind of show that we are doing it for work, but I feel in a way it introduces an element of competition particularly actually it’s a bit of both you know when they do the you can see the report on how you’ve done I think that can work in two ways, one it can say phew you know this is working something I’m doing is working ok, on the other hand I find that it also brings in that kind of what am I competing against, what am I trying to kind of achieve here, and differences in approach that I find there’s something very cognitive about it there’s something very fixed, this is the way that therapy might be done and this is the way you can use it, and this is the way we are going to outcome, and for me that loses some of this spontaneity and the using yourself in therapy.

When discussing the training of new therapists in the use of CORE-Net their views were largely positive as to how this would be useful and how to make it easier for them:
TH Sally: I can only assume that counsellors as they're coming up and they start working with NHS and this is how, what is expected and that's what they're introduced to they will probably become even more creative and accepting and learning how to work with it better than certainly me. I think working creatively with it enabled me to feel easier with it to allow it to be there part of what I do but also not feel that it's taken over my session, so I made my peace with it through working with it creatively let's put it that way. Share the different things that people did to make it less intrusive and make the most of it without it being felt as an intrusive thing.

TH Phoebe: Doing some role play around it at you know working with it so that the different ways of looking at it differently.

Non punitive supervision

Therapists had a consensus about the use of supervision not to be used to judge them purely on the basis of CORE-Net scores but that if it was used fairly as a part of an assessment that might be acceptable and that if a therapist is no good any good supervisor would know that and feed this back to the therapist with or without clinical scores as expressed by the following quotes:

TH Selaye: Well I suppose it depends on whether it really would be a part of a more global assessment, but if it boils down to somebody looking through the pattern of a particular therapist's clients and they're really only going from CORE-NET, then they don't have any of that back up information .... Well I'm concerned that it would be exclusively CORE-NET.

TH Tamsin: I think it mirrors what happens, in you know a good supervisory alliance, there's an experience where the therapist can be measured by the supervisor within relationship and context and I think that is a mirror exactly of what can happen with the client and the therapist and these CORE measures are there that can distract from or they can be helpful, but they can be a distraction it's something about for me I would want to be assessed I would hope that my supervisor would say your practice is rubbish or what's going on with you, whatever, rather than saying oh I've got you know I've got these measures. I would hope that a supervisor would know.

Recommend 'creative' CORE-Net

All therapists when asked if they would recommend CORE-Net's use to others said they would although you need to make the best of it by being 'creative' in how you use it as seen by the
following quotes:

TH Phoebe: Be creative with it.

TH Sally: Introduce it and make the best you can out of it.

TH Tamsin: I'd say this is how it's going to be in the NHS get on with it, yes. I think creativity is interesting, I think that's something I've gained out of today.

Not enough clients to practice

Unfortunately, they all felt that they did not have enough clients to practice with as one therapist had seen only three during the trial and others seeing more and up to twenty for one so there was an average of seven to eight clients seen by them as they were also seeing clients who were from other settings but not part of the trial.

TH Jennifer: It seems from what other people have said that there has been some scope for creativity, from my perspective within the six month period I don't think there has been enough clients or enough sessions to both establish how it works, would it work and then to kind of find ways of using it creatively.

4.6 Summary of Occupational Health Focus Group (FG-OH)

Overall, therapists in OH using CORE-Net for six months had reservations of the use of CORE-Net like challenges of the technology which they found interrupting the process of the session and being intrusive, jarring with theoretical training and orientation and within the session itself, fear of changing the way they work, illusion of the perfect curve and expectations set up that may be unrealistic, discrepancies between the scores and how the clients present and fear of the therapist being assessed negatively. Therapists mentioned the interruption of the process and that "it was the jarring" and "interruption in the process" that felt unhelpful. The majority of the therapists found the measures mostly helpful in term of the visual representation of clients' feelings and validation of change, useful for assessment and especially risk assessment.
Therapists said they perceive also that their clients "like visual representation of change" when they look at the screen together as this makes the client feel "feel connected and makes them feel motivated". For a summary of the positives of OH focus group therapists please see Figure 4:4.

Therapists felt they were more confident with "their own subjective measure of clients" and CORE-Net and ARM-5 only "confirm this". Some worries were expressed about "changing the way I work" so that they may not be giving of their best as therapists to the client. It was felt that they found the CORE-Net score was often "incongruent with how they felt the client presented" in the session. A consensus expressed that with ARM-5 clients and therapists seem to do it perfunctorily/automatically" and not with much care or thought into it. Therapists often "forget" to use ARM-5 at the end of their sessions. CORE-Net was seen as being useful in "pinning down risk" and informing the work in this specific way. All therapists found ARM-5 "useless" and "meaningless" and given the choice would never use it again. Each of the participants was asked to rate their comfort using ARM on a scale of 1 (least comfortable) to 10 (most comfortable) and all of the focus group participants rated their comfort at 1 and even went so far as to say it was "embarrassing" to implement. A concern was expressed about therapist's motivation of the use of measures and whether it was voluntary which was the ideal and if not then resistance was to be expected.

These therapists had a preoccupation with the physical logistics and technicalities of routine measuring as being both "intrusive in the sessions" and that it may impact on the therapeutic relationship. The barriers identified of this group are highlighted in Figure 4.5 and after looking at the focus group data from both the new users (6 months) and the longer term users (18 months) of CORE-Net there appeared to be a distinct time frame between the two groups in perceptions.
Please see Figure 4:6 which illustrates this apparent time frame difference. Please bear in mind this is just supposition as data was collected from different settings entirely at the different time spans and is therefore not based on just one group's journey through the full time span. The metaphors given at the start of the groups as an ice-breaker to describe their use of CORE-Net to date appeared very powerfully throughout in the therapist's discourse and following initial training of the OH group, minimal training for the PCC group although they recommended the training elements in Figure 4:6 which were had been included in the training for the OH group. During the first six months the metaphors of elephant, deadweight and rose with thorns described the fears that they had to overcome to and this early period of using CORE-Net was facilitated by therapists using it voluntarily, having clinical supervision and practising. The process of clinical integration had already begun by the end of the six months with the metaphors
Figure 4.4 Images of Positives: FG-OH (6 month users of CORE-Net)
description of paper weight and mixed bag. Therapists at this stage were seeing some of the benefits of using CORE-Net in the initial assessment of the client and highlighting risk visually and also noticing discrepancies in the scores and how the client presented and able to discuss this at some level. By eighteen months therapists metaphors are more about insight and maturity like hawk, wasp and singing birds and this is because they are using CORE-Net more as a clinical support tool so their metaphors are more positive than the early users.
Figure 4:6 Timeline of the process of clinical integration

START

TRAINING

Metaphors:
Elephant,
Deadweight,
Rose with thorns

6 MONTHS

Overcoming fear

Metaphors:
Mixed bag
Paperweight

1.5 YEARS

Process of Integration

Metaphors:
Octopus
Eagle/hawk
Wasp
Singing birds

Theory
Practical Know how
Clinical Integration
Voluntary use
Practising
Supervision
Assessment
Risk
Discrepancies

Viewed more as
clinical support tool

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4.7 Findings for Non-CORE-Net Users with Primary Care Counsellors (I-PCC)

The decision to individually interview this group of therapists (seven) was to try to understand the reasons why these therapists declined the initial invitation to use CORE-Net alongside their team who were the earliest users of CORE-Net in the U.K. This would hopefully give some insight as to why therapists may not want to engage in using technology in therapy sessions. These therapists were questioned about the benefits and challenges of clinical integration with the manual forms as well as views of future use of CORE-Net. Pseudo-names have been given to all therapists and clients who participated in the research project. These non-users were on the eve of beginning their training for CORE-Net use to join the rest of their team who had already been using it for 18 months. Please see Table 3-4 for the demographic details of these therapists. Highlights of the demographic data of these seven therapists show that again the majority of theoretical orientation of the therapists is integrative with an average age of 51 years for therapists, mostly female, all working part-time with average hours per week of 20 and 11 years post qualifying experience and an average of 5 years using CORE-OM (manually filled out forms). Table 4-3 shows the three main themes of the findings for Non-CORE-Net users. I will only discuss the themes with illustrative quotes which have added to the further understanding of the key issues raised thus far from both focus groups of therapists.

<table>
<thead>
<tr>
<th>Table 4-3 Non-CORE-Net Users (I-PCC) Results Themes</th>
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<tbody>
<tr>
<td>(1) Outcome measurements help to integrate client-therapist relationships</td>
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<tr>
<td>(2) CORE creates changes in assessments</td>
</tr>
<tr>
<td>(3) Therapists would recommend CORE-Net to other therapists</td>
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4.7.1 Outcome measurement helps to integrate client-therapist relationships (Theme 1)

All the therapists talked about how outcome measures benefit the client-therapist relationship and the specific reasons are given as to in which ways it does this.
Focuses the session

On of the ways that outcome measures integrate the client-counsellor relationship it that it enables the provision of a good focus for the work in short-term work to be made in order that a contract can be agreed between client and therapist.

TH Denise: I've been very positive about integrating it over the last few years, as with anything new initially I probably have some resistance because I thought how's this going to set the client counsellor relationship, but I have found that because it's very much time limited therapy that it provided a really good focus for assessing the client mood so that a contract can be agreed, also obviously and I have got to something to say about risk, but as a way of identifying risk immediately is if the client has written truthfully about that I found that really useful so that I can then take action you know, and explore that further with the client if necessary.

Conversation enhancers

They were also informed by the way that their clients can see how they are doing and the questions help to draw out clients in ensuing collaborative conversations. Therapists felt that outcome measurement enhanced conversations about the scores and thus informing them about their clients as can be seen by the quotes below:

TH Liticia: I think it is a very good thing and of course at the end invariably they do make improvement and they’re delighted to see that it’s very reassuring for them.

TH Jackie: I think its useful to actually draw out feelings about what's going on with a client, some times they struggle a little in the first session so sometimes some of the questions do help to try and figure out what's really going on underneath. Sometimes it's always interesting that you have clients who actually have their score maybe really low but actually the level and depths of distress is a lot more than what they would score themselves, so I find that quite interesting.

TH John: I do think that if the outcomes from the forms do give you some other data to ask questions on and open up the dialogue between therapist and client.

The discrepancies or incongruence of scores with how clients present in sessions provide an
opportunity for discussions informs therapists about their clients as can be seen by this quote:

TH Samantha: I find that a sizeable minority of clients who present in a self-dismissive way—score low—don’t want to draw attention to their difficulties. On talking with them though, I find they have very real problems—they usually work really well. They may have a low score and yet notice that they do need help. I think people may also not be in touch with their feelings; their scores are low to start with and may then therefore, go up in CORE scores as they begin to get into contact with their emotions. If they score low on CORE I usually find it not appropriate to discuss right there and then because I then only add it up when client has left and then explore it at the next session.

4.7.2 CORE creates changes in assessment (Theme 2)

All therapists were able to discuss how using CORE created changes in how they undertake assessments with their clients. They mentioned that it specifically makes the therapist become more focused on highlighting specific issues of high scores or risk or distress with the client thus acting as a safeguard measure and the client likes to see at the end that they have changed and made progress. They were able to demonstrate advanced clinical integration of such measures in their work by triaging of sessions based on clinical cut off scores.

Triaging of sessions

Most therapists discussed how they use the clinical cut off scores for triaging the number of sessions that may be needed by the client demonstrating advanced clinical use of the measure in an integrated way into their clinical practice. Therapists were mindful that it may be several months since the referral and before the initial assessment and that clients may already be feeling better. They would also be informed by the clinical score at the end of therapy to make a decision as to whether to ask for more sessions for the client’s specific needs. Specific examples of participants’ responses that address triaging of sessions are provided below:

TH. Jackie: If they are really on the border line of the clinical cut-off I tend to still offer a few sessions. I would probably; depends on agreement of what we wanted the piece of works we wanted to do, I would probably do about
four to six. I would probably still work with someone, I mean if they were very low beneath the cut off I would probably still do two sessions and find out about the level of anxiety and depression and then maybe refer on. The other end is if I work with people who have quite a high score and I might go up to twelve because I feel there is a clinical need.

TH. Liticia: We are now doing partway ones we're doing the shorter one, but also you get a feel for how well somebody's doing as well but now we are introducing the short one but some people improve immediately they just do so well from session one even if they've had a very high risk factor, and within six sessions they're fine, you know they're ready to finish Some people sort of yoyo, are up and down and if when we come to the sixth one something has happened, they're on a real low there's another crisis then I will offer perhaps two more sessions and I do it that way I won't, I won't say right let's give you six more sessions I would just do it like perhaps one or two at a time

Advanced dialogical use of scores

All of the participants mentioned the therapist's role in client assessment by using the scores and talking about them especially if there are areas for concern or incongruence of scores and how the clients presents in the session. Particular quotations from the interview transcripts are provided below:

TH Donna: I would actually at this point, take it at face value. I would then go back should the patient then tell me things throughout the session that make me think you know something's not quite right here something doesn't tally, then I will go back to CORE and say look this is how you feel but it seems like you know that it doesn't, the story doesn't quite match the way that you filled out your form.

TH Tanya: I suppose if somebody comes up with a lot of 4's, a very high score, yes if they come up with the high risk areas, it would influence, I think, you know. I can think of a client I had recently, she had a very high score and I was really concerned about her and I sort of really we looked at the areas where she was feeling you know had highlighted particular depression so I suppose if it's a very high extreme end but probably not if its in the middle range.

TH Jackie: You know when I say oh lets have a look at this, they like it because they can see that it measures some change. What I tend to when I ask the questions in the beginning of assessment with the CORE is: Is this for example they're saying you know they have marked quite high how they're feeling desperate or hopeless I would say, well realistically where would you like to be, you know, and then we will try and do a more
preferred feelings away from desperation, so sometimes I do use the form and the words and the feelings to try and promote change.

Variation of timing when giving out the measure

All of the participants also spoke with regard to knowledge about how they present the CORE system to the client and in particular that they would time it according to how the client presented. Some direct quotations from participants are listed below:

TH Denise: Ok, well firstly I'll use it to complement you know how the client is, my understanding of how the client is presenting, so if they're distressed, wouldn't actually necessarily use it straightaway, but generally I would introduce it quite early on in the session and I would explain that it's part of an assessment tool that actually helps the client, for me to understand the client more easily and given that we have a short time to work together, and I offer them then I'd just say, if you'd be so kind as to, would you like to, you know offer it to them, and would you be so kind as to fill in the form and generally most people are fine about that.

TH Liticia: Right, well in the assessment session we use the 34 statement CORE in the assessment session I usually have a chat with the patient first I don't actually give them CORE straight the moment they walk in the door, I think that's a little too abrupt.

Support and supervision

Some participants mentioned that they handle assessments differently with regards to support and supervision as a result of CORE. CORE initial assessments raises issues of concern like risk which make therapists deal differently with it and more mindful of tapping into GP and/or supervisor support. These participants' responses can be found below.

TH Samantha: If I am concerned I talk to head of the counselling service if high scores. On one occasion I contacted my line manager and one GP.

TH Jackie: Yes and go straight to the GP... Yeah often that's the case that we do, but obviously inform our manager as well.
4.7.3 Therapists would recommend CORE-Net to others (Theme 3)

All of the participants discussed feelings about the CORE system and their initial resistance/anxiety to introducing it into their clinical practice due concerns about how it might impact on the therapeutic relationship and its intrusiveness in the room, the challenge of the discrepancies or the incongruence of scores with how the client presents in the session, taking away the intuitive part of being a therapist and worry about being judged for their performance as therapists.

TH John: Well, I felt initially that it kind of took away the intuitive part of being a therapist. I've since changed really, I do value the output that I get because it is hard data which when you've got a hard client and in the short term its intensive work.

TH Donna: Well, when I was first introduced to the idea of CORE I had a mixture of feelings; one was that it was a way of for others to see tapping into my performance.

TH Jackie: Yeah, in the beginning it certainly raised my anxieties because I think one item just made perhaps an assumption that this is more work, I guess that's just the pressure of nature that we take on quite a lot so it felt oh more work to do and one it brought up the old anxieties for me of more intrusion in the room.

Participants mentioned recommending to therapists with regard to ways their team will use CORE-Net which will be based on their experience of using CORE manual forms. They concluded that they needed to be open minded and that using CORE-Net should not be mandatory for therapists but a choice although they were in agreement that in the current NHS climate you do need to show you are working effectively. Specific examples from the participant interview transcripts are provided below.

TH Denise: Well, because of the experience I've had with CORE then I would have no hesitation but I'll have to keep an open mind on the CORE-NET.

TH John: I'm not a prescriptive sort of person, I think that certainly it's a choice I mean I think anybody doing our sort of therapy that certainly ought to consider as a choice. My favourite way would probably be to leave it as a choice rather than as routine. I think, in a managed service working with the NHS I think you haven't got a choice whether you've got to do it with every client because we do need, we do need the data to show that we're working effectively.
However, they go on to make suggestions as to what would make it easier for themselves and others who want to start using CORE-Net. These include the fact that the measures provide a paper trail and evidence of their work and that clients would like to see the visual graphs that represent their progress.

**Paper trail/evidence**

Therapists were able to work through their resistance by reasoning over time that it was important to use outcome measures as they produce evidence or proof of what you are doing as therapists as can be seen by these quotes:

TH Denise: It's great to have evidence of progress in black and white for changing the client so that the client can actually, you know at the end when you've done you're second OM you know the client can say, yeah that's how I feel I do feel different and there is the evidence, and I suppose as a means of evaluating my performance overall when I have my meetings, professional development meetings with Tom.

TH Donna: However, on the other hand and that was a feeling that grew and become stronger, was actually it gave me some sense of confidence that finally there is some proof that counselling does work, and that it could only strengthen my profession.

TH Liticia: I think its valid I think in this day and age times have changed now and we do have to be accountable for what we're doing.

**Benefits**

Some of the participants mentioned benefits when asked to summarize their views of how the rest of their team currently used CORE-Net. Specific examples from the participant interview transcripts are provided below.

TH Donna: Well I think, I think that from what I've seen is that a graph appears it kind of very visual and I you know for the patient just to look at it, its instant you know way of seeing how they're doing... I think in the kind of setting that I work in I think it can only be beneficial.
TH John: Yeah, I think it could be very positive I think that aspect interests me more really. I do find it helps the client to see limits and time limits. Figure 4:7 shows the barriers as perceived by these therapists in their work with CORE manual forms and routine outcome measurement. Figure 4:8 shows some of the sub themes highlighting the various benefits as perceived by this team of using CORE manual forms in routine outcome measurement. The evidence suggests an advanced clinical integration of the use of CORE measures already in routine practice.

4.8 Summary of results for non CORE-Net users (I-PCC)

These therapists' recollection of using outcomes routinely in their practice (pre and post) was that it was anxiety provoking initially. This anxiety was about worrying that it was intrusive and might impact on the therapeutic relationship negatively. This group had all had several years experience using CORE manual forms routinely in their clinical practice and this was very much evidenced when they talked about its' clinical use. They had found that they could see the value of using the measures in both risk assessment and triaging of sessions and that the clients appeared to like to know how they had done in therapy with regard to a score that showed their progress. The information they had heard about from the other members of their team using CORE-Net made them think about the potential barriers to its use like worrying about the technology in the room and possibly the negative impact on the therapeutic relationship. However, they emphasised that with support in the form of training and supervision this was to assist them in their future use of CORE-Net and they felt positive enough about it to recommend it to others.
Figure 4.7 Barriers that (I-PCC - Non CORE-Net Users) find about using CORE-OM – some sub themes
Figure 4:8 Benefits of CORE-OM: (I-PCC) – some sub-themes
4.9 Findings of the Occupational Health Clients (I-OH)

Ten clients were interviewed within a month of completing therapy. The demographic data is shown in the Methods Chapter Three and Table 3-6. All these clients were referred in the normal way through routine procedures which are largely self referral, followed by management referral and seeing one of the OH health professionals already such as a nurse or a doctor at the same time or after they have discharged them and are solely in the therapist’s care and with or not care of their GP depending on whether they are off sick or not and on medication or not. All clients who were interviewed gave informed consent and details of this and other ethical issues about interviewing them are found in Chapter 3. The main themes of the analysis of the OH clients are seen in Table 4-4.

Table 4-4 Main Results of Analysis of OH Clients

<table>
<thead>
<tr>
<th>(1)</th>
<th>Clients feel outcome measures should be used routinely</th>
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<tbody>
<tr>
<td>(2)</td>
<td>CORE-Net provides a visual representation of clients’ feelings</td>
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<tr>
<td>(3)</td>
<td>Visual representations are helpful and therapeutic</td>
</tr>
<tr>
<td>(4)</td>
<td>CORE-Net and ARM-5 helps client-therapist relationships</td>
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<tr>
<td>(5)</td>
<td>Clients will self refer in the future</td>
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4.9.1 Clients feel outcome measurements should be used routinely (Theme 1)

All of the clients said it is important to use outcome measures primarily because it assesses the client but also it monitors the clinical effectiveness of the service including assessment of the therapists.

Assessment of client

Nearly all of the clients said that outcome measures helped to assess the clients by them having a visual on the computer screen of how they are doing every time they have counselling and
whether they are making progress or not and helps the therapist decide whether you need more
sessions or not. This is illustrated in the following quotes:

CL Bernadette: Obviously answering the question on the computer each time, it obviously
gives the counselor an idea of which level you have gone up or down or
established, so they need to know, and obviously you'll know for yourself
you know you can see, oh dear you know of, you've sort of improved or
not. I think that's a good idea to do that yeah.

CL Katherine: Yes definitely because you only have six sessions sometimes it, you might
need more, you might need less you know depends on the client
themselves. But yeah you definitely need to know where you're at with it
you know.

Establishes standards and benchmarks

Most of the participants felt that the use of outcome measures helped establish standards and
benchmarks so that the therapist knows you are doing the right thing and that as a service you
know whether the outcomes are useful or not.

CL Bernadette: Absolutely. I mean you need to know that obviously you're doing the right
thing really.

CL Belinda: I don't think for me it's made that much difference but I can see that it will
be useful when you're providing a service to know whether the outcomes
are useful or not and whether it's beneficial but I think you can probably
see that with the interaction anyway, but you understand that you're
looking for a measuring tool that you can use probably to do that so yeah.

All of the participants said that outcome measures were important to ensure clinical
effectiveness. Most of them were very concise with their statements.

CL Amy: Yes so in my opinion it's an important measure to have...I can see it that it
will be useful when you're providing a service to know whether the
outcomes are useful or not and whether it's beneficial.

CL Vanessa: Yeah I think it's necessary, I mean it helps to improve the services and it
helps the clients' measure their feelings and I mean the outcome or
whatever counselling can help...So I think it's really good.
4.9.2 **CORE-Net provides a visual representation of clients' feelings (Theme 2)**

All of the clients said they like the visual representation of their feelings and most talked about the process of how it was used in the session with their therapist and their emotional response to it which included the questions being 'spot on'; criticism of the questionnaire itself, automatic response, crying when seeing questions on the screen, becoming more self aware and sceptical.

**Visual representation of feelings**

All of the participants mentioned that the outcomes measures provided a visual representation of their feelings.

- **CL Dorcas:** I thought that was really good actually, I thought it was good that I could put the information in for myself and I thought that it was really good that at the end of it we could have a look at it and go through it, so I did think that was good that it wasn't just a, you are this on a scale but this is why you are.

- **CL Katherine:** Yes I thought it was excellent, I have to say, I mean the thing is you can see where you were at you know, after the session where you, where your anxiety levels were, stuff like that so yeah I mean I'm computer literate so you know and it definitely works for me, the computer.

**Process of CORE-Net use**

Most of the clients mentioned the process when discussing how the measure was used on screen by the therapist with them during the session.

- **CL Amy:** Ok so we're computer based system and I've being asked a series of questions at the being of each session just to assess the way I've been feeling over the past week or so, so that we can compare them with the previous sessions and see whether there has been an improvement or a decline in the way I've been feeling.

- **CL Charmaine:** We always did it at the beginning of the session, we had a few minutes when we chat and...then on to measure.
Emotional response

Most of the clients spoke of their emotional response to the use of the measure.

CL Bernadette: Yes I mean I was more than happy to do it, and for my own experience the questions were sort of spot on. It was like you know, the way you’re feeling and it was good to see obviously the table worked very useful for which way you were going and it was remarkably right, it did seem to work in the right direction and I was happy about doing that.

CL Chantelle: Yeah because we were working out what I’d done over the last say two weeks or weeks, and then we was working out that little things like a disagreement has brought on, I felt a bit bad that day because in the questionnaire it says how have you felt the past week or you know, and there has been days where I felt low and then we work them out why I felt low on them particular days, and then we worked out how to go forward from there.

4.9.3 Visual Representations are helpful and therapeutic (Theme 3)

Most of the clients said helpful and therapeutic and said comfortable with it and liked it. The specifics of why they found it helpful or therapeutic will be discussed.

Visual charts were helpful or therapeutic

Most of the participants mentioned viewing the visual charts as helpful or therapeutic as it helped them to chart their progress session by session.

CL Bernadette: It was helpful.

CL Vanessa: So when I started initially I was a bit sceptical about it but later on when I discovered that I mean at the end of each session I’m able to know if I’m getting better or getting worse. I mean it was good, it was really good I was able to assess myself and to caution myself.

Comfortable

Nearly all clients felt comfortable with the routine outcome measurement done sessionally during their therapy experience.
CL Bernadette: Yeah, absolutely, I was comfortable with the whole thing
CL Chantelle: Yes and we literally took one bit at a time. I felt very comfortable

**Liked ARM-5 to comment on therapist**

Most clients liked it because they really liked their therapist and highlights the quality of the therapist relationship and alliance as being important in the process. This is illustrated in the quotes below:

CL. Amy: But I thought it was quite a direct way of measuring the relationship you have with your therapist definitely.

CL. Bernadette: Using that was fine and obviously all the answers I gave were always very positive...Top, I did actually give her top marks because you know because I couldn't have given her anything else, because it really was you know, she was fantastic so top marks for all of it... Spot on for me and I was happy to obviously you know; fill in that form so fine.

CL. Vanessa: The section addresses, I was able to build confidence talking to her. Initially I wasn't very sure what I was going to get and how it was going to, I mean come out at the end, so and I wasn't very sure if I mean every detail was going to be passed on to manager or whatever I wasn't very sure I mean she reassured me... Yeah and with time I was able build this relationship with her. I relaxed more and I was able to really tell her how I really felt, it was good.

**Resistance to ARM-5**

A sizeable minority spoke about resistance or ambivalence towards the use of it especially at assessment when they have just met the therapist and don't feel have enough information to answer the questions fully or because they might be worrying about the issues they brought to therapy and so to also comment on the therapist's way of working seemed challenging. Please note that all these clients except Sabrina liked their therapists and did not have an issue with them but they commented on how some 'might' feel if they did not get on with their therapist. This is illustrated in the quotes below:
CL. Belinda: Thinking particularly about the responses I was giving. I remember thinking the question is, I can't remember what the question was, one of the questions was how you get on with your therapist do you think this is a good relationship... Yes. I remember thinking the first time I filled it out was I don't know I've never met this woman before, you know so how can I answer this question, you know so it's kind of well yeah, whatever, sort of thing.

CL. Dorcas: I didn't mind filling it in, the only thing I would say about it is because you are directly commenting on how you feel about your therapist to your therapist, two things: - one is that you might not be one hundred percent honest and the second one is that you've already got enough going on in your own life that you might not want to get into another issue, do you know what I mean... Yeah it's like I've got enough going on in my own life now I don't want to confront you do you know what I mean... To say maybe it's not working or whatever.

CL. Sabrina: Well no I didn't like that... Only because there were certain issues that I would have thought, I don't know didn't, weren't extracted from me so to speak very well but I felt compelled to say good, good, good because I'm sitting in front of you and I couldn't say oh I didn't really like that very much.

Suggestions to improve ARM-5 use

A couple of clients discussed the future option of improving the use of ARM-5 by not using it in the session but asking for it to be done afterwards outside the session or asked not by the therapist directly but by for example the Head of Service. This was particularly highlighted in the cases where the clients thought the relationship may not be so good and that it would be difficult to address directly with the therapist concerned. These suggestions are illustrated in the quotes below:

CL. Charmaine: But in a view she asked me how I feel about this questionnaire and I answer some people may find difficult to answer in front of the therapist honestly actually... And they may not you know be so honest... and not mean it yeah. It may be this one should be done instead in front of the therapist done outside and then posted to

CL. Dorcas: Yeah I wonder because if you asked me what I thought about someone else that's easier than if they ask me what I think about them... Or maybe if you did it as some sort of an exit interview or a piece of paper you filled out in reception but when it was all over I don't know. I'm not really sure how you... And in a way maybe that's where I was at, it's like I already
can't deal with stuff like if somebody is bothering me I don't tell them, well sometime I do but it's like maybe therefore ... Yeah haven't got the energy, without knowing it was too close to home maybe....

Honesty with ARM-5

Most clients felt they could be honest as it was good feedback for the therapist and that you are seeking help so it is in your best interests to be honest even if there was not such a good experience with the therapist but all these quotes are from clients who were happy with their therapist:

CL. Amy:  Yeah that was quite, there wasn't any emotional attachment to marking down honestly what I thought...So I thought that was good and its good feedback for the therapist as well ... I would have been able to be honest with using that questionnaire yes and the therapist did say how do you feel so there's various different mechanisms by which you can communicate that so I could as you say, come to yourself head of service, or I could use the questionnaire or I could speak to the therapist directly so hopefully you know clients should be able to find one of those avenues.

CL. Bernadette:Yeah oh there was no hesitation filling out that form I didn't have to think it was just yes you know top marks for this lady because everything about the whole session was I was happy to whatever happened whether answering the questions on the computer you know talking and obviously you know the whole thing was just fine you know a great experience.

CL. Katherine: Yeah, I think the first, the first session if you ask someone, a client to do this they may feel uncomfortable because they you know they're probably in a high state of anxiety and it's all a bit confused but I mean afterwards once they've sort of settled I think they shouldn't have a problem with it. I mean I certainly didn't so....Yeah that people that come here there not coming here for fun, there coming here so that they can work through what they need to work through so I was happy, yeah I would have definitely been honest.

Dishonest with ARM-5

Some clients could see they had experienced a good relationship with their therapist but if they had not that it may have been harder to be honest and this would be the case especially if you were feeling vulnerable due to the issues you were bringing to therapy and one client had a very negative experience with their therapist which is illustrated also in one of the quotes below:
CL. Belinda: Yeah had I felt that the relationship wasn't a positive one then I probably would have found it quite difficult... I think if I had felt that it wasn’t helping or I had somebody with that sort approach the emotional place that I was in I would have found it quite difficult to comment on, or to say actually this isn’t working, and I probably what I would have realistically done, is just not come back or ended the sessions or whatever rather felt able to write down or express that this isn't a positive thing...But I think that's just the emotional state I was in you know.... because it's hard to make decisions when you're feeling that vulnerable and I think that would have been another decision that I wasn't able to make but you know that didn't apply, so you know its speculation I don't know if that's the truth.

CL. Dorcas: No I probably because again I don't know that I was entirely honest when I filled this out and because it was at the end of the session, if it was at the beginning of your next session it would be different ... Yeah and because it was at the end of the session and I was quite emotional it was just circle, circle, circle goodbye, kind of get me out of here..... Yeah but because the thing is I think I'm quite a straight forward out there person and there's a lot of people in England who are very reserved, so surely they must find this very, I like you, no I really like you, they must find that difficult if they don't if they're not having a good relationship with their therapist.

CL. Sabrina: You know where she said will you fill this in, I couldn't turn round and say well actually I think you're absolutely awful and I don't want to come back to you again. ..It was just something, I don't know it was just the answers that I was giving her, she just seemed to sort yeah ok and I just got the impression she wasn't really listening to what I was saying.

Improving the change of therapist process

Some clients expressed ideas about how to improve the change of therapist process especially if they are feeling unable to make that sort of decision due to their emotional state if they are not getting on with their therapist by telling someone other than the therapist or even telling the therapist directly as seen by these quotes:

CL. Belinda: If that had been an option on the form say kind of without any sort of loading you know, do you feel this isn't working for reason would you like to speak to somebody different then it would be more of a, I would feel more comfortable with having that as an option to say yes or no. if I felt the need to..Yeah because then you're, it's it's ok to say yes rather than ...I don't know that you know for me it was a particular low point when I came here and I don't know if I'm typical of the people that you see or not but I just felt where I was I wasn't capable of making any sort of ...Yeah decision ...In only respect and I think another kind of decision would have been one too many.
When asked if at the time of allocation of the therapist it may have been helpful to mention the change of therapist option and process, this client responded that too much may be going on in the beginning for the client to absorb this option in the first session as seen below:

Cl. Belinda: I think I probably would have done but again because you're in kind of a very negative frame of mind just you know where I was and I think hearing that I'd maybe come and say well its not going to work then do you know what I mean, it's like are you expecting it to fail. I think maybe that's something that again you know maybe if you said after the first session or second session or whatever you know that this is an option because again initially your head is all over the place its very difficult to sort of take in and retain any sort of information... think the first one isn’t necessarily the right time to do it... I think you know very quickly if you're going to get on with somebody and you're going to share information with them or not and it depends kind of how desperate you are whether you do or you don't, to a certain degree, I felt very positive about it, that I was prepared to share, I understood the confidentiality issues and that if I was going to get anything out of it I needed to trust this person

Cl. Dorcas: Yeah I wonder because if you asked me what I thought about someone else that's easier than if they ask me what I think about them.... Or maybe if you did it as some sort of an exit interview or a piece of paper you filled out in reception but when it was all over I don't know. I'm not really sure how.

4.9.4 CORE-Net and ARM-5 helps client-therapist relationship (Theme 4)

Most of the clients said outcome measures helped relationships with therapists and we should continue to use CORE-Net as a service. Some said there were problems with measures like the timing of giving the ARM-5 measure, being honest with therapist in rating them when you are feeling vulnerable as a client and a couple said already had a good relationship with therapist.

Helped relationship with therapist

Most of the clients said that the use of outcome measures like benefited the client/therapist relationship and all clients except one had complimentary things to say about their therapist and their relationship with them.
CL Bernadette: Well yeah definitely because it lets the therapist know that you feel at ease with them and you feel comfortable to talk to them about anything and you can open up and basically that the therapist will no that's nice of them to know I think because then they'll you know its just good for them to know that, that side of it so it will help them as well.

CL Chantelle: Yeah because especially number 3 my therapist and I have difficulty working jointly as a partnership you need to answer that question you know and I always strongly disagreed, always and the rest of the questions were strongly agree.

CL Katherine: Yeah I mean as I said I would have just said is you know I need to swap therapists if I was having a problem, but you know I'm that type of person, I don't know how others would react but yeah I think you need this because you need to know that somebody's going to get on with someone, it's no good going to someone you're not going to get on with.

Yes, continue using CORE-Net

The service continuing to use CORE-Net was something that about half of the clients directly commented on that should continue.

CL Bernadette: I mean as I stated before its, I was more than happy to use it and it was helpful for myself as well as the therapist and anything like that in the future if I come back again I'd be more than happy to participate in that's right absolutely.

Please see Figure 4:9 which show the benefits that the OH clients perceived of outcome measurement.

Problems using measures

A sizable minority of clients said they had problems with the use of the measures. This appeared to be either due to the timing of it if they were distressed or emotional and one particular client who was most unhappy with the therapist was due to the therapist discharging them due to too many perceived cancellations and not giving notice for non-attendance. Another client felt that the questionnaire was too vague in what it required them to consider at each time. These are
illustrated in the following quotes:

CL Dorcas: Yeah and because it was at the end of the session and I was quite emotional it was just circle, circle, circle goodbye, kind of get me out of here.

CL Sabrina: Well I think you've got to you can't always be a hundred percent; you've got to have a bit of flexibility somewhere. I mean if we were that inflexible upstairs by saying one strike and you're out.

CL Tabitha: The only gripe I would have is that the sometimes frequently often not at all, the sometimes is too vague.

4.9.5 Clients will self refer in the future (Theme 5)

Most of the participants said that they would self refer in the future as can be seen be below:

CL Bermadette: I think in my own situation it is possible that I will likely need to come back and see Tamsin again, and I know that coming back to Tamsin is going to be a help, it really will. Yes at least I know I can come back and it will help me again sort of get through another difficult time and so yeah she was brilliant.

CL Charmaine: I was very grateful and it helped me a lot actually, was a very positive experience and I definitely would come back if I was to have a similar situation or need.

CL Belinda: I would do it again yeah, yes I would yes.

They also summarised their overall feelings regarding outcome measures which were largely positive.
Figure 4.9 Benefits of CORE-Net and OH Clients – some subthemes

- Helps with therapist relationship
- Could be honest and comfortable with it
- Visual representation of feelings
- All Services should use Outcome Measure
- Emotional response by seeing questions on screen
- Helpful and good to monitor
- Allows discussion of scores and progress (counselling journey)
- Establishes benchmark, assesses client and therapist
- Liked questions 'spot on' and one at a time

OH Clients
CL Amy: I'm quite happy with the service that has been provided to date.

CL Vanessa: It's good because I mean when you go through some stresses in life, sometimes you want to tell yourself that it's not getting to you or there are some aspects that you will over look that might be very dangerous to you as a person but with the questionnaire and everything on the screen you are able to assess all round aspects of yourself and you are able to tell which aspect you need to work on. Yeah and I really found it really really good because I mean I wasn't sleeping at this stage but I didn't see, I was just telling myself if I relaxed I will be fine and when I went through the questionnaire I discovered that I mean a lot of things were wrong that I was over looking so I mean it's really good.

CL Tabitha: I think it's invaluable, I know it's a very busy service but you do your utmost and you obviously prioritise on a needs basis and I think it's absolutely vital as without it there would be a good many difficult situations that wouldn't be addressed and people would have nowhere to go. Coming from someone who was very very oh I'm not going to talk to anybody because I'll just deal with it myself yeah it's changed my view.

5. Automated online response by clients each time they fill out a questionnaire

CORE-Net has an automatic feature built into the software that asks the client at the completion of every online questionnaire how they felt about completing it.

Of the 74 OH clients seen during the study, all gave online feedback. This was automatically gathered every time a client filled out a CORE-Net questionnaire online after each session. Over half (approximately 51%) of these clients were "quite happy" to fill the questionnaires in and nearly 38% "didn't mind" which means that nearly 88% of clients that were seen appear "quite happy" and "didn't mind" filling them in at each session. Only 2.86% were 'not keen' and 0.28% 'disliked it'. Additionally, all these clients also an alliance measure, ARM-5, in a manual version at the end of each session.

The PCC clients totalled 300 during the duration of the time that this setting had used CORE-Net. As in the OH context described above, client feedback was automatically gathered every time a client fills out an online questionnaire. In the PCC setting, this was done after most, but not all, sessions in between pre and post; each client provided feedback for their first and last
session. 47%) were “quite happy”, 45% who “did not mind”, indicating that nearly 92% who were “quite happy” and who “didn’t mind” when they were asked to fill out an onscreen outcome measure. Only 3% were ‘not keen’ and 0.77% ‘disliked it’. In the PCC setting, clients only filled out an online CORE-Net questionnaire but not an alliance measure, as clients did in the OH setting.

OH clients gave specific suggestions on how to improve the use of ARM-5 and which shows the factors that clients find challenging about both CORE-Net and ARM-5. Please see Figure 4:10 which show suggestions from these clients.

4.10 Summary of OH-Clients
The clients seen by Occupational Health therapists were all in favour of the importance of routine outcome measurement of services as they felt it assesses both clients and therapists and establishes standards and benchmarks. They particularly liked the visual representation on the screen and were able to describe the process of therapy as they experienced it with some detail including their emotional responses at times to the visualisation of their feelings in the graphs. They found these to be helpful and even therapeutic and mostly felt comfortable with the process with both measures. With reference to ARM-5 in particular they gave suggestions to improve its use or concept of feedback of the therapeutic alliance and were mostly able to be honest with it and felt it did help with the relationship with the therapist although many expressed feeling already positive and having a good relationship with the therapist and would self refer in the future and recommend the service to others. Features that were expressed by the minority as not being helpful were that the measures could be done automatically without much thought and be asked to do them at a time when they are distressed or too emotional to focus. Finally, for both ARM-5 and CORE-Net, the minority view was that one could hide behind ARM-5 if they wanted to hide their feelings.
Figure 4.10 OH Clients Suggestions to Improve ARM-5

- Explain to our clients our job which is not to tell them what to do but to facilitate change
- Make clear the purpose of counselling at the start
- Ask verbally not in a written format
- Maybe completed at the end of the counselling episode
- Maybe give at the beginning of next session
- ARM 5 to be posted back & not filled out in front of therapist

OH Clients’ suggestions to improve ARM-5 Use in Therapy
Figure 4:11 Factors that OH clients find challenging with ARM-5 and CORE-Net

- ARM 5 at end & appropriate timing of its use
- ARM 5 - Emotional clients unable to decide if they should change therapist
- OH CLIENTS
- Loss of Social Interplay
- Awkward when clients distressed
4.11 Summary of Chapter Four

This chapter covered both focus groups of new and experienced users followed by the non CORE-Net users and finally the views of clients seen by the Occupational Health therapists.

The participants of the FG-PCC identified several positives of the measure. These positives included user flexibility, the provision of insight, the provision of a safeguard measure of risk, the speeding up of assessment, and the visual tracking of progress. The FG-PCC participants also mentioned several recommendations for training, including simplification, training about technology, and integrating the vision and purpose of the measure. The participants of the FG-OH identified a few positives of the measure. The participants determined that the measure engages the client, alerts to risks (safeguard measure of risk), and provides visual tracking of progress. The members of FG-OH also mentioned several hurdles or obstacles to the implementation. The hurdles included fears of changing practice, intrusive/space and time taken in session, fears of technology, fears of being judged as therapists, and discrepancies between the clinical scores and how the client present. The FG-OH also mentioned that they did not like the ARM-5 and if given the choice, would not use it again.

The findings for the non CORE-Net users illustrate the initial worries that therapists have when outcome measurement is introduced into practice but that through time they come to see that it helps to integrate the client counsellor relationship in many ways. They find that using CORE creates changes in how they undertake assessments and especially in risk assessment and triaging of sessions. They recommend the use of CORE-Net to therapists for a variety of reasons including the speed of instant feedback to both therapist and client and the visuals for the client to track their progress.

The clients seen by Occupational Health therapists felt sessions should be routinely measured and counselling services monitored for the benefit of both therapists and clients. The minority
view was that clients can "hide" behind both questionnaires if they want to and not put how they are really feeling for whatever reason. All clients "like the visual representation" of CORE-Net for session tracking. There were mixed views on the use of ARM5 ranging from "no problem with it" to "difficult to tell the truth if you don’t like the therapist" and unease about "how to make a decision about the therapist when you are feeling vulnerable yourself". Overall clients were much more positive about the use of both CORE-Net & ARM 5 than their therapists were. Clients stressed that how they felt about the therapist was more important to them than any measures.

Please see Figure 4:12 and Figure 4:13 which illustrate some of the factors from the themes and subthemes analysed that may increase or decrease therapists’ motivation to engage in CORE-Net/Routine Outcome Measurement (ROM) based on all the data analysed. These overviews indicate practical issues for the implementation of CORE-Net and ARM-5 including practical initial training with continuous support via clinical supervision.

Chapter Five will further present further findings of the results of this study and will include the therapist diaries (TD-OH) and supervision session (SS-OH) from the Occupational Health therapists and the key informant interview with David (I-DAVID) from the Primary Care Counselling service. The final overarching themes will be determined from the individual resultant themes present after the chapter summary of Chapter Five.
Figure 4:12 Overview of I-PCC; FG-PCC & FG-OH

- Learning Curve to appreciate CORE-NET as risk tool & speeding up assessment
- Understanding the philosophy of "why routinely OM"
- Given choice to participate voluntary
- Regular case discussion ongoing
- Role play in training - "how to"

- MAY Increase Motivation
- To participate in CORE-NET
Figure 4:13 Overview from I-PCC; FG-OH & FG-PCC

- Intrusive Fears
- Impact on relationship
- Technology Logistics in room
- Challenge of Clinical integration
- Theoretical training background & minimal know how of the Philosophy of OM

May Decrease Motivation

To participate in CORE-NET
CHAPTER 5

Findings 2: Therapists Diaries, Supervision Sessions and David's Interview
CHAPTER 5

5.1 Introduction

This chapter includes the analysis and findings for the OH setting therapists' diaries of work with their ten clients (TD-OH), therapists' supervision sessions (SS-OH), and then lastly with the findings of the individual interview between the researcher from the OH setting and David (I-David) a key informant from the PCC setting. I will conclude the chapter with a full summary of the findings for both Chapters and the final overarching themes.

The same five therapists who were part of the OH setting Focus Group were also asked to complete diaries in relation to the first client seen in the first three months and a second client seen within the second three months of the trial using CORE-Net and ARM-5 for the first time. This was requested so as to be able to capture a very personal moment by moment and fresh account of the therapist's work with their clients and to write about it on a session by session basis to encapsulate data that was close in time to the event and during the trial period of six months. A diary format was designed to make it easy in terms of time to enable therapists to have reminder headings to focus their thoughts for writing due to the reality of a busy clinical practice setting. The personal narratives from this data would then be compared to the group dynamics within the focus group data when all the therapists on the team came together at the end of the trial to be interviewed as a group and allow methodological triangulation and thus allows a more complete picture of the issue researched as well as enhancing the validity of the research findings.
5.2 Data Analysis of Occupational Health Therapist Diaries

The diaries were analysed using a Conventional Content Analysis approach as outlined by Hsieh and Shannon (2005). The aim of the analysis was to identify how therapists and clients perceive and experience using CORE-Net and ARM-5 in an OH department. Following the steps outlined by Hsieh and Shannon (2005), I analysed the diaries in the following way: First, I read through all ten diary transcripts several times to get a feel for the experiences and perceptions overall. Second, I reviewed each transcript and made notes in the margins summarising particular thoughts, words or expressions that seemed key to the experience or perception of the therapist or client. Once I had been through 4 of 10 diaries I had an idea of the codings that were common and focused on using these when I went through the remaining six diaries, only adding new codings when no other seemed appropriate.

5.3 Examples of how codes were identified within the text

Each diary was read and codes were identified. Below are two examples of how text was broken down and assigned to different codes.

Example 1: CORE-Net Text: “Talked about research project looking at progress throughout counselling sessions – client was very happy to take part. Introduced idea at start of session and then asked client to complete CORE-Net about halfway through session after she had described her current problems in detail and then paused because she was upset. She said she thought it would be a good idea to do CORE-Net at that point while she gathered herself together” (TH: Selaye 3.1, which means Therapist Selaye, diary 3, session 1)

The above paragraph was split into 3 codes:

1. How CORE-Net is introduced: as “a research project”
2. Timing of CORE-Net in a session: "about halfway through the session"
   a) Reasons – "after she had described her current problems in detail"
   b) Reasons – instigated by client “she thought it would be a good idea to do CORE-Net at that point”

3. Client reactions to CORE-Net: "client was very happy to take part"

Example 2: CORE-Net Text relating to Client experiences:

The following statements are examples from the diaries of three of the five therapists that relate to deterioration in progress shown on the CORE-Net graphs and clients reactions to this.

- “Client disappointed that graph had gone up, due to an unexpected incident this week” (TH: Selaye 2.7).
- “Talked about rise in score since last week and asked client why she thought that might be. She suggested it was because she had had to make a number of lifestyle changes because of recently identified health risks and she said she found it hard to change her habits and that it didn’t come easy to her” (TH: Selaye 3.2).
- “Score =24 (deterioration). Client was a bit disappointed about this but said she could see that the last week had been stressful and she was trying to change aspects of herself and her behaviour that were deeply ingrained.” (TH: Selaye 3.4).

The above statements were covered by a main code: “therapists perceive that clients engage with CORE-Net” and the following sub-codes:

1. Clients are disappointed when deterioration shows;
2. Clients can explain why change has occurred; and
3. Clients think about ways that they can change.
Once I had gone through all of the diaries, I collated all of the answers given to that question from the 10 diaries. I labelled each quote with a diary number (1-10) followed by the appropriate session number (e.g., 1-9). This enabled me to see at a glance the answers that were being given to each question and to begin to draw out the preliminary codings that I had started writing in the margins of the printed diaries. The initial codes that emerged were as follows:

2. How therapists use CORE-Net.
3. Therapists' feelings about using CORE-Net.
4. Therapists' negative experiences using CORE-Net.
5. Therapists' practical difficulties using CORE-Net.
6. Therapists' positive aspects of CORE-Net.
7. Therapist perceptions of client experiences of CORE-Net.
9. How therapists use ARM-5.
10. Therapists' "felt-sense" using ARM-5.
11. Therapists' negative experiences using ARM-5.
12. Therapists' positive aspects of ARM-5.
13. Therapists' perceptions of client reactions to ARM-5.

I then went through the quotes under each heading to identify the sub-codes. It was obvious from the way the pre set questions had been answered that therapists had interpreted questions in different ways, and therefore the text could not be analysed under the questions as they had been asked, but needed to be re-grouped under the new sub-headings before the analysis could continue and meanings extrapolated. Some text needed to be deleted completely when it was
ambiguous, had no meaning, or when the therapist was discussing his or her thoughts about the client rather than about CORE-Net or ARM-5 in the session. This made the analysis more complicated as often only partial answers were given to questions, or the answers referred back to previous questions. Immersion in the diaries was needed in these cases to get a sense of what each therapist was talking about and whether it was relevant.

When I had re-arranged the quotes under the new sub-codes I then reviewed them to identify whether any could be linked together, needed to be broken down into further sub-codes, or to be removed entirely.

5.4 Findings of the Occupational Health therapist diaries (6 month users)
Therapists were writing these process diaries after every session with two clients one within their first three months of CORE-Net use and the other client in the second three months. I will only be illustrating with quotes the themes that added to the existing knowledge of the already discussed findings from the PCC individual interviews, PCC and OH focus groups. The main themes are in Table 5-1

<table>
<thead>
<tr>
<th>Table 5-1 Main Themes of OH Therapist Diaries</th>
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<tbody>
<tr>
<td>(1) Therapists are initially and anxious and resistant</td>
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<tr>
<td>(2) Therapists find the visuals of CORE-Net useful</td>
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<tr>
<td>(3) Therapists perceive that clients 'like the visual graphs'</td>
</tr>
<tr>
<td>(4) Therapists find difficulty in using ARM-5</td>
</tr>
<tr>
<td>(5) Therapists perceive that clients are not engaging with ARM-5</td>
</tr>
</tbody>
</table>

5.4.1 Therapists are initially and anxious and resistant (Theme 1)
Therapists are initially anxious and resistant and find it difficult to use CORE-Net in sessions.
They tend to either distance themselves from the process by introducing CORE-Net in the first session as part of a research project (2/5), by checking that the client has received the paperwork and asking whether they have any questions (3/5) or saying it is something ‘new’ to the way they work (2/5). They expressed anxieties about how to integrate it into the therapy session and the impact on therapy sessions.

**Time and timing of CORE-Net has an impact on therapy sessions**

Therapists experience CORE-Net as taking longer to complete and that it ‘takes time out of the session’ (TH: Tamsin) or ‘got in the way’ (TH: Jennifer) (3/5). This is less with the shorter forms. They also have concerns around the length of time it takes to complete the paperwork associated with using CORE-Net and ARM-5 in a session and ‘whether fewer client sessions should be booked in day to allow CORE-Net admin time’ (TH: Selaye). Therapists appear unsure about when in the session to ask the client to do CORE-Net as ‘finding a good time to slot CORE-Net into session when client had a lot to say was quite hard’ (TH: Selaye). If it is left to the end of session they worry that ‘we might run out of time and not have time to do the online form’ (TH: Jennifer) or the session may run over ‘to accommodate CORE-Net and ARM’ (TH: Selaye). Supervision is a time when therapists want to discuss ‘how to integrate discussion of CORE-net comparisons and ARM into framework of session’ (TH: Selaye) and to deal with time issues.

**Therapists vary in when they introduce CORE-Net into a session.**

They generally take the client’s state of mind into account before deciding when to ask them to complete CORE-Net. Most therapists seem to ask the client to complete CORE-Net at, or towards, the beginning of the session (3/5). At other times they may wait for a ‘natural break’ (1/5), or until the end of the session (2/5). Sometimes clients themselves will decide when they want to complete the form. These have implications.
Therapists ask clients to complete CORE-Net at beginning of the session

Therapists may introduce CORE-Net in a first session as a way of ‘finding out what was bringing her to therapy’ (TH: Jennifer). However, asking a client to complete CORE-Net right at the start of a session, seems to cause difficulties when the therapist does not have enough information about what is bringing clients to therapy and this makes it difficult and ‘awkward’ to explore the story-boards and score in any detail. ‘I felt I was fumbling around because I had nothing to link it to’ (TH: Jennifer).

In later sessions therapists might introduce CORE-Net at the beginning of the session as ‘as a means of assessing and confirming her statements’ (TH: Phoebe), to ‘give us an indication of how she was since our last session’ (TH: Jennifer) or ‘before the client became involved in the counselling’ (TH: Phoebe). Some therapists have CORE-Net up on the computer when the client arrives, or they might quickly review how a client is before directing them to the computer to complete CORE-Net. Either way, therapists check that the client is happy to complete CORE-Net before they start, and often give them a choice of now or later. After a while, therapists find that clients expect to complete CORE-Net at the start of the session, and ‘expected it and went straight to the computer to do it’ (TH: Sally), so it needs no introduction. In a final session, therapists might introduce CORE-Net at the beginning of the session ‘as an introduction to the therapy and an overall assessment of the whole of therapy’ (TH: Phoebe).

Therapists may wait until the end of a session before asking a client to complete

This might be the case if ‘a client had a lot to talk about’ (TH: Selaye), ‘was in full flow for most of the session’ (TH: Selaye) or ‘wanted to talk about recent events’ (TH: Selaye) and update the therapist. Alternatively, a therapist might feel that ‘the client needed to talk and make contact with me before engaging with the questions’ (TH: Phoebe) and so consciously leave it until the
However, leaving CORE-Net until later in the session can raise therapist's anxieties as they are aware of having to ask the client to complete it at some point. 'I took advantage of a natural break to ask her to complete CORE-net, but had worried before that about whether there would be enough time left to do it. I felt this slightly distracted me from what the client was saying'. (TH: Selaye). As such, the 'session over-ran to accommodate CORE-Net and ARM5' (TH: Selaye). Dealing with time issues is something that therapists discuss in supervision.

5.4.2 Therapists find the visuals of CORE-Net useful (Theme 2)

Therapists are also able to experience some of the ways that CORE-Net can be beneficial in a session. These include helping identify risk, focus a session, see a client's progress or to guide the therapy session and raise issues and challenge a client if there are inconsistencies between their score and their presentation in a session. Therapists generally ask clients to confirm that the score represents their experience (4/5).

Therapists use CORE-Net to track a client's progress

Therapists track client's progress in order to bring up the ending of therapy or when to extend the number of sessions (3/5). If the client's CORE-Net score is showing improvement in the healthy range, therapists can use it to discuss ending with the client improvement: 'towards the end of the session – and with the CORE-NET score in mind, we decided that the following session would be the final session' (TH: Phoebe). However, they may also decide to extend sessions while a client 'implements changes to benefit her health' (TH: Selaye).

CORE-Net provides therapists with an overview of the client's issues

Due to therapists gaining an overview of the client's issues they discussed therapeutic aims,
thus allowing CORE-Net data to act as a tool to inform them in this process (2/5). When a therapist has not done the initial assessment, CORE-Net can provide 'an instant overview of what could be the primary issues' (TH: Phoebe) and allow 'talk about issues that might have taken longer to introduce. It also kept the session focussed and added direction for the rest of the therapy.' (TH: Phoebe). It can give the therapist 'an idea where she is starting from' (TH: Jennifer) and where a client’s initial score is low it can also be a prompt for discussing the aims of therapy with a client: 'as the score was low we spoke about how I could help, what else this could mean, and what she wanted from therapy' (TH: Phoebe) and limiting the number of sessions offered.

CORE-Net used to guide and provide structure to sessions
Therapists used CORE-Net to guide and provide structure to sessions in the room or on the telephone (2/). CORE-Net also acts as a structure for phone sessions as 'it gave me a better opportunity to discuss how she was feeling and to explore aspects of this in relation to the answers she gave' (TH: Jennifer) and 'it gave more meaning to it' (TH: Jennifer). It can also be used interactively with the therapist watching the client complete the form and asking questions as they go along. In a final session, CORE-Net can provide a way of 'looking at the graph over the whole of the therapy in relation to her well-being, problems and sense of her own emotional health' (TH: Phoebe).

Therapists can identify discrepancies with CORE-Net scores
Therapists can identify discrepancies between CORE-Net scores and the way they client presents in a session and raise these for discussion (2/5). 'The graph clearly showed how she felt and opened up questions if I felt that it was contradictory. Also it highlighted key areas for discussion' (TH: Phoebe). CORE-Net can help a therapist understand a client better and confirm whether changes are real or temporary, 'as she began to speak I asked if there was a difference
in how she was feeling and what the score was – as it appeared to be lower that what I felt to be the case. We spoke about this and she repeated on two occasions that the score reflected how she was feeling. I feel that after my questioning the difference of CORE-Net score and what the client was saying, that she does feel able to cope and supported’ (TH: Phoebe). The inconsistency that therapists perceive between the CORE-Net score and the presentation of some clients in the therapy room remains an area of concern for therapists, particularly in relation to knowing when to end therapy and they discuss this in supervision.

5.4.3 Therapists perceive that clients ‘like the visual graphs’. (Theme 3)

Therapists perceive that clients both ‘like the visual graphs’ and are able to ‘engage with them’ (5/5). Clients seem happy to complete the forms, particularly when there are ‘fewer questions’.

Clients appear to like the visual graphs and engage with the process

When therapists ask clients whether the scores are accurate representations of how they feel, they generally say yes. Therapists perceive that clients like ‘being able to see her progress over the weeks’ (TH: Selaye), can explain any changes in the score and also play a more active part in thinking about what changes need to be made to reach the healthy scores: ‘the visual aspect was helpful, it confirmed to her how she was feeling and we talked about making sure she does not deteriorate any further and how we can achieve that’ (TH: Sally). Clients seem ‘reassured’ when ‘the graph confirmed her experience’ (TH: Tamsin) and ‘pleased’ and ‘encouraged’ when the graphs show improvement: ‘she could see the effects of the changes she had implemented and could see the CORE-Net scores moving in the right direction’ (TH: Selaye). Even when clients appear ‘a bit disappointed’ when the scores show deterioration they can still explain why this has occurred and make meaning of it: ‘she saw the score as indicating she had more work to do’ (TH: Selaye). It may act as a prompt for them to discuss ways of changing and ‘as a spur for her to take action’ (TH: Selaye).
Clients seem ‘happy’ or ‘content’ to complete CORE-Net

After a while, therapists perceive that clients anticipate that they will have to complete CORE-Net, and are pleased when they find out that it is a shorter form (3/5). At other times, clients actively choose when in the session to complete CORE-Net: ‘she had described her current problems in detail and then paused as she was upset. She said that she thought it would be a good idea to do CORE-Net at that point while she gathered herself together’ (TH: Selaye).

5.4.4 Therapists find difficulty in using ARM-5 (Theme 4)

Therapists are initially anxious about using ARM-5 (2/5). They may be anxious or ‘embarrassed’ about using ARM-5 in sessions and introduce it ‘without much explanation’ (TH: Tamsin) and ‘with resistance’ (TH: Tamsin) (1/5). They sometimes ‘forget’ to ask clients to complete it suggesting ambivalence (2/5).

Therapists introduce ARM-5 to clients in different ways at end of the session

Therapists introduce ARM-5 to clients in different ways, but all ask the client to complete it at the end of the session. Generally therapists introduce the idea of ARM-5 at the beginning of the first session and then ask clients to complete it as the last thing in the session, after arranging a date for the next session. Some introduce ARM-5 to clients as a research project (2/5) which may create some distance from it. Others focus on the benefits for the client. This may be as a way for the client to ‘show how she felt the session had gone and how our relationship had been for her’ (TH: Selaye) (4/5) so that ‘if she has any concerns about us working together… we could try and change it or find a solution’ (TH: Selaye). Or it could be as a way to make sure that the client ‘is getting what she needs from our sessions’ (TH: Sally) (3/5) and the ‘importance for her to name or recognise what she needs within the therapy’ (TH: Phoebe). Generally therapists introduce ARM-5 as a combination of these. Once clients have completed the form a couple of
times, therapists find that they no longer need to introduce it because ‘the client already knew what to expect so she just did it’ (TH: Sally) (2/5).

Therapists engage with and use ARM-5 to different degrees.
Sometimes they calculate the score but ‘did nothing with it during the session’ (TH: Tamsin) (1/5). Often they notice the score and reflect on the session but do not discuss it with the client (4/5) or actively engage with the forms and discuss the scores with clients (4/5). Sometimes they may also use it to inform them about the client (1/5) and this seems to reflect whether they see ARM-5 as adding any value to their work.

Therapists question the validity of ARM-5
Therapists not only question the validity of ARM-5 but also express resistance to using it in sessions (4/5). They are ‘not sure about its value’ (TH: Sally) and question clients’ ability to be ‘honest’ in their ratings, particularly when they then cancel or end therapy abruptly.

Therapists feel that ARM-5 is ‘generally unhelpful’
Therapists not only feel that ARM-5 is ‘generally unhelpful’ but they are ‘not sure about its value’ (4/5). To some therapists, ARM-5 feels ‘uncomfortable’ and frustrating, and they appear ambivalent in the way they ‘took it from her & left it on the side’ or ‘did nothing with it during the session’ (TH: Tamsin). In some cases therapists forgot to ask the client to complete the form altogether: ‘my forgetting must be an unconscious resistance’ (TH: Tamsin). Therapists resent ARM-5 taking time in sessions or causing them to overrun.

Therapists see some benefits to using ARM-5 in sessions
Therapists are able to see that there are some benefits to using ARM-5 in sessions (4/5). ARM-5 can highlight the therapeutic relationship, provide confirmation that the client is getting what they
need and provide clues about the client from the way they answer the form which can then be discussed in therapy. The score also has an emotional impact on the therapist (2/5).

**It highlights the therapeutic relationship**

ARM-5 is felt to highlight the therapeutic relationship and allows the therapist to 'question my felt sense and the client' (3/5). Along with CORE-Net, ARM-5 'indicates and visually demonstrates the working relationship and the client's progress' (TH: Phoebe) and 'it has enabled me to work with more focus on our therapeutic relationship' (TH: Phoebe). ARM-5 can help identify when there is need for improvement, 'I know there is room for improvement, especially in her view of whether she has faith in my ability as a therapist' (TH: Jennifer), as well as whether the relationship is getting better.

**ARM-5 confirm that the client is getting what they need**

Therapists agree that ARM-5 can confirm that the client is getting what they need and this can make the therapist feel good (3/5). When the score is high the therapist may feel good: 'I also felt heartened by the full score' (TH: Phoebe) and 'I was amazed and grateful (after client left)' (TH: Selaye). In instances where the therapist is unsure if the client is getting what they need, ARM-5 can indicate that 'even if I was wondering whether she was getting any benefit from the session, she seemed to suggest she was in the way she scored it' (TH: Jennifer). Sometimes therapists make inferences about the client based on the scores they give: 'taking note of the improved score – which I took to indicate that the client felt as though her needs were being met' (TH: Phoebe) and 'I wondered if it indicated that she had found the therapy useful' (TH: Phoebe). Discussing ARM-5 scores with gives them the opportunity to confirm how they feel and thereby reassure the therapist further: 'She had confirmed in the session that she had found our sessions helpful and that it was a shame we could not continue. As such I was less surprised that she rated the session fairly highly.' (TH: Jennifer).
5.4.5 Therapists perceive that clients are not engaging with ARM-5 (Theme 5)

Therapists perceive that clients are not engaging with ARM-5 but come to expect it. Therapists wonder whether clients 'can be honest' in their ratings, and therefore question the validity of the ARM-5 (3/5). Therapists often explicitly encourage clients to be 'as honest as possible' when completing ARM-5 (4/5). However, when clients ask if they should 'be honest' and show 'anxiety' at doing so, or when the scores they give are always the same, therapists are left wondering 'whether they would feel ok about not giving me top scores' (TH: Sally). When therapist's "felt-sense" of the session feels incongruent with the client rating, it adds to their ambivalence about ARM-5: 'I feel we have made little progress even though the client has consistently scored me high – this feels incongruous' (TH: Tamsin). This may be further compounded when a client cancels sessions or ends therapy abruptly, 'especially in the light of her enthusiastic ARM-5 scores', leaving a therapist confused and feeling 'that it ended without any resolution to the question of why she didn't attend when she rated the sessions at the maximum on ARM-5' (TH: Selaye).

5.5 Summary and Conclusions to OH Therapist Diaries of new CORE-Net users

Therapists are initially anxious about using CORE-Net in sessions and generally introduce it as part of a research project or something new. They experience some practical difficulties associated with IT, room layout and timing of CORE-Net in sessions and seek guidance in supervision about how to integrate CORE-Net into sessions more comfortably. Therapists vary in whether they ask clients to complete CORE-Net at the beginning or end of sessions, or try and slot it in more organically. However, they identify difficulties associated with timing in the session - introducing it too early in a session and not having enough information to explore the results fully, or in leaving it too late and becoming anxious about running out of time. This takes some trial and error.
Once therapists have used CORE-Net they generally begin to identify some benefits of using it in a session and these include flagging up risk, tracking a client's progress over time, discussing progress with clients, using CORE-Net to guide therapy – and identify aims for therapy – or using it as a focus in a session, whether this is in the therapy room or on the phone. They can also see that clients like the graphs and can engage with it and take more responsibility for their progress.

Therapists continue to be sceptical about using CORE-Net in sessions and question what value it adds to their work. This is particularly the case when CORE-Net scores appear incongruent with the way the client presents in therapy and whilst they discuss this with clients, they express concerns about using it as a guide for terminating therapy with a client 'too early'. Therapists appear resistant to using ARM-5 in sessions and generally see no, or limited, value in using it, question its validity and sometimes forget to ask clients to complete the form altogether. They perceive that clients are also not engaging with ARM-5 and may find it hard to be honest in their ratings.

5.6 Analysis and elicitation of themes of the Occupational Health therapist supervision sessions

The following is a review of how the interview transcripts were analysed and how this process relates to the five stages of analysis outlined by Thomas (2003). The five stages are identified in italics.

Stage 1: Preparation of the raw data files. I tidied up the transcripts before I began the analysis process.
Stage 2: Close reading of the text. I first read through all of the interview transcripts to get an overall feeling for the experiences, feelings and processes that were being expressed in relation to using CORE-Net and ARM-5 in sessions with clients. This gave me a sense of the bigger picture, an idea of some of the themes and a basis for beginning the categorisation process.

Stage 3: Creation of categories. Once I had tidied up the transcripts I began the process of categorising. I identified sections of the text where therapists included references to the process of using CORE-Net and ARM-5 and associated feelings and experiences, for both themselves and that they perceived from their clients. After reading the transcripts, I identified twelve themes as follows:

1. Therapist process and practical issues;
2. Therapist anxieties and resistance — emotional experiences;
3. Therapist perceived positives of CORE-Net;
4. Therapist perceived negatives of CORE-Net;
5. Therapist perceptions of client experiences — positive;
6. Therapist perceptions of client experiences — negative;
7. Therapist perceptions of CORE-Net: post focus-group (i.e., at the end of the trial period);
8. ARM-5 — therapist anxieties;
9. Therapist experiences — positive;
10. Therapist experiences — negative;
11. ARM-5 — Therapist perceptions of client experiences; and
12. Therapist perceptions of ARM-5 — post focus-group (i.e., at the end of the trial period).

I then began to cut and paste quotes from the OH Therapist interviews into a new document under these twelve category headings. It soon became obvious that these categories were not
unique and that many of the quotes fell into several of them. In addition to this, once the quotes were split down they lost meaning and wholeness. It was at this stage that I then re-read the transcripts and free-associated categories and sub-categories in an attempt to re-focus my mind and gain a better picture of the transcripts as a whole (back to Stage 2).

Once the texts had been re-assigned under categories and sub-categories, I then went through each of these to identify whether they would stand-alone or needed to be merged for the main report. An example follows:

Example: The following quotes were identified as relating to therapists feeling anxious or resistant to using CORE-Net in sessions. Within this, the quotes also suggest that after initial sessions therapists may either feel more comfortable and interested in using CORE-Net, or they may continue to feel reserved and resistant:

SELAYE: I was incredibly nervous in week one and I think the interesting thing is because it all went wrong.

TAMSIN: I feel extremely anxious; I feel it’s going to pull me in a direction I don’t naturally go at all. I’m going to be pulled right in another direction. So I can’t, my thoughts are, my anxieties are that the client will get a very poor experience from me because I feel I will be not working in a way that I feel I work best.

SALLY: Very mixed feelings, I guess before she walked in I was quite anxious, thinking will I get it all right will I do all the right things. Ok, so I felt nervous I think what I did was tell her this is also the first this my first you know my first person I am doing this research with, so that sort of made me feel a bit settled in it and then after that it seemed to go alright, seemed to go alright, she wasn’t sure about the
SALLY: I still have reservations. I think I still need to have worked with it for much longer period.

In the same way as above, each section of text within the interview transcripts was reviewed to identify what the therapist was saying and what other meanings could be identified within this. As part of the analysis I also looked at the individual therapist journeys using CORE-Net and ARM-5 over the trial period from what they had said in their interviews. Whilst individual journeys are not reported in this thesis, they were used to identify the structure of the report in terms of linear progress and importance of the sub-categories.

Stage 4. ‘Uncoded text’ – text that is not relevant to the research aim. In the process of re-assigning quotes under different category headings (Stage 3 above) I also deleted some text from the supervision interview transcripts where therapists were solely talking about clients’ problems or stories as these were irrelevant to the process. I also deleted segments of the text where I felt that the researcher was “leading” the discussion or giving their own opinions because I wanted to focus on the actual experience that the therapists expressed.

Stage 5: Continuing revision and refinement of category system. Throughout the writing of the findings, I continued to refer back to the transcripts to make sure that I had not missed any key points. I integrated quotes from therapists to improve the descriptions and finally ended up with seven main themes which will be described in the next session.

5.7 Findings of Therapists’ Supervision Session of new CORE-Net and ARM-5 Users - 6 months (SS-OH)

Five therapists in OH were involved in the current research project to explore the processes, experiences and feelings of therapists and clients using CORE-Net and ARM-5 in therapy. In addition to completing process diaries, and taking part in a focus group discussion towards the
end of the trial period, therapists were also regularly interviewed by the researcher in routine clinical supervision sessions – about their experiences of using CORE-Net and ARM-5 in sessions. I will only discuss the themes with illustrative quotes that are adding to the existing data already discussed in the OH focus group and therapist diaries. Table 5-2 is a summary of the main themes of the Therapist Supervision Sessions.

Table 5-2 Themes of Therapists Supervision Sessions

| (1) Therapists are initially anxious and resistant |
| (2) Therapists can identify positive uses for CORE-Net in therapy |
| (3) Therapists perceive that clients like the visual graphs and engage with CORE-Net |
| (4) Therapists are concerned about being assessed |
| (5) Therapists initially anxious about using ARM-5' |
| (6) Therapists perceive that clients feel 'anxious' completing ARM-5 |
| (7) Therapists will generally not continue using ARM-5 |

5.7.1 Therapists are initially ‘anxious' and resistant (Theme 1)

It is a change to the way they work and it feels uncomfortable. However, they tend to feel less anxious after they have used CORE-Net in a couple of sessions.

Therapists feel ‘more confident' and ‘more comfortable'.

After using CORE-Net for the first time. They find that the experience of using CORE-Net in a session was ‘not too bad’ (TH: Tamsin) or ‘about what I expected’ (TH: Sally) but not generally worse than they anticipated. As such, they feel 'more confident, more comfortable because I've done the first one' and that 'I had a bit more of an idea of what I needed to do and how I needed to fit it in’ (TH: Jennifer). Seeing clients engaging with CORE-Net also helps: ‘that was quite
useful for me that my first client was quite interested to see a chart you know what I mean some people don't want it and some people do.....So that was quite, so that relieved kept my anxiety down a bit' (TH: Tamsin). Once they start using CORE-Net, some therapists begin to feel 'intrigued' and find 'I am warming up quite well to the CORE-Net and looking at on a weekly basis or on a per session basis on the level of stress and how they are getting on and I found it very interesting' (TH: Sally) whilst also continuing to struggle and 'have reservations’ (TH: Sally).

Concerns about timing of CORE-Net introduction into

How and when to introduce CORE-Net into a session is a concern therapists raise along with related implications on timing and the therapeutic relationship. Therapists may ask clients to complete CORE-Net at the start of a session, wait for a ‘natural break’ in conversation, or actively choose to leave CORE-Net until the end of a session.

Therapists experience CORE-Net as time consuming and getting in the way

Therapists experience CORE-Net as taking longer to complete and taking time out of the session or getting in the way. Therapists struggle to balance CORE-Net and having time to discuss the clients issues. They find that the CORE-Net 34-item form takes a long time to complete, but the shorter forms can also take up time in the session when clients are slow to complete it or when clients talk a lot about what they have rated: 'I'm finding the time very reduced' (TH: Tamsin) and 'I suppose with the other client, no, with the other client she's quicker on the computer but she has a lot to say so I feel you know that all of her time would be needed and it's a reduced time because of that so I'm finding that quite difficult' (TH: Tamsin). Sometimes they worry about not having time to fit CORE-Net in, 'I think the difficulty from my point of view has been actually fitting it into the session for someone who talks an awful lot' (TH: Selaye) and then running out of time in the session.
Therapists look for ‘organic’ ways of integrating CORE-Net into the session

They try to wait for a ‘natural break’ (TH: Selaye) in conversation and then suggest to the client that they complete CORE-Net to find out whether it ‘shows the same sort of things that she’s been talking about in the session’ (TH: Selaye). This can be difficult to do for someone who talks a lot and the therapist becomes aware that time is running out. As a result, the session may run over time.

Therapists actively choose to introduce CORE-Net later in session

Therapists sometimes actively choose to leave CORE-Net until later in a session and this can be beneficial. There are times when a therapist notices a client ‘back off’ and makes an active decision to continue to develop the therapeutic relationship rather than to rush in with CORE-Net. This has implications for being guided by the client, rather than by the need to get CORE-Net done in a session: ‘I noticed him back off and I just felt that I would not engage him as a person at all if I carried on, so I didn’t use CORE to begin with. I used it at the end and so the session was about him developing trust with me’ and ‘if I’d done the CORE before that I would have missed it completely and I think the session would have developed in a different way and would have missed that very important component’ (TH: Phoebe). At other times a therapist might leave CORE-Net until the end of the session when they sense that work needs to be done on the therapeutic relationship, or this has been indicated by ARM-5 scores, ‘I introduced it at the end with her and I think the reason I did that was because the ARM score in the last one we hadn’t met so I wanted to meet her very strongly in today’s session which I managed to do (Th. Phoebe.) by keeping CORE-Net out of the way for a bit’. (TH: Phoebe). This focuses on the therapeutic relationship and can have a positive impact on it.

Therapists have concerns about using CORE-Net scores to end therapy

Therapists raise concerns about using CORE-Net alone to bring up endings with clients just
because they are in the healthy range. Therapists identify certain instances in which CORE-Net scores need to be mediated by their knowledge of the client, context and personal judgement when considering endings. Bearing in mind the number of sessions on offer, a therapist might decide that 'it is not appropriate' to encourage a client to experience their full emotions ‘because there isn’t enough time’ to deal with them (TH: Tamsin) and then use their personal judgement on how many sessions to offer. Therapists also want to check that clients' progress is consistent over a couple of weeks’ before they make a decision and discuss ending with a client.

**Therapists take individual client needs over CORE-Net scores**
Therapists take into consideration the context of the client and may decide to override the CORE-Net score in certain circumstances. This could be the case if they feel the client 'is still vulnerable' (TH: Phoebe); has a longer-term physical illness like cancer; if they are grieving (bearing in mind the grieving cycle) and may need further support; if a client has a longer-term mental health issue and has been 'zigzagging in therapy, or if they are waiting for longer-term therapy and need support in the meantime. At these times, they may continue to consider the CORE-Net scores and chart the client's progress but will not base decisions on it, 'so i think not ignoring CORE NET aspect but I'm taking it into account the other stuff'. (TH: Phoebe). They will use CORE-Net scores in conjunction with their own 'felt-sense' and personal judgement in working with the client and deciding whether it is appropriate to encourage the client to be more honest in their rating or leave it because this is short-term work, or to broach ending with the client. Therapists discuss these dilemmas in supervision.

**Therapists want control of how to use CORE-Net in order to continue using it**
Some therapists would continue using the online version of CORE-Net whilst others continue to have 'mixed feelings' about it. However, they want to retain control in when and how they use it between the first and last sessions.
Therapists would continue to use CORE-Net as a measure at the beginning and end of a contract, as long as they 'have the individual choice' when and how they use it in between. 'It has different levels of value with different clients and I can see that with some clients it would be very valuable, but with others it seems to make the sessions more difficult and to impose something on the session' (TH: Selaye). ‘I wouldn’t use it every session’ (TH: Sally). They might use it for clients that are not aware of themselves or their patterns of behaviour: ‘I think it would be useful to see it ....Visually and also feel that clients who aren’t aware of themselves. It depends if there seems to be a feeling of clarity with me and with the client and we don’t need it then that’s fine. If there’s some discrepancy either with themselves like them not, like I’m feeling there’s a lot more going on here than I’m being shown then sometimes the questions can be very useful as eliciting more information’ (TH: Phoebe)

5.7.2 Therapists can identify positive uses for CORE-Net in therapy. (Theme 2)
They find it useful for focussing sessions, identifying risk, tracking the client’s progress, identifying patterns of behaviour or inconsistencies in the client. They recognise that clients engage with the graphs and see CORE-Net as a way for the client to 'take on board some of that responsibility' (TH: Sally).

Therapists clarify CORE-Net inconsistencies
Therapists can clarify inconsistencies between CORE-Net scores and client presentation in the therapy room. Sometimes it seems that a client may be interpreting and rating the questions in a way that only focuses on one part of their problems so the CORE-Net score is not representing the whole picture, ‘I don’t think it gave representative idea of where she is because talking to her later it was evident that a lot of the focus was being put on the work but actually it’s a much broader issue’ (TH: Jennifer). Therapists can explore these inconsistencies with the client: ‘so she’s gone down to the healthy range and the minute she filled it in she then started saying how
anxious she was. So I explored the difference with her and she said that she was feeling very healthy but she was feeling anxious' (TH: Phoebe) and proceeded to explain why and that if asked to complete it again, 'she would still fill it out the same way' (TH: Phoebe). This can give therapists a better understanding of the client which they can then use when considering their wellbeing as a whole and whether to consider ending therapy.

**CORE-Net can help therapists identify patterns of behaviour.**

'It has allowed us to look a lot at her thought processes and also how those are reflected in her language', and to see that 'reflected in CORE-Net as well as what she is actually saying in the session' (TH: Selaye). This gives the therapist a better understanding of the client and can focus a session.

**Therapists use CORE-Net to triage when to end or give more sessions**

Therapists can use CORE-Net to explore ending therapy, to limit the number of sessions offered, or to extend therapy. When a therapist sees the client is in the healthy range and is thinking about ending therapy but is not sure that the client is really ok, tracking their progress over a few weeks can reassure a therapist that it is ok to end, 'I wasn't sure what was happening but now I am fairly confident that she's fine'. CORE-Net can also be used to explore ending with clients who seem to be 'stuck' and who may need longer-term therapy, by showing them their 'stuckness' on the graph and discussing alternative forms of support for the future. If the graph shows deterioration in a final session and a client expresses anxiety at this, the therapist can use it to offer more sessions, 'her score had gone up and what was difficult which is why I've offered her another final session is because that would have been her ending session. She was also quite anxious about the fact that it should have been her last one as well because she was feeling so in such a difficult place and her scores then, and so her graph is sort of going down and then up and here we are meant to be ending. So she and I have taken a couple of weeks to
do like and have a follow up one, but I think it sort of confirmed her anxiety and how she feels that she needs quite a lot more support’ (TH: Tamsin).

5.7.3 Therapists perceive that clients like the visual graphs and engage with CORE-Net.

(Theme 3)

They can explain why changes have occurred, reflect on the changes they have made and feel that their experiences are ‘validated’ by the score. They seem ‘reassured’ when the graph shows improvement and ‘disappointment’ when it shows deterioration, even though they might expect it.

Clients may appear emotional or mechanical in completing CORE-Net

Sometimes clients appear emotional when completing CORE-Net but at other times they seem to complete it in a ‘mechanical way’. Therapists comment that, ‘she was just feeling emotional and I think each question was making her feel a bit more emotional because, oh yeah, suppose I don’t ever feel this’ (TH: Tamsin). However, other clients seem to complete it in a ‘mechanical way’, ‘assessing their own feelings’ (TH: Sally) and it is only when they start talking that emotion comes in.

Clients like the visual graphs

Clients like the visual graphs and ‘engage’ in exploring what they mean and what they need to do to bring about changes. Therapists comment that clients seem ‘very much engaged in seeing the graph and saying “yeah that’s how the week has been for me, I can understand why the graph is as it is”’ (TH: Selaye). They are ‘quite keen to track her progress on the graph’ (TH: Selaye) and can explain why changes are happening and take an active part in their progress and exploring ways of bringing their CORE-Net score down: ‘I said what can she do to bring it down and that worked because that’s what she’s been doing all week and during the session
she gave me examples of everything that she’s been doing’ (TH: Phoebe). They can then see the results of the changes they are making, ‘she’s seeing visually her process of coping and finding that extremely interesting’ (TH: Phoebe) so ‘CORE-Net visually has been very informative for her and for me’ (TH: Phoebe). In doing so, ‘I think that they are feel proactive, they feel they are a part of that process of getting better’ and ‘take on board some responsibility as they see it going up and down’ (TH: Sally).

**Therapists perceive that clients find graphs reassuring**

Clients find the graphs ‘reassuring’ when they confirm how they are feeling, and ‘proud’ when the score shows an improvement. For some clients the score ‘confirms’ what they already know, and ‘there’s an element of reassurance I think for the client, seeing it. It’s almost an affirmation of how they are feeling, like they can trust their feelings because it’s affirmed’ (TH: Sally). Clients seem to ‘feel encouraged by the graph’ (TH: Sally) and it ‘gives them something that validates their experience’ (TH: Sally). When clients see positive changes on the graphs they are pleased, ‘when she saw the score when she saw the graph, she smiled and she felt good and she felt proud and its just I thought you know it’s good, so she felt good’ (TH: Phoebe). However, there are times when therapists perceive that clients themselves are questioning the score, ‘I’m not entirely sure if she thought that the improvement shown in the graph actually reflected what she felt. She sort of looked at the graph and said ‘oh that’s nice but if I’m showing that improvement why do I still feel so awful’ (TH: Selaye).

**Therapists perceive clients may be disappointed when there is deterioration**

Clients appear shocked or ‘disappointed’ when the graphs show high scores or deterioration, even when they have predicted the outcome. Therapists perceive that seeing the CORE-Net scores on a graph can, be ‘a bit of a shock to her I think’ (TH: Selaye) and ‘sometimes it’s alarming for them’ (TH: Tamsin). However, ‘it doesn’t really tell them anything they don’t already
know' (TH: Tamsin) and clients can often accurately predict whether the graph will go up or
down before they complete CORE-Net, ‘Yeah they kind of say oh it’ll be better or it'll be worse or
what ever and ninety nine percent of the time that appears to be the case, so it feels as though it
doesn’t really surprise them. Do you know what I mean which is, which is good I guess because
then they feel it's as they thought’ (TH: Tamsin). Even when the graphs show deterioration they
can make meaning of it and explain why it has occurred and what they need to do to change:
’she explained that she knows that she has to make a number of changes. so she feels that the
deterioration is a record of the fact that she has been doing difficult things and that it is difficult
for her to do and it’s been quite stressful for her’ (TH: Selaye). As such, rather than seeing it as a
negative, deterioration seems to engage a client in their own process.

5.7.4 Therapists are concerned about being assessed (Theme 4)
They feel that when being used as a measure of therapist success, client context should be
taken into account, ‘and actually give the space to discuss clients rather than just looking at the
ending of what measures say’ (TH: Sally) because ‘Yeah you know very well also that the ups
and downs have some most of the time nothing to do with what's actually going on in the
session but more what’s going on for the client’ (TH: Sally)

5.7.5 Therapists may initially be anxious about using ARM-5 (Theme 5)
Therapists may initially be anxious about using ARM-5 in sessions and introduce it as something
for the client, whilst asking them to be 'honest' Whilst 'it didn’t feel too disruptive or too scary' it
can still feel ‘a little bit awkward, still a bit awkward, so its just another thing to have to do at the
end” (TH: Jennifer) particularly as some clients come to expect to have to complete it. They may
feel anxious about time running out in a session, ‘I found myself feeling anxious, I was aware of
time running out’ (TH: Tamsin) or concerned about the way clients feels completing ARM-5. As
such, they may introduce ARM-5 as something to benefit the client, as a way for them to ‘make
sure that we are both communicating well with each other’ (TH: Sally) or that it is important that 'you kind of feel comfortable in the way that you’re working with the therapist' (TH: Jennifer).
They try to reassure them and encourage them to be honest in their ratings, 'it's important that you just be honest' (TH: Tamsin).

**Therapists may monitor scores without discussing with client**

Therapists may look at the scores to monitor their relationship with clients, but not discuss this with the client. Therapists might not discuss ARM-5 scores with clients if they feel that the scores are high and always the same. However, they tend to look at the scores themselves and use it to inform them about the therapeutic relationship, the client, or whether the client is engaging with the process, 'she's engaged yes, the score she gave was sevens'. (TH: Phoebe). ARM-5 scores can be reassuring if the therapist is unsure whether the client is getting anything from the therapy, and they interpret from the ARM-5 scores that 'it seems like she's getting something' (TH: Jennifer). Low scores can feel like failure and can be hard to experience; however, they can also give the therapist an indication that work needs to be done on strengthening the therapeutic relationship. The therapist can use this information to their advantage, such as by leaving CORE-Net until later in the session, and using the ARM-5 score to monitor whether the relationship has improved.

**Therapists might discuss ARM-5 with clients and thereby clarify the scores.**

Discussing the ARM-5 score with them is an opportunity to confirm that they are finding therapy useful and can also put the therapist's mind at rest if they remain unsure what the client is getting from therapy or why the score is less than full marks, 'we did talk and she said that it wasn't fair to give full marks the first time anyway' (TH: Sally).
Manner of client completion of ARM-5 informs therapist

The way that clients complete ARM-5 can provide therapists with information about the client. The scores may suggest that the client is 'compliant' or has 'low self-esteem' which can then be explored with the client.

Therapists question whether ARM-5 adds any value to their sessions with clients

'I still really, ARM-5, I'm sure it has some value but I'm not sure that there is much value in it in all honesty' (TH: Sally). Even though ARM-5 may provide therapists with information about the client's patterns of behaviour, they feel that they do not have time to explore these in short-term work, 'it's very hard to engage with that in such short-term work I think. I mean I've commented on it but it's so difficult in just a few sessions, given that she's coming full of other stuff, to get into that' (TH: Tamsin). As such, 'the awareness can be created but there isn't the time to work with it really given that they often come in with a mountain of other stuff and that's what they want to focus on in the moment' (TH: Tamsin). Therapists feel that they already know how a client is feeling so ARM-5 does not add anything new, 'you know it anyway, so for them to write it doesn't, it either confirms they haven't the courage to speak out which you kind of know in the work anyway, or they vote with their feet by not coming back because they hadn't the courage to' (TH: Tamsin).

Therapists question the validity of ARM-5.

They do this when ARM-5 has 'been consistent, it hasn't changed' (TH: Phoebe). Or when they are surprised by the score because 'I just don't know if she's getting anything from the sessions' (TH: Jennifer). They also question how 'accurate, how genuine the answer is' (TH: Tamsin) because they notice that some clients seem 'anxious' about being honest and wonder if clients feel that they can be honest.
Therapists sometimes forget to ask clients to complete ARM-5

Therapists may ‘forget’ to ask clients to complete ARM-5 if they feel that the scores never change and it starts to feel ‘tedious’: ‘the thing that seems to be difficult and to the point that I forgot to give one in one session to somebody was, is the ARM thing because they just seem to do the same thing every single time regardless, I’m not sure, I’m not sure how accurate, how genuine the answer is but however they start they just seem to follow the same route. So it feels kind of tedious in a way’ (TH: Tamsin); However, in supervision therapists can reflect on their reasons for forgetting and whether there are resistances at work in the client that may have impacted on their ‘forgetting’. This can give them some insight into a client’s behaviour or patterns, such as clients who are ‘keeping relationships at bay’ and ‘maybe something that I’m picking up on that would be too intimate. I don’t know, it would be asking him about relationships. I don’t know actually but it’s interesting that I forgot’ (TH: Phoebe). However, again they may not have time to explore these issues in any depth in short-term work.

5.7.6 Therapists perceive that clients feel ‘anxious’ completing ARM-5 (Theme 6)

Therapists perceive that clients feel ‘anxious’ completing ARM-5 and refusing to complete it might be ‘therapeutic’ in itself. Whilst therapists ask clients to be as honest as possible in their ratings, they sometimes perceive that clients feel ‘anxious’ about completing ARM-5 and that this may be intensified if a client has a need to please, low self-esteem, or experiences feelings of rejection and may find it ‘too risky’ to say what they really feel. Sometimes clients refuse to complete ARM-5 and just allowing a client to say ‘no’ could be considered therapeutic in itself, ‘she won’t use ARM’ and ‘her underling core thing I believe is rejection. It is intolerable. And fear of... Yeah. I think ARM might be useful for her in a longer term therapy where it would become therapeutic for her to have the confidence to say...as part of the work; but at the moment I think it’s too risky for her and it’s also her way of saying ‘no’ which I think is therapeutic’. (TH: Phoebe).
Therapists perceive that clients do not engage with ARM-5.

When therapists discussed the scores with client they found that ‘she didn’t seem to want to engage with it really, she just said oh well yeah yeah and then she changed it. I raised that and she said well yeah, she didn’t really and I didn’t know whether she was just trying to be seen to be a bit more critical I don’t know really. So I felt she fell into the same category in a way as the others who were just doing it because it felt like she was just doing the same thing all the time. It didn’t seem like she particularly thought about it or wanted to think about it with me’ (TH: Tamsin). Others clients may appear to give the same scores without really engaging with it, and ‘just say the 6, 7 or whatever it is, 77177 every time without really thinking about it’ (TH: Tamsin).

5.7.7 Therapists will generally not continue using ARM-5 (Theme 7)

They are relieved that ARM-5 will not be mandatory: ‘I feel very pleased about it being an individual decision to use ARM-5 because I didn’t personally find that particularly helpful’ (TH: Selaye). Many felt that ‘it hasn’t proved useful to me’ (TH: Selaye) ‘I don’t think I’ll be using ARM, it hasn’t shown any variation at all from my clients that I’ve used it with’. (TH: Selaye) Therapists perceive that some clients find it difficult to answer honestly and that ‘if they feel that they are not happy or they don’t feel it’s a good fit they may shy away from doing that and give top marks just because they don’t know what to do about it’ (TH: Sally). Therapists therefore question whether it is useful or valid other than for indicating something about the client themselves, or their patterns of behaviour, which there may no time to focus on in therapy.

Therapists would prefer to ‘ask clients directly about the relationship’.

This is because ‘it seems easier I think to have a dialogue’ (TH: Selaye), or to use ‘my own gut instinct’ (TH: Phoebe).
Therapists may continue using ARM-5

Therapists may continue using ARM-5 'as another tool to help us look at what's going wrong in the relationship'. (TH: Sally). I think if I feel that there is a miss match I would tell my client I will give it to her or him, tell her this is a questionnaire that might help us both look at what's going on between us that may not be working, I might give it to her to look at home and think about it and (Th. Sally.) Bring it back with a view of not even handing it to me but looking at it and maybe we talk about it together' (TH: Sally), but not every session.

5.8 Summary for Occupational Health Therapists' Supervision Sessions

Therapists have some difficulties using CORE-Net in sessions to begin with but overcome these with practice, trial and error and supervision. They can see some positive aspects to using CORE-Net in sessions and in spite of also identifying some concerns or ongoing resistance, they would be happy to continue using CORE-Net after the trial period – as long as they can decide when and how often to use it.

Whilst some therapists can identify that ARM-5 indicates times when they need to focus more on the therapeutic relationship, they generally question the validity and value of using it in sessions. They wonder whether clients are being honest in their ratings, feel that there is lack of time in short-term work to explore issues about the client that are raised from the way they complete ARM-5, and they would rather ask clients about the relationship directly in the session. Therapists who were asked at the end of the trial would generally choose not to continue ARM-5 in their work with clients, although they might use it as another tool for exploring the therapeutic relationship on an ad-hoc basis.
5.9 Results of the interview with I-DAVID

David is a PCC therapist who started with the PCC setting focus group and was part of the longest users of CORE-Net and was on the eve of delivering the training to the non-CORE-Net users in his team who were interviewed individually by the researcher and whose results are seen in the section under I-PCC. David was asked to interview the researchers’ team at the end of the trial period and these results are under the section FG-OH. David was then interviewed by the researcher as a key informant to discuss what learning can come through his observation of his own team (FG-PCC) and the (FG-OH) which he had interviewed. This interview with I-David took place later in the day after he had interviewed the FG-OH. The details of David can be found alongside the demographic details of the rest of his team in Chapter 3 and in Table 3-4. This section presents the results of the interview with David, a primary care counsellor (PPC). I have chose to only present the main themes relating to his recommendations for training and supervision of therapists as the details of the main themes are a repetition of themes already stated in the findings of Chapter 4 and findings earlier in this Chapter.

5.10 Themes of I-David

Overall David’s observations of the OH team and his own team were the OH therapists were more negative now at six months use of CORE-Net and minimally clinically integrating it into their practice compared to his team after 18 months use. He did acknowledge that at six months his own team had also been anxious about the process and especially about the use of the computer in the room.
Table 5-3 Main results of Interview with David

(1) The OH therapists more negative than PCC therapists
(2) The PCC group had integrated its use more meaningfully into clinical practice
(3) The comprehensive training of therapists is essential
(4) CORE Scores inform supervision

5.10.1 The OH therapists were found to be more negative than PCC therapists (Theme 1)
The OH therapists were found to be more negative after 6 months than the PCC therapists were both at around 6 months and after 1.5 years CORE-Net use David expressed that generally were the OH group "can't quite see how it helps them in the terms of the usefulness to them in their work with their client there not really seeing a benefit in using CORE-NET".

5.10.2 The PCC group had integrated its use more meaningfully into clinical practice (Theme 2)
The PCC group had integrated its use more meaningfully into clinical practice and were able to see the benefits more clearly. David observed in comparison to his interview of the OH focus group that his own team in the PCC setting were clinically processing the CORE-Net data in a much more advanced way and using the scores to inform their work and enhancing conversations between themselves and their clients.

5.10.3 The comprehensive training of therapists is essential (Theme 3)
The training of therapists is essential and should include the theory of outcome measurement, practical skills like inputting data, role play of how it may be introduced into a session organically David made several recommendations as to both training and supporting therapists to be better able to engage with CORE-Net. These are discussed in turn.
The appraisal process

David observed the necessity of making it clear to therapists that the appraisal process was not a punitive exercise but one that encourages professional reflection on their cases:

"It's a tool for encouraging professional reflection. It's about ok where at you know where all on a journey learning and developing our practice but we could always do better so we just start on this is our reference point and what can help us to get inch ourselves forward bit by bit by bit so next year I'm a little bit better counsellor than I was this year and so forth and so on."

Counsellor resistance

David saw the need for creating regular group discussions in the early stages to talk about the fears and anxieties of CORE-Net and of being measured as a therapist so that there is a regular forum for the counsellors to air their views once they had started to use CORE-Net in addition to one to one supervision and in a group setting.

So as long as you can pick up on the stuff we've discussed today that they need that regular early stage I suppose you call it supervision, its sort of a group discussion about experiences using it so they address their fears because they have got the, everyone's got fears its not particular to this team or any other team, all the counsellors that are coming at it new are going to have anxieties and it's about drawing those out, working them through and managing them. They're all going to have issues about being measured.

David also raised the issue of fear of IT skills as the possibility of impacting on his team but that in the OH team it appeared to be more to do with the concept of having to produce a computer in the room and the process of client, therapist and computer in the therapy:

One of the things that I guess I discovered from my own team is that where they were weak was in IT skills, a lot of the reason that people haven't volunteered or haven't engaged with it initially when they had a chance is not because they have a problem with the psychometrics and the outcome measurement, they were already sold on that they had a problem with using IT it was back to the same thing here it was about the computer it's the idea of fiddling with a computer in the middle of the counselling session.... The difference here (OH team) is they seem to be quite good at IT, no-body really spoke about IT skills as being an issue for them, what they did seem to have a block with is conceptually the idea of actually just producing a computer into a room
Learning curve

David observed that the OH team used CORE-Net in an 'organic' way or in a way that worked for them so that they could use it 'creatively' and in a way that they could cope with and he encouraged this way of working as he felt there was no right or wrong way to use it with regard to the timing of it in sessions:

OK one last point on recommendations what seemed to come out is that when you ask questions about how they use it the early questions they're all using it slightly differently, and or all doing it slightly differently and had got, one of them, two of them talked about being organic you'll hear that right at the beginning of the tape is that rather then do it at the beginning of the session they will do it in the session when it feels right and they had certain intuitions about how to make this work for themselves and it was their own creativity of how to do that, that need building upon and I think once the others heard about oh I hadn't thought about doing it that way, oh god yeah and this whole idea about engaging their creativity in that you've got a task in your counselling task and the client there's plenty of that there you've got this new thing that's been added on is how can I use my own ingenuity personal ingenuity to make this fit for me.

Training (regular coaching forums)

David specifically raised getting therapists to move beyond the Intellectual understanding of why to outcome measurement and to emotionally engage which would then flow into the clinical practice and that a regular forum for this would consolidate their gains of learning:

But that's why I think, exactly and that's why I think there's a piece of the training process which has to be frequent reflection on the experience of doing it and the data they are getting because if early on in their learning of using CORE NET that this is their practical learning if they are having the experience of well I collected this data but it makes no sense to me and if that continues for any length of time then I think that will undermine any confidence in the value of it. They've got to have done it with two or three clients and then better look at it with a bit of coaching if you like that says or supervision perhaps well lets look at the data and try and make the connection back to the rationales they've already gained and I think that's just some..

5.10.4 CORE scores inform supervision (Theme 4)

Supervision is utilised differently than before in that therapists discuss actual case examples and the meanings of CORE-Net scores of each individual client. He felt that the way his team used supervision seemed to be set up to have meaningful discussion around CORE manual forms pre
and post scores and therefore this should follow for CORE-Net once everyone in his team had been trained:

It's already automatic that you would use CORE information as part of your case description if you were presenting or talking about a case you would always say what the original CORE score was and any other scores. However, because we've got mixed supervision groups where there are people, some using CORE NET and some not using CORE NET, CORE NET was very rarely spoken about specificity we just talk about a CORE score...I think once everybody in the primary care team is using CORE NET then I think it will become more of a feature of supervision.

In discussing his observations of the OH group therapists he noted that when he asked if they talk about CORE-Net in supervision they responded "Oh yes we use it all the time and yes it's obviously relevant to supervision".

5.11 Summary Of I-David
The OH therapists were found to be more negative after 6 months than the PCC therapists after 1.5 years CORE-Net use. The PCC group had integrated its use more meaningfully into clinical practice and were able to see the benefits more clearly but at the same time acknowledging that it is a journey and freely relating how it was for them all initially which was a rocky road but the theme of voluntary use of CORE-Net as therapist as opposed to ‘being told to do it’ seemed to be an important difference in the two groups and resonated by the non-CORE-Net users as very important to bear in mind. The training of therapists is essential and needs to be comprehensive especially with continuous forums for support both during the early learning curves and beyond. The key elements of training should include: The theory of outcome measurement, practical skills like inputting data, role play of how it may be introduced into a session organically. There needs to be a continuous experiential learning process of coaching sessions either individually or in a group. Supervision is key to discussing actual case examples and the meanings of CORE-Net scores of each individual client. The time frame for learning depends on the number
of clients seen per week but on average six months integrate CORE-Net minimally into clinical practice to eighteen months to more fully integrate it meaningfully into clinical practice. Please see Figure 5:1 for David's themes and suggestions for training of therapists.
Figure 5:1 I-David Comparisons

- **Positive metaphors**
  - Octopus
  - Wasp
  - Bird of Prey

- **COMPARISONS**
  - FG – PCC: More positive evidence of clinical
  - Appréciate its use in clinical practice as a clinical support tool

- **I - David**
  - FG-OH: More negative – struggling with concept of Routine Outcome Measurement (ROM)

- **Recommendations**:
  1. Learning curve
  2. Appraisal process
  3. Counsellor resistance
  4. I.T. Skills

- **Negative Metaphors**:
  - elephant,
  - dead weight,
  - rose with thorns,
  - mixed bag of stone and fruit

- Not convinced adds anything to practice aside from risk & assessment
- Don't like ARM at all
5.12 Summary of Chapter Five

This chapter included the analysis and findings for the OH setting therapists’ diaries of work with their clients (TD-OH), therapists’ supervision sessions (SS-OH), and the analysis of the one to one interview between the researcher from the OH setting and David (I-David) from the PCC setting.

From the OH setting therapists’ diaries it can be seen that therapists perceive that clients like to see their progress on the CORE-Net graph, feel reassured when the score confirms the way they feel, and when it shows progress. They seem ‘disappointed’ if the graph shows deterioration. Therapists identify that clients can explain why changes have occurred, whether this is improvement or deterioration, and can talk about what they need to do to improve. Clients seem to engage with and make meaning of the graphs. In terms of how therapists feel about ARM-5, they are initially anxious about using ARM-5 and introduce it as ‘research’ or focus on the positives for the client – of making sure that they get what they need from therapy and from the therapeutic relationship. Therapists ask clients to complete ARM-5 at the end of sessions but sometime forget. They are concerned about the additional time it takes from the session and how sessions may overrun as a result. Therapists see some benefits of using ARM-5, as reassurance that the client is getting what they need from therapy, as an indicator that work needs to be done on the therapeutic relationship and whether this is working. It can also provide more information about the client that can be used in therapy. However, they generally remain sceptical of ARM-5 and question its ‘validity’ and whether it adds anything to the session. They wonder whether clients are rating ‘honestly’ and indeed whether they even feel they can, and are confused when they wonder what the client is getting from therapy, or when they rate ARM-5 highly but then cancel or terminate therapy abruptly.

Therapists perceive that clients are not engaging with ARM-5. They notice they are anxious, or
bored, question whether they can be honest and why they need to complete the forms every week. They seem generally uninterested in the forms, but when asked they confirm that the scores represent how they feel and add no more.

From the therapists' supervision sessions it can be seen that therapists are initially anxious about using CORE-Net in sessions because it feels 'at odds' with the way they like to work, and their way of working. Once therapists have used CORE-Net a couple of times in sessions their anxiety reduces and they become more comfortable using it. Some therapists become interested in using CORE-Net whilst others remain resistant and they discuss these anxieties in supervision. Therapists are initially concerned about practical issues of using CORE-Net in a session, including how to lay out the chairs and move from the computer into the room, what to do if CORE-Net does not work and how to talk about the CORE score. However, they often find their own ways through these difficulties, either with trial and error, discussing the difficulties with clients, or using supervision to practice ways of working with their clients, such as where to place the chairs. This reduces their anxiety.

Therapists also have concerns about when and how to introduce CORE-Net into a session and try different ways of working with different clients. CORE-Net forms can take longer to complete, particularly if the client is slow, or has a lot to say about the score. At times therapist might use CORE-Net at the start of the session, or they might try to be more 'organic' and wait for 'a natural break' in a session. Sometimes they actively decide to use CORE-Net at the end of a session. Therapists identify pros and cons of each of these. At the beginning, the therapist might not have enough information to base the discussion on, but at other times it can be a focus for therapy and an opportunity to get the client to talk about themselves. When therapists try to integrate CORE-Net into the middle of a session 'organically' they might feel anxious throughout the session if the client is talking a lot or time is running out and then the session runs over.
However, the benefit is that they can use CORE-Net as an opportunity to check whether what
the client has been saying is reflected in their score and progress on the graph. Using CORE-
Net at the end of a session may mean that there is not enough time to discuss CORE-Net
scores and progress, but it can be an opportunity for the therapist to focus on engaging with the
client or building trust, which may be more difficult if CORE-Net is introduced too early.

Therapists identify positive and negative aspects of using CORE-Net in sessions. CORE-Net
can be a useful tool for identifying risk, tracking and monitoring a client's progress, identifying
patterns of behaviour or inconsistencies, focussing a session and considering whether to end or
extend sessions with a client. Therapists identify these elements of CORE-Net as helpful in
sessions and they like the CORE-Net graphs which help to inform them about their clients and
guide their work in therapy. However, they also question the validity and usefulness of CORE-
Net at times when they perceive that there is a mis-match between the CORE-Net score and the
clients' presentation in the session and express concern about using CORE-Net to end therapy
with a client. They identify occasions when they feel that they need to use their own judgement
and understanding of the client and the context and make their own decisions about the work
and whether to end therapy or not. This may include if a client is still vulnerable, is perceived as
being afraid of their true feelings, is experiencing grief, long-term psychological distress or is on
a waiting list for counselling. Therapists reflect that they need to be aware of both CORE-Net
scores and their own understanding of the client.

At the end of the trial, therapists that were asked were generally happy to continue using CORE-
Net with their clients as they liked the graphs and the immediate way of seeing the clients
progress. Whilst they are happy to use CORE-Net as a measure in the first and last session with
a client, they wanted to be able to use their discretion in when and how often they use CORE-
Net in sessions in-between. This is because they can recognise that CORE-Net could be useful

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with some clients but experience it as less useful with other clients. However, some therapists continue to have mixed-feelings about using CORE-Net in sessions and want to ensure that they continue to use their own intuition with clients and to find their own ways of using CORE-Net. They also express concern about using CORE-Net as a tool for assessing therapists and emphasise that time should be given to exploring each client as sometimes the graph reflects changes in the client's world, rather than the ability of the therapist. In spite of this, therapists feel that new counsellors should use CORE-Net from the beginning of their work with clients as a way of measuring outcomes.

Therapists perceive that clients like the visual graphs and engage with CORE-Net. They can often correctly predict the change in the graph from week to week, can explain changes shown on the graphs and are open to discussing what they need to do to change. Clients appear 'reassured' when the graphs show improvement, particularly when they have worked hard to make changes, and 'validated' when it reflects how they are feeling. Even when the clients seem 'disappointed' or 'anxious' that the chart shows no improvement or 'deterioration', they can explain why this is and what they need to do to change; it is also often what they expect. Deterioration seems to engage clients in their own progress and to look for ways to improve.

Therapists are anxious or 'embarrassed' about asking clients to complete ARM-5 and feel that they might be 'bothering them'. They tend to introduce ARM-5 as something that will benefit the client or as it being important for the client to feel comfortable with the therapist. They also reassure clients that they need to be as honest as possible. Therapists use ARM-5 to varying degrees with their clients. Generally they will look at the scores and use these to inform them about the client, how well the client is engaging with the therapy, as an indication of whether the client feels they are getting what they need or whether there is room for improvement in the therapeutic relationship. This can reassure a therapist, particularly when they are concerned
about whether a client is getting what they need. This can be enhanced when therapists ask clients about their ratings directly in sessions. The way that ARM-5 is completed by clients can inform therapists about the client, and may be seen as therapeutic even when the client refuses to complete the form.

However, therapists tend to be more ambivalent about ARM-5 overall and feel that it takes time out of the session, does not provide them with any information that they do not already know, and that even when ARM-5 suggests something about the client there is not time to address this in short-term work. Some even forget to ask the client to complete ARM-5 at all. Therapists generally question the validity and value of ARM-5 as they experience that clients are anxious about completing it and might find it difficult to be honest in their ratings, or they give the same scores each week. As such, therapists tend to feel that ARM-5 does not add anything to their work and those asked at the end of the trial said that they would rather not use ARM-5 in the future, but would prefer to ask clients about the relationship directly. However, one therapist did say that they would consider using ARM-5 as another tool for exploring the therapeutic relationship with clients when they felt that they were not working well together.

Therapists perceive that clients vary between feeling ok completing ARM-5, expressing anxiety about it and seeming disinterested or ambivalent about it. Therapists tend to ask clients explicitly to be honest but still experience clients as feeling anxious about being honest and or that it might be too risky for them to give negative feedback. However, being able to say 'no' to completing ARM-5 may also be therapeutic in itself for clients who find it hard to say 'no'. When therapists asked clients about the ARM-5 scores, they found that some seemed disinterested and did not want to explore the scores any further, and they felt that sometimes clients tended to rate the questions without thinking too much about them.
The main findings for the key informant interview with David were that the OH new users were much more negative about CORE-Net than the PCC group. He acknowledges that there is the time difference and that the PCC group also initially had been anxious about CORE-Net use for similar reasons. He emphasised that clinical supervision needs to be focused on clinical outcomes for individual case discussion and that training and support needs to go beyond the theory or philosophy but needs to gain the therapist for emotional engagement with the process for them to be able to see early on through regular coaching sessions the clinical utility of using CORE-Net with clients. This would then encourage clinical integration of CORE-Net into their routine practice. He stressed that as it is a learning curve individual attention is needed for each therapist so that they can become confident in their learning.

5.13 Final Overarching Themes of the Study

The data and subsequent analyses presented in both Chapters 4 and 5 resulted in the determination of several resultant themes. These themes were considered and six overarching themes were developed from these previously mentioned themes and were determined based upon their frequency and prominence in the several resultant themes as the most frequently and most strongly mentioned notions throughout the data:
Table 5-4 Final Overarching Themes

1) Therapists were initially anxious and resistant
2) Therapists adapt ‘creatively’
3) Outcome measures help the client-therapist relationship
4) Clients perceive visual measures as helpful
5) CORE scores inform supervision
6) Proper and ongoing training/support of therapists is necessary

As can be seen in Table 5-4 themes 1) to 4) produced the most data for answering the first aim of the study (i) To elicit the perceptions of therapist (both experienced and trainees) and clients in relation to their use of a system of continuous monitoring of their therapy via a feedback system that includes regular outcome measuring (CORE-Net) and therapeutic alliance measure (ARM-5); and themes 5) for aim (ii) To elicit the perception of therapists in utilising feedback information in supervision and finally theme 6) for aim (iii) To elicit the perception of therapists with regard to the training elements required in the process of implementation of this type of routine measurement in clinical practice.

Figure 5.2 illustrates how the therapeutic alliance may be seen as grounding together all the work that is undertaken through the process of implementation of routine outcome measures from the new users through to the experienced users of CORE-Net and the survival strategies needed to cope with the process. The clients also needing to adapt to engagement with the process of routine outcome measurement.
Figure 5.3 includes the client's view of the therapeutic alliance and their view of ROM as influencing their experience of a satisfactory counselling outcome as well as to some degree influencing their therapist's motivation to engage. Therapists' perceptions are influenced by their motivation to take ownership of ROM which is in turn influenced by seeing the benefits, challenges, whether it is voluntary or mandatory use of ROM, training provided and support via supervision and most important of all their confidence in the therapeutic alliance.

5.14 Summary of the CORE-Net metaphors for both focus groups of six month users and eighteen month users

A journey which a therapist needed to undergo to integrate CORE-Net routinely into their clinical practice became apparent. This journey started with the belief and/or acceptance of the promise of an "illusion of perfection" and the "perfect graph" for each client for the new users of CORE-Net. The reality was that there are many "thorns" along the way such as being anxious about the technology and an internal process like "fighting scrappy baby sparrows" that battle with the "minutia of inputting data" and resistance in not wanting to use it at all which can be seen by feeling like there is no control or choice about using CORE-Net and the metaphor of the elephant and wanting to say to it "stand over there" and expressed similarly in "not sure I want one in my room". Therapists worried about the negative impact on the therapeutic relationship alongside the not knowing how to integrate it into a session, it feels "right in the way" and "takes up a lot of room in the session" for the therapist. These metaphors related to the physical logistics of using CORE-Net into the room and the feeling of intrusion upon the therapy work itself by having a computer in the room as a third dyad alongside the challenge of actually fitting its use into a session with time limits as an additional almost immovable challenge.

This was combined with the feeling of "hard to kind of get to know" because of "lack of experience" and not being "very successful with it" which depicted the internal challenges of
therapists in the early learning curve process of newness and lack of practice resulting in self confidence being adversely affected and feeling incompetent in their work or even impotent as to the choice not to use CORE-Net. After six months use therapists were able to see that it has "some useful parts to it" like pinning down risk, visual representation of client's feelings, allowing an overview of what is going on and instant access to results for both therapist and client. After eighteen months therapists were able to see the more "complex" side of using CORE-Net and the "fascinating parts" which only come through the process of time as "initially not appealing" but becomes "amazing", "changes shape in a way that defies physics" as depicted by the metaphor of the octopus and also the "mature" bird singing in the trees which typifies getting to a place of clinical integration.
Figure 5:2 Therapeutic Alliance

- Therapeutic Alliance
  - Non-CORE-Net users (I-PCC): value risk assessment, speeds up assessment, session tracking, anxious about CORE-Net technology
  - FG-OH new users (6 months): Logistics in room, Anxiety technology, Value Risk Ass.
  - Client diaries
  - Supervision sessions
  - FG-PCC (18 month use): Initially challenging Technology, Logistics in room
  - OH Clients Positive about OM
  - Therapist survival strategies:
    - Use it "organically" and "slot it where it flows" timing wise in session, user flexibility
  - PCC FG 18 months practice integrated into clinical practice
  - Outcome of therapy - Satisfactory
Figure 5:3 Influences that affect Therapists' Motivations for Engaging in Routine Outcome Measurement
The longer the therapist used CORE-Net, the more the recognition of the nuances of its process, its potential to be flexible and complex making the clinical practice fascinating. Therapists were able to still reflect that this was not always the case and that initially it was not an appealing process but now it felt like they had reached a level of maturation which signified better integration of CORE-Net use into their clinical practice.

5.14.1 Overlapping themes of both focus groups
Initially using CORE-Net was less appealing like "fledglings" leading to some therapists feeling a sense of lack of experience/incompetency and/or success with their client cases. All felt it was useful in "initial assessment" and "risk assessment" as a safeguard measure. They expressed liking the "up to date visual picture for client" and "overview of what's going on for therapist". The worrying about the "minutia of inputting data" initially diminished with time and practice as therapists gained confidence with the experience of time. It seemed important for each client session to be seen as unique with different needs and therefore to use CORE-Net "organically" or "slot it where it feels it flows.

Use of CORE-Net for session tracking was a journey that therapists embarked upon and found initially intrusive but with time and practice became more integrated into practice. It was seen as useful for initial assessment and risk assessment. Clients and therapists liked the instant and visual feedback to see the progress but therapists needed to have the flexibility to decide on individual client need how to use it organically in sessions. ARM-5 not useful to therapists as an alliance measure and they would prefer not to use any alliance measure at all but prefer to ask the client how they feel the sessions are going and if their needs are being met adequately. Clients overall are happier with both measures than therapists.
5.14.2 Differences and similarities of themes of both focus groups

There were more similar themes between the six month CORE-Net user group and the non-CORE-Net users group than the themes between the two focus groups which were both core-net users of different durations. The similarities around the non CORE-Net users and new CORE-Net users were around anxieties about the use of technology in the room and the physical logistics of incorporating this into the session with worries of it being intrusive and impacting upon the therapeutic alliance which acted as resistance to starting ROM or once started to be preoccupied with these issues for the greater part of six months. Voluntary participation seemed to be expressed as a key concept in reducing resistance to the introduction of ROM. Although the eighteen month CORE-Net user group did acknowledge that at the start they were also anxious about using the technology and how it might impact in the therapeutic space psychologically and logistically but their themes were more about the complexities of CORE-Net and its use clinically to impact on the therapy. The main differences between the focus groups appeared to be in how the use of CORE-Net is introduced to clients and the ownership of the process; the importance of assessments and how these are viewed and what the information is used for in terms of its usefulness with the new users of CORE-Net seeing less value in this; the newer users seemed to be more confident with their subjective view of client's well being and that the CORE-Net or ARM-5 scores only confirmed this but did not necessarily add to the process. Similarities were around seeing value in CORE-Net alerting one to risk earlier and the value of the therapeutic alliance no matter what ROM system one is using and also how CORE-Net use may enhance conversations around the scores with the client especially when there was apparent incongruence between the scores and how the client presented in the session; introduce CORE-Net 'organically/slot it where it flows'. All therapists could see the benefits of clinical supervision and training in assisting therapists to adapt to ROM. All therapists felt that the client is interested in knowing their scores and seeing their progress and that the visual representation of graphs would be appreciated by clients. Clients confirmed
this aspect of visual representation of their feelings and enjoyed charting their progress and the conversations with their therapists around this and that this complemented the therapy process. They expressed appreciation for the therapist they had which highlights the importance of the therapeutic alliance which was expressed by all the therapists and seemed to resonate with their clients. The minority expressed a feeling of ROM seeing to be a separate process and that clients could hide behind the scores or the technology as this is easier than being asked certain questions face to face which would be harder to lie if you have a good therapist who could sense how you are really feeling by your body language.

5.14.3 The therapist's journey in the process of clinical integration using the initial metaphors

Starting with the metaphors for CORE-Net use they beautifully typify the journey that therapists take in overcoming many obstacles before they can integrate CORE-Net clinically and meaningfully into their practice. The metaphors move from images of an elephant (big, immovable, in the way, intrusive); rose with thorns (illusion of perfection and the expectation of the perfect curve but thorns of the reality of the ups and down of life), mixed bag (fruit like benefits of risk assessment but stones for being hard to swallow or adapt to by changing the way one works), scrappy baby sparrows (initially fighting for getting it right and the pre-occupation with the minutia of detail of the technology and input) and dead weight (heavy, burdensome but some use) to different images of an octopus (fascinating, clever, changes shape and very complex and although initially not appealing becomes fascinating later) a bird of prey (overview, insight) and a wasp (speed of instant results and feedback) through the passage of time and with practice. The scrappy sparrow was an image from the CORE-Net users of 18 months acknowledging the initial journey like 'fledglings' that the OH therapist with six month use had begun and also resonating the feelings of some of the PCC non-CORE-Net users and their reasons for not having joined the CORE-Net team and their ongoing anxieties about their imminent start with CORE-Net. The therapeutic relationship was emphasised both by clients and
therapists as crucial to the work and highlighted as the factor that brought about the therapeutic change.

5.14.4 Differences and Similarities of OH therapists themes in Focus Group and in the Diaries and Supervision Sessions

The Focus group data appeared much more negative than the personal narratives when the same therapists wrote the diaries and the supervision sessions. In particular, the group dynamics in some ways seemed to facilitate discussion on certain threads of conversation by the interaction of the participants but for some threads it appeared to close it down so that once one participant said for example about ARM-5 being 'meaningless' that seemed to get a unanimous vote. In the diaries which were done by the therapists closest to the time of the work with the client there was a lot more details of the benefits of ARM-5 and CORE-Net and its usefulness as well as in the supervision sessions personal narratives. Equally, in the diaries and one to one supervision there was more detail on the reasons for the anxiety and the other barriers to the process. I was also mindful of the impact of the supervision sessions and myself as both researcher and team leader/supervisor and made sure I excluded any sections prior to analysis from the transcripts where I thought I was leading the therapist by my line of reasoning or questioning. The analysis of both as triangulated data assisted me to gain an overall sense of what they are saying.

5.14.5 Non-CORE users (I-PCC)

It was most useful to have had this data gathered as it helped me to see how developed this group was in comparison to my team in their clinical use of pre and post manual CORE forms even prior to their starting the training of CORE-Net use. The demographic data shows that this group had been on average using Routine Outcome Measures for many more years than the OH team which could be one aspect of this. The comments from the non-CORE-Net users about
their future use of CORE-Net showed how much easier it would be if you are already using measures routinely and have clinically integrated them into your practice. They demonstrated these highly developed skills by discussing how they introduce it in the session and their use of dialogical discussion with the clients about the scores and especially with regard to risk assessment. This indicated that they allow the measures to inform their work with the client and this in turn allows them to make clinical decisions of whether to continue to work with them or to refer them on or triaging of sessions which is about making decisions of how many sessions to offer them based on their clinical cut-off score. These same principles of pre and post outcome measurement used routinely can be transferred easily into session tracking as long as the therapist has already emotionally engaged with the need to outcome measure in the first place and then they need to understand the principle of session tracking for more immediate decision making processes.

5.14.6 OH Clients

Clients were able to give very detailed answers as to their recent experience of counselling and even the one client who had a largely negative experience was happy to come and be interviewed. These clients were more positive than their therapists about the use of outcome measures in their therapy and some of the minority views such as it maybe hiding how you feel or interrupting/intruding the space/process resonate with their therapists. Also, both clients and therapist belief in the therapeutic alliance as the agent for therapeutic change is seen throughout the data and it appeared that if the client liked the therapist then they were positive about their counselling experience and if they did not they were negative about their experience. One of the anxieties of therapists was that the session use of measures would adversely impact on the client. Most clients expressed the fact that they would return to the service should they need to in the future and recommend it to others which is a favourable outcome.
Figure 5.4 is a dynamic model that depicts the time ordered journey using the therapists' original metaphors to show the changes that they have to undergo in order to clinically integrate their work and be as 'eagles' but always grounded in the therapeutic alliance.
Figure 5.4 Dynamic Model

**Changing Metaphors**

**METAPHORS DESCRIBING EARLY USE:**
- Elephant
- Rose with thorns
- Stones in bag
- Dead weight

**Therapist views of Routine Outcome Measurement (ROM) with CORE-Net**
- Therapist intuition/subjective view is valued
- Intrusive in room space and impact on therapeutic relationship
- Fear/anxiety of how to integrate it
- Computer technology learning
- Theoretical training & orientation
- Illusion of perfection & expectations
- Fear of Therapist being judged
- Criticism of questions
- Client discrepancies in filling it
- Discrepancies of clinical scores and client presentation

**Therapeutic Alliance (Facilitates or Grounds) Clinical Integration**

**METAPHORS DESCRIBING USE AFTER 6 MONTHS**
- Paper weight
- Fruit in mixed bag

**METAPHORS DESCRIBING USE AFTER 18 MONTHS:**
- Octopus
- Bird of prey
- Singing birds
- Wasp

**Don't make assumptions of age of clients and IT technology**
- Settle client into session and explain clearly
- Be enthusiastic when introducing it
- Assure anonymity to client
- User flexibility adapt to client needs i.e. paper version or read out to them
- Don't introduce as a separate issue but say it is part of what we do
- Say it helps to get an up to date picture
- Speeds up assessment & is paper less

**Gives overview/insight into work**
- Instant feedback
- Alerted to risk earlier – safeguard measure (SM)
- Referral to GP earlier – SM
- Multi-disciplinary team access/use
- Conversation enhancers
- Validates client change
- Aids self awareness
- Validated clients feelings
- Engages client
- User flexibility needed
- Validates gut feelings of therapists
CHAPTER 6

Discussion and Conclusions
CHAPTER 6

6.1 Introduction

This study sought to answer the overarching research question: How do therapists and clients perceive and experience CORE-Net and ARM-5 in the NHS? This study had three specific aims to help aid in the answering of the research question. The aims of the study were:

1. To elicit the perceptions of the therapists (both experienced and trainees) and clients in relation to their use of a system of continuous monitoring of their therapy via a feedback system that includes regular outcome measuring (CORE-Net) and therapeutic alliance measure (ARM-5);
2. To elicit the perception of therapists in utilising feedback information in supervision; and
3. To elicit the perception of therapists with regard to the training elements required in the process of implementation of this type of routine measurement in clinical practice.

Chapters 4 and 5 presented the findings of the study. This chapter discusses the conclusions based on the findings presented in the previous chapters and the practical implications of the results as well as the limitations inherent to the study. The chapter concludes with recommendations for future research.

6.2 Conclusions & Discussion

The six overarching themes answer the three research questions by giving 'voice' to both therapists and their clients of how they perceive routine outcome measurement for session tracking. The themes also indicate the role of ongoing supervision/support and elements of
training for the implementation of ROM.

1) Therapists were initially anxious and resistant – the psychological component of the change of new skills must not be underestimated as therapists feel great anxiety about the process, find it intrusive in the room and therapeutic space, have fears about being judged as therapists, feel it may negatively impact on the therapeutic alliance, wanting it to be a voluntary process and trusting their own subjective experience of the client over clinical scores.

Routine Outcome Measurement (ROM) for session tracking will feel like learning a new model to many therapists. It is essential to bear in mind the change processes and learning models (Kluber-Ross 1969; Prochaska & Velicer 1997) that therapists undergo which can be rather traumatic with many physical and psychological barriers to the implementation of ROM (Marks 1998; Huxley 1998; Callaly 2006) and personally challenging as they learn new skills in their practice. Rock et al. (2001) suggest a ‘bottom up’ approach which engages clinicians and this resonates with the therapists in my study wanting it to be a voluntary process and not mandatory. My study showed similar concerns initially by the therapists to the one by Gardiner et al. (2001) whereby the therapists had anxiety and fears at the start and worried about the extra paperwork and that it may divert from the therapeutic relationship.

Daniel and Mcleod (2006) highlighted counsellor’s complex ability to evaluate their own practice by ‘weighing up the evidence’. In my study particularly, the early users of CORE-Net in the OH setting felt very strongly about their intuitive sense and trusting this over any clinical client scores through informal evaluation or by not using standardised measures of evaluation. This is the rich heritage that experienced counsellors bring to routine outcome measurement and it is about building upon or complementing this so that they view session tracking as an additional element of information that can inform them about their practice like a clinical support tool rather than
surplanting the skills and knowledge they already have. Therapists also need to bear in mind that other studies show that therapists are not so good at predicting those clients that will not do so well with them in therapy (Grove et al. 2000; Najavits & Strupp 1994; Hannan et al. 2005).

The attitude of the therapist was highlighted in my study as being one of seamlessly and non-threateningly introducing the measures into the sessions as the best way forward as this will be conveyed to the client through our words and body language. Hunter et al. (2009) emphasise the importance of gaining clinician engagement as this could affect measurement errors for example (Soderberg et al. 2005).

2) Therapists adapt 'creatively' – therapists like to feel they have some control or flexibility in how they will use the measures with individual clients with regard to timing and what they say to introduce or process information with clients.

Henry et al. (1993a) reported that when training therapists to adhere to a manualised psychodynamic model this could adversely affect the therapeutic relationship and increased the likelihood of therapist hostility towards their client. Rather, it appears preferable to follow the suggestions by the Mackay et al. (2001) study for counsellors to learn new models by trying to 'absorb the spirit of the model' rather than 'slavishly' following it so that the aim is to see 'beyond the details of the model to the underlying principles being suggested'. All therapists in my study did this by adapting 'creatively' and using the measures 'organically' as survival strategies in the implementation of the measures in their clinical practice.

3) Outcome measures help the client-therapist relationship – the measures are useful for speeding up assessment and alerting the therapist to risk factors as well as to the client not making the desired progress. It 'oils the wheels' of conversation or dialogue between client and
therapist to also discuss any discrepancies in how the client presents and their clinical score. OH therapists were largely negative about using ARM-5 the alliance measure but could see that it could be useful to inform them further on the state of the therapeutic alliance.

My study gave confirmation to studies undertaken previously which although had used only pre and post measures, did comment on the benefits of alerting therapists to risk and helped clients to focus more clearly on their reasons for attending counselling (Gardiner et al. 2003; Davy 2008). My study added more depth to the survey undertaken by Smart et al. (2006) in terms of therapists views and added the client dimension too which a lot of previous studies have missed out in relation to session tracking.

4) *Clients perceive visual measures as helpful* – clients like the measures more than their therapists as they like to see the visual representation of their feelings and their progress or lack of progress and are able to dialogue with the therapist as to why they may have deteriorating at any given point during their therapy.

Previous studies (Trauer et al. 2009a; 2009b) have hinted at the possible benefits of having visual feedback that is readily available for discussion between therapists and their clients but have not explored this and gained the clients view point. My study gives a unique insight into the clients process of being the other party to a collaborative exploration of their counselling journey with session tracking via instant feedback on a computer screen.

5) *CORE scores inform supervision* – therapists learn via individual case discussion and learning the clinical utility of the various features of CORE-Net and how colleagues are using it. Supervision is to be non-punitive.
A study by Isakson et al. (2002) highlighted that feedback to therapists in supervision by means of visual charts is to be recommended. Other studies (Mothersole (2006); McNaughton et al. 2006; Trauer et al. 2009a; 2009b) suggest that it is important to make the data more meaningful to clinicians via regular meetings. All therapists in my study indicated this was useful for learning from other colleagues and their case by case discussion of how the clinical scores can inform their practice.

6) Proper and ongoing training/support of therapists is necessary – therapists valued what training they received and suggestions for a comprehensive training include: theoretical (the philosophy of outcome measurement) and the practical know how (for e.g. role play, practicing with dummy clients on screen, IT skills)

Several studies highlight the importance of thorough training and ongoing support for the implementation of routine outcome measurement (Crocker & Rissel 1998; Gardiner et al. 2003; Trauer et al. 2009a, 2009b). My study raised some of the issues relating to this and what was useful and suggestions for improvement.

6.3 Original Contribution to Research

This study appears to be the first of its kind since no qualitative studies were found in the published literature up to September 2009 regarding the use of CORE-Net in delivering psychological therapy. This study is also the first to study the use of CORE-Net in conjunction with an alliance measure (in this case, ARM-5) in routine practice. This study contributes to knowledge about both clients' and therapists' perceptions of CORE-Net (outcome measure) and ARM-5 (alliance measure). Existing research evidence demonstrates that the study of both outcome and alliance measures may be used in practice to improve the collaborative relationship in two ways. First, the collaborative relationship could be improved due to an
improvement in outcome (Whipple et al. 2003). Second, the collaborative relationship may be improved because of an earlier decision about the benefit of changing therapists (Miller et al. 2005). However, the implementation of such systems is rather more complex (Huxley 1998; Marks 1998; Hatfield & Ogles, 2004) and this study contributes to an in-depth understanding of these issues and provides suggestions for easier implementation. The data of this study may also be used in practice by future researchers for possible quantitative studies including validation studies for ARM-5. The data will be added to a database, and future studies may choose to use this data in conjunction with their own data. Since this is the flagship study of CORE-Net and ARM-5 measures, it should inspire future research and serve as the basis for such research.

Most previous studies of routine outcome measurements have gained the views of therapists mainly by surveys and some by interviews but these have been obtained many months or years after the start of the implementation and not for every session use and no interviews/surveys were undertaken with clients (Trauer et al. 2006; 2009a; 2009b). Only the survey study by Smart et al. (2006) had therapist views on every session use for outcome and alliance measures but again no perspectives gained from the clients. A mixed methods study by Davey (2008) used interviews to elicit the views of clients in whether they felt that therapy had benefited them but was not asking about the routine measurement specifically and in this study the measures were used just pre and post not throughout for session tracking. Davey (2008) recommended that session tracking be undertaken in private practice in his proposed model and McLeod (2001) spoke of the need in the field of workplace counselling in getting the ‘client’s voice’ in future research. My study uniquely captures a very ‘immediate’ and ‘fresh’ perspectives from the therapists during the implementation of such continuous monitoring systems using both outcome and alliance measures through the therapist diaries and regular supervision sessions.
Also, the client's personal experience shortly after completion of their therapy is heard so that therapists are able to see that clients are actually more positive than their therapists when it comes to routine outcome measurement and session tracking with a computer in the room. Clients affirm the value of the therapeutic alliance as leading to a satisfactory outcome of counselling for them.

This research creates a better understanding of the "actual lived" experience for both clients and therapists when this is done routinely and with technology in the room. Therapists' worry that clients may feel negative about the routine use of measures appears unfounded as generally clients are more positive than their therapists. Clients may benefit from such a system of routine session tracking by receiving the proper amount of treatment sessions when the therapists triage the amount of sessions based upon the clinical cut off score and are alerted to risk earlier for appropriate management of such. The feedback system may reduce the number of sessions needed by a client, or may indicate that more sessions are needed in order to suit the needs of each individual client. More focussed use of sessions should increase the efficiency of sessions and clients should have shorter wait times. I further expand on this in section 6.7.

6.4 Limitations

Particular limitations are inherent in the study design reported in this thesis and when compared to published quality guidelines in published research. Elliot et al. (1999) presented evolving guidelines for publishing qualitative research in qualitative psychology after undertaking an exhaustive review of the literature. These standards include: owing ones perspective; situating the example, grounding in examples, providing credibility checks,, accomplishing general versus specific research tasks and resonating with readers. Morrow (2005) later build on these and gave specific chapter by chapter recommendations for conducting and writing qualitative
research based on a four chapter dissertation. She emphasised additionally the importance of "paradigm-specific as well as transcendent criteria (e.g. authenticity criteria, social validity, transgressive validity), where appropriate, should be used in research and reflected in the research report" (Morrow 2005:257). She also recommended that an audit trail is always to be kept with the possible inclusion of an abbreviated version in the appendix to a thesis or dissertation. Gomm et al. (2000) highlight nineteen questions to ask about qualitative research and the appraisal issues involved. This work has been particularly useful during my research project and for the write up of the thesis. The following are some limitations of my study:

- One limitation was the sampling procedures used. It is possible that a sampling bias may exist. Although purposive sampling was determined to be the most appropriate sampling method for this study, this method limits the study because samples are not random and may not be fully representative of the subject population. There is not necessarily a close relationship between what participants say in an interview or focus group and what they do or feel in the situations which they have discussed. This is an issue for all self-report methods (Gomm et al. 2000:309). An implication is that participants' self-reports may need in some cases to be verified by relevant observations. The focus groups were small with only five participants in one group and four in the other and there were only seven individual interviews with non-CORE-Net users. For the OH group only ten clients were interviewed and was based on their experience with very few clients overall during the trial period due to non hospital clients also needing to be seen during the trial period and these not being included in the study.

- Although focus group environments were designed to make the participants as comfortable as possible, participants in focus groups may have made particular statements because of social influences that did not reflect their actual beliefs but were
results of influence from the opinions of their peers. For example, in the Occupational Health focus group when one therapist said ARM-5 was "meaningless" the other therapists immediately agreed and the flow of ideas stopped but in their diaries and supervision sessions more detail was given of positives. Although the appropriate design for this study utilised qualitative analysis procedures, further analysis, specifically of the effectiveness of the therapy by looking at the measures used and their clinical scores, could be conducted quantitatively.

- The results of this study may only be applicable to populations similar to the composition of the sample population. The results are not necessarily generalisable to other populations of interest. The researcher for this study was the team leader of the Occupational Health therapists, so some researcher bias may have been inherent to the study's design and the dynamics of the research may have been influenced somewhat by this reality (Gomm et al. 2000: 308).

- The credibility of the results would be enhanced if external validation of themes had been possible for the analyses of the data. There were limitations in theoretical formulation for theory building due to the methods of data analysis used although the methods used were chosen for more of an evaluative purpose. Lincoln and Guba (1985) recommended "member checking" as a way to ensure that the researcher's interpretations honour the meaning as conceived by the participants and if requested at multiple points can both increase the collaborative relationship between the researcher and participants and establish trustworthiness. Williams and Morrow (2009: 579) indicate that it can also serve as a check that the "researcher has achieved the desired balance between participants' voices (subjectivity) and the researcher's interpretation of the meaning (reflexivity)". Although member checking was undertaken at multiple points and feedback was
requested from participants in my study, this process could have been enhanced if I had
guided the participants by perhaps asking them some questions about the themes to
enable them to engage more and stimulate some ideas.

• The study aimed to measure the effects of continuous outcome measurement in
therapists and clients but the questions in Appendix 14 asked merely about the effects of
outcome measuring, neglecting the continuous aspect of the task. Thus a further
question needed to have been included on what it feels like to have to use CORE-NET in
every session. Despite this omission in the interview schedule the training of these
therapists and the instructions for this given in Appendix 27,28 and 29 do give explicit
instructions that it was to be for sessional use and therefore there is some degree of
confidence that the therapists on the day of the focus group did have awareness that
they were being asked about session tracking which is different to what they had
undertaken previously to the commencement of the study which as only pre and post
measurement.

• The design study unfortunately only had client interview data from the OH site and not
the PCC site. This additional client information would have been much more accurate to
the task and the topic, as compared with the abundance of therapist data from both sites.
The reason why this was not included was due to the practical logistics of a single
researcher with limited resources in trying to achieve this in the time frame of the study.

• The data of both the OH and the PCC site lack comparability in that the data coming from
the OH site includes two outcome measures and is therefore significantly different from
the data coming from the PCC site as they only used the outcome measure and not the
alliance measure. There are obvious differences in the task of having to introduce two
questionnaires in a short therapeutic session as opposed to only introducing one. Thus the data lack comparability.

6.5 Reflections on Methodology

Triangulation of data (interviews (individual/focus groups & diary methods) can support conclusions so that they are more convincing (Gomm et al. 2000:310). However, using different data sources and different methods of analysis was extremely challenging and conclusions did not appear at first glance to be compatible and I will explain this now. I found it to be a beneficial to my learning to use both Conventional Content Analysis to analyse the therapist diaries and a General Inductive Approach to analyse the therapist interviews and the outcomes.

Conventional Content Analysis involves identifying key themes as codes and then looking at the hierarchy of importance of the sub-codes from the frequency with which an answer is given. In the therapists' diaries, questions were often answered ambiguously and this added to the complexity of the analytic process. For example, Question 5: "How did it feel for you? What was your 'felt-sense'? " This question was answered in at least three different ways from linking it to Question 4: "How did you process it?" which related to ARM-5; to reflecting on how it felt using ARM-5, CORE-Net or both in a session, or focussing on how the therapist felt about the session in general with no reference to ARM-5 or CORE-Net. An important part of the analysis was to interpret what was written and what a therapist was referring to in different questions and then to decide whether it was relevant.

Rather than simply being able to list the answers given under the question headings and do a more quantitative-type analyse on each question, I found that there was a greater need to immerse myself into the diaries and to allow themes to emerge from the whole. In this way, I found Conventional Content Analysis to be fairly similar to the General Inductive Approach that I
used to analyse the OH interviews. The main difference was that when I had rearranged the quotes from the therapist diaries under the new codes and sub-codes, I had to count how many therapists had at least one quote under each of these and treat it more quantitatively for the final report i.e. how many of the five therapists had contributed to each code or sub-code. In the final report, one OH therapist is quoted more than others and this is a result of the way the therapist answered the questions compared to other therapists who may have suggested the same thing, but gave more ambiguous answers.

In contrast, I found using a General Inductive Approach to analyse the interview transcripts simpler in some ways than using Conventional Content Analysis to analyse the diaries, particularly as there was not such a focus on how many therapists mentioned similar themes. However, it was also easier to immerse myself in the interview transcripts themselves more than the diaries. This was because, whilst being structured by the interviewer’s use of similar questions in each interview and with each therapist, the discussions were more free-flowing and therapists had a chance to explain what they meant when they explained their experiences and how they actually felt. As such, the interviews were more contained and the meanings more explicit and less ambiguous and gave more information to analyse.

As I was analysing the diaries and the interviews, I felt that the diaries identified some feelings and experiences around using CORE-Net and ARM-5 in sessions but that the interviews expanded on these and often gave greater insight and different interpretation of the meaning of comments made in the diaries. For example, sometimes therapists waited until later in the session before using CORE-Net. In the diaries, reasons for this included clients talking a lot, or therapists not really knowing how or when to bring CORE-Net into sessions and feeling anxious about it. However, a different picture emerged from the interviews where it appeared that therapists were sometimes making conscious decisions to wait until later in the session to
introduce CORE-Net if they felt that they needed to connect with a client first or if ARM-5 suggested that more focus and work was needed on the therapeutic relationship. As such, what could be interpreted as a difficulty from the therapist diaries', could be seen to be an important element of the session and relationship from the interviews. In this way, the diaries and interviews complement and need to be read in conjunction with each other.

6.6 Researcher involvement and experience in the trial

As has been discussed in some detail already in Chapter 3, my dual role as researcher and participant was a challenging one. In an ideal world, I would have had a different person come and conduct the therapist supervision sessions to reduce researcher influence on the data being gathered. Williams and Morrow (2009:259) bracketing and journaling as ways to help researchers “stay attuned to their own perspectives in ways that helps them recognize their own experiences as separate from the participants’ stories”. In order to encourage reflexivity I did keep a journal which I wrote in free hand and which I discussed in Chapter THREE. Unfortunately, I ran out of time to type it up and analyse as part of the researchers journal which would have given valuable insight into my personal struggle and the anxiety invoked in myself as team leader to the OH team when I myself was a novice to the implementation of routine outcome measurement for session tracking. Keeping this journal was key in keeping me reflexive and helping me to bracket my own assumptions and feelings when being immersed in my dual role as both therapist manager and researcher.

I was also learning for the first time and saw as many clients on my own as I work full-time. Also, the whole of my immediate team was engaged this research project. My experience is more similar to the PCC focus group and I think it is purely based on two factors. Firstly, I had engaged emotionally with the project as it was my research project and I had read up and understood the theory behind session tracking. Secondly, I had many client numbers to practice
on and I think this is also an important factor. All the therapists on my team work a day a week which means they did not get too much practice time for the duration of the trial. In terms of suggested time taken to implement outcome measurement for session tracking Marks suggests, "it takes at least a year to implement outcome measurement to the point where clinicians do it as a routine and regard it not as a non-clinical nuisance" (1998: 283). However, a more recent study by Meehan et al. (2006:585) suggested "the large scale implementation of outcome measures will take... at least five years to achieve". This study by Meehan et al. (2006) was not for session tracking though and from my study I would say that it depends on the level of support after initial training and number of clients seen by the therapists. It is not clear from the previously cited studies how many hours and clients were seen so the following is purely based on my experience. In the case of my therapists they had not used pre and post measures CORE manual forms prior to the start of the study for too long and that the level of support I would have liked to have continued to give them was not practicably feasible and so after six months they were still only barely touching clinical integration into their practice. In my case as a clinician who saw many more clients, my view is that potentially, with the correct support and training one can be as advanced clinically as the PCC group who had used it for eighteen months with minimal initial and continuous training. Therefore I feel it may be feasible that for a full-time clinician to take between six months and two years to integrate it meaningfully into practice, which is much faster than stated by Marks (1998) and Meehan et al. (2006). This appears to be due to the nature of session tracking and immediate engagement with the process with the visuals of computer technology but it has to be stated that the essential framework of initial and ongoing training and support is key to this process.

In my dual role with my team, there would inevitably be my enthusiasm for the study that would be impacting on the positivity of how I carried out the research as well as the therapists who had been there longer perhaps wanting to support me in this research has to be taken into account in
this small scale study and it highlights how much harder it is for larger teams that are geographically widespread and who don’t know each other and may feel they are just being mandated to do it with little support.

6.7 Suggestions for Future Research

This study is the first of what is hoped to be many studies regarding the use of outcome measures (CORE-Net) and alliance measures (ARM-5) with regard to psychological therapy. As the first of its kind, this study should serve as the foundation and inspiration to other studies regarding the use of these measures within the psychotherapy realm. Because this study focused on a particular sample population, future studies should attempt to extend the results of this study to other populations by completing similar research with a sample of participants with different makeup than the sample studied here. Because this study was limited due to its analysis procedures, other qualitative analysis methods such as other types of content analysis, grounded theory, and phenomenology would add additional knowledge about the advantages and disadvantages of specific analytic approaches. Future research could also assess the generalisability of the results of this study with its current population since there is no specific previous research which addresses the aims of this study. As it is a study using session tracking outcome measures with alliance measures, the quantitative data that is routinely collected is available for both validation studies of the alliance measure but also in other quantitative studies looking at whether there was an improvement in clinical effectiveness as a result of session tracking with an alliance measure. This would be with a view to validate the US studies in this field but using the UK measures.

My study only used the client's scale of the ARM-5 measure not the parallel form which is the therapist's scale. I now have been collecting these alongside the clinical supervision templates for all sessions for over a year now and this data needs to be analysed to see how therapists are
using them and if this is benefiting the client and improving their clinical practice.

A mixed methodology study could be undertaken to include both interviews/survey/randomised controlled trial or effectiveness study on multi-sites who are using both alliance and outcome measures for session tracking in the UK. It does not have to be with CORE-Net and ARM-5 but can be with any of the IAPT measures being used in both primary and secondary care services. These studies would give a more comprehensive view of how therapists are integrating these measures into their clinical practice and whether it is indeed benefitting their clients.

Further research could also be undertaken to formulate a validated and comprehensive model of change (including dissemination and implementation) specific to routine outcome measurement for session tracking that could be used as a template and/or tick sheet as to what needs to be happening in order to successfully support mental health professionals in embracing ROM and showing clinical improvement (my proposed model is only an outline of the issues to be further expanded upon in Figure 6.1). I think the models I mentioned in my model as well as Miller’s work on Motivational Interviewing could be explored in more depth later in regards specifically to routine outcome measurement for session tracking (Miller 1991). I personally would be very interesting in undertaking some research that will give an in-depth study of the major change models and their relation to routine outcome measurement and whether there are differences between trainee psychotherapists and experienced psychotherapists in the way they embrace the philosophy of routine outcome measurement for session tracking and whether this would then have implications for psychotherapy training institutions and their curricuiums.

6.8 Practical Implications for clinical practice

The recommendations for training and support of therapists add practical insight into how team leaders of psychological services may successfully implement routine outcome measures into
their teams. The training and support implications indicate that voluntary use of the measures with comprehensive initial training which needs to include various elements to be successful and ongoing support may contribute to better ownership of the process and emotional engagement with it throughout the learning and adapting phase where therapists are trying to integrate it into their clinical practice. An important factor is to allow therapists to see that the use of ROM does not take away their intuitive part as therapists but can complement this like a clinical support tool at their disposal to inform their practice and engage the client at each session at potentially different levels due to the way the visuals flag up various issues like risk and the severity drop down rating colours.

There were particular changes that occurred as a direct result of this study in the researchers own clinical practice. I personally became more convinced of the possibilities that are offered to improve clinical practice and effectiveness of working in such a way and have changed the advertisement and job description and interview presentation subject to one on therapist’s views on outcome measurement as I feel it is important to recruit therapists that will support routine use of outcome measures. Our service has active participation in national practice research networks. There have been changes to the advertising literature of the service to include the fact that we value client feedback and have a Client Directed Outcome Informed (CDOI) approach to our service. I have seen the need to provide more regular and ongoing support in the use of the measures much earlier on and for this to be ongoing even if I am unable to be present for the supervision session when I am off site, as CORE-Net is web based I can still have a telephone session with the therapist from another geographic location and both look at their data on the computer screen and discuss it clinically in supervision.
This research has so far been disseminated in some wider multi-disciplinary settings like Occupational Health for discussion with medical doctors and nurses, research conferences, several CORE user conferences, my own university research conference and PhD group, presentations at my previous psychotherapy training institution, discuss at the London Staff Counsellors forum, and articles in two non peer reviewed journals.

Since the completion of the study my team and I have continued to use CORE-Net and ARM-5 and I have started a completely new team in the implementation of CORE-Net and the use of ARM-5 not just the client scale but also the therapist scale (Appendix 41). This has been embraced by therapists more enthusiastically as they are able to compare how the client rated the alliance for a particular session with how they rated the same session as the therapist. This has proved entirely useful to clinical supervision sessions and appears to show more clinical utility and meaningfulness to the therapist than when using just the client’s scale. I have developed a template to assist with clinical supervision and consideration of clinical scores for session tracking (Appendix 42). As I have become more proficient in the use of both I know that I am more effective at teaching it to others and am able to apply the clinical utility more readily and in a more engaging manner.

In March 2009, I was invited to present as a guest speaker with Scott Miller specifically on the use of ARM-5 and CORE-Net for session tracking in front of a large audience from a mental health NHS Trust. I also presented at the CORE user conference later that month on the same subject. A video recording was undertaken of a colleague of mine and myself talking about a client in supervision and being informed by both CORE-Net and ARM-5 client and therapist scores. This has led to my invitation to be a part of an exciting new international group of
therapists creating an 'International Centre for Clinical Excellence (ICCE)' website for 'therapist interactional learning' from other therapists. The first phase of the beta-testing is now completed and I await the commencement of phase two in the near future.

In July 2009 I asked COREIMS to look at my data and make an initial exploration of the data to see if clinically there were any differences to our clinical practice since we started the trial and the session tracking methodology. Comparative performance data for May 05 – April 09 were analysed and compared with available benchmark data from the CORE National Database for Workplace Counselling of just under 15,000 clients. The key findings are highlighted below:

Phase 1 (May 2005-April 2007) methodology involved:
- Manual pre and post-therapy completion of the CORE-OM by clients.
- Manual completion by practitioners of the CORE therapy assessment and end of therapy forms to profile client presentation, demographic data and service delivery.
- Manual completion of the CORE workplace assessment and end of therapy forms to profile pre and post-therapy work-related problems, work functioning and absence.
- Initial annual analysis and reporting by the Trust audit department and from May 2005 input of case data into CORE PC by an administrator and annual analysis within the team using CORE-PC for reporting and service improvement.

Phase 2 (May 2007- April 2009) methodology involved:
- Onscreen sessional completion of CORE-10 measures by clients for session tracking and progress review.
- Manual completion of the ARM-5 therapeutic alliance measure (Agnew-Davies et al. 1998) at
the end of sessions, together with a discussion of alliance and relationship issues.

- Onscreen completion by practitioners of the CORE therapy assessment, end of therapy and workplace forms.
- Regular team and individual reviews.

The key objective of Phase 2 of the project was therefore to embed a sessional measurement methodology in the service which would:

- Accelerate and streamline data collection via a virtually paperless system.
- Increase practitioner engagement with measurement and ownership of their own and service outcomes.
- Engage clients and therapists more collaboratively, and empower clients in the therapeutic relationship and their progress/outcome.
- Support a reduction in patient drop-out rates, increased efficiency and improved outcomes.

**Overall performance**

- Benchmarking against the CORE national database shows that the PWBS has been consistently in the top performing quartile of services for waiting times and pre/post-outcome measure completion rates between May 05 - April 09. Planned endings to therapy are also consistently high – the mean overall rate of planned endings is six points above the national average at 74 per cent.

**Impact on work performance and absence**

- **Improved work performance.** Analysis of pre and post CORE data for work status for May 07 – April 09 (i.e. in Phase 2) shows a 3.5-fold increase in the number of clients recorded as functioning normally at work following therapy, and a 100 per cent reduction in clients on sick leave or absent from work.

- **Reduced work absence.** For the same period there was a recorded reduction of 470 days in (pre to post therapy) absence from work in the previous 20 days (n = 291 clients). If each day is estimated conservatively as costing the organisation £250 in terms of cover, lost productivity, etc., the saving is £117,500.
Outcomes since introduction of sessional outcome and alliance tools

- **Effective therapy is delivered using almost 25 per cent fewer sessions.** Between May 08 – April 09 (Phase 2) clients used an average of 4.34 therapy sessions, compared with 5.7 sessions between May 05 – April 06, a reduction of close to 25 per cent. Clinical and/or reliable improvement remained unchanged at 68 per cent, which was, also the mean level for May 05 – April 09. The average length of client contact with the service also reduced (118 days from May 05 – April 06, to 74 days between May 08 – April 09).

- **Session attendance has improved.** During Phase 2 clients attended 80 per cent of appointments offered, compared with 76 per cent during Phase 1. Latest year (May 08 – April 09) figures show an increase of 6 per cent over the previous year, consistent with an increased proficiency on the part of practitioners in using outcome and alliance feedback to secure client commitment.

- **Outcome data is available for many more clients.** Sessional measures enable outcome profiling of clients who attend more than one session, even if they terminate counselling prematurely. Phase 1 and Phase 2 outcome measure completion rates show that the mean level of Time 2 outcomes has risen from 78 per cent to 93 per cent. This brings the service in line with the 90 per cent target set by the DH for IAPT services.

- **Positive feedback from clients.** Feedback from clients has been that they like CORE-Net because it provides a visual representation of their feelings that is both helpful and therapeutic and that helps the client/therapist relationship.

Cultural change

Implementation of session tracking, alliance monitoring and real-time feedback has been instrumental in transforming the culture and ways of working of the service and made routine evaluation part of everyday clinical practice. In essence:

- Embedding measurement, transparency and ownership of psychological therapy outcomes.
- Facilitating client-focused feedback and a ‘stepping-across’ to alternative therapists as appropriate - moving from ‘therapies that work’ to ‘therapists that work’.
- Providing instant alerts of clients who may need immediate referral to other services.
- Changing evaluation and performance monitoring from an annual event to a continual process.
- Enhancing the process of supervision and CPD (Appraisal function).
- Enabling the service to provide an optimum number of sessions to each client based on progress feedback – resulting in an overall increase in service efficiency.
• Complementing efficiency gains from reduced sessions with reduced administrative costs due to direct data entry by clients and practitioners.

Within the OH team, the psychological therapists work with doctors and nurses who regularly undertake assessments for fitness to work of staff who have been management referred. For the first time in the UK, the OH multi-disciplinary team (including doctors and nurses) will pilot the use CORE-Net to assess psychological cases or those who have had physical illness and may have developed psychological symptoms. This will enable us to have a continuous on-screen tracking for the patient's benefit in that once they are referred to the counselling team we know what their levels of distress at initial assessment under management referral was with doctor/nurse and then we can continue our therapy and when they go back to the doctor or nurse for review, they can easily track their progress to see if counselling has been beneficial to them. This will enable a more seamless level of continuity of care for patients, allowing us to monitor their levels of well being at a quick glance at any part of their journey through their management referral process and management. A first for me to train non-psychological therapists will commence this October 2009 within the multi-disciplinary team that I work with.

Validation of ARM-5 client's scale has been completed and the paper has been submitted for publication (Cahill et al. [submitted]) and I have been included as one of the authors as the OH team I manage donated the data for one site in the validation study.

I have extended my proposed Dynamic Model shown in Figure 5.4 to Figure 6.1 which shows how it relates to the change models discussed in Chapter TWO section 2.10.2 and I also added one more called the 'Conscious Competence' model for learning stages developed by Gordon Training International. This has traditionally 4 learning stages: 1. unconscious incompetence - the individual neither understands nor knows how to do something, nor recognises the deficit, nor has a desire to address it; 2. conscious incompetence - though the individual does
understand or know how to do something, he or she does recognise the deficit, without addressing it yet; 3. conscious competence – the individual understands or knows how to do something, however, demonstrating the skill or knowledge requires a great deal of consciousness or concentration and 4. conscious competence – the individual has had so much practice with a skill that it becomes "second nature" and can be performed easily (often without concentrating too deeply). He or she may or may not be able to teach it to others, depending upon how and when it is learned. The fifth as 'conscious competence of unconscious competence'. This describes a person's ability to recognise and develop unconscious competence in others. This has been a powerful concept to me personally because I am mindful that I was teaching others when I myself was also learning and did not have conscious competence of what I was doing only theoretical knowledge and belief in what I was doing. Only now in reflection can I see how much better it is to have integrated it myself first before teaching others and how this may be a way forward to teach others by a rolling programme of new learners gaining experience and then teaching their colleagues.

My proposed model incorporates four stages as experienced by therapists in my research and their process of change during routine outcome measurement implementation: 1. Anxiety/Resistance; 2. 'Creative' adaptation; 3. Practicing and 4. Meaningful integration and the suggested time frame for this to occur. The dissemination and implementation suggestions are from my study but also informed by previous studies (Soderberg 2005; Smart et al. 2006; Trauer et al. 2006, 2009a, 2009b; Bickman 2008).

Therapists need to take ownership of ROM and realise that they are not going to 'lose' their 'intuitive processes of evaluating clients' but that the clinical support tools that give them feedback on their practice are just that: they support their work or complement their work but do not take away. This is a key concept in 'gaining the hearts' of therapists for engagement in the implementation programme of ROM. The theoretical part of the initial training delivered to
therapists needs to emphasise the acknowledgement of the existing strengths of therapists ability to assess intuitively by ‘weighing up the evidence’ as highlighted by Daniel and McLeod (2006). Managers must not underestimate the massive psychological component in the implementation of ROM and its maintenance in seeing clinical practice improve because just gathering data routinely will not improve clinical practice. There needs to be engagement with the process by the therapists and this will transfer positively to their clients. This will be facilitated by ongoing and regular quality mentor/supervision support as well as having regular feedback of their data in comparison to their teams or national/international benchmarking which helps therapists to see the ‘whole picture’.

Supervision needs to be non-punitive and supervisors must not be overly strict on supervisees’ application of new models could affect interpersonal processes. (Henry et al. 1993a). McKay et al. (2001) provide a reminder that ‘absorbing the spirit of the model’ is preferable to ‘slavishly’ following. Richards et al. (2006) emphasise the need to adapt research to local needs for services. All of the above may help facilitate therapists’ processes for the changes in their clinical practice to integrate routine outcome measurement for session tracking meaningfully into their work. However, I am left with questions about therapists highly developed subjective evaluation of their work that Daniel and McLeod (2006) speak of and how this may impact on new therapists who learn routine outcome measurement from the beginning of their training as therapists. Will these new therapists develop the ‘subjective intuitive’ way of evaluating clients and then viewing the clinical support tools (CST) as complementing their work or will they not develop it as well as therapists who developed confidence first through experience in the ‘subjective intuitive’ way of evaluating informally without formal outcome measurement and who then add the clinical support tools for routine outcome measurement later in their professional development?

My research project has left me with more questions than I set out to find out but has sufficiently
excited me to be interested in undertaking further research projects in the field of session tracking in psychological therapy.
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<tr>
<td>Immobilisation/shock Denial</td>
<td>Unconscious competence</td>
<td>Precontemplation Contemplation Preparation</td>
<td>Shock/denial</td>
<td>Anxiety/Resistance</td>
<td>Lack of ownership, fear of being judged, not the way I work, intrusive, fear of impacting on therapeutic alliance, logistics of computer in the room, not knowing how to interpret scores to clients</td>
<td>Training to include theory (philosophy of outcome measurement/benefits/challenges) &amp; practical ‘know how’ (role play sessions, training in use of measures, technology, logistics in the room especially if computer involved). One to one mentoring to discuss fear/anxieties for ‘holding containment’ of therapists, Training can be a combination of online and face to face in groups with no more than 10 individuals and ideally consisting of 2-4 sessions spread out.</td>
<td>3-6 months prior to commencement start to have meetings and send information to start to prepare for the training sessions.</td>
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<tr>
<td>Incompetence Accepting Testing</td>
<td>Conscious incompetence</td>
<td>Action</td>
<td>Anger/guilt Depression &amp; Detachment</td>
<td>‘Creative’ adaptation</td>
<td>User flexibility, being ‘organic’ in timing and manner of using it with different clients, beginning to see some benefits in assessments, clients appear to like it</td>
<td>Allow therapist to be creative in how they use the measures as they adapt to it in practice. Continue to offer regular training and support of the clinical utility of the measures. Continuing ongoing supervision/mentor support for continuous learning which includes feedback.</td>
<td>3-4 months after initial training is the minimum time it will take for therapists to begin to experiment and adapt.</td>
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<tr>
<td>Search for meaning</td>
<td>Conscious competence</td>
<td>Maintenance</td>
<td>Dialogue &amp; Bargaining</td>
<td>Practicing</td>
<td>Gaining confidence in own skills, developing clinical utility with risk features of measures and dialogue with clients</td>
<td>Regular consideration of case examples individually and with the team to allow therapists to see the ‘whole’ in terms of the data gathered as a team and how it may compare to national benchmarking, Continued ongoing supervision/mentor support for continuous learning.</td>
<td>4-12 months</td>
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<td>Integration</td>
<td>Unconscious competence</td>
<td>Relapse</td>
<td>Acceptance</td>
<td>Meaningful Integration</td>
<td>Validates clients feelings and therapist ‘gut feeling’, confidence in risk alerts and own performance.</td>
<td>Ongoing regular monitoring and case example consideration and development of clinical utility of measures and appraisal of how to improve performance against self and others.</td>
<td>12-18 months</td>
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Table 6-1 Proposed Model of Change for ROM
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necessary to implement the HSE Management Standards: Phase Two

Appendix 1 CORE Outcome Measure 34 Questions

**Clinical Outcomes in Routine Evaluation**

**Outcome Measure**

**IMPORTANT - PLEASE READ THIS FIRST**

This form has 34 statements about how you have been OVER THE LAST WEEK. Please read each statement and think how often you felt that way last week. Then tick the box which is closest to this.

Please use a dark pen (not pencil) and tick clearly within the boxes.

**Over the last week**

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<th>Statement</th>
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<td>I have felt terribly alone and isolated</td>
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<td>I have felt tense, anxious or nervous</td>
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<td>I have felt I have someone to turn to for support when needed</td>
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<td>I have felt O.K. about myself</td>
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<td>I have felt totally lacking in energy and enthusiasm</td>
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<td>I have been physically violent to others</td>
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<td>I have been physically able to cope when things go wrong</td>
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<td>I have been troubled by aches, pains or other physical problems</td>
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<td>I have thought of hurting myself</td>
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<td>Talking to people has felt too much for me</td>
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<td>Tension and anxiety have prevented me doing important things</td>
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<td>I have been happy with the things I have done</td>
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<td>I have been disturbed by unwanted thoughts and feelings</td>
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<td>15</td>
<td>I have felt panic or terror</td>
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<tr>
<td>16</td>
<td>I have made plans to end my life</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>I have felt overwhelmed by my problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>I have had difficulty getting to sleep or staying asleep</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>19</td>
<td>I have felt warmth or affection for someone</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>20</td>
<td>My problems have been impossible to put to one side</td>
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<tr>
<td>21</td>
<td>I have been able to do most things I wanted to</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>22</td>
<td>I have threatened or intimidated another person</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23</td>
<td>I have felt despairing or hopeless</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24</td>
<td>I have thought it would be better if I were dead</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>I have felt criticised by other people</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>26</td>
<td>I have thought I have no friends</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>I have felt unhappy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>Unwanted images or memories have been distressing me</td>
<td></td>
<td></td>
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<tr>
<td>29</td>
<td>I have been irritable when with other people</td>
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<tr>
<td>30</td>
<td>I have thought I am to blame for my problems and difficulties</td>
<td></td>
<td></td>
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<td>31</td>
<td>I have felt optimistic about my future</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>32</td>
<td>I have achieved the things I wanted to</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>33</td>
<td>I have felt humiliated or shamed by other people</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>34</td>
<td>I have hurt myself physically or taken dangerous risks with my health</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Thank you for your time in completing this questionnaire.

Total Scores:

Mean Scores:

(Results are for each dimension divided by number of items completed in that dimension)

Survey: 151
### Appendix 2 Therapy Assessment Form

**Clinical Site ID**
- [ ]
- [ ]

**Outcomes in Routine Evaluation**
- [ ]
- [ ]

**Therapy Assessment Form**

#### Referral Date
- [ ]

#### First Assessment Date Attended
- [ ]

#### Last Assessment Date
- [ ]

**Total Number of Assessments**
- [ ]

**Previously Seen for Therapy in This Service?**
- [ ] Yes
- [ ] No

**Months since last episode**
- [ ]

**Is this a follow-up/review appointment?**
- [ ] Yes
- [ ] No

**Relationships/support**
- [ ] Full time carer (of disabled/elderly etc)
- [ ] Living in shared accommodation eg lodgings
- [ ] Living in temporary accommodation eg hostel
- [ ] Living in institution/hospital
- [ ] Other

**Current/previous use of services for psychological problems?**

#### Primary
- [ ] GP or other member of primary care team eg practice nurse, counselor

#### Secondary
- [ ] In primary care setting
- [ ] In community setting
- [ ] In hospital setting on sessional basis
- [ ] Day care services eg day hospital
- [ ] Hospital admission \( \leq 10 \) days
- [ ] Hospital admission \( > 10 \) days

**Specialist**
- [ ] Psychotherapy/psychological treatments from specialist team (e.g. psychiatrists)
- [ ] Attendance at day therapeutic programme
- [ ] Inpatient treatment

**Other**
- [ ] Counselor in eg voluntary, religious, work, educational setting

**Is the client currently prescribed medication to help with their psychological problem(s)?**
- [ ] Yes
- [ ] No

**If yes, please indicate type of medication:**
- [ ] Anti-psychotics
- [ ] Anti-depressants
- [ ] Anxiolytics/Hypnotics
- [ ] Other
### Identified Problems/Concerns

| Category                  | Yes | No | Other
|---------------------------|-----|----|-------
| Depression                |     |    |       |
| Anxiety/Stress            |     |    |       |
| Psychosis                 |     |    |       |
| Personality Problems      |     |    |       |
| Cognitive/Learning        |     |    |       |
| Eating Disorder           |     |    |       |
| Physical Problems         |     |    |       |
| Addictions                |     |    |       |
| Trauma/Abuse              |     |    |       |
| Bereavement/Loss          |     |    |       |
| Self Esteem               |     |    |       |
| Interpersonal/Relationship|     |    |       |
| Living/Welfare            |     |    |       |
| Work/Academic             |     |    |       |
| Other Specifically         |     |    |       |

### ICD-10 CODES

<table>
<thead>
<tr>
<th>Code</th>
<th>Main Code</th>
<th>Sub-code</th>
</tr>
</thead>
<tbody>
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<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### What has the client done to cope with/avoid their problems? Please tick and then specify actions

<table>
<thead>
<tr>
<th>Positive actions</th>
<th>Negative actions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Assessment outcome: tick one box only

- Assessment/one session only
- Accepted for therapy
- Accepted for trial period of therapy
- Long consultation
- Referred to other service
- Unsuitable for therapy at this time

### If the client is not entering therapy give brief reason

*Page 2 of 2*
<table>
<thead>
<tr>
<th>CLINICAL OUTCOMES in ROUTINE EVALUATION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>END OF THERAPY FORM v2</strong></td>
</tr>
</tbody>
</table>

**CLINICAL**
- Client ID
  - ID numbers
- Therapist ID
  - ID numbers
- SCF numbers
- SCS numbers

**OUTCOMES in ROUTINE EVALUATION**
- Date therapy commenced
  - D M Y Y
- Date therapy completed
  - D M Y Y

**END OF THERAPY FORM v2**

**Survey:** 78 **Page:** 1

---

**What type of therapy was undertaken with the client?**
- Psychodynamic
- Psychoanalytic
- Cognitive
- Behavioural
- Cognitive/Behavioural
- Structured/Brief

**What modality of therapy was undertaken with the client?**
- Individual
- Group
- Family
- Marital/Couple

**What was the frequency of therapy with the client?**
- More than once weekly
- Less than once weekly
- Weekly
- Not at a fixed frequency

**Which of the following best describes the ending of therapy?**
- Unplanned
  - Due to crisis
  - Due to loss of contact
  - Client did not wish to continue
  - Other unplanned ending (specify below)
- Planned
  - Planned from outset
  - Agreed during therapy
  - Agreed at end of therapy
  - Other planned ending (specify below)
Appendix 4 CORE-Net Visual Session Tracking

Client: J236  Therapist: GU

Average Score x 10

Severe
Moderate Severe
Moderate
Mild
Low Level
Healthy

F 1st Session
D During Therapy
D During Therapy
<table>
<thead>
<tr>
<th>Frequency</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>0. Not at all</td>
<td>1. I have felt terribly alone and isolated</td>
</tr>
<tr>
<td>1. Often</td>
<td>10. Talking to people has felt too much for me</td>
</tr>
<tr>
<td>2. Sometimes</td>
<td>11. Tension and anxiety have prevented me from doing important things</td>
</tr>
<tr>
<td>2. Sometimes</td>
<td>12. I have been happy with the things I have done</td>
</tr>
<tr>
<td>2. Sometimes</td>
<td>13. I have been disturbed by unwanted thoughts and feelings</td>
</tr>
<tr>
<td>3. Often</td>
<td>14. I have felt like crying</td>
</tr>
<tr>
<td>2. Sometimes</td>
<td>15. I have felt panic or terror</td>
</tr>
<tr>
<td>0. Not at all</td>
<td>16. I made plans to end my life</td>
</tr>
<tr>
<td>2. Sometimes</td>
<td>17. I have felt overwhelmed by my problems</td>
</tr>
<tr>
<td>2. Sometimes</td>
<td>18. I have had difficulty getting to sleep or staying asleep</td>
</tr>
<tr>
<td>1. Often</td>
<td>19. I have felt warmth or affection for someone</td>
</tr>
<tr>
<td>2. Sometimes</td>
<td>20. My problems have been impossible to put to one side</td>
</tr>
<tr>
<td>1. Often</td>
<td>21. I have been able to do most things I needed to</td>
</tr>
<tr>
<td>1. Occasionally</td>
<td>22. I have threatened or intimidated another person</td>
</tr>
<tr>
<td>2. Sometimes</td>
<td>23. I have felt despairing or hopeless</td>
</tr>
<tr>
<td>1. Occasionally</td>
<td>24. I have thought it would be better if I were dead</td>
</tr>
<tr>
<td>2. Sometimes</td>
<td>25. I have felt criticised by other people</td>
</tr>
<tr>
<td>2. Sometimes</td>
<td>26. I have thought I have no friends</td>
</tr>
<tr>
<td>4. All of the time</td>
<td>27. I have felt unhappy</td>
</tr>
</tbody>
</table>
IMPORTANT - PLEASE READ THIS FIRST
This form has 5 statements about how you have been OVER THE LAST WEEK. Please read each statement and think how often you felt that way last week. Then tick the box which is closest to this.

Please use a dark pen (not pencil) and tick clearly within the boxes.

Over the last week...

1. I have felt terribly alone and isolated
2. I have felt OK about myself
3. I have felt panic or terror
4. I have been happy with the things I have done
5. I have felt despairing or hopeless

**Total Score**

**Total Score multiplied by 2**

(i.e. Clinical Score*)

* Procedure: Add together the item scores, then divide by the number of questions completed to get the mean score, then multiply by 10 to get the Clinical Score. Quick method for CORE-5 (if all items completed): Add together the item scores to get the Total Score, then multiply the Total Score by 2 to get the Clinical Score.

Thank you for your time in completing this questionnaire.

CORE-5 Copyright CORE System Trust (February 2000)
IMPORTANT - PLEASE READ THIS FIRST
This form has 10 statements about how you have been OVER THE LAST WEEK. Please read each statement and think how often you felt that way last week. Then tick the box which is closest to this. Please use a dark pen (not pencil) and tick clearly within the boxes.

Over the last week...

1. I have felt tense, anxious or nervous
2. I have felt I have someone to turn to for support when needed
3. I have felt able to cope when things go wrong
4. Talking to people has felt too much for me
5. I have felt panic or terror
6. I have made plans to end my life
7. I have had difficulty getting to sleep or staying asleep
8. I have felt despairing or hopeless
9. I have felt unhappy
10. Unwanted images or memories have been distressing me

Total (Clinical Score*)

* Procedure: Add together the item scores, then divide by the number of questions completed to get the mean score, then multiply by 10 to get the Clinical Score.

Quick method for the CORE-10 (if all items completed): Add together the item scores to get the Clinical Score.

Thank you for your time in completing this questionnaire

CORE-10 Copyright CORE System Trust (February 2000)
IMPORTANT - PLEASE READ THIS FIRST
This form has 18 statements about how you have been OVER THE LAST WEEK.
Please read each statement and think how often you felt that way last week.
Then tick the box which is closest to this.
Please use a dark pen (not pencil) and tick clearly within the boxes.

Over the last week

| Statement                                                                 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 |
|--------------------------------------------------------------------------|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|
| I have felt tense, anxious or nervous                                     |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |
| I have felt OK about myself                                               |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |
| Unwanted images or memories have been distressing me                     |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |
| I have achieved the things I wanted to                                  |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |
| I have felt humiliated or ashamed by other people                        |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |
| I have felt like crying                                                  |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |
| I have felt warm and affection for someone                               |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |
| My problems have been impossible to put to one side                       |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |
| I have been physically violent to others                                 |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |
| I have felt despairing or hopeless                                       |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |
| I have felt criticised by other people                                   |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |
| I have felt able to cope when things go wrong                            |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |
| I have felt unhappy                                                      |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |
| I have been irritable when with other people                             |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |
| I have felt overwhelmed by my problems                                  |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |
| I have felt panic or terror                                              |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |
| I have felt optimistic about my future                                   |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |
| I have hurt myself physically or taken dangerous risks with my health   |   |   |   |   |   |   |   |   |   |    |    |    |    |    |    |    |    |    |    |

Total Scores

Mean Scores

(18 total scores each dimension divided by number of items completed in that dimension)

(W)  (P)  (D)  (D)  All items  All minus 1
IMPORTANT - PLEASE READ THIS FIRST
This form has 18 statements about how you have been OVER THE LAST WEEK. Please read each statement and think how often you felt that way last week. Then tick the box which is closest to this. Please use a dark pen (not pencil) and tick clearly within the boxes.

Over the last week

1. I have felt terribly alone and isolated
2. I have difficulty getting to sleep or staying asleep
3. I have felt pessimistic about my future
4. I have felt totally lacking in energy and enthusiasm
5. I made plans to end my life
6. I have been troubled by aches, pains or other physical problems
7. Talking to people has felt too much for me
8. I have felt OK about myself
9. Tension and anxiety have prevented me doing important things
10. I have been disturbed by unwanted thoughts and feelings
11. I have felt overwhelmed by my problems
12. I have felt I have someone to turn to for support when needed
13. I have felt like crying
14. I have screamed or intimidated another person
15. I have been able to do most things I needed to
16. I have thought I have no friends
17. I have thought I am to blame for my problems and difficulties

Total Scores

Mean Scores

Survey: 55
Copyright MHP and CORE System Group
Page: 1

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Appendix 10 CORE Workplace Assessment Form

**Identified Workplace-specific Problems/Concerns**

<table>
<thead>
<tr>
<th>Problem/Concern</th>
<th>Code 1</th>
<th>Code 2</th>
<th>Code 3</th>
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<tbody>
<tr>
<td>Change of job situation</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Workload &amp; related issues</td>
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<tr>
<td>Work conditions</td>
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<tr>
<td>Work relationships</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Bullying/harassment</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Traumatic incident(s)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Violence/assault</td>
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<td>Work-related health issue(s)</td>
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<tr>
<td>Career issues</td>
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<td></td>
</tr>
<tr>
<td>Organisation/employment issues</td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Formal proceedings</td>
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</tr>
<tr>
<td>Other (Specify below)</td>
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**Workplace problems/concerns sub-codes**

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</tr>
<tr>
<td>Sub-code</td>
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</tbody>
</table>

**Site specific sub-codes (numbers only accepted)**

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<th>Code 1</th>
<th>Code 2</th>
<th>Code 3</th>
<th>Code 4</th>
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</thead>
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<td>User 5</td>
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<tr>
<td>User 6</td>
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</tbody>
</table>

In the last week, how have the client's problems/concerns affected their work? Tick one only

- Work functioning as normal - problems/concerns not impacting on work
- Work functioning satisfactory - but problems/concerns limiting achievement/performance
- Work functioning impaired - problems/concerns severely impacting on achievement/performance
- Work functioning severely impaired - problems/concerns resulting in sporadic work attendance
- On sick leave or absent from work

How many days in the last four weeks has the client been absent from work?

---

Survey: 34/4
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Page: 1
Appendix 11CORE Workplace End of Therapy Form

CLINICAL OUTCOMES in ROUTINE EVALUATION

WORKPLACE COUNSELLING END OF THERAPY FORM v2

Identified Workplace-specific Problems/Concerns

<table>
<thead>
<tr>
<th>Change of job situation</th>
<th>Violence/assault</th>
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</thead>
<tbody>
<tr>
<td>Workload &amp; related issues</td>
<td>Work-related health issues</td>
</tr>
<tr>
<td>Work conditions</td>
<td>Career issues</td>
</tr>
<tr>
<td>Work relationships</td>
<td>Organisational/employment issues</td>
</tr>
<tr>
<td>Bullying/harassment</td>
<td>Formal proceedings</td>
</tr>
<tr>
<td>Traumatic incident(s) (not inc. violence/assault)</td>
<td>Other</td>
</tr>
</tbody>
</table>

In the last week, how have the client’s problems/concerns affected their work? Tick one only

Work functioning as normal - problems/concerns not impacting on work
Work functioning satisfactory - but problems/concerns limiting achievement/performance
Work functioning impaired - problems/concerns severely impacting on achievement/performance
Work functioning severely impaired - problems/concerns resulting in sporadic work attendance
On sick leave or absent from work

How many days in the last four weeks has the client been absent from work?

Please specify in what specific ways counselling helped the client in their workplace...
### ARM-5 Client’s Scale

**Client ID:**  
**Session:**  
**Date:**

**Thinking about today’s meeting, please indicate how strongly you agreed or disagreed with each statement by circling the appropriate number.**

<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>My therapist is supportive</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>My therapist and I agree about how to work together</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>My therapist and I have difficulty working jointly as a partnership</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td>I have confidence in my therapist and his/her techniques</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>My therapist is confident in him/herself and his/her techniques</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>
Appendix 13 ARM-5 Scoring Demo

ARM-5 Client's Scale

Client ID: Session: Date:

Thinking about today's meeting, please indicate how strongly you agreed or disagreed with each statement by circling the appropriate number.

<table>
<thead>
<tr>
<th></th>
<th>strongly disagree</th>
<th>moderately disagree</th>
<th>slightly disagree</th>
<th>neutral</th>
<th>slightly agree</th>
<th>agree</th>
<th>moderately agree</th>
<th>strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>My therapist is supportive</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>2</td>
<td>My therapist and I agree about how to work together</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>3</td>
<td>My therapist and I have difficulty working jointly as a partnership</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>4</td>
<td>I have confidence in my therapist and his/her techniques</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>5</td>
<td>My therapist is confident in him/herself and his/her techniques</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

Scoring instructions
1) Reverse negatively worded item 3. Reversing is 7=1, 6 = 2, 5 = 3, 4 = 4,
3 = 5, 2 = 6, 7 = 1.

2) Sum scores for all items.
3) Divide total score by 5.

4) If one or more items are missing do not compute mean.

**Worked example** (scores highlighted in pink denote circled items).

- Reverse item 3: 2 = 6.
- Sum items: 6 + 4 + 6 (reversed item) + 5 + 7 = 28.
- Divide total score by 5 to give the mean score 28/5 = 5.6.

Scores range from 1 to 7, with 1 signifying a poor relationship and 7 an
excellent relationship.
Appendix 14 OH Focus Group Interview Schedule

Preliminary discussion: Introductions, ice-breaker and outline the focus group process

1. Tell me what your experience has been in using CORE-Net and ARM-5 in your practice
   a) provide examples of how you introduced them to the client
   b) give examples of how often you used them with the clients
   c) provide examples of the ways you and the client processed the information together
   d) can you describe how you handle initial assessment and risk assessment with CORE-Net and whether in your view this is different to when you were not using it

2. What are your perceptions when using CORE-Net and ARM-5 with clients?
   a) Describe how it felt to use them
   b) How does using CORE-Net differ from when you were using manually filled in CORE forms?
   c) What are your feelings about the use of ARM-5?
   d) What are your feelings about the use of CORE-Net?
   e) On a scale of 1-10, how comfortable were you using the measures?

   Not comfortable 1----------------------5---------------------------10 very comfortable
   f) In your view are there discrepancies between your CORE scores and your assessment of clients?

3. 
   a. How were the measures helpful to you?
   b. How were they helpful to your client?
   c. Have you used other measures in the past? If so were they effective?
   d. Tell me whether you would use these measures in the future with clients

4. Tell me if you understand the measures as a means to create change
   a. What changes did you see occur in your client after using this approach?
   b. How does being informed of change in CORE scores inform/affect how you proceed with the therapy?
   c. Tell me if you saw any changes occur in how you work with clients
   d. What do you typically do when you notice your clients are still not making improvement by session 3 or 4?
   e. What is your perception with regard to whether you feel CORE-Net may allow you to be more alert to possible treatment failure? How?

5. What additional resources would you find helpful in using the measures
   a. What would help you as a counsellor become more sensitive to outcomes?

6. What was your experience of the training given before you started using the measures?
   a. On a scale of 1-10, how useful was the training that was held?
   Not useful 1----------------------5---------------------------10 very useful
   b. In your view what else could the training have included?
   c. Tell me about your views on CORE-Net and its potential usefulness in supervision and in training counsellors
   d. What is your view with regard to CORE-Net and ARM-5 use by other therapists and is there anything in your view that may hinder its use?

7. What else would you like to say about the use of the measures?
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Appendix 15 PCC Focus Group Interview Schedule

Preliminary Discussion: introductions and ice-breaker

1. Tell me about what your experience has been in using CORE-Net in your practice:
   a) provide examples of how you introduced them to the client
   b) give examples of how often you used it with the clients
   c) provide examples of the ways you and the client processed the information together
   d) Can you describe how you handle both initial assessment and risk assessment with CORE-Net and whether in your view this is different to when you were not using it

2. What are your perceptions when using CORE-Net with clients?
   a) Describe how it felt to use it
   b) How does using CORE-Net differ from using manually filled CORE forms?
   c) What are your feelings about using CORE-Net?
   d) On a scale of 1-10, how comfortable are you with using CORE-Net?

   Not comfortable 1----------------------5---------------------------10 very comfortable

   f) In your view are there discrepancies between your CORE scores and your assessment of the client?

3.
   a) How is CORE-Net helpful to you?
   b) How were they helpful to your client?
   c) Have you used other measures in the past? If so were they effective?
   d) Tell me whether you will continue to use CORE-Net for the foreseeable future with clients

4. Tell me if you understand CORE-Net as a means to create change
   a) What changes did you see occur in your client after using this approach?
   b) How does change in CORE scores inform/affect how you proceed with the therapy?
   c) Tell me if you saw any changes occur in how you work with clients
   d) What do you typically do when you notice your clients are still not making any improvement by session 3 or 4?
   e) What is your perception with regard to whether you feel CORE-Net may allow you to be more alert to possible treatment failure? How?

5. What additional resources would you find helpful in using CORE-Net
   a) What would help you as a counsellor become more sensitive to outcomes?

6. What was your experience of the training given before you started using the measures
   a) On a scale of 1-10, how useful was the training that was held?
      Not useful 1----------------------5---------------------------10 very useful

   b) In your view what else could the training have included?
   c) Would you recommend that others in the profession use CORE-Net? Why?
   d) Tell me about your views on CORE-Net and the potential for its usefulness in supervision and also its potential for training counsellors.
   e) What is your view with regard to Core-Net’s potential use by other therapists and is there anything in your view that may hinder its use?

7. What else would you like to say about the use of CORE-Net?
V5_02.2007
Appendix 16 Face to Face Interview with PCC Therapist

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<th>Introduction</th>
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<table>
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<tr>
<th>Prompts:</th>
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<td>Essentially comparing his observations from the OH therapist focus group he facilitated with his experience of the use of CORE-Net in his team</td>
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<table>
<thead>
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<th>Use of clinical supervision</th>
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<th>Use of ARM-5</th>
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<table>
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<tr>
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<th>Future recommendations for his team</th>
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V5_02.2007
Appendix 17 OH Client Interview Schedule

Introductions and any questions prior to starting and re-check consent and if happy to continue.

1. Have you ever had counselling before this episode where outcome measures were used?

2. In your opinion is it important for a service to measure its outcomes with client's and hear their views in this way with measurement routinely?

3. Tell me your experience of the way they were used on screen in this service for your outcome measure during this current episode?

4. What is your view and how did you feel about inputting it yourself and then looking at specific items on the visual chart on screen?

5. How did you feel about doing it?

6. How did you find using ARM-5 at the end of each session when you were able to consider and comment in a very direct manner how you felt about your relationship with the therapist?

7. In your view were you able to be totally honest?

8. Do you feel this helped your relationship with the therapist? How?

9. Anything else you would like to add?

V5_02.2007
### Introductions

#### Prompts:

- Feelings/views generally speaking about outcome measurement per se
- Knowledge if any about the specifics of the subject and understanding of their use of CORE System, how are they using it?
- Views on how they deal with assessments and the issues of risk and triaging of sessions
- General views of the rest of the team using CORE-Net
- Future Use of CORE-Net?

V5_02.2007
Appendix 19 OH Therapist Diary Outline

<table>
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<th>Date of Client Session and which session:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapist ID:</td>
</tr>
<tr>
<td>Client ID:</td>
</tr>
</tbody>
</table>

1. How did you introduce CORE-Net?


3. How did you introduce ARM-5?

4. How did you process it?

5. How did it feel for you? What was your ‘felt sense’?

6. How did the client respond to it?

7. Describe any therapeutic benefit of using CORE-Net/ARM-5 in the session

8. Describe any negative aspects if any of using CORE-Net-ARM-5 in the session

Points to raise in supervision:

Points to consider following supervision:

V5_02.2007
Appendix 20 PCC Therapist Invitation Letter

(Researcher hospital headed paper)

Date

Dear (Therapist – PCC)

I am writing to ask if you would be willing to take part in a research project that:

Explores what your perceptions and experience as a counsellor and those of your client's is with regard to using CORE-Net in your practice. The aim of the study is:

To elicit the perceptions of therapists in relation to their use of a system of continuous monitoring of their therapy via a feedback system with CORE-Net and ARM-5.

You are being asked your service is the longest user of CORE-Net in the U.K. The project is due to start between April and May 2007 and to run until 31st December 2007. The research is being carried out by myself as a practicing psychotherapist working in Occupational Health at Kingston Hospital NHS Trust.

All you need to do is indicate at this stage if you are willing to take part in the study. Participation will mean taking part in either a focus group with your other colleagues within your service currently using CORE-Net or one to one interview if you have used CORE-Net in the past but have now discontinued its use or you do not use CORE-Net at all. Finally, when the data has been transcribed and analysed you will be sent a copy for any comments you may have before the finalizing of the report is made. You will of course also receive a final version of the complete report at the study's conclusion.

Enclosed is a questionnaire for Additional Therapist Details Questionnaire in order for me to be able to determine the various factors that make up the group of therapists. Please would you complete and send back to myself in the enclosed envelope along with the consent form. You are under no obligation to participate if you do not want to. Also enclosed is a Participant (Therapist) Information Sheet which sets out the key details that you may want to know in coming to a decision about whether to take part.

If I receive your completed questionnaire/consent form back, I will then inform you of the date for the focus group/one to one interviews. If you have any queries or concerns, please feel free to contact me as per letterhead details. It would be appreciated if you could respond within two weeks of receipt of this letter. A stamped addressed envelope is enclosed for your reply.

Thank you in anticipation

Yours sincerely

Gisela Unsworth (Senior Adult Psychotherapist M.A, UKCP Registered)
Head of Psychological Well Being Service
Occupational Health Department
Kingston Hospital NHS Trust
Telephone Number 0208 546 7711 ext. 2615

V5_02.2007
PARTICIPANT (THERAPIST PCC) INFORMATION SHEET

Study Title: Therapists' and Clients' Perceptions of Using CORE-Net and ARM-5 in the NHS

You are being invited to take part in a research study to explore what your experience as a therapist and those of your client’s is with regard to using CORE-Net in your practice. Your service has been identified as being the longest users of CORE-Net in the U.K. Personally as a therapist you may have started to use CORE-Net and discontinued its use or you may not have used CORE-Net at all and your views are also sought. You are under no obligation to take part if you do not want to. Please take time to read the following information carefully and discuss with others if you wish. Please feel free to ask me if there is anything that you are unclear about or need to know to give your informed consent to participate in this study. One other counselling service, an employee counselling service will be using an alliance measure called ARM-5 in this study.

Purpose of the Study:
To elicit the perceptions of therapists and clients in relation to their use of a system of continuous monitoring of their therapy via a feedback system with CORE-Net and ARM-5 in the NHS

The overall research will contribute to the wider understanding with regard to the actual experience for both clients and counsellors in using the technology of visual progress charts (a feedback system) during therapy. International research indicates that benefits to the client may be that they may need to attend less therapy sessions for optimal psychological benefits and therapists give them more therapy if scores are still above clinical-cut off at session 4 or 5 out of a possible six. Overall it may increase the efficiency of sessions of the service so that the clients have a shorter wait time for initial assessment thus reducing wait list times.

What is required:
1) Complete the enclosed therapist questionnaire and send back with the consent form
2) Take part of a taped focus group if you are a current CORE-Net user or part of one to one taped interview if you have discontinued its use or do not use CORE-Net at all.
3) Once the data is transcribed and analysed you will be sent a copy should you wish to make any comments before the finalization of the report. The study is anticipated to start in April/May 2007 and be finished in the main by 31st December 2007. Tapes will be stored securely and without identifying data and only heard by researcher, transcriber and responsible examiners. They will be erased once the project is completed.

Thank you for your time

Gisela Unsworth. February 2007
V6_03.2007
PARTICIPANT (THERAPIST-PCC) CONSENT FORM

Title of Project: Therapists' and Clients' Perceptions of Using CORE-Net and ARM-5 in the NHS

Name of Researcher: Gisela Unsworth (Kingston Hospital NHS Trust)

1. I confirm that I have read and understand the information sheet dated 13.03.2007 (version 6) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily □ (please initial box)

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. □ (please initial box)

3. I understand that only my anonymous data that is collected during the study from taped interviews and CORE-Net may be looked at by responsible individuals from University of Surrey (includes the researcher), transcriber, and COREIMS LTD. I give permission for these individuals to have access to my Interview/CORE-Net (if applicable) data as part of this study. □ (please initial box)

4. I agree to take part in the above study. □ (please initial box)

<table>
<thead>
<tr>
<th>Name of Therapist</th>
<th>Date</th>
<th>Signature</th>
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<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Name of Person taking consent (if different from researcher)</th>
<th>Date</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gisela Unsworth Researcher</td>
<td></td>
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</table>

**When completed, 1 copy to be kept by therapist and original to be sent to the researcher Gisela Unsworth, Kingston Hospital NHS Trust in the enclosed envelope. V6_03.2007**
Appendix 23 Additional Therapist Details

(Researcher hospital headed paper)

Additional Therapist Details Questionnaire

1. What is your main theoretical orientation (please circle only one):
   a) Psychodynamic       e) Cognitive/Behavioural     i) Systemic
   b) Psychoanalytic      f) Structured/Brief        j) Supportive
   c) Cognitive           g) Person-Centred          k) Art
   d) Behavioural         h) Integrative

   Other (please specify) __________

2. What is your age?

3. What is your gender?

4. Who is your professional registration/accrediting body or if you are a trainee how many supervised clinical hours have you accumulated approximately to date?

5. If you are a qualified (BACP or equivalent) therapist how many years experience post qualifying?

6. Do you work part/time or full-time and how many hours are you contracted to work?
   - Full-time: YES □ NO □
   - Part-time: YES □ NO □

   Number of hours ______

7. What is your work contact number?

8. What is your work email address?

9. Do you routinely give clients the consent and information form on CORE to fill out?
   - YES □ NO □

10. Do you routinely give out to all clients a service user satisfaction evaluation form at the end of therapy? Or later?
    - YES □ NO □

11. Do you have access to a PC and internet during your therapy sessions?
    - YES □ NO □

12. How long approximately have you been using CORE System/CORE-Net (cross out irrelevant one)
    ____________?
Appendix 24 OH Therapist Letter

(Researcher hospital headed paper)

Dear (Therapist- OH)

I am writing to ask if you would be willing to take part in a research project that aims to: explore what your perceptions and experience as a therapist and those of your client's is with regard to using CORE-Net and ARM-5 in your practice. The aim of the study is:

To elicit the perceptions of therapists (both experienced and trainees) and clients in relation to their use of a system of continuous monitoring of their therapy via a feedback system that includes regular outcome measuring (CORE-Net) and therapeutic alliance measure (ARM-5).

You are being asked because your service is willing to trial CORE-Net and ARM-5 within the time frame of the researcher's research project. The data collection of the project is due to start between April and May 2007 and run until December 2007 by which time it is anticipated that your opportunity in giving feedback if appropriate after seeing the transcribed data and preliminary report may be concluded. The research is being carried out by Gisela Unsworth who is a practicing psychotherapist working in Occupational Health.

All you need to do is indicate at this stage if you are willing to take part in the study. All therapists need to be prepared to continue in the study for the duration of the study that is approximately 9/10 months (April/May-December 2007) but data collection finishes which includes the focus groups at the end of six months Oct/November 2007. You will receive training and support and will be given a final summary of the research results after the completion of the study.

Enclosed is a questionnaire for therapist demographic detail purposes (Appendix 3) so that I will be able to determine the various factors that make up the group of therapists. Please would you complete and send back to myself in the enclosed envelope along with the consent form (Appendix 4). You are under no obligation to participate if you do not want to. There is also a Participant (Therapist) Information Sheet (Appendix 2) which sets out the key details that you may want to know in coming to a decision about whether to take part and a chart (Appendix 10) showing the study design and timeline.

If I receive your completed questionnaire/consent form back, I will then inform you of the details of the online tutorial training and face to face training which will be delivered in advance of the start of the data collection period. If you have any queries or concerns, please feel free to contact me by phone or email as per letterhead details. It would be appreciated if you could respond within two weeks of receipt of this letter. A stamped addressed envelope is enclosed for your reply.

Thank you in anticipation

Yours sincerely

Gisela Unsworth (Senior Adult Psychotherapist M.A, UKCP Registered)
Head of Psychological Well Being Service
Occupational Health Department
Kingston Hospital NHS Trust (0208 546 7711 ext. 2615)
V5_02.2007
PARTICIPANT (THERAPIST - OH) INFORMATION SHEET
Study Title: Therapists’ and Clients’ Perceptions of Using CORE-Net and ARM-5 in the NHS
You are being invited to take part in a research study to explore what your experience as a therapist and those of your client’s is with regard to using CORE-Net in your practice. You are under no obligation to take part if you do not want to. Please take time to read the following information carefully and discuss with others if you wish. Please feel free to ask me if there is anything that you are unclear about or need to know to give your informed consent to participate in this study. One other counselling service, a primary care counselling service will also be participating in this study.

Purpose of the Study:
To elicit the perceptions of therapists and clients in relation to their use of a system of continuous monitoring of their therapy via a feedback system with CORE-Net and ARM-5 in the NHS

The overall research will contribute to the wider understanding with regard to the actual experience for both clients and counsellors in using the technology of visual progress charts (a feedback system) during therapy. International research indicates that benefits to the client may be that they may need to attend less therapy sessions for optimal psychological benefits and therapists give them more therapy if scores are still above clinical-cut off at session 4 or 5 out of a possible six. Overall it may increase the efficiency of sessions of the service so that the clients have a shorter wait time for initial assessment thus reducing wait list times.

What is required:
1) Complete the enclosed therapist questionnaire and send back with the consent form
2) Attend training on CORE-Net and the use of ARM-5 and use in routine practice.
3) Keep x 2 process diaries of your first two clients using the above measures
4) Choose one of these clients at the end with their consent for me to contact them for a one to one interview and again after you have used the measures for 4.5 months ask just one other client to do the same.
5) During this time the researcher who is a participant observer will be keeping reflective field notes/process journal and recording formal and informal discussions during the study period with the therapists
6) Attend x 2 focus groups at the end of the data collection period after six months on the same day with the x 1 group facilitated by Gisela Unsworth and the second group facilitated by a current CORE-Net user from the primary care counselling service in this study.
7) Once the data is transcribed and analysed you will be sent a copy should you wish to make any comments before the finalization of the report. The study is anticipated to start in April/May 2007 and be finished in the main by 31st December 2007. Tapes and other data gathered during the study will be stored securely and without identifying data and only heard by researcher, transcriber and responsible University examiners. Tapes will be erased once the project is completed.

Thanking you for your time

Gisela Unsworth. February 2007

V6_03.2007
Appendix 26 OH Therapist Consent Form

(Researcher hospital headed paper)

Centre Number: KH-OH
Study Number: 07/Q0806/12
Therapist Identification Number for this study:

PARTICIPANT (THERAPIST - OH) CONSENT FORM

Title of Project:

Therapists' and Clients' Perceptions of Using CORE-Net and ARM in the NHS

Name of Researcher: Gisela Unsworth (Kingston Hospital NHS Trust)

1. I confirm that I have read and understand the information sheet dated 13.03.2007 (version 6) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily □ (please initial box)

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. □ (please initial box)

3. I understand that only my anonymous data that is collected during the study including taped conversations/interviews once anonymised may be looked at by responsible individuals from the University of Surrey, COREIMS LTD, researcher and transcriber and ARM-research team at Leeds University as part of this study. I give permission for these individuals to have access to my CORE-Net/ARM-5 data and interview/process diaries data (both mine and the researcher's) as part of this study □ (please initial box)

4. I agree to take part in the above study. □ (please initial box)

Name of Therapist ____________________________ Date __________ Signature __________

Name of Person taking consent ____________________________ Date __________ Signature __________

(if different from researcher)

Gisela Unsworth ____________________________ Date __________ Signature __________

Researcher

**When completed, 1 copy to be kept by therapist and original to be sent to the researcher Gisela Unsworth, Kingston Hospital NHS Trust in the enclosed envelope.

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Appendix 27 CORE-Net & ARM-5 Training Schedule

April 2007 Training Schedule for Doctorate Research Project

a) Human Givens and Bill Andrews CORE – UK presentations – 20-30mins

b) CORE-Net demo recording x 30 mins

CORE-Net practice time 30 mins

Triage at assessment (decide how many sessions to offer based on clinical cut-off scores) and during therapy when improved to below clinical cut off plan to end and when still above clinical cut off by 3/4 session discuss this directly and perhaps agree to give more than the usual say (6) until they get to below cut off scores. The preamble to them filling out the CORE-Net 34 on assessment is to say something like “I would like you to fill out a questionnaire that will give me an indication of how you are and what has brought you here, please be as honest as you can and indicate how you have been feeling and try to capture what has brought you here when you fill this out”. Remember if they score in the healthy population or just over the score of 10 you may want to say something like this “According to this score as you can see on the screen you appear to be doing very well, do you think this accurately reflects how you are and what has brought you to counselling today? So what do you think brings you to counselling, what do you think you would like out of it?” You may then explore whether they are truly scoring that or whether they are afraid to say in case you judge them to be “mad” or “too mad” to help them. That is why you need to state about them being completely honest so that you can get an accurate picture of how to best assist them. If their score is in the healthy range you need to explore your goals and how you will achieve them in much less than 6 sessions. If they score any items in the risk factors the next session you have with them must be an 18 item and no less. Always use the same 18-item measure with them for e.g. there is an 18 item –A version and an 18 item-B version. So if you start with an A version only use A with this client until there is no more risk and then you can use 5 or 10 measure. If they score no risk you can immediately move to 5 or 10 for the in-between sessions until you conclude on the last session with a 34 item full measure.

c) How to introduce to client including consent forms (15 mins)

“This service uses outcome measures to check how you are doing and if you are happy with the way we are working with you. Currently we are using a computer software system as part of a trial for a research study which captures data anonymously and I need to give you the information to read before we start but you don’t have to decide to donate your anonymous data for research purposes until the end of our session today. However, if you want to sign the consent form now you may also do so if you so wish.” (If client does not consent to the study use the previous CORE paperwork information sheet as normal but they will need to enter data onto core-net and you don’t use ARM-5 with them). You need to make a note that this client declined to give consent for the study on the sheet saved on your v drive under client consent forms details. If they consent you need to do ARM-5 at the end of the session and collect and put in an envelope all forms and in my tray.

d) ARM-5 (15 mins) – give out form at the end and ask them to fill it out as honestly as
possible and fold it up and then to give it to you as they are leaving. You may wish to say as you introduce it: "This measure allows you to tell me how you think the session has gone today and whether you think we are on track and I will only look at it once you have left the room, so please be as honest as you possibly can and when you are finished, fold it over once and leave it on the table. I will look at it only after you have gone". You then add up the scores as per instructions and write down a total. Then make three copies (one for you, and two for me).

e) Based on 2005 Harmon et al. paper on several interventions proposed as possibilities for therapists to consider if client is not making the expected progress (not "on track" or "off-track") or alliance measure (ARM-5) indicates a low rating of the therapeutic alliance:

- Discuss the here and now relationship with your client
- Give and ask for feedback on the therapeutic relationship
- Spend more time exploring your client's experience
- Pay careful attention to the agreement between you and your client concerning the overall goals of treatment and the tasks necessary to achieve those goals
- Accept responsibility for your part in alliance ruptures
- Reframe the meaning of tasks or goals and/or modify them in order to increase co-operation and satisfaction
- Work with resistance
- Provide a rationale for your techniques, actions and/or behaviours
- Pay attention to subtle cues that there may be a problem with the alliance allow the client to assert his/her negative feelings about the relationship
- Explore with your client his/her fears about asserting negative feelings about the relationship
- Give more positive feedback
- Process transference and be aware of counter transference
- Discuss therapist and therapeutic style match
- Discuss shared experiences

In addition we can take also into account clinical support tools like the suggestions on research on the stages of change and motivational interviewing:

- Ask open-ended questions about the client's problem behaviours. Persuade talk about the behaviour. Attention alone may help them become aware of their problems
- Discuss the positive and negative effects of the behaviour. Help the client to identify the costs and benefits of his or her behaviour
- Give straightforward advice and professional information about the negative consequences of their behaviour of if the client seems ready to hear it
- Show strong confidence that the client has the inner strength to overcome the problem
- Avoid offering solutions for the problems at this stage; rather, focus on giving clients the opportunity to explore and resolve ambivalence for themselves
- Avoid focusing on the same issue. The client may not give the problem the same weight you do. The client may have larger
concerns that he or she has not yet revealed to you.

f) Fill out the diary forms saved on your v drive for just the first two clients that you see. I will indicate which client you will choose out of your first two for you to ask for them to be interviewed by me for up to 30 minutes face to face within a month of them completing therapy. When you do ask them it will be at your last session with them and you may say something like "I would like to ask you if Gisela Unsworth who is the Head of the Psychological Well Being Service may call you to arrange a one-off face to face interview of up to 30 minutes to get your views on how you have found filling out these forms on screen as part of your therapy and your experience of seeing your sessions tracked on a chart?"

***PLEASE NOTE ALL CLIENT AND THERAPIST ID CODES REMAIN AS YOU HAVE ALWAYS HAD THEM***
Please note all copies needed for the research are kept in the therapy room in the right hand side bottom desk draw in core-net research file.

As a summary of the research process:

**Gisela Unsworth will email or send to clients in advance the information needed for the study including the Non-Attendance leaflet. If there is no time to do this before you see the client you will undertake this yourself as below and Gisela will make a note of this. If you are taking on new clients on a day that Gisela is not present you need to send the information to them via email or internal post if there is time or when they arrive follow the instructions below. In the core-net research folder in your ‘v’ drive what you need to send to the client is saved for you to attach and send or take from the file copies to post internal post to them. Remember even if this is done you still need to have hard copies when they arrive in case they did not get the information, forgot it or did not read it in advance.**

Each therapist will ask every client for consent to participate in the study and give out special research information sheet **PARTICIPANT (CLIENT-OH) INFORMATION SHEET** at the start of the session after you have done point 1. below and point 2. below. If they consent start them on the screen questionnaire and continue as point 3. and 4. below. If they don't consent but will let you know at the end of session still continue as normal. At the end if they say yes then plan next date of session and then give them ARM-5 following instructions on number 5. below. If they don’t consent to research give our normal CORE information sheets and consent form and don’t do ARM-5 but use core-net as normal.

For just the first two clients that you see who consent to using core-net and being in the research study you will fill out the **therapist diary outline** at each session you see them. Gisela will let you know which one of the two you will ask at the end of therapy with them if she can contact them within a month of finishing therapy according to number 9. below. For the duration of the study Gisela will be recording interactions with the team in reference to the research and finally at an agreed date you will all be part of a focus group to be interviewed by Tony Jordan one of the longest users of CORE-Net in the UK from Sussex Partnership NHS Trust who provides primary care counselling. This is anticipated to be in November 2007.

1. Set up core-net before client arrives so that the questionnaire for assessment (called First Session) or other in-between is open ready for them to click away. Very important if it is a First Session that you put in the correct Client ID which is the next number that you use and have always used from CORE-PC so **no new coding needed** here for the purposes of this study.

2. **Please note that when you open a new client in CORE-Net, you MUST immediately change the client ID from the default long number to your own client ID (e.g. X123). If you do not do that before you leave the front screen, you CANNOT change the ID later. Also, at present you cannot delete a client if you make a mistake, so be very careful!**

How to introduce to client including consent forms
3. **Introducing the consent forms:**

**PARTICIPANT (CLIENT-OH) INFORMATION SHEET AND PARTICIPANT (CLIENT-OH) CONSENT FORM**

“This service uses outcome measures to check how you are doing and if you are happy with the way we are working with you. Currently we are using a computer software system as part of a trial for a research study which captures data anonymously and I need to give you the information to read before we start but you don’t have to decide to donate your anonymous data for research purposes until the end of our session today. However, if you want to sign the consent form now you may also do so if you so wish.” (If client does not consent to the study use the previous CORE paperwork information sheet as normal but they will need to enter data onto core-net and you don’t use ARM-5 with them). You need to make a note that this client declined to give consent for the study on the sheet saved on your v drive under **Client Consent Forms details**. If they consent you need to do ARM-5 at the end of the session and collect and put in an envelope all forms and in my tray. Please do not forget to enter ID codes on ARM-5 forms and once completed and you have scored them do 3 copies one for you to keep and two in Gisela’s tray.

4. Ask client if they know how to use a computer mouse and where to click away and if they don’t know please demonstrate simply how they need to click the mouse. Once they have finished this the screen is handed back to you and you login again and look at the chart with them and explain the scores and look at some of the detail if relevant particularly if there is any risk score.

5. Triage at assessment (decide how many sessions to offer based on clinical cut-off scores) and during therapy when improved to below clinical cut off plan to end and when still above clinical cut off by 3/4 session discuss this directly and perhaps agree to give more than the usual say (6) until they get to below cut off scores. The preamble to them filling out the CORE-Net 34 on assessment is to say something like “I would like you to fill out a questionnaire that will give me an indication of how you are and what has brought you here, please be as honest as you can and indicate how you have been feeling and try to capture what has brought you here when you fill this out”. Remember if they score in the healthy population or just over the score of 10 you may want to say something like this “According to this score as you can see on the screen you appear to be doing very well, do you think this accurately reflects how you are and what has brought you here, please be as honest as you can and indicate how you have been feeling and try to capture what has brought you here when you fill this out”.

Remember if they score in the healthy population or just over the score of 10 you may want to say something like this “According to this score as you can see on the screen you appear to be doing very well, do you think this accurately reflects how you are and what has brought you here, please be as honest as you can and indicate how you have been feeling and try to capture what has brought you here when you fill this out”. You may then explore whether they are truly scoring that or whether they are afraid to say in case you judge them to be “mad” or “too mad” to help them. That is why you need to state about them being completely honest so that you can get an accurate picture of how to best assist them. If their score is in the healthy range you need to explore your goals and how you will achieve them in much less than 6 sessions. If they score any items in the risk factors the next session you have with them must be an 18 item and no less. Always use the same 18-item measure with them for e.g. there is an 18 item –A version and an 18 item-B version. So if you start with an A version only use A with this client until there is no more risk and then you can use 5 or 10 measure. If they score no risk you can immediately move to 5 or 10 for the in-between sessions until you conclude on the last session with a 34 item full measure.
6. ARM-5 – give out form at the end and ask them to fill it out as honestly as possible and fold it up and then to give it to you as they are leaving after you have finalized the next session time. Please remember to be meticulous with ID codes and paperwork and fill in a.s.a.p. the client code on the ARM-5 corresponding to your ID client code for CORE-Net. Also you will need to fill this same ID code for the same client on their client consent form and your therapist diary outline (for the outline just the first two clients per therapist). For all clients that consent ARM-5 is done with each one. You may wish to say as you introduce it “This measure allows you to tell me how you think the session has gone today and whether you think we are on track and I will only look at it once you have left the room, so please be as honest as you possibly can”. You then add up the scores as per instructions and write down a total on the actual sheet. Then make three copies (one for you, and two for me). Following this you need to print out the ARM-5 Score Information Sheet and fill it in manually and keep it with the client notes. To use the calculator on the computer: Click “Start” (bottom left of screen) — Click “Programs” — Click “Accessories” — Click “Calculator”. To put a shortcut on your desktop — right click “Calculator” — calls up menu — select “send to desktop as shortcut”.

7. After they leave type up the notes as normal and in addition for just the first two clients that you see you will do the Therapist Outline Diary as per training instructions for each session that you see the client. Don’t forget to fill out the Therapy Assessment Form (TA) and Workplace Assessment Form.

8. If a client is not on track or we feel they are stuck or have rated us with a low score on the ARM-5 you may wish to consider the points in this number 7 and number 8 which is based on research to try to move clients on after we have negative feedback from them or when they deteriorate within the first few session. Based on 2005 Harmon et al. paper on several interventions proposed as possibilities for therapists to consider if client is not making the expected progress or alliance measure indicates a low rating of the therapeutic alliance:
   - Discuss the here and now relationship with your client
   - Give and ask for feedback on the therapeutic relationship
   - Spend more time exploring your client's experience
   - Pay careful attention to the agreement between you and your client concerning the overall goals of treatment and the tasks necessary to achieve those goals
   - Accept responsibility for your part in alliance ruptures
   - Reframe the meaning of tasks or goals and/or modify them to increase cooperation and satisfaction
   - Work with resistance
   - Provide a rationale for your techniques, actions and/or behaviours
   - Pay attention to subtle cues that there may be a problem with the alliance
   - Allow the client to assert his/her negative feelings about the relationship
   - Explore with your client his/her fears about asserting negative feelings about the relationship
   - Give more positive feedback
   - Process transference and be aware of counter transference
• Discuss therapist and therapeutic style match
• Discuss shared experiences

9. In addition we can take also into account clinical support tools like the suggestions on research on the stages of change and motivational interviewing:

• Ask open-ended questions about the client's problem behaviours.
• Persuade them to talk about the behaviour. Attention alone may help them become aware of their problems
• Discuss the positive and negative effects of the behaviour. Help the client to identify the costs and benefits of his or her behaviour
• Give straightforward advice and professional information about the negative consequences of their behaviour of if the client seems ready to hear it
• Show strong confidence that the client has the inner strength to overcome the problem
• Avoid offering solutions for the problems at this stage; rather, focus on giving clients the opportunity to explore and resolve ambivalence for themselves
• Avoid focusing on the same issue. The client may not give the problem the same weight you do. The client may have larger concerns that he or she has not yet revealed to you.

Fill out the diary forms saved on your v drive for just the first two clients that you see. I will indicate which client you will choose out of your first two for you to ask for them to be interviewed by me for up to 30 minutes face to face within a month of them completing therapy. When you do ask them it will be at your last session with them and you may say something like "I would like to ask you if Gisela Unsworth who is the Head of the Psychological Well Being Service may call you to arrange a one-off face to face interview of up to 30 minutes to get your views on how you have found filling out these forms on screen as part of your therapy and your experience of seeing your sessions tracked on a chart?"

10. ***PLEASE NOTE ALL CLIENT AND THERAPIST ID CODES REMAIN AS YOU HAVE ALWAYS HAD THEM

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## Checklist for Each Session Using Core/Core-Net (30.4.07)

<table>
<thead>
<tr>
<th>First Session</th>
<th>Other Sessions</th>
<th>Last Session</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Before Client</strong></td>
<td><strong>Before Client</strong></td>
<td><strong>Before Client</strong></td>
</tr>
<tr>
<td>Set up Core-Net for client (34 items)</td>
<td>Set up Core-Net for client (18 items if risk or 5 or 10 items)</td>
<td>Set up Core-Net for client (34 items)</td>
</tr>
<tr>
<td>Remember to change client ID!</td>
<td>With client</td>
<td>With client</td>
</tr>
<tr>
<td>Client completes Core-Net</td>
<td>Client completes Core-Net</td>
<td>Client completes Core-Net</td>
</tr>
<tr>
<td>Core-Net information sheet</td>
<td>Discuss Core-Net</td>
<td>Discuss Core-Net</td>
</tr>
<tr>
<td>Core-Net consent form</td>
<td>Discuss Arm-5 from last session</td>
<td>Discuss Arm-5 from last session</td>
</tr>
<tr>
<td>Discuss Core-Net scores</td>
<td>Session as usual</td>
<td>Session as usual</td>
</tr>
<tr>
<td>Date for next session</td>
<td>Date for next session</td>
<td>Date for next session</td>
</tr>
<tr>
<td><strong>If Client Consents to Research:</strong></td>
<td><strong>If Client Does Not Consent to Research:</strong></td>
<td><strong>If Client Does Not Consent to Research:</strong></td>
</tr>
<tr>
<td>Arm-5 (at end of session)</td>
<td>Client information sheet and consent form if you like to do it at the start or do at the end (last session) if that is what you are used to</td>
<td>Client information sheet client consent to use of Core-Net</td>
</tr>
<tr>
<td><strong>After Client</strong></td>
<td><strong>After Client</strong></td>
<td><strong>After Client</strong></td>
</tr>
<tr>
<td>Score Arm-5 and fill out Arm-5 score information sheet</td>
<td>Score Arm-5 and fill out Arm-5 Score Information Sheet</td>
<td>Score Arm-5 and fill out Arm-5 Score Information Sheet</td>
</tr>
<tr>
<td>Type up notes</td>
<td>Type up client notes</td>
<td>Type up client notes</td>
</tr>
<tr>
<td>Complete consent status form</td>
<td>Complete Core-Net TA &amp; workplace &amp; admin screens</td>
<td>Complete Core-Net TA &amp; workplace EOT screens</td>
</tr>
<tr>
<td>Opas as usual</td>
<td>Opas as usual</td>
<td>Opas as usual</td>
</tr>
<tr>
<td>Send forms (consent and Arm-5 if appropriate to GU)</td>
<td>Arm-5 &amp; consent forms to GU</td>
<td>Arm-5 &amp; consent forms to GU</td>
</tr>
<tr>
<td><strong>For First Two Research Clients</strong></td>
<td><strong>For First Two Research Clients</strong></td>
<td><strong>For First Two Research Clients</strong></td>
</tr>
<tr>
<td>Complete therapist outline diary</td>
<td>Complete therapist outline diary</td>
<td>Complete therapist outline diary</td>
</tr>
<tr>
<td><strong>Seek Permission for Interview with GU with Just One Client</strong></td>
<td><strong>If Client Does Not Consent to Research:</strong></td>
<td><strong>If Client Does Not Consent to Research:</strong></td>
</tr>
<tr>
<td>Client information sheet client consent to use of Core-Net</td>
<td>Client information sheet client consent to use of Core-Net</td>
<td>Client information sheet client consent to use of Core-Net</td>
</tr>
</tbody>
</table>
PARTICIPANT (CLIENT-OH) INFORMATION SHEET

Study Title: Therapists' and Clients' Perceptions of Using CORE-Net and ARM-5 in the NHS

You are being invited as a counselling client to take part in a research study undertaken by Gisela Unsworth, Head of Psychological Well Being Service, Occupational Health at Kingston Hospital. This is part of her further studies at the University of Surrey. Please read the following information carefully and discuss with your therapist if you wish.

What is the reason for this study:
The study is to look at your views of the relationship between you and the counsellor and your progress during treatment. Your feedback will tell us both if you are benefiting from the treatment or if we need to change something so that you can get what you want out of the treatment.

What will I have to do in this study?
You will be asked to fill out two forms (one directly onto a computer screen) to give feedback on how you are getting on with the counselling. If you have never used a computer before, the therapist will assist you with this aspect. You may be asked to be interviewed (taped) by the researcher within one month of finishing your therapy on your experience of counselling. Once this data is transcribed and analysed you will be sent a copy should you wish to make any comments before the final report.

What are the risks/benefits of this study?
There are no risks involved in this study. There are no direct benefits to you for taking part, however we expect to learn valuable information which will help us to improve our service by involving and learning from you.

What are your options if you do not participate in this study?
It is ok to say no if you do not wish to participate or withdraw at anytime and this will not affect your therapy.

Will my personal information be passed onto others?
The personal information that identifies you will only be kept by the counselling team. Only anonymous (where you as a person cannot be identified) information relating to your views of the counselling and health progress will be used for the study. The service will donate the anonymous data from the two forms for the relevant research and service improvement. Any research published in the future will always have client anonymity. If you have been asked to be interviewed, tapes will be stored securely and without identifying data and only heard by researcher, transcriber and responsible University examiners. Tapes will be erased once the project is completed.

Who has reviewed this study?
London Surrey Borders Ethics Committee and Epsom and St Heller NHS Trust Research and Development Committee have reviewed this study to ensure that it meets the NHS ethical standards.

THANK YOU FOR YOUR TIME
Gisela Unsworth
March 2007 (Contact on Gisela.unsworth@kingstonhospital.nhs.uk or 0208 546 7711 ext. 2615)

V6.03.2007
Appendix 31 OH Client Consent Form

(Form to be on researcher headed paper)

Centre Number: KH-OH:
Study Number: 07/Q0806/12
Client Identification Number for this study:

CLIENT (OH) CONSENT FORM

Title of Project: Therapists' and Clients' Perceptions of Using CORE-Net and ARM-5 in the NHS

Name of Researcher: Gisela Unsworth (Kingston Hospital NHS Trust)

1. I confirm that I have read and understand the information sheet dated 15.02.2007 (version 4) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily □ (please initial box)

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. □ (please initial box)

3. I understand that only my anonymous data that is collected during the study from CORE-Net/ARM-5/including taped interviews(if applicable) may be looked at by responsible individuals from University of Surrey, COREIMS LTD, the researcher, transcriber and the researchers of ARM-5(Leeds University) as part of this research. I give permission for these individuals to have access to my anonymous data □ (please initial box)

4. I agree to take part in the above study. □ (please initial box)

Name of Therapist ___________________________ Date ___________ Signature ___________

Name of Person taking consent (if different from researcher) ___________________________ Date ___________ Signature ___________

Gisela Unsworth ___________________________ Date ___________ Signature ___________

Researcher ___________________________ Date ___________ Signature ___________

**When completed, 1 copy to be kept by OH Client and original to be sent to the researcher Gisela Unsworth, Kingston Hospital NHS Trust in the enclosed envelope.
V5_02.2007
Appendix 32 CORE-Net & ARM-5 Therapist Diary

<table>
<thead>
<tr>
<th>Date of Client Session and which session:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapist ID:</td>
</tr>
<tr>
<td>Client ID:</td>
</tr>
</tbody>
</table>

1. How did you introduce CORE-Net?


3. How did you introduce ARM-5?

4. How did you process it?

5. How did it feel for you? What was your ‘felt sense’?

6. How did the client respond to it?

7. Describe any therapeutic benefit of using CORE-Net/ARM-5 in the session

8. Describe any negative aspects if any of using CORE-Net-ARM-5 in the session

Points to raise in supervision:

Points to consider following supervision:

V5_02.2007

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16 March 2007

Mrs Gisela Unsworth  
Head of Psychological Well Being Service  
Kingston Hospital NHS Trust  
Occupational Health Department  
Galsworthy Road  
Kingston-Upon-Thames, Surrey  
KT2 7QB

Dear Mrs Unsworth

**Full title of study:** Therapists' and Clients' Perceptions of Using CORE-Net and ARM-5 in the NHS  
**REC reference number:** 07/Q0806/12

Thank you for your email of 15 March 2007, responding to the Committee's suggestions following the meeting on 07 March 2007.

Received documents

The list of documents received following the favourable opinion given on 07 March 2007

- Email dated 15 March, notifying amendments.
- Appendix 8 – Client Information Sheet, dated March 2007
- Appendix 2 – Therapist Information Sheet, version 6, dated March 2007

The Committee is happy to maintain the favourable opinion given and confirm that you are still to use Appendix 16 to undertake the "diary/journal/reflective notes" section of the study.

Conditions of approval

The favourable opinion was given provided that you comply with the conditions set out in the document "Standard conditions of approval by Research Ethics Committees" enclosed with the initial favourable opinion letter. If you require a further copy of these conditions please refer to www.corec.org.uk or contact the REC office.

Statement of compliance
The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

REC reference number: 07/Q0806/12
Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely

Mrs Sheree Manson
Committee Co-ordinator

E-mail: sheree.manson@stgeorges.nhs.uk
23 April 2007  
Ms Linda Unsworth  
Head of Psychological Well Being Service  
Kingston Hospital  
Golborne Road  
Kingston upon Thames  
Surveymen  
KT2 5PD  
Dear Linda  
Therapists and Clients Perceptions of Using CORE-Net and ARM-5 in the NHS (Our Ref. EC/2003/063) - Compliance  
I am writing to inform you that the Ethics Committee has now approved the above protocol on the understanding that the Ethical Guidelines for Recruiting and Research are observed.  
Date of approval to protocol 23/04/07  
You are asked to ensure that a further submission to the Ethics Committee will be required in the event that the study is not completed within five years of the above date.  
Please inform me when the research has been completed.  
Yours sincerely  
Professor Geoff Hunt. EHMS Ethics Committee  
EHMS  
c: Professor Fons Davis. Supervisor. EHMS  
D: Andy Evans
Dear Mrs. Unsworth,

RAMC ID: 0877/NOCI/2007
TITLE: Therapists' and Clients' Perceptions of Using CORE-Net and ARM-5 in the NHS.

Thank you for your application to the Research Approval and Monitoring Committee (RAMC) for registration for this study.

A sub-committee of the RAMC have considered this study. The documents considered were as follows:

- NHS REC form parts A and B (signed and dated 15/02/07)
- NHS SSI form (signed and dated 15/02/07)
- Letter from Dr. Geoff Mothersole, Consultant Counselling Psychologist, Sussex Partnership NHS Trust regarding service management authorisation (signed and dated 12/02/07)
- Protocol (version 4 dated 15/02/07)
- CORE therapy assessment form (version 2 undated)
- CORE outcome measure (no version control undated)
- CORE end of therapy form (version 2 undated)
- CORE-5 ongoing monitoring form (no version control undated)
- CORE-10 screening measure form (no version control undated)
- CORE short form A (no version control undated)
- CORE short form B (no version control undated)

26 March 2007

Mrs. Gisela Carvalho Chan Unsworth
Head of Psychological Well Being Service
Occupational Health Department
Kingston Hospital NHS Trust
Galsworthy Road
Kingston-upon-Thames
Surrey
KT2 7QB
I am pleased to tell you that the study was registered, and so may proceed. This registration is valid in the following Organisations:

- Sussex Partnership NHS Trust

Your RAMC registration is valid providing you comply with the conditions set out below:

1. You commence your research within one year of the date of this letter. If you do not begin your work within this time, you will be required to resubmit your application to the committee.
2. You notify the RAMC by contacting me, should you deviate or make changes to the RAMC approved documents.
3. You alert the RAMC by contacting me, if significant developments occur as the study progresses, whether in relation to the safety of individuals or to scientific direction.
4. You complete and return the standard annual self-report study monitoring form when requested to do so at the end of each financial year. Failure to do this will result in the suspension of RAMC approval.
5. You comply fully with the Department of Health Research Governance Framework, and in particular that you ensure that you are aware of and fully discharge your responsibilities in respect to Data Protection, Health and Safety, financial probity, ethics and scientific quality. You should refer in particular to Sections 3.5 and 3.6 of the Research Governance Framework.
6. You ensure that all information regarding patients or staff remains secure and strictly confidential at all times. You ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice, Data Protection Act and Human Rights Act. Unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

Please contact the Consortium Office if you wish this approval to be extended to cover other Consortium Organisations; such an extension will usually be agreed on the same day. We also have reciprocal arrangements for recognition of Research Governance approval with some other NHS Organisations; such an extension can usually be arranged within ten working days.

Good luck with your work.

Yours sincerely,
Mrs Helen Vaughan
Senior Research Governance Officer
Email: helen.vaughan@wash.nhs.uk
Tel: 01903 285222 x 4190
Fax: 01903 209684
## Appendix 36 Source List of All Participants with Recording Identifiers

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Appendix 37 Nvivo7 Initial Coding Categories (44) and Subcategories (225)

FG-PCC FOCUS GROUP QUESTIONS (9 coding reports with 76 subcategories)

1. FG-PCC-Ice breaker (5 subcategories)
   - Bird of prey giving birds-eye view
   - Clever as a hawk
   - Octopus - shape-shifting - clever
   - Scrappy sparrows
   - Wasp - fast - alert

2. FG-PCC-Q1-Experience using CORE-Net (5 subcategories)
   - Q1-Manual forms needed on occasion
   - Q1a-How introduced to client
   - Q1b-How often used with client
   - Q1c-How you & client processed information together (4 subcategories)
     - Q1c-Informative
     - Q1c-Physical environment
     - Q1c-Reassures & engages client
     - Q1c-Working with other GPs
   - Q1d-Initial & risk assessments with CORE-Net (2 subcategories)
     - Q1d-Clients misread questions
     - Q1d-Safeguard measure

3. FG-PCC-Q2-Perceptions when using CORE-Net with clients (6 subcategories)
   - Q2-Speed important
   - Q2a-How it felt to use CORE-Net
   - Q2b-How CORE-Net differs from manual CORE forms
   - Q2c-Feelings about using CORE-Net (5 subcategories)
     - Q2c-Anxious
     - Q2c-Do not want to go back to paper version
     - Q2c-Positive feelings
     - Q2c-Technicalities
     - Q2c-Varies by client
   - Q2d-Scale 1-10 comfort level using CORE-Net (2 subcategories)
     - Q2d- Scale 8
     - Q2d- Scale 9 or 10
   - Q2e-Discrepancies CORE & your assessment (3 subcategories)
     - Q2e-Discrepancies
     - Q2e-No discrepancies
     - Q2e-Reasons for discrepancies

4. FG-PCC-Q3-Measures helpful & use (4 subcategories)
   - Q3a-CORE-Net helpful to you (3 subcategories)
     - Q3a-Helpful to me
     - Q3a-Not helpful to me
     - Q3a-Treatment failure
   - Q3b-CORE-Net helpful to clients (2 subcategories)
     - Q3b-Helpful to clients
     - Q3b-Not helpful to client
5. FG-PCC-Q4 - CORE-Net as means to create change (5 subcategories)
   • Q4a-Changes in client after using (2 subcategories)
     Q4sa-Therapeutic relationship creates change in client
     Q4sb-Yes engages client
   • Q4b-How CORE scores affect how you proceed (2 subcategories)
     Q4ba-Flag to address & explore
     Q4bb-No effect on how you proceed
   • Q4c-Changes in how you work with client (2 subcategories)
     Q4ca-Alerts me to change in client
     Q4cb-Does not affect my working with client
   • Q4d-What you do clients not improving by Session 3 or 4
   • Q4e-How CORE-Net alerts you to possible treatment failure (3 subcategories)
     Q4ea-CORE-Net differs from reality
     Q4eb-Mid or extreme score
     Q4ec-Rate & direction of change

6. FG-PCC-Q5 - Additional resources helpful using CORE-Net (3 subcategories)
   • Q5-Dialogue & discussion
   • Q5-Happy with resources
   • Q5a-What helps you become more sensitive to outcomes

7. FG-PCC-Q6 - Experience training before starts using CORE-Net (8 subcategories)
   • Q6-Current training
   • Q6-Positive experience
   • Q6-Trial & error
   • Q6a-Scale 1-10 how useful was training (2 subcategories)
     Q6aa-Not rated
     Q6ab-Scale 7-8
   • Q6b-What else should training include (4 subcategories)
     Q6ba-Cannot think of anything
     Q6bb-Simplification
     Q6bc-Technical know-how
     Q6bd-Vision purpose integration
   • Q6c-Recommend others use CORE-Net — why
   • Q6d-CORE-Net in supervision & training counsellors (2 subcategories)
     Q6da-Using in supervision
     Q6db-Using to train counsellors
   • Q6e-Usefulness CORE-Net to other therapists (2 subcategories)
     Q6ea-Hindrance
     Q6eb-Useful tool

8. FG-PCC-Q7 - Anything else

9. FG-PCC-Q - Closing

FG-OH FOCUS GROUP QUESTIONS (9 coding reports with 68 subcategories)

1. FG-OH-Ice breaker (4 subcategories)
• Dead weight
• Elephant in the room
• Illusion of perfection
• Mixed bag

2. FG-OH-Q1-Experience using CORE-Net & ARM-5 (7 subcategories)
   • Q1-Experience - client reaction
   • Q1-Experience - negative
   • Q1-Experience - positive
   • Q1a-How introduced to client
   • Q1b-How often used with client
   • Q1c-How you & client processed information together (4 subcategories)
     Q1c-Demoralizing to client
     Q1c-Informative
     Q1c-Logging in interfered with therapy
     Q1c-Not informative
   • Q1d-Initial & risk assessments with CORE-Net (2 subcategories)
     Q1d-Clints misread questions
     Q1d-Safeguard measure

3. FG-OH-Q2-Perceptions when using CORE-Net & ARM-5 with clients (8 subcategories)
   • Q2-ARM-5
   • Q2-CORE better than CORE-Net
   • Q2a-How it felt to use them (4 subcategories)
     Q2a-Cannot bring myself to do it
     Q2a-Meaningless
     Q2a-Patronising
     Q2a-Questions are confusing
   • Q2b-How CORE-Net differs from manual CORE forms
   • Q2c-Feelings about using ARM-5
   • Q2d-Feelings about using CORE-Net
   • Q2e-Scale 1-10 comfort level using measures (2 subcategories)
     Q2e-ARM (score 1 everyone)
     Q2e-CORE-Net (scores 1-6)
   • Q2f-Discrepancies CORE & your assessment (3 subcategories)
     Q2f-CORE understates
     Q2f-No discrepancies
     Q2f-Reasons for discrepancies

4. FG-OH-Q3 Measures helpful & use (4 subcategories)
   • Q3a-Measures helpful to you (2 subcategories)
     Q3a-Helpful to me
     Q3a-Not helpful to me
   • Q3b-Measures helpful to clients (2 subcategories)
     Q3b-Not helpful to client
     Q3b-Reflects client feelings
   • Q3c-Other measures used
   • Q3d-Choose to use measures in future (2 subcategories)
     Q3d-No
     Q3d-Yes
5. FG-OH-Q4-Measures as means to create change (5 subcategories)
   • Q4a-Changes in client after using (2 subcategories)
     Q4a-Did not integrate it into practice
     Q4a-Yes engages client
   • Q4b-How CORE scores affect how you proceed (2 subcategories)
     Q4b-Flag to address & explore
     Q4b-No effect on how you proceed
   • Q4c-Changes in how you work with client
   • Q4d-What you do clients not improving by Session 3 or 4
   • Q4e-How CORE-Net alerts you to possible treatment failure

6. FG-OH-Q5-Additional resources helpful using measures (2 subcategories)
   • Q5-Cannot think of any
   • Q5a-Helps you become more sensitive to outcomes (4 subcategories)
     Q5a-Already sensitive to outcomes
     Q5a-Depends on definition
     Q5a-Explore within supervision
     Q5a-Training & studying

7. FG-OH-Q6-Experience training before starting using measures (5 subcategories)
   • Q6-Experience before using measures
     Q6a-Scale 1-10 how useful was training (2 subcategories)
     Q6a-Scale 10
     Q6a-Scale 6
   • Q6b-What else could training have included
   • Q6c-CORE-Net in supervision & training counsellors (2 subcategories)
     Q6c-Using in supervision
     Q6c-Using to train counsellors
   • Q6d-Usefulness to other therapists

8. FG-OH-Q7-Anything else

9. FG-OH-Other - Scope for creativity

PCC INTERVIEW QUESTIONS (8 coding reports with 26 subcategories)

1. I-PCC-Introduction - CORE & CORE-Net training

2. I-PCC-Q1-Opinion about outcome measurements (6 subcategories)
   • Q1-Integrating client-counsellor relationship
   • Q1-Resistance
   • Q1-Paper trail - evidence - proof
   • Q1-Opinions friends & other therapists
   • Q1-Experience other outcome measurements
   • Q1-Confidence - strengthens profession

3. I-PCC-Q2-Knowledge about CORE system and how it is used (5 subcategories)
   • Q2-Therapist role in client assessment
   • Q2-Presenting CORE system to client
   • Q2-Feelings about CORE system
   • Q2-Knowledge & training for CORE system

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• Q2-Session tracking

4. I-PCC-Q3-Handle assessments different now with CORE (7 subcategories)
   • Q3-Creates change
   • Q3-Support and supervision
   • Q3-Creative process
   • Q3-Forms force structure
   • Q3-Intuition and gut feeling
   • Q3-Spend time on risk questions
   • Q3-Value CORE now

5. I-PCC-Q4-Issues of risks and triaging of sessions (2 subcategories)
   • Q4-Handling risk
   • Q4-Triaging of sessions

6. I-PCC-Q5-Views of you and team using CORE-Net (6 subcategories)
   • Q5-Presenting to client
   • Q5-Recommend to therapists
   • Q5-Benefits
   • Q5-Integration
   • Q5-Technology issues
   • Q5-Hurdles - resistance

7. I-PCC-Q6-Future use of CORE-Net

1. I-PCC-Gisela wrap-up and closure

OH INTERVIEW QUESTIONS (11 coding reports with 33 subcategories)
(10 interviews; two interviews for Belinda combined as one)

1. I-OH-Introduction

2. I-OH-Q1-Experience prior counselling with outcome measures (4 subcategories)
   • Q1-Counselling without measured outcomes
   • Q1 No counselling - therefore no measured outcomes
   • Q1-Comments about training
   • Q1-Counselling with measured outcomes

3. I-OH-Q2-Opinion of using outcome measures (5 subcategories)
   • Q2-Important
   • Q2-Assessment of client
   • Q2-Establishes standards & benchmarks
   • Q2-Assessment of therapist
   • Q2-Has not made much difference

4. I-OH-Q3-How measure used on screen current episode (3 subcategories)
   • Q3-Visual representation of feelings
   • Q3-Process
   • Q3-Emotional response

5. I-OH-Q4-Feel about inputting & looking at visual charts (3 subcategories)
6. I-OH-Q5-How did you feel about doing it (4 subcategories)
   - Q5-Comfortable
   - Q5-Indifferent - disconnected
   - Q5-Anxious
   - Q5-Easier to hide feelings

7. I-OH-Q6-Opinion using ARM-5 to comment therapist relationship (3 subcategories)
   - Q6-Like it
   - Q6-Resistance
   - Q6-Suggestions to improve

8. I-OH-Q7-Were you able to be honest (3 subcategories)
   - Q7-Honest
   - Q7-Dishonest
   - Q7-Improving change of therapist process

9. I-OH-Q8-Did this help with therapist relationship & how (5 subcategories)
   - Q8-Yes helped relationship with therapist
   - Q8-Yes continue CORE-Net
   - Q8-Problems using measures
   - Q8-Already had good relationship
   - Q8-Previous therapists

10. I-OH-Q9-Anything else (3 subcategories)
    - Q9-Self refer in future
    - Q9-Summary of feelings
    - Q9-Recommend service to others

11. I-OH-Q-Gisela counsellor & closing

DAVID INTERVIEW (7 coding reports with 22 sub-categories)

1. I-Q1-Compare OH-FG observed vs PCC-David's team (2 subcategories)
   - I-Q1-OH focus group observed
   - I-Q1-PCC David's team

2. I-Q2-Client assessment - risk - triage (3 subcategories)
   - I-Q2-OH focus group observed
   - I-Q2-PCC David's team
   - I-Q2-Perception regarding differences

3. I-Q3-Use of clinical supervision (2 subcategories)
   - I-Q3-OH focus group observed
   - I-Q3-PCC David's team

4. I-Q4-Use of ARM-5 (2 subcategories)
• I-Q4-OH focus group observed
• I-Q4-PCC David's team

5. I-Q5-Failing clients (3 subcategories)
   • I-Q5-OH focus group observed
   • I-Q5-PCC David's team
   • I-Q5-Perception regarding differences

6. I-Q6-Training aspects (2 subcategories)
   • I-Q6-OH focus group observed
   • I-Q6-PCC David's team

7. I-Q7-Future recommendations (8 subcategories)
   • I-Q7-Appraisal process
   • I-Q7-Counsellor resistance
   • I-Q7-IT skills
   • I-Q7-Learning curve
   • I-Q7-Session tracking or using ARM
   • I-Q7-Training
   • I-Q7-Triad client counsellor computer
   • I-Q7-Valuing outcome measurement
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<td>Q2-Has not made much difference</td>
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<td>I-OH-Q3-How measure used on screen current episode</td>
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<td>Q3-Process</td>
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<td>Q7-Improving change of therapist process</td>
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<td>Q8-Problems using measures</td>
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<td>Q8-Already had good relationship</td>
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<td>Octopus - shape-shifting - clever</td>
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<td>Wasp - fast – alert</td>
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<td>Q1b-How often used with client</td>
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<td>Q1c-How you &amp; client processed information together</td>
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<td>Q1c-Informative</td>
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<td>Q1c-Physical environment</td>
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<td>Q1c-Reassures &amp; engages client</td>
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<td>Q1d-Safeguard measure</td>
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<td>Q2b-How CORE-Net differs from manual CORE forms</td>
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<td>Q2c-Feelings about using CORE-Net</td>
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<td>Q2c-Do not want to go back to paper version</td>
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<td>Q2c-Positive feelings</td>
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<td>Q2c-Varies by client</td>
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<td>Q2d-Scale 1-10 comfort level using CORE-Net</td>
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<td>Q2d-Scale 8</td>
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<td>Q2d- Scale 9 or 10</td>
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<td>Q2e-No discrepancies</td>
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<td>Q3a-CORE-Net helpful to you</td>
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<td>Q3a-Not helpful to me</td>
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<td>Q3b-CORE-Net helpful to clients</td>
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<td>Q3c-Other measures used</td>
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<td>Q3d-Yes - choose to use CORE-Net in future</td>
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**Frequency Counts**

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**FG-PCC-Q4**

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<td>Therapeutic relationship creates change in client</td>
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<td>Q4b-How CORE scores affect how you proceed</td>
<td>Flag to address &amp; explore</td>
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<td>Q4b-No effect on how you proceed</td>
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<td>Q4c-Changes in how you work with client</td>
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<td>Q4c-Alerts me to change in client</td>
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<td>Q4c-Does not affect my working with client</td>
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<td>Q4d-What you do clients not improving by Session 3 or 4</td>
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<td>Q4e-How CORE-Net alerts you to possible treatment failure</td>
<td>CORE-Net differs from reality</td>
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<td>Q4e-Mid or extreme score</td>
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<td>Q4e-Rate &amp; direction of change</td>
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**FG-PCC-Q5**

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<td>Q5-Happy with resources</td>
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<td>Q5a-What helps you become more sensitive to outcomes</td>
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**FG-PCC-Q6**

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<td>Q6-Trial &amp; error</td>
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<td>Q6a-Scale 1-10 how useful was training</td>
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<td>Q6a-Scale 7-8</td>
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<td>Q6b-What else should training include</td>
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<td>Q6b-Simplification</td>
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<td>Q6c-Recommend others use CORE-Net - why</td>
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**FG-OH FOCUS GROUP QUESTIONS**

**FG-OH-Ice breaker**
- Dead weight | 1 |
- Elephant in the room | 1 |
- Illusion of perfection | 1 |
- Mixed bag | 1 |

**FG-OH-Q1-Experience using CORE-Net & ARM-5**
- Q1-Experience - client reaction | 1 |
- Q1-Experience - negative | 1 |
- Q1-Experience - positive | 1 |
- Q1a-How introduced to client | 1 |
- Q1b-How often used with client | 1 |
- Q1c-How you & client processed information together | 1 |
  - Q1c-Demoralising to client | 1 |
  - Q1c-Informative | 1 |
  - Q1c-Logging in interfered with therapy | 1 |
- Q1c-Not Informative | 1 |
- Q1d-Initial & risk assessments with CORE-Net | 1 |
  - Q1d-Clients misread questions | 1 |
- Q1d-Safeguard measure | 1 |

**FG-OH-Q2-Perceptions when using CORE-Net & ARM-5 with clients**
- Q2-ARM-5 | 1 |
- Q2-CORE better than CORE-Net | 1 |
  - Q2a-How it felt to use them | 1 |
    - Q2a-Cannot bring myself to do it | 1 |
    - Q2a-Meaningless | 1 |
    - Q2a-Patronising | 1 |
- Q2a-Questions are confusing | 1 |
- Q2b-How CORE-Net differs from manual CORE forms | 1 |
- Q2c-Feelings about using ARM-5 | 1 |
- Q2d-Feelings about using CORE-Net | 1 |
- Q2e-Scale 1-10 comfort level using measures | 1 |
  - Q2e-ARM (score 1 everyone) | 1 |
  - Q2e-CORE-Net (scores 1-6) | 1 |
- Q2f-Discrepancies CORE & your assessment | 1 |
  - Q2f-CORE understates | 1 |
  - Q2f-No discrepancies | 1 |

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<td>Q3a-Not helpful to me</td>
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<td>Q3b-Measures helpful to clients</td>
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<td>Q3b-Not helpful to client</td>
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<td>Q3b-Reflects client feelings</td>
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<td>Q3d-Choose to use measures in future</td>
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<td>Q3d-No</td>
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<td>Q3d-Yes</td>
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<td>Q4a-Changes in client after using</td>
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<td>Q4a-Did not integrate it into practice</td>
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<td>Q4a-Yes engages client</td>
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<td>Q4b-How CORE scores affect how you proceed</td>
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<td>Q4b-Flag to address &amp; explore</td>
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<tr>
<td>Q4b-No effect on how you proceed</td>
<td>1</td>
</tr>
<tr>
<td>Q4c-Changes in how you work with client</td>
<td>1</td>
</tr>
<tr>
<td>Q4d-What you do clients not improving by Session 3 or 4</td>
<td>1</td>
</tr>
<tr>
<td>Q4e-How CORE-Net alerts you to possible treatment failure</td>
<td>1</td>
</tr>
<tr>
<td><strong>FG-OH-Q5</strong> Additional resources helpful using measures</td>
<td></td>
</tr>
<tr>
<td>Q5-Cannot think of any</td>
<td>1</td>
</tr>
<tr>
<td>Q5a-Helps you become more sensitive to outcomes</td>
<td></td>
</tr>
<tr>
<td>Q5a-Already sensitive to outcomes</td>
<td>1</td>
</tr>
<tr>
<td>Q5a-Depends on definition</td>
<td>1</td>
</tr>
<tr>
<td>Q5a-Explore within supervision</td>
<td>1</td>
</tr>
<tr>
<td>Q5a-Training &amp; studying</td>
<td>1</td>
</tr>
<tr>
<td><strong>FG-OH-Q6</strong> Experience training before starting using measures</td>
<td></td>
</tr>
<tr>
<td>Q6- Experience before using measures</td>
<td>1</td>
</tr>
<tr>
<td>Q6a-Scale 1-10 how useful was training</td>
<td>1</td>
</tr>
<tr>
<td>Q6a-Scale 10</td>
<td>1</td>
</tr>
<tr>
<td>Q6a-Scale 6</td>
<td>1</td>
</tr>
<tr>
<td>Q6b-What else could training have included</td>
<td>1</td>
</tr>
<tr>
<td>Q6c-CORE-Net in supervision &amp; training counsellors</td>
<td></td>
</tr>
<tr>
<td>Q6c-Using in supervision</td>
<td>1</td>
</tr>
<tr>
<td>Q6c-Using to train counsellors</td>
<td>1</td>
</tr>
<tr>
<td>Q6d-Usefulness to other therapists</td>
<td>1</td>
</tr>
<tr>
<td>FG-OH-Q7-Anything else</td>
<td>1</td>
</tr>
<tr>
<td>------------------------</td>
<td>---</td>
</tr>
<tr>
<td>FG-OH-Other - Scope for creativity</td>
<td>1</td>
</tr>
</tbody>
</table>
Appendix 39 Example of Memos for CORE-Net Metaphors for FG-OH & FG-PCC

Th. SALLY:

“Well it took some thinking however; I thought at the end it reminded me of a rose. A rose is perfect and it has a lot of meaning as soon as you see it, it’s about love, it’s about appreciation, it’s about a lot of things so the connotations are already there. It immediately gives explains a lot of things that don’t need to be said when you give the rose ... However, it also has got a lot of thorns ...... And some of those thorns if they get stuck in your finger are very painful and may have difficulty in getting them out and or the fingers might bleed and actually when that happens is to immediately throw the rose and never want to have anything to do with it. So I don’t and that’s how I feel about CORE it gives the illusion of perfection but it isn’t”

The image is of a rose with thorn possibly implying it has a double edge i.e. immediate and obvious meaning with and the symbolism of love and appreciation possibly representing the offer of the therapeutic relationship with its benefits to the client with a potential to help them. The thorns that prick you and results in pain and the immediate reaction to discard and have nothing to do with it. The illusion of perfection but not so in reality may be implying something about what CORE promises but is unable to fulfil in reality and thus the illusion may be shattered (images of blood coming out as the act of thorns pricking). This may suggest that CORE may harm in some way and hence the need to “throw it away immediately”.

Th. TAMSIN

“I feel a bit inadequate now because (laughs) I haven’t got that far at all and although I saw the request I then promptly forgot about it and I was reminded and I’m thinking I guess my just reflect I thought it was like an elephant because it was right in the way for me and I wanted to say can you stand over there. So I guess that’s not very deep thinking as Sally’s was but I guess that’s how it feels too big ...... It is meaningful, I’m not a bad creature I like elephants but not sure I want one in my room “

An elephant depicts large, immovable, and in the way (intrusive) mostly, although can be meaningful. The “right in the way” may be to do with how to fit CORE-Net into the sessions with regard to how to time it order to try to fit it in and “too big” may be about the enormity of the task of integrating it meaningfully into clinical practice routinely which would no doubt require the process of time and change perhaps of philosophy of working with a client. She wanted to say to it “stand over there” may be implying not wanting to use it in sessions and perhaps wanting to control or have choice as to whether to have it in her room or not. She goes on to say, “not sure I want it my room” may be inferring choice or control over the issue and a reluctance or possible resistance to having ownership of the process.

Th. JENNIFER:
"I'm Jennifer. When I first started to think about it I was thinking, the first thing that came up was dead weight, I find it very hard in the room, I find it gets in the way of my relationship with my clients and I haven't had very much experience with it and the clients I've had haven't been very successful with it and then I was thinking well maybe that's a bit harsh and actually it's a bit more like a paper weight in the fact that it does pin down some quite interesting points particularly risk and the clients can see where they are but for me its harder, harder to kind of get to know so maybe this more use in the paper weight but I haven't quite figured out how to use it effectively yet."

Two metaphors are used and the first one is about initially it feels like a “dead weight” that implies a heaviness without much use and the phrases of "hard to use in the room" and "getting in the way of the therapeutic relationship" but this could be due to "not having much success with clients" due to "lack of experience" and not yet figuring out "how to use it effectively". Changes perhaps indicating after the process of time the recognition that it moves from the image of "dead weight" to the other metaphor of "paper weight", which has some use and one such uses of the "paper weight" is how CORE-Net specifically pins down risk and allows clients to see where they are.

Th. SELAYE:

"I'm Selaye. My immediate thought was in fact an elephant because it takes up a lot of room, it takes up a lot of room in the session I find, but that doesn't mean there aren't useful parts of it but I try to think of a more positive metaphor and I just keep coming back to elephant, so I have actually been thinking about it and I thought of elephant probably a week or so ago and I haven't managed to move my thinking on from that."

Views elephant as a negative metaphor and "takes up a lot of room in the session" may indicate time wise how to fit it in and integrate into clinical practice but acknowledges some useful parts to it. The image of the elephant may also depict immovability and not much flexibility which may also indicate the issue of choice or control in using CORE-Net and how does one get past the "elephant" which seems fixed and immovable and inflexible.

Th. PHOEBE:

"I'm Phoebe. I find this very hard actually, I've worked with it as best as I can and the metaphor I have come up with is literally a mixed bag. I find it mixed, I think inside the bag there's a lot of pebbles and a lot of stones that I feel as though I've had to swallow or deal with in some way but then you know in some other ways it has shown some useful things so it's a fruit in there as well but it's a mixed bag for me."

A two-fold image of a metaphor of a "mixed bag" with stones and fruit. The process appears hard overall as symbolised by the pebbles and some acknowledgement of trying to integrate it into clinical practice and can see that in this process has had to swallow or deal with the possible
implication of having no choice or control due by saying 'had to swallow' but can see it has shown some useful things as symbolised by the fruit.

Th. DAVID:

"Well I hadn't got a particular bird in mind but yes, I mean the metaphor of birds useful because I think it gives you a birds-eye view it allows you, it gives you more vision of what's going on so, I suppose yes I would, I think a birds a good .....View of what's going on I think, CORE-NET helps you in that regard.....One that soars around......Bird of prey perhaps"

He provides the image of a bird of prey as a positive metaphor about the height that a bird of prey has to escalate to get enough distance for an overview of the situation or insight once it has prey in its vision. One may wonder of the end result of a bird of prey which is to effectively catch the prey so in this instance the imagination may wonder whether the client and the therapist are both 'prey' to CORE-Net use. Equally, he may be implying that just as a bird of prey is skilful in what it does in catching the prey or accomplishing the tasks at hand so might the therapist become skilful in their tasks of therapy through the use of CORE-Net or indeed that CORE-Net itself provides the insight in order that a therapist may gain the skills through time to integrate into their clinical practice to a point where CORE-Net allows an overview or vision of what is going on in the therapy.

Th. TOM:

"I thought about oddly enough about an Octopus, because I mean they're the most amazing creatures that I've watched when I've been diving and stuff and they kind of change shape and they're really actually very, very clever and if you try to watch one move they seem to move in a way that defies physics its like they sort of expand themselves and then sort of do this I can't describe it really but it's very, very complex and at first not necessarily that appealing but actually when you start looking at that mirrored part that's fascinating stuff ".

He uses a complimentary metaphor of a complex octopus that changes shape and is clever although not necessarily appealing initially. The therapist appears to be alluding to the nuances that a therapist may develop through the process of time in the journey of integration of CORE-Net into their clinical practice. This may be envisioned when therapists integrate clinically and change their practice to fully appreciate the "mirrored part that's fascinating stuff". It may be a thought to consider although not implied here that an octopus can also strangle its prey.

Th. BONITA:

"I think this is a very silly exercise, I'm having terrible problems with it with the concept of it but if I had to then I guess kind of a wasp for how alert they are and CORE-NET as we're using it now finally being on line
is actually really, really fast and kind of straightaway accessible to the client not taking too much
time so there’s something about the speed and alertness you know to the results.”

The wasp is mentioned as a positive metaphor in how a wasp is alert and fast and this reflects
the speed of the technology with broadband and the instant results alerting therapists and clients
to the results. However, a wasp is also stings so this has potential for harm too although not
mentioned explicitly within this metaphor by this therapist at this time.

Th. ALINE:

“Well as I did not get your email because my emails
been down and when you mentioned bird I thought of
two fighting sparrows that I’d seen the other day,
whether they were babies or what I don’t know but for
me it feels sometimes twitchy and flurry and
worryingly kind of with the minutia of the input of
information on a broader side I think it is wonderful but
I think the thing that popped into my mind was this
scrappy fighting to overcome for me the technological side of it all and the inputting, its been a
huge lot better now, so maybe I’m a mature, it’s a mature sparrow sitting in the trees singing
now but you know at the beginning it felt scrappy, fighty kind of oh I don’t know ramble, ramble
anyway that’s got me talking.”

Aline may be describing a journey or a process of change from the images of possibly baby
sparrows fighting about the worrying tasks of the “minutia of inputting data” with the technology
to a more “wonderful” place where a “mature bird sings in the trees” which is presumably the end
result one may need to get to as a therapist which is to integrate it into clinical practice and
feeling more comfortable with the technology. The image of the “scrappy, fighty, sparrows”
initially may imply the internal struggles of the therapist in this journey.

After re-reading all the metaphors again and looking at the three levels of coding the seven
categories that came from 35 units of meaning from all ten metaphors can be reduced and
combined into the following five minor categories with their subcategories:

A. CORE-Net has potential to help clients
   (i). By offering therapeutic benefit through the therapeutic relationship in therapy
   (ii) By pinning down risk
   (iii) Clients can track their progress visually and have instant access to results

B. CORE-Net is technically/logistically difficult/painful to use
   (i) CORE-Net is painful/difficult to use due to physical logistics of having it in the room
   and the technology of inputting data
   (ii) Therapists want to have control/choice over its use or not use it at all

C. There are difficult new skills for the therapist to learn
   (i) CORE-Net needs to be integrated into clinical practice

D. CORE-Net gets in the way of therapeutic work with clients
   (i) Feels intrusive in the room
   (ii) Affects the therapeutic relationship
E. CORE-Net offers a vision/overview that greatly enhances the therapists' insights and knowledge
(i) Offers an overview of the complex work
(ii) Allows the therapist to be informed about the client's progress
(iii) Instant access to results represented visually on screen
**Appendix 40 Sample Analysis - Icebreaker - Metaphor Example**

<table>
<thead>
<tr>
<th>Literal text</th>
<th>1&lt;sup&gt;st&lt;/sup&gt; Level of Category Coding</th>
<th>2&lt;sup&gt;nd&lt;/sup&gt; Level of Category Coding</th>
<th>3&lt;sup&gt;rd&lt;/sup&gt; Level of Category Coding</th>
</tr>
</thead>
</table>
| **SALLY: (5 units of meaning)**
Well it took some thinking however; I thought at the end it reminded me of a rose. A rose is perfect and it has a lot of meaning as soon as you see it, it’s about love, it’s about appreciation, it’s about a lot of things, so the connotations are already there. It immediately gives explains a lot of things that don’t need to be said when you give the rose.
... However it also has a lot of thorns. And some of those things if they get stuck in your finger, are very painful and may have difficulty in getting them out, and oh the fingers might bleed and... When that happens is to immediately throw the rose away and never want to do anything with it. So, that’s how I feel about CORE, it gives the illusion of perfection but it isn’t | 1. Perfect
   - love/appreciation
2. Immediate and inherent meaning | 1. The offer of a potential therapeutic relationship
2. Potential to harm/difficulties
3. Difficulty/possible resistance | 1. CORE-Net has potential to help clients
2. CORE-Net is difficult to use
3. Illusion of perfection but not in reality |
<table>
<thead>
<tr>
<th>Literal text</th>
<th>1st level of Category Coding</th>
<th>2nd level Category Coding</th>
<th>3rd level of Category Coding</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TAMSIN: (6 units of meaning)</strong> I feel a bit inadequate now because (laughs) I haven't got that far at all and although I saw the request I then promptly forgot about it and I was reminded and I'm thinking I guess my just reflect I thought it was like an elephant because it was right in the way for me and I wanted to say can you stand over there. So I guess that's not very deep thinking as Sally's was but I guess that's how it feels too big ..... It is meaningful. I'm not a bad creature I like elephants but not sure I want one in my room.</td>
<td>4. Right in the way for me/intrusive 2. Stand over there</td>
<td>4. Interferes with therapeutic work 4. Feel too big/intrusive 1. It is meaningful 1. I like elephants 4. Not sure want one in the room</td>
<td>4. CORE-Net gets in the way of the therapeutic work 2. CORE-Net gets difficulties to us 1. CORE-Net has the potential to help clients</td>
</tr>
<tr>
<td>Literal text</td>
<td>1st level of Category Coding</td>
<td>2nd level Category Coding</td>
<td>3rd level of Category Coding</td>
</tr>
<tr>
<td>-------------</td>
<td>----------------------------</td>
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<td>------------------------------</td>
</tr>
</tbody>
</table>
| **JENNIFER:** (6 units of meaning)  
I'm Jennifer. When I first started to think about it I was thinking the first thing that came up was dead weight. I find it very hard not just this morning. I find it gets in the way of my relationship with my clients and...  
and then I was thinking well maybe that's a bit harsh and actually it's a bit more like a paper weight  
in the fact that it does pin down some quite interesting points particularly risk and the clients can see where they are but for me  
so maybe there's more use in the paper weight particularly with CORE-Net.

| 2. Hard in room/difficult  
4. Affects therapeutic relationship
| 1. Fine down risk  
1. Clients can see where they are
| 1. CORE-Net is difficult  
2. CORE-Net gets in the way  
Of therapeutic work with clients

| **SELAKE:** (3 units of meaning)  
I'm Selake. My immediate thought was in fact an elephant because it takes up a lot of room. It takes up a lot of room in the session. I find... but that doesn't mean there aren't useful parts of it. I go to think of it as more positive metaphor and I've kept coming back to elephant, so I have actually been thinking about it even thought of elephant possibly a week or so ago and I haven't managed to move away from thinking on from that.

| 2. Takes up a lot of room in the session/metaphor  
1. Useful parts to it  
2. Elephant for a less positive metaphor to emphasise point made  
| 2. Difficulties in room  
1. Potential to help clients by having useful parts to it
| 1. CORE-Net has the potential  
To help clients
<table>
<thead>
<tr>
<th>Literal text</th>
<th>1st level of Category Coding</th>
<th>2nd level Category Coding</th>
<th>3rd level of Category Coding</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PHOEBE:</strong> I'm Phoebe and I'm a mixed bag and the metaphor I have come up with is literally a mixed bag. I find it very mixed. I think inside the bag there's a lot of pebbles and a lot of stones that I feel as though I've had to swallow or deal with in some way but then you know in some other ways it has shown some useful things so it's a fruit in there as well but it's a mixed bag for me.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>DAVID:</strong> (2 units of meaning) Well I hadn't got a particular bird in mind but yes, I mean the metaphor of birds useful because I think it gives you a birds-eye view it allows you, it gives you more vision of what's going on so, I suppose yes I would, I think a birds a good .... View of what's going on I think, CORE-NET helps you in that regard...... One that soars around...... Bird of prey perhaps</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOM:</strong> (4 units of meaning) I thought about oddly enough about an Octopus, because I mean they're the most amazing creatures that I've watched when I've been diving and stuff and they kind of change shape and they're really actually very, very clever and if you try to watch one move they seem to move in a way that defies physics its like they sort of expand themselves and then sort of do this I can't describe it really but its very, very complex and at first not necessarily that appealing but actually when you start looking at that mirrored part that's fascinating stuff</td>
<td></td>
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</tr>
</tbody>
</table>

6. CORE-Net offers vision/Overview to give insight to therapists
6. CORE-Net gives vision/overview/complexity/versatility to therapist's work

6. CORE-Net offers vision/overview/complexity/versatility to therapist's work
<table>
<thead>
<tr>
<th>Literal text</th>
<th>1(^{st}) level of Category Coding</th>
<th>2(^{nd}) level Category Coding</th>
<th>3(^{rd}) level Category Coding</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BONITA:</strong> (2 units of meaning) I think this is a very silly exercise, I'm having terrible problems with it with the concept of it but if I had to then I guess kind of a wasp for how alert they are and CORE-NET as we're using it now finally being on time is actually really, really fast and kind of straightaway accessible to the client not taking too much time so there's something about the speed and alertness you know to the results.</td>
<td>1. Alert and speed being online</td>
<td>1. Potentially helpful to clients to be able to see instant results</td>
<td>CORE-Net has potential To help clients</td>
</tr>
<tr>
<td><strong>ALINE:</strong> (5 units of meaning) Well as I did not get your email because my emails been down and when you mentioned bird I thought of two lightning sparrows that I'd seen the other day whether they were hobbies or what I don't know but for me it feels sometimes twitchy and flurry and worryingly good of with the minutes of the input of information on a broader side I think it is wonderful but for me personally I think the thing that popped into my mind was this scrappy lightning to overcome for the live technological side of it all and the inputing is been a huge lot better now so maybe I'm a mature, it's a mature sparrow sitting in the trees singing now oh I don't know ramble, ramble anyway that's got me talking.</td>
<td>2. Minutes of inputted data</td>
<td>2. Difficulties with technology</td>
<td>6. CORE-Net is technically difficult to use</td>
</tr>
</tbody>
</table>
## Appendix 41 ARM-5 Therapist's Scale

**Client ID:**  
**Session:**  
**Date:**

Thinking about today's meeting, please indicate how strongly you agreed or disagreed with each statement by circling the appropriate number.

<table>
<thead>
<tr>
<th></th>
<th>disagree</th>
<th>strongly disagree</th>
<th>moderately disagree</th>
<th>slightly disagree</th>
<th>neutral</th>
<th>slightly agree</th>
<th>agree</th>
<th>moderately agree</th>
<th>strongly agree</th>
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<tbody>
<tr>
<td>1. I feel supportive</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. My client and I agree about how to work together</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td></td>
<td></td>
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<tr>
<td>3. My client and I have difficulty working jointly as a partnership</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. My client has confidence in me and my techniques</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td></td>
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<tr>
<td>5. I feel confident in myself and my techniques</td>
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<td>6</td>
<td>7</td>
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</table>
### Appendix 42 - ARM5 Score Information Sheet

<table>
<thead>
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<th>Session Number</th>
<th>Client ID</th>
<th>Therapist ID</th>
<th>Date</th>
<th>CORE-Net Score</th>
<th>ARM-5 Total Score</th>
<th>Simple Score (ARM-5/5)</th>
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<tbody>
<tr>
<td>1</td>
<td>C</td>
<td>T</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
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<table>
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<th>Total Score</th>
<th>Mean Score</th>
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# CASE PROGRESS NOTE

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**Entry Type**
CORE-Net and ARM-5

**Client ID**

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<th>1. CORE-Net Score:</th>
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<table>
<thead>
<tr>
<th>2. ARM-5 Score Client’s Scale:</th>
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</table>

<table>
<thead>
<tr>
<th>3. ARM-5 Score Therapists Scale:</th>
</tr>
</thead>
<tbody>
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<td></td>
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<th>6. Plan</th>
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Staff member

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CASE PROGRESS NOTE

Date
Entry Type CORE-Net and ARM-5
Client ID

1. CORE-Net Score: 

2. ARM-5 Score Client's Scale: 

3. ARM-5 Score Therapists Scale: 

4. Progress (did the score go up, down or stay the same?): 

5. How was the score addressed?

6. Plan 

Staff member
CASE PROGRESS NOTE

Date

Session 3

Entry Type CORE-Net and ARM-5

Client ID

1. CORE-Net Score: __________

2. ARM-5 Score Client’s Scale: __________

3. ARM-5 Score Therapists Scale: __________

4. Progress (did the score go up, down or stay the same?): __________

5. How was the score addressed?

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Staff member
Date

Entry Type  CORE-Net and ARM-5

Client ID

1. CORE-Net Score:  

2. ARM-5 Score Client's Scale:  

3. ARM-5 Score Therapists Scale:  

4. Progress (did the score go up, down or stay the same?):  

5. How was the score addressed?  

6. Plan  

Staff member  

Session 4
CASE PROGRESS NOTE

Date ________________________________

Entry Type CORE-Net and ARM-5

Client ID ________________________________

1. CORE-Net Score: ________________________________

2. ARM-5 Score Client’s Scale: ________________________________

3. ARM-5 Score Therapists Scale: ________________________________

4. Progress (did the score go up, down or stay the same?): ________________________________

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2. ARM-5 Score Client's Scale: 

3. ARM-5 Score Therapists Scale: 

4. Progress (did the score go up, down or stay the same?): 

5. How was the score addressed? 

6. Plan 

Staff member
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Overview of Knowledge, Research and Practice

Name: Gisela Unsworth
Course: Doctorate of Clinical Practice
Cohort: 2005
Director of Studies: Professor Sara Faithfull
Principle Supervisor: Professor Helen Cowie
Co-Supervisor: Dr. Anita Green
I affirm that this work is offered for assessment as my original work and any quotes used from written sources are duly and appropriately acknowledged.

Name...... Gisela Unsworth......

Signature

Date...... September 2009......
Overview of integration of knowledge, research and practice

Introduction

I entered the doctoral programme feeling confident as a competent psychotherapist in clinical practice but having little confidence in research skills and in reading research papers. The Masters degree that I had undertaken nearly six years earlier had minimally prepared me to study at Doctoral level. There are six modules that constitute the Doctorate of Clinical Practice and after the completion of the studies a student should be able to demonstrate an ability to synthesise these elements in their research and practice thus facilitating successful practice development. A description of how I integrated the knowledge, research and practice during the four year programme follows.

Introduction to Doctoral Studies (IDS)

I started my doctorate studies as a person who liked to have as much planned in my work and life as possible and as I embarked through the doctorate, I became engaged in a process of challenging my beliefs and widening my horizons which I have valued as important for learning. The uncertainty of the process has been not always felt comfortable for me and at times decidedly chaotic. Metaphorically, I have started out as a caterpillar and metamorphosed into a butterfly in terms of research and its many facets.
The introductory element to the Doctorate of Clinical Practice was an excellent basis to initiate me to both the University setting and in the development of core competences to assist me in my research journey. I was able to understand what critical analysis and synthesis means in theory but of course applying it in my own writing is an entirely different matter. I was able to begin to consider looking at different kinds of professional knowledge in a way that I had not considered before. It has been crucial to have had time at the start to reflect the practical issues of how to manage doctoral study, develop search skills for evidence retrieval and learn how to develop more effective writing skills. This is no easy task as I found out having written two formative assignments with positive feedback and then consequently went on to fail my policy review assignment. However, writing the formative assignments of the Review of my Learning and Development needs and the Topic Review helped me to gain more confidence in writing and looking at the constructive criticism of this writing to work at improving future writing. These two assignments helped me to have more confidence by the time I wrote the Policy Review. The knowledge gained about critical analysis assisted me to look at the policy I chose for the policy review in my specialist field in a more critical way and to also look at the Health and Safety Executive's (HSE) involvement with current work in my field and has given me the confidence to contact them and feedback some constructive criticism on how they are delivering some work on stress management standards nationally. In the past I would not have had the confidence to do this feeling that they have experienced researchers who must be have it all fairly finalised and therefore there could not possibly be anything that I could constructively add. Happily, I changed the chosen policy and used a different one and passed successfully for the Policy Review assignment the second time round.

Advanced research methods for the reflective practitioner (ARM)
The presentations that I undertook regularly as part of the course to my peer group were been immensely constructive in improving my delivery skills and boosting confidence. Learning in an
inter-professional environment has been richly rewarding as this has enabled me to expand my reading beyond my own field and also to be able to compare across other field's of practice. Most importantly it has enabled me to then be motivated to read more on my own field of practice and to see how literature of other fields is also applicable to my own practice.

**Professional Ethics in a risk society (PE)**

The training element on Ethics of research is something that I had only done minimal reading on Professional Ethics for my field of clinical work but not on the Ethics of Research which I have now begin to read about.

**Policy, Politics and Power (PPP)**

This module really helped me to appreciate how different policy influences and the critical factors that enhance policy dissemination and power as well as the models of change. It has directly influenced me in writing policy for my organisation in consultation with key stakeholders and through the research project bringing about changes to my workplace and service delivery.

**Policy review**

The policy review in particular and the reading done for this assignment has assisted me to have a much broader view of the context of policy context, dissemination and implementation. I had not clearly linked the vital need to be able to be emotionally intelligent by demonstrating clear leadership qualities within various organisational contexts and success. In the lectures I have been assisted to do this via presentations and prior preparation and reading which I have found to be crucial to application of knowledge The Myer Briggs Personality Test was helpful in seeing how I may be different to others and how to work with the difference in other's in a more constructive way. A very meaningful short paper by Debra. E. Meyerson “Entitled Radical Change, the Quite Way”, showed how small things can make a difference.
When doing the policy review I was able to think through in my view the inadequacy of the HSE's way of wanting to get organisations to work with the new management standards for stress without enough emphasis on the policy statement's local application and implementation as being a way to provide the framework for the new standards. Appreciating the literature on evidence based practice and understanding how difficult implementation in organisations can be was helpful in seeing the contextual factors that influence change and practice.

Communities of Practice (CP).
The value of Communities of Practice in achieving change is a concept I am becoming familiar with and can see as an essential element to service and organisational development both within my Trust and with external organisations.

Emotions, leadership and innovation in organisations (ELO)
Desire to develop others on team across disciplines i.e. in nurse led audit within my department and auditing across the Trust. Will work on the service development project to make further needed changes with the OH's Psychological Well Being team.

1. Promote multi/inter professional working
Sharing knowledge and good practice – I have delivered regular presentations to doctors and senior managers in reference to CORE and counselling service and stress management and shared good practice with several public/private sector organisations nationally.

2. Contribute to the production of new forms of inter-disciplinary knowledge
I work closely within the wider OH team. I am hoping to contribute more by teaching on how
meaningful audit can be especially if followed through to action planning based on recommendations. Up to date due to scarcity of time other professionals in the team lead on projects that are rarely followed through or followed through in a reasonable time frame. It is common to see the start of an audit and inputting of data say on excel and then never hear any more about it in terms of recommendations and action planning.

I have received constructive and challenging supervision with appropriate encouragement at lower points. I have been able to attend various events and to present which has been beneficial. Below is a non-exhaustive list of some of these.

| Posters presented | November 2007 Kingston hospital clinical audit seminar
| Research proposal presentation | July 2008 Festival of Research (UniS)—Poster displayed
| Preliminary findings presented of research study | ANHOPS - Association of National Health Occupational Physicians (ANHOPS) May 2007
| Presentation on CORE-Net and Dialogical use of pink drop downs. | University of Surrey PhD Group January 2008
| | 9th May 2008 - British Association for Counselling and Psychotherapy (BACP) Research Conference
| | June 2008 Birmingham (Dr Scott Miller)
| Presentation on Clinical Utility of CORE-Net and ARM-5 | 18th March 2009 Presented alongside Dr Scott Miller to new CORE-Net users at a mental health trust in Oxford.

Implications of the research for my own clinical practice

Having undertaken this programme has enabled me to critically evaluate my practice and to make changes to the service based on the findings from the research. I had an opportunity when my entire counselling team moved on through end of contracts and retirement to recruit for the
first time since the study completed. Through my learning and the training delivered to the therapists in the research study I was able to adjust the job description and advert to include three key factors: the service values client feedback and we have a Client Directed Outcome Informed (CDOI) philosophy, we routinely measure outcomes and session track all our clients and finally the job interviewees needed to present on their interview on the subject of outcome measurement in psychological therapy services. We also changed our service advertising literature and I increased the induction programme from one day to two days to include all the essential features suggested for the training for CORE-Net and ARM-5 that arose out of the study. This has resulted in a much easier implementation of routine outcome measurement and I have found that the current team are much faster at meaningfully integrating clinical outcomes into their work than my previous team during the research project time. This has given me increased confidence compared to the first time around and I am very keen to enter discussions now within my wider occupational health team to see whether we can involve the doctors and nurses in using CORE-Net when assessing their psychological referral cases so that we can have client follow through within their journey in the occupational health department so that their care is integrated within this multi-disciplinary team.
Clinical Paper

Therapist' and clients' perceptions of routine outcome measurement in the NHS

Name: Gisela Unsworth
Course: Doctorate of Clinical Practice
Cohort: 2005
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Name.....Gisela Unsworth.............

Signature  Date.....September 2009......
Therapists’ and clients’ perceptions of routine outcome measurement in the NHS

Submitted to Counselling and Psychotherapy Research – linking Research with Practice. 28 March 2009

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Helen Cowie, Faculty of Health and Medical Sciences, University of Surrey
Anita Green, Sussex Partnership NHS Foundation Trust

Work was undertaken in the NHS within an acute district general hospital and in a mental health Trust that provides primary care counselling.

*First Author for correspondence

Word count: 4,340 words

Conflict of interest, source of funding and authorship

The authors declare that they have no conflict of interest. No funding declared.

GU conceived and designed the study as part of her doctoral thesis, analysed and interpreted the data and drafted the paper.

HC & AG worked on the development of the initial design of study, oversaw the research process and critically reviewed the paper.
Abstract

Primary Objective: This qualitative study elicited the perceptions of both psychological therapists and their clients in the use of Clinical Outcomes in Routine Evaluation (CORE-Net) where instant visual feedback was given on a computer screen and the combined use of an alliance measure (Agnew Relationship Measure, ARM-5) at each therapy session for session tracking. It elicited how therapists view its potential value in supervision and their suggestions for improving training in it.

Research Design: A purposive sample of convenience was used with therapists in a primary care counselling setting (PCC) who are the longest users of CORE-Net in the UK and an employee counselling service (OH) in the NHS just beginning to use CORE-Net and ARM-5 with their clients.

Methods and Procedures: Data were collected using focus groups, interviews and diaries. All data were analysed using a general inductive approach except the therapist diaries which were analysed using conventional content analysis.

Results: The study identified six overarching themes: 1) therapists were initially anxious and resistant; 2) therapists adapt ‘creatively’; 3) outcome measures help the client/therapist relationship; 4) clients perceive visual measures as helpful; 5) regular clinical supervision is key; and 6) proper and ongoing training/support of therapists is necessary.

Conclusions: The implementation of routine outcome measurement is a challenge but can be made easier with proper training and supervision of therapists. Clients appear happier than their therapists when routine outcome measurement is used.

Key words
Agnew Relationship Measure, CORE-Net, practice based evidence, qualitative study, routine outcome measurement in psychotherapy.
Introduction

As a practicing integrative psychotherapist, delivering a comprehensive employee support service, the bulk of my (first author) work is the provision of individual counselling.

In the UK, recommendations have been made to routinely measure outcomes from psychological therapy so as to ensure treatments are effective and of the shortest duration possible (National Institute for Mental Health England [NIMHE], 2005). The government’s initiative of Improving Access to Psychological Therapies (IAPT) emphasised that outcome measurement has the primary purpose of improving people’s experience and benefits from the service and is part of ongoing and collaborative service evaluation that has feedback from patients at its heart (IAPT, 2008). One benefit, according to IAPT (2008), is that:

- people can chart their progress towards recovery and see at what point their psychometric score falls within the normal range and can set their own goals for therapy and by giving ongoing feedback on whether it is working and which elements are helpful or unhelpful. (p. 7)

Patient-focused research in psychotherapy is aimed at monitoring an individual patient’s progress over the course of therapy (Howard, Moras, Brill, Martinovich, & Lutz, 1996). Lambert et al. (2003) discuss the predicted trajectory and its use for triage or comparison with client's actual progress as a basis for clinical decisions during treatment. They highlight the beneficial effects of giving therapists feedback on their clients’ progress relative to predicted trajectories and how this feedback to the practitioner enables them to make attendant treatment modifications in real time. Other studies found that clients at risk of a negative outcome were less likely to deteriorate and twice as likely to achieve a clinically significant change when their therapists had access to outcome and alliance information (Whipple et al., 2003) and to achieve improved client retention (Miller, Duncan, Sorrell, & Brown, 2005). Written and graphic performance yields better results than verbally delivered feedback (Kluger & DiNisi, 1996).

The practicality of implementing a feedback system in routine practice is a real challenge. Generally clinicians do not see the value of frequent assessments based on standardised scales
(Hatfield & Ogles, 2004) because they may be confident in their ability to accurately observe if their patient deteriorates and their provision of an appropriate response to them. Evidence suggests that psychotherapists are not alert to treatment failure (Hannan et al., 2005). It is possible that therapists' confidence in their own clinical judgments may stand as a barrier to the implementation of monitoring and feedback systems and that by monitoring therapists' outcomes it inevitably makes their practice 'transparent' and that in itself may evoke evaluation anxiety and fears of losing control (Lambert, 2007). Other challenges in implementation include the cooperation of therapists and the time that it would take before they can see the clinical utility of such feedback systems and the actual practical difficulties of adding monitoring activities to such busy practices.

Several survey studies have evaluated therapists' attitudes to routine outcome measurements (Johnston & Gowers, 2005; Smart et al., 2006; Callaly, 2006). None of these studies, however, include the views of recipients or patients and none include diaries that therapists fill out as they implement routine outcome measurements (Barkham & Margison, 2006; Mellor-Clark, Curtis Jenkins, Evans, Mothersole, & McInnes, 2006) for the first time in their clinical practice in conjunction with the Agnew Relationship Measure (ARM-5) an alliance measure (Agnew-Davies, Stiles, Hardy, Barkham, & Shapiro 1998).

The study that this paper covers, considered the perceptions of both therapists and clients and the experience of the use of such technology in their therapy sessions through the use of CORE-Net and ARM-5 (this alliance measure was piloted for the first time as a 5 item in this study). As of 2008, no qualitative research studies on CORE-Net were found. The purpose of this study was to answer the research question: How do therapists and clients perceive and experience CORE-Net and ARM-5 in the NHS? There were three specific aims related to the research question:

1) To elicit the perceptions of therapist (both experienced and trainees) and clients in relation to their use of a system of continuous monitoring of their therapy via a feedback
system that includes regular outcome measuring (CORE-Net) and therapeutic alliance measure (ARM-5);

2) To elicit the perception of therapists in utilising feedback information in supervision; and

3) To elicit the perception of therapists with regard to the training elements required in the process of implementation of this type of routine measurement in clinical practice.

Methods
This study involved routine outcome measurement in two settings: an occupational health (OH) department for employees in a public health care sector organisation in the UK and an NHS primary care counselling (PCC) service.

Therapists and clients
Five OH therapists were new users (six to seven months) to CORE-Net and ARM-5 and consisted mainly of trainee psychotherapists. The five PCC therapists were the longest users (18 months) of CORE-Net in the UK with mainly fully trained therapists. Ten clients were interviewed from the OH setting only. Seven additional PCC therapists were interviewed. These were experienced users of pre and post CORE manual forms but non CORE-Net users who were soon to begin their CORE-Net training.

Procedures
The research adopted a multi-modal approach to elicit a range of perspectives. OH therapists used CORE-Net and ARM-5 at every session and PCC therapists used only CORE-Net. Data were gathered from the following sources:

- 2 Focus groups with both OH and PCC therapists using semi structured questions;
- 10 Interviews with OH individual clients using semi structured questions;
- Interviews with PCC therapists (non CORE-Net users) using semi structured questions;
• 1 Interview with key informant (PCC therapist) using an unstructured format;
• 10 Diaries of OH therapists that recorded their experiences using CORE-Net/ARM-5 with their first two clients; and
• 28 Interviews of therapist supervision sessions (OH) that were recorded throughout the research project time.

Ethical approval

Formal ethical approval was given to gather data from therapists and participating OH clients. Participants were informed that they could withdraw consent at any stage of the process even if they had given initial consent.

Analysis of the Data

All interviews and focus group data were transcribed and provided the raw data for the qualitative analysis. Conventional Content Analysis was used to analyse the OH therapist diaries as this was deemed an appropriate method since it is generally used with a study design whose aims are to describe a phenomenon when existing theory or research literature on the phenomenon is limited (Hsie & Shannon, 2005). In the analysis, the researcher avoids using preconceived categories but rather immerses themselves in the data to allow new insights to emerge. Data from the interviews and focus groups was analysed using a general inductive approach for qualitative data analysis (Thomas, 2006). This approach was chosen because its purpose is to (1) condense extensive data into a brief summary format; (2) establish links between the research objectives and the findings from the data; and (3) develop a model or theory about the underlying structure of experiences or processes in the data. The data from the various sources allowed for a triangulation of themes comparing the narratives from the individual interviews with the focus group narratives.
Results
Six primary themes were constructed from the analysis of all data sources and are discussed in turn. See Table 1.

Table 1. Primary themes and sub themes

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<thead>
<tr>
<th>Primary Theme</th>
<th>Sub theme</th>
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<tr>
<td>Therapists initially anxious &amp; resistant</td>
<td>Therapists distance themselves</td>
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<td>Impact of Technology</td>
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<td>Fear of being judged</td>
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<td>Therapists trust their own experience</td>
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<td>Therapists adapt 'creatively'</td>
<td>Organic Use</td>
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<td>Outcome measures help the client/therapist relationship</td>
<td>Safeguard measure</td>
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<td>Measures helpful</td>
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<td>Conversation enhancers</td>
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<td>Focuses the session</td>
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<td>Triaging of sessions</td>
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<td>Advanced dialogical use of scores</td>
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<td>Helped relationship with therapist</td>
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<tr>
<td>Clients perceive visual measures as helpful</td>
<td>Visual representation of feelings</td>
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<tr>
<td>Regular clinical supervision is key</td>
<td>Client risk and endings</td>
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<tr>
<td>Proper and ongoing training/support of therapists is necessary</td>
<td>Comprehensive training</td>
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<td>Regular coaching</td>
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Therapists initially anxious and resistant

These themes were more dominant in the new users of CORE-Net than the longer users.

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Therapists are initially resistant to using CORE-Net, stating, 'it’s not how I work' and 'it’s like a square peg in a round hole.' They fear that CORE-Net is going ‘to pull me in a direction I don’t naturally go at all’ and are ‘anxious about whether I’m going to be giving my clients anything useful.’ It feels like a ‘struggle’ and can be very uncomfortable for therapists and a barrier to work through.

Therapists distance themselves
Therapists tried to distance themselves from the process by telling clients it is for research, thus there was a ‘lack of ownership’ and feelings of ‘dissociating myself’ and ‘so it belonged to her’ (the researcher). The hope was that the researcher/team leader had explained everything to the clients, so that all that was left for the therapists to ask the clients before commencing therapy was if they had any questions.

Impact of Technology
The CORE-Net system logs the client out once they complete the questionnaire on screen, which requires the therapist to log back on so that both therapist and client can look at the screen together for the visual chart of the results. This process of logging in and out into the system every time the client filled the questionnaire impacted the sessions due to the logistics of the room (which for some of the therapists was very small). This was expressed by one therapist as ‘the impact of that for me was it was all this chair changing I couldn’t be doing with that because the client would go there and then I would have to get up and I’m thinking .... Very jarring.’

Fear of being judged
Therapists felt that the graphs did not always present the ideal or expected pattern of improvement visually, that it was unrealistic to assume this for all clients, and that ‘what
happens in people's lives is messy' and to expect that there will be a 'perfect graph' in six sessions is 'unrealistic.' All agreed that they had a fear of being judged as therapists for their performance based on a set of scores.

**Therapists trust their own experience**

The new users to CORE-Net only used the scores to inform them how to proceed in a limited way, for example, in terms of whether to continue work with the clients or to discharge them. They felt quite strongly that the 'relationship with the client' and their 'own subjective measure' based on their own experience is what informs and 'influences' the therapy process and their work, rather than the scores.

**Therapists adapt ‘creatively’**

Therapists adapted by using the measures 'organically' or 'slot it where it flows' in the timing of when to fit the measures into a session. They expressed the need for user flexibility when using it, such as when a client is unable to use a computer (and they needed to read the statements to the clients and input responses on their behalf) or if the client is 'too distressed.'

**Outcome measures help the client/therapist relationship**

Outcome measurement was seen to both 'ground' and 'integrate' the client/therapist relationship in several ways as will now be discussed in turn.

**Safeguard measure**

All therapists felt strongly that CORE-Net was a 'safeguard' measure in visually flagging risk and in helping them with initial and risk assessments 'when it might not have come up naturally or I might not have been sure.'
Measures helpful

Therapists expressed that the measures were helpful to them and their clients in the initial assessment and that it validated the feelings of their clients. They felt that in the past when they did not use measures they may have had a ‘gut feeling’ that clients had improved or not but now they feel with CORE-Net it is ‘a lovely excuse to actually validate it on more than our perception.’

Therapists raised that fact that the visuals of CORE-Net graphs impact clients positively since they can track their own progress. This was expressed as clients ‘always love the graph’ and they can see that:

- hopefully that they are getting better, they’ll say ‘oh look that’s where I started and here I am and except when we have a glitch and they can remember when they shot up but they’ve now settled down and hopefully again and they find that useful too.

Conversation Enhancers

PCC therapists (who had used CORE-Net for a longer time) demonstrated advanced dialogical use of CORE-Net by allowing scores to inform their work (and the subsequent conversations that ensued with their clients) more than the OH therapists. They would ask which items on the questionnaire stood out for the client and ‘talk about it in that way and bring focus to that and that was helpful and we would talk explore that in greater detail.’

Focuses the session

The use of the measures provided a focus for short-term work and a contract that was agreed upon between client and therapist. This was helpful as ‘it provided a really good focus for accessing the client mood so that a contract can be agreed, and I have got to something to say about risk but as a way of identifying risk immediately.’ This was found to be ‘really useful so that I can then take action and explore that further with the client if necessary.’
Therapists discussed how they used the clinical cut off scores for triaging or deciding the number of sessions that might be needed by the client. This demonstrated advanced clinical use of the measure in an integrated way into their clinical practice. For example, the therapists in the PCC setting were mindful that the initial assessment might have been several months since the referral and that some clients might already be feeling better. As a result, the client might not need many sessions of therapy. They would also be informed by the clinical score at the end of therapy to make a decision as to whether to ask for more sessions if the client was still distressed, or to end sooner if the client was making and sustaining progress. This was expressed aptly by one therapist who said if clients are in the non clinical population she would still ‘do two sessions and find out about the level of anxiety and depression and then maybe refer on.’ On the other hand, it may be useful to increase the number of sessions, ‘if I work with people who have quite a high score and I might go up to twelve because I feel there is a clinical need,’ noted another therapist.

Advanced dialogical use of scores
Therapists mentioned their role in client assessment by using the scores and talking about them, especially if there were areas for concern or incongruence of scores, and how the client presents in the session. This idea was aptly described by a therapist when she said she may take note of the score at the start of the session and then after observing the client in session may return to the scores because ‘something’s not quite right here something doesn’t tally and the story doesn’t quite match the way that you filled out your form.’

Another therapist expressed the idea of being able to focus on the change process within brief therapy and encouraged the client to look at the items they marked high like:

they’re feeling desperate or hopeless I would say “well realistically where would you like to be?” then we will try and do a more preferred feelings away from desperation
so sometimes I do use the form and the words and the feelings to try and promote change.

This would encourage the client to imagine getting better and how this might feel like.

*Helped relationship with therapist*

All clients felt that counselling services should be measured and monitored for effectiveness. They said that the use of ARM-5 benefited the client/therapist relationship and had complimentary things to say about their therapists and their relationships with them. This was typically expressed by one client who felt that it 'lets the therapist know that you feel at ease with them and you feel comfortable to talk to them about anything and you can open up' and that then the 'therapist will know that's nice of them to know I think that side of it so it will help them as well.'

*Clients perceive visual measures as helpful*

Clients said they liked the visual representation of their feelings. This was typically highlighted by this client, who said:

> It was good that I could put the information in for myself and I thought that it was really good that at the end of it we could have a look at it and go through it so I did think that was good that it wasn't just you are this on a scale but this is why you are.

Most clients talked about the process of how the visual representations were used in the session with their therapist and their response to the questions. They felt the questions were 'spot on' and helped them to become more 'self-aware' through discussion of the scores and their progress. They also described their 'emotional response' when they saw the questions they had just entered graphically represented and the severity colour rating of the items on the questionnaire. They found discussions with the therapist 'therapeutic' and 'helpful.' They indicated a secondary or deeper impact after the initial inputting of the data once they could see
the visuals and discussed them with the therapists.

**Regular clinical supervision is key**
Therapists like to bring CORE-Net scores to supervision as it is helpful to be 'looking at the journey a client has been on and where they started and where they are now that they have ended therapy.' Talking about endings with clients is helpful in supervision as well as discussing risk issues.

**Proper and ongoing training/support of therapists is necessary**
Therapists suggested that the training for CORE-Net has the 'technical bit of how you do it, how you click this and go from that screen to that screen' and then 'there's the how can you actually make it work for you.' In other words, it is important to get the therapists to play with the computer system to feel at ease technically and then the clinical utility in practice will follow. They suggested that therapists be given 'some of the possibilities and the visions' and personal experiences of therapists: 'I've tried it this way and this seems to help.' They also recognised that the 'fears to the process...any problems of using it are a function of the counsellors, problems or the clinicians' problems' and therefore even if a therapist started out feeling 'I'll do it but I think what I'm doing is really wrong,' it is important not to let this impact the client because if the therapist is 'apologetic to the client then of course the client will pick up on it.'

These findings suggest the need for therapists to move beyond the intellectual understanding and to emotionally engage which would then flow into the clinical practice and be conveyed positively to the client. Regular coaching either through supervision or other forums was suggested for 'frequent reflection on the experience of doing it and the data they are getting.'

This was felt to be because:

- If early on in their learning of using CORE NET they are having the experience of well
- I collected this data but it makes no sense to me and if that continues for any length
of time then I think that will undermine any confidence in the value of it.
Then, they could 'with two or three clients look at the data and try and make the connection back
to the rationales they've already gained.'

Discussion
Therapists embark on a journey when they begin to use Routine Outcome Measurement (ROM)
for session tracking. Initially, therapists have anxiety about the use of technology in the room
and the physical logistics of incorporating this into the session, both practically and clinically (it
might be intrusive and impact upon the therapeutic alliance). These may act as barriers that
manifest in therapists' resistance to starting ROM or once started to be preoccupied with these
issues for the greater part of six months. Voluntary participation seemed to be expressed as a
key concept in reducing resistance to the introduction of ROM. All therapists had adapted to the
process by using the measures 'organically/slot it where it flows' so that it worked for them. Soon
therapists saw value in CORE-Net alerting them to risk earlier and grounding the client/therapist
relationship positively by enhancing conversations around the scores, especially when there was
incongruence between the scores and how the client presented in the session. Therapists could
see the benefits of clinical supervision and training in assisting therapists to adapt to ROM and
they perceived that clients are interested in knowing their scores and seeing their progress
visually. Clients confirmed that they were interested in the visual representation of their feelings
and charting their progress. Also, clients expressed appreciation for the therapists and their work
with them, which highlighted the importance of the therapeutic alliance. The therapists that used
the alliance measure ARM-5 did not like it much but said they may continue to use it with their
clients on an ad-hoc basis.

Limitations
Convenience sampling was small and thus not fully representative of the subject population. The
researcher was also the team leader of the OH therapists so researcher bias may have been inherent to the study's design and the dynamics of the research may have been somewhat influenced by this reality. The credibility of the results would have been enhanced if there had been external validation of the themes. The methods used for data analysis were more for an evaluative purpose and thus limited theoretical formulation for theory building.

**Implications for practice and training**

ROM for session tracking takes time, and depending on number of clients, from a minimum of six months to one and a half years in order for therapists to use the measures clinically and as a support tool complementing their work. Their initial fears and anxiety need to be addressed and supported through the initial phases of implementation. Comprehensive training that includes the theory of outcome measurement, practical skills like inputting data, role-play of how to introduce it into a session organically, and its dialogical use with the client is essential. This could take the form of regular coaching either through supervision sessions or other meetings but the emphasis has to be on regular and continuous forums for such to take place.

**Conclusion**

Although therapists are initially anxious and resistance to ROM, finding it intrusive and impacting upon the therapy session, through practice and time they could see the benefits of CORE-Net alerting them to risk assessment and focusing sessions in assessment so as to speed them up and to give an up-to-date picture of their progress with clients. Clients are happier than their therapists about using outcome measures and they particularly like the visuals of CORE-Net. They find them helpful and therapeutic as they integrate the client/therapist relationship. The implementation of ROM needs to include comprehensive training of therapists, ongoing clinical supervision and coaching forums at regular intervals. This will assist therapists in integrating ROM into their clinical practice.
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PART TWO

CLINICAL PRACTICE DEVELOPMENT

Including:
Policy Review
Service Development Project
Research Log

Faculty of Health and Medical Sciences
Division of Health and Social Care

University of Surrey

March 2009

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Division of Health and Social Care

Policy Review

Organising and Delivering Psychological Therapies

7th January 2008
Doctorate of Clinical Practice

Student: Gisela Unsworth
Course Leader: Dr. V. Vydelingum
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Statement of Originality

"I declare that this essay is wholly my own work, except where acknowledged specifically as the published work of others"

Gisela Unsworth

Date 7th January 2008
Organising and Delivering Psychological Therapies: A Policy Review

Introduction

Policy analysis is the systematic evaluation of alternative means of achieving social and public policy goals. This policy review will consider a policy entitled: Organising and Delivering Psychological Therapies (DH 2004c). This policy has direct relevance to the specialist area of practice and research of the author and more details about this policy will be provided later in the paper. The author works as a psychotherapist in an occupational health setting within an acute hospital in the public sector. Work undertaken to date within this setting involves the broader remit of organisational stress management and the reduction of stress which also includes the reactive provision of one to one psychological therapy (this is the bulk of the work) to support employees who are suffering from psychological distress.

Following an introduction of the policy and the rational for choice, a policy analysis tool will be identified. This will be followed by a critical evaluation of the policy using the tool elaborated upon and implications for future policy and practice will be considered.

What is Public Policy?

Policy

Finding an authoritative definition of "policy" is no easy task. Hogwood and Gunn (1984:13-19) discuss possible categories of policy including policy as: a label for a field of activity; an expression of general purpose or desired state of affairs; specific proposals; decisions of government; formal authorisation; a program; an output; a theory or model; a process. Policy may be viewed as an outcome of an action taken by government and Colebatch (1998:1) describes policy within the current political practice as "a prior statement of actions and
commitments of future government in respect of some area of activity". As such it is thus important to understand the general meaning of "public policy" before understanding "policy analysis".

A key concept of 'public policy' is the involvement of key stakeholders in a dynamic and iterative process (Blaikie and Soussan 2001). This process is clearly influenced by policy drivers that seek to define broad goals and specific mechanisms and is mediated and interpreted through different institutions that take actions to implement policy (Blaikie and Soussan 2001). Dye (1992:2) defined public policy as "whatever governments choose to do or not to do". Such a definition covers government action, inaction, decisions and non-decisions as it implies a very deliberate choice between alternatives. Hogwood and Gunn (1984:24) say that for a policy to be considered a public policy "it must to some degree have been generated or at least processed within the framework of governmental procedures, influences and organizations". Jenkins (1978) understands public policy making to be a process and not simply a choice. Public policy may be seen as a set of interrelated decisions taken by a political actor or group of actors concerning the selection of goals and the means of achieving them within a specified situation where those decisions should, in principle, be within the power of those actors to achieve.

**Policy Analysis**

Policy analysis has attracted a very large and rapidly growing literature. There is a wide choice of analytical tools which exist to enable analysts to use these to identify important aspects of policy as well as to explain and predict policy and its consequences. Being rather abstract in character, some of these tools for example, are useful for providing a general understanding of policy processes but are more difficult to apply in the actual policy settings. It is crucial to understand the nature of the policy context as this assists in the explanation of why issues appear on the political agenda (Collins 1999). Colebatch (1998) highlights that policy analysis
cannot be viewed as separate from the policy making process. He also argues for a synthesis between the classical (Rational Model) and interactional (Structured Interactive Model) views of policy seeing the models as the vertical and horizontal dimensions of policy. In the vertical dimension, Colebatch (1998) argues that the focus is on authorities making decisions in the context of problem identification, identifying and comparing possible solutions, and checking that policies have been implemented correctly and that they are achieving the desired results. In the horizontal dimension the focus is on the range of participants, the diversity of their agendas, the activities of negotiation, coalition building and the ratification of agreed outcomes. The author's view is that this is a useful way to view policy analysis as it includes both the necessary and key elements included in both the classical and interactional models of policy analysis and thus complement each other for comprehensive policy analysis.

The author has thus chosen Blaikie and Soussan (2001) policy analysis framework as it goes beyond the narrow, legalistic, formal and written aspects of policy and avoids some of the worst aspects of a solely rationalist approach to policy which often leads to a shopping list of unrealistic policy recommendations. It also taps into recent policy discourses concerning the legitimacy, realism and efficiency of policies and part of this reflecting the fact that policy processes are political rather than technocratic processes. The approach is able to capture the different interests and perspectives of different stakeholders and the incremental and complex nature of policy development which takes account of the role that the full range of policy actors plays in the policy process (Pasteur 2001). The author therefore sees Blaikie and Soussan's (2001) model as complementing Colebatch's (1988) recommendation of the synthesis of both the classical and interactional models of policy analysis and suitable for the analysis of the 'Organising and Delivering Psychological Therapies' policy which will be referred to throughout this essay as 'Organising Therapies' policy for short.
Blaikie and Sousson (2001) describe two dominant approaches to policy analysis. One is society-centred which aims to assist both in understanding not only how policy is made but also the different factors, influences and perspectives within the policy process itself. The other is state-centred which is based upon rationalistic assumptions which often take little account of external factors and influences but have the goal of improving policy and policymaking. Blaikie and Sousson (2001) describe six steps (key policy milestones; political and governance contexts; key policy issues; policy development processes; outputs, outcomes and impacts; the future) for policy process analysis which consists of two processes: policy development and policy process (See Appendix 43). This model has been developed to be used in both research and practice in the 'real world'. The main elements of this policy process model includes influences; agents of change or resistance; policy drivers; macro and micro policy and policy content; communication and dissemination and finally implementation. All of the aforementioned elements will be utilised within this policy analysis.

The author has undertaken a systematic search of sources of information that include psychology, medical, sociological, political, economic, and governmental and department of health databases and the media. Some of the key words used include policy analysis, health, public health, partnership working, mental health, psychological therapy, care pathways, outcome measurement, evidence based practice and practice based evidence.

The Choice of Policy

For the purposes of this policy analysis the choice of policy needed to meet the following criteria: to be directed towards issues within the health sector with clear objectives in mind; clear actions for implementations; applicable to the author's field of work i.e. psychological therapy provision and recently produced. This last point ensures that the analysis of the policy has not only direct implications but also applicability to the current and future working of the author's clinical
practice. The policy chosen meets the criteria and outlines a strategy that potentially has far reaching implications for both providers and users of psychological therapy in the U.K.

Outlines and Description of the Policy Paper
This section will outline the key components of the policy and why it was needed and the aims and recommendations within the policy. A brief description will follow outlining the key components of the policy and its strategy for delivery.

The Policy: Organising and Delivering Psychological Therapies (DH 2004c)
This policy was commissioned by the Mental Health Care Group Workforce Team (MHCGWT) to assist thinking about the most effective way to organise and develop effective psychological therapy services and to inform training commissioning. The aim is to help translate national policy to improve standards of mental health treatment and care into local action. This would enable local commissioners and providers to develop such services and organise and manage them more effectively.

The policy begins with a brief overview of the policy and highlights that it is written for a range of stakeholders including commissioners, providers, trainers and practitioners; provides an impetus to review and improve the delivery of psychological therapy services; highlights issues of access to psychological therapy services, waiting times, how to improve care pathways; the needs and interests of service users and carers, training issues and finally the importance of mainstreaming psychological therapies, of strengthening choice and or co-ordinating services. The policy then goes onto outline the strategy as follows:

The strategy
To redress the difficulties in the organisation and delivery of psychological therapy, the strategy
The policy concludes by first of all emphasising that due to the growing evidence base of the effectiveness of psychological therapies they should no longer be viewed as 'optional'
components of mental health care but should be viewed as having an important place amongst the range of treatments available as part of comprehensive, user-centred mental health services. To that end the policy is aimed at helping local commissioners and providers to develop effective services and to organise and manage them well. The policy's recommendations are based on a range of well-established scientific evidence alongside professional consensus and the views of service users.

Influences for this policy development
As outlined in section 2.1, this policy analysis will be considered in relation to the six elements of policy analysis as described by Blaikie and Soussan (2001). Firstly a consideration of the key influences within the policy analysis process will now follow. These are: key policy milestones (such as policy heritage, legal frameworks and specific events); political governance contexts (such as social, political and economic contexts); institutional influences; donor and external influences and innovations and technology.

Key Policy Milestones

Policy Heritage
During the last Conservative Government (1990-1997), public services were run in a very similar way to the private sector. However, unlike the private sector many argued that the public sector was dominated by producer interests and little regulation of these in terms of market forces (Klein 2001). As a result of this public services were not efficient in their use of resources and neither were they responsive to consumer needs and this led to the fragmentation of public services and the introduction of quasi-market forces. The introduction of performance targets and incentives alongside purchaser-provider divide within organisations was encouraged (Cutler and Waine 2000). The 'Organising Therapies' Policy very much emphasises the need for choice
of treatment by consumers (DH 2004c:7).

The current Labour Government's means and methods of change are sometimes termed the 'Third Way', which emphasises individualism and personal responsibility and sees the state as a partner at all levels rather than a dominating force. In regards to public policy for the NHS, these partnerships would be at a local level, with investment tied to targets and measured outcomes, with national standards but there would be local freedom to manage and innovate (Klein 2001). The political ideology would thus inform policy and the policy development process. The 'Organising Therapies' Policy (DH 2004c: 28, 29) encourages cost effective and safe services taking both efficacy and effectiveness into account.

The emerging public sector management agenda once Labour came into power in 1997 was to improve performance measures in order to make them a more effective means of improving standards and efficiency and to reform the markets so they involved a mix of both partnership and competition (Cutler and Waine 2000). The idea being that the traditional organisational form of the public sector with its inefficient hierarchical bureaucracy had to make way for the introduction of market mechanisms which would enhance the efficiency of public service delivery (Klein 2001). In order for this to be undertaken specific changes had to be realised like the abolition of the internal market between General Practitioner's (GP's) and hospitals as well as the contracting out of public services to the private sector. However, this transition was not smooth since more emphasis was placed with securing the best outcome rather than on the process by which it was achieved (Klein 2001).

The 'Organising Therapies' Policy (DH 2004c: 31, 33) emphasises the need for co-ordination and partnership between stakeholder organisations and the roles they will take. The empowerment of users in being able to choose from a range of psychological therapy treatments
that are delivered in an acceptable, user-friendly way with timely access and based on best evidence practice and delivered in a manner which has had input from users themselves is key. In this way people become more involved in their health and when they need access to mental health services they are personalised to them. The ability to have choice is that makes access equitable is key (DH 2003a). It is however arguable as to whom the best outcome is for in terms of patients or GPs. Under practice-based commissioning for example, the aim is not only to involve clinicians and practitioners more directly in the whole process and giving them a central role in planning what services their patients needs and deciding how these services will be provided but to encourage and support GPs in managing referrals more effectively so that money can be saved in secondary care and reinvested in primary care. In theory this might be viewed as achieving the ideological goal for the government who set the goal with a view to improving patient care but the reality may look different as increasing competition between services within the NHS and from the private and voluntary sector are causing high levels of anxiety amongst staff in the NHS of which services are under threat and hence individual redundancies are commonplace throughout the NHS (NHSE 2006) and in turn patient care must surely suffer even if in the short-term as a necessary evil that has to be addressed for better service provision in the long-term.

The National Health Service

It is important to acknowledge the policy drivers that led to much policy formulation under the current government that have also influenced the 'Organising Therapies' policy under consideration. The policy drivers include: the need for quality standards, postcode lottery (rationing), costs, and rise of consumerism and patient's expectation. The following account describes these policies and a brief rationale for their existence.

In the past twenty years mental health services in England have changed considerably and
community services have developed, asylums have closed and mental health has become one of several priority areas for development. The present government first set out its view of modern mental health services for adults of working age in the White Paper Modernising Mental Health Services: Safe, Sound and Supportive (DH 1998a). Importantly, this announced the Government's intention to invest an additional £700 million in mental health services over three years and to create a National Service Framework for Mental Health (DH 1999) for working age adults and was followed by another updated paper (DH 2004h). The White Paper built on already published documents detailing intended reforms to health and social services including: Our Healthier Nation (DH 1998b); The New NHS: Modern and Dependable (DH 1997); Modernising Social Services (DH 1998c); A First Class Service: Quality in the new NHS (DH 1998d). The publication of the National Service Framework for Mental Health (DH 1999) set out for the first time a set of officially sanctioned minimum standards to which mental health services were expected to attain. The Labour Government's key concept of developing quality services was seen as crucial to the rejuvenation of the health care system and the key objectives for the NHS modernisation reform involved an increase both in financial resources and in autonomy which would devolve power from the Government to the local health services (DH 2000a). A series of publications and the key concept of 'decentralisation' is fundamental to the 'third way' philosophy, and key initiatives followed which related to increasing autonomy and power to the public in order to actively involve them in making choices and decisions about their own health by having greater involvement and responsibility for the monitoring and enhancement of their health and use of health services and people were to be informed by better availability of information (DH 2000b; DH 2001a; 2001d, 2004a; 2004b; 2004e; 2004f; 2004g; 2004h).

The Labour Party Manifesto (Blair 1997) highlighted as a theme the idea of 'partnership' and this has now become central through all the reports and policies during the first eight years of the Labour Government. Dowling et al (2004) highlight that there is a lack of evidence to support the
view that partnerships produce successful outcomes for staff, users, financial sponsors and other stakeholders. This however has not prevented the widespread advocacy of ‘partnerships’ as an essential prerequisite of health service reform. The ‘Organising Therapies’ Policy also advocates this ethos by encouraging ‘co-ordination and work in partnership’ and this principle includes "... the importance of jointly agreed local pathways (maps) covering the routes for common conditions between primary care and specialised mental health service" (DH 2004c:19, 20).

Legal Frameworks

The following key legislation may be viewed as part of the policy drivers in the influences to the ‘Organising Therapies’ policy and having applicability in the provision of psychological therapy services.

The Mental Health Act 1983 – this is the principle Act governing the treatment of people with mental health problems in England and Wales. It covers all aspects of compulsory admission and subsequent treatment. The ‘Organising Therapies’ policy defines clear ‘care pathways’ to psychotherapeutic help for different psychological conditions whereby if care provided by primary care services are not sufficient to aid a patient then referral to a secondary care facility is needed is then arranged (DH 2004c: 20). Attention to the needs of different groups and situations like the elderly, in-patients on acute psychiatric wards and those with learning disabilities and ethnic minorities are to be considered in the provision of psychological services. The principles of The Race Relations Act 1976, 2000 and the Health and Social Care Act 2001 as well as the Disability Discrimination Act 1995 highlight the need for the provision of psychological services to be equitably available to all ethnic minority groups and others who have to be cared for by institutions for their mental health needs.
Specific Events

The media exerts a powerful influence on the public and several high profile media cases may also have potentially served as influences for this policy and specifically serving as a policy driver. The high profile cases of Dr Daksha Emson and Rocky Bennett (LMN 2004) received much media attention. Dr Emson was a young psychiatrist with a history of severe depression who killed her baby and herself whilst suffering from post-natal depression in October 2000 (BBC 2003) The report of an independent inquiry of this case concluded that the treatment she received during this period serves to highlight the enduring stigma of mental illness amongst NHS employees and that as a doctor who was also a patient she received significantly poorer standard of care than that which her own patients might have expected. Unusually, this report looks beyond the actions of individual professionals and organisations to focus on the need for significant and urgent change at a national level in order to prevent a similar tragedy (NEL NHS SHA 2000)

Rocky Bennett was a 38 year old black man who died in Norwich in 1998 after being restrained by 5 nurses in a psychiatric clinic and then their was a two day delay in informing his family. The report on the inquiry had twenty-two recommendations and called for new standards on the use of force when restraining patients, resuscitation procedures and dealing with racist behaviour. (IRRN 2004). The ‘Organising Therapies’ policy is clear about the careful consideration of psychological provision to meet the needs of the UK population (DH 2004c: 5). It makes the recommendation that comprehensive and accessible services should provide for different levels of need and at different points in a person’s life (see Appendix 44).

Political and Governance Context

Social, Political and Economic Context

Under Blair’s first term in office a series of changes within central and local Government were
made which began a process of devolving central held responsibility (Klein 2001). This meant that ministers and other officials were made accountable for the quality and efficiency of the services they provide and these were to be provided where they were needed, and had to take account of the users and recipients of these services. Government ministers were to be accountable directly rather than the agencies they controlled for the aims, delivery and achievement of departmental targets by means of Public Service Agreements. In the past application was made to the Treasury for additional funds but now resource allocation was fixed for three years and a key aim of the agreements was to enable departments to manage their own resources (Department of Trade, Local Government and Regions 2001) In order to improve the delivery of local public services, Local Public Service Agreements (LPSA) were piloted and then rolled out to local authorities from 2000. These LPSAs focused on targeted outcomes with support from Government and was in agreement with the White Paper's ethos of the Government's aim of having modern local governments playing a vital role in improving the quality of people's lives by providing high quality services through modern councils being in touch with the people (Office of Deputy Prime Minister 1998).

An increased budget for the NHS during Labour's first seven years in office was cited in their paper, 'The NHS Improvement Plan: putting people at the heart of public services' (DH 2004b). The proviso attached was to see increased performance, a stronger emphasis on quality and safety, alongside a continuing focus of providing services efficiently, fairly and in a personal way. The optimistic aim was that patients would be able to choose from a growing range of independent providers that would include the independent sector by 2008. The 'Organising Therapies' Policy considers the importance of local audit and service monitoring and benchmarking to include routine outcomes measurement and looking at whether services are cost effective. (DH 2004c: 30, 31). The Healthcare Commission was to monitor and inspect these providers in order to ensure that high quality care was provided to patients. A key method
to enable patients to make choices outlined in the report was the setting up of information systems such as electronic booking, NHS Direct, NHS Direct Online and NHS Digital Television (DH 2004b). According to the Wanless Report (2002), the most significant determinant of future health costs in a review of long term health care trends is the extent to which the public are engaged in modifying their own health-related behaviours. This finding has served as a strong influence for the changing social focus upon people acting in partnership with health care providers, and thus taking more personal responsibility for their health and behaviour. The policy 'Organising Therapies' makes explicit the need to provide acceptable, user-friendly services by emphasizing the importance of involving service users and carers in decisions about their care and of providing information about psychological therapies to enhance engagement and choice (DH 2004c: 1). It thus makes explicit the relationship between providing clear and accurate information, in a manner which is tailored to the individual's needs in relation their mental health needs and goes so far as to say that psychological therapies depend for their effectiveness on a good alliance between therapies and patient and patient information on choice for treatment of their condition. This makes the implicit argument that by providing individuals with information, choice and services that have had users involved in their design and delivery, then patients take more active responsibility for their own mental health treatments (DH 2004c:11, 12).

Institutional Influences

According to Soussan and Blaikie (2001), institutional influences include the structure and capability of formal institutions: central government agencies, local government, the private sector, political parties and organised religion. The development and provision of health services are influenced by the private health care sector and changes which are taking place between the public and private health care sector may lead to a weakening of the power of the public sector to influence the direction and delivery of public health care services in the future
(Lethbridge 2002). This is important in order that a greater choice and higher quality of services for patients may be provided in a timely manner. Public-private partnerships (PPPs) that involve the NHS contracting a variety of goods or services from the private sector became one of the most influential changes in the public and private sector relationship. These changes lay the basis for policies like the 'Organising Therapies' policy in order to make possible the various choices in psychological therapies appropriate for patient needs.

The Blair government, whilst leaving services free at the point of use, has encouraged outsourcing of medical services and support to the independent and voluntary sector now called the 'third sector'. Under the Private Finance Initiative (PFI), an increasing number of hospitals have been built or rebuilt by private sector consortia which then lease to the NHS for twenty years or longer. It is likely that these private sector providers will have increasing control and authority over the direction and development of health services. The overall long-term aim of the Government for involving the private sector relates to the transferable skills and resources to benefit the public sector, including commercial incentives leading to increased efficiency; a focus on customer requirements; new and innovative approaches; business and management expertise (Department of Treasury 2003). The process of formalizing links and partnerships between organizations in the public-private domain already exists and is a significant outcome and in time they may become more institutionalised and may therefore have a greater impact upon future policy. A clear benefit of these partnerships may well be the combination of strengths and skills to meet health service needs; however they also present with complex ethical and process related challenges such as the different and sometimes conflicting interests and objectives of the different players, working within different governance structures (Nishtar 2004).
Donor and External Influences

Within the provision of mental health services key donor and external influences with relation to the influences for the 'Organising Therapies' Policy (DH 2004c: 19) include voluntary health service providers and also patient and user representative forums. There are a number of voluntary and charity organisations providing additional services to that provided by the NHS for mental health such as MIND (2003). The ethos of the Labour Government is that public services should be provided effectively with the resources available without an ideological preference as to whether these are provided by the public sector, private sector and voluntary and community sector (Blackmore et al. 2005). The focus should therefore be upon developing greater choice of provider and should improve public services.

Various Department of Health documents have highlighted the stipulation that health service providers are also required to actively involve the public in the planning and development of future services (DH 2001a, 2001d). The Patient and Public Involvement Forums and development of user-led management programmes to enhance people's ability to self manage their own health care have been given an increasing focus at a clinical level so as to seek users views about services. Users of services are being encouraged at a strategic level to participate in the planning and development of services (DH 2000b; 2001d). The Expert Patients Programme (EPP) (DH 2006) is a lay-led self-management programme that has been specifically developed for people living with long-term conditions in order to support people to increase their confidence, improve their quality of life and better manage their condition. The Community Care Needs Assessment Project commented that users should be involved in setting the agenda, not just respond to what has been decided by service providers (CCNAP 2001). Specifically in relation to mental health services, the development of partnerships at all levels of care is crucial in evaluating the effectiveness of services from a user perspective (Roberts et al. 2003) and the involvement of consumers/users of mental health services is
believed to result in health care of a greater quality and clinical relevance (Wallcraft et al. 2003). Key barriers to health consumer groups according to Jones et al (2004) include problems relating to the political agenda, problems with the consultation process, lack of resources and working within a context of unequal power relationships.

The 'Organising Therapies' Policy recommends that whilst the NHS provides the backbone of psychological services, especially for those with severe and complex disorders, the voluntary, charity and private sectors offer useful and appropriate support for many people. It goes onto comment that a variety of key stakeholders, including those from the community and voluntary sector, and patient organisations are co-coordinated and work in partnership for the provision of psychological services (DH 2004c: 5,18,19). This is thus seen as one way of working in 'partnership' with other organisations to endeavour to meet the ever-increasing demands for psychological therapy provision. This policy fits well with the Third Way ideology of the greater inter-working of 'partnerships' to deliver good quality service provision regardless of whether the provision is from the private, voluntary or charity sectors and thus it can lay the basis for it's translation into practice (Klein 2001).

Innovations and Technology

Watmore (2004) discusses the role of information technology (IT) which includes the internet, media and digital services as essential to the provision of both information and services that are prompt, convenient, responsive and of the highest quality with the flexibility of being tailored around the individual to the public the services they expect. The e-government unit exists with the purpose of delivering such an agenda. The Prime Minister Tony Blair has set information technology (IT) professionals in Government the mission of 'ensuring that IT supports the business transformation of Government itself so that we can provide better, more efficient, public services' (Cabinet Office 2005).
The presentation of one joined up Government service that is a citizen centred online service is one aim for the e-government unit, regardless of which agencies are involved behind the scene. With specific relation to the 'Organising Therapies' Policy, technological advances have had some influence on the policy development and the mechanisms for implementation to date and will be gaining in influence in the future (DH 2004c: 14, 15). Examples include the Internet and web-based assessment and treatment programmes for depression and anxiety (NICE 2006) and audio and pictorial information for those with language or learning difficulties (Macdonald et al. 2003; Hollins et al. 1998). These technological advances clearly enhance the availability of assistance to many patients as well as having a long term implication of a possible reduction of labour costs resulting in staff redundancies.

Summary and Discussion of the Implications

The development of the 'Organising Therapies' policy (DH 2004c) has been impacted upon by the previously outlined influences. The implications for practice of this policy is that through its' implementation it will assist with the development of the organisation and delivery of suitable psychological therapy services to citizens enabling easy access for the most appropriate treatment needed in a timely manner. The political ideology of the Labour Government has had particular relevance with the ‘Third Way’ principle of decentralisation of power and responsibility with the ideal promoted that health providers and recipients should be equal partners in the health care system as this is advocated as increasing accessible, equitable and quality services (Klein 2001). Lord Layard (2004) highlighted that the British public want access to psychological therapy as a preferred choice of treatment and thus future demands for services are likely to rise and there is an urgent need for more therapists thus requiring additional funding into mental health services (DH 2004d).
Agents of Change or Resistance

Strategically placed individuals and institutions become agents of change or resistance as the influences outlined above act upon them (Blaikie and Soussan 2001). With relation to 'Organising Therapies' Policy these include both institutions such as NHS Trusts, PCT's, individual members of the workforce, other stakeholders such as voluntary and community organisations, and individual citizens. The policy goes on to highlight that well trained and supported staff as well as good leadership and management is essential for the preservation of effective psychological therapy services (DH 2004c: 35, 36). The conclusion of the policy helpfully provides a framework for developing quality standards in psychological therapy services in order to assist those directly involved in auditing services and/or with responsibility for clinical governance (DH 2004c: p50-52).

To be successful, a change management process must include an effective communication strategy. It is not common practice for government policy to identify implementation plans or change management strategies. All stakeholders must have opportunities to express their views and attitudes as part of the planning process as much about improvement is about changing mindsets (NHS Institute for Innovation and Improvement 2005). According to the Department of Health (DH 2003), evaluations of change agents to date have predominantly been based upon social intervention theory which suggests that local habit, socially accepted norms of appropriateness and peer acceptance are powerful motivators of change. They suggest that there is a need for rigorous evaluation of the effectiveness and cost effectiveness of change agents (DH 2003). The 'Organising Therapies' Policy recognizes the need to target the most effective treatments where they are most needed which will involve reducing wastage and risks associated with failure to train and retain staff or deliver services safely. It is essential that all staff agree to deliver the treatments and this is a key area for action because it involves incorporating routines outcome measurement into clinical practice requiring training and
changes in culture of practice (DH 2004c: 28-20). Financial constraints are a major resistor to implementation of the services outlined in the ‘Organising Therapies’ Policy even though most stakeholders support the strategy. It is not only the financial resources for the services that are a major resistor to implementation, but also the lack of trained therapists nationally who are backed by ethical and supervisory support and within the framework of clinical governance to deliver effective and appropriate psychological treatments (DH 2004c: 5, 6; Wilson 2002). This will be discussed further when considering implementation of the policy.

**Macro Policy and Policy Content**

The ‘Organising Therapies’ Policy identifies several key stakeholders who will play a role in shaping and delivering the actions set out in the strategy. These include both state and non-state institutions.

*Actions of State Agencies*

A reflexive relationship between policy and existing institutions and their mandates occurs when the extent to which the mandates in the policy are then followed by changes to institutional structures and capabilities, budget flows and the legal framework in which agencies work (Blaikie and Soussan 2001). The policy ‘Organising Therapies’ (DH 2004c: 5), outlines how psychological therapy provision is already a priority within the National Service Frameworks (DH 1999), NHS Plan (DH 2000a) and Priorities and Planning Framework (PPF) for 2003-6. (DH 2002). A capable workforce is essential with systems in place to ensure patients and their relatives have suitable and accessible information about, and clear access to, procedures to register formal complaints. This would enable staff to discover areas in which both the individual and generic practices are problematic (DH 2004c: 36). The policy goes on to emphasize that information about the choices available in the range of therapies to patients and the public and reiterates the importance of gaining and using service user views to improve services (DH
as stated also by the NHS Plan (2000a). This plan explicitly outlines where and how patients must be involved in the development of services and states that the NHS must be responsive to the varying needs of individuals within communities, irrespective of gender, ethnicity, age, religion amongst other characteristics. In the Health and Social Care Bill (2000), the NHS has a duty to consult with and involve the public on the planning and delivery of local health services and has mechanisms that place patients at the heart of a modernized service and the public in the driving seat. In so doing the Bill provides a statutory duty on all NHS organizations to: consult with and involve patients and the public; to set up statutory, independent Patient Forums; appoint new independent support for patients’ complaints and to be scrutinized by elected local councillors at a local government level.

The ‘Organising Therapies’ Policy supplements and builds on many of these existing Government and agency policies and thus does not change the legal framework within which many institutions already operate. The Policy does, however, imply significant changes to the potential resource and budget implications for many institutions since the specification and costing of a good mental health service to include service and workforce planning, budgeting, financial review and policy monitoring was yet to be undertaken at the time of the policy being issued.

**Actions of Non-state institutions**

The ‘Organised Therapies’ Policy sets regulations within which it aims to change the behaviour of non-state institutions including the media, voluntary and community based organisations, and the general public. The policy recognises that although the NHS provides the backbone of psychological services, the public obtain psychological therapy services from a variety of sources outside the NHS, which may be more sensitive to supporting ethnic minorities as one example (DH 2004: 19). The third sector therefore acts as non-state institutions which are
essential in the involvement of the policy process and implementation of the actions as an active partnership with the NHS. The policy goes onto state that "good co-ordination with NHS mainstream services is essential" (DH 2004c: 19) in order to ensure that patients are offered a choice of available help and that those with complex conditions and higher levels of need are helped appropriately. This however presents significant challenges as it includes common assessment and treatment protocols and outcome measurement throughout the various systems.

Communication and Dissemination

Blaikie and Soussan (2001) highlight that lack of attention to the process of communication and dissemination following the formalisation of the policy can result in a failing of the adoption and utilisation of the policy. They go on to indicate that this stage is key to the effectiveness of the policy but is often not recognised. The 'Organising Therapies' policy is a best practice guidance policy and has a circulation list and target audience that includes: PCT CEs, NHS Trusts CEs, SHA CEs, Care Trusts CEs, Directors of HE WDC CEs, Allied Health Professionals, Directors of Nursing, Professional Bodies, Higher Educational Institutions and user groups. The policy specifically affects the following groups of personnel for dissemination and implementation: HR/Workforce, Management, planning, clinical, estates, performance, IM&T, finance and partnership working. This policy supports improvements in the delivery of psychological therapy services by highlighting issues of access, waits, and how to improve care pathways as well as drawing attention to the needs of service users and carers and to the training and support needs of staff. It is freely available on the Department of Health website. Colebatch (1998: 61) outlines this process of the policy process as the vertical and horizontal dimensions, which play a significant role. This may mean that a policy can only be communicated effectively if there is recognition of the different dimensions involving different stakeholders. This 'Organised Therapies' policy has been in place now for three years and there is some evidence that it has
been adequately disseminated throughout these dimensions to date as will be seen in the next section on implementation of the policy.

**Implementation**

The process of implementation only begins once the specific mechanisms for action have been specified in the macro policy and how the policy is interpreted by the implementing agencies is a critical issue. Blaikie and Soussan (2001) identify six broad categories of implementation agencies: lead agencies; other state agencies; civil society, non-government organisations, private sector and individuals. Each of these agencies has three stages with regard to the direct effects of the policy: interpretation of the policy, actions and outcomes. Institutional culture, capabilities, priorities and resources influence the interpretation of the policy. They describe actions as reflecting a series of choices on what to do that reflect policy interpretation and the resources and capabilities of the institution and outcomes as relating to changes to patterns of resource management and changes to availability of resource flows. If implementation is not effective these outcomes can be less than or different to those intended. A widely acknowledged problem with implementation is that the actions required do not work at 'ground level' and therefore the outcomes are likely to be different from the original states intentions (Colebatch 1998:56). Lipsky (1980) coined the phrase 'street level bureaucrats' as he examined what happens at the point where policy is translated into practice and argues that policy implementation in the end comes down to the people who actually implement it: the practitioners or 'street level bureaucrats' and to affect and relate to their practice. They should be seen as part of the policy-making community since they exercise a large amount of influence over how public policy is actually carried out. He discusses several pressures that determine the way in which street-level bureaucrats implement policies such as: the problem of limited resources, the continuous negotiation that is necessary in order to make it seem like one is meeting targets, and the relations with (non-voluntary) clients. He concludes that potentially there are means of
changing street-level bureaucracies to become more accountable to 'clients' and less stressful for the 'bureaucrats'.

Appleby et al. (1995) conclude that there are four main issues to consider with regard to translating information on clinical effectiveness into changes in clinical practice: the nature of the innovation or evidence for change itself, the mechanisms for communicating that information to those who need to implement or adopt it, the characteristics of the adopters, those organisations and individuals who have to make the change happen and lastly, the organisational and social context in which change takes place. The ability of an intervention to 'produce benefit in practice' depends on a number of organizational and individual factors. It also depends on the effectiveness of the system that is used to disseminate the information (NHS Institute for Innovation and Improvement 2005). As Stocking (1992:56-60) writes "To improve clinical care we need not only sound information but also to understand how people react to change and the processes and influences that can be used to bring about change". Watt et al. (2005) highlight that if policy is to be used as a tool for practice change, and then it must address the organisational, professional and social context within which the policy is to be implemented.

In order to support this policy, many other documents (both from third sector and government) have been commissioned to support various aspects in regards to the provision of psychological services provision (DH 2001c; NIHME 2005a; 2005b; Sainsbury Report 2005; 2006). Lord Layards paper and speech (Layard 2004; 2005) and the subsequent media attention have given renewed impetus to the British publics vote of confidence in psychological therapies.

The 'Organising Therapies' Policy encourages the active participation and involvement from a number of groups (DH 2004c: 38, 39). The overarching message for these groups is the need for information dissemination to both service users and carers in order to allow patients to make
choices and the co-ordination of services with Trust board level support for the regulated provision of psychological therapies for successful implementation in partnership with the third sector.

Conclusion

Political and social changes focusing upon devolution of authority to more local agents has meant an increase in the identification of the need to develop partnerships to provide more appropriate services to match the needs of local communities. In more recent years, collaboration between the NHS and other voluntary and private sector organisations have been working towards increasing this provision (Nishtar, 2004:1). This seems to be helpful and working well in some areas but there is however, lack of regulation to date for the thousands of psychological therapists practicing in the U.K. and a lack of overall evaluation of the joint or ‘partnership’ delivery of psychological provision via the NHS and from other external organisations (NIHME 2005a: 27). Long-term reductions in health care costs can only be brought about by improvements in public health and this has led to much debate about both the rights and the responsibilities of individuals and how they use health services (Klein 2001). These issues impact on the ‘Organising Therapies’ policy not only in terms of the influences for the development of the policy but also how the policy fits within the broader context of health services. The policy makes implicit that the organisation and delivery of psychological services can be improved via it’s recommendations and action plans for a range of stakeholders to encourage improvements in relation to access, waiting times, care pathways, involving service users and carers, mainstreaming psychological therapies, strengthening choice, co-ordinating services and issues relating to the training of staff to deliver such services.

In relation to mental health, Layard (2004:2) noted mental illness as being one of the biggest causes of misery in our society. It not only imposes heavy costs on the economy (some 2% of
GDP) and on the Exchequer (again some 2% of GDP) but there are now more mentally ill people drawing incapacity benefits than there are unemployed people on Jobseeker's allowance. The power of media influence has been highlighted in this issue which has gained momentum in the last two years and together with the third sector working closely with the NHS has resulted in this economic argument finally winning through. The biggest investment into UK provision of mental health history to date was pledged by the Secretary for Health Alan Johnson on World Mental Health Day (10th October 2007) for £170 million over the next three years (Johnson 2007). This will hopefully give a more realistic implementation plan to the 'Organising Therapies' policy of funding more staff to provide the choice and quality of psychological therapies that the UK population need and have asked for to alleviate suffering due to mental illness. This will have major implications to the way psychological therapies are delivered effecting changes to local teams of therapists in how they work and also existing multi-disciplinary staff like social workers and nurses who are expected to train in Cognitive Behavioural Therapy techniques over two years (Centre for Economic Performance 2006).
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## Appendix 43 Policy Process Analysis Matrix

### Policy Process Analysis Matrix Adapted From Blaikie and Sousanna (2001)

<table>
<thead>
<tr>
<th>Stage of Policy Analysis</th>
<th>Related Elements of the Policy process Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Key Policy Milestones - Policy Heritage, legal frameworks and specific events</td>
<td></td>
</tr>
<tr>
<td>2. Political and Governance Contexts - Social, political and economic contexts, Institutional Influences, Donor and external Influences and innovations and technology</td>
<td>Influences Agents of Change and Policy Drivers</td>
</tr>
<tr>
<td>3. Key Policy Development Process</td>
<td></td>
</tr>
<tr>
<td>4. Policy Development Process</td>
<td>Macro Policy, Content Implementation</td>
</tr>
<tr>
<td>5. Implementation Process: Outputs and Outcomes</td>
<td>Mechanisms</td>
</tr>
<tr>
<td>6. The Future</td>
<td></td>
</tr>
</tbody>
</table>
A comprehensive accessible service that is able to provide for different levels of need and at different points in a person's life (DH 2004 pg5)

- acute adjustment disorders such as reactions to bereavement, divorce and other life events
- longer term more complex reactive disorders such as post traumatic disorder
- depression, anxiety, eating disorders and somatic complaints
- people with psychosis and early psychosis as well as age specific needs
- long term co-morbid conditions (e.g. psychiatric and medical conditions)
- complex cases involving long term psychological problems such as personality disorders that impair the user's life and are resistant to change.
Service Development Project

CORE (Clinical Outcomes in Routine Evaluation) for Outcome Management in Workplace Counselling Setting

12th April 2006
Doctorate in Clinical Practice

Student: Gisela Unsworth
Course Leader: Dr Sara Faithful
Word Count: 1198
Statement of Originality

"I declare that this essay is wholly my own work, except where acknowledged specifically as the published work of others"

Gisela Unsworth

Date 12th April 2006
## Glossary of Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CORE</td>
<td>Clinical Outcomes in Routine Evaluation</td>
</tr>
<tr>
<td>CORE-OM</td>
<td>CORE Outcome Measure</td>
</tr>
<tr>
<td>COREPC</td>
<td>Computer Software Version of CORE</td>
</tr>
<tr>
<td>DNA</td>
<td>Did Not Attend</td>
</tr>
<tr>
<td>DOH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>NHS</td>
<td>National Health Service</td>
</tr>
<tr>
<td>PRN</td>
<td>Practice Research Network</td>
</tr>
</tbody>
</table>
CORE (Clinical Outcomes in Routine Evaluation) for Outcome Management in
Workplace Counselling Setting

Introduction

An outcome based audit evaluating the psychological therapy service provided by Occupational Health’s Psychological Well Being Service using a standardised measure known to be reliable and valid to produce key management information such as DNA rates and to evaluate clinical and reliable change in client’s well being. This is the fourth annual Outcome Audit report. Previous reports have been used for the purposes of outcome management to improve service provision.

For the purposes of this report seven extra points for analysis have been requested in addition to the normal analyses from previous reports.

1. Male -v- female clients and whether counsellors equally effective with both
2. Effectiveness of counsellors with pure depression -v- depression/anxiety mix
3. List of all positive and negative actions taken by people
4. Compare ALL clients (not just the 104) including ones with no second outcome measure form. It is of value to see how unwell people were at the start of therapy to compare to existing clinical/non clinical populations even if they did not complete a second measure.
5. Difference, if any, between white staff and non-white staff in terms of therapy benefit done
6. Difference, if any, between clinical and non-clinical staff groups in terms of benefit of therapy
7. Difference, if any between clients with more than 2 outcome measure forms and clients with more than 2
The Project Method

Data was collected prospectively using 3 data collection forms:

CORE - Therapy Assessment Form
CORE - End of Therapy Form
CORE - Outcome measure (completed pre and post therapy)

The data from these forms was merged in SPSS to form one data set using client id as the identifier. Data was anonymous. Only client episodes for which data from all 4 forms was available were included in the analysis. 104 client episodes met this criterion. The data was analysed by Kingston District Audit Staff. The data collection forms and the analysis followed the Core System User Manual guidelines.

Audit Results and Evaluation

Note that due to rounding percentages may not total to 100%.

Management information

Referral dates

Clients were referred between 10th August 2001 and 2nd June 2005.

Waiting times

N = 103. Clients waited between 0 and 63 days, with a median wait of 4 days between referral and first assessment date. 75% of clients were seen within 7 days of referral and 91% were seen within 14 days.

DNA (non-attendance) rates

N = 99
The mean number of sessions attended was 8; the modal number attended was 6. The number attended ranged from 0 sessions to 46 sessions. 41% of clients attended all their planned sessions. The median non-attendance rate across all clients was 11%; the mean rate was 15%. 64% of clients who did miss sessions (N= 58) only missed 1 or 2 of their sessions. In total, out of the 899 planned sessions, 85% were attended. This is the same attendance rate as the July 2004 audit, which had an attendance rate of 81%.

Referrers

N = 104, missing data in 5 cases

As the table below shows the majority of clients were self-referrals.

Table: 1 Referrers

<table>
<thead>
<tr>
<th>Referrer</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self</td>
<td>54</td>
<td>55%</td>
</tr>
<tr>
<td>Colleague</td>
<td>5</td>
<td>5%</td>
</tr>
<tr>
<td>Occupational Health</td>
<td>16</td>
<td>16%</td>
</tr>
<tr>
<td>Manager direct referral</td>
<td>10</td>
<td>10%</td>
</tr>
<tr>
<td>Manager indirect referral</td>
<td>14</td>
<td>14%</td>
</tr>
<tr>
<td>Total</td>
<td>99</td>
<td>100%</td>
</tr>
</tbody>
</table>

Episode number - N = 104

Thirteen patients have previously had sessions and been discharged from the Occupational Health Department Staff Counselling Service. In all thirteen cases the episode in this date set was their second.

Sickness due to presenting problem, N = 104

Table: 2 Number of Days Off Work

<table>
<thead>
<tr>
<th>Number of days off work</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>58</td>
<td>56%</td>
</tr>
<tr>
<td>3</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>5</td>
<td>5</td>
<td>5%</td>
</tr>
<tr>
<td>6</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>Number of days off work</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>------------------------</td>
<td>----</td>
<td>----</td>
</tr>
<tr>
<td>7</td>
<td>2</td>
<td>2%</td>
</tr>
<tr>
<td>9</td>
<td>2</td>
<td>2%</td>
</tr>
<tr>
<td>10</td>
<td>6</td>
<td>6%</td>
</tr>
<tr>
<td>14</td>
<td>3</td>
<td>3%</td>
</tr>
<tr>
<td>15</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>21</td>
<td>2</td>
<td>2%</td>
</tr>
<tr>
<td>22</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>30</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>40</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>60</td>
<td>6</td>
<td>6%</td>
</tr>
<tr>
<td>84</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>90</td>
<td>3</td>
<td>3%</td>
</tr>
<tr>
<td>99</td>
<td>5</td>
<td>5%</td>
</tr>
<tr>
<td>180</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>270</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>320</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>365</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>104</td>
<td>100%</td>
</tr>
</tbody>
</table>

44% of the clients reporting having time off work due to the presenting problem, in total the 46 clients who time off had 2665 days off work. To check the accuracy of this figure, the serial numbers of the therapy assessment forms and the corresponding clients ids for client taking over 60 days sick leave are presented in the table below:

**Table: 3 Serial Number and Client ID**

<table>
<thead>
<tr>
<th>Serial Number</th>
<th>Client ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>53</td>
<td>E0026</td>
</tr>
<tr>
<td>55</td>
<td>E0067</td>
</tr>
<tr>
<td>131</td>
<td>J0023 2</td>
</tr>
<tr>
<td>117</td>
<td>J0034</td>
</tr>
<tr>
<td>128</td>
<td>D0047</td>
</tr>
<tr>
<td>9</td>
<td>F0010</td>
</tr>
<tr>
<td>52</td>
<td>E0017</td>
</tr>
<tr>
<td>42</td>
<td>N0011</td>
</tr>
<tr>
<td>46</td>
<td>A0033</td>
</tr>
<tr>
<td>57</td>
<td>E0073</td>
</tr>
<tr>
<td>56</td>
<td>E0070</td>
</tr>
<tr>
<td>61</td>
<td>E0097</td>
</tr>
<tr>
<td>8</td>
<td>F0004</td>
</tr>
</tbody>
</table>

**Time from end of therapy until last assessment date**

N = 93, missing data or excluded in 14 cases.
(Follow-up appointment when CORE outcome form post-therapy completed). 94% of clients completed the post-therapy assessment on the same day as their therapy ended. The remaining 6 cases completed it within 91 days.

**Time from end of therapy until last assessment date**

**Client Details**

N = 104

**Table: 4 Client Details Age and Sex**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>17-25</th>
<th>26-35</th>
<th>36-45</th>
<th>46-55</th>
<th>56-65</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>2</td>
<td>3</td>
<td>6</td>
<td>3</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>10</td>
<td>27</td>
<td>22</td>
<td>18</td>
<td>13</td>
<td>90</td>
</tr>
<tr>
<td>Total</td>
<td>12</td>
<td>30</td>
<td>28</td>
<td>18</td>
<td>16</td>
<td>104</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age Group</th>
<th>17-25</th>
<th>26-35</th>
<th>36-45</th>
<th>46-55</th>
<th>56-65</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>14%</td>
<td>21%</td>
<td>43%</td>
<td>21%</td>
<td>100%</td>
<td></td>
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<tr>
<td>Female</td>
<td>11%</td>
<td>30%</td>
<td>24%</td>
<td>20%</td>
<td>14%</td>
<td>100%</td>
</tr>
<tr>
<td>Total</td>
<td>12%</td>
<td>29%</td>
<td>27%</td>
<td>17%</td>
<td>15%</td>
<td>100%</td>
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</tbody>
</table>

**Table: 5 Employment Group**

<table>
<thead>
<tr>
<th>Employment Group</th>
<th>Number of referrals</th>
<th>% of referrals</th>
<th>total</th>
<th>Number of staff employed by KHT in the category</th>
<th>Referral rate (number of referrals/divided number of staff employed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>6</td>
<td>6%</td>
<td>375</td>
<td>2%</td>
<td></td>
</tr>
<tr>
<td>Nursing</td>
<td>50</td>
<td>48%</td>
<td>1191</td>
<td>4%</td>
<td></td>
</tr>
<tr>
<td>PAMs</td>
<td>9</td>
<td>9%</td>
<td>183</td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td>Scientific/professional</td>
<td>5</td>
<td>5%</td>
<td>27</td>
<td>19%</td>
<td></td>
</tr>
<tr>
<td>Pharmacy/technical</td>
<td>11</td>
<td>11%</td>
<td>317</td>
<td>3%</td>
<td></td>
</tr>
<tr>
<td>Building/maintenance/ancillary</td>
<td>4</td>
<td>4%</td>
<td>43</td>
<td>9%</td>
<td></td>
</tr>
<tr>
<td>Admin/clerical</td>
<td>13</td>
<td>13%</td>
<td>540</td>
<td>2%</td>
<td></td>
</tr>
<tr>
<td>Manager</td>
<td>6</td>
<td>6%</td>
<td>60</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>104</td>
<td>100%</td>
<td>2736</td>
<td>4%</td>
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</tbody>
</table>
Table: 6 Ethnic Group

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>N</th>
<th>%</th>
<th>Number of staff employed by KHT in the ethnic group</th>
<th>Referral rate (number of referrals/divided number of staff employed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>British</td>
<td>76</td>
<td>73%</td>
<td>1618</td>
<td>5%</td>
</tr>
<tr>
<td>Any other white background</td>
<td>4</td>
<td>4%</td>
<td>148</td>
<td>3%</td>
</tr>
<tr>
<td>White and Black Caribbean</td>
<td>1</td>
<td>1%</td>
<td>2</td>
<td>50%</td>
</tr>
<tr>
<td>White and Black African</td>
<td>3</td>
<td>3%</td>
<td>4</td>
<td>75%</td>
</tr>
<tr>
<td>White and Asian</td>
<td>2</td>
<td>2%</td>
<td>10</td>
<td>20%</td>
</tr>
<tr>
<td>Any other mixed background</td>
<td>1</td>
<td>1%</td>
<td>25</td>
<td>4%</td>
</tr>
<tr>
<td>Indian</td>
<td>9</td>
<td>9%</td>
<td>121</td>
<td>7%</td>
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<tr>
<td>Any other Asian background</td>
<td>1</td>
<td>1%</td>
<td>228</td>
<td>0%</td>
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<tr>
<td>Caribbean</td>
<td>2</td>
<td>2%</td>
<td>41</td>
<td>5%</td>
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<tr>
<td>African</td>
<td>2</td>
<td>2%</td>
<td>127</td>
<td>2%</td>
</tr>
<tr>
<td>Chinese</td>
<td>3</td>
<td>3%</td>
<td>37</td>
<td>8%</td>
</tr>
<tr>
<td>Total</td>
<td>104</td>
<td>100%</td>
<td>2799</td>
<td>4%</td>
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</tbody>
</table>

Overall the referral rate for staff from ethnic minorities (shaded rows) is 4% (24/595), the same rate as white staff. Note staff population figures are from July 04.

Relationships/support

N = 104 cases with missing data. Multiple-response, clients could indicate more than one category

Table: 7 Relationships/Support

<table>
<thead>
<tr>
<th>Relationships</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living alone (not including dependants)</td>
<td>33</td>
<td>32%</td>
</tr>
<tr>
<td>Full time carer (of disabled/elderly)</td>
<td>2</td>
<td>2%</td>
</tr>
<tr>
<td>Living with partner</td>
<td>55</td>
<td>53%</td>
</tr>
<tr>
<td>Living in shared accommodation</td>
<td>8</td>
<td>8%</td>
</tr>
<tr>
<td>Caring for children under 5 year</td>
<td>15</td>
<td>14%</td>
</tr>
<tr>
<td>Caring for children over 5 years</td>
<td>25</td>
<td>24%</td>
</tr>
<tr>
<td>Living in institution / hospital</td>
<td>5</td>
<td>5%</td>
</tr>
<tr>
<td>Living with parents / guardian</td>
<td>8</td>
<td>8%</td>
</tr>
<tr>
<td>Living with relatives / friends</td>
<td>2</td>
<td>2%</td>
</tr>
</tbody>
</table>
Current/previous use of services for psychological problems

N = 104. Multiple-response, clients could indicate more than one category

Table: 8 Current Previous Use of Services for Psycholoigcal Problems

<table>
<thead>
<tr>
<th>Service</th>
<th>% using concurrently</th>
<th>% using within last year</th>
<th>% using over 1 year ago</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP or other primary care team member (e.g. practice nurse, counsellor)</td>
<td>38%</td>
<td>5%</td>
<td>2%</td>
</tr>
<tr>
<td>Secondary service - in primary setting</td>
<td>1%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Community setting</td>
<td>1%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Hospital setting or sessional basis</td>
<td>1%</td>
<td>0%</td>
<td>0%</td>
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<tr>
<td>Day care services</td>
<td>1%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Secondary care - Hospital admission for 10 days or less</td>
<td>1%</td>
<td>4%</td>
<td>0%</td>
</tr>
<tr>
<td>Secondary care - Hospital admission for 11 days or more</td>
<td>1%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Psychotherapy/psychological treatments from spec. team</td>
<td>1%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Attendance at day therapeutic programme</td>
<td>1%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Inpatient treatment</td>
<td>1%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Other counsellor</td>
<td>1%</td>
<td>3%</td>
<td>3%</td>
</tr>
</tbody>
</table>

Use of medication

N = 99, 5 cases with missing data.

21 clients were prescribed medication: 13 had anti-depressants, 1 had anti-psychotics, 2 had...
minor tranquillizers, 1 other (unspecified) and 4 cases with missing data.

**Identified problems/concerns**

N = 104. Multiple-response, clients could indicate more than one category. Severity rating has not been included due to small group sizes.

<table>
<thead>
<tr>
<th>Table: 9 Identified Problems/ Concerns</th>
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</tbody>
</table>
the table below.

Table: 10 Presenting Problems and Occupational Group

<table>
<thead>
<tr>
<th>Interpersonal/relationships</th>
<th>% reported occurrence clinical staff</th>
<th>% reported occurrence non-clinical staff</th>
<th>$X^2$</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interpersonal/relationships</td>
<td>52%</td>
<td>21%</td>
<td>10.24</td>
<td>0.001</td>
</tr>
</tbody>
</table>

Presenting problems and ethnicity

N = 104

For the purposes of analysis ethnic group was regrouped into white (including Irish) versus everyone else. Then the frequency of reported occurrence was compared across the two groups. There were no presenting problems with statistically significant differences.

Risk

N = 104, except Legal/forensic N = 103, one case with missing data

Table: 11 Risk

<table>
<thead>
<tr>
<th></th>
<th>Mild (N)</th>
<th>Moderate (N)</th>
<th>Severe (N)</th>
<th>% of clients at risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide</td>
<td>17</td>
<td>3</td>
<td>3</td>
<td>22%</td>
</tr>
<tr>
<td>Self-harm</td>
<td>17</td>
<td>2</td>
<td>2</td>
<td>20%</td>
</tr>
<tr>
<td>Harm to others</td>
<td>6</td>
<td>1</td>
<td>2</td>
<td>7%</td>
</tr>
<tr>
<td>Legal/forensic</td>
<td>5</td>
<td></td>
<td></td>
<td>5%</td>
</tr>
</tbody>
</table>

Therapy details

Type of therapy -N = 104

Table: 12 Type of Therapy

<table>
<thead>
<tr>
<th>Type of therapy</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychodynamic</td>
<td>11</td>
<td>11%</td>
</tr>
<tr>
<td>Structured/Brief</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>Person-centred</td>
<td>9</td>
<td>9%</td>
</tr>
<tr>
<td>Integrative</td>
<td>77</td>
<td>74%</td>
</tr>
<tr>
<td>Combinations of therapy type</td>
<td>6</td>
<td>6%</td>
</tr>
<tr>
<td>Total</td>
<td>104</td>
<td></td>
</tr>
</tbody>
</table>
Table: 13 Frequency of Therapy

<table>
<thead>
<tr>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than once weekly</td>
<td>3</td>
</tr>
<tr>
<td>Weekly</td>
<td>38</td>
</tr>
<tr>
<td>Not a fixed frequency</td>
<td>63</td>
</tr>
<tr>
<td>Total</td>
<td>104</td>
</tr>
</tbody>
</table>

Table: 14 How the Therapy Ended

<table>
<thead>
<tr>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unplanned</td>
<td>2</td>
</tr>
<tr>
<td>Client did not wish to continue</td>
<td>4</td>
</tr>
<tr>
<td>Other unplanned ending</td>
<td>1</td>
</tr>
<tr>
<td>Planned</td>
<td>20</td>
</tr>
<tr>
<td>Planned from outset</td>
<td>10</td>
</tr>
<tr>
<td>Agreed during therapy</td>
<td>57</td>
</tr>
<tr>
<td>Agreed at end of therapy</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>104</td>
</tr>
</tbody>
</table>

7% of clients' therapy ended in an unplanned way.

Therapy outcome scores

Pre and Post therapy mean scores on the CORE outcome measure. N = 93, 11 cases with missing data (only cases with no missing data across any items were included)

Table: 15 Therapy Outcome Scores

<table>
<thead>
<tr>
<th>Mean score</th>
<th>Wilcoxon Signed Ranks Test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre-therapy</td>
</tr>
<tr>
<td>Total Score</td>
<td>1.86</td>
</tr>
<tr>
<td>Total of all non-risk items</td>
<td>2.18</td>
</tr>
<tr>
<td>Well-being</td>
<td>2.60</td>
</tr>
<tr>
<td>Symptoms</td>
<td>2.29</td>
</tr>
<tr>
<td>Functioning</td>
<td>1.94</td>
</tr>
<tr>
<td>Risk</td>
<td>0.33</td>
</tr>
</tbody>
</table>
The mean total score and the total score of all non-risk items post-therapy were lower than the pre-therapy mean scores. The differences are statistically significant at $P < 0.001$. This suggests that as measured by the CORE outcome scale, the therapeutic interventions have had a positive impact on the clients' well being.

The mean scores post-therapy were lower on all dimensions than the pre-therapy scores; again the differences are statistically significant at $P < 0.001$. These scores are illustrated on Figure 1.

Figure 1 Mean CORE Outcome Scores Pre and Post Therapy
Clinically significant change

Using the cut-off scores presented in the CORE system user manual, each client's scores were re-coded into clinical and non-clinical scores. That is scores typical of a clinical and scores typical of a non-clinical population. Note that the cut-off scores vary by sex.

Scores in the range of the clinical population.

N = 93, 11 cases with missing data (only cases with no missing data across any items were included)

Table: 16 Scores in the Range of the Clinical Population

<table>
<thead>
<tr>
<th></th>
<th>% scores in clinical population</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre-therapy</td>
<td>Post-therapy</td>
</tr>
<tr>
<td>Total Score</td>
<td>82%</td>
<td>11%</td>
</tr>
<tr>
<td>Total of all non-risk items</td>
<td>84%</td>
<td>16%</td>
</tr>
<tr>
<td>Dimensions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well-being</td>
<td>78%</td>
<td>16%</td>
</tr>
<tr>
<td>Symptoms</td>
<td>80%</td>
<td>15%</td>
</tr>
<tr>
<td>Functioning</td>
<td>77%</td>
<td>17%</td>
</tr>
<tr>
<td>Risk</td>
<td>35%</td>
<td>17%</td>
</tr>
</tbody>
</table>

76 clients (82%) had a total CORE score in the clinical range when measured pre-therapy, only 10 clients (10%) remained in the clinical range post-therapy. These findings are similar to last year's findings, when 97 clients (81%) had a total CORE score in the clinical range when measured pre-therapy, only 11 clients (10%) remained in the clinical range post-therapy.

The impact of client variables on CORE scores

The data was analysed to establish whether two key client variables - living alone and previous or current use of services for psychological problems - impacted upon the efficacy of therapy. In both cases no statistically significant effect could be found when comparing the mean change
score (total CORE score at time 2 - total CORE score at time 1) across the groups ("living alone" versus not "living alone" and "use of services versus" no "use of services"): P = 0.256 and P = 0.805 respectively.

**Counsellor variables and the impact on CORE scores**

Table: 17 Counsellor Variables and the Impact on CORE Scores

<table>
<thead>
<tr>
<th>Therapist ID</th>
<th>N</th>
<th>Mean change in CORE score (Time 2 score - Time 1 score)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>-1.06</td>
</tr>
<tr>
<td>2</td>
<td>9</td>
<td>-0.97</td>
</tr>
<tr>
<td>3</td>
<td>1</td>
<td>-0.35</td>
</tr>
<tr>
<td>4</td>
<td>9</td>
<td>-0.74</td>
</tr>
<tr>
<td>5</td>
<td>1</td>
<td>-1.35</td>
</tr>
<tr>
<td>6</td>
<td>55</td>
<td>-1.19</td>
</tr>
<tr>
<td>7</td>
<td>2</td>
<td>-1.54</td>
</tr>
<tr>
<td>8</td>
<td>7</td>
<td>-0.90</td>
</tr>
<tr>
<td>9</td>
<td>6</td>
<td>-0.89</td>
</tr>
<tr>
<td>10</td>
<td>1</td>
<td>-1.35</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>93</td>
<td><strong>-1.09</strong></td>
</tr>
</tbody>
</table>

Therapist -N = 93

The difference in change scores between the therapists was not statistically significant: H = 7.13, P = 0.62.

**Frequency of sessions -N = 93**

Table: 18: Frequency of Sessions

<table>
<thead>
<tr>
<th>Frequency of therapy with the client?</th>
<th>N</th>
<th>Mean change in CORE score (Time 2 score - Time 1 score)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weekly</td>
<td>34</td>
<td>-0.94</td>
</tr>
<tr>
<td>Less than once weekly</td>
<td>3</td>
<td>-0.85</td>
</tr>
<tr>
<td>Not a fixed frequency</td>
<td>56</td>
<td>-1.19</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>93</td>
<td><strong>-1.17</strong></td>
</tr>
</tbody>
</table>
The difference between the 3 groups did not reach statistical significance:

\[ H = 2.95, \ P = 0.23. \]

**Additional analysis**

N = 93. 11 cases with missing data (only cases with no missing data across any items were included)

**Male versus female clients.**

Table: 19 Male v Female Clients

<table>
<thead>
<tr>
<th>Sex</th>
<th>Mean change in total score</th>
<th>N</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>-0.92</td>
<td>13</td>
<td>0.87</td>
</tr>
<tr>
<td>Female</td>
<td>-1.11</td>
<td>80</td>
<td>0.78</td>
</tr>
<tr>
<td>Total</td>
<td>-1.09</td>
<td>93</td>
<td>0.79</td>
</tr>
</tbody>
</table>

The difference between the sexes was not statistically significant: \( Z = -1.09 \) and \( P = 0.28 \).

**Clients presenting with depression only versus those presenting with depression and anxiety**

Table: 20 Clients Presenting with Depression only v Those Presenting with Depression and Anxiety

<table>
<thead>
<tr>
<th>Presenting problems</th>
<th>Mean change in total score</th>
<th>N</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neither depression and anxiety</td>
<td>-1.15</td>
<td>70</td>
<td>0.73</td>
</tr>
<tr>
<td>Depression only</td>
<td>-0.59</td>
<td>2</td>
<td>4.16E-02</td>
</tr>
<tr>
<td>Depression and anxiety</td>
<td>-0.93</td>
<td>21</td>
<td>0.99</td>
</tr>
<tr>
<td>Total</td>
<td>-1.09</td>
<td>93</td>
<td>.79</td>
</tr>
</tbody>
</table>

Only two clients presented with depression. Only the difference between these two and the 21...

438
clients who presented with depression and anxiety was not statistically significant: \( Z = -0.44 \) and \( P = 0.38 \).

**Clients from ethnic minorities versus white clients**

Table: 21 Clients from Ethnic Minorities v White Clients

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Mean change in total score</th>
<th>N</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>White inc. Irish</td>
<td>-1.12</td>
<td>71</td>
<td>0.83</td>
</tr>
<tr>
<td>Ethnic minority</td>
<td>-0.98</td>
<td>22</td>
<td>0.67</td>
</tr>
<tr>
<td>Total</td>
<td>-1.09</td>
<td>93</td>
<td>0.79</td>
</tr>
</tbody>
</table>

The difference in total change score between white clients and non-white clients was not statistically significant: \( Z = -1.25 \) and \( P = 0.21 \).

**Clients who are clinical staff versus those that are non-clinical staff**

Table: 22 Clients who are Clinical Staff v Non Clinical Staff

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Mean change in total score</th>
<th>N</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>non-clinical staff</td>
<td>-1.09</td>
<td>32</td>
<td>0.84</td>
</tr>
<tr>
<td>clinical staff</td>
<td>-1.08</td>
<td>61</td>
<td>0.77</td>
</tr>
<tr>
<td>Total</td>
<td>-1.09</td>
<td>93</td>
<td>0.79</td>
</tr>
</tbody>
</table>

The difference in total change score between clinical staff clients and non-clinical staff clients was not statistically significant: \( Z = -0.55 \) and \( P = 0.59 \).

Appendix: ICD-10 codes - primary code only - \( N = 101 \), 3 cases with missing data

Table: 23 ICD Codes

<table>
<thead>
<tr>
<th>ICD10 Code</th>
<th>Diagnosis</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z–56–03</td>
<td>18</td>
<td></td>
<td>18%</td>
</tr>
<tr>
<td>Z–63–00</td>
<td>13</td>
<td></td>
<td>13%</td>
</tr>
<tr>
<td>Z–56–04</td>
<td>8</td>
<td></td>
<td>8%</td>
</tr>
<tr>
<td>F–32–00</td>
<td>5</td>
<td></td>
<td>5%</td>
</tr>
<tr>
<td>Z–60–05</td>
<td>5</td>
<td></td>
<td>5%</td>
</tr>
<tr>
<td>ICD10Code</td>
<td>Diagnosis</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>-----------</td>
<td>-----------</td>
<td>----</td>
<td>-----</td>
</tr>
<tr>
<td>Z--73--03</td>
<td>5</td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td>F--32--</td>
<td>4</td>
<td>4%</td>
<td></td>
</tr>
<tr>
<td>F--41--</td>
<td>3</td>
<td>3%</td>
<td></td>
</tr>
<tr>
<td>Z--56--06</td>
<td>3</td>
<td>3%</td>
<td></td>
</tr>
<tr>
<td>Z--63--0</td>
<td>3</td>
<td>3%</td>
<td></td>
</tr>
<tr>
<td>Z--63--03</td>
<td>2</td>
<td>2%</td>
<td></td>
</tr>
<tr>
<td>F--31--00</td>
<td>1</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td>F--33--</td>
<td>1</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td>F--40--00</td>
<td>1</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td>F--41--00</td>
<td>1</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td>Z--33--</td>
<td>1</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td>Z--33--00</td>
<td>1</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td>Z--39--</td>
<td>1</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td>Z--56--3</td>
<td>1</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td>Z--56--1</td>
<td>1</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td>Z--56--3</td>
<td>1</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td>Z--56--5</td>
<td>1</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td>Z--59--1</td>
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<td>1%</td>
<td></td>
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<tr>
<td>Z--59--03</td>
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<td>1%</td>
<td></td>
</tr>
<tr>
<td>Z--60--</td>
<td>1</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td>Z--60--5</td>
<td>1</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td>Z--60--00</td>
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<td>1%</td>
<td></td>
</tr>
<tr>
<td>Z--60--02</td>
<td>1</td>
<td>1%</td>
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</tr>
<tr>
<td>Z--60--04</td>
<td>1</td>
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<td></td>
</tr>
<tr>
<td>Z--61--3</td>
<td>1</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td>Z--61--00</td>
<td>1</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td>Z--61--03</td>
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<td></td>
</tr>
<tr>
<td>Z--62--3</td>
<td>1</td>
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<td></td>
</tr>
<tr>
<td>Z--63--</td>
<td>1</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td>Z--63--0</td>
<td>1</td>
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<tr>
<td>Z--63--02</td>
<td>1</td>
<td>1%</td>
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<tr>
<td>Z--63--04</td>
<td>1</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td>Z--63--07</td>
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<td></td>
</tr>
<tr>
<td>Z--63--08</td>
<td>1</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td>Z--73--06</td>
<td>1</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>104</strong></td>
<td></td>
<td><strong>103%</strong></td>
</tr>
</tbody>
</table>
Table: 24 Wait Frequencies

<table>
<thead>
<tr>
<th>WAIT</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid</th>
<th>Cumulative Percent</th>
</tr>
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<tbody>
<tr>
<td>0</td>
<td>12</td>
<td>11.5</td>
<td>11.7</td>
<td>11.7</td>
</tr>
<tr>
<td>1</td>
<td>7</td>
<td>6.7</td>
<td>6.8</td>
<td>18.4</td>
</tr>
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<td>2</td>
<td>15</td>
<td>14.4</td>
<td>14.6</td>
<td>33.0</td>
</tr>
<tr>
<td>3</td>
<td>10</td>
<td>9.6</td>
<td>9.7</td>
<td>42.7</td>
</tr>
<tr>
<td>4</td>
<td>9</td>
<td>8.7</td>
<td>8.7</td>
<td>51.5</td>
</tr>
<tr>
<td>5</td>
<td>8</td>
<td>7.7</td>
<td>7.8</td>
<td>59.2</td>
</tr>
<tr>
<td>6</td>
<td>3</td>
<td>2.9</td>
<td>2.9</td>
<td>62.1</td>
</tr>
<tr>
<td>7</td>
<td>16</td>
<td>15.4</td>
<td>15.5</td>
<td>77.7</td>
</tr>
<tr>
<td>8</td>
<td>5</td>
<td>4.6</td>
<td>4.9</td>
<td>82.5</td>
</tr>
<tr>
<td>9</td>
<td>2</td>
<td>1.9</td>
<td>1.9</td>
<td>84.6</td>
</tr>
<tr>
<td>10</td>
<td>1</td>
<td>1.0</td>
<td>1.0</td>
<td>85.4</td>
</tr>
<tr>
<td>11</td>
<td>2</td>
<td>1.9</td>
<td>1.9</td>
<td>87.4</td>
</tr>
<tr>
<td>12</td>
<td>1</td>
<td>1.0</td>
<td>1.0</td>
<td>88.3</td>
</tr>
<tr>
<td>13</td>
<td>2</td>
<td>1.9</td>
<td>1.9</td>
<td>90.3</td>
</tr>
<tr>
<td>14</td>
<td>1</td>
<td>1.0</td>
<td>1.0</td>
<td>91.3</td>
</tr>
<tr>
<td>16</td>
<td>1</td>
<td>1.0</td>
<td>1.0</td>
<td>92.2</td>
</tr>
<tr>
<td>19</td>
<td>1</td>
<td>1.0</td>
<td>1.0</td>
<td>93.2</td>
</tr>
<tr>
<td>23</td>
<td>1</td>
<td>1.0</td>
<td>1.0</td>
<td>94.2</td>
</tr>
<tr>
<td>24</td>
<td>1</td>
<td>1.0</td>
<td>1.0</td>
<td>95.1</td>
</tr>
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<td>30</td>
<td>1</td>
<td>1.0</td>
<td>1.0</td>
<td>96.1</td>
</tr>
<tr>
<td>35</td>
<td>1</td>
<td>1.0</td>
<td>1.0</td>
<td>97.1</td>
</tr>
<tr>
<td>50</td>
<td>2</td>
<td>1.9</td>
<td>1.9</td>
<td>99.0</td>
</tr>
<tr>
<td>63</td>
<td>1</td>
<td>1.0</td>
<td>1.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>103</td>
<td>99.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Missing System 1 1.0 1.0 100.0
Total 1.0 100.0

Discussion-Conclusions:

75% of staff seen within the Department of Health standard of 1 week with a median wait time improved from 5 to 4 days which shows good accessibility to the service.

85% of all planned sessions were attended this is an improvement of 4% compared to the last report and median DNA rate improved from 17% (last report) to 11% and mean DNA from 20% to 15% this report.

The number of clients self-referring in this cohort has increased from 43% last report to 55% which shows increasing awareness of the service.
For 18% of clients which is a reduction from last time of 23% their main complaint was stressful work schedules. Clients often had more than one complaint, however, and the most reported presenting problems were anxiety/stress (65%), work/academic (45%), and interpersonal relationship problems (41%). Work/academic has reduced from last report at 57%.

No statistical significance difference between ethnic minority groups with particular presenting issues to the service and other groups. An increase of more poorly people to the service needing GP services concurrently from 16% to 38%. More referrals from scientific professional and managers than from any other occupational groups per number of staff employed in these groups. 52% of clinical staff reported interpersonal/relationship difficulties as compared to 21% of non-clinical staff, this is statistically significant. Most clients were female in the 26-35 age range which is equitable with Trust figures. Suicide risk increased from 16% to 22% and self harm risk increased from 16% to 20%. Harm to others increased from 1% to 7% and legal/forensic risk from 1% to 5%.

The ideal is for client and therapist to agree either at the beginning or during therapy when to end not for it to be decided on the last session or to have an unplanned ending. Last report was 42% of clients agreed to end on the last session whereas an improvement has occurred to 10%; also agreed to end during therapy has increased from 45% 5o 55%; planned endings increased from 8 to 19% and sessions planned from the outset increased from 1% to 10%. This is showing a great improvement in terms of efficiency use of service

The Counselling Service had a statistically significant positive impact on client's well being with a much reduced percentage of clients in the 'clinical' range post-therapy. This has been sustained despite the fact that the intake scores were higher on average for clients in this report compared to the last one. In other words, clients were more poorly when presenting for therapy but the
level of help to these clients was slightly better than results achieved last report with less poorly clients. This shows an effective delivery of counselling for client improved well being. No statistical significance identified between the counsellor performance by orientation or frequency of sessions delivered.

Table: 25 Recommendations - Action Plan

<table>
<thead>
<tr>
<th>Problem</th>
<th>Action to be taken</th>
<th>Person responsible</th>
<th>Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide, self Harm, harm to others and legal/forensic risk have all increased</td>
<td>Detailed case by case exploration and discussion with counselling team on risk assessment and offer further training if needed</td>
<td>Gisela Unsworth</td>
<td>1st May 2006</td>
</tr>
<tr>
<td>Number of managers for last two annual reports are particularly high</td>
<td>Discussion with HR Director</td>
<td>Gisela Unsworth</td>
<td>1st June 2006</td>
</tr>
<tr>
<td>Other issues as decided by team at May 2006 meeting</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

443
An audit of the internal provision of staff counselling delivered via an occupational health department within an acute district general hospital setting in the NHS using the CORE system. Introducing CORE system when we did just over four years ago was innovative alongside less than a handful of workplace counselling services nationally and with the introduction of an innovative system of audit into daily routine practice comes many challenges for the implementation of this individual level change intervention in a service[1,2,3].
Rationale - Staff in distress need to be seen in a timely and confidential way and this service provision needs to be accountable not only to the users but also to the organization in terms of clinical governance [4] and be following government guidelines [5].

Clinical Governance - NICE guidelines on Clinical Audit [6] highlight the significant shifts in society's attitude to quality in healthcare which has lead to the introduction of clinical governance in the NHS. Clinical audit is one component that offers the greatest potential to assess the quality of care routinely provided for NHS patients/users. Our chosen audit system is CORE system which was developed following government policy in 1996 in reference to a review of NHS psychotherapy services in England [7] and followed by other policies relating
to mental health and the delivery of psychological therapies [8, 9, 10, 11]

**Organizational accountability** - Management want to know what they are getting for their money and whether services are meeting their patient needs in an efficient and effective manner.

Interventions need *good quality* evaluation – The developing research paradigm of Practice Based Evidence (PBE) *complements* Evidence Based Practice (EBP) in that it is directly relevant to practice as data is collected routinely [12, 13]. The field of outcome measurement is very important as it shows how feedback gathered via data being routinely collected can enhance practice so as to improve outcome [14, 15]. It is therefore important to audit the service provision to our staff in order to evaluate the areas for improvement in clinical practice.

**What is CORE?** – CORE is comprised of CORE-OM 34 item self report outcome measure that is filled at the beginning and end of therapy by clients and contextual forms for additional key management data that is completed by the therapist [16]. (See Appendix on presentation hand out). CORE-OM captures information across 4 main subgroups: well-being, social functioning and problems/symptoms, risk to self and risk to others. It has been nationally validated to show both good internal and external validity [17, 18, 19, and 21].

**Critique of CORE** – There are several factors to bear in mind [17, 20]:

1) CORE provides quantitative data and does not capture how clients and therapists feel about using the system.

2) Is a routine generic measure and does not comment on underlying personality traits.

3) It ignores substance abuse

4) Unable to pick up on suspected cases of trauma

As a self report measure we are seeing very much what the client wants us to see and some people too mentally ill to report accurately or their reading skills may be limited Initially, having to
get to grips with using the forms and correctly filling and getting the client to do the same without interfering with the therapy process.

CORE strength is as a system used routinely to produce relatively robust data that can generate very large data sets which can in turn be used to produce benchmark data. Standardisation helps produce results that are comparable and it is from this that the greatest benefits to practice are likely to be derived [21, 22, 23, and 24].

Figure. 4 Slide 3 - Background and Contextual Analysis

Where does counselling fit into stress management within an organisation?

The 6 Management Standards for Stress Prevention released on 4th November 2004 by the Health and Safety Executive (www.hse.gov.uk/stress) indicate that they favour the primary level intervention as the main work for organisations [25, 26]. However, it is inevitable that staff will at some point need a tertiary level intervention which is where counselling comes in as this is an
individual level intervention and CORE to evaluate the interventions.

The DOH policy review [7] highlighted a wide gap between research on psychological therapies and its everyday practice. For example, you may have a "Gold Standard" Randomized Control Trial (RCT) or Evidence Based Practice (EBP) on a particular therapy intervention for pure depression which has strict inclusion and exclusion criteria. It seems rigorous on paper but if you were to translate this to everyday practice you would see how different it is in that our everyday practice we meet most clients with a mixture of depression and say anxiety or other issues alongside depression. This then makes it difficult to translate/generalize RCT findings to our specific setting in clinical practice. However, if you routinely collect data with clients and the data (PBE) is part of a national practice research network (Pens) which allows benchmarking of like for like services then this is powerful research data when thousands of clients' data accumulate on the database [27]. CORE is such a system and trials began in 1996/7 with the collaboration of work between COREIMS Ltd and Psychological Therapies Research Centre (PTRC) at Leeds University and are now the largest database set in the U.K. and second to U.S.A. Internationally for psychological therapies [28].

The most exciting part of CORE now is CORE-PC computer software that allows data management and immediate analysis of data [29]. The audit I am discussing today is a traditional audit. You gather information, you evaluate, you make changes and then you re-audit but there is a time lag in doing this from gathering data to getting results.

CORE-PC allows you to look at data that is routinely gathered making it a 'dynamic' form of audit and means you can make the changes during the course of therapy so as to have a different outcome before the last session with a client. Also, now available is a shortened version of CORE-OM which is 18 items ([http://www.coreims.co.uk/](http://www.coreims.co.uk/)) and this can be administered at every
session in between first and last which uses 34-item OM. You need to bear in mind that there are variables for change which include 'therapist effects' like their skills in responding to this type of information and then how they meaningfully use this with clients during therapy [30, 31].

Figure. 5 Slide 3 - Aims and Objectives

The audit aims to provide demographic data as well as data for analysis that can be compared to the performance indicators as required for the provision of psychological services. Please note that the results that I will discuss for this 4th cycle of audit was only able to be improved based on our previous audit results but not as a result of national benchmarking. This is only possible by using CORE-PC which our service has just started to use. However, I was offered an opportunity for our last audit results to be benchmarked [32] (Please see Appendix) and the preliminary findings are encouraging although you need to bear in mind it has not been analyzed
against workplace counselling services as a subset.

The CORE system requires both practitioner and user to co-operate in form filling and on the 5 indicators above the results for our audit (sample 104 clients) indicate that there is continuous improvement in all areas. For example, the last audit identified 'a hot spot' in that the number of ethnic minority groups were overrepresented (it was statistically significant) in relation to numbers in the Trust in terms of presenting with work place issues like bullying and harassment. This was fed back to HR and collaborative work was done such as setting up a mediation service to informally resolve conflict before it became formal. Our current report shows no statistical significance between ethnic groups. We have increased EFFICIENCY in that last report clients having unplanned therapy endings was 42% and this was reduced to 10% in current report. Under ACCESSIBILITY the median wait time improved from 5 to 4 days. Under ACCEPTABILITY 85% of all planned sessions attended which is a improved of 4% from last audit.

Areas needing closer examination are: increased number of staff presenting with high scores in the clinical population and concurrently also seeing GP, from 16% to 38%. Suicide, self harm, harm to others and legal/forensic risk all increased with overall scores from 33% to 54% on all factors combined.

How it leads to research proposal – My research is in the field of outcome management and in the developing research paradigm of practice based evidence. I will be comparing whether there will be statistical significant difference if core measures are used just as an outcome measure (just given to clients without any discussion/feedback) or as a therapy tool (used as part of the therapy) where OMs will be given at each session to track client progress on screen with a 5 -Item measure that is easy for clients to complete on computer screen [33]. It will be
conducted only with workplace counselling [34,35,36,37,38,39], to date there is no nationally published benchmark data for workplace counselling services and my research would be original in it’s contribution to the workplace counselling field in the U.K. of using computerized feedback within therapy sessions with CORE system. To date in the U.K. using this type of feedback with CORE has only just begin this year and is being trialled in primary care counselling settings not in workplace counselling settings.

Selling Services. Although there is workplace counselling research using computer feedback in U.S.A.[34,35,36,37,38,39], to date there is no nationally published benchmark data for workplace counselling services and my research would be original in it’s contribution to the workplace counselling field in the U.K. of using computerized feedback within therapy sessions with CORE system. To date in the U.K. using this type of feedback with CORE has only just begin this year and is being trialled in primary care counselling settings not in workplace counselling settings.
NICE guidelines [6] for clinical audit highlight establishing the right environment which includes a supportive culture and structure as being necessary to see change. It is useful to use a framework [40] for identifying barriers to change which is necessary for successful change and if adhered to assists with the process of the elements of the audit cycle and parallels the challenges our service faced as a team working with CORE system. The CORE audit cycles have *individual change* as a key factor to the change process. A trans-theoretical model [41] was developed for the management of people with addictive behaviours such as smoking.

Individual behaviour change is seen as a transition through a series of 5 stages:
- Pre-contemplation – the individual has no intention of changing
- Contemplation – change is regarded as a possibility in the near future
- Preparation – explicit plans are made
- Action – the change occurs
- Maintenance – the changed behaviour is consolidated

Both therapists and clients went through each stage thus through the audit cycle enabled to use CORE system for outcome management. This parallel process is described next with the challenges (in bold italics) of the transition stages (both psychological and practical) within the audit cycle.

**Define criteria & standards** – DOH policy documents [5, 8] to set the standards for example for workplace counselling staff to be seen within a week [42]. CORE national benchmarking available for primary care. No funding from our Trust prior to this year to enable us to be benchmarked nationally and we had to analyse our data internally via our audit department. Getting to grips with change to how we work as individual therapists required much reflection.

**Data Collection** – CORE forms from clients and from therapists need to be accurate in terms of data inclusion. Overcoming therapist ‘resistance’ to doing extra paperwork, making their work ‘transparent’ and adding another process to work with clients and gaining client’s co-operation.

Regular emails exchanged as discussion forums as therapists working on different days part-time, regular arrange meetings arranged for raining/support for troubleshooting and keeping up levels of motivation in using the system.

Assess performance against criteria and standards – we have been able to assess against previous audits, DOH recommendations of seeing clients within a week [42]. *We did not know how we were doing* against other like services nationally. Performance anxiety of therapists when data analysed.

**Identify changes and implementation** – this is crucial to improvement in practice but also in
feeding back 'hot spots' to relevant stakeholders in the Trust so that essential work to address these issues can begin. Keeping CORE on the agenda on HR, OH and Clinical Governance with regular meetings for feedback, recommendations and action planning.

Re-audit – necessary for continual improvement so that it is a continuous cycle or an iterative process. The need to meaningfully work with therapist resistance and/or lack of motivation as well as varying challenging factors outside our service with the various stakeholders in regards to the implementation of recommendations for example.

Figure. 7 Slide 6 – Process Involvement

Stakeholders - Users - staff members wanting a good service; Practitioners - both qualified and trainees wanting to improve their clinical practice; Occupational Health Consultant - wanting a
quality and audited service using validated outcome measures that could also help identify risk and organizational 'hot spots'; Human Resources and Clinical Governance - wanting a service provision with continuous quality audit for improvement of factors such as accessibility, acceptability, efficiency, efficacy and an equitable service to all staff according to government policy for psychological services and other relevant research[43,44,45,46]. The cycle of change has been continuous with audit and re-audit with the involvement of all stakeholders. Due to financial constraints we have a service with a combination of top heavy trainee psychotherapists to qualified psychotherapists ratio all at different levels of experience and working with different theoretical orientations. We wondered if CORE would pick this up and show any statistical significant differences due to the 'transparency' of this type of audit which allows to comparison of therapist to therapist within the same service. There were no statistical differences shown. In the last report extra questions were asked for analysis for e.g. are counsellors equally effective with male and female clients, with depression versus depression/anxiety as presenting issues, with white and non-white staff, between clinical and non-clinical staff.

**Ethical issues** - audit developed with support of Trust Audit Department; clients free to take part with no impact on their care; all clients signed consent forms; confidential - anonymous data leading to research study for ethical approval; the results of audits have raised ethical issues about how to deal with organizational 'hot spots' that involve stakeholders outside this service and other issues that need further exploration like why has suicide risk increased [47, 48, 49, 50]. Issues arise in practice that are different to guidelines for e.g. no difference in therapist orientation although CBT recommended by NICE [44,45] and this is also confirmed by CORE national benchmarking data and the greatest difference being shown to be therapist effects differential data rather than theoretical orientation[30,31].

**Audit Critique** - **Strengths** - use of an outcome measure that is nationally both internally and
externally validated as a standardised measure and free to use; Quantitative approach to data collection and areas of clear improvement of service delivery; All clients seen by the service accepted to fill out outcome measures

Weaknesses - Some missing data items; Time lag for traditional audit to work on recommendations and implementation of results; cannot capture qualitative aspect of the process of form filling for client or practitioner without using other methods.

Outcomes - Statistically significant clinical improvement in clients well being with pre and post test outcome measure results showing that the service has a positive impact on staff well being. Clear improvement in areas identified to work on the last report like unplanned endings.
University of Surrey
Faculty of Health and Medical Sciences
Division of Health and Social Care

Research Log

Name: Gisela Unsworth
Course: Doctorate of Clinical Practice
Cohort: 2005
Director of Studies: Professor Sara Faithfull
Principle Supervisor: Professor Helen Cowie
Co-Supervisor: Dr. Anita Green
Statement of Originality

"I declare that this essay is wholly my own work, except where acknowledged specifically as the published work of others"

Gisela Unsworth

Date 31st March 2009
Log Book of Research experiences

Introduction
This paper provides a summary of my research experiences from January 2005 to March 2009 whilst a student on the Doctorate of Clinical Practice Programme. A description of the highlights of my research experiences during this period will be discussed and includes a record of the development of advanced research skills, evidence of the research decision making process and is a form of governance to support the research project submitted.

When I commenced the programme I had been post qualified as a psychological therapist and practicing for around ten years. I had worked in the NHS with the occupational health department and responsible for staff psychological support for seven years. My remit also included organisational stress management and I had been working full-time in my current post for three years. I had completed a Masters Degree in Psychotherapy and Counselling but had not been required to undertake a formal research dissertation and therefore had no experience of completing a research project. There was nearly a six year gap from my last experience of formal studying and at last I felt motivated to undertake another four years of study! I knew that I wanted to research a subject in the wider area of stress management which included one to one clinical work but I was unsure of exactly what it should be.

2005 - The challenges of narrowing down the research question

Value of Topic Review assignment
The first term of the programme set a formative piece of work called a Topic Review which was enormously helpful in both the skills in learning to write again after a huge gap in formal study and in learning how to undertake electronic literature searches with some teaching guidance
from our University librarian. Completing this made me aware of the fact that the field of stress management is enormous and that there is bountiful evidence of the effectiveness of organisational interventions to manage stress such as individual psychological interventions. By the end of the first year 2005, I had decided that I wanted to focus on the one to one work as this was the bulk of my work.

Notable influences
The first notable influence was a report by on the Facts of Workplace Counselling by Mcleod (2001) which led me to make the research decision to study about outcome measurement and using CORE system which my service had already been using for some years. The second notable influence was also in my first year when I attended a lecture by Professor Ian Robbins at the University of Surrey who talked about quantitative and experimental research. I had little confidence in reading papers on statistics but was willing to consider a design study that including this. I began to read as much as I could on randomised controlled trials and in the hopes that once I was clearer on the research question I would be able to design a study in the area of workplace counselling.

2006 – Finalization of the research question and Ethics submission

The Process of Developing the Research Question
The Service Development assignment was undertaken in Year 2 (2006) and this helped me to focus on using CORE System. Having decided to focus on one to one therapeutic interventions and their effectiveness I began another literature search and yielded the most stimulating research literature to date for me. The research I was read resonated with me and I became very excited about it. I came across the work of Dr Scott Miller and Dr Barry Duncan from The Institute for the Study of Therapeutic Change (ISTC) in the USA who promoted practice based
evidence (PBE) as a complementary paradigm to evidence based practice (EBP) and the Client Directed Outcome Informed (CDOI) approach for therapy by session tracking with outcome and alliance measures routinely. I immediately joined an international email forum of six to seven hundred psychological therapists and began a fascinating journey of learning from colleagues around the world. In the UK, I began to collaborate with CORE System personnel such as Dr John Mellor-Clark to look at the logistics of using the CORE research network for my research. In finalising the proposal for Ethics approval, I had corresponded with the authors of relevant research papers (Michael Lambert, Michael Barkham and Bill Stiles) on outcome measurement and session tracking to finalise the design. I then met up with Michael Barkham and Bill Stiles to discuss the statistical analysis of my design. The research question was: "Does the use of CORE-Net improve clinical outcomes in therapy?"

**The process of ethical approval**

In October, 2006, I was alone at the Ethics Committee meeting. The Committee suggested that I requested client consent and wanted me to also use a more complicated cluster design for the statistical analysis of the data using Hierarchical Linear Modelling (HLM). I had been brave enough to have chosen a quasi-experimental design but was I going to be able to accommodate these changes? This kind of analysis meant having to use many more therapists than I had originally planned in my design. When I went back to those therapists and asked them if they would include client consent they said no as they were too busy and did not routinely ask clients for consent so it would put too much pressure on them in their work. As the therapists withdrew their interest, this further reduced therapist numbers which would not make the study viable. After further exploration of possible avenues like using therapists from a national Employee Assistance Programme which was not going to work out within my time frame, I had no choice but to withdraw this application. I considered a realistic time frame and my supervisors supported my decision to change the design completely.
2007 – Ethical approval gained and data collection

Ethics resubmission

I had a few months to re-submit a new application with a new title and different design entirely which I did in time for March 2007. I knew I was now five months behind my intended schedule and was not feeling very confident. I set up a realistic time frame for the remainder of the time on the doctoral programme (Appendix 45). I finalised a qualitative study proposal that was entitled "Therapists' and Clients' perceptions of using CORE-Net and ARM-5 in the NHS. Based on the literature searches and the gaps in literature, I had decided to add an alliance measure (ARM-5) now with CORE-Net for session tracking as it was just the therapists in my own service that would be using this in the study and it would be more manageable to deliver in practice. The second group of therapists that I was interviewing from another NHS organisation was not using the alliance measure. Going through Ethics again was a much better experience and my Collaborative Supervisor at work, the Occupational Health Consultant, Dr Thayalan accompanied me and I had minor amendments to the client information and consent sheets to make which was done and final Ethics approved was granted within days. After approval in March 2007, I had excellent and efficient co-operation for speedy approval from my University Ethics Committee, my local hospital Research and Development and the other NHS Trust involved in the research on the south coast.

Data collection challenges

As CORE-Net is a web-based it presented with a little more issues than had been anticipated with our hospital IT department whose staff were excellent but they were involved in a number of projects and I had to wait in line for my turn which took longer than expected and delayed the start of the study by over a month. In the meantime, I had designed the training that was to be delivered to the therapists on my team, in conjunction with research papers, international
contacts, CORE IMS Ltd. Once I started the delivery of the training sessions, my team assisted me to simplify it into "Noddy Instructions" to make it easy to follow for the remainder of the training sessions I was to deliver and for them to have as a 'crib sheet' for easy reference. The individual interviews began with the other NHS Trust therapists almost simultaneously to my own team starting the research project. Only two small challenges took place during the data collection period which otherwise ran very smoothly and was completed at the end of November 2007. One of the therapists on the team left the service suddenly and at the start of the data collection period due to unforeseen circumstances. This meant the loss of one therapist to an already small group and the data that I was to collect from them such as their therapist diary and the interviewing of two of their clients. One of the tape recordings for one of the telephone interviews with a therapist from the other NHS team did not work and I was unable to re-do this interview so have to write it up from memory.

2008 - Challenges of resources at work, the analysis and write up

Challenges of resources at work
As a clinician and team leader, the uncertainty of undergoing several changes within the department that I work in proved challenging and exhausting over a period of eighteen months. Time management became a key issue. The entire department then became at risk of being outsourced completely or/and some members of staff being made redundant. Fortunately, the conclusion of the matter was that our department was cost effective and that the status quo was to be maintained for the foreseeable future. Since that time, the department had 70% turnover of staff with key people leaving such as the department manager and consultant physician who was also my Collaborative Supervisor. My immediate team (the counselling team) changed 100% within six months after the conclusion of the study due to the natural end of honorary contracts and the permanent staff making decisions to increase private practice and reduce their
hospital work. I was therefore under-resourced for seven months until adequate staffing levels were achieved. In the type of work I do you can't just book 'a temporary counsellor' as the recruitment and selection, CRB clearance and obtaining references all takes a very long time and I was keen that the service did not accrue a wait list. One of the new counsellors' recruited received an unexpected injury at home shortly after induction in the counselling service and this further extended the shortfall of resources by another two months meaning that I was unable to take block time out to finish the analysis and write up until the end of 2008. It was clear at this point that I would need to ask for an extension of three months in order to complete the writing up of the thesis.

The analysis and write up

I had made a decision to use NviVo 7 data management software for analysis and attended a short training session for the basics of its functions. What I have learned from hindsight is that it is not ideal to learn to use this software programme if you are unfamiliar with the process of qualitative analysis. Lack of time was a major issue for me as I struggled to maintain a full-case load working full-time and working many hours as goodwill overtime. This inevitably reduced both my time and energy for my doctoral studies. It would have been helpful if I had attended the Nvivo training session earlier than I did in order to familiarize myself with the basics such as how to import the documents as soon as they were transcribed into the NviVo 7 project. My biggest challenge to completing the thesis has been the lack of flow due to working full-time and only being to work at weekends as I was too tired to study after twelve hour working days during the week.

Dissemination strategy

During 2007/2008 I was able to present the proposal and preliminary findings to my Trust, other local Trusts, my previous training institution, various practice research networks, our University
PhD group, and posters for both my Trust and university research seminar/festival, BACP conference and a special workshop by Dr Scott Miller on Outcome Measurement. I submitted two short articles for non peer reviewed journals on the research.

2009 – Final revisions and write up

This year has been busy with many revisions undertaken to the final copy of the thesis which has taken longer than I could have imagined. Highlights so far this year in March have been to present alongside Scott Miller at a mental health trust that have just started to use CORE-Net and I talked about the clinical utility of CORE-Net and ARM-5. I facilitated a workshop at the CORE user conference and will be one of the authors in a peer reviewed journal article with Michael Barkham and his team about ARM-5.

Conclusion

The doctoral thesis has been an amazing journey thus far and opened up an entirely new world to me of research which is exciting and has helped me to grow in confidence as a team leader both within my counselling team and wider department and with the organisation as a whole. I feel the process of support through the doctoral programme is crucial for success. This support was given via regular academic supervision from both my university supervisors, my personal tutor at university, the process and learning around the time of the annual reports at university and my collaborative supervisor at my workplace.
Reference

Appendix 45 Gantt Chart of Project Time

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