A Practical Guide to Using Service User Feedback & Outcome Tools to Inform Clinical Practice in Child & Adolescent Mental Health Some initial guidance from the Children and Young P…

Book · January 2012

1 author:

Duncan Law
University College London
61 PUBLICATIONS **404** CITATIONS

Some of the authors of this publication are also working on these related projects:

Project Goals & goal-based outcomes (GBOs) View project

Project Working with goals in psychotherapy and counselling View project

A Practical Guide to Using

Service User Feedback & Outcome Tools

to Inform Clinical Practice in

Child & Adolescent Mental Health

Some initial guidance from

the Children and Young Peoples' Improving Access to Psychological Therapies Outcomes-Oriented Practice (CO-OP) Group

Version 1.3 - Feb 2012

Edited By

Duncan Law

Chair CO-OP group

Contents

Contents	Page

Contents	Page

Acknowledgements and Development

This document has been developed thus far from discussions and debate within the Children and Young Peoples' Project for Improving Access to Psychological Therapy (CYP-IAPT) Outcomes and Evaluation Group, and Critical Friends Forum, and from the voice of young service users involved in the Young Minds VIK "Talking About Talking Therapies". It includes learning from the Child and Adolescent Mental Health Services Outcomes Research Consortium (CORC) collaborative and from clinicians and service users who have experience of outcomes in the UK, Europe and USA and, with input from the other CYP-IAPT task and finish groups, HEIs, and collaborative leads. A full list of contributors can be found at the back of the document.

Introduction

Intentions of this document

This is a working document – to be revised and developed over time. It is intended as a guide in the true sense of the word: to be used and adapted in line with clinician's own clinical practice and in the context of the intervention with the children, young people and families with whom they are working. Its intention is to offer some helpful ideas to supervisors and clinicians who are using outcome measures and tools in their clinical practice, to add to the clinical information they routinely gather, in order to try to get better at what they do. The particular focus is aimed at those in the first wave of CYP-IAPT, who are using the outcomes recommended through the CYP-IAPT Outcomes and Evaluation task and finish Group (OEG). (Please see (**Children & Young People's IAPT Routine Outcome**

> This is a guide that aims to make helpful suggestions around using information from outcomes – the idea is that the suggestions are adapted to best fit with the style of the clinicians using them and context of the service users they are working with

Monitoring, Briefing Note <http://www.iapt.nhs.uk/silo/files/rom-dec11-03.pdf> **)**
See Appendix 1. for a summary table of the recommendations form the OEG.

It is intended as a start – to give guidance, and to stimulate discussion, and will be added to and improved over time as more views are added from the clinicians and services users who have developed expertise through the repeated use of the measures and tools. The intention is to set up a web-based version, or Wiki that will allow people to add their own expertise through experiences.

The Task of the CO-OP Group

The aim of CYP-IAPT is to improve both the effectiveness and service user experience of child mental health services. A major part in achieving this aim is to embed evidence

> The aim of the CO-OP groups is to offer guidance on how to use outcome measures and tools to enhance clinical practice.

based practice and, the use of service user feedback and outcome measures in CAMHS, to improve clinical practice and, in turn, get better service users experience and clinical outcomes. There is good evidence that the model of therapy used in an intervention has a significant effect on clinical outcomes (Fonagy et al 2002, Weisz and Kazdin 2010), and there is a well-developed curriculum to provide training in evidence-based interventions, relating to particular models of intervention. Outcomes, and outcomes-oriented practice, are equally embedded in the CYP-IAPT programme. However, there is a less well-developed curriculum for the implementation of this aspect of the CYP-IAPT model. There is a particular need to develop the therapeutic and supervision processes, and language, to use outcomes informed practice in everyday clinical practice, in real world CAMHS settings, embedded in supervision, and across all therapeutic modalities. The task of the CO-OP group is to work with others to produce information and guidance that will enable clinicians to use outcomes in a practical and effective way.

Why Measure Outcomes and Get Service User Feedback?

1. It is what service users want

Young service users, and carers, quite rightly, want their voice heard in interventions decisions, and therapy, and to collaborate in service development. They see the use of feedback and outcomes tools as an important aspect of this process in this (See Young Minds – Talking About Talking Therapies).

2. To provide better therapy

Fundamentally, the most important reason for using outcome measures must be to improve the relationship between service users and therapists and, in turn, to enhance clinical practice. There is good evidence that the relationship between therapist/practitioners and the children and families they work with, contributes significantly to clinical outcomes regardless of the model of therapy that is used in the intervention (Lambert 2005). This relationship relies on good feedback from children, young people and families to the therapist working with them. There is positive, emerging evidence that good collaborative practice between service users and clinicians can be significantly supported by feedback from frequent outcome monitoring (Miller et al 2006) reducing drop-out and improving clinician outcomes. Furthermore, these improvements in outcomes can occur across the broad spectrum of CAMHS regardless of the therapeutic model (Reich and Bickman (in Press)). Simply put: using questionnaire based outcomes and feedback tools can help us provide better therapy.

> There is good evidence that using feedback from outcomes tools can improve clinical practice

3. To ensure we continue to have appropriate service

Over the past decade clinical outcome monitoring in CAMHS has become part of the therapy landscape; its importance has grown due to political drivers to monitor and evaluate services and new initiatives, commissioners have increasingly been interested in receiving evidence that the services they commission provide good value and effectiveness, and supervisors and managers have encouraged clinicians to produce more objective information to evidence their practice. The question of whether to monitor outcomes or not is no longer in debate – we must use them to ensure good services continue to be commissioned and to support arguments to bring new money into CAMHS. Measures are also helpful in guiding us to ensure the level of service provided matches with the severity of the problems we are dealing with (DH 2010).

> Outcomes monitoring is important for service evaluation but the needs of the client should always take precedence over the wishes of the service to collect data

All three reasons for using outcomes tools are vital, and the CYP-IAPT outcomes framework (see OEG briefing paper **http://www.iapt.nhs.uk/silo/files/rom-dec11-03.pdf**) has had the challenge of producing measures that achieve all these aims in the most practical and effective way possible, within the limits of the resources available. But the use of outcomes tools to inform commissioners, service mangers or the Department of Health (DH), must always be secondary to what helps improve practice, and if there is a conflict between the two, that would negatively affect clinical practice, the clinical intervention must always win out.

Frequent and less frequent measures

The CYP-IAPT outcomes model incorporates both frequent (session-by-session) measures and less frequent (six monthly or at the end of the intervention). Both have their value and challenges. Less frequent tools can be longer and arguably more robust measures of outcome – but create operational challenges not least remembering to give them out! Session-by-session measures are, by their nature, more routine and therefore more likely to be used, but need to be kept brief and focused. They provide vital information to help keep interventions on tack, reducing drop-out, and can have a significant effect on outcomes.

Using this guide

This guide focuses on using outcomes tools to improve clinical practice. It is intended as a guide: suggestions of when, and when not, to use outcomes, with some suggested language about how to introduce outcome measures in therapy, how to feedback information to CYPFs, and ideas on how to use the information from outcomes tools in supervision – along with all other clinical information – to help keep interventions on track to prevent drop-out and to allow best clinical practice to be delivered, and attempt to improve it.

A Word on Language

Clearly language is important and it is easy to get paralysed by the complexity of semantics. We have tried to use language with its broadest meaning: 'Outcomes' is used broadly to mean any information gathered from using the tools, measures, questionnaires, recommended in the CYP-IAPT outcomes and evaluation group. Terms such as 'service users', 'Clients' 'Children young people and families' (CYPFs), 'patient' are used interchangeably, as are the terms 'Clinician', 'Practitioner', 'Therapist' and similarly 'Intervention' 'Therapy' 'Treatment', and finally,

'information' can mean 'Data' – we hope you go along with the spirit of the language – to keep things simple. However, over time, in future iterations of this guide, we would hope that the language is refined - as well as the guidance given – based on feedback from clients, service users, children, adolescents, young people, families, carers, clinicians, practitioners, therapists……….

Part I

Outcomes-Oriented Practice & Service User Feedback

The Service Structures to Support the Effective use of Outcomes

Getting the service structure right

The CYP-IAPT programme clearly acknowledges the vital importance of service structures to enable and support excellent clinical practice. This is certainly true for any service seriously wanting to use clinical outcomes to improve practice - before it is possible to collect any information around outcomes there needs to be reasonable service structures to support it. The development and sustainably of these structures relies on effective and committed clinical and operational leadership.

Facilitating the right culture

To enable the effective use of feedback from clinical interventions requires a certain mind-set that embraces a reflective stance to clinical practice, and uses information, from a variety of sources, to facilitate such reflection. For some individual clinicians outcome evaluations is already a part of their practice, and for others not. Within CAMHS there is great variety amongst clinicians as to how big a shift it would be to adopt a reflective practice based on outcome measures. This change would need support to embed any routine system of evaluation fully. But most importantly clinicians must have ownership of the information and models, and see the benefits, for any improvement in service

> There is a need for a supportive management environment that allows clinicians to explore their successes, and more feel confident that they can explore their 'failures' - to learn from them, and improve their practice

quality. Such cultural change needs to flourish in a learning organisation with a supportive management environment that allows clinicians to explore their successes, and do more of what works, but more importantly, feel confident that they can explore their 'failures' and learn from them, and improve their practice – this is a particular challenge given the understandable anxieties associated with shrinking services and potential job losses. Creating the right culture needs to come from the top down (commissioners, Chief Executives, managers, service leads, supervisors) as well as from the bottom up (Clinicians and practitioners). It is important to recognise what is realistic and possible within CAMHS, given the current clinical and scientific knowledge and resources available.

Infrastructure

The learning from other programmes where routine outcomes have been introduced shows that successful implementation of evaluations

> Without sustainable infrastructure in place, the implementation of outcomes monitoring fails

systems requires a supportive infrastructure. . The requirements need not be costly but require, as a minimum, reasonable IT systems and good administration support - reducing burden on clinicians' time.

Costs and Potential Savings

Implementing good systems of evaluation always have a cost - financial costs: setting up IT infrastructures to support the process, extra admin personnel, licensing and so on. But often the most expensive deficits come from hidden costs: shrinking capacity for clinicians where clinical contact time is reduced due to increased burdens of administration. A helpful consideration is to way up the cost of the system with the benefits it may bring – both in terms of better quality patient care but also real economic savings. American colleagues (whose services have always been driven payment by results and the demands to reduce health insurance costs) have

demonstrated that effective clinical monitoring systems can lead to more effective and efficient interventions (Lambert et al 2001), leading to cost saving across the board.

Evidence suggests that effective clinical monitoring systems can lead to more effective and efficient interventions

This section is to be developed over time with input from the CYP-IAPT Service Development Task and Finish Group and other collaborators.

The Specific Role of Supervisors

The routine and frequent use of clinical outcome tools in CYP-IAPT is one of the key strands of the programme, leading to improved and efficient practice across child and adolescent mental health services. It is

> Supervisors have a key role to create a facilitative culture where clinicians feel safe to use and reflect on the information gathered from outcomes tools

also an anxiety provoking and exposing practice to clinicians using the measures in their work. For the measures to be useful clinicians need to understand their purpose and feel comfortable in sharing the information produced, and to reflect on and challenge their practice – in order to learn and improve what they do. Supervisors have a particularly important role in enabling this to :

- Create the right culture to facilitate clinicians to use and share outcome information in productive co-operative environment

- Encourage clinicians to use the measures to aid shared decision making with the young people and families

- Help clinicians to review and reflect on the information from outcomes tools in the context of other clinical information in with a focus on keeping interventions on track

It is important that supervisors and supervisees work together to understand the outcomes and feedback. It is likely that a range of supervision structures will be effective in helping create the best environment for the above tasks: individual, group, and peer supervision. Supervisors should model openness and feedback with supervisees by sharing their own outcome data and introducing feedback at the end of supervision along the lines of the Session Rating Scale (SRS).

This section to be developed further over time with feedback from supervisors and clinicians using the CYP-IAPT feedback and outcomes measures in supervision.

Using information from outcome tools to improve clinical practice

Some Do's and Don'ts of using clinical outcome tools	
Do	Make sure you have the questionnaires you need, ready before the session
Do	Always explain why you are asking anyone to fill out a questionnaire
Do	Look at the answers
Do	Discuss the answers with service users
Do	Share the information in supervision
Do	Always use information from outcomes in conjunction with other clinical information
Don't	Give out a questionnaire if you think the person doesn't understand why they are being asked to complete them
Don't	Give use any outcome measure if you don't understand why you are using it
Don't	Use the tools if the service users is too distressed
Don't	See the numbers generated from outcome tools as an absolute fact
Don't	See your clinical judgement as an absolute fact

Starting on the right track

It is important to get things right from the start when working with children, young peoples and their families. There are three elements to this: understanding the problem (assessment), agreeing how and what to work together on (goals or aims), and getting on well enough together (engagement or alliance) to be able to do the agreed work (intervention). These are inter-related and mostly rely on good clinical skills to get right – outcomes tools can help.

Understand the problem

The of the most important things at the start of any good intervention is to give time to hear from the family in their own words about the difficulties they are experiencing and how they understand them.

Outcome tools can help collect certain different information to add to an understanding of the person's difficulties. However, collecting information in such a way is contentious; there are strong opposing ideas that range from:

- A view that it is essential to collect good, standardised assessment information around symptoms and presenting problems, to

- A view that even asking such questions imposes a narrow cultural definition of the problem which is unhelpful to families and clinicians ways of working.

Most clinicians seem to take a moderate stance somewhere between these two views.

The SDQ and the RCADS are the tools recommended to be use to help understand a families difficulties (and are also an important part of the evaluation of the CYP-IAPT programme), but services and clinicians are encouraged to use other assessment

tools as they see fit. They both have good psychometric properties and norms that allow some guide to the severity of the problems as well as a description of them.

It is helpful to either send out the SDQ and the RCADS to clients and families prior to a first appointment or ask the client and or family to fill the questionnaires out in clinics prior to the first meeting. Either way it is important to accompany the questionnaires with a clear letter that sets out:

- who is being asked to fill out the form

- why they are being asked

- how the information will be used

- how the information will be useful for that family and possibly subsequent families

- be clear that it is optional

- take into account literacy and language difficulties

- be clear that there will be an opportunity to discuss the measure with the clinician at the first (and any subsequent meeting).

It would be good for services to share examples of these letter across the collaboratives, as they are developed.

Agreeing the shared aims or goals of the work

Understanding the problem includes understanding what a person wants to change and a clear understanding what their aims or goals of coming to a service are. Without this interventions can be vague and unfocused making it hard to be clear about what is being agreed to work on together. Tools such as the goals based outcomes (GBO) or the (Children's) Outcomes Rating Scale - (C)ORS, when used

clinically, can help bring some clarity to the aims of the intervention. Getting to the stage of writing down a goal or aim means there is some agreement at least about the focus of the work – if you can't write the goal down then it suggests you need to do a bit more work. Having an agreed goal is good clinical practice helps create a better working relationship. Scoring progress to the goal at the start of an intervention gives a baseline - this can be used as a clinical guide to track progress. Similar baselines can be achieved with the (C)ORS, baseline scores – but it is important to remember that these are subjective tools and do not have the robust psychometric properties and norms of standardised outcome measures. Feedback from young people show they value clinicians taking time to understand their personalised and specific wishes for therapy and do not like being treated just as a 'diagnosis' or a 'symptom'. (See the Section of Goals for ideas on setting goals).

Once a problem is understood well enough, the symptoms checklist or measure should be selected – ideally this should be a collaborative process with the clinician guiding the young person to the a few measures that best fit with the problem description they have heard;

> *"….Ok, from what I have heard so far it seems that the main thing you want to change is around worries? One of the things that can be helpful is to check how your worries are doing over time, to see if they are getting better or not, one way we can do this is to ask you some questions about worries each time we meet….."*

The therapist may want to show the young person a couple of the symptom checklists that relate to worries and ask:

> *"…… out of the checklists we have looked at just now, which set of questions would make most sense to you to ask each time we meet?"*

It is important that the checklist makes sense to the young person, and fits with their understanding of the difficulties they want to work on.

Working well together

There is very good evidence that how well a clinician and service users work together in therapy has a big impact on the outcomes of the work. Working together well reduces early drop-out from treatment, and increases the chances of a person significantly improving. This is a particular kind of 'working well' – we know that if certain aspects of the therapeutic relationship are right, the therapy is more likely to go well, these include: feeling listened to or heard, working on the right things together, feeling you are getting something useful from the sessions, and working in the right way together. Research also tells us that clinicians find it difficult to predict accurately how well they are working together with service users. Using outcome tools can aid this important feedback process – but even then clinicians need to find ways of genuinely encouraging both positive and helpful negative feedback from clients. How we introduce the measure will make a big difference to how helpful the feedback we get back might be, for example:

> *"……..one of the things that is really important is making sure that we work together well and feel OK to let each other know how things are going. Sometimes that might be easy - if things are going well it is usually easier to let someone know - but sometimes that might be more difficult – particularly if things don't seem to be going so well. I will try and get things right, so we can work together well, but I know that sometimes I will get it wrong; towards the end of each session I want us to check how well we are working together (or not) – I really want to hear from you if things are going well so we can carry on doing what works, and I really, really want to hear from you if you think things aren't going so well, so we can work to improve things ……"*

Some clinicians choose to add at this point that the young person won't be in trouble if they give negative feedback – and stress that they will be thanked for it, as it will help both do a better job together.

> *"….. I have a few short questions for us to look at together towards the end of each time we meet which might help with this….."*

Use your judgement to decide how much time might be needed to review the questions - this will vary – particularly if things are going less well – sometimes even with planning there may not be enough time to discuss all that is helpful – if this is the case agree to give time in the net session to discuss more fully. In some sessions the scoring and discussion may only take seconds, whereas in others a significant part of the session might be about working to get the alliance back on track.

The (Children's) Session Rating Scale - (C)SRS, or the four alliance questions are recommended to help with this feedback. Again the scores can provide a useful clinical baseline to track the alliance in therapy.

Staying on track

Session-by-session, or frequent outcome monitoring, allows for the potential to pick up subtle and rapid changes that might begin to move an intervention off-track - leading to potential drop-out, or poor outcomes. As ever, outcomes tools are not the only way to monitor trajectories, but evidence suggests they are an important part of the monitoring process, to offer clues that interventions may be going off track.

> Use session-by-session information to check if the intervention is 'on-track'

General rules when spotting an 'off-track' clue: first of all remember there is nothing magical about numbers, they may provide helpful hints and clues that something may not be going to plan, the tools can help clients hint at problems that they may not be able to say out-right, but these are only indicators (not facts), and like any clue it needs to be examined and discussed to understand it more fully – so discuss the change with the client:

"…. *from the answers you have given on the SMS it looks like the score for 'listening' is a bit lower than usual? Lets spend a minute or two*

understanding that and see if we can figure out if there is something I need to do differently next time…. Is it Ok to talk about it now? ……."

It is also good to discuss changes in supervision, understand what lies behind it, come up with a plan to get things back on track – try out the plan, continue to monitor progress. This may seem a simple cycle in theory but to achieve it requires very good clinical skills. This cycle is set out on the diagram below:

Getting things back on track
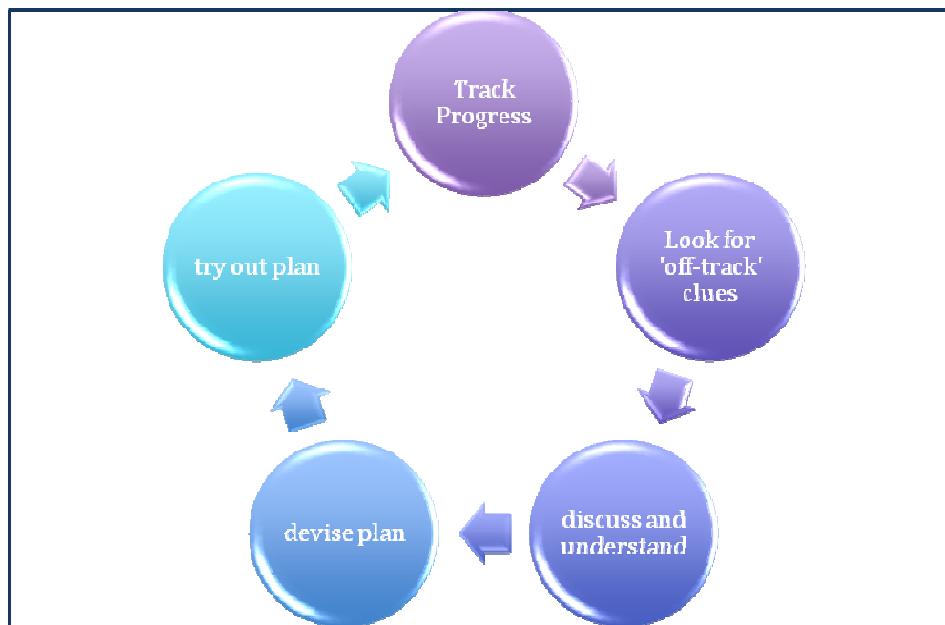
This table sets out some of the clues that an intervention may be starting to go off track, and suggest some things to consider:

Clues	Possible Problem	Possible Solution
A sudden drop in the working well together (alliance) scores or SRS	Might suggest a difficult session or early indicator of an alliance problem?	Discuss changes – Was it a 'one-off'? Decide if anything needs to change for next session.
A general decline in working well together (alliance) scores or SRS over a number of sessions	Problem with alliance?	Discuss changes – are you still working on the important goals? Have problems/symptoms got worse? – review symptoms checklist Is there an issue outside of therapy?
Sudden decline in goals score	Have goals changed? Have problems got worse? Is there an issue outside of therapy?	Review goals with young person Check to see if there are other external issues that need to be discussed
A general decline in goal scores over a number of sessions	Have goals changed? Have problems got worse? Is there a problem with the therapeutic approach? Is there an issue outside of therapy?	Review goals with young person Check to see if there are other external issues that need to be discussed Discuss therapy model – does it need to change? Consider change of therapist?
Sudden decline in the ORS	Have problems got worse? Is there a problem with the therapeutic approach? Is there an issue outside of therapy?	Check to see if there are other external issues that need to be discussed Discuss therapy model – does it need to change? Consider change of therapist?

Clues	Possible Problem	Possible Solution
Sudden decline in symptom scores	Have problems got worse? Is there a problem with the therapeutic approach? Is there an issue outside of therapy?	Check if significant event has happened in between sessions Check if scores match real experience - does the client subjectively feel things are much worse?
A general decline in ORS scores over a number of sessions	Have problems got worse? Is there a problem with the therapeutic approach? Is there an issue outside of therapy?	Check to see if there are other external issues that need to be discussed Discus therapy model – does it need to change? Consider change of therapist?
A general decline in symptom scores over a number of sessions	Have problems got worse? Is there a problem with the therapeutic approach? Is there an issue outside of therapy?	Review goals with young person Check to see if there are other external issues that need to be discussed Discuss therapy model – does it need to change? Consider change of therapist?

Tips for reviewing information from outcomes tools

Learning within interventions

The two-minute review:

Look for surprises

If all you have is two minutes to review the information from the outcomes in the sessions (which in many cases will be all clinicians have between session) have a quick scan of the answers on the outcome tools – look for surprises – is there anything on the questionnaires that don't fit with what you heard in the session?   Did you hear that

> Remember there is nothing magical about scores on a questionnaire or outcome tool. The information is no better or worse than what clients tell us verbally in a session – it is just different. Both are useful in their own right, but used together, they can really complement each other.

everything was fine but the symptoms checklist scores very high? Did you hear that things were going well but the goals measure is scored very low? Or maybe you heard that there had it had been a very bad week – but the ORS scales are rated quite high. If you didn't already discuss these in the session you just had, make a note to ask next time.

The ten-minute Review:

Create a 'story' or narrative of the case

With a little more time - it is helpful to do more than a quick scan of the information from outcomes. A useful exercise is it to create a story or narrative that includes all

> If you have slightly longer you can create a story or narrative about the data – challenge yourself, with your supervisor to come up with alternative explanations of the data

the clinical information about the case (presenting problem, formulation, motivation, contextual factors etc) and includes the information gathered from the outcomes tools. It should be possible to tell a story where all the information hangs together – the outcomes run in a 'positive' direction (if you have information from a number of session) – what was it about the factors of the case that explain that? Similarly if they run in a negative direction – what factors might account for that? Try and make the story as coherent as possible (make sure the story is logical and accounts for the changes and any anomalies – the more all the information hangs together the more coherent the narrative).

You may find that the stories you create tend to attribute clinical success to your own good clinical skill, and that you tend to attribute less good outcomes to factors outside of therapy - contextual factors! (Some practitioners will tend to make attributions in the opposite direction). Your initial attributions may well be true in some cases, but we know clinicians tend to overestimate their abilities (Norcross 2010) and have a tendency to view things either overly positively or overly negatively - to improve our practice we need to be a bit more reflective and objective. One way is to try and create an alternative account of the information you have. Play 'devils-advocate', challenge yourself to find alternative explanations to the outcome. Creating two alternative narratives gives you a kind of binocular view of the outcomes (rather than the usual one dimension we tend to create) this gives the outcomes data a depth in which to explore and reflect on our practice.

Using a supervision to create the narratives can be extremely fruitful – the colleague or supervisor can take the 'devil's advocate' role which can make it easier to create the alternative view.

The six-month review

Both the RCADS and the SDQ will be given out again after six months (if the case is still open – some services may choose to send out these questionnaires even if the

26

case is closed when the tools will have been given again, to see if progress has been sustained) and the CHI-ESQ is also given out then. This is a good opportunity to do a more in-depth review of a case. Review the results of the SDQ and RCADS in conjunction with the session-by-session data and other clinical information about the case. Take it to individual supervision and/or peer group supervision to get a range of views; are the goals still clear and appropriate?, are you working well enough with the child or family? Are symptoms showing signs of improvement? Is the intervention still the most appropriate one for the case? Consider whether change of therapist or therapeutic approach might be indicated.

> It is helpful to do a more in-depth review of a case at six months including the information from the second SDQ, RCADS and CHI-ESQ

Learning across a number of interventions

Look out for 'themes' across the information

Once you have information over a number of cases it can be helpful look for themes in the information - it helps to set out information in a table where you can easily scan the data across clients, rather than trying to look at one case at a time. The themes might relate to particular presenting problems: do you tend to get better outcomes with one particular client group (e.g. OCD) than another (e.g. eating disorders). Do you tend to get high scores on certain items on the CHI-ESQ (e.g. "listens well") and do less well on others (e.g. "explained clearly")? Are there many service related themes? "Convenient appointments", "surroundings". Look at the qualitative comments from the SDQ and especially the CHI-ESQ. What can you do to improve things? Do they point to any further training or issues to discuss in supervision?

> When you have outcomes information on a number of clients you can start looking for themes across the cases – what do you do well at? What areas of development can you identify?

Next steps and future challenges

This is very much a first step to develop a practical guide for clinicians and supervisors to help with using information from outcomes tools to inform and enhance clinical practice. The aim is to refine and improve the information over the lifetime of the CYP-IAPT project through feedback from trainees, supervisors in the CY-IAPT training, and the cohort of CAMHS clinicians who use the measures, from discussion with experts in the field of outcomes. We are also aware that embedding outcomes in practice has particular challenges for some modes of therapy more than others, and the creative solutions needed to use outcomes across all CAMHS and therapy settings, integrated in all therapeutic modalities – for the benefit of service users. This development will be achieved by:

- Focus groups with CYP-IAPT supervisors and trainees

- Discussions with CYP-IAPT service mangers

- Learning from individual and group interviews with services users who have experience of interventions where outcome measures have been used

- Interviews with experts in the outcomes field

- Interviews with clinicians out side of the CYP-IAPT training

- Input from the CYP-IAPT task and finish groups

- Input from the HEIs and CYP-IAPT collaboratives

- Consultation with professional bodies including the Association of Family Therapy, British Association for Counselling and Psychotherapy , and the Association of Child Psychotherapists, the British Psychological Society and, the Royal College of Psychiatry.

References

Badham. B., (2011) Talking about Talking Therapies: Thinking and planning about how best to make good and accessible talking therapies available to children and young people. Young Minds

Bickman, L., Andrade, A.R., Lambert, E.W., Doucette, A., Sapyta, J. & Boyd, A.S. (2004). Youth Therapeutic Alliance in Intensive Treatment Settings. *Journal of Behavioral Health Services & Research, 3* (2), 134-148

Bordin, E.S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy,* **16**: 252-260.

Department of Health (2010) The NHS Outcomes Framework 2011/12

Fonagy, P., Target, M., Cottrell, D., Phillips, J, and Kurtz, Z., (2002) What works for whom? A critical review of treatments for children and adolescents. Guilford Press

Horvath, A. O. & Symonds, B. D. (1991). Working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology*, 38, 139-149

Kazdin, Alan E. (Ed); Weisz, John R. (Ed), (2003). *Evidence-based psychotherapies for children and adolescents*, (pp. 439-451). New York, NY, US: Guilford Press

Lambert, M.J. (Ed). (2005) Enhancing psychotherapy outcome through feedback. Journal of Clinical Psychology, *61, 141-217.*

Miller, S. D., Duncan, B. L., Brown, J., Sorrel, R., & Chalk, B. (2006). Using outcome to inform and improve treatment outcomes. *Journal of Brief Therapy*, **5**, 5-22.

Norcross, J.C. (2010). The therapeutic relationship. In B.L. Duncan, S.D. Miller, B.E.

Reich, S. & Bickman, L. (forthcoming). Client driven and clinician focused feedback: Theory, research and practice. In S. I. Donaldson, C. A. Christie & M. Mark (Eds.), What Counts as Credible Evidence in Evaluation and evidence-based practice? Thousand Oaks, CA: Sage.

Wampold, & M.A. Hubble (Eds.), *The heart and soul of change 2nd ed.: Delivering what works in therapy (pp.113-141).*Washington, D.C.: American Psychological Association.

Part II

Specific Tools

Strengths & Difficulties Questionnaire - (SDQ)

Adapted from SDQ Info http://www.sdqinfo.com/a0.html

The Strengths and Difficulties Questionnaire (SDQ) is a brief behavioural screening questionnaire about 3-16 year olds. It exists in several versions to meet the needs of researchers, clinicians and educationalists. Each version includes between one and three of the following components:

A) 25 items on psychological attributes.

All versions of the SDQ ask about 25 attributes, some positive and others negative. These 25 items are divided between 5 scales:

1) emotional symptoms (5 items)   }

2) conduct problems (5 items)

3) hyperactivity/inattention (5 items)

4) peer relationship problems (5 items)

5) prosocial behaviour (5 items)

Sections 1) to 4) added together to generate a total difficulties score (based on 20 items)

The same 25 items are included in questionnaires for completion by the parents or teachers of 4-16 year olds (Goodman, 1997).

A slightly modified informant-rated version for the parents or nursery teachers of 3 (and 4) year olds. 22 items are identical, the item on reflectiveness is softened, and 2 items on antisocial behaviour are replaced by items on oppositionality.

Questionnaires for self-completion by adolescents ask about the same 25 traits, though the wording is slightly different (Goodman et al, 1998). This self-report version is suitable for young people aged around 11-16, depending on their level of understanding and literacy.

In low-risk or general population samples, it may be better to use an alternative three-subscale division of the SDQ into 'internalising problems' (emotional+peer symptoms, 10 items), 'externalising problems' (conduct+hyperactivity symptoms, 10 items) and the prosocial scale (5 items) (Goodman et al. 2010)

B) An impact supplement

Several two-sided versions of the SDQ are available with the 25 items on strengths and difficulties on the front of the page and an impact supplement on the back. These extended versions of the SDQ ask whether the respondent thinks the young person has a problem, and if so, enquire further about chronicity, distress, social impairment, and burden to others. This provides useful additional information for clinicians and researchers with an interest in psychiatric caseness and the determinants of service use (Goodman, 1999).

C) Follow-up questions

The follow-up versions of the SDQ include not only the 25 basic items and the impact question, but also two additional follow-up questions for use after an intervention. Has the intervention reduced problems? Has the intervention helped in other ways, e.g. making the problems more bearable? To increase the chance of detecting change, the follow-up versions of the SDQ ask about 'the last month', as opposed to 'the last six months or this school year', which is the reference period for the standard versions. Follow-up versions also omit the question about the chronicity of problems.

There is currently no guidance on the language for using this measure

References

Goodman R (1997) The Strengths and Difficulties Questionnaire: A Research Note. Journal of Child Psychology and Psychiatry, 38, 581-586. (Abstract)

Goodman R, Meltzer H, Bailey V (1998) The Strengths and Difficulties Questionnaire: A pilot study on the validity of the self-report version. European Child and Adolescent Psychiatry, 7, 125-130. (Abstract)

Goodman R, Scott S (1999) Comparing the Strengths and Difficulties Questionnaire and the Child Behavior Checklist: Is small beautiful? Journal of Abnormal Child Psychology, 27, 17-24. (Abstract)

Goodman R (1999) The extended version of the Strengths and Difficulties Questionnaire as a guide to child psychiatric caseness and consequent burden. Journal of Child Psychology and Psychiatry, 40,791-801. (Abstract)

Smedje H, Broman J-E, Hetta J, von Knorring A-L (1999) Psychometric properties of a Swedish version of the "Strengths and Difficulties Questionnaire". European Child and Adolescent Psychiatry, 8,63-70. (Abstract)

Goodman R, Renfrew D, Mullick M (2000) Predicting type of psychiatric disorder from Strengths and Difficulties Questionnaire (SDQ) scores in child mental health clinics in London and Dhaka. European Child and Adolescent Psychiatry, 9, 129-134. (Abstract)

Klasen H, Woerner W, Wolke D, Meyer R, Overmeyer S, Kaschnitz W, Rothenberger A, Goodman R (2000) Comparing the German versions of the Strengths and Difficulties Questionnaire (SDQ-Deu) and the Child Behavior Checklist. European Child and Adolescent Psychiatry, 9, 271-276. (Abstract)

Goodman R, Ford T, Simmons H, Gatward R, Meltzer H (2000) Using the Strengths and Difficulties Questionnaire (SDQ) to screen for child psychiatric disorders in a community sample. British Journal of Psychiatry, 177, 534-539. (Abstract)

Koskelainen M, Sourander A, Kaljonen A (2001) The Strengths and Difficulties Questionnaire among Finnish school-aged children and adolescents. European Child and Adolescent Psychiatry, 9, 277-284.(Abstract)

Mullick MSI, Goodman R (2001) Questionnaire screening for mental health problems in Bangladeshi children: a preliminary study. Social Psychiatry and Psychiatric Epidemiology, 36, 94-99.(Abstract)

Goodman R (2001) Psychometric properties of the Strengths and Difficulties Questionnaire (SDQ). Journal of the American Academy of Child and Adolescent Psychiatry, 40, 1337-1345. (Abstract)

Woerner W, Becker A, Friedrich C, Klasen H, Goodman R, Rothenberger A (2002) Normierung und Evaluation der deutschen Elternversion des Strengths and Difficulties Questionnaire (SDQ): Ergebnisse einer repräsentativen Felderhebung. Zeitschrift für Kinder- und Jugendpsychiatrie und Psychotherapie, 30, 105-112. (Abstract), (Zusammenfassung)

Mathai J, Anderson P, Bourne A (2002) The Strengths and Difficulties Questionnaire (SDQ) as a screening measure prior to admission to a Child and Adolescent Mental Health Service (CAMHS). Australian e-Journal for the Advancement of Mental Health, 1, Issue 3. (Abstract)

Glazebrook C, Hollis C, Heussler H, Goodman R, Coates L (2003) Detecting emotional and behavioural problems in paediatric clinics. Child: Care, Health and Development, 29, 141-149. (Abstract)

Muris P, Meesters C, van den Berg F (2003) The Strengths and Difficulties Questionnaire (SDQ): Further evidence for its reliability and validity in a community sample of Dutch children and adolescents. European Child and Adolescent Psychiatry, 12, 1-8. (Abstract)

van Widenfelt BM, Goedhart AW, Treffers PDA, Goodman R (2003) Dutch version of the Strengths and Difficulties Questionnaire (SDQ). European Child and Adolescent Psychiatry, 12, 281-289. (Abstract)

Mathai J, Anderson P, Bourne A (2003) Use of the Strengths and Difficulties Questionnaire as an outcome measure in a child and adolescent mental health service. Australasian Psychiatry, 11, 334-337. (Abstract)

Muris P, Maas A (2004) Strengths and difficulties as correlates of attachment style in institutionalized and non-institutionalized children with below-average intellectual abilities. Child Psychiatry and Human Development, 34, 317-328. (Abstract)

Mathai J, Anderson P, Bourne A (2004) Comparing psychiatric diagnoses generated by the Strengths and Difficulties Questionnaire with diagnoses made by clinicians. Australian and New Zealand Journal of Psychiatry, 38, 639-643. (Abstract)

Hawes DJ, Dadds MR (2004) Australian data and psychometric properties of the Strengths and Difficulties Questionnaire. Australian and New Zealand Journal of Psychiatry, 38, 644-651. (Abstract)

Muris P, Meesters C, Eijkelenboom A, Vincken M (2004) The self-report version of the Strengths and Difficulties Questionnaire: Its psychometric properties in 8- to 13-year-old non-clinical children. British Journal of Clinical Psychology, 43, 437-448. (Abstract)

Goodman A, Lamping DL, Ploubidis GB (2010) When to use broader internalising and externalising subscales instead of the hypothesised five subscales on the Strengths and Difficulties Questionnaire (SDQ): data from British parents, teachers and children. Journal of Abnormal Child Psychology, 38, 1179-1191. (Abstract)

Revised Children's Anxiety and Depression Scale – (RCADS)

Adapted from, the Revised Children's Anxiety and Depression Scale   User's Guide. Prepared by Dara C. Weiss and Bruce F. Chorpita February 2, 2011 www.childfirst.ucla.edu

Background

The Revised Child Anxiety and Depression Scale (RCADS) is a 47-item, youth self-report questionnaire with subscales including: separation anxiety disorder (SAD), social phobia (SP), generalized anxiety disorder (GAD), panic disorder (PD), obsessive compulsive disorder (OCD), and major depressive disorder (MDD). It also yields a Total Anxiety Scale (sum of the 5 anxiety subscales) and a Total Internalizing Scale (sum of all 6 subscales). Items are rated on a 4-point Likert-scale from 0 ("never") to 3 ("always"). Additionally, The Revised Child Anxiety and Depression Scale – Parent Version (RCADS-P) similarly assesses parent report of youth's symptoms of anxiety and depression across the same six subscales.

Scoring

The RCADS and RCADS-P can be scored either manually or by using an automated scoring procedure.

Manual Scoring. To score the RCADS manually, each item is assigned a numerical value from 0-3, where 0 = Never, 1 = Sometimes, 2 = Often, and 3 = Always. For each subscale add the numerical values for each item together. The items that comprise each subscale are listed below. For example, for Generalized Anxiety you would add the numerical values for items 1, 13, 22, 27, 35, and 37. Thus, the highest score possible is 18, the lowest 0.

Disorder/Syndrome	Related Items
Social Phobia	4, 7, 8, 12, 20, 30, 32, 38, 43
Panic Disorder	3, 14, 24, 26, 28, 34, 36, 39, 41
Major Depression	2, 6, 11, 15, 19, 21, 25, 29, 40, 47
Separation Anxiety	5, 9, 17, 18, 33, 45, 46
Generalized Anxiety	1, 13, 22, 27, 35, 37
Obsessive-Compulsive	10,16, 23, 31, 42, 44

Using the raw score for each subscale, look up the corresponding T-score from the appropriate grade level chart in the Appendices. For example, if the raw score for a girl in 5th grade on the SP (Social Phobia) subscale was 12, the T-score would be 48 (see Appendix Table A, p.6).

Automated Scoring. Scoring programs for youth and parent versions are available at www.childfirst.ucla.edu/resources.html for scoring the RCADS and calculating T scores. Begin by entering youth's gender and grade level on top right hand corner. Note: only grade level should be entered (not youth age). Continue by entering scores (0-3) for all 47 items. Raw scores by subscale will be generated and data points plotted along the corresponding figure. The figure shows a dashed line at T = 65. T scores of 65 or higher will show in a yellow background, indicating scores at the borderline clinical threshold. T score of 70 or higher will show in an orange background, indicating scores above the clinical threshold.

Languages

The RCADS is available in English (US), Spanish (US), Chinese, Dutch and Danish. The RCADS-P is available in English (US), Spanish (US), Dutch and Danish. Currently, norms and scoring programs for both the RCADS and RCADS-P are based on English versions. Use of norms and interpretation of T-scores should be done cautiously with non-English versions, as research is still underway on these instruments. Users are

encouraged to check the UCLA Child First Site (www.childfirst.ucla.edu) for updates on additional scoring programs, and updates to norms will continue to be posted as new research emerges.

Summary of Research

In a school-based sample of 1,641 children and adolescents, Chorpita and colleagues (2000) reported a factor structure consistent with DSM-IV anxiety disorders and depression, and favourable internal consistency. Similarly, the RCADS-Parent version (RCADS-P) shows high internal consistency and convergent validity, and has been shown to accurately assess anxiety and depression symptoms in youth (Ebesutani et al. 2010). Further evidence for the RCADS has been demonstrated in other samples, including clinical samples and Australian youth (e.g., Chorpita, Moffitt, and Gray, 2005; de Ross, Gullone, and Chorpita, 2002). The RCADS' ability to help inform diagnoses, track clinical change, and further delineate between anxiety and depression disorders shows its strong utility in both clinical and research contexts (e.g., Chorpita et al. 2000; Chorpita et al. 2005).

There is currently no guidance on the language for using this measure

References

Brown, T. A., Chorpita, B. F., Korotitsch, W., & Barlow, D. H. (1997). Psychometric properties of the Depression Anxiety Stress Scales (DASS) in clinical samples. Behaviour Research and Therapy, 35, 79- 89.

Chorpita, B. F., Yim, L. M., Moffitt, C. E., Umemoto L. A., & Francis, S. E. (2000). Assessment of symptoms of DSM-IV anxiety and depression in children: A Revised Child Anxiety and Depression Scale. Behaviour Research and Therapy, 38, 835-855.

Chorpita, B. F., Moffitt, C. E., Gray, J. A. (2005). Psychometric properties of the Revised Child Anxiety and Depression Scale in a clinical sample. Behaviour Research and Therapy, 43, 309-322.

Chorpita, B. F., & Nakamura, B. J. (2008). Dynamic structure in diagnostic structured interviewing: A comparative test of accuracy and efficiency. Journal of Psychopathology and Behavioral Assessment, 30, 52-60.

de Ross, R. L., Gullone, E., & Chorpita, B. F. (2002). The Revised Child Anxiety and Depression Scale: A psychometric investigation with Australian youth. Behaviour Change, 19, 90-101.

Ebesutani, C., Bernstein, A., Nakamura, B., Chorpita, B. F., & Weisz, J. (2010). A psychometric analysis of the Revised Child Anxiety and Depression Scale - Parent Version in a clinical sample. Journal of Abnormal Child Psychology, 38, 249-260.

Ebesutani, C., Chorpita, B. F., Higa-McMillan, C., Nakamura, B., Regan, J., & Stumpf, R. (in press). A psychometric evaluation of the Revised Child Anxiety and Depression Scale – Parent Version in a school sample. Journal of Abnormal Child Psychology.

Muris, P., Merckelbach, H., Ollendick, T., King, N., & Bogie, N. (2002). Three traditional and three new childhoodanxiety questionnaires: Their reliability and validity in a normal adolescent sample. Behaviour Research and Therapy, 21, 685–692.

Muris, P., Dreesen, L., Bogels, S., Weckx, M., & van Melick, M. (2004). A questionnaire for screening a broad range of DSM defined anxiety disorder symptoms in clinically referred children and adolescents. Journal of Child Psychology and Psychiatry,45,813–820.

CHI-Evaluation of Service Questionnaire (CHI-ESQ)

Adapted from the CORC website: www.corc.uk.net

The CHI-ESQ was developed by the Commission for Health Improvement (CHI) (Astride-Stirling, J. (2002), now the Care Quality Commission (CQC)), the tools was devised from focus groups around issues raised as important in determining satisfaction with services, and then piloted with carers and children using CAMHS. The CHI-ESQ was originally used as an anonymous measure for one-off audits of service delivery. It has high face validity but there is not other information on its information on its psychometric properties.

The CHI-ESQ consists of 12 items (see CYP-IAPY data-set for scoring) and three free-text sections looking at what the respondent liked about the service, what they felt needed improving, and any other comments.

Versions:
- Parent/carer CHI-ESQ
- Self-report CHI-ESQ for 12-18 year olds
- Self-report CHI-ESQ for 9- 11 year olds

As with all feedback tools, in order to get honest information clinicians need to find ways of genuinely encouraging both positive and helpful negative feedback from clients. How we introduce the measure will make a big difference to how helpful the feedback we get back might be, for example:

"……..over the time we have been meeting we have been getting regular feedback about how each session is going - now we have been working together for some time it will be helpful to get an idea about how things are going more broadly, and how you are finding the service as a whole. This questionnaire (hand the CHI-ESQ) is one of the ways that helps us get that kind of information. It is really helpful if you answer as honestly as possible. We hope there are things that we do OK but we know that there are always things that we can improve on – the best people to help us with that are people like you have used the service for a while."

Some clinicians choose to remind service users at this point that they won't be in trouble if they give negative feedback – and stress that they will be thanked for it, as it will help both do a better job together. For services where the feedback is read by the clinician (recommended) the clinician should make it clear to the service user that they will see the questionnaire. The questionnaire can either be filled in at the end of the session, (recommended) or be completed away from the clinic and posted back – although experience has shown that less good return rates are likely with this method.

References

Astride-Stirling, J. (2002) Development of methods to capture user views of Child and Adolescent Mental Health Services for clinical governance reviews. Commission for Health Improvement: Project Evaluation Report.

Barber, A.J., Tischler, V.A. and Healy, E. (2006) Consumer satisfaction and child behaviour problems in child and adolescent mental health services. Journal of Child Health Care, 10(1), 9-21

The Outcome Rating Scales (ORS) & Session Rating Scales (SRS):

Feedback Informed Treatment in Child and Adolescent Mental Health Services (CAMHS)

Prepared for CYP-IAPT by: *David C. Low, Norfolk & Suffolk NHS Foundation Trust, Scott D. Miller, International Center for Clinical Excellence (ICCE), Brigitte Squire, Cambridgeshire & Peterborough NHS Foundation Trust.*

Introduction

Monitoring the young persons and carers feedback on progress with the Outcome Rating Scale (ORS) and the alliance with Session Rating Scales (SRS) is a natural fit for clinicians who strive for a collaborative clinical practice. The ORS and SRS gives young people and carers a voice in treatment as it allows them to provide immediate feedback on what is working and what is not. This section details how clinicians can use the ORS and SRS for real time feedback to inform treatment thereby improving the outcome of services they offer to young people and families. A brief overview of the empirical evidence of both scales, and the research of their combined use will be provided. In addition, the majority of this section will be practical and provide an introductory illustration to the use of the ORS and SRS throughout the therapy process. At the end you will be sign posted to how to access the measures and resources available to support your use of them.

Key Evidence Base Findings

Since the introduction of the ORS and SRS in 2000, research has progressed from instrument validation to randomized control trials (RCTs).

- Research on the ORS and SRS demonstrate impressive internal consistency and test-retest *reliability* (Miller et al., 2003; Duncan et al., 2003; Bringhurst et al., 2006; Duncan et al., 2006; Campbell & Hemsley, 2009).

- In those studies the ORS and SRS show moderately strong concurrent *validity* with longer, more established measures of treatment outcome and therapeutic alliance.

- *Feasibility* (i.e. the degree to which it can be explained, completed, and interpreted quickly and easily) of the ORS and SRS is high as they are ultra brief. As a result clinicians and clients don't mind using them and so their utilization rates are higher than other measures (Miller, et al. 2003; Duncan et al., 2003). If session by session measures do not meet the time demands of real clinical practice, clinicians and clients alike may use them with reluctance at best, and resistance at worse. Much of the fear and loathing involved in doing session by session measures is not there with the Outcome and Session Ratings Scales as they usually take on average a minute for administration and scoring.

- Over 3000 young people participated in the four year validation study of the ORS with adolescents aged 13 -17, and the Child Outcome Rating Scale (CORS) for children aged 6-12 (Duncan, et al., 2006). The ORS with the adolescents and CORS significantly correlated with the Youth Outcome Questionnaire (YOQ 30), and both showed robust reliability, validity and feasibility.

- Four studies, including three RCTs, support the efficacy of using the ORS and SRS as a client feedback intervention across various treatment approaches (Miller, et al., 2006; Anker et al., 2009, Reese et al. 2009a & 2009b).

The three RCT's and several quasi-experimental studies to date provide ample evidence that routine use of the scales improves retention and outcome (in terms of functioning) while decreasing deterioration, length of stay and costs. Shortly, the

ORS & SRS: Feedback Informed Treatment (FIT) will receive designation as an evidence-based practice by the U.S. federal government.

ORS and CORS

The ORS is a simple, four-item session by session measure designed to assess areas of life functioning known to change as a result of therapeutic intervention (see appendix). To encourage a collaborative discussion of progress with clients, Miller and Duncan (2000) developed the ORS as an ultra brief alternative to longer measures whose length of administration, scoring, and interpretation made them less practical. The ORS assess four dimensions of client functioning that are widely considered to be valid indicators of successful outcome (Lambert et al., 1996):

1. *personal or symptom distress* (measuring individual well being).
2. *interpersonal well-being* (measuring how well the client is getting along in intimate relationships)
3. *social role* (measuring satisfaction with work/school and relationships outside of the home).
4. *overall well being*.

The ORS translates these four dimensions of functioning into four visual analogue scales which are l0cm lines, with instructions to place a mark on each line with low estimate to the left and high to the right (see appendix). The ORS rates at a 13 year old reading level, making it feasible for adolescents and adults. Clients are asked to fill in the ORS at the beginning of each session.

The Child ORS (CORS) was developed for children age 6-12 (see appendix). It has the same format as the ORS but with more child friendly language and smiley and frowny faces to facilitate the child's understanding when completing the scales (Duncan et al., 2003). Some young teens might prefer the CORS format over the ORS. You can use your clinical judgment here to consider which version will engage

the young person the best. So, some teenagers might fill in the CORS and some older children may fill in the ORS.

For children 5 or under there is also Young Child Outcome Rating Scale (YCORS) which has no psychometric properties but can be a useful way of engaging small children regarding their assessment of how they are doing (see appendix).

Other Ways the ORS is Different

- One source of potential confusion is that the ORS/CORS, unlike other measures, is not designed to predict what diagnosis a young person is likely to have, nor is it measuring symptom reduction. The research makes it clear that people do not seek, or stay in services when they experience symptoms, but rather when those symptoms begin to impact on their functioning (Hill & Lambert, 2004). The purpose of the ORS/CORS is to provide real time feedback on progress in client functioning.

- The ORS also has a Reliable Change Index (RCI) that provides a useful guide to help identify when change is clinically significant and attributable to therapy rather than chance. On the ORS the RCI = 5 points. So, change that exceeds the RCI and crosses the clinical cut off scores can be considered reliable change.

- Most important, unlike other existing measures, the ORS provides session by session predictive trajectories to let clinicians know at a given session if their client is at risk of drop out or negative outcome. To help make this clinical judgment, the client's current ORS scores can be compared to similarly scoring individuals in treatment.

Deciding Who Fills out the ORS/CORS

If two clinicians from a multi disciplinary team are separately seeing the young person and carers within the same week, you will need to decide between you who will be administering the ORS/CORS.

"Where is the Distress?"

The ORS/CORS is designed to assess distress and help measure progress. So in deciding who in the family is to fill out the ORS/CORS, ask yourself: Where is the

distress? In most first interviews you won't know where the distress is, so you can ask all family members to complete the measures on themselves to see who is distressed.

Child and Young Person
The young person who is referred or is seeking help, is always asked to fill out the ORS (ages 13 to 18) or CORS (ages 6-12) on themselves.

Carer
The carer is always asked to complete the ORS/CORS on the young person. For instance, if the young person is 13 or over and fills out the ORS, the carer fills out the ORS on how they perceive the young person doing. Similarly, if the young person is 12 and under and fills out the CORS, than the carer fills out the CORS on the young person.

N.B. Even if the carer is invited to fill out the ORS on themselves, they still fill out the ORS or CORS on the young person.

Carer and/or Other Family Members who are Distressed
If it turns out that the carer and/or other family members are distressed, and the distress is related to problems in the family (including the child), then you can continue to have the carer and family members filling out the ORS/CORS on themselves. Your plan and approach should consider how those individual family members' needs will be met.

If the distress of a carer seems separate and/or beyond what your service can provide, discuss and plan with the carer what individual services they would find beneficial.

Teachers and Other Professionals
Teachers or other professionals closely involved, and who can attend periodic meetings, can also be asked to fill out the ORS/CORS on the young person.

Mandated or Involuntary Clients

Mandated or involuntary clients, who frequently present as not distressed or report they have no problem, can be asked to fill out the ORS/CORS from the point of view of the person who is distressed and who has concerns for them. Similarly, you can ask them to fill the ORS/CORS from the perspective of the referrer who has concerns about how they are doing. At the same time, ask the client to fill out the ORS/CORS on themselves, with the rational that you want to make sure that whatever you do together doesn't impact their stated functioning negatively.

Introducing the ORS/CORS at the First Session

Avoid clinical jargon and explain the purpose of the ORS or CORS and its rational in a common sense way. For instance, you can introduce the ORS/CORS by saying that it is designed to assess distress and help measure progress. The specific wording is not important. When administering the ORS and CORS it is useful to read the instructions out to the clients and ask if they have any questions before they start. The following are a couple examples:

To young person and carer: *Before we get started I would be grateful if could help me out by taking a minute to fill out a very brief questionnaire to help me understand how things are going for (young person's name). Every time we meet I will ask you to fill the form again to help us track progress. Are you ok with that? Ok, so let me go over the instructions with you.*

However, at most first interviews you won't know where the distress is, so you can ask **all** family members present to complete the ORS on themselves. This allows you to "see" who is distressed.

To carer and other family members present: *I would also be grateful if all of you can fill the form out on yourselves to help me understand how things are going for you too. Even if things are going ok with you, I would be grateful if you could do this today and on a periodic basis, to ensure that whatever we do together doesn't impact you negatively.*

When the carer is asked to fill out the ORS on themselves, they are still asked to complete the ORS about the young person. This may sound cumbersome, but remember the measure is ultra brief and takes a minute to do.

Discussing the ORS/CORS Results

You can ask family members to feel free to talk amongst themselves for a couple minutes while you score the ORS. Scoring is done in front of the client using a centimeter ruler. Each of the four visual analogue scales is 10cm, so the score for each of the four visual analogue scales is the measurement length on the ruler (e.g. 3.3cm = score of 3.3) with 10 being the highest score for each scale. You simply write the score in the right margin, and then add the four scores for the overall score. The total possible score is 40. If working with families, you can teach family members how to do the scoring to help save time and as a way of engaging them in the process.

Next plot each person's overall score on a graph (see appendix) or entered into an electronic data base to monitor the trajectory of progress.

The ORS/CORS cutoff scores between the clinical population and the non-clinical population are different depending on the age of the client:

- 13-17 year olds (self reporting & carer reporting on teen) = 28
- 18 and over = 25

    The CORS (ages 12 and under) cutoff scores are:

- Child Self Reporting = 32
- Carer Reporting on Child = 28

It is important to explain these cutoff scores to the young people and carers.

To young person and carer: *Great, thanks. Let me show you what I have done. The four lines on the form are each 10cm. I have used the ruler to come up with a score for each line. I then have added the numbers for a total score and plotted them on this graph.*

(Young person's name) I have put your score here, and (mum's name) I have placed your score here. Scores above this line represent young people who seem to be plodding along all right in life and don't seek help. Scores below this line, like yours, are typically young people who are having problems and wanting help to make some changes. Is that true for you?

Ok, so when we fill out this form each time we meet I will be putting your scores on the graph and connect the dots, and hopefully we will soon see a line going up which will tell us we are on the right track. If it does not go up, or goes down, we will know about it right away and we can talk about it, and together work out what might need to be different and what might be more helpful.

Collaborative Formulations and the ORS/CORS Scores

It is important to help the young person and carer connect the problems that brought them to you with their ORS and CORS scores. You can incorporate this within your usual style of doing assessments and/or how you construct collaborative formulations with young people and carers.

To young person and carer (laying out the ORS or CORS in front of them). *I would be grateful if you both tell me a bit about why you put the marks where you placed them so I can better understand the problems that brought you here.*

This will often end up with a narrative about the problem which is fine. Such discussions can be apart of your normal interviewing style and how you come up with shared formulations with clients. For example:

To the young person: *It sounds like you are spending a lot of your day worrying and avoiding places out of fear, does that explain your mark here on the Me (How am I doing?) scale?*

To the parent: *It sounds like there is a lot of arguing and anger amongst family members including (young person's name), does that explain your mark here on the Family (How are things in my family?) scale?*

To teacher: *It sounds like running out of class and not knowing where he is going is your biggest concern for Kevin. Does that explain your mark here on the School (How am I doing at school?) scale? Is there anything else that helps explain your mark?*

Explore Differences in Perceptions

It is common for the young person and carer to have very different scores on the different scales which can be useful perceptual differences to explore:

"Sebastian, I noticed you rated how things are going in the family closer to the frowny face, and Emma (mother) you rated your son closer towards the smiley face. What do you both make of that?"

"Lucy, I noticed that you rate you rated yourself high on Individual (Personal well being), and Sarah (mother) you rated her quite low. Lucy, what do you suppose you know about yourself and what has changed that your mother doesn't know?"

Working out Shared Goals and Exploring Strong Preferences

You can use the scales to help establish what kind of changes and goals the young person and carers want from your help. If they have any strong preferences and ideas about treatments try to accommodate their preferences.

To young person or carer: *a) What will you and others notice that will be different when your marks on this line move from where you placed it to over here at this end near the smiley face? b) What ideas do you have about what needs to happen to move your mark from here to there (pointing at the smiley face)?*

Carer's Distress and Needs

In situations where it seems the carer's distress goes beyond the problems related to the young person, and you are concerned it is negatively impacting the young person's ORS/CORS scores, consider meeting with the carer separately to help them explore how to have their needs met e.g., using their own network of family and friends, parenting groups, couple therapy, individual therapy and doctor etc.

Session Rating Scale (SRS) and Child Session Rating Scale (CSRS)

Researchers have repeatedly found that the therapeutic alliance –i.e. agreement on goals, agreement on tasks in therapy & emotional bond (Bordin, 1979)—is one of the best predictors of outcome across different types of therapy including psychopharmocology (Symonds, 1991; Martin et al., 200; Wampold, 2001; Norcross, 2010). Evidence regarding alliances contribution to outcome is reflected in more than 1,000 studies (Orlinsky, Ronnestad, & Willutzki, 2004). A strong therapeutic alliance may be even more critical for youth psychotherapy than adult therapy, given that the child and young people are typically not self-referred, and the carers or extended family usually play a vita role in treatment (Shirk & Karver, 2003).

The quality of the therapeutic alliance with the carer impacts treatment outcome for the young person. (Kelley, Bickman, and Norwood, 2010). For instance, a strong therapeutic alliance with the carer will be critical when treatment requires a focus on the carer making some direct changes to positively impact the young person. In individual therapy that is focused on the young person, a strong therapeutic alliance with the carer will be important because it is the carers who schedule and keep the appointments, provide information needed about the young person, and encourage the young person's treatment adherence in between therapy sessions (Fields, Handelsman, Karver & Bickman, 2004). Further, a strong therapeutic alliance with a carer is likely to convey hope and other positive attitudes about treatment that may encourage the young person's participation in treatment, which then in turn will positively influence youth outcomes (Kelley, et al., 2010).

In family work, establishing multiple alliances simultaneously with each individual can be a formidable task (Friedlander, Escudaro, & Heatherington, 2006). Even agreeing with one family member on the need for therapy can alienate another family member who may have come to the session unwillingly. Gaining shared agreements on the *goals* and *tasks* of therapy is an enormous challenge when family members have differing developmental needs, hidden agendas, highly variable

motivations for treatment, are in conflict with one another, or have contrasting views of the problem and differing views about who and what needs to change. For instance, validating the goal of one party can alienate another. The challenge is to try to align simultaneously with all members in the pursuit of a common goal (Friedlander, Lambert, Muniz de la Pena, 2008).

Research has shown that clinicians are poor at gauging their client's experience of the alliance (Norcross, 2010) and they need to request real time alliance feedback. The benefits of requesting real time feedback on the therapy alliance include: empowering clients, promoting collaboration, making necessary adjustments to therapy, and enhancing outcomes (Lambert, 2005).

The Session Rating Scale (SRS) was developed for exactly these reasons. The SRS is a simple, 4-item pencil and paper alliance measure designed to assess key dimensions of effective therapeutic relationships (see appendix). The SRS is administered, scored and discussed at the end of each session to get real time alliance feedback from young people and carers so that alliance problems can be identified and addressed (Miller et al., 2002).

The SRS translates what is known about the alliance into four visual analogue scales (see appendix) to assess the clients' perceptions of:
- Respect and understanding
- Relevance of the goals and topics
- Client-practitioner fit
- And overall alliance.

The SRS is used with young people age 13 to adults (see appendix). The Child Session Rating Scale (CSRS) is for young people aged 6-12 (Duncan, et al. 2003).There is also a Group Session Rating Scale (GSRS) for ages 13 to adults, and Child Group Session Rating Scale (CGSR) for ages 6-12.

The cutoff score on the SRS, CSRS and GSRS is 36 out of a possible 40.

For children 5 or under there is also the Young Child Session Rating Scale (YCSRS) which has no psychometric properties but can be a useful way of engaging small children regarding their assessment of the alliance.

Introducing the SRS/CSRS at the First Session

Everyone who attended the session is invited to fill out a SRS or CSRS. In introducing the SRS/CSRS you want to convey that you are really interested in everyone's feedback about how the session went for each of them. You can explain that scores on the forms provide an opportunity for you to learn what to keep doing that is useful, and importantly what you might need to do different next time to make it better for them.

To young person and carer: *Ok, we need to end, but before we do I would be grateful if you would take a minute to fill out this form which asks your opinion about our work together today? Now, I rely on this feedback to keep me on track, and let me know when I am off track and need to make some changes for you. So, please give me your honest opinion when filling this out. Ok?*

NB: Recall that when giving the CORS to young people you also give CORS to the carer. Here when you give the CSRS to young people, you give the ORS to those 13 and over. If you are working with a family, have everyone fill out the SRS or CSRS as your alliance with each of them is important.

Discussing the SRS/CSRS Results

Score the SRS/CSRS in front of the client. If you are working with more than one person in a session, to save time you can teach the family to score their SRS/CSRS so there is more time for discussion about the scores and address any difficulties in the alliance.

Positive feedback is valuable as it helps you know what to do more of that matches the sensibilities of a specific client and family. Although we all prefer positive feedback as it feels nice, you have to convey to clients that negative feedback is like

gold to you, as it gives you a chance to make adjustments to make a better fit for them.

When scores are at the cutoff score of 36 and above:

These marks are way over to the right which suggests you are feeling understood and that we are working on the right things that are important for you, and how we are doing seems to fit for you? Is that right? Can you think of anything at all that I might be able to do different to make these meetings even better for you?

Scores that go down even a single point are significant and should be checked out with the clients. It is important to discuss any downturn on the SRS even when scores are above the cutoff. Any scores less than 9 on the four scales is an invitation for you to check out if you might have done or said something that did not sit well with them and/or how you can improve the sessions for that young person or family member.

When scores are below 36 (or one scale is significantly below 9)*:*

When you are getting scores below 36 it helps to adopt a posture of gratitude versus disappointment. Treat low SRS scores as a gift from your clients as they allow you the opportunity to repair ruptures to the alliance, and make the necessary adjustments in therapy to help improve your client's outcomes.

Ok, it seems that I could be doing better. I am grateful for you being honest and giving me a chance to try to make some changes. What could I do different next time to make things better for you?

Subsequent Sessions

Each session the ORS or CORS is given out at the beginning of the session to compare current ORS and CORS scores with previous ratings. If individual therapy is being offered to the young person, it is still important to try to capture the carer's scores by having a few minutes before each session. It can be very useful to have periodic review sessions where the carers (e.g., parent or teacher) and possibly other family members can fill out the ORS or CORS.

In each session the SRS or CSRS is given at the end of the session. It is important to leave yourself enough time for the clients to fill it out and pick up on any alliance difficulties. In many cases there might not be a next time as if there is a poor alliance the clients are likely to not attend, or come back with no change as what you are doing together is not a good fit.

To the young person and/or carer: *These scores suggest that for the past few weeks I have not been getting things quite right for you? Can you help me understand what I need to do different to make these sessions fit better for you?*

Role of Supervision and Team/Peer Reviews
Supervision is a key mechanism for supporting supervisee's integration of feedback into their clinical practice. Supervisees should bring the clients' ORS/CORS and the SRS/CSRS and graphs to supervision. The measures and the graphs bring the feedback and voice of the young person and carer directly into the supervisory session which is an invaluable addition to the clinician's perceptions of progress and the alliance. The measures can be used in a similar way in multi-disciplinary team/peer reviews and Care Plan Approach (CPA) reviews.

Further, supervisors can also utilize the measures and graphs across multiple cases to incorporate the voice and feedback of young people and carers to help the supervisee reflect on patterns of strengths and shortcomings to assist in the targeting areas for professional growth and development.

ORS/CORS Scores Increase

When scores increase we can help clients see their hand in the changes.

To the young person: *That is encouraging: your total score increased 4 points! What did you do different to make that happen? What have you learned about yourself?*

To carer: *Your rating of (young person's name) has gone up. What have you and/or others been doing different to make things better (young person's name)? What have you noticed (young person's name) doing different that is helping?*

Young people with complex problems might only make slight improvements and need longer interventions, but a discussion of alternatives remains an important intervention at recurrent stages.

ORS/CORS scores that exceed the RCI (5 points) and cross the clinical cut off scores can be considered reliable change. This is a good time to review the progress towards the therapeutic goals with the young person and carer, and consider starting some consolidation and response prevention and end therapy.

ORS/CORS Scores Don't Improve or Go Down

In general, discuss any lack of progress or downturn on the ORS/CORS with the clients.

Look Closely at the SRS/CSRS Scores

The following are possible things to consider with clients, supervisors and multidisciplinary/peer and CPA reviews:

- Is there a problem in the alliance with the young person or carer that is getting in the way of progress?
- Review the treatment goals to see if they still fit. Are you working on the clients' goals versus the referrers? Do the goals need to be revised from the absence of symptoms (e.g., less depressed) to improvement in functioning (e.g. going out with friends and doing usual pleasurable activities).

- If you are working with more than one member of the family and there is blaming and conflict, consider using empathic messages to both sides of a conflict along with pointing out everyone's good intentions. You may also want to transform individual goals that involve others changing, to common shared goals involving improved family relationships (e.g., "to get the family back on track" or "to restore intimacy, closeness or trust") emphasizing mutual collaboration.
- Check out that the approach is fitting and whether you need to adjust, or change to another approach.
- If there is a rupture in the alliance that you don't seem able to overcome, consider referring to a colleague.

ORS/CORS Scores Show No Progress after 3rd Session

When you have had no progress on the ORS/CORS after the 3rd session, discuss with the client and carers, and with supervisor.

To young person and carer: *The scores have not gone up, what are you hunches about why that is? These scores indicate we might need to try to do something quite different as you don't seem to be benefitting. What are your thoughts about that? What do you think we need to do differently to increase the chances of this line moving in an upward trend?*

At this point you might consider:

- Do you need to expand the work to include different members of the family, and/or school?
- Do you need to meet with the carer (e.g. parent and/or school) to ensure they understand how they can best help the young person, and/or better understand what support and help they need?

ORS/CORS Scores Show No Progress after 5th or 6th Session

If there is no improvement by the 5th or 6th visit consider adding additional services with young person, carer, and supervisor. This may involve a referral to another agency.

ORS/CORS Scores Show No Progress after 8th-10th Session

If no progress by the 8th-10th visit discuss with the client and carer about whether they need to see someone else such as another clinician with a different approach, and/or a higher level of care.

To the young person and/or carer: *I am wondering if I might not be the best person to help with this problem. Would it be useful for me to go over different types of therapies and clinicians we have and maybe what one of them has to offer might be a better fit with you than what I can offer?*

ORS & SRS Together Facilitate Better Outcomes in CAMHS

Using the ORS and SRS provides an outcome management process to monitor and adjust treatment as a result of client feedback. The ORS/CORS and SRS/CSRS measures are clinical tools that both facilitate better outcomes IF used together to enhance engagement and participation in the care provided as the measures are discussed with young people and carers. The following is how CAMHS clinicians from different disciplines have found using the ORS/CORS and SRS/SRS to help their clinical practice:

*"The ORS/SRS measures fit incredibly well into the Cognitive Behaviour Therapy (CBT) model of working, allowing monitoring of progress in functioning in a measurable way, which is explicit to clients, and also enabling monitoring of the therapeutic alliance as part of the process of obtaining feedback from clients. The young people I work with have engaged well in adopting these measures as part of the work, and have benefited from the opportunity for self-reflection and celebration of progress which these measures facilitate. For me, as a Clinical Psychologist, the measures have furthered my self-reflection, enabling me to better tailor my work to the needs' of my clients on the basis of their feedback, thus promoting the client centred, idiosyncratic approach." -- **Maria Loades, Clinical Psychologist, CAMHS, Suffolk**

"I have been using the ORS and SRS in both my Cognitive Behaviour Therapy work and in my role as a Primary Mental Health Worker. In both roles it gives me a true sense of how the client is finding our work, rather than my best (and usually inaccurate) guess. In the PMHW role, where work is often brief, the ORS has the added benefit of helping to quickly identify which areas the client is finding most difficult so that intervention can be targeted to this. I have found both measures easy to use and that they can quickly be adopted into my routine with clients. Parents and children find the visual representation of progress on the ORS very useful, and combining this with monitoring the therapeutic relationship through the SRS can give great clarity on what to do when therapy runs into problems. It is also a great aid for supervision discussions, helping aid reflection on factors affecting progress." –
Rebecca Light, Primary Mental Health Worker & Cognitive Behavioural Therapist, CAMHS, Suffolk

"I have found the ORS and SRS really useful in my Specialist Nurse practice. The measures have been a significant aid in supporting me with keeping client focused and this has had the knock on effect of enhancing client motivation and engagement. The measures have also been useful in facilitating conversations about what's not been quite right in sessions and challenged unhelpful assumptions that I have made within sessions, in a non confrontational manner. The measures are also great for clinician's self esteem as they provide 'evidence' of when you have done a cracking job, or are simply needing reassurance that you are doing 'ok' with a case." –
Rachael Ewan, Specialist Nurse, CAMHS, Suffolk.

"The ORS and SRS fit very well with family work. The ultra brief design and formats for different age groups including small children, allows all members of the family an important feedback voice into the therapeutic system, and enhances everyone's engagement and participation in family work. As the measures are ultra brief they do not take much time out of the session. Families are generally curious about each others ORS scores. Where differences of opinion exist, a graph on which each family members outcome score is plotted in different colours provides a useful structure for a manageable inclusive discussion about the problem and its resolution from

different perspectives. The feedback from the SRS helps clinicians make the necessary adjustments to align simultaneously with all family members in the pursuit of common agreement on goals and tasks in therapy." -- **David C. Low, Family and Systemic Psychotherapist, CAMHS, Suffolk**

"I've been using the ORS/CORS and SRS/CSRS in my day to day clinical practice for many years now. It's hard for me to imagine practice without using them these days. There is no magic about them of course, but they have really helped me think a lot more carefully about what I do and how I do it. Whether in short term work or longer term treatment, from the very first meeting the young people and their families are being included in an active way giving me feedback about what is important to them and teaching me about what I need to reconsider. It is a bit daunting at first, particularly getting the feedback through the SRS/CSRS. Not many of us like to be confronted with feedback about what our patients see needs to change with what we are doing, but this is the aspect of using feedback that has most influenced and challenged my practice. Whether using individual or family meetings, prescribing medication, liaising with other agencies, or deciding on frequency of meetings, the feedback you get about what works and what is helpful is invaluable. In fact so inspired I have incorporated the rating scales and the philosophy around them into a whole service model for Lincolnshire CAMHS known as the Outcome Orientated CAMHS (OO-CAMHS) Project." -- **Sami Timimi, Consultant Child and Adolescent Psychiatrist, CAMHS, Lincolnshire,** sami.timimi@lpft.nhs.uk. www.oocamhs.com

"The introduction of the ORS (CORS) and SRS (CSRS) in the Cambridgeshire Early Intervention Service in CAMH enthused clinicians as it enriched their practice by obtaining so much more relevant information of their clients. Children and young people made it their own story of what was upsetting for them, which could not be captivated in by a symptom measure. They were able to express what they like or not like about the session and the therapists were very positive about any negative feedback as they change their approach. Clinicians want to continue using the measures because of their clinical significance." **Brigitte Squire, Clinical Psychologists and MST Programme Manager, Cambridgeshire.**

Additional Guidelines and Examples

- Additional guidelines and examples can be found in the ORS/SRS manual (Miller & Duncan, 2004).

- There are also 6 newly developed manuals covering every aspect regarding the use of the ORS and SRS measures in clinical practice. These were developed as part of the International Center for Clinical Excellence's (ICCE) application to the National Registry of Evidence Based Programs and Practices (NREPP) in the United States. Each service will find the manuals a valuable resource.

- These manuals and other resources are available at www.scottdmiller.com.

How to Get the Measures Free

The ORS/CORS and SRS/CSRS measures are licensed for members of CORC and CYP IAPT by Scott D. Miller and ICCE (www.centerforclinicalexcellence.com). CORC and IAPT may distribute the measures to their practitioners. Users may also obtain the measures in English and languages other than English at www.scottdmiller.com.

Note: When down loading the measures for the first time, you may need to adjust the analogue scales to make sure they are exactly 10cm. Beyond that adaptation the license agreement involves no alterations to the ORS/CORS and SRS/CSRS.

For Comments or Information on Training in using the ORS/CORS and SRS/CSRS

For comments or information about training on skills for improving client engagement in treatment services, and how to integrate real time outcome and alliance feedback using the ORS & SRS to improve clinical effectiveness with young people and families contact:

- David C. Low, Family and Systemic Psychotherapist, Norfolk and Suffolk, NHS Foundation Trust, CAMHS, -- david.low@nsft.nhs.uk

- Brigitte Squire, Consultant Clinical Psychologist, Cambridgeshire & Peterborough NHS Foundation Trust, CAMHS-- brigitte.squire@cambridgeshire.gov.uk

- Scott D. Miller, Ph.D., Director of the International Center for Clinical Excellence -- info@scottdmiller.com

- **Appendix 1: ORS & SRS Samples**

Outcome Rating Scale (ORS)

(Ages 13 to Adult)

Name _____Age (Yrs):____ Session # ____ Date: _____
Who is filling out this form? Please check one: Self_____   Other_____
If other, what is your relationship to this person? _____

Looking back over the last week, including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels. *If you are filling out this form for another person*, *please fill out according to how you think he or she is doing.*

Individually
(Personal well-being)

|--|

Interpersonally
(Family, close relationships)

|--|

Socially
(Work, school, friendships)

|--|

Overall
(General sense of well-being)

|--|

© 2000, Scott D. Miller and Barry L. Duncan

SCORING

Each line is 10cm.

Score with ruler e.g. 3.5cm = score of 3.5.

Write the scores for each of the four lines here in the margin.

Add the four scores for a total score.

Plot overall score on the

Session Rating Scale (SRS V.3.0)

(Ages 13 to Adult)

Name _____Age (Yrs):____ Session # ____ Date: _____

Please rate today's session by placing a mark on the line nearest to the description that best fits your experience.

Relationship

I did not feel heard, understood, and respected. |--| I felt heard, understood, and respected.

Goals and Topics

We did *not* work on or talk about what I wanted to work on and talk about. |--| We worked on and talked about what I wanted to work on and talk about.

Approach or Method

The therapist's approach is not a good fit for me. |--| The therapist's approach is a good fit for me.

Overall

There was something missing in the session today. |--| Overall, today's session was right for me.

© 2002, Scott D. Miller, Barry L. Duncan, & Lynn Johnson

Child Outcome Rating Scale (CORS)

(Ages 6 to 12)

Name _____ Age (Yrs):____ Session # ____ Date: _____
Who is filling out this form? Please check one: Child_____ Caretaker_____
 If caretaker, what is your relationship to this child? _____

How are you doing? How are things going in your life? Please make a mark on the scale to let us know. The closer to the smiley face, the better things are. The closer to the frowny face, things are not so good. *If you are a caretaker filling out this form, please fill out according to how you think the child is doing.*
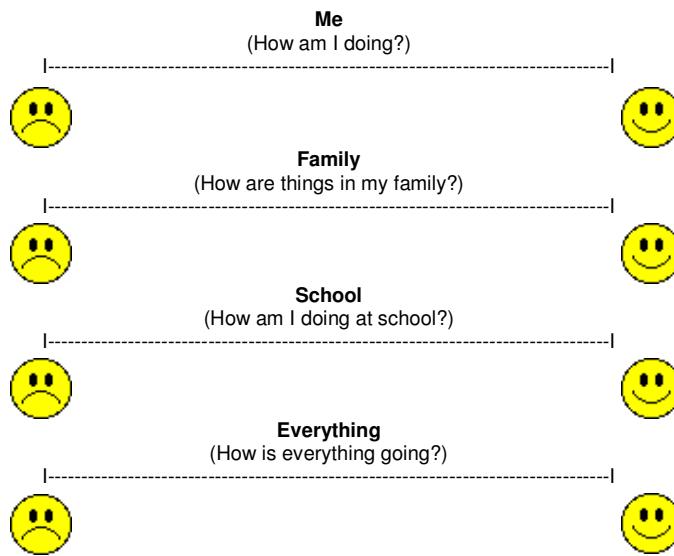
Me
(How am I doing?)

|--|

Family
(How are things in my family?)

|--|

School
(How am I doing at school?)

|--|

Everything
(How is everything going?)

|--|

SCORING

Each line is 10cm.

Score with ruler e.g. 3.5cm = score of 3.5.

Write the scores for each of the four lines here in the margin.

Add the four scores for a total score.

Plot overall score on the

© 2003, Barry L. Duncan, Scott D. Miller, & Jacqueline A. Sparks

Child Session Rating Scale (CSRS)

(Ages 6 to 12)

Name _____ Age (Yrs):____ Session # ____ Date: _____

How was our time together today? Please put a mark on the lines below to let us know how you feel.
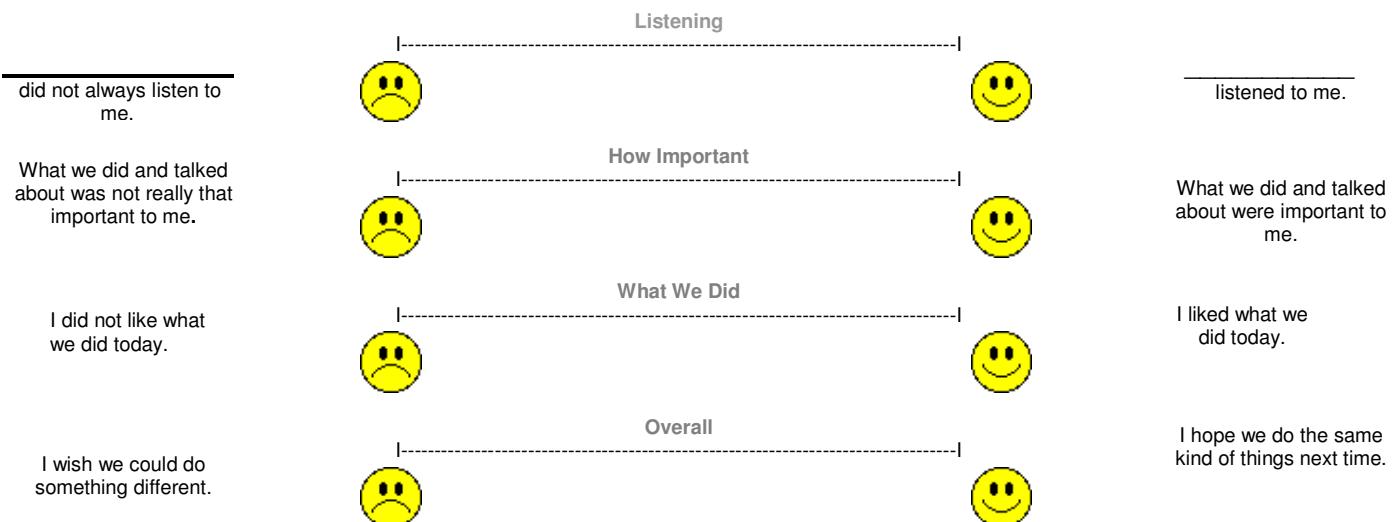
Listening

|--|

did not always listen to me.   listened to me.

How Important

|--|

What we did and talked about was not really that important to me**.**   What we did and talked about were important to me.

What We Did

|--|

I did not like what we did today.   I liked what we did today.

Overall

|--|

I wish we could do something different.   I hope we do the same kind of things next time.

© 2003, Barry L. Duncan, Scott D. Miller, Jacqueline A. Sparks

65

Young Child Outcome Rating Scale (YCORS)

Name _____Age (Yrs):____ Session # ____ Date: _____

Choose one of the faces that shows how things are going for you. Or, you can draw one below that is just right for you.
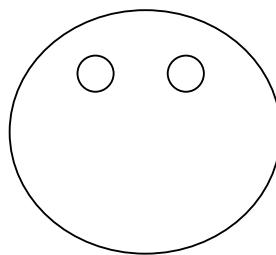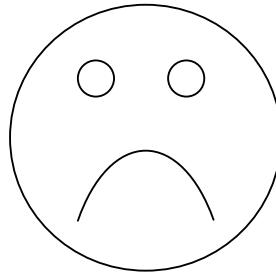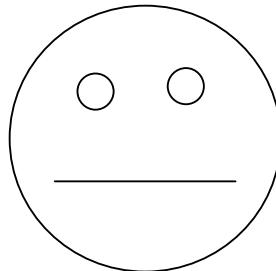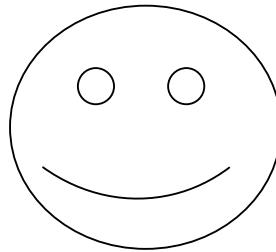
# Young Child Session Rating Scale (YCSRS)

Name _____Age (Yrs):____ Session # ____ Date: _____

Choose one of the faces that shows how it was for you to be here today. Or, you can draw one below that is just right for you.
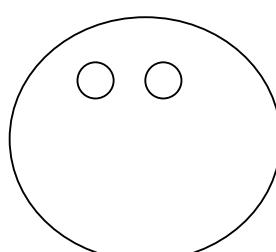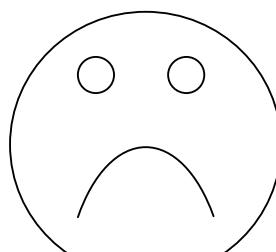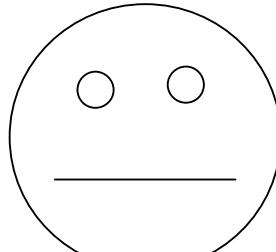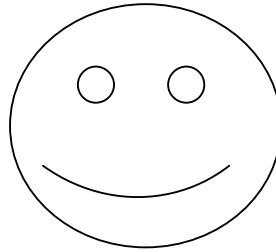
Group Session Rating Scale (GSRS)
(ages 13 to adult)

Name _____ Age (Yrs):____ Session # ____ Date: _____

Please rate today's group by placing a mark on the line nearest to the description that best fits your experience.

Relationship

I did not feel understood, respected, and/or accepted by the leader and/or the group. |--| I felt understood, respected, and accepted by the leader and the group.

Goals and Topics

We did *not* work on or talk about what I wanted to work on and talk about. |--| We worked on and talked about what I wanted to work on and talk about.

Approach or Method

The leader and/or the group's approach is a not a good fit for me. |--| The leader and group's approach is a good fit for me.

Overall

There was something missing in group today—I did not feel like a part of the group. |--| Overall, today's group was right for me—I felt like a part of the group.

© 2007, Barry L. Duncan and Scott D. Miller

Child Group Session Rating Scale (CGSRS)
(Ages 6-12)

Name _____ Age (Yrs):____ Session # ____ Date: _____

How was our group today? Please put a mark on the lines below to let us know how you feel.

Listening

The leader or group did not listen to me or like |--| The leader and group listened to me and liked me.

How Important

We did not talk about or do important things**.** |--| We talked about and did important things.

What We Did

I did not like what we did today. |--| I liked what we did today.

Overall

Today was not good for me—I did not feel like a part of this group. |--| Today was good for me—I felt like a part of this group.

© 2011, Barry L. Duncan, Scott D. Miller, Jacqueline A. Sparks, & John J, Murphy

ORS/SRS Graphs

Young Person Scale (Age 13-17)

SRS Cutoff (36)

Discuss

ORS Cutoff
(28)

Session Number	1	2	3	4	5	6	7	8	9	10
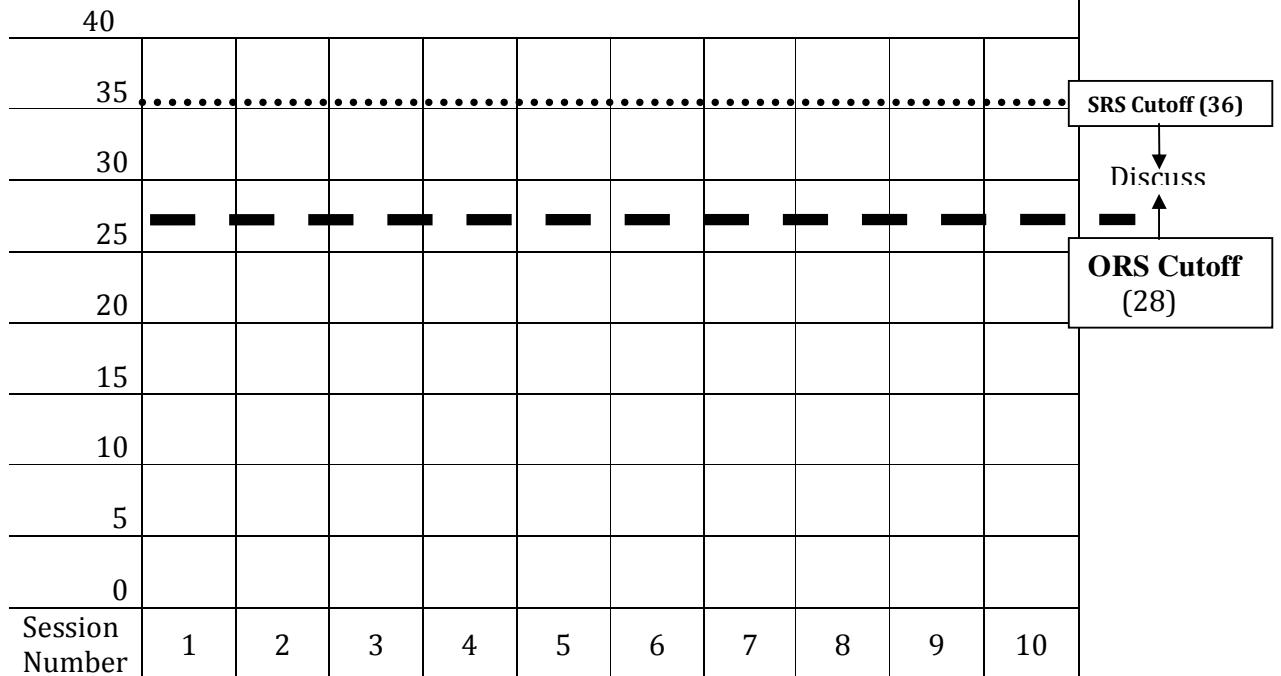
Parents Young Person Scale (Age 13-17)

SRS Cutoff (36)

Discuss

ORS Cutoff
(28)

Session Number	1	2	3	4	5	6	7	8	9	10
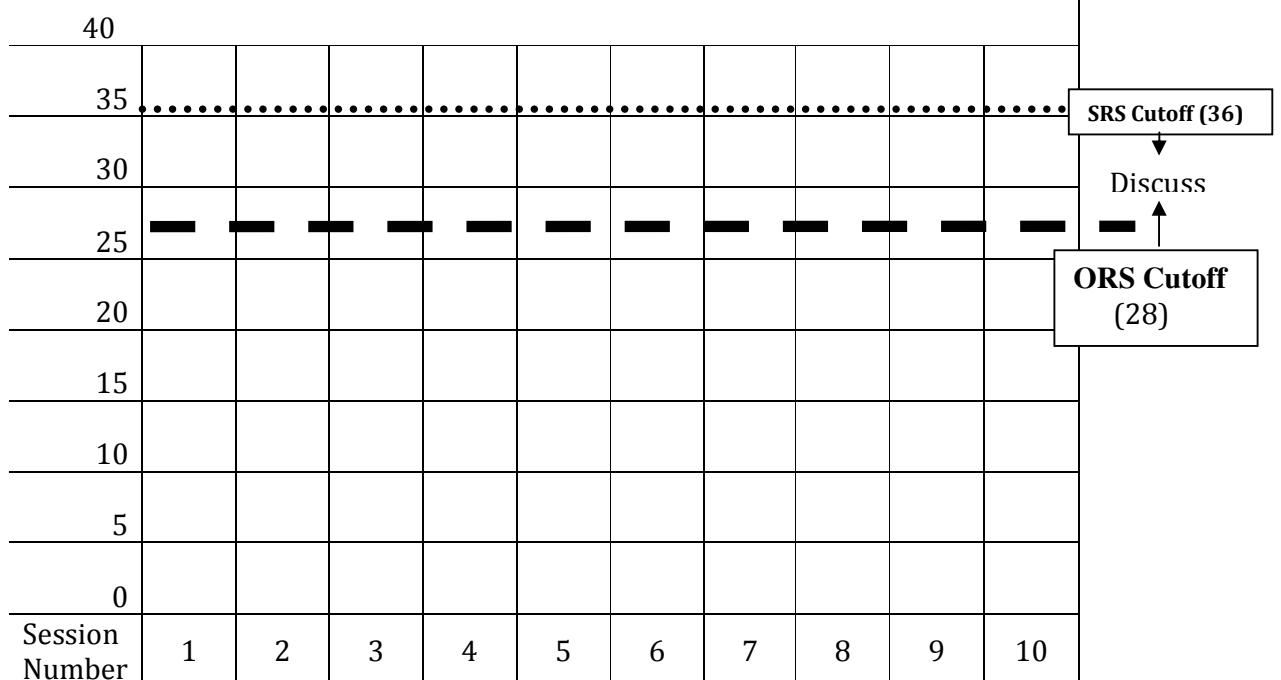
CORS/CSRS Graphs

Child Scale (Age 6-12)

Session Number	1	2	3	4	5	6	7	8	9	10

SRS Cutoff (36)

Discuss

ORS Cutoff (32)
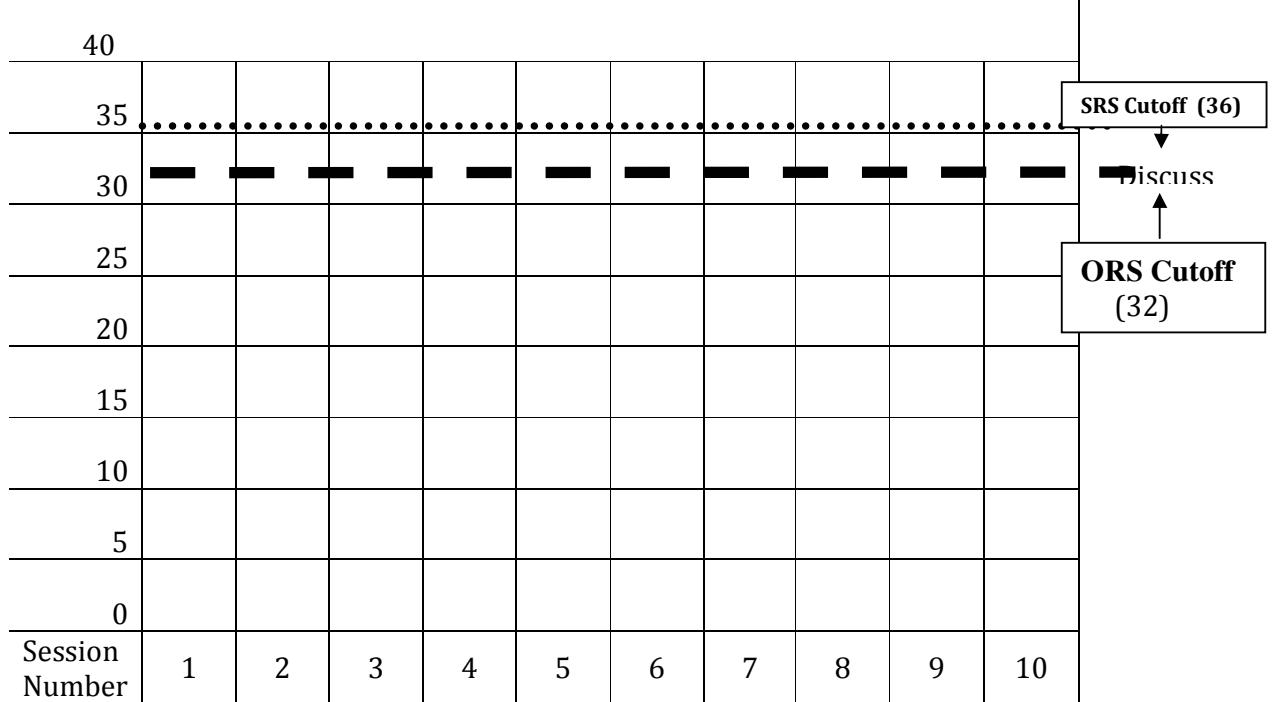
Parent Child Scale (Age 6-12)

Session Number	1	2	3	4	5	6	7	8	9	10

SRS Cutoff (36)

Discuss

ORS Cutoff (28)
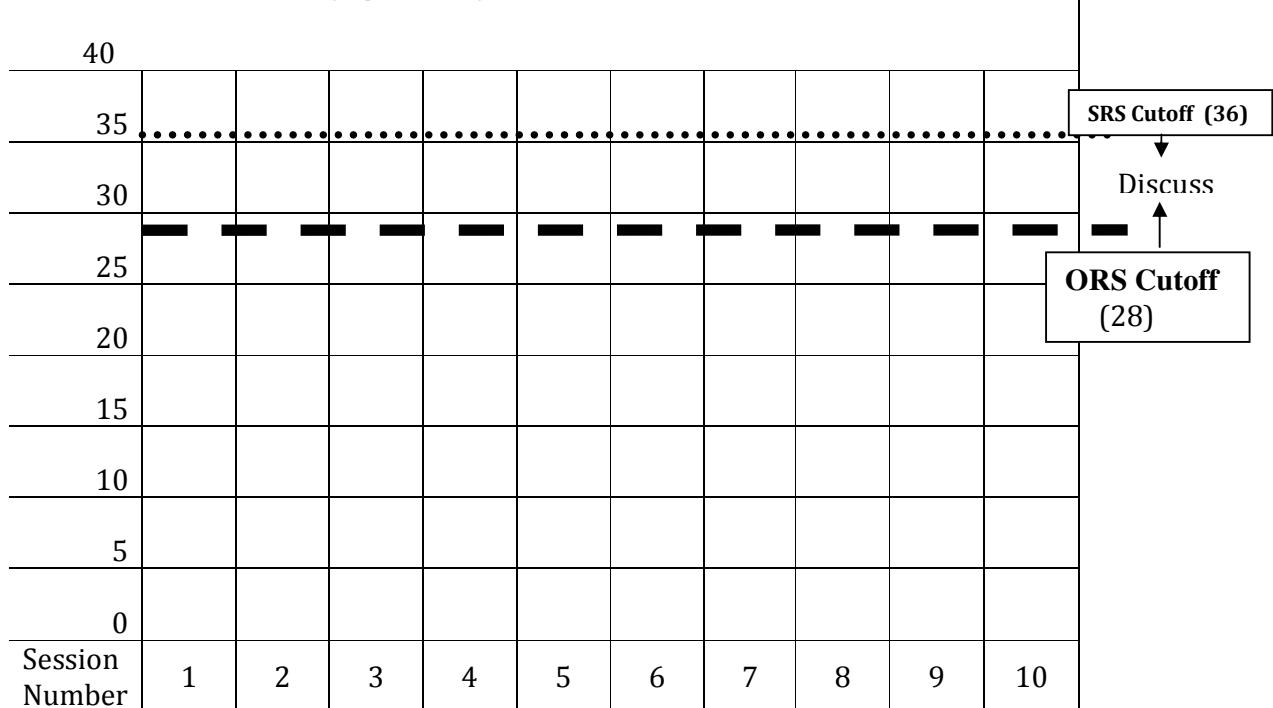
References

Anker, M.G., Duncan, B.L., & Sparks, J.A. (2009). Using client feedback to improve couple therapy outcomes: A randomized clinical trial in a naturalistic setting. *Journal of Consulting and Clinical Psychology, **77***, 692-704.

Bordin, E.S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy, **16***: 252-260.

Bringhurst, D. L., Watson, C. W., Miller, S. D., & Duncan, B. L. (2006). The reliability and validity of the Outcome Rating Scale: a replication study of a brief clinical measure. *Journal of Brief Therapy, **5***, 23-30.

Campbell, A., & Hemsley, S. (2009). Outcome Rating Scale and Session Rating Scale in psychological practice: Clinical utility of ultra-brief measures. *Clinical Psychologist,* 12, 1-9.

Duncan, B.L., Miller, S. D., Sparks, J., Claud, D., Reynolds, L., Brown, J., & Johnson, L. (2003). The Session Rating Scale: Preliminary psychometric properties of a "working" alliance measure. *Journal of Brief Therapy, **3***, 3-12.

Duncan, B. L., Sparks, J., Miller, S. D., Bohanske, R., & Claud, D. (2006). Giving youth a voice: A preliminary study of the reliability and validity of a brief outcome measure for children, adolescents, and caretakers. *Journal of Brief Therapy,* 5, 66-82.

Fields, S., Handelsman, J., Karver, M.S., & Bickman, L. (2004). *Parental and child factors that affect the therapeutic alliance.* Paper presented at the 17th Annual Meeting of the Florida Mental Health Institute's A System of Care for Children' Mental Health: Expanding the Research Base, Tampa, FL.

Friedlander, M.L., Escudero, V., & Heatherington, L, (2006). *Therapeutic*

alliances in couple and family therapy: an empirically informed guide to practice.
Washington D.C.: American Psychological Association.

Friedlander, M.L., Lambert, J.E., & de la Pena, C.M. (2008). A step toward
disentangling the alliance/improvement cycle in family therapy. *Journal of
Counseling Psychology,* **55**:118-124.

Hawley, K.M., & Weisz, J.R. (2005). Youth versus parent working alliance in usual
clinical care: Distinctive associations with retention, satisfaction and treatment
outcome. *Journal of Clinical Child and Adolescent Psychology*, **34**, 117-128.

Hill, C.E. & Lambert, M.J. (2004). Methodological issues in studying psychotherapy
processes and outcomes. In M.J. Lambert (Ed.), *Handbook of psychotherapy and
behavior change* (5th ed.). New York: Oxford University Press.

Horvath, A.O., &Symonds, B.D. (1991). Relation between working alliance and
outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology,* **38**,
139-149.

Kelley, S.D., Bickman, L., & Norwood, E. (2010). Evidence-based treatments and
common factors in youth psychotherapy. In B.L. Duncan, S.D. Miller, B.E.

Wampold, & M.A. Hubble (Eds.), *The heart and soul of change 2nd ed.: Delivering
what works in therapy (pp.325-355).*Washington, D.C.: American Psychological
Association.

Lambert, M.J. (Ed). (2005) Enhancing psychotherapy outcome through feedback.
Journal of Clinical Psychology, *61, 141-217.*

Martin, D.J., Garske, J.P., & Davis, M.K. (2000). Relation of the therapeutic alliance
with outcome and other variables: A meta-analytic review. *Journal of Consulting and
Clinical Psychology,* **68**, 438-450.

Miller, S.D., & Duncan, B.L. (2000). *The outcome rating scale.* Chicago: Author.

Miller, S.D., Duncan, B.L., Johnson, L. (2002). *The Session Rating Scale 3.0*. Chicago: Author.

Miller, S. D., Duncan, B.L., Brown, J., Sparks, J., & Claud, D. (2003). The Outcome Rating Scale: A preliminary study of the reliability, validity, and feasibility of a brief visual analog measure. *Journal of Brief Therapy*, **2**, 91-100.

Miller, S.D., & Duncan, B.L. (2004). *The Outcome and Session Rating Scales: Administration and scoring manuals.* Chicago: Author.

Miller, S. D., Duncan, B. L., Brown, J., Sorrel, R., & Chalk, B. (2006). Using outcome to inform and improve treatment outcomes. *Journal of Brief Therapy*, **5**, 5-22.

Norcross, J.C. (2010). The therapeutic relationship. In B.L. Duncan, S.D. Miller, B.E. Wampold, & M.A. Hubble (Eds.), *The heart and soul of change 2nd ed.: Delivering what works in therapy (pp.113-141).*Washington, D.C.: American Psychological Association.

Orlinsky, D.E, Ronnestad, M.H., & Willutzki, U. (2004). Fifty years of psychotherapy process-outcome research: Continuity and change, In M.J. Lambert (Ed.), *Handbook of psychotherapy and behavior change* (5th ed.). New York: Oxford University Press.

Reese, R.J., Norsworthy, L., & Rowlands, S. (2009a). Does a continuous feedback system improve psychotherapy outcomes? *Psychotherapy,* 46, 418-431.

Reese, R.J., Usher, E., Bowman, D., Norsworthy, L., Halstead, J., Rowlands, S., & Chisholm, R.R. (2009b). Using client feedback in psychotherapy training: An analysis of its influence on supervision and counselor self-efficacy. *Training and education in Professional Psychology,* **3(3)**, 157-168.

Shirk, S.R. & Karver, M.(2003). Prediction of treatment outcome from relationship variables in child and adolescent therapy: A meta-analytic review. *Journal of Consulting and Clinical Psychology,* **71**, 452-464.

Wampold, B.E. (2001). *The great psychotherapy debate: Models, methods, and findings.* Mahwah, NJ: Erlbaum.

Goal Based Outcomes (GBOs)

Adapted from Law D. (2011) Goals and goal based outcomes: some useful information http://www.corc.uk.net/

What are goal based outcomes (GBOs)?

Goal based outcomes (GBOs) are a way to evaluate progress towards a goal in clinical work with children and young people, and their families and carers (but the ideas can equally be adapted to work in adult mental health or learning disability settings). They simply compare how far a young person feels they have moved towards reaching a goal they set at the beginning of an intervention, compared to where they are at the end of an intervention (or after some specified period of input). GBOs use a simple scale from 0-10 to capture the change; the outcome is simply the amount of movement along the scale from the start to the end of the intervention. (see Examples section below).

It is a tool to track the progress of *what the service user wants* to achieve

Goals should be those that the young person (and/or their family/carers) themselves want to reach from coming to a particular service – not the goals a clinician or practitioner might wish to see them achieve (although there is often need for some negotiation – see the next section on goal setting & negotiating). As such it gives a different perspective to clinical outcome measures and can measure different sorts of change that might not always be captured using only behavioural or symptom based outcome measures. For example, let's say a goal of parents of a young child with autism and challenging behaviour is to "cope with tantrums", an intervention might help the parents feel more confident about dealing with the tantrums, e.g. by working on ways of helping them to keep calm at the time. Such an intervention may

not necessarily have much of an impact on the child's behaviour (in the short term at least), but despite this, it is clearly an important and successful intervention for the family, if they feel more confident in dealing with their child's tantrums.

They allow measurement across a *broad spectrum* of interventions

Goal based outcomes (GBOs) enable us to measure the effectiveness of an intervention across the whole spectrum of work we do, across a variety of settings, and with a variety of service users. The goals could be those of a young person in individual therapy, or a family in a systemic intervention. Similarly they can be used to track progress towards the goals through a staff team in a care home receiving consultation from a service, or a teacher implementing a new class based approach to managing behaviour. In this sense the 'service user' is the person involved in the intervention (not always the child) and the goals that are set are should be the goals of the person doing the work. Goals are, by their nature, varied and subjective – in GBOs what is important to measure is the amount of movement towards a goal – and not the goal itself.

Do GBOs dictate a way of working?

Once a goal has been set it is possible to use any suitable intervention to collaborate to reach it. GBOs should not dictate any particular way of working or therapeutic approach – they are merely another piece of information to help assess the success of an intervention. They work on the principle that there are many potential routes to the same destination. Having said that, there are many approaches that use goals as part of the work: CBT, Solutions Focused Therapy, CAT, Personal Construct Psychology and many more……equally the goals set as part of GBO measures can be used in the work if this is helpful.

Goal Setting & Negotiating

Helping to *set goals*

Some service users are very clear about the goals they want to achieve and others are more vague, and some have very little idea of what they want to achieve other than a notion that 'something must change'. For many people the first step is identifying some potential goals. There are many ways of facilitating this process and these depend on the particular context of the work. It is important to hear from the service user what has brought them to the service – to hear their story. At the point where you feel the family have told you enough initial information it can be helpful to start to introduce goals along the lines of:

> *"That has been really useful in helping me understand a little about what has brought you here today, next it might be helpful for us all to think together about what your hopes for the future might be?"*

What comes out of the following discussion can begin to be shaped into goals,

> *"So, from what you have told me so far, what would you say your main goals are from coming to this service? If we were to work together in a very helpful way, what things would you hope to be different in the future, when we agree to stop meeting, from how things are now?"*

Sometimes it is easier for families to start with what they know they don't want (as we did in the introduction to this document): "I don't want to be depressed", "I don't want to get into fights," "I don't want to feel so scared all the time". In some cases these statements can be good enough to start work (the "anywhere but here" goal), however, if a family or CYP can be helped to think more specifically about where they want to get to – rather than where they don't want to be - it helps bring a focus to the goal, making it clearer to therapist and client where they are both heading, and it can help the process become more collaborative.

76

One way of turning a problem into a goal can be simply to turn the problem on its head by asking,

> *"When you are no longer depressed, what would you want life to look like then?", or "When you are no longer getting into fights, what do you want to be doing instead?".*

With more entrenched problems some of the more solution focused techniques can help with goal setting. Good examples are the 'miracle question' used in solution focused therapy,

> *"Imagine when you go to bed tonight a miracle happens that makes all the difficulties you have go away. When you wake up in the morning, what will you notice is different ….?"*

or by asking what a person might change if they were given three wishes:

> *"If you had three wishes, what are the things you would wish to change that would make life better for you than it is now?"*

Once a goal has been agreed it is useful to find a sentence that summarises the goal:

> *"Ok, so we have agreed that one of your goals is to: 'get back into school full time'"*

This helps make reference to goals easier – the summary sentence can then be recorded on the GBO record sheet (see appendix 2.) At this point some choose to make the goals SMART – Specific, Measurable, Attainable, Realistic and Timely, to really tie down the focus, but this is not always necessary or indeed desirable in some aspects of clinical work.

Goals can be problem focused

Having said all that, some families and clinicians prefer to keep the goal identified as what the family does not want – to be more problem focused rather than solution focused. For some people to work away from a problem makes more intuitive

sense. This is fine, as the key to using goals is to help work with people in a way that is most helpful to them. When scoring these problem focused goals the scale needs to run from zero = the problem has not even started to shift, to ten = the problem has gone. Whether a goal is problem focused or solution focused depends on what works best for that particular young person or family working in collaboration with the clinician.

Goal setting should be *collaborative*

Although the goals set should reflect the wishes of the service users there clearly needs to be some collaboration between the clinician and the service user to ensure that the service is the right place to help with an intervention. It is also helpful to guide users to make more focused and achievable goals whilst still keeping to the spirit of what they want - if say an adolescent wanted to "be happier" it might be helpful to think about what the markers might be for them in being 'happier'. Similarly, carers of a looked after child wanting to "cope better", might need some input to unpick what 'coping better' might look like, and to break this broad statement down into some smaller focused goals. We would expect this process to be achieved within the first three meetings.

The *goal must be agreed on, and owned* by the person asking for help

The key rule is that the person setting the goal is the person doing the work – so, in the care home example an appropriate goal would be for the staff team to set goals on managing the behaviour of a child if the work is with a team on what they can do differently, but it is not appropriate for the team to set a behaviour change goal if the focus of the work is individual therapy with the child in question. The reason for this is that the person working towards the goal needs to agree and own it themselves – otherwise you are measuring someone else's outcome!

How many goals and ranking of goals

The CORC protocols allow for up to three goals to be scored and rated. Sometimes families come with long lists of things they want to be different. This is fine and suggests motivation to really make big changes to their lives, however, too many goals can be distracting; trying to do everything at once can result in very little focus to the work. For this reason, asking a service user for their top three goals brings a focus to the intervention. Taking it a step further and asking service users to rank their top three goals can help bring further focus. You may agree together that, for practical reasons, you don't always choose to start with tackling the top ranked goal.

For families with certain presenting difficulties, picking only one goal to work on might be the most helpful strategy – this is particularly useful in work around conduct and behaviour difficulties. For other families, acknowledging a long list of goals can be helpful and validating, but by agreeing up to three goals to focus on gives a clear focus as to what the shared agreement for the intervention is from the start.

Scoring goals

Once a goal has been set the next step is to get the initial (time 1) score for the goal. You may want to say something like:

> "*Ok, now we have agreed the goals you want to work on, it would be helpful to get an idea of where you are now with each of the goals. This will help us get an idea of where we are starting from, and what you have already managed to achieve, and it can help us keep track of how far you have moved on at a later date*" (you may want to specify at this point how often you would expect to review progress towards the goal - every session, at the end of the intervention etc.) *"Taking your first goal: 'To get back into school full time'. On a scale from nought to ten, where ten means that you have fully reached your goal, and nought means you haven't even begun to make progress towards it, and a score of five is exactly half way between the two,*

today what score would you give your progress towards 'getting back into school full time'?"

It can help to make the scale visual by showing the service user the GBO score sheet with the numbers on, or by drawing a line on a white board. Younger children might prefer a visual metaphor such as a ladder with the numbers 0 – 10 on the rungs, or (if you have the space) you can have squares set out on the floor and children can walk or jump to the relevant square.

Dangerous and 'Unacceptable' Goals

In most cases the clinician should take on the role of facilitator to help shape and guide a young person in settings goals *they* chose to work on. However, there are occasions where a client may choose a goal that is unacceptable – either because it is dangerous (e.g. an teenager with anorexia wanting to set a goal to lose 10kgs, or someone with depression wanting to be helped to end their life), or because a goal is so unrealistic that it may be unethical to try to work towards it (e.g. a child with a physical disability wanting to be a professional footballer), or where a goal simply does not fit with what a service is able to provide (e.g. a parent who wants an assessment for dyslexia in a service that is not able to provide such an assessment). In each of these cases, even though the goals may be judged unacceptable, they should not be simply dismissed but there needs to be more careful negotiation, to either steer a goal to a place of overlap between what the young person wants and what the service feels able to provide – safely and ethically – or to signpost a family to another service that may be better placed to help.

Even the most seemingly unacceptable goals can yield acceptable goals if the time is taken to ask a young person more about they want; by understanding what is hidden behind an initially stated goal, it is usually possible to find some point of overlap to agree goals and begin a collaborative intervention. It is often helpful to ask,

"What would you hope to be different if you lost the 10kgs?"

This gives the young person the opportunity to talk about their hopes, *"I would hope I'd feel more confident if I was thinner"* or *"I would feel I had achieved something."* This then opens the door to negotiating goals that both therapist and service user can agree to work together on: building confidence, being successful. But, beware *'perverse' Goal Setting – (See the next section on Cautions).*

'Stuck' goals

Sometimes families and young people come to child services "stuck" in their attempts to reach a goal - in such cases it may be helpful to move away from goal focused talk to "un-stick" the problem before moving on. The goal might always be in the mind of the therapist but not always the direct focus in the room. Taking a sailing analogy – it might be thought of as similar to 'tacking'– depending on the direction of the wind, it is quicker and easier to divert away from the direct route you are heading in but still know where you want to get to in the end.

What if goals change?

Goals often do change during the course of an intervention and the work should change focus accordingly if this is helpful - although you may want to question how helpful it is if goals change regularly throughout an intervention. And, depending on the type of intervention you are working on with a young person, you may want to formally reset the goals. (But, if you are using GBOs as part of the CORC collaboration, when it comes to scoring the GBOs to submit to CORC ***you must only record the scores of the original goals set at the start of the intervention*** - in the first three sessions). For your own records you might find it helpful to keep a note of those cases where the goals changed mid-intervention, and those that did not. This may help in interpreting the data in a more meaningful way if you choose to dig deeper into the GBOs data.

Cautions When Using GBOs

Subjectivity – "A Double Edged Sword"

Goals, by their nature, are subjective – this gives them strengths as well as weaknesses. The difficulty with such subjective measures is that their scientific validity is difficult to establish – as a young person moves towards a goal it is difficult to be sure that what they rate on the 11 point scale reflects a "true" shift. The strength is that in much work with young people it is their *subjective* view of change that is arguably a vitally important measure of success.

Beware 'Perverse' Goal Setting

Remember the aim of using any outcome measure is to gain useful feedback on our work to improve services we and our teams provide. However, it is easy to be seduced into 'collaborating' with clients in perverse ways, to set 'easy' goals that are more achievable – not to help provide users with a sense of achievement, but to make our outcomes look good! Watch out, and question yourself, *"is this refinement in goal for my benefit or the client's?"*

This process can equally be at play from the young person's side; if they feel that setting complex goals may lead to their receiving a 'better' service, or if they fear that showing progress towards a goal may lead to a useful service being stopped.

Guarding Against GBOs Problems

Transparency and dialogue are very helpful tools to help guard against the potential pitfalls in collaborating to set goals. Discussions with the goal setter about their choice, and scoring, of the goals, and from the practitioner's perspective help towards this; also, using supervision structures to explore any possible unspoken

motivation that might be at work. However, as with most other outcome measures, we can never be entirely confident that the goals and their scoring are representations of the 'truth'. For this reason, as with all outcome measures, the gold standard is to not rely on just one measure of change, but to gather information from more than one source to help provide a more detailed picture.

Using Goals in Clinical Practice:

Tracking Progress

Regular and session-by-session monitoring of goals

Although originally Goals Based Outcomes (GBOs) were adopted to use as an outcome tool: to track the amount of change towards a goal at the end of an intervention compared with where things were at the start of an intervention, it is possible to use the GBOs rating more frequently throughout an intervention, to track progress as an intervention proceeds.

CORC will now collect data on frequent GBO scores – the chart on the following page can be used to track GBOs regularly or every session if required, it is written in a way that allows progress to be monitored and shared with the service user and/or with a supervisor, as well as being useful for clinicians and practitioners to use themselves to reflect on progress.

Tracking progress regularly allows the therapist and service user to monitor progress together. Sharing the information in sessions can lead to helpful discussions about what is helping a goal to be reached and how this progress can be maintained, or conversely can flag if progress appears to be moving away from a goal. This can be the basis of a useful shared discussion between therapist and service user about why the progress may be heading in a particular direction and can allow any necessary issues to be addressed such as how well the therapist and service user are working

together, if the model is still the most appropriate for the intervention, if there are any external factors that need addressing, or to review the client's motivation. It may be helpful to score the GBOs early in a session to allow for discussion and for issues to be addressed quickly where necessary.

The idea of regular monitoring should be introduced at the first therapy session. Each subsequent session might helpfully be introduced by saying:

"OK, let's have a look at where you feel you are at with the goals we agreed on at the start of the work together. Let's look at goal one first which was to… (insert goal summary sentence)" - on a scale from nought to ten…. etc....., today how would you rate your progress on that goal?"

Once the rating has been obtained it may be helpful to compare it to last week's score and discuss as appropriate:

"OK, it looks like you have moved 3 points towards that goal – what do you think has helped?" Or *"Ok, it looks like you have moved back three points – what do you think might be the reasons"*

It might be necessary to guide a young person to think what the reasons may be: With the external context:

"Has anything particular happened this week that might have affected progress.... at home, school etc..."

Or with the therapeutic alliance:

"Is there anything that we could do differently in this session which might help things move forward? Is there anything I could do that would make things more helpful?"

Or with the model:

"Does the way we have been working still seem to be helpful – or do you have some thoughts on what might be a more useful way of doing things?"

Or with the service user's motivation:

"Do the goals we set at the beginning of the intervention still feel the right ones that you want to work towards? …. how much do you feel you want to work towards the goals we agreed?"

Clearly these questions, and the phasing of the questions would be adapted to fit the client and based on the clinical judgement of the therapist - but is always helpful to keep these four broad areas in mind.

Some Examples of Scoring Goals

Example 1.

Sally, is a 17 year old who was referred by her GP with concerns about possible depression and self-harm. At the first appointment she was clear that one of her goals was "to feel less down". *She rated herself on this first goal (goal one) as currently 2/10* – as she had been feeling down much of the time recently. In the next session there was more time to talk about the self-harm. Sally said she had been frightened to give it up but as there had now been some chance to discuss alternative coping styles and wanted to stop cutting herself. This became *her second goal (goal two) which she rated at 3/10* – she said she had already tried stopping cutting and was having some success, even if it was only delaying the harm rather than stopping it completely.

Sally progress towards these goals were rated each session – at the end of the intervention Sally did a final rating of the goals : *goal one (feeling low) she now rated at 7/10* – she felt less low much of the time. **Goal two (self-harm)** she now rated at 5/10 – despite a lot of effort she still found it difficult at this stage to stop.

So her outcomes were:

Goal one (low mood) T1 = 2/10, T2 = 7/10, therefore GBO score = 7 – 2 = 5

Goal two (self harm) T1 = 3/10, T2 = 5/10, therefore GBO score = 5 – 3 = 2

Example 2.

David is a ten year old referred due to, "difficult behaviour at home". He attended with his parents. All agree to work to try and find better ways for David to manage. Part of this work will be individual work with David, to develop some strategies to control his aggression when he gets upset – *This is the first goal (goal one) and David scores himself 1/10*. As David's parents are also going to do some work around this, they set the same goal for themselves – *they score this (goal two) as 3/10*.

The goals where rated each session to track progress, after four months all agree that things are going well and it is agreed to end the intervention at this stage. All agree there have been great improvements. *David now rates himself 7/10 (goal one) and his parents' rate things 9/10 (goal two).*

So the outcomes here are:

Goal one (David) T1 = 1/10, T2 = 7/10, therefore GBO score = 7 − 1 = 6

Goal two (Parents) T1 = 3/10, T2 = 9/10, therefore GBO score = 9 − 3 = 6

References

Bickman, L., Andrade, A.R., Lambert, E.W., Doucette, A., Sapyta, J. & Boyd, A.S. (2004). Youth Therapeutic Alliance in Intensive Treatment Settings. *Journal of Behavioral Health Services & Research, 3* (2), 134-148

CORC (CAMHS Outcomes Research Consortium). (2011a) *CORC Measures.* Available at: www.corc.uk.net

CORC (CAMHS Outcomes Research Consortium). (2011b) *CORC Protocol.* Available at: www.corc.uk.net

Doran, George T. *There's a S.M.A.R.T. way to write management goals and objectives.* Management Review 70.11 (Nov. 1981)

de Shazer, S. (1988) *Clues; Investigating Solutions in Brief Therapy.* W.W. Norton & Co

Horvath, A. O. & Symonds, B. D. (1991). Working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counselling Psychology*, 38, 139-149

Kazdin, Alan E. (Ed); Weisz, John R. (Ed), (2003). *Evidence-based psychotherapies for children and adolescents*, (pp. 439-451). New York, NY, US: Guilford Press

Law, D. (2006) *Goal Based Outcomes (GBOs): Some Useful Information.* Internal CORC publication; Available at: www.corc.uk.net

Rethink (2008) *A brief introduction to the recovery approach.* www.rethink.org/living_with_mental_ illness/recovery_and_self_management/recovery [accessed February 2008]

York A, & Kingsbury S (2009). *The Choice and Partnership Approach: A guide to CAPA.* London: Child and Adolescent Mental Health Services Network.

Symptoms Checklists

Once a problem is understood well enough the symptoms checklist or measure should be selected, this is the tool that will be used each session (where appropriate) to track progress in terms of symptom change and to give more information around symptoms as the progress progresses – ideally the selection of the tool should be a collaborative process with the clinician guiding the young person or carer, to the a few measures that best fit with the problem description they have heard;

> *"….Ok, from what I have heard so far it seems that the main thing you want to change is around worries? One of the things that can be helpful is to check how your worries are doing over time, to see if they are getting better or not, one way we can do this is to ask you some questions about worries each time we meet….."*

The therapist may want to show the young person a couple of the symptom checklists that relate to worries and ask:

> *"…… out of the checklists we have looked at just now, which set of questions would make most sense to you to ask each time we meet?"*

It is important that the checklist makes sense to the young person, and fits with their understanding of the difficulties they want to work on. It is important that the whole checklist is used – it is not helpful to select individual items from the checklist, or to mix items from different checklists together. In certain circumstances two checklists may be helpful to use – but be careful not to overload the session with two many questionnaires. If two checklists are used it may be helpful to alternate the completion of the tool - e.g. if the measures selected are the "feelings" (depression) and the "impact of events" (PTSD) checklist – give the feelings questionnaire one session and the impact of events the next, and keep alternating in this way as the intervention progresses.

The current of set of 12 symptoms checklists for CYP-IAPT are listed below (adapted from the OEG briefing note (Please see **Children & Young People's IAPT Routine Outcome Monitoring, Briefing Note** http://www.iapt.nhs.uk/silo/files/rom-dec11-03.pdf)

Symptom specific measures: "How are things …?"

Problem description (source of Items to be used each meeting, or weekly as relevant)

1. Depression / low mood

(RCADs) Never = 0 Sometimes =1 Often =2 Always =3

- I feel sad or empty
- Nothing is much fun anymore
- I have trouble sleeping
- I have problems with my appetite • I have no energy for things
- I am tired a lot
- I cannot think clearly
- I feel worthless
- I feel like I don't want to move
- I feel restless

2. Out of control behaviour child view (Me & My School)

Never = 0 Sometimes = 1 Always = 2

- I get very angry
- I lose my temper
- I hit out when I am angry
- I do things to hurt people
- I am calm
- I break things on purpose
- I bully others

3. Out of control behavior- parent/carer view (Scott adapted DSM IV items – for parent report)

Never = 0 Sometimes = 1 Always = 2

- often loses temper
- often argues with adults
- often actively defies or refuses to comply with adults' requests or rules
- often deliberately annoys people
- often blames others for his or her mistakes or misbehaviour
- is often touchy or easily annoyed by others
- is often angry and resentful
- is often spiteful or vindictive

4 Anxious away from home (Separation anxiety)

(RCADs) Never = 0 Sometimes =1 Often =2 Always =3

- I would feel afraid of being on my own at home
- I worry about being away from my parents
- I feel scared if I have to sleep on my own
- I have trouble going to school in the mornings because I feel nervous or afraid
- I am afraid of being in crowded places (shopping centres, the movies, buses, busy
- playgrounds)
- I worry when I go to bed at night
- I would feel scared if I had to stay away from home overnight

5 Anxious in social situations (Social anxiety or phobia)

(RCADs) Never = 0 Sometimes =1 Often =2 Always =3

- I worry when I think I have done poorly at something
- I feel scared when I have to take a test
- I feel worried when I think someone is angry with me

- I worry that I will do badly at my school work
- I worry I might look foolish
- I worry about making mistakes
- I worry what other people think of me
- I feel afraid if I have to talk in front of my class
- I feel afraid that I will make a fool of myself in front of people

6. Anxious generally (Generalized anxiety)

(RCADs) Never = 0 Sometimes =1 Often =2 Always =3

- I worry about things
- I worry that something awful will happen to someone in my family
- I worry that bad things will happen to me
- I worry that something bad will happen to me
- I worry about what is going to happen
- I think about death

7. Disturbed by traumatic event (PTSD)

Impact of Events Scale

0 = Not at all   1 = A little bit   2 = Moderately 3 = Quite a bit 4 = Extremely

- I thought about it when I didn't mean to
- I tried to remove it from memory
- I had waves of strong feelings about it
- I stayed away from reminders of it
- I tried not to talk about it
- Pictures about it popped into my mind
- Other things kept making me think about it
- I tried not to think about it

8. Compelled to do or think things (OCD)

RCADs Never = 0 Sometimes =1 Often =2 Always =3

- I get bothered by bad or silly thoughts or pictures in my mind
- I have to keep checking that I have done things right (like the switch is off, or the door is locked)
- I can't seem to get bad or silly thoughts out of my head
- I have to think of special thoughts (like numbers or words) to stop bad things from
- happening
- I have to do some things over and over again (like washing my hands, cleaning or
- putting things in a certain order)
- I have to do some things in just the right way to stop bad things from happening

9. Panic

RCADs Never = 0 Sometimes =1 Often =2 Always =3

- When I have a problem, I get a funny feeling in my stomach
- I suddenly feel as if I can't breathe when there is no reason for this
- When I have a problem, my heart beats really fast
- I suddenly start to tremble or shake when there is no reason for this
- When I have a problem, I feel shaky
- All of a sudden I feel really scared for no reason at all
- I suddenly become dizzy or faint when there is no reason for this
- My heart suddenly starts to beat too quickly for no reason
- I worry that I will suddenly get a scared feeling when there is nothing to be afraid of

Symptom specific measures for those whose maturity/life circumstances are that of a young adult (~16+)

Problem description

Items to be used each meeting (or weekly as relevant)

10. Depression / low mood

(PHQ-9) Not at all = 0 Several days = 1 More than half the days =2 Nearly every day = 3

Over the last 2 weeks, how often have you been bothered by any of the following problems?

- Little interest or pleasure in doing things
- Feeling down, depressed, or hopeless
- Trouble falling or staying asleep, or sleeping too much
- Feeling tired or having little energy
- Poor appetite or overeating
- Feeling bad about yourself or that you are a failure or have let yourself or your family down
- Trouble concentrating on things, such as reading the newspaper or watching television
- Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual
- Thoughts that you would be better off dead or of hurting yourself in some way

11. Anxious generally (Generalized anxiety)

(GAD-7)

Not at all = 0 Several days = 1 More than half the days =2 Nearly every day = 3

Over the last 2 weeks, how often have you been bothered by any of the following problems?

- Feeling nervous, anxious or on edge
- Not being able to stop or control worrying
- Worrying too much about different things
- Trouble relaxing
- Being so restless that it is hard to sit still
- Becoming easily annoyed or irritable
- Feeling afraid as if something awful might happen

12. Note for those who are using this approach in wider CAMHS with difficulties that are not relevant to any of the problem descriptions above then use:

RMQ (regular monitoring scale): 5 pt scale

Since coming last time, are your difficulties......

How much have your difficulties been upsetting or distressing you? (5 pt scale) How much have your difficulties been interfering with your everyday life in the following areas?

      a.   Home life b. Friendships

      c.   Ability to learn or work

      d.   Leisure activities

Thinking about the future: How much better do you think you will be in one month's time?

Appendix 1.

Client Feedback Tools & Outcome Measures

Summary Tables

There are two sets of measures to be used:
1. **Review Measures** - these are uses at the start of the intervention and at regular intervals as fits with service protocols e.g. every six months (if intervention is still ongoing), and at the end of the intervention. These measures are fixed – all measures should be given out for every client or family

2. **Frequent or Session-by-Session Tools** – these are used at the start of an intervention and every session, as long as this is appropriate. There are three sub-sets to these tools:
    i. **Progress Tracking**
    ii. **Symptoms Tracking**
    iii. **Session Feedback**

    Tools should be used for each of these three sub-sets – but there is some choice of tools to use within each of these sets. Once a tool has been chosen it should continue to be used each session.

Review Measures:

At start of Intervention	At six months and/or at end of intervention
RCADS and SDQ	RCADS and SDQ and CHI-ESQ

Frequent/ session-by-session tools:

Tools/Measures	Frequency
Progress Tracking:	
Goals Based Outcomes (GBOs) and/or **ORS/CORS**	Each Session (if appropriate)
Symptom Tracking:	
Choose, with the client, one or two of the **symptoms tracking measures**	Each Session (if appropriate) CYP-IAPT requirement based on 90% of clients having at least two completed questionnaires in this section
Session Feedback (Alliance Tools):	
SRS/CSRS or **"How are we doing" Tool**	Each Session (if appropriate)

NB this summary is based on current information from the OEG at time of going to press and is not formal CYP-IAPT advice, Please also sign up at the IAPT website for updates to the Children and Young Peoples IAPT Project at www.iapt.nhs.uk and read documentation from the Outcomes and Evaluation Group (ORG): **Children & Young People's IAPT Routine Outcome Monitoring, Briefing Note http://www.iapt.nhs.uk/silo/files/rom-dec11-03.pdf, as advice may change.**

Appendix 2.

List of Individual Contributors

Bill Badham

Peter Fonagy

Emma Karwatzki

Steve Kingsbury

David Low

Raphael Kelvin

Margaret Murphy

Claire Maguire

Scott Miller

Kathryn Pugh

Stephen Scott

Brigitte Squire

David Tricky

Paul Wilkinson

Miranda Wolpert

Ann York

This is a list of individuals who have made some contribution to the development of this document - it does not imply that they endorse all aspects of this guide.

We want your input!

This is a working document and we want your comments and feedback to improve and develop it.

Particularly we want:

- Ideas and tips of how you have use these measures and tools to improve your practice

- The language that you and services users find helpful in discussion tools and measures

- Tips for spotting when things are going off track

- Ideas for supervision

- Feedback from service users about the measures

- Ideas on how to improve this document

Eventually this will be available as a wiki to comment directly on line – for now please email ideas to: duncan.law@hertspartsft.nhs.uk

Thank you!

IAPT National Team February 2012