Using Measurement in Therapy

Lecture Transcript

The title of this lecture is Using Measurement in therapy. I'm placing a verb 'using' before a noun 'measurement' and are specifically going to be focusing on activities that are about asking clients to complete questionnaires. That would be usually before therapy starts and typically, where possible, after therapy is ended, but much more commonly today, using measurement throughout therapy. Something that's called 'routine outcome measurement', where you're giving a brief measure to clients at each of the sessions that they attend. More about that later.

There are some common terms describing measurement and specifically the use of measurement in therapy. In this little table, on the left hand side, are terms that I would say were very common as I was starting my career in the eighties and in the nineties, outcomes measurement, outcomes research, service evaluation, outcomes monitoring, routine outcomes measurement. At the beginning I would say of the 21st century, we move the emphasis away from doing measurement to using measurement and terms to have more to do with the use of measurement with clients are outcomes management, client directed outcome informed therapy, feedback informed therapy and most recently, measurement based care. So, you can Google any of these terms and you will be able to read, probably a rich history of the evolution of measurement in and across the psychological therapies.

What do we mean by measurement itself? Well, here's an item taken from a measure. So, we're usually talking about quantitative questionnaires, typically presenting clients with a range of questions or statements to which there's a standard response scale. Here's a question. Here's a standard response scale. So, let's have a look at some examples common across the UK.

Here from BACP is an excellent resource, which really goes into some really good reasons why you might use measurement and the frequency with measurement and they have examples of tools within this toolkit. The most common of which is the 'Strengths and Difficulties' questionnaire, but there are other questionnaires as well, including the 'revised children's anxiety and depression scale'. Again, what you're noticing is statements around a time period with a response scale.

Many of you will have heard of IAPT, improving access to psychological therapies and they have two questionnaires that are used routinely at each session. The patient health questionnaire known as the P.H.Q nine and the GAD seven, the general anxiety scale for measuring anxiety. We have the CORE outcome measure, typically used at the beginning of therapy and a brief court ten measure used throughout therapy before the CORE measure is given again at that last therapy session.

So, just to sum up. What are the characteristics of all of these measures? Well, firstly, there's a range of questions with a specific focus. Strengths and weaknesses across schools, depression, anxiety across IAPT or overall psychological distress across CORE users. They include a time frame over which to assess yourself in terms of filling out the questionnaire. So SDQ, the Strengths and Difficulties questionnaire would ask you to reflect on the last six months, PHQ nine or GAD seven would ask you to reflect on the last two weeks and the CORE outcome measure or core 10 would ask you to reflect on the last week.

Equally, they all provide a response scale known as a Likert scale and that is to help communicate the frequency of a feeling, of a behavior or indeed of an experience. Finally, they all offer a scoring system which will help you as practitioners, add up the total value of responses and convert those scores to symptoms or general distress severity ratings. What do we mean by that? Well, mild, moderate, severe are very common severity rating used across most measures that I've given you examples of.

So how do practitioners generally respond to measurement? There is a long history to this and you will find, if you go searching a lot of views, you will find a lot of survey research that's been done. I've been asking practitioners to engage in measurement. As I said earlier, for about 35 years now, and I think over the time I found it really to be a bit of a 'Marmite' experience, you know, that idea of either loving it or hating it. There are very few people that sort of sit on the fence and say, "okay, I'll give it a go". Mostly there are enthusiastic or really not that keen. If we look at some of the reasons for not being keen then some of the common reasons, certainly that I've heard and colleagues of mine have heard over the years when we've been training, are getting in the way of forming

and maintaining an alliance so critical at the beginning of a relationship. Clients will find it intrusive and a burden. Most of our clients benefit from therapy, so it'll take time and have very little value and outcome measures can't capture the breadth of the benefits of therapy and are therefore potentially insensitive to showing the individual change or improvement that that particular client has experienced. In 50 minutes there isn't time to administer measures. I lack confidence that my data will be managed confidentially or interpreted reliably. I think probably one of the most common anxieties that we experience when introducing measurement into services is an anxiety about whether this is a measurement of performance as a therapist. We did a review of the literature back in 2014, and if you're interested, you can read this paper, 'Leading Horses to Water', which summarizes the research of others and indeed our own experience.

What about the more positive aspects, though, of measurement and attitudes? Well, I relate some of my own personal experience, I have to say, in health care and the management of my own health and the monitoring of interventions to try to help problems that I've had, personally, I find measurement to be extraordinarily effective. As I've moved out of my thirties and nudged towards my forties, I tended to have less time for activity. I tended to de-prioritize it over my enthusiasm to sit at my desk and write etc. and weighing the scales became a really important tool for me to actually quantify the impact of the sedentary life that I was moving towards. Not surprisingly, with an increase in weight, I began to experience an increase in blood pressure and a blood pressure monitor cuff became really important to me and really helpful as I began to change my diet and my lifestyle. As we entered 2000 - 2010, I increasingly began to use an activity watch to begin to count my daily steps, as many of yourselves might do. Also, I then became more sophisticated with my measurement and the next watch even had a heart rate so I began to monitor my heart rate as I walked the local hills or went to the gym and used cardio equipment. If we use a reference to something at the time that this lecture is being recorded, Covid-19, then when I've had concerns about symptoms that I'd begun to experience, particularly in the early days, the thermometer was incredibly helpful to reassure me that fortunately I wasn't experiencing the key symptom of Covid-19, which was that feverish temperature. So, these are all tools that I personally used and I'm sure that many of you will have used those tools yourself, but what do we offer to clients who are coming for therapy? What tools do we offer to them that may help them to quantify and understand, not just the extent of their distress at the beginning of their journey in therapy, but more importantly the impact of therapy and how it may be helping to alleviate some of that distress in a measurable way. It's those ideas that I really want you to hold in mind as I begin to introduce the CORE measure as an example of measures used in therapy today.

First of all, let's start with our history. The official site for the history of the CORE Outcome Measurement Initiative is run by the CORE system trust, a group of trustees who own the copyright for the CORE measures, but give them and give them freely to the profession so that you can download them. Here on the right hand side, you can see through this site that you can download the measures as paper forms. You can download PDF's for printing. You can download Google forms or really usefully, particularly for online therapy, you can download fillable PDF forms that you can send to clients for them to fill in and return to you. The whole history of the CORE outcome measure and initiative is very well documented on the trustees Web site, the address of which is on the page here.

There are other resources as well where the support organization helping services and practitioners that are using CORE and obviously having been in existence for the best part of 20 years now, over the years, we've developed a lot of resources ourselves and you'll find those on our site. Then there are other sites, too numerous to mention, but I'm going to pick up just one in particular and that is the site Therapy Meets Numbers, which has a page dedicated to all of those common measures that I've mentioned earlier in the lecture. You might find that to be beneficial. If you're a member of the ACP, then counselling and psychotherapy research, which is available to you, if you did a search for the term core within that journal, you're going to find a lot of resources by students, by professional researchers, by services that will give you great insight into that measure. But equally, GHQ nine, GAD seven or if you work with children, the Strengths and Difficulties questionnaire, that's a very good resource. Finally, other resources, whilst we provide software ourselves because CORE is free, then Iaptus, PCMIS software that's used by app services principally also have the CORE measures available as well as P.H.Q nine, Gad seven, Wemwebs another measure used commonly. Bacpac, another system that has CORE available and Pragmatic Tracker to name just a few. There are others as well, but those are the ones that I'm certainly aware of and we've worked with over the years to help to provide those measures.

What about its characteristics? Well, before we get into the structure, let's just put it into context. Firstly, as I've said, it's free to use, free to copy and free to digitize. You can reproduce it yourself in your own databases and your own tools, provided that you acknowledge it and the full rules for reproduction are provided on the trustees website. It's a mature measure now, 22 years of age, to be precise. It's pan theoretical. That means that it doesn't matter what particular theory of therapy that you are particularly aligned with, whether that CBT, whether that's integrative therapy, whether that is a person centered approach, a psychoanalytic approach, a psycho-dynamic approach, the model behind CORE specifically is that it should be pan theoretical. It's widely used across multiple sectors NHS, workplace, education, voluntary sector, private practice, plus settings, plus professions. There are as many clinical psychologists as

psychotherapist as counselors proportionately using the measure as there are for any of the measures. If you were looking specifically at the tools and the references to those tools, then go to Google Scholar and put in CORE outcome measure, you'll find a hundred publications and many of those publications, if you don't have access to academic resources, then many of them contain free pdf's for you to download. Up until 2015, when tools like Google Scholar took over as being excellent resources, then the CORE system trust monitored and put up on their site all of the publications from 1988 through until about 2015.

What about its structure? Well, the CORE outcome measure itself consists of 34 items over two sides as a paper tool, it's four domains, specifically for those 34 items, four items on subjective well-being, twelve items on symptoms or problems, twelve items on functioning and six items on risk. In here, I've included the original references for the measure, both describing its design back in the late 90's and then describing the psycho metrics and publishing the psycho metrics of the measure. More about that later by Chris Evans and colleagues in 2002, published in the British Journal of Psychiatry.

If we understand how it's scored, then when we originally designed the measure back in 1998, what we had to do was to go out and give it to people to make sure that it was sensitive to being able to differentiate people within therapy from people in the general population. So the concept of normative data means going out and giving your measure to people in a normative, a normal population and giving it out to people in a clinical population and determining that there is a difference between the two. In this diagram that's taken from the original paper, you can see what's called a 'box plot' of about a thousand clients filling it in within therapy and within the general population. You can see that the average score of people filling in the measure in the clinical population, had an average of around two, with the range being anything from zero through to about three point eight, whereas the average score for somebody that is in the general population and not in therapy is more closely around the nought point five mark with a range of zero through to about two. So, the top of the range for people in the general population is actually the average score of people in the clinical population. From that you can determine a cut off and the cut off, that is the score that differentiates the clinical population from the non-clinical population, a little like a thermometer gives you a normative score. That is what you would use to determine whether a change has occurred. If a person moves from this population, the clinical into having a score more akin to this population than we talk about terms such as 'reliable change' that is improvement or clinical change, which is recovery. To be precise, moving from a clinical population into a non clinical population is called recovery and moving reliably that is a statistically significant amount of change, that is called improvement. On the CORE outcome measure, you'll find that there is a reliable change index for it. As an average, if they change by more than six points or six points or more, should I say, then that

constitutes reliable change. Good graphically, as we do in software and others do in software, then what this is showing you is that the scores of people, each of these are individual clients who are reaching that level of clinical or reliable change. These are the clients not changing and on this side of the graph are the odd client, each dot represents a client and they are deteriorating and their score is getting worse within therapy. Again, all of these computer programs would have this to do for you. That's the scientific scoring. What about practical scoring? If we look at practical scoring, then there are a number of tools that are going to be in the download pack that you can access. There's a look up table for CORE that you can quickly work out what the score is and what the severity of that score is. There's a paper tracking graph that you can download to plot change over time and even a matrix to help you think about how you might quantify and summarize change at a practical level for a group of clients attending therapy.

If we look at tracking change for individual clients, I've already talked about tracking tools on paper. Again, in the downloading tool that you could access the PDF, you've got a tool here for tracking change over time. A little bit like the chart of an end of a bed being able to measure over time. This is the same concept applied in a computer program where the red line constitutes the risk score on CORE and the blue line constitutes the overall score on the CORE and these are the different time points marked across the different severity bands. For this client, we can see they had three, six, nine sessions of therapy. At the beginning they started out in the moderate to severe range for their initial score. They were also at risk of potential suicide or self-harm. They went through therapy and at the end they ended up in the mild range with no risk.

If we're looking at change for multiple clients, again, as the tool that I mentioned earlier, two tools here, scatter plot tool that you'll find in most of the software available for CORE and other measures or a practical matrix on paper, which you'll find in the resources pack to go along with this lecture.

Let's think about for now as a skill. Let's think about outcome measurement as a skill, and let's think about moving up skill levels with experience. What we've talked about so far is about using CORE as an outcome measure but now I want to move on to thinking about in a level in CORE, which is using it for quality evaluation, digitizing and what that might bring tracking responses to items as a sort of master's level and then finally, when you're really experienced and confident with measurement beginning to be creative and blending measurement, adding one measure to another measure for different purposes in order to be able to have a pack of measures that meet a range of different objectives.

Moving into these. The first thing I want to point out is for the measurement, the use of skills if you haven't tried it before then there are some skills that will take a little bit of practice. One of the resources that we're providing in the pack is access to a site where we've done some role play videos about introducing core, responding to risk scores, responding to higher scores, introducing session measurement, introducing the tracking chart that we've put in the pack, how to score improvement and communicate improvement to a client and talk about improvement with the client and then how to score lack of change and how to actually address that with a client when a score may not be changing over time for any number of very valid reasons. This is the link, the address and this is a password that you'll be asked for in order to access these resources.

Moving on to look at CORE is a quality evaluation system. It's accompanied by a therapy assessment form and an end of therapy form and has a quality evaluation system the purpose of using an outcome measure is to be able to quantify change. At the simplest level you might have people that have improved, people who have stayed the same and people who have deteriorated. To do quality evaluation, that is, evaluate or measure in pursuit of improving your own personal quality as a therapist or your quality as a service, you'd want to reflect on people who perhaps don't change, or for those few people, perhaps the people that deteriorate. Having a standardized set of forms that profile the client and what you did with the client, we considered to be very useful and wrote that up as a quality evaluation model back in 2012.

So, these two tools, standardized assessment end of therapy answer, the how, the what, the who, the why, the where and the when of therapy, profiling the client and what they bring and profiling you and what you bought and what you delivered to the therapy encounter with the client.

The whole idea was to provide a model that track the client and followed the client and collected data on the client's journey through therapy from referral through to waiting through to their assessment into therapy and to the end, and then to link that to a quality evaluation model in which you would analyze data in terms of the equity of representativeness, the ease of access, the appropriateness of referrals, the efficiency with in terms of CNA's that's client cannot attends and did not attend, cancellations, etc, the acceptability, those are early endings and ultimately the effectiveness of therapy. If you look at it, effectiveness of therapy measured by an outcome measure is one fifth of this journey, accounting for potentially 20 percent of the value and it's interesting that if you were just using a measure at the beginning of therapy and at the end of therapy, it's not uncommon to only have about 20 to 30 percent of people measurable at the end relative to those that were measurable at the time of their referral. Again, resources that address this in far greater detail are given on the bottom of the slide.

Once we had collected data on these particular performance indicators, if you like, for services, then we published a book of indicators that you can download summaries from the CORE Web site which are essentially giving thermometer's or Benchmark's where you can look up your particular figures to find out how you compare with all the other people using the CORE measures. Now, these are outdated resources. These are from 2006 and they are before particular sectors and there are huge differences between sectors. If we just took an indication like a client ending, does the client come to a planned ending or drop out. National averages at the time in 2006 were 50 percent, but there were huge ranges across services wherein some services, perhaps because of the populations they worked with, they managed 20 percent planned endings, where in others they had a 95 percent. So, there's a huge range, as you can see.

Moving on. Tracking responses to measures is an approach that we developed around 2014. This was an approach that began to try to squeeze the ultimate therapeutic or conversational juice out of CORE by communicating clearly with clients whether items, specific items within the measure had gone up or gone down week to week. So, the therapist could communicate back and see that over this last week, you've been sleeping better. You felt a lot less isolated. You've been less irritable, but there are still some things that are actually a real struggle for you. You can get that stands there of communicating improvement or worsening through a tool such as Trim. Again, I put a reference in here for that paper. If you're interested and if you Google that, you would find a free copy of that paper up on the Internet for you to be able to explore.

Finally, sorry ultimately, I think digitizing CORE measurement tries to communicate what we found over the best part of 20 years really as to how therapists can get the maximum value out of measurement. I think we would reflect that people who use it, any measure Core PHQ nine, GAD seven, the strengths and difficulties questionnaire if you're using it with children. If you're using it just at the beginning of therapy and at the end of therapy because of the problem of dropout and because it's a static measurement, you're measuring at two time points, you're drawing a straight line between those two talking points, people that are just doing that are not particularly engaged I would have to say. They are mainly doing measurement, perhaps to be seen to be doing the right thing rather than because they find an intrinsic value in it. When therapists begin to use session measurement, they begin to report finding much greater value in it, having a conversational use, discussing it with clients, etc. then when they move to using it on modern tablets through various software forms or their own systems sometimes that they've designed to use on a tablet, then they find that it becomes a really valuable communicative tool, but the ultimate warmth or engagement or positivity or general self-confidence, if you like, with measurement really begins when you start to use measurement at every session, ideally on a tablet and then turning that tablet around

immediately the client has filled in a questionnaire and sharing the results with them and communicating with them. We had a whole project looking at this journey from this stage through to this stage, and that's written up in this resource here, which is in a book which is freely downloadable as a chapter, again, on the Internet. That was our SILC project done back in 2019 in collaboration with colleagues at Birmingham City University.

Finally, moving towards the end of this lecture. Let me bring it back up to date into the 21st century and talk about what people who have used measurement for a number of years are beginning to ask of measurement. As I said earlier, if you're using measurement, what you tend to find is that you'll begin to get interested in quantifying the outcomes, the different categories of outcomes, people that improve, people that stay the same and the small number of people that perhaps deteriorate in their therapy journeys, I would say impressionisticly, if you're having anywhere between 40 to 60 percent improvement, you are in an average for services seeing a cross section of client distress. That means that perhaps 50 percent of people are not improving as a result of their experience in psychological therapy. The people that are finding that are finding that they're really wanting to get involved with other measures to add other measures to PHQ nine to CORE and to measures that they've used that can help them. The latest generation of measures that are beginning to come out now are what are called adaptive questionnaires. This is where they're designed to be used on a computer. You as a client fill in a questionnaire typically now on your phone and that questionnaire will adapt to how you fill it out. So, there'll be trigger questions that are trying to assess whether you are depressed or anxious or have somatic problems, etc. These questionnaires, because they are organized to focus on specific presentations and adapt to your individualism, the whole idea of them is that they're highly individualized. We're doing a lot of filming at the moment to bring these tools as blended measurement to services who are wanting to explore how do we help those 50 percent of people who are not being shown to improve according to PHQ nine, according to GAD seven or according to our CORE measures.

In conclusion, in the last couple of minutes, that I have for this lecture, I'd like to offer you an invitation. For those of you that are new to measurement that perhaps have not used measures before or who've used it and who perhaps haven't had for one reason or another, a positive experience. It's a three step invitation in which I'd like you to download a measure, either a common measure of your choice or one that you're being asked to use. There are measures that you can download in the pack that accompany this lecture. I'd like you to complete that outcome measure ideally, firstly for yourself and then secondly, for a client that you've seen recently. I'd like you to reflect on the experience, both of you filling it in and filling it on behalf of your client and think about both the use of your responses in conversation with family or friends for yourself and

the use of the client's responses if you are to be using that measure with your clients going forward. Ask you to reflect on how you would bring value to your client for having the experience, which is very challenging of actually completing that measure.

I've added some reference sources. Everything that is referenced within this lecture is contained on these pages and it just remains for me to say to don't forget to claim your CPD certificate (alarm going off) and that's my timer going off to say that I was on time. Don't forget to claim your CPD certificate and to remind you of the note that all the resources, the links and the downloads that have been provided in this lecture are all available for download or for access on the lecture delivery page. Just remains for me to say 'bon voyage' and I hope that your journey with measurement is hopefully a little bit richer for having a listen to this lecture.

Thank you very much indeed for listening. Bye now.