Learning from CORE Measurement: Reflections on Two Decades of Data

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Core Values

CORE IMS Ltd

Putting quality at the heart of therapy
Model: Evidence Based Practice

Activity: Service systems generate questions relevant for rigorous research to assess the potential for practice

Yield: research is led to investigate issues important to whole service

Method: Rigorous efficacy studies
Meta-analytic studies and randomised controlled trials

Product: Sets common and specific data goals drawn from pool of standardised and face-valid tools

Yield: Services are led to deliver evidence-based interventions

Activity: Rigorous research delivers hypotheses relevant for naturalistic investigation through practice applications

Method: Relevant effectiveness studies and practice research within services linked through practice research networks

Model: Practice Based Evidence

Bridging Evidence-Based Practice and Practice-Based Evidence: Developing a Rigorous and Relevant Knowledge for the Psychological Therapies

Michael Barkham* and John Mellor-Clark
Psychological Therapies Research Centre, University of Leeds, Leeds, UK

Four key areas of research work are identified: efficacy, effectiveness, practice, and service system. These research areas are placed within the paradigms of evidence-based practice and practice-based evidence. This article provides an introduction to these two paradigms and how they are research areas together with examples of current work. From this basis, we argue for a knowledge base for the psychological therapies in which each area has a place within an overall research model and in which the interdependence of each area on the others is acknowledged. A cyclical model exemplifying the complementary relationship between evidence-based practice and practice-based evidence is presented as a means for furthering the delivery of a rigorous but relevant knowledge base for the psychological therapies.

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Practice-based Evidence
Barkham, Stiles, Lambert & Mellor-Clark (2010)

RCTs
- Top-down driven by researchers
- Formal design defines process
- Led by researcher allegiance
- Stringent inclusion criteria
- Single, specific manualised treatment
- Rich data on small N

PBE Data
- Bottom-up driven by practitioners
- Informal design
- Focused on service delivery
- Naturalistic
- All treatment as delivered in practice
- Rich data on large N

Putting quality at the heart of therapy
The CORE Outcome Measure

CORE-OM is a 34-item questionnaire designed to measure a client’s global distress across 4 domains

- Subjective well-being
- Commonly experienced problems or symptoms
- Life and social functioning
- Risk to self and others


Putting quality at the heart of therapy
4 CORE-OM Abbreviations

2 CORE-OM Adaptations

20+ CORE-OM Translations

Pu#ng quality at the heart of therapy
CORE ‘Quality Evaluation’ Model


Putting quality at the heart of therapy
Using the CORE System for Service Quality Development

Referral
Do client profiles suggest equity in their representation of local populations?

Waiting
Are first contact sessions easy to access?

Assessment
Are clients’ assessed problems appropriate to the therapies offered?

Therapy
How efficiently does the service use its resources and how acceptable are therapy experiences to clients?

Ending
How effective is therapy?


Using the CORE System for Service Quality Development


# Benchmarks for Primary Care Counselling Services

**Outcome Measure Completion Rates**

## Table 2: Descriptives and benchmark figures for the percentage of valid CORE-OM completed (service level)

<table>
<thead>
<tr>
<th>Time of CORE-OM completion</th>
<th>Pre- and post-therapy</th>
<th>Pre-therapy</th>
<th>Post-therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>42</td>
<td>81</td>
<td>43</td>
</tr>
<tr>
<td>Standard deviation</td>
<td>17</td>
<td>11</td>
<td>17</td>
</tr>
<tr>
<td>Minimum</td>
<td>9</td>
<td>54</td>
<td>9</td>
</tr>
<tr>
<td>Maximum</td>
<td>88</td>
<td>99</td>
<td>90</td>
</tr>
<tr>
<td>25th Percentile (95% CI)</td>
<td>34 (17.5 to 37.1)</td>
<td>81 (71.4 to 88.9)</td>
<td>36 (20.3 to 39.0)</td>
</tr>
<tr>
<td>50th Percentile (95% CI)</td>
<td>41 (35.1 to 47.2)</td>
<td>90 (81.9 to 94.6)</td>
<td>43 (36.7 to 48.0)</td>
</tr>
<tr>
<td>75th Percentile (95% CI)</td>
<td>49 (45.6 to 61.3)</td>
<td>95 (92.8 to 97.7)</td>
<td>51 (46.1 to 61.8)</td>
</tr>
</tbody>
</table>

Planned Endings (estimated) (n=31,882)
Learning from CORE Outcomes

Putting quality at the heart of therapy
Successive discrete CORE outcome data pools provide little evidence of superiority of any of the common UK therapy models (Stiles et al., 2006; 2008; in press). CBT, psychodynamic therapy and humanistic counselling all have similar outcome profiles in terms of recovery and improvement for clients presenting with mild to moderate severity profiles.

“... we have argued that the Stiles et al. (2006, 2007) studies do not provide good evidence that CBT, PCT and PDT are of equivalent effectiveness when given to patients with equivalent problems . . . . Getting, and making publicly available, close to complete data on recovery rates will be an important step forward”. 
Pu#ng quality at the heart of therapy


Putting quality at the heart of therapy
Putting quality at the heart of therapy
The proportion of clients that have post-therapy outcomes using traditional T1+T2 measurement methods is typically around 25% of those attending assessments and 50% of those entering therapy. Similar proportions appear common in IAPT datasets despite the increased frequency of measurement.
The flagship programme to widen access to psychological therapies in the NHS is only helping one in ten patients referred by GPs and each session could be costing over three times as much as official estimates, claims a new analysis. The analysis found that success rates significantly lower if all the patients referred to the Improving Access to Psychological Therapies (IAPT) programme were included, with a recovery rate of 12%. This compares with official NHS England figures that show a 40% recovery rate, although this is only based on those patients who were ‘at caseness’ to begin with and were considered to have completed treatment.

Researchers from the University of Chester’s Centre for Psychological Therapies in Primary Care (CPTPC) published their analysis in two papers in the Journal of Psychological Therapies in Primary Care this month. They concluded that their data raised questions over the sustainability of the programme, and urged CCG leaders to ‘look behind’ Government figures to judge whether to invest in IAPT.

In the first paper, an analysis of IAPT data from the NHS Information Centre for 2011-2012, the team reported that the official figure for patients moving to recovery was 44%, based on those patients who were ‘at caseness’ to begin with and were considered to have completed treatment. However, when the researchers considered all patients entering treatment - completing at least one session - the figure fell to just 22%. If the full quota of patients referred for IAPT was considered, the proportion of patients moving to recovery fell even further, to just 12%.
Few psychological therapy referrals lead to 'recovery'
29 January, 2014 | By Judith Welikala

Fewer than 6 per cent of referrals made under the £400m Improving Access to Psychological Therapies programme resulted in “reliable recovery”, data suggests.

Figures from the Health and Social Care Information Centre show only 51,900 out of 883,968 new referrals in 2012-13 led to “reliable recovery”. A further 82,910 referrals led to “reliable improvement”.

Andy Bell, deputy chief executive of the Centre for Mental Health, said it would be “unfair” to say the data indicated “a lack of success”. He added that the success of therapy depended upon the circumstances of people undergoing treatment. “If someone’s depressed because they’ve lost their job, in a sense psychological therapy will help with that, but so will effective employment support,” he said.

“IAPT is undoubtedly ahead of the curve in terms of mental health services in trying to measure outcomes… We need to regard that as progress and encourage more of that.”

Fifty one per cent of referrals under IAPT did not lead to treatment. Half of those were attributed to patients declining or dropping out of treatment.

Mr Bell said: “A degree of that is to be expected. People drop out of therapy of their own accord. What would be useful is to know why. It would be worrying if it was related to long waits.”
The proportions of clients measured to achieve clinical and/or reliable change is typically around 1-in-3 of those assessed. Similar proportions are found in IAPT datasets and in PBE data collected by Lambert and colleagues using the OQ Suite.


# PBE Outcomes in United States

<table>
<thead>
<tr>
<th>SITE (N= 6,072)</th>
<th>SESSIONS</th>
<th>DET.</th>
<th>NO CH.</th>
<th>IMPRO</th>
<th>RECOV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee assistance</td>
<td>3.6</td>
<td>6.6%</td>
<td>58.5%</td>
<td>19.7%</td>
<td>15.2%</td>
</tr>
<tr>
<td>University clinics</td>
<td>5.8</td>
<td>9.7%</td>
<td>57.6%</td>
<td>20.1%</td>
<td>12.6%</td>
</tr>
<tr>
<td>Local outpatient clinics</td>
<td>3.3</td>
<td>14.1%</td>
<td>53.9%</td>
<td>20.5%</td>
<td>11.4%</td>
</tr>
<tr>
<td>National outpatient clinics</td>
<td>5.1</td>
<td>7.5%</td>
<td>48.1%</td>
<td>28.5%</td>
<td>15.9%</td>
</tr>
<tr>
<td>Clinical trainees</td>
<td>9.5</td>
<td>3.2%</td>
<td>45.6%</td>
<td>31.2%</td>
<td>20%</td>
</tr>
<tr>
<td>Community mental health center</td>
<td>4.1</td>
<td>10.2%</td>
<td>60.7%</td>
<td>20.5%</td>
<td>8.6%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>4.3</td>
<td>8.2%</td>
<td>56.8%</td>
<td>20.9%</td>
<td>14.1%</td>
</tr>
</tbody>
</table>

"Elephant in the room" is an English metaphorical idiom for an obvious truth that is either being ignored or going unaddressed. The idiomatic expression also applies to an obvious problem or risk no one wants to discuss. [https://en.wikipedia.org/wiki/Elephant_in_the_room](https://en.wikipedia.org/wiki/Elephant_in_the_room)
How often should measures be used?
In ‘real world’ settings as opposed to being part of a randomised controlled trial, clients often do not complete all therapy outcome measures (Barkham et al., 2012), which poses a real challenge in being able to fully understand the effectiveness of an intervention, as typically those who do complete outcome measures may have better outcomes or have attended more sessions of counselling. Therefore, for data to be meaningful and valid, it is essential for as many clients as possible to complete both pre and post outcome measures.

Using measures at every session
It is important to use at least one outcome measure every session to ensure that even in the case of unplanned endings there is a post-counselling measure for clients. A client may choose to no longer attend for a variety of reasons, and therefore not have a planned ending to their counselling. In this event it would be less likely that post-counselling outcome measures would be able to be completed. Without a post-counselling measure clients cannot be included in any analysis of the data collected - reducing the validity of the results. In contrast, if outcomes are collected at every session then both start- and end- point measures for all clients can be guaranteed. Measures can be selected which are relatively brief and non-intrusive.

http://www.bacp.co.uk/research/resources/using-routine-outcome-measures.php
Implementing routine outcome monitoring in clinical practice: Benefits, challenges, and solutions

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Abstract
This article reviews the benefits, obstacles, and challenges that can hinder (and have hindered) implementation of routine outcome monitoring in clinical practice. Recommendations for future routine outcome assessment efforts are also provided. Spanning three generations, as well as multiple developed tools and approaches, the four authors of this article have spent much of their careers working to address these issues and attempt to consolidate this learning and experience briefly here. Potential “elephants in the room” are brought into the discussion wherever relevant, rather than leaving them to obstruct silently the field’s efforts. Some of these topics have been largely ignored, yet must be addressed if we are to fulfill our promise of integrating science and practice. This article is an attempt to identify these important issues and start an honest and open dialogue.

Keywords: routine outcome monitoring; feedback; science-practice integration; dissemination and implementation
PBE data suggest 50% of clients show no reliable change when treatment ends and 10% experience deterioration.

In addition, treatment dropout rates are estimated to be in the range of 20% (adult) up to 40% - 60% (child).

ROM tools could be useful to supplement clinical judgement as there’s no current evidence to suggest practitioners are able to accurately detect when their clients are worsening.

RCTs demonstrate where ROM tools are used to supplement clinical judgement in trials, clients in the feedback group were 3.5 times more likely to achieve reliable change.

The sum of evidence suggests that it is in the clients’ best interest to formally monitor treatment responses in order to increase the potential for reliable post-treatment change.

Source: Mellor-Clark et al. (2014)
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Surveys report practitioners estimate 85% of their clients improve or recover at the end of their treatment – negating the potential value of ROM.

Practitioners are overscheduled with no time to assess ROM systems, plan implementation, interpretation, reporting and client feedback.

Practitioners may resist ROM because they believe that clients may find it a burden or that the process may interfere with the alliance.

Implementing ROM needs software, training and support that’s not currently funded leaving services to finance from existing tight budgets.

Practitioners lack confidence that data will be managed confidentially, or interpreted reliably, leaving them feeling exposed to performance assessment.

The sum of evidence suggests that it is in the clients’ best interest to formally monitor treatment responses in order to increase the potential for reliable post-treatment change.

Source: Mellor-Clark et al. (2014)
The Cognitive Science of Mistakes

Confirmation bias

Base rate fallacy

Attentional bias

Anchoring bias

Availability heuristic

Putting quality at the heart of therapy
Putting quality at the heart of therapy
Revisiting the Personal Questionnaire
(Shapiro, 1975; Elliot et al, 1999)
Leading Horses to Water: Lessons from a Decade of Helping Psychological Therapy Services Use Routine Outcome Measurement to Improve Practice

John Mellor-Clark, Simone Cross, James Macdonald & Tommy Skjulsvik
<table>
<thead>
<tr>
<th>QIF Phases</th>
<th>QIF Critical Steps</th>
<th>CORE IMS ROM Implementation Resources and Processes</th>
</tr>
</thead>
</table>
| Assess the Host Setting | 1. Assess needs and resources.  
2. Assess fit.  
3. Assess capacity/readiness for change.  
4. Make decisions about innovation adaptations.  
5. Secure practitioner buy-in.  
6. Build service capacity.  
7. Staff recruitment.  
8. Deliver pre-implementation training. | i. Meet with nominated service’s ROM Lead to conduct a Pre-implementation Planning Meeting and undertake a Service Profile Survey to assess the fit between the service’s aspirations and their readiness for organisational change.  
ii. Administer Routine Outcome Measurement Survey to all service practitioners and managers to assess individual philosophical and practical attitudes towards sessional ROM relative to traditional T1+T2 and discretionary measurement.  
iii. Select and/or review nominated ROM Mentors in light of survey results. |
| Create a Structure for Implementation | 9. Create an implementation team.  
10. Develop an implementation plan. | iv. Create a local Implementation Management Group to review data from the ROM Survey, set appropriate quarterly data targets, and agree off-track actions as advance remedial steps for missed targets.  
v. Write and deploy Implementation Plan to communicate the concrete quarterly performance indicators defining successful implementation and remedial actions for missed targets.  
vi. Deliver Training and E-learning Resources that address the common ROM restraints to help build a consensus opportunity. |
13. Supportive feedback mechanisms. | vi. Deliver Data Quality Reports at Months 1, 2, 3 and 6 to profile individual practitioner engagement relative to data quality targets.  
vii. Provide Mentor Support Calls to discuss implications of data quality reports and Chair Quarterly IMG Meetings to agree reparative actions to keep service on-track to meet agreed targets. |
| Improve Future Applications | 14. Learning from experience. | ix. Support Mentors to teach their Mentees to Clear Flags with brief reflective case notes for all clients lacking any reliable improvement on sessional measurement scores after 3-6 sessions (duration depending on case mix).  
x. Provide and manage a ‘Basecamp’ Resource to encourage Managers, Mentors and Mentees to chart their ROM implementation ‘journey’ – reflecting on how challenges were overcome and iteratively sharing positive experiential and empirical yields as they occur in (near) real-time. |
Lessons from CORE Implementations?

Practitioners carry a wide range of beliefs, attitudes, feelings, and experiences into the introduction of routine outcome measurement that are rarely if ever systematically assessed by managers or researchers.

Measurement is commonly implemented as an administrative and/or technical process rather than a clinical one that strip client’s ROM responses of therapeutic significance.

Where ROM data are reviewed they are rarely explored in any depth for fear of exposing individual practitioners. This perpetuates clinical apathy, poor data quality and minimum reflectivity on service development implications.
Learning from Active ROM Implementation?

Appropriately resourced, led and managed, ROM implementation can be a success that brings unity, curiosity and pride to services.

Leadership appears a critical factor of success and effective process ineffectively led will fail to meet data quality and engagement targets.

Practitioner safety is paramount and the challenges that the ROM process places on self-efficacy assessments shouldn’t be underestimated and case mix optimisation should be key.
“The psychotherapist learns little or nothing from successes. They mainly confirm in him his mistakes, while his failures on the other hand, are priceless experiences in that they not only open a deeper truth, but force him to change his views & methods.”  
Carl Jung (1875-1961)
Welcome to SILC

Welcome to an exciting new membership organisation: a UK learning community for voluntary sector counselling and psychotherapy services.

SILC is an innovative collaborative learning initiative creating a network of voluntary sector services currently using CORE to help evidence their value. Through shared learning and collaboration, SILC aims to demonstrate and enhance the value of the voluntary sector as a unique national resource requiring secure and sustained funding.

“The goal is to turn data into information, and information into insight”.
Carlly Fiorina - Former CEO, Hewlett Packard

Latest News and Events

Welcome to SILC, and our first ever post
Where to start…Preparation work for bringing SILC into fruition began at the end of last […]

Core Data Donation Critical To SILC Project Success
By John Mellor-Clark, SILC Strategic Director
Feedback from users of the
Pu#ng quality at the heart of therapy