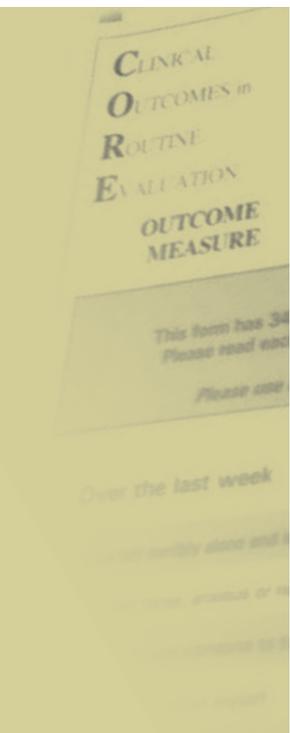


# CORE: A DECADE OF DEVELOPMENT



This publication is dedicated to the memory of Dr Graham Curtis Jenkins, who sadly passed away in July 2007. Graham envisioned and indirectly shaped many of the achievements profiled here and, while his presence is sadly missed, his spirit remains with many of us as we continue to work to bring his vision to fruition.

*John Mellor-Clark*

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OF DEVELOPMENT

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## Foreword

In 1993, we jointly organised a two-day conference for the Mental Health Foundation to identify priority areas for targeted research funding in the psychological therapies. A multicentre collaborative group, led by Michael Barkham won the ensuing competition to develop an outcome measure, and Clinical Outcomes in Routine Evaluation (CORE) was born. Its success has been truly phenomenal. Success has come not only because of being in the right place at the right time to meet the demand for outcome monitoring, or by making the measures royalty free, but also through understanding what users need in order to make the system accessible and useful. This publication tells the story of a decade of hard work by a small team, informed by the input of many users, and directed in its development by the necessity of solving unanticipated crucial problems. Achievements have built on the foundation of a robust, clinically responsive measure by providing information technology and online tools to facilitate the scoring and interpretation of results, short versions of the CORE Outcome Measure (CORE-OM) for intense use, training and support for organisations in the throes of adopting CORE, a CORE user network and a shared database for benchmarking.

The success of CORE has been marked by the rapidity with which organisations, particularly those in the fields of primary healthcare and the psychological therapies, have integrated the system into routine practice, and the willingness of purchasers and commissioners to accept CORE data as a valid performance indicator. Along the way, CORE-OM has generated scientifically important findings concerning therapeutic change in clinically representative settings. In its evolved form, CORE scores highly in ease of use and external validity, but its demonstrated overlap with other measures brings non-empirical factors into play for those choosing between CORE-OM and competing comparable measures. In addition, as recognised from the outset by its developers, CORE-OM may need to be complemented by domain-specific measures to do justice to complex clinical situations. It is important not to reify apparent exactitude, in risk assessment. As was also recognised from the outset, CORE-OM is not a substitute for clinical judgement.

Service providers are in the midst of a revolution in accountability. If the challenging move towards payment by results is completed, account will have to be given of what was done for whom and to what effect. CORE is well placed to play a central role in this process, and to help clinicians reflect on individual results. Equally, services will be assisted in comparing benchmarks with peers, and in undertaking pragmatic practice-based research into who and what works best. Each step brings closer an exciting future of outcome-informed practitioners.

*Mark Aveline*

*Honorary Professor of Counselling and Psychotherapy, University of Leicester  
President, British Association for Counselling and Psychotherapy 1994–2000  
President, Society for Psychotherapy Research 2003–04*

*David A Shapiro*

*Honorary Professor, University of Leeds  
Professor of Clinical Psychology and Director, Psychological  
Therapies Research Centre, University of Leeds, 1995–99  
Team Leader, MRC/ESRC Social and Applied Psychology Unit, University of Sheffield, 1977–94  
President, Society for Psychotherapy Research, 1993–94  
Managing Editor, Psychotherapy Research, 1989–94*

# I. The CORE method

## What is CORE?

*Clinical Outcomes in Routine Evaluation (CORE) was launched in 1998 as the result of a three-year collaboration between researchers and practitioners. The aim was to design an evaluation system that would help to inform the development of client care in and across psychological therapy services.<sup>1-3</sup>*

The CORE System consists of three interdependent fee-free paper-based tools, supported by specialist software services, training and backup provided by CORE Information Management Systems (CORE IMS).

The *CORE Outcome Measure* (CORE-OM) is a client self-report questionnaire designed to be administered before and after therapy. The client is asked to respond to 34 questions about how they have been feeling over the last week, using a 5-point scale ranging from 'not at all' to 'most or all of the time'. The 34 items of the measure cover four dimensions: subjective well-being; problems/symptoms; life functioning; and risk/harm. The responses are designed to be averaged by the practitioner to produce a mean score to indicate the level of current psychological global distress (from 'healthy' to 'severe').<sup>4</sup> The questionnaire is repeated after the last session of treatment; comparison of the pre- and post-therapy scores offers a measure of 'outcome' (i.e. whether or not the client's level of distress has changed, and by how much).<sup>5-7</sup>

The CORE-OM was designed as a non-proprietary measure of psychological distress. Crucially, it was informed by feedback from practitioners as to what

they considered to be important to include.<sup>2</sup> Since its development the CORE-OM has been validated with samples from the general population,<sup>8</sup> NHS primary<sup>9,10</sup> and secondary care,<sup>11</sup> and in older adults.<sup>12</sup>

Two practitioner-completed forms complement the CORE-OM by providing contextual information.

- The *Therapy Assessment Form* helps to profile the client, their presenting problems/concerns and their pathway into therapy.
- The *End of Therapy Form* helps to profile the client's pathway through and out of therapy, alongside a range of subjective outcome assessments.

*'I have found CORE very useful as it has allowed both local and national benchmarking. It allows us to look at service provision at individual, system and service levels to address issues around the service and profile quality, outcomes and risk. It brings attention to service delivery aspects that may remain hidden.'*

Dr Amra S Rao, Clinical Psychologist and Head of Psychological Therapies Service, East London Community Mental Health Trust, Newham

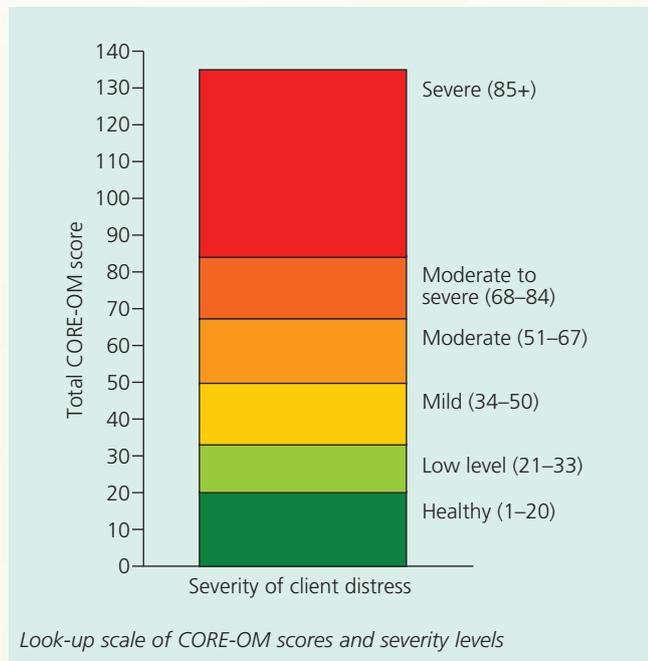
The use of CORE Therapy Assessment and End of Therapy Forms alongside the CORE-OM distinguishes CORE from standalone outcome measures by routinely adding critical contextual detail on the client and the therapy process.<sup>5</sup>

### How is CORE used?

When the CORE-OM was developed, the aim was for practitioners to calculate a mean item score by summing the individual item scores and dividing by 34 to yield a mean score ranging from 0 to 4. Over the years, however, the system has changed to take into account feedback from practitioners who have found it easier to assign meaning to whole numbers rather than fractions. It is now standard practice to multiply the mean item score by 10, to give the clinical score.

The therapist can examine the extent to which a client's CORE-OM score represents a 'clinical population' by comparing the score at referral with a national 'clinical cut-off' score of 10. This clinical cut-off was established by asking a large sample of the UK population to complete the questionnaire and comparing their scores statistically with those for large samples of clients in therapy.<sup>4,6</sup> Four bands of scores above the clinical cut-off have been established as representative of mild, moderate and severe levels of distress (see figure, opposite).<sup>8</sup>

For practitioners to assess meaningful improvement over the course of therapy,



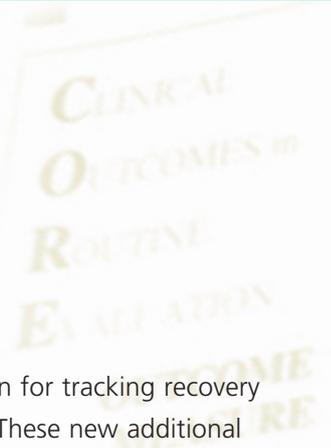
two measures are essential: reliable change and clinically significant change.

- Reliable change is change that exceeds that which might be expected by chance alone or measurement error, It is represented by a change of 5 or more in the clinical score.
- Clinically significant change is indicated when a client's CORE score moves from the clinical to the non-clinical population.

### The family of CORE measures

For assessment and outcome, the full CORE-OM is recommended, or the full version can be used without the risk items (i.e. CORE-NR). Several shorter forms of the CORE-OM have also been derived for screening and research purposes. For repeated administration (session-by-session), two parallel short versions were





designed for research studies whose objectives required administration of alternate forms in order to reduce memory effects. There is also a version for use in the general population, named GP-CORE, comprising 14 items derived from the CORE-OM.<sup>13</sup> In addition, further versions are being developed for particular groups. For example, a version for young people (YP-CORE) is well advanced, and a programme of work is focusing on developing translations of the CORE-OM for ethnic and European languages (see page 24).

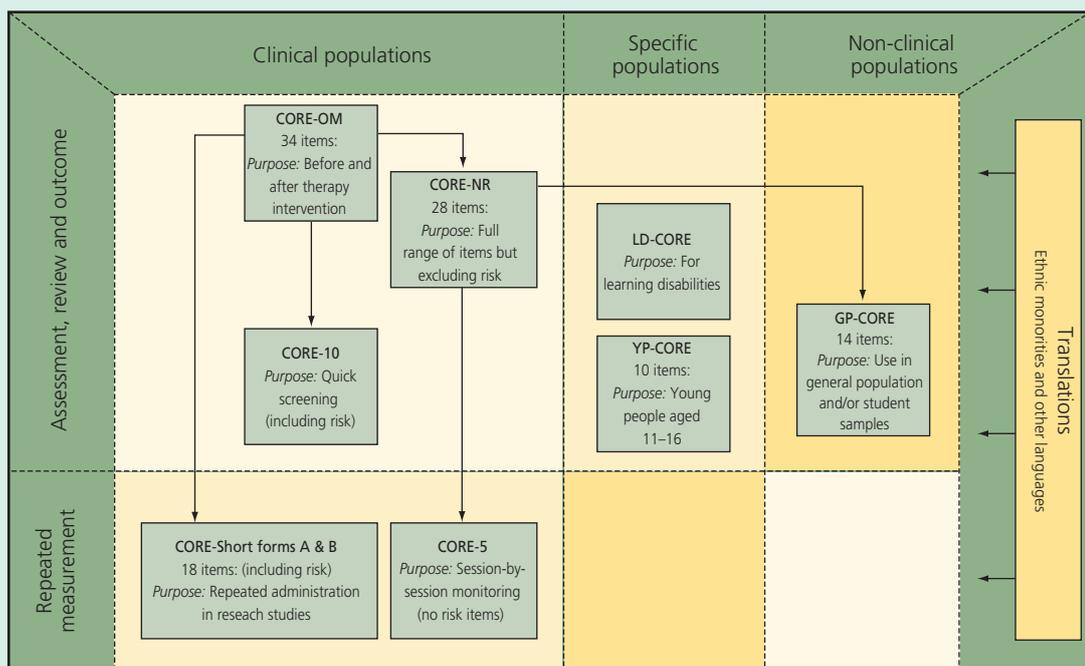
In 2006, at the request of the CORE user network, the CORE System was enhanced by the addition of a 10-item version of the CORE-OM for screening and review,

and a 5-item version for tracking recovery and improvement. These new additional outcome monitoring and management tools form essential resources for CORE Net second-generation IT support software.

### CORE software systems

CORE software provides comprehensive data capture, storage, filtering, analysis and report functions, all designed to support service management, compliance with clinical governance and ongoing quality improvement.

CORE-PC (i.e. CORE for personal computers) has been in use across the NHS since 2001.<sup>14</sup> Developed in response to requests from services for a clearer



Map of the family of CORE outcome measures



*Dr Al Thompson, GP using CORE Net in surgery with a patient*

understanding of their CORE System data, the software was designed to help resource service quality assessment and development. CORE-PC can be used to quantify the numbers of clients who fall into specific categories (e.g. age bands, ethnicity, gender, employment, medication, problem presentation, and type of therapy ending), and offers tools to identify and explore sub-sets of those who fall into categories outside service quality targets (e.g. long waiting times, early termination of therapy, clinical deterioration, and/or poor attendance or psychological mindedness). CORE-PC has a current active user base of over 250 UK services that are currently collating data for over 100,000 patients annually.

CORE Net is a new web-based system that offers dynamic, real-time data collection, harnessed to 'outcomes management' methodology informed by US insurance-based managed health care. The methodology is much less reflective than traditional approaches to evaluation and outcome measurement. It complements the CORE-OM with new shorter 10- and 5-item CORE measures that provide information to inform tracking and flag reports to help maximise the potential for client gains. Forms can be completed online by a practitioner and client working together, or privately by clients, or can be used as traditional 'pen and paper' measures for subsequent online entry by administrative staff.

## CORE IMS support services

Along with the above software support systems, CORE IMS offers a range of training and management support for psychological therapy services using the CORE System. Since 2001, CORE IMS has provided CORE software to over 400 UK psychological therapy services involving more than 4000 practitioners and 600,000 clients. It has also delivered over 350 CORE implementation workshops, and has amassed and published detailed insight into contributory factors that help services to successfully implement routine CORE data collection into their clinical practice.<sup>14</sup>

A key insight gained from this work was that using outcome measures on their own is not enough to develop service quality. Typically, fewer than half of all clients referred for therapy have pre- and post-therapy measures to inform effectiveness profiling.<sup>15</sup> Moreover, services and individual practitioners have varying degrees of success in introducing routine outcome measurement into their client work. Such findings highlight the imperative for outcome measures to be supported by appropriate training to help secure practitioner engagement, and by complementary data to provide

contextual information for understanding clients' journeys through therapy.

CORE implementation training enables practitioners to understand how to use CORE to enhance client management; to secure, develop and grow services; and to optimise assessment, risk management and clinical outcomes monitoring. CORE data management training provides managers with the knowledge and skills to structure and produce CORE reports for stakeholders, to use benchmarking for service delivery and development, and to introduce clinical performance coaching for continuing professional development of practitioners.

CORE IMS also provides research consultancy and support for services and organisations in planning, executing and disseminating research, audit and evaluative studies.

## The CORE user network

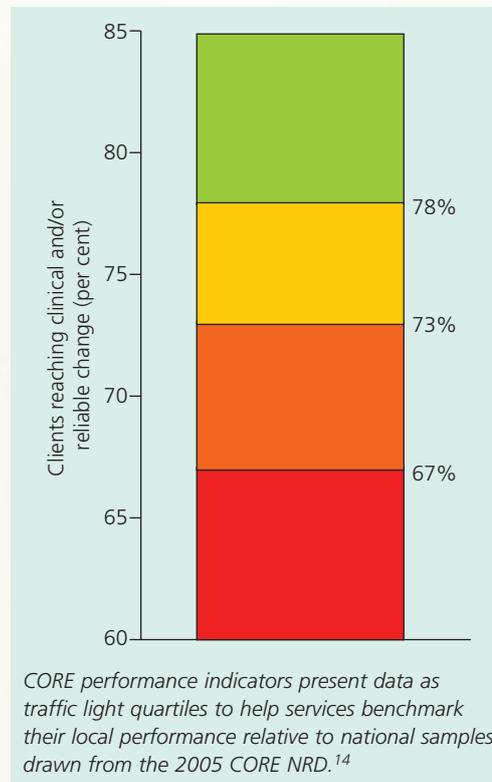
Services that use CORE software are automatically signed up to the CORE user network when they purchase a licence, and are encouraged to adopt a common methodology. This includes induction training for practitioners, data management training for service managers, and adoption of a common

*'CORE forms a routine part of my clinical practice. I also use the graphs at annual reviews of therapy with clients, with my team, with my peer group for supervision and reviews, and this year in my appraisal. As a result, the Psychology Service is taking up CORE-PC across adult specialities, and the Trust is interested in the wider application of CORE elsewhere in its clinical portfolio.'*

Dr Jenny Crisp, Consultant Psychiatrist, North Staffs Combined Healthcare NHS Trust

reporting framework. The report function in CORE-PC offers a pragmatic structure that aligns with the Department of Health’s performance and service quality assessment requirements,<sup>16</sup> and also reflects the client’s journey through therapy. Among the 12 key indicators are: waiting time between referral and first contact, patient intake, therapy duration, client-initiated termination of therapy, clinical outcomes, and risk assessment.

Membership of the CORE user network has a number of significant advantages. Chief among these is that it allows service benchmarking to identify, develop and disseminate best practice in the provision of psychological therapy. Services collectively pool anonymous data to populate a unique national research database (NRD) of practice-based evidence, with a current growth rate of around 75,000 clients per annum. The NRD is used to develop and evolve a set of comparative service quality indicators – benchmarks – designed to help members explore the performance of their own service and of individual practitioners within their service. The benchmarking indices are commonly presented in the form of anonymised, traffic-light ‘thermometers’ (see figure above). The band at the top of the thermometer, profiling the percentage range for services making up the top quartile, is coloured green; subsequent quartiles are sequentially



coloured yellow, amber and red, with red denoting the percentage range for the lowest quartile of services.

Since 2004, CORE IMS, in conjunction with the CORE user network, has begun to develop data sources for the creation of benchmark indicators in specific sectors, including primary care and, workplace and student counselling services.

CORE user network members are also encouraged towards active and open participation in group benchmarking workshops. Thus, the network provides a level of peer support to CORE-using services in keeping with the participatory, ground-up learning ethos that has underpinned CORE since its inception.

## II. Developing and delivering best practice with CORE



### Securing good CORE-OM completion rates

*Kitty McCrea managed the student counselling service at De Montfort University, Leicester. When Kitty first suggested using CORE in 2002, the counselling team were opposed, to the extent of threatening industrial action. Things have improved hugely since the early days, and now final CORE-OM completion rates approach an average of 60 per cent. Kitty explains how she won her counsellors round.*

'I was appointed manager of the student counselling service at De Montfort University in 2001', says Kitty. 'When I was appointed there had been a long history of discontent with the service, both within the counselling team, who felt beleaguered and unsupported, and within the University because of a history of stress and long-term sick leave. The team had had a revolving leadership, an arrangement that was most unsatisfactory from the University's point of view, and there were long waiting lists. The team were operating as private practitioners with no centralisation of record keeping, and were suffering from a lack of management. But although the service badly needed modernising, they were very resistant to change'.

*'I am using CORE as a change management tool. The work of the counsellor is hard to reach in any sense other than anecdotally. With CORE data we can begin meaningful dialogues between team members, counsellors and management about counselling practice. By managing the process to ensure that the data is seen as 'friendly', my hope is that the team will feel able to be curious about its potential as a reflective tool and a platform for research.'*

John Cowley, Head of Counselling,  
Cardiff University and Deputy Chair,  
British Association for Counselling and Psychotherapy

'I decided to implement CORE not because we were under pressure to demonstrate outcomes, but to get a grip on what was happening in the service', says Kitty. 'I saw it as an opportunity to review and revise everything we did, as part of a transformation to a managed service that was accountable and transparent. Unfortunately I was then faced with a collective grievance, which meant that I was unable to fully introduce CORE for a further 12 months. At that point we were operating over two sites, and the smaller campus was happy to start using CORE straight away. For the main site I devised a careful implementation plan which proposed the staged introduction of CORE to allay the team's fears and worries about the new system'.

### CORE roll-out

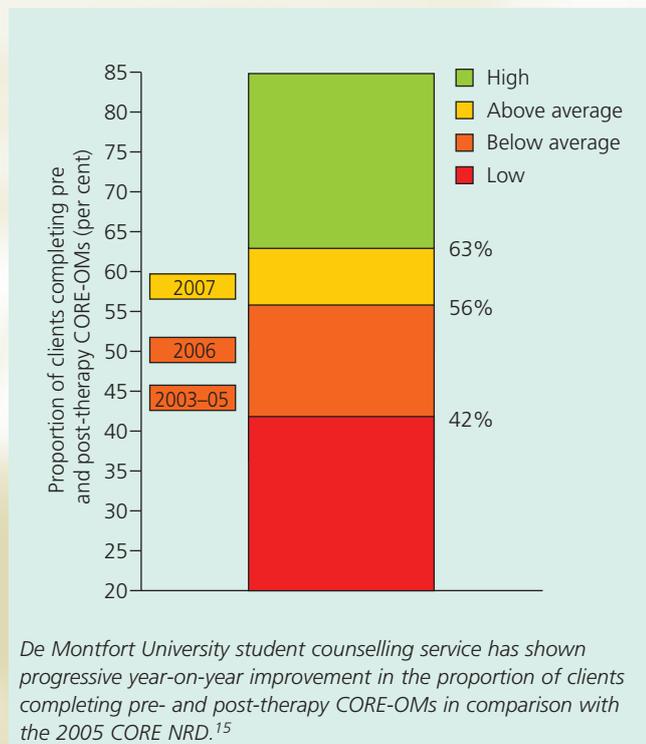
'In autumn 2003 we were able to roll out CORE at the main University campus and start collecting data', says Kitty. 'Initially, it was run alongside an existing data collection system, and all the data was entered by an administrator. In the first year, CORE-OM completion rates were relatively low: 85% pre-therapy and 29% post-therapy completion. This was, I think, due largely to a lack of buy-in by the counselling team, compounded by a

lack of ownership because they were not required to enter their own data'.

'Things started to shift significantly in 2006 after we got CORE-PC networked so that all the counsellors were connected to it and were inputting their own data', says Kitty (see chart). 'The sense of commitment grew as practitioners began to see how therapeutically useful it was with clients – which is what counsellors are really interested in'.

### Transforming the service

'Using CORE has transformed our service', says Kitty. 'We are the one team within the wider group of student services at the University that is able to demonstrate outcomes, which has greatly strengthened our status. CORE has also shone a light on what we do in terms of highlighting the numbers of sessions, unplanned endings, the types of clients we see, and so on. It has helped to eliminate the waiting list, along with a move to brief work, and allowed us to reduce what was a relatively high level of client-initiated terminations. We have also started to be more aware of who we accept into therapy, and have introduced a coaching service for clients who score below the clinical cut-off. I also use CORE as a management tool for assessing and agreeing targets in relation to unplanned



endings and final CORE-OM completion rates for individual counsellors'.

'CORE-OM completion rates for clients who have been accepted into and finished counselling now stand at an average of 58 per cent', says Kitty. 'There has been some staff attrition in that there is only one counsellor remaining from the original team I inherited in 2001. Strangely, they are all men except one, while the reverse was true before. It makes me wonder whether men are more well-disposed towards using CORE, though it's probably a coincidence'.

Kitty McCrea,  
 Manager (2001–07),  
 Student Counselling Service,  
 De Montfort University, Leicester



## Minimising waiting times and maximising effectiveness

*Counselling Team Ltd provides psychological services to the Shepway locality of Eastern and Coastal Kent Primary Care Trust (PCT). The service has consistently demonstrated clinical improvement for over 80 per cent of all clients accepted for therapy – a rate that is double the national average. Belinda Wells, the founder and director, explains how.*

'I started work as a counsellor with an NHS drug and alcohol team', says Belinda. 'It was a dreadful experience, but I learnt a lot about how patients should be treated, teams motivated and services managed differently. When I left I was invited by a local GP service to join them as their practice counsellor, and when fundholding came to an end I was encouraged by the GPs to tender for providing counselling services across a group of eight practices in the Folkestone area. I was competing against an established psychology service who expected to get the funding, and I was amazed that they gave the contract to me'.

'To begin with, I worked in all the GP practices myself to find out the differences in culture between GPs, surgeries, and towns and rural areas. Then slowly I hand-selected my team of counsellors and developed the team. I knew that how it was managed and cared for was crucial to the success of the service, and I allowed it to evolve in an organic way'.

'In October 2006 we won a competitive tender to provide counselling services across a further 11 GP practices, with a start date of 1 January 2007. We recruited six more counsellors and provided intensive training. Some of the new GPs were extremely angry. All they

could see was that they were going to lose their tried and tested counsellors, with their six-month waiting lists. On 1 January we hit the ground running, and by 25 January we had cleared the waiting lists'.

### The value of CORE

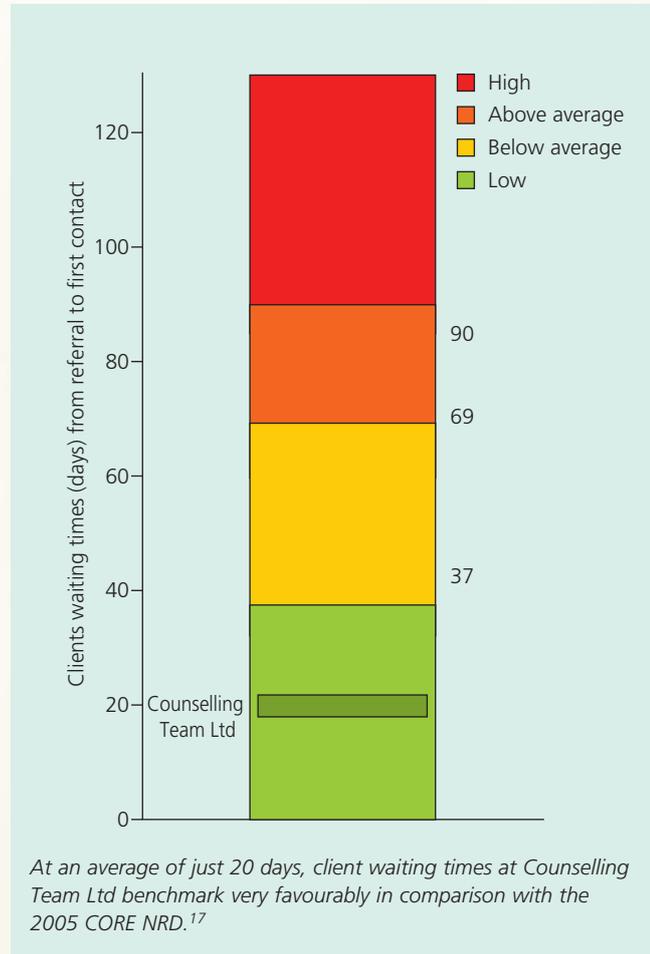
'We offer an initial assessment and up to six sessions of talking therapy', says Belinda. 'All our counsellors use CORE outcome measures at the beginning and end of therapy, and in the middle if there is a need, for example because of risk issues. We use CORE in three ways: clinically with our clients to complement the assessment interview; reflectively, to measure the effectiveness of interventions; and as a management tool to appraise counsellors and develop the performance of the service; for example, to assess the proportion of did-not-attends (DNAs), and identify inappropriate referrals'.

'Practitioners tend to hate CORE to begin with', says Belinda. 'They are often scared, ambivalent, angry, and they don't want to do it. But it isn't a choice – it is part of our service and is integrated fully into all the assessment and end sessions across the team. Once the therapists accept CORE and start to

see the benefits, they love it! There are enormous benefits to using CORE. If we are getting a consistently poor standard of referrals, it provides clinical support in giving feedback to GPs. It allows us to give our PCT commissioners regular, accurate and clear information, which I know has helped them to make up their minds in commissioning our service. It also really helps to get therapists shaped up into practitioners of excellence – we have used it a lot with counsellors who were underperforming, with positive results, and to celebrate counsellors' progression'.

### Minimising the waiting list

'I have an abhorrence of waiting lists', says Belinda. 'If GPs refer people with long-term, diagnosable mental health problems, we will not usually take them for short-term therapy because they are not going to benefit. We do not reject clients out of hand because they have a low clinical CORE score or because they are at risk. We always look first to see if there is something we can do. If we can't take the person on, we will recommend an appropriate way forward, for example, referring an at-risk client to the secondary mental health services, or



someone with long-term difficulties to the voluntary services. GPs aren't used to mental health services saying 'No'. But I have learned that wooliness and lack of clarity about what you're delivering are just not effective. If you truly care about people, you need to deliver something that works'.

Belinda Wells, Director, Counselling Team Ltd

**'Practitioners tend to hate CORE to begin with. They are often scared, ambivalent, angry, and they don't want to do it'.**

Belinda Wells, Director, Counselling Team Ltd



## Reducing DNAs and unplanned endings

*KCA provides psychological therapy services to 160 GP surgeries in East and West Kent. One strength of the service is that the CORE data collection is almost totally complete, with only 1 per cent of the forms incomplete. However, this has made their rate of unplanned endings look high. Over the past year, they have taken a number of steps to address this issue.*

'KCA is a team of 36 counsellors and psychotherapists, providing psychological therapy services in 79 GP practices, and a further 81 practices refer to us', says Service Manager, Jane Hetherington. 'Referrals come by letter from the GPs, and patients are asked to telephone us for a 30-minute assessment appointment, which usually takes place within a fortnight. We then send them a letter with a CORE outcome measure, together with information about counselling, confidentiality and our complaints procedure. We accept about 84 per cent of those referred, to whom we offer brief solution-focused therapy of up to six sessions. All counsellors have attended CBT [cognitive behaviour therapy] training and use CBT techniques as part of therapy,

'KCA has used CORE routinely since 2001, and CORE-PC since April 2006. Thanks to CORE, we offer practice-based evidence, good reporting, and very good stats – the quality of our data is excellent', says Jane. 'CORE allows us to see which clients we can work well with and which we can't, and to look at patterns of referral within the service. The data is also extremely valuable to me as service manager in revealing which counsellors are working effectively and with whom'.

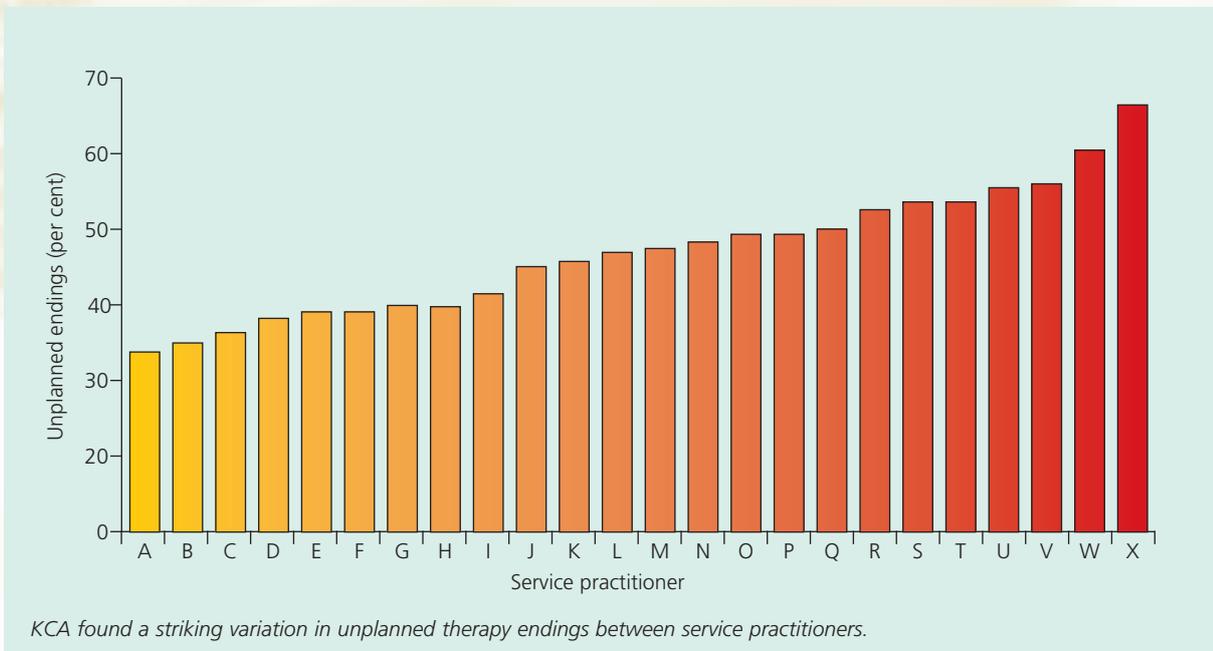
### Interesting findings

'Reducing DNAs depends first of all on taking only clients who are likely to respond, i.e. those who have mild-to-moderate mental health problems, as defined by CORE, and who are psychologically minded, as defined by the Therapist Assessment Forms', says Jane. 'While in the old days we would take everyone, now we are a lot more selective – and in reflecting this back to the GPs, we have gained more respect'.

'Interesting findings emerged as the data started to improve', says Jane. 'We were particularly puzzled by an unusually high rate of unplanned endings compared with the national average, so we asked John Mellor-Clark of CORE IMS to look at this with us. It emerged that unplanned endings were high for two reasons. The first was

*'I am reviewing what constitutes an unplanned ending and will narrow down the definition as far as possible. Ideally it will be limited to client death (except by assassination because that would have been planned by the assassin!).'*

Wendy Jefferson, Counsellor KCA



that the quality of the data was so good in that the type of therapy endings, i.e. planned or unplanned, were recorded for every client. The second was that we were using an over-rigid definition of "unplanned", which included any endings that had not occurred during face-to-face contact with a therapist. We now take a more flexible approach. If there is any contact from a client saying that they do not want to continue, we record that as a planned ending'.

'CORE alerted me to the fact that some counsellors were getting more DNAs than others, and that this needed managing', says Jane. We subsequently tightened up our DNA and cancellation policy – we do not now offer a second appointment to someone who has missed an appointment without notifying us. It also allows us to identify groups who regularly miss

appointments. Younger men are invariably among them, unfortunately – they are a casualty of many services. As a result of the changes we have made, our DNA rate has improved by five per cent over the past six months'.

'Another area in which CORE has been particularly valuable is that of risk assessment, in that it allows us to inform a patient's GP immediately after assessment if the person might need more in the way of secondary care services or other support. We very much regard CORE as a research tool as well as a management tool in the service. Our most recent analyses showed that unplanned endings have remained fairly static over the past six months, so we are now looking at ways of improving these further. We were delighted to see that all our other key indicators improved significantly over the period'.

Jane Hetherington,  
Service Manager, KCA



## Managing risk

*The Kent Staff and Practice Support Service provides support interventions for 13,500 NHS staff working for the Strategic Health Authority, the Mental Health Trust, local primary care trusts and all general practices across the county. CORE data has been instrumental in providing and demonstrating effectiveness and facilitating service development, according to Head of Service, Jan Prior.*

'We faced a number of challenges that were quite specific to providing staff support', says Jan. 'The biggest difficulty initially was having no budget apart from the salaries we were already spending. Resources were limited to the existing staff (one full-time consultant clinical psychologist and three part-time counsellors), and there was no additional funding for accommodation or administrative support. We had to build a business case to attract new customers in order to secure our future. Another danger was of being seen as a luxury in a cash-strapped system. We have had to demonstrate the importance of keeping the workforce in good shape to look after patients. Having CORE data has greatly

helped to convince our commissioners and potential customers'.

'The Staff and Practice Support Service currently has a core team of eight staff, including two clinical psychologists, two half-time counsellors and a mediator, and is based in a dedicated centre. Clients self-refer, and therapy is provided by a team of 50 qualified and experienced affiliates – counsellors and psychotherapists who work from their own premises on a self-employed basis, allowing the service to offer a wide range of interventions, including brief therapy (of up to seven sessions), coaching, mentoring and workplace mediation and facilitation. CORE-OM and therapist assessment forms are routinely completed pre-and post-therapy, and whenever work-related issues are highlighted on these forms practitioners also use the green CORE Workplace Assessment Form to highlight issues of bullying, harassment, high workloads, stress and so on. Payment for the affiliates is linked to the completion and return of the forms, and feedback is provided to the commissioners on a strictly confidential and anonymised basis'.

## Risk management

The Staff and Practice Support Service probably has one of the most thorough



*'CORE is absolutely terrific. After being initially sceptical about more paperwork, I find it extremely useful. It alerts me to clients "saying one thing and writing another", and has given me an invaluable insight into how people are thinking'.*

Jean Keeley, Affiliate Therapist with the Kent Staff and Practice Support Service



and detailed risk management processes in place in the UK, prompted by an unfortunate incident involving one of its clients. 'The service had been developing really well when one day we had a wake-up call that alerted us to the fact that we needed to reassess our procedures for managing risk', says Jan. 'One of our clients had been arrested on suspicion of seriously harming another, and the police became involved. One of the first things we did was to check the CORE score. The form showed that although there was some risk of self-harm, it had not highlighted any risk of harm to others – we had done all we could'.

'Following this incident we put together a formal policy and procedure on risk management which has to be followed with all clients whose CORE scores indicate a degree of risk either to themselves or others', says Jan. 'We run a risk file that includes anyone with a risk score; we run fortnightly management meetings where we discuss clients who are at risk; and our staff also flag at-risk

clients at the end of therapy and follow these cases up with the affiliates. We have also run training days on risk management for our affiliates. There is a real clinical value to the use of CORE in at-risk cases – it is not just a tick-box scheme, but a useful clinical tool which assists us in providing a safer service'.

### Competition

'We are now at a point – with Foundation Trust status on the horizon and the market opening up around healthcare services generally – where we have to compete potentially with big national employee assistance programmes on cost and cost-effectiveness', says Jan. 'We are disadvantaged in terms of size, but having the evidence base puts us in a competitive position in allowing us to demonstrate the effectiveness of the service we provide. CORE is key to this – it's been a main plank in our ability to survive and develop, and will continue to be so over the next few years'.

Jan Prior,  
Head of Service,  
Kent Staff and Practice  
Support Service



## Introducing CORE data into supervision

*ICAS provides well-being and employee assistance programmes (EAPs) globally to more than 900 companies, and is the only European provider to measure the success of counselling and therapy on a session-by-session basis. ICAS is one of just three organisations and the only private-sector company currently acting as a demonstration site for CORE Net. Laura Galbraith, International Operations and Clinical Director, was responsible for bringing CORE to ICAS.*



'ICAS provides a service 24 hours a day, 365 days a year, to its client organisations, representing a million employees and their families', says Laura. 'When an employer buys the service, the employees are entitled to a telephone number, which means that they can access us confidentially at any time. The telephone is answered by a counsellor who is fully trained and mature, someone with life experience as well as strong credentials. This person takes an assessment, and any psychological needs are addressed there and then, after which

a decision is made as to whether further interventions are required and, if so, what sort. It might be face-to-face counselling, online CBT, coaching or practical support, for example legal advice on a divorce or information on debt management'.

'We take about 7000 client calls a month, with 10,000 clients going on to face-to-face counselling in a year', says Laura. 'This means that on any one day we are managing 2000 people in counselling in the UK'.

'The counselling service is provided by 750 affiliates – counsellors, psychotherapists and psychologists who work independently on a contract basis, many in remote locations', says Laura. 'We provide counselling within half an hour's travel of the employee's workplace or home. The wide geographical spread of our client organisations, along with the fact that we don't see our affiliates, means that a key challenge for us is to know and be secure about the type of service we are providing remotely. Network management is a key element of our quality control'.

### Ensuring quality

'Part of my role when I joined ICAS was to review outcome measures for the quality of counselling', says Laura. 'We

thought about developing a bespoke package, but decided to use CORE, largely because of the benchmarking element, which would allow us to demonstrate the quality of the work we do in an increasingly sophisticated market – and provide us with a means for monitoring and maintaining continuous improvement'.

Following a successful pilot of the system in Strathclyde, ICAS began to roll out CORE throughout the UK. 'We were careful with the roll-out in terms of providing training workshops to our affiliates in using CORE and giving good support', says Laura. 'We lost a few people, but largely because of the technology'.

'The case managers provide the quality control element of our service', says Laura. 'One of their functions is to help

the affiliates to see the organisational perspective, especially when this involves helping employees to return to work from absence. Another is to use CORE data alongside direct telephone contact to provide a window on the work of individual practitioners, and thereby maintain and improve service provision. It is not the same as clinical supervision – though we require our affiliates to have clinical supervision. It is about managing the service to become more efficient and effective because we have an evidence base'.

'Case managers also provide a mentoring role to a section of our affiliate networks via the use of CORE Net', says Laura. 'We plan to introduce this across the whole of the service as soon as we feasibly can'.

Laura Galbraith,  
International Operations  
and Clinical Director, ICAS

***'I am an unashamed enthusiast of CORE, having been introduced to it when working as a counsellor in a consortium of NHS GP practices in the East End of Glasgow in 2000. So I was very pleased when ICAS decided initially to pilot the system with one of our key EAP clients in Glasgow, and even more pleased when, as a result of the success of the pilot exercise, the decision was taken to roll out the service to the whole of the EAP'.***

Laurence Herbert, Case Manager, ICAS

### III. Researching best practice with CORE



#### Using CORE to profile therapy effectiveness

*Michael Barkham was the project lead on the design of the CORE-OM, and has published widely on its psychometric properties, applications in practice and the paradigm of practice-based evidence. Here he comments on the rationale behind developing CORE and its role in profiling therapy effectiveness.*

'I trained as a clinical psychologist, and went to work as a scientist for the Medical Research Council in Sheffield, where I carried out comparative trials of psychological therapies', says Michael. 'However, I became increasingly aware of the limitations of this method as a route to bridging the scientist-practitioner gap, and of the need to carry out research in real-world settings. So I went to the University of Leeds as principal investigator on successive grants from the Mental Health Foundation, which funded the development of CORE-OM'.

'We spent the first two years developing the outcome measure, with a team that included Chris Evans and Frank Margison', says Michael. 'John Mellor-Clark later took the leading role in the implementation phase – which was about getting the measure adopted as widely as possible'.

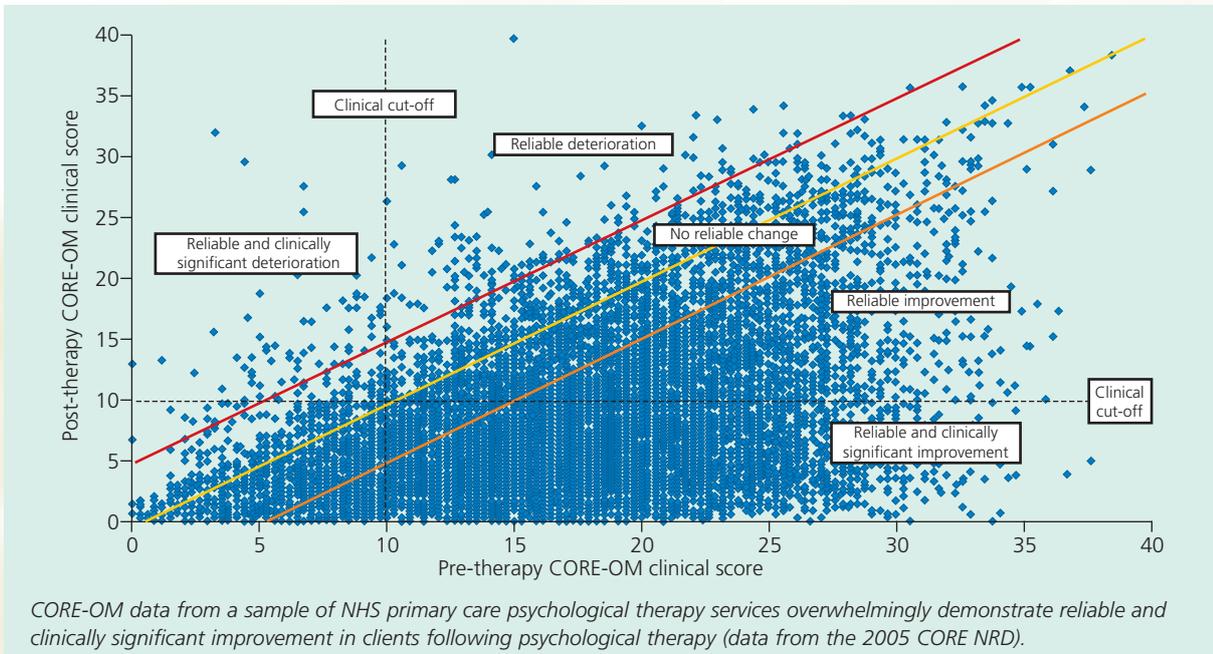
'Our rationale in developing CORE was to find a simple user-friendly measure that could be adopted by practitioners of all persuasions as a common instrument for the widespread collection of data in routine care', says Michael. 'Before CORE, practitioners used diverse measures for historical reasons, often not knowing why they were using them. The information they produced was fragmented and lacked the potential to

develop a body of knowledge on effectiveness. We wanted to develop a common metric that would capture the vast majority of what people would recognise as psychological distress, whatever approach they took: psychoanalytical, behavioural or humanistic'.

#### Multiple impacts

'The CORE-OM has a number of features that make it appealing to practitioners, not least the fact that we elicited information from practitioners as to what kind of items should be included', says Michael. 'People who had not used a measure before adopted it because it was free, UK-based and – crucially – supported by an infrastructure. A lot of services that were already using the Beck depression inventory (BDI) also migrated to CORE because it saved them a lot of money'.

'We published a series of papers on the psychometric properties of CORE', says Michael.<sup>1,6,7,11,12,18</sup> The first of these presented the rationale underlying the need for a core outcome battery in the psychological therapies'.<sup>1</sup> 'Another summarised the development and psychometrics of the CORE-OM, and presented the first example of its use in



benchmarking service data.<sup>7</sup> This remains our most cited publication'.

'We have produced a stream of papers about the application of CORE in clinical practice.<sup>11,19-21</sup> One study, led by Bill Stiles, showed that the phenomenon of sudden gains (i.e. substantial gains between adjacent sessions) occurs at a lower incidence in routine practice than in clinical trials.<sup>19</sup> Another, which assessed the appropriateness of the CORE-OM and short-form CORE-A measures for determining the severity of presenting problems, showed that the only differences between the profiles of people presenting to primary and secondary care services were the higher levels of risk and the duration of problems among those in secondary care.<sup>11</sup> We also showed that although CBT has a numerical advantage over

person-centred and psychodynamic therapies in NHS settings, the advantage is small when compared with the overall changes across treatment'.<sup>20</sup>

'We continue to argue the case that we need evidence from trials and routine practice,<sup>22</sup> and that both paradigms – i.e. evidence-based practice and practice-based evidence – can inform each other to yield a more robust knowledge base', says Michael. 'CORE is now being included in randomised controlled trials, which is a key indicator of impact. Another indicator is that it has emboldened service managers and practitioners to present on the effectiveness of their service. For me, the paradigm of practice-based evidence is paramount, with the CORE system being far and away the best measurement system for delivering on that agenda'.

Professor Michael Barkham,  
Director,  
Centre for Psychological  
Services Research,  
University of Sheffield



## Developing service quality through CORE

*John Mellor-Clark has been a leading player in the development and deployment of the CORE System, and in the production of benchmarks that allow services to reflect on their personal strengths and weaknesses. The idea that service quality could, and should, be developed through research has been a prime motivator.*

'I trained as an organisational psychologist', says John. 'I went to work initially in the voluntary sector with Relate, where I implemented practitioner evaluation for counsellors and a service evaluation system for managers. In 1995 I moved to the University of Leeds, where I was tasked with designing a standardised evaluation system, first for the local community mental health trust and then nationally for counselling in primary care – a project supported clinically by the Counselling in Primary Care Trust (CPCT), and financially by the Artemis Trust'.

'Gradually I became disillusioned with evaluation, or, more specifically, with the split between research and practice', says John. 'Few practitioners, managers or

policy makers read such research, as it seemed of little relevance to their work. So I identified an academic course concerned with quality assurance in health care, which helped me to reframe the values and potential of evaluation. Shortly after graduating I left the University of Leeds to explore changing and modifying evaluation to bring it closer to routine practice.

'The Mental Health Foundation funded the research and development of the CORE-OM originally', says John. 'This involved a survey of commissioners and providers to inform the design.<sup>2</sup> The system officially became CORE at its launch meeting in June 1998. Subsequently, I teamed up with



**'By taking what researchers did with data and building it into a computer program, the CORE software allowed managers and practitioners to do the analysis for themselves'.**

John Mellor-Clark, Director of CORE IMS

Alex Curtis-Jenkins to design the first version of CORE-PC, which we launched in June 2001, along with the publication of the first large-scale CORE System outcomes paper,<sup>10</sup> which offered a profile of therapy provision and effectiveness in a sample of over 3000 clients'.

'Since 2001 we have provided licences to over 450 services in the UK, which have been used to collate data for one-third of a million clients', says John. 'Some of the licence holders are one-off users, but 250 services renew their licences annually. This has allowed us to generate NRDs, and in turn to benchmark service quality'.

'The development of the CORE system has represented a paradigm shift in service evaluation', says John. 'Prior to CORE, psychologists tended to use a variety of psychometric instruments to assess outcomes; counsellors and psychotherapists used a range of satisfaction-style questionnaires; and evaluation was largely the province of academics. By taking what researchers did with data and building it into a computer program, CORE software allows managers and practitioners to do the analysis for themselves'.<sup>23</sup>

'Prior to CORE, there was a paucity of academic research on organisational variables associated with psychological therapies delivery', says John. 'The CORE system has changed this by asking questions of service delivery that are less clinical and more organisational. By creating a large network of services that use the same tools to record and capture data through CORE-PC, we now have performance indicators that enable services to confidentially benchmark their service quality.<sup>24</sup>

'Publication of the special issue of *Counselling and Psychotherapy Research* in March 2006<sup>14</sup> was the first time that the therapy room door had been opened widely and transparently enough to raise the issue of differences – not only between services but also between practitioners within those services', says John. 'CORE has taught us that there are significant challenges to delivering a good psychological therapy service, and that some people are better than others at meeting those challenges'.

John Mellor-Clark,  
Director, CORE IMS



## Using CORE to research outcome measurement

*Chris Leach and Mike Lucock have been involved with CORE from its beginning. Jointly responsible for the development of one of the first large databases of the use of CORE in routine clinical practice, they have published a number of key papers looking at the relationship between CORE and other outcome measures, and its use to track client progress during therapy.*



'From the early 1990s, the services I worked in always attempted to monitor clinical outcomes, and in about 1996–97 we began using CORE-OM as well as the Beck depression inventory (BDI), Beck anxiety inventory (BAI) and the short-form inventory of interpersonal problems (IIP-32)', says Mike. 'This involved using the measures at referral, assessment, the beginning of therapy, at discharge and six-month follow-up. I presented the work at the CORE launch conference in 1998'.

'Soon after the launch we were successful in securing a Yorkshire Health Authority R&D grant to investigate the prediction of client progress during therapy at our service in Wakefield', says Mike. 'This involved using short versions of the CORE-OM at every session. It was difficult to get the staff on board, but we managed to run the system for two years and generated a large database of clients<sup>25</sup> with sessional CORE-OM data, which has since been utilised in collaborative studies with researchers in the USA and Switzerland.

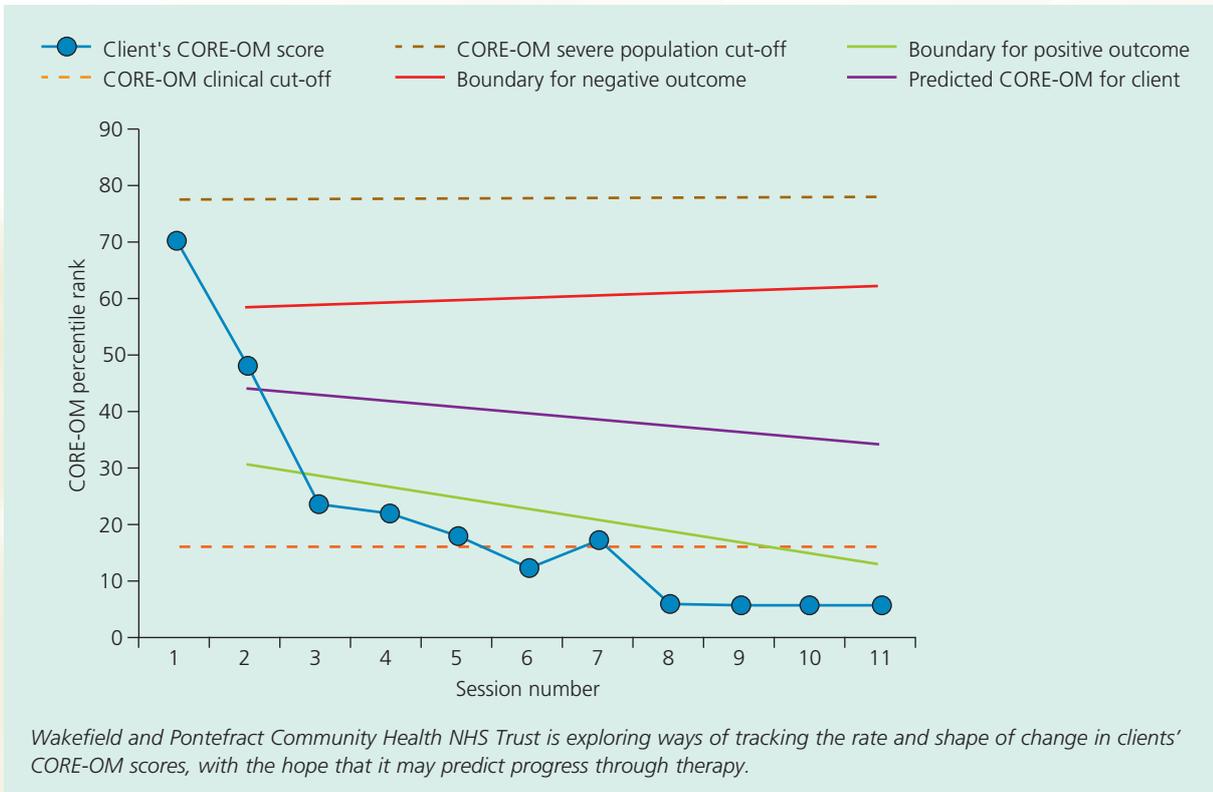
### CORE and other measures

'We have since published on the use of the CORE-OM in routine psychological therapy services, generating practice-based evidence and investigating its

relationship with other measures, particularly the BDI and the Health of the Nation Outcome Scale (HoNOS)', says Mike. 'A 2006 study led by Chris found a high correlation (0.86) between the CORE-OM and BDI in a sample of 2234 clients.<sup>26</sup> This led to the development of tables for transforming between the measures, which, in turn, allowed for the comparison of research studies and benchmarking of service outcomes using the two measures'.

'We have also studied the relationship between CORE-OM and the HoNOS scale in assessing risk and emotional disturbance in a group of 315 clients in primary care', says Mike.<sup>26</sup> 'Our analysis revealed a weaker overall correlation than with the BDI (0.5). However, the six-item CORE risk scale showed a stronger correlation with HoNOS risk items (0.57), supporting the use of CORE as a brief self-report measure of risk'.

'We have a continuing interest in being able to predict the rate and shape of change in therapy based on the characteristics of clients (e.g. gender and pre-treatment scores) and the type of therapy employed', says Mike. 'A 2005 study using the database of CORE-OM measures developed in Wakefield described new methods of tracking client



progress by comparing individual clients with previously treated clients who closely match them.<sup>27</sup> This "nearest neighbour" approach proved superior to an alternative method in predicting the rate of change over the course of therapy. For the future we would like to see if it is possible to use this approach to predict likely progress for different types of client'.

'As well as using CORE to identify research questions, we have also used it to develop and evaluate our service in Wakefield, and have published on how the system is integrated into service provision and used to feed information

back to clinicians, managers and commissioners', says Mike.<sup>25</sup> 'And we have recently used the CORE-OM in two controlled trials of guided self-help interventions provided by graduate mental health workers, one of which has just been completed'.

What have we learned from CORE? 'That a compact generic measure can be used at various stages in therapy to track progress', says Chris. 'That filling in questionnaires every session is perfectly possible', says Mike. 'And not to use too many measures, particularly the BDI and CORE together. There's no point in filling in two questionnaires when one will do'.

*Professor Chris Leach,  
Consultant clinical psychologist,  
South West Yorkshire Mental  
Health NHS Trust,  
and Visiting Professor,  
University of Huddersfield and  
University of Leeds*

*Professor Mike Lucock,  
Director of Psychological  
Research in the South West  
Yorkshire Mental Health Trust,  
and Professor of Clinical  
Psychology within the  
Department of Health and  
Social Studies at the  
University of Huddersfield*

# IV. CORE: the next decade



## Translating CORE tools for wider application

*Translation of the CORE-OM started in 2001 with Norwegian (Bokmål). We now have translations into Slovak, Italian, Swedish, Icelandic, Albanian, Greek, Dutch, Gujarati, Welsh and Kannada, a South Indian language, writes Chris Evans.*

The translation of CORE tools has been conducted without formal funding, simply by linking with interested and generous people. We require at least three independent translations by native speakers of the target language who are fluent in English. At least one must be a professional translator or interpreter, one a mental health professional and one a lay person. For some languages we have had 10 forward-translations that all differed! I meet with the translators to review all options, and we reach a penultimate draft, which they talk through with older

and younger people and identified minorities. For example, for Welsh we considered North/South differences, and for Dutch we considered how Flemish people would find the draft. We incorporate this information, get a check back-translation and reach a final version. We are currently producing translations for all CORE-OM derivatives as PDFs. Translations into Spanish, Portuguese, Sami, French, German, Kurdish, Polish, Arabic, Turkish and, hopefully, Mandarin, Japanese, Tamil and other Indic languages will all be completed in 2008.

Greek translation of the CORE-OM

**Importante - da leggere prima della compilazione**  
Questo questionario contiene 24 affermazioni che possono descrivere come si è sentito nel corso dell'ULTIMA SETTIMANA. Legge ogni affermazione, cercando di ricordare quante volte si è sentito così negli ultimi 7 giorni. Segna quindi la risposta che più si è avvicina. La preghiamo di usare una penna (non una matita) e di segnare il modo chiaro le caselle.

**Nell'ultima settimana**

- 1 Mi sono sentito terribilmente solo e isolato.
- 2 Mi sono sentito triste, ansioso e nervoso.
- 3 Ho sentito di avere qualcuno a cui rivolgermi per ricevere un sostegno quando ne ho avuto bisogno.
- 4 Mi sono sentito a posto con me stesso.
- 5 Mi sono sentito completamente privo di energia e di entusiasmo.
- 6 Sono stato violento fisicamente verso altre persone.
- 7 Mi sono sentito incapace di adattarmi in caso di difficoltà.
- 8 Sono stato disturbato da malumori, dolori o altri problemi fisici.
- 9 Ho pensato o fatto del male.
- 10 Non ho avuto la forza di parlare con le persone.
- 11 La tensione e l'ansia mi hanno impedito di fare cose importanti.
- 12 Sono stato contento per le cose che ho fatto.
- 13 Sono stato disturbato da pensieri e stati d'animo indesiderati.
- 14 Ho avuto voglia di piangere.

Si prega di voltare pagina

**Nell'ultima settimana**

14. He proevt passief te worden.
15. He probeert de motoren te stoppen.
17. Ik voel me niet profiteren van mijn problemen.
18. Het is moeilijk om mijzelf te ondersteunen en te motiveren.
19. He probeert iemand te raken of te pijnigen.
20. Het is onmogelijk om mijn problemen te stoppen.
21. Ik ben niet in staat om de meeste problemen te stoppen die ik ervaar.
22. He bedreigt of intimideert iemand.
23. Ik voel me alleen en zonder hoop.
24. He denkt: "Het zou beter zijn om te sterven".
25. Ik voel me kritiek van anderen.
26. He denkt van niet aan vrienden.
27. Ik voel me onzeker.
28. Ik ben vaak lastig voor anderen en verlang naar aandacht.
29. Ik voel me irritant en heb moeite met anderen.
30. He denkt dat hij niet de oplossing van zijn problemen en de moeilijkheden is.
31. Ik voel me onzeker voor de toekomst.
32. He doet dingen die hij niet wil.
33. Ik voel me onzeker en heb moeite met anderen.
34. Ik voel me niet in staat om mijn problemen en de moeilijkheden te stoppen.
35. Ik voel me vaak onzeker en heb moeite met anderen.

Grade del tempo dedicato a compilare il questionario: [ ] → [ ] → [ ]

Punteggio totale: [ ] + [ ] + [ ] + [ ] + [ ] + [ ] = [ ]

Punteggio medio: [ ] / [ ] = [ ]

Punteggio medio (per numero di items compilati): [ ] / [ ] = [ ]

Italian translation of the CORE-OM

Our methods provide excellent translations into lay language. The CORE tradition that the paper versions can be copied free of charge provided that they are not altered in any way means that they are used as services want – which varies with the nature of services in different countries. We are now starting

to work with groups in Norway and the Netherlands to see how CORE IMS software might be adapted and translated for them. We have real aspirations that the CORE system will become a truly international, multilingual phenomenon over the next decade, developing from the platform of this early work.

*Professor Chris Evans, Consultant Psychotherapist and Research Programmes Director, Nottinghamshire Healthcare NHS Trust, and CORE System Trustee*

**‘We have real aspirations that the CORE system will become a truly international, multilingual phenomenon over the next decade.’**

Professor Chris Evans, Consultant Psychotherapist and Research Programmes Director, Nottinghamshire Healthcare NHS Trust, and CORE System Trustee



## Managing therapy outcomes with CORE Net

*In January 2006, five practitioners from a primary care counselling service within Sussex Partnership NHS Trust began to help trial and develop CORE Net – a new multi-measure client tracking and clinical decision support system, write Geoff Mothersole and Tony Jordan.*



The aim of the CORE Net trial was to help develop an internet-based version of CORE that would allow therapists to capture outcome measures at every session and use these to help enhance their practice. The CORE questionnaire is completed online by clients during their sessions, and the results are displayed immediately for discussion between therapist and client. The challenge was to come up with a system that would elegantly integrate technology and outcome measurement with the art of therapy in such a way as to complement the therapy.

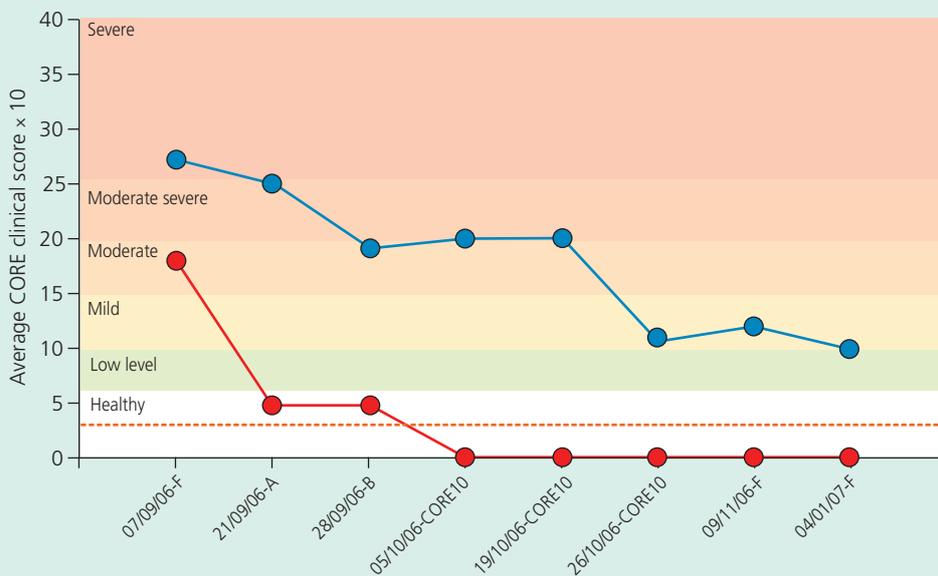
Five counsellors volunteered to take part in the development trial, which started in late 2005. The first issue to be addressed was how to introduce the system into clinical work. Counsellors had experience of using paper versions of the CORE-OM, but now

needed to manage a process in which clients completed the measure on a laptop and received an immediate presentation of the results. Fortunately, our concerns that clients might find the process unhelpful seemed groundless, as a feedback question that we built into the system showed that the vast majority felt positive about being asked to complete the measure. These results compared well with the feedback we had gathered over years using the paper version.

The next issue to be resolved was the form of the feedback. Perhaps the key feature as far as clients are concerned is the graphical representation of scores. The development of the display (shown opposite) is a nice example of the circular, ground-up process that has characterised the development of the CORE system.

*‘CORE Net provides an exciting real-time insight into our work. The system opens up the possibility for routine measurement to play a role in shaping work that is underway’.*

Dr Geoff Mothersole, Head of Primary Care Mental Health,  
Sussex Partnership NHS Trust



CORE Net progress tracking offers feedback to both GP and patient on improvement and recovery. The blue line displays the psychological distress score. The red line represents the risk score, and the dotted red line the clinical cut-off for risk.

A year and a half into the pilot, there is strong agreement that CORE Net can integrate well with practice to provide valuable clinical feedback *during* therapy, rather than waiting until the end. There are now data from more than 600 clients in the database, and the system is about to be rolled out across all psychological therapy services within the Sussex Partnership Trust.

Several key benefits of CORE have emerged. First, the success in providing practitioners with a useful clinical tracking tool, and in particular with a visual indication of progress (see chart above). Second, the ability for practitioners to manage their own database of cases to

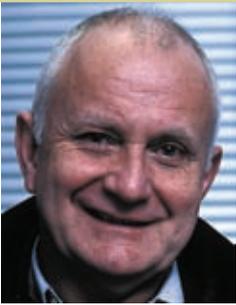
monitor and reflect on ongoing work.

Third, the client is provided with a standardised external reference of their emotional state, and participates in interpreting what it means for them. Fourth, service managers are provided with a far more accurate picture of service performance because the old problem of missing 'post' measures is effectively overcome. Finally, there is an opportunity for researchers to study outcome data captured *through* the process of therapy.

CORE Net in effect means that patients' mental health can be charted over extended periods, and the relative effectiveness of different treatment options easily evaluated.

Dr Geoff Mothersole,  
Head of Primary Care Mental  
Health, Sussex Partnership  
NHS Trust

Tony Jordan,  
primary care counsellor,  
Sussex Partnership NHS Trust



## Using CORE Net in general practice

*A single CORE-OM assessment is probably no more informative than a questionnaire in a women's magazine, writes GP Al Thompson. Keeping CORE in a cupboard is of even less value.*

I have been using CORE Net for the past 15 months, which has generated data on over 200 patients and 1000 assessments. The two sentences above summarise my year's learning.

GPs are currently asked to complete a validated mental health assessment for each patient they consider to be depressed. This is part of the GP payment scheme known as the Quality and Outcomes Framework (QOF), in which mental health measurement is a target, and the PHQ-9 is probably the most widely used GP mental health assessment tool.

Having serendipitously discovered CORE Net in planning a GP education session, this appeared much simpler. CORE Net is a validated mental health assessment tool that supports on-screen completion of CORE measures with a patient, and gives an

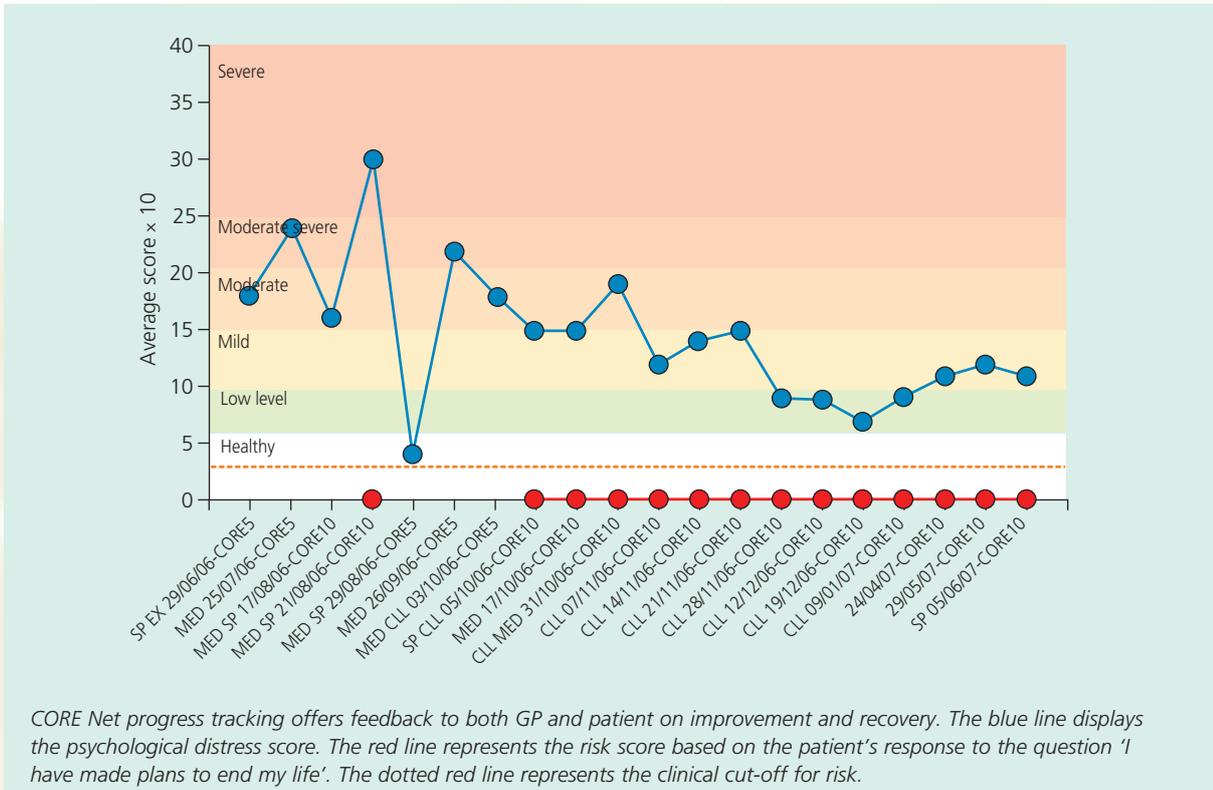
automatic presentation of risk and severity scores. Previous assessment scores and other information are included. The patient sees not only how ill they are that day, but how they progress with repeated scoring.

*Best practice in managing risk*, a Department of Health document from June 2007, describes how clinicians have moved from assessment as clinical hunch, through actuarial (number-generating) assessments to structured clinical assessment, which is how we use CORE-10. The 10 questions (shown below) form a structure on which we can expand our clinical assessment of a patient and begin to construct a management plan.

A high score on question 6 ('I have made plans to end my life') suggests hospital referral. A high score at question 10 (about unwanted memories or images) suggests a particular issue that may respond to

Over the last week...	Not at all	Only occasionally	Sometimes	Often	Most or all of the time
1 I have felt tense, anxious or nervous	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
2 I have felt I have someone to turn to for support when needed	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
3 I have felt able to cope when things go wrong	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0
4 Talking to people has felt too much for me	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
5 I have felt panic or terror	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
6 I made plans to end my life	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
7 I have had difficulty getting to sleep or staying asleep	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
8 I have felt despairing or hopeless	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
9 I have felt unhappy	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
10 Unwanted images or memories have been distressing me	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
<b>Total (Clinical Score*)</b>					<input type="text"/>

The CORE-10 questions



counselling. High scores on questions 1 or 7 suggest the use of self-help booklets or perhaps exercise to relieve stress or sleeplessness. High scores in response to other questions may suggest the use of CBT or social remedies. So with the combined use of CORE-10 and CORE Net, we have an expert support system that not only informs clinicians but also helps patients gain insight into their problems.

The move from a paper CORE assessment to the CORE Net web-based trajectory graph as an expert resource moves my practice into the 21st century. So let's stop using our cupboards as repositories for CORE information and start letting technology help us to share this information with those who may value it most – our patients!

Dr Al Thompson,  
GP, Wigan

**‘With the combined use of CORE-10 and CORE Net we have an expert support system that not only informs clinicians but also helps patients gain insight’.**

Dr Al Thompson, GP, Wigan



## Routine CORE measurement as a skills framework

*CORE IMS training has designed a set of best practice competences to optimise the use of CORE tools and data for practitioners, managers and services, writes Head of Training, Barry McInnes.*

Because the results of ongoing CORE national benchmarking research continue to demonstrate significant differences both between practitioners and between services in CORE data quality and utilisation, CORE IMS training has started promoting a set of best practice measurement competences that are allied with nationally recognised guidelines on implementing outcome measurement.<sup>29</sup> The three developmental stages of the best practice measurement competences and their specific aims and objectives are highlighted in the diagram opposite.

Development of the CORE skills set is informed by ongoing action research focused on identifying best practice in the introduction of routine measurement. This work is helping to resource an exciting new framework that comprises over 30 specific (CORE) skills, ranging from successful ways of introducing CORE-OM to clients through to developing effective

and efficient management skills to repair ruptured alliances.

Both individuals and services that use CORE should benefit from this framework in a range of ways, including:

- continuing development of service quality through quality evaluation
- recognition and development of the range of practitioner/service skills inherent in effective and efficient routine outcome measurement, monitoring and management
- being able to compare personal /service CORE use with empirically supported best practice
- enhanced potential to be able to train new practitioners more efficiently
- development of the capacity to identify local and national examples of excellence in specific aspects of CORE data use to resource management, supervision and mentoring for continuing professional development.

***‘Ongoing research focused on identifying best practice in the introduction of routine measurement is helping to resource a new framework that comprises over 30 specific (CORE) skills’.***

Barry McInnes, Head of Training, CORE IMS

Best use of CORE tools for outcomes measurement

Obtain high levels of initial CORE-OM from clients at assessment/intake to help inform safe and appropriate service delivery

Secure complete and high quality contextual data from the CORE Therapy Assessment and End of Therapy Forms to help resource outcome/s interpretation

Best use of CORE data for outcomes monitoring

Utilise computerised data management tools to help produce regular reports for routine feedback to stakeholders in service commissioning, management and development

Benchmark key service performance indicators such as waiting times, case mix, risk management, client initiated termination, and clinical effectiveness with national resources to help profile and develop service quality

Best use of CORE data for best outcomes

Introduce individual performance appraisal as routine practitioner feedback to help resource continuous professional development in key service quality areas

Introduce session-by-session measurement with CORE-10 or CORE-5 to provide routine client feedback and the potential for maximising clinical effectiveness

CORE best practice measurement competences

Barry McInnes,  
Head of Training, CORE IMS



## Developing service performance by benchmarking

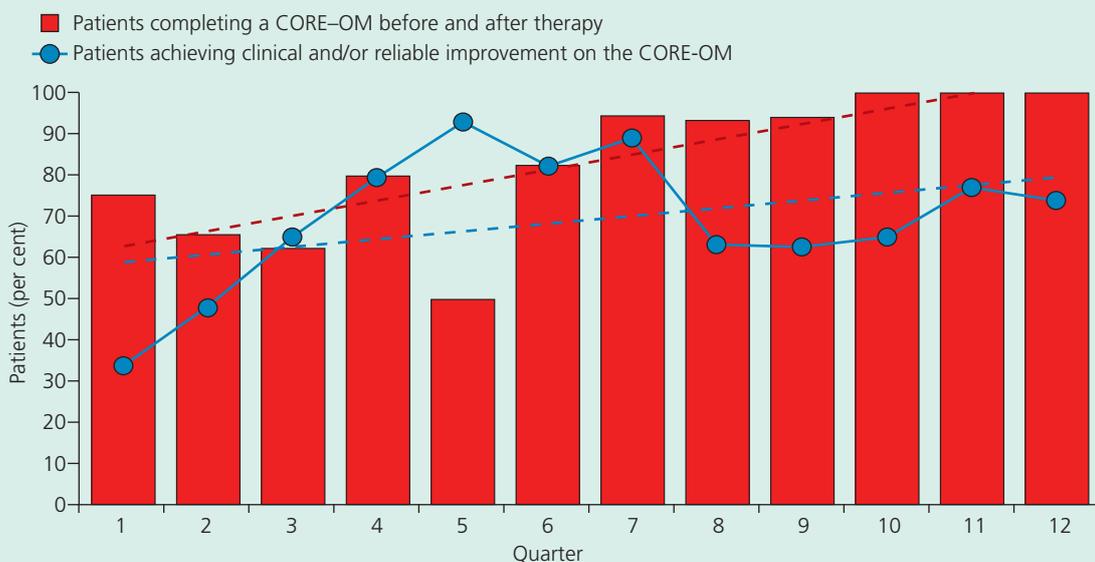
*There are good reasons for The CORE Partnership to remain committed to the continuing development of benchmarking resources over the coming years, writes Richard Evans.*

Benchmarking makes a positive difference to service engagement in routine measurement because it offers something to measure service quality against. The contributors to Section II, who profile their development and delivery of best practice, we're able to do so because they can confidentially benchmark their service performance against a unique set of national service quality indicators. This is possible only because services donate their anonymised data to allow CORE IMS to develop a range of NRDs.

We have growing evidence that the availability of benchmarks is aiding the

development of national service quality. We have found that managers can most effectively monitor service quality by tracking quarterly performance on the twin indicators of percentage clinical improvement and percentage of patients having measured endings.<sup>30</sup> Moreover, while in the early days it might have taken services up to three years to reach rates of 70 per cent measured endings, more recent CORE users are achieving these levels within little more than a year – with the best now demonstrating over 90 per cent measured endings and 80 per cent of patients recovered or improved (as shown below).

*Richard Evans, CORE System Trustee*



*Our analysis shows that managers can most effectively monitor service quality by tracking quarterly performance on the twin indicators of percentage clinical improvement and percentage of patients having measured endings. The dotted lines show the overall respective trends. (Data from the 2005 CORE NRD)*

## Application of CORE methodology in the Netherlands

*The Department of Health in the Netherlands is in the process of transferring the provision of health care to private healthcare insurance companies. CORE has considerable potential to promote the development of better mental health care in this context, writes Henk Maasson.*



Mental health care in the Netherlands is in the process of shifting from being government financed to being paid for by healthcare insurance companies. Determining and demonstrating the cost-effectiveness of interventions is thus increasingly important. It was in this context that fellow psychotherapist Peter Coppoolse and I founded the organisation Mentaal Beter ("Better mental health"), seeing an opportunity to organise and facilitate private practice and encourage transparency and accountability in service delivery. Mentaal Beter believes that mental health care can be provided better, faster, more cheaply and more effectively, with greater satisfaction for patients, professionals and purchasers.

In an effort to further the concept of transparency, in March 2007 Mentaal Beter organised a conference on therapy outcomes monitoring together with Erasmus University. The CORE System was among the monitoring systems presented. Mentaal Beter was impressed with the simplicity of the measures, the enormous amount of data collected, and the potential of the system to promote service improvement and individual practitioner development. It was easy to see how CORE had the potential to speed up the development of Dutch mental health care

within five or ten years, since data on effectiveness could be collected across treatments, practitioners and services, and for individual patients. The planned use of CORE in the Netherlands should open the private consulting room door and allow a transparent measurement culture that benefits all.

Mentaal Beter will implement the CORE System in 2008. We believe that the use of CORE over the coming years will quickly help to realise our ambition to organise and facilitate innovative and transparent mental health care in a socially responsible manner.

*Henk Maasson, CEO,  
Mentaal Beter, the Netherlands*

***'It was easy to see how CORE had the potential to speed up the development of Dutch mental health care within five or ten years.'***

**Henk Maasson, CEO,  
Mentaal Beter, the Netherlands**





## Key points

**N**HS policy documentation over the last decade has given psychological therapy services a consistent message that routine outcome measurement is critical for the local and national development of high quality patient care.

**H**owever, the use of outcome measures alone is not enough to develop service quality. Typically, fewer than half of all clients referred for therapy have pre- and post-therapy measures to inform clinical effectiveness profiling. Such findings highlight the imperative for outcome measures to be supported by appropriate training to help secure practitioner engagement and develop measurement skill, and complementary data to provide a context for understanding patients' journeys through therapy services.

**B**y working closely and intensively with provider services, CORE IMS has developed unique expertise and insight into the critical resources required by practitioners and services to meet the increasingly sophisticated requirements of outcome measurement, monitoring, management and benchmarking advocated by the National

Institute for Mental Health in England (NIMHE) *Outcome Measurement Implementation Best Practice Guidance*.

**D**eveloping benchmarks to resource best practice guidance, and then working with services to introduce and develop them, has taught us that there are a variety of different ways to organise and deliver services – and that some clearly produce better benchmarked service quality profiles than others.

**I**n a context in which there are fewer than a handful of books on managing psychological therapy services, and where professional bodies at present offer little in the way of service management and development guidance, it seems vital to continue to identify demonstrable best practice, document it, and pass it to others who clearly have the potential to benefit.

**S**uch activity will continue to be the strategic imperative of the CORE Trustees and CORE IMS as we continue to work in partnership to sustain and resource CORE System users on their journey towards developing therapy excellence.

*John Mellor-Clark  
Director, CORE IMS*

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*'CORE has proved to be an excellent tool for individual supervision, for team building and for making the department feel part of the wider community of psychological therapies'.*

Dr Stewart Grant, Consultant Clinical Psychologist and  
Head of Adult Mental Health, Dumfries and Galloway Health Board

*'Using the client-completed CORE-OM has encouraged me to be more reflective more often about my clients. When I see the client's OM answers just before I am due to meet them for the first time, I am curious to know why they rate themselves as they do. When I am in session with a client, I reflect on their written numeric answers in conjunction with my experience of their verbal and physical presentation. Finally, when I am inputting their scores after the session, I often notice aspects of their voice that perhaps I have missed, and resolve to find out more next time'.*

Nic Streatfield, Counsellor, University of Manchester Counselling Service

*'CORE is integral to how StaffCare delivers its service. It underpins the ethical governance and is at the heart of all aspects of service delivery: individual case management, risk management, effective delivery, audit of practice, and benchmarking progress internally and against national comparative data. CORE yields high quality and meaningful data to be offered back to the commissioning organisation, thus feeding into preventative programmes that help improve the working experience of the employees we serve. CORE enables me to demonstrate unequivocally the raison d'être of the StaffCare counselling service'.*

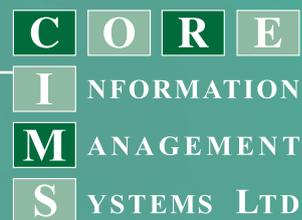
Dr Hadyn Williams, Clinical Manager, StaffCare, Birmingham City Council

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