CORE SYSTEM USER MANUAL

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SECTION A

CLINICAL
OUTCOMES in
ROUTINE
EVALUATION

INTRODUCTION
to
THE CORE SYSTEM

The CORE System: A Summary

The CORE System Group [CSG] have been working for nearly 4 years to develop, pilot and implement a co-ordinated quality evaluation, audit and outcome benchmarking system for psychological therapy services. This has involved working closely with a range of stakeholders groups representing psychiatry, psychotherapy, clinical psychology, and counselling. The CORE System comprises three components, which act as the standardised 'hub', which can be complemented by either methodological or domain/population/diagnostic-specific 'spokes'.

CORE Administration Checklist
One of the consistent challenges to traditional service evaluation has been the collection of comprehensive and representative datasets. For a variety of reasons, many evaluations to-date have suffered from considerable data attrition. The CORE Administration Checklist has been designed to audit CORE System Data administration and collection. This helps to not only co-ordinate the day-to-day administration of the CORE System, but also collect information on data representativeness and associated problems.

CORE Assessment & End of Therapy Forms
Traditional evaluation methodologies are largely reliant on service administrators and practitioners ensuring that clients/patients (hereafter termed clients) receive questionnaires to complete throughout various stages of their contact with the service. The experience of CSG members is that services report considerable resource constraints in attempting to efficiently and effectively administer, process and utilise self-report questionnaires which lead to problems securing data which is representative of service provision. Consequently, over the last three years, the CSG has worked closely with practitioners from health, education and voluntary sector services to devise two pragmatic practitioner-completed data capture forms which can be used for both treatment evaluation and service audit purposes. The CSG believes such an approach has several advantages over client/patient-reliant methodologies:

- Completed for every client by every practitioner, the forms help assure *comprehensive profiling* of service throughput
- The forms collect data on routine *audit items* (e.g. waiting times, appropriateness of referral, non-attendance rates) to help inform and enhance service efficiency
- The forms collect data on *presenting and emerging problems/concerns* via a categorisation framework complemented by an international classificatory system (ICD 10) to help profile service populations
- The forms collect data on *the benefits of therapy* to help profile outcomes for those clients coming to unplanned endings
- The forms collect data on *therapy descriptors* (e.g. therapy type, duration and frequency) to help profile services and contextualise client self-report and practitioner-rated outcomes
- Methodologically, the forms offer the opportunity to focus client-collected data specifically on therapy issues, which enhance assessment, therapy planning and discharge.

CORE Outcome Measure

The CORE Outcome Measure has been designed to be suitable for use across a wide variety of service types; the measure taps into a pan-theoretical 'core' of clients' distress, including subjective well-being, commonly experienced problems or symptoms, and life/social functioning. In addition, items on risk to self and to others are included.

The CORE Outcome Measure addresses global distress and is therefore suitable for use as an initial screening tool and outcome measure; like most self report measures, it cannot be used to gain a diagnosis of a specific disorder. The mean of all 34 items can be used as a global index of distress, the main design intention. However, mean item scores for the dimensions of well-being, problems/symptoms, life functioning, and risk can also be used separately where that distinction may be desired. The risk items should not be regarded as a scale but as clinical flags and some services may wish to use them to trigger more discussion of risk at assessment.

The measure has been extensively piloted and resultant data (in press) suggest: the measure (1) has considerable clinical face value; (2) has supportive validity and reliability; and, (3) distinguishes between clinical and non-clinical or general populations. The CSG believe the CORE Outcome Measure has the following advantages over the range of client-completed protocols utilised in existing measurement practice:

- As the measure is both very *brief* (2-sided) *& user-friendly* (measured reading ease), client compliance appears high
- The content of the measure addresses those *patient aspects* identified by practitioners as routine assessment domains
- As the measure can be *practitioner-scored*, subjective well-being, symptom, functioning and risk profiles are pragmatic for assisting assessment and discharge
- Practitioners utilising the measure are able to compare individual scores with supplied *normative data* for clinical and non-clinical populations allowing clinically significant change to be determined
- As the CSG are committed to the national implementation and support of the measure, our aim is to help it become both widely used and durable, quickly growing a substantial dataset of *comparative outcome data* to complement research efficacy data
- As the measure is designed to have *generic applicability* across all levels of service delivery, resultant data should be highly useful for comparing presentations and outcomes at different levels of service provision

Principal Advantages of the CORE System

- As the CORE System Group use *optical scanning technology* data is mounted considerably faster than manual entry (75%+) allowing data feedback on a regular basis (e.g. every three months)
- As the CORE System is standardised, highly efficient *automated reporting* is possible. This offers the potential for a range of reports which can include individual practitioner feedback, practice feedback, service feedback, domain feedback and symptom group feedback
- The CORE System links practitioners to a *national practice research network* providing comparative service delivery and outcome data for a range of provision domains (i.e. primary, secondary and specialist care) across a range of provider affiliations (i.e. counselling, clinical psychology, psychotherapy, art therapy)

CORE System Implementation Guidelines for Best Practice

The CORE System Group would like to minimise the amount of ' organisational change' that CORE System implementation causes. However, we are aware that for many services and practitioners this is the first time that such routine evaluation has been undertaken, and therefore will be a challenging experience. Feedback from many CORE System users is now beginning to offer a wealth of experience to guide practitioners and services in implementing CORE. We offer the following purely as guidelines for 'best practice' but encourage practitioners to find their own 'comfort' with the System.

Preparing for Implementation:

- Read the CORE System Guidelines thoroughly before starting to use the forms
- Understand the value of collecting CORE System information for enhancing your practice and your service
- If you are not sure of certain issues, talk to colleagues to get their views or ring the CORE System Group for support
- Meet regularly with colleagues to share individual experiences and some consistency in the administration and completion of CORE System Forms
- If you work in more than one service setting consider ordering extra copies of the CORE System Guidelines so that a copy can be kept at each service setting
- Prepare a Client Information Sheet which explains the use of the CORE System by you and your service (sample contained in Appendices)

Implementing the CORE Outcome Measure:

- Ideally the CORE Outcome measures should be completed by clients prior to the first face-to-face contact with a practitioner, and immediately preceding their final therapy session
- Try not to be apologetic when introducing the CORE System Outcome Measures to clients
- Use clients responses to items within the CORE System Outcome Measures to help understand some of the main problems/concerns that the client is experiencing
- To get the best possible return of questionnaires, it is better to administer the CORE Outcome Measure to clients/patients in the service setting rather than sending them through the post
- Do offer help to clients who struggle with the CORE Outcome Measure or any of the items

Completing the Therapy Assessment Forms and End of Therapy Forms:

- Try to complete the Therapy Assessment Form for each new client in retrospect at the end of the session or day rather than during the session
- Where the information is available, fill in certain details before seeing the client (i.e. ID info, age, gender, referral reason)
- **And most importantly - remember to complete the End of Therapy Form for every client who enters therapy irrespective of whether their therapy ending is planned or unplanned**

CORE System Administration Checklist Guidelines for Completion

The CORE Administration Checklist should be completed by the practitioner for every client seen irrespective of whether they enter therapy or complete a CORE Outcome Measure. This form is used to profile the total throughput of the service for the data collection period and audit the completion of CORE System Forms. If forms are not completed for any reason, it is imperative to report the reason/s on this form.

The first set of information required is identification information which allows us to link up CORE System Forms for individual clients/patients.

Site ID	A Site ID will be pre-allocated to your service. All practitioners within one service should use the same Site ID.
Client ID	It is imperative that each client within your service has a unique ID number and that this is written clearly on all forms (Administration Checklist, CORE Outcome Measure, Assessment and End of Therapy Forms) completed by/for each client; this ensures that the correct forms are linked up. It is preferable, but not mandatory, that the 'numbers only' part of the Client ID section is used to uniquely identify each client (numbers are more accurately processed by the scanning software).
Therapist ID	The Therapist ID should be used to identify the therapist. This will be the same as on the CORE Assessment and CORE Outcome Measure Form.

Pre-therapy

CORE Outcome Measure: Completed by client	It is critical to be able to paint an accurate picture of CORE Outcome Measure administration. If an outcome measure is not completed by the client/patient, please enter the reason in the box provided. Examples of reasons for non-completion might include: client refused, forgot to administer or client too distressed.
Therapy Assessment Form: Completed by therapist	A Therapy Assessment Form needs to be completed for every client/patient. However there may be very rare occasions when it is not possible to complete or supply the forms. Where this is the case please report the reasons in the box provided.

Post-therapy

CORE Outcome Measure: Completed by client	It is recognised as difficult to secure post-therapy outcome forms for a proportion of clients. However, once again it is imperative to know why forms do not get completed. Examples of reasons for non-completion might include: unplanned ending, client refused or client too distressed.
End of Therapy Form: Completed by therapist	Where clients/patients have more than a single session or a series of assessments it is imperative to complete the End of Therapy Form. However there may be very rare occasions when it is not possible to complete or supply the forms. Where this is the case please report the reasons in the box provided.

SECTION B

CLINICAL OUTCOMES in ROUTINE EVALUATION

OUTCOME MEASURE

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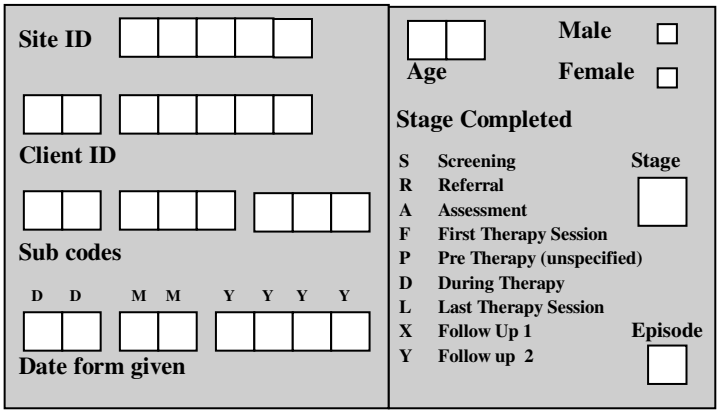
GUIDELINES FOR COMPLETION

The 'grey' section at the top of the CORE Outcome Measure should be completed by the practitioner.



Site ID	A Site ID will be pre-allocated to your service. All practitioners within one service should use the same Site ID. To differentiate between sectors or practitioners within a service, the sub-codes should be used (see below).
Client ID	It is imperative that each client within your service has a unique ID number and that this is written clearly on all forms (CORE Outcome Measure, Assessment and End of Therapy Forms) completed by/for each client; this ensures that the correct forms are linked up. It is preferable, but not mandatory, that the 'numbers only' part of the Client ID section is used to uniquely identify each client (numbers are more accurately processed by the scanning software).
Therapist ID **Sub-codes**	The first sub-code (labelled therapist ID) should be used to identify the therapist. These would normally be the same as on the CORE Assessment and End of Therapy forms. These are entirely for your own use. They should be used whenever you feel it would be advantageous to compare one group of clients/patients with another. Examples include: in-patients versus out-patient services; secondary versus tertiary care; group versus individual therapy; behavioural versus cognitive therapy; therapist identification. These codes may differ from those on the CORE Assessment and End of Therapy forms These sub-codes will be individual to each service, and therefore allocated by yourselves. **It is important that the use of sub-codes is agreed within your site before data collection commences.**
Date form given	This is the date the form is posted or given to the client. This helps distinguish forms completed by the same client, ensuring that pre-therapy and post therapy measures are not confused.
Stage Completed	It is important that the 'stage completed' is accurately completed. This is especially important when clients complete multiple forms, again ensuring pre and post therapy measures are not confused. Services will differ in their coding practices (e.g. what one site may term 'assessment' another may term 'screening'). It is vitally important that you are consistent within your service. If measures are not completed consistently at any one stage, i.e. some are administered at referral some at assessment and some at the first session, it may be advantageous to use code 'P' (pre-therapy, unspecified) and similarly 'X' at the end of therapy. **It is important that the codes your service will use are decided before data collection commences.**
Episode	This should be used when a client is re-referred to your service. Write in number of episodes of therapy undertaken by this client within your service. For example if this is the first time the person has been seen write '1'. If it is the second time they have been seen write '2'.

STRUCTURE

The 34 items of the measure cover three dimensions:

1. subjective well-being (4 items),
2. problems/symptoms (12 items),
3. life functioning (12 items).

These should be compatible with the phase-model of change which suggests a sequential impact on (remoralising) subjective well-being early in therapy, progressing to (remediating) symptoms, and then to (rehabilitating) aspects of life functioning for many therapies (Howard, Lueger *et al*, 1993). In addition, it contains:

4. risk/harm (6 items).

These items should be used as clinical indicators of the patient being 'at risk' to themselves or others.

Features of the measure include high and low intensity items to increase sensitivity and 25% of the items are 'positively' framed. The items are presented in Table 1.

Table 1. Dimensional breakdown of the CORE Outcome Measure

Dimension	Item		Severity/ Intensity	Item N°
Subjective Well Being	I have felt O.K. about myself	Pos	Lo	4
Subjective Well Being	I have felt like crying		Hi	14
Subjective Well Being	I have felt optimistic about my future	Pos	Lo	17
Subjective Well Being	I have felt overwhelmed by my problems		Hi	31
Symptoms - anxiety	I have felt tense, anxious or nervous		Lo	2
Symptoms - anxiety	Tension and anxiety have prevented me doing important things		Hi	11
Symptoms - anxiety	I have felt panic or terror		Hi	15
Symptoms - anxiety	My problems have been impossible to put to one side		Lo	20
Symptoms - depression	I have felt totally lacking in energy and enthusiasm		Hi	5
Symptoms - depression	I have felt despairing or hopeless		Hi	23
Symptoms - depression	I have felt unhappy		Lo	27
Symptoms - depression	I have thought I am to blame for my problems and difficulties		Lo	30
Symptoms - physical	I have been troubled by aches, pains or other physical problems		Lo	8
Symptoms - physical	I have difficulty getting to sleep or staying asleep		Lo	18
Symptoms - trauma	I have been disturbed by unwanted thoughts and feelings		Hi	13
Symptoms - trauma	Unwanted images or memories have been distressing me		Hi	28
Functioning - general	I have felt able to cope when things go wrong	Pos	Hi	7
Functioning - general	I have been happy with the things I have done	Pos	Lo	12
Functioning - general	I have been able to do most things I needed to	Pos	Lo	21
Functioning - general	I have achieved the things I wanted to	Pos	Hi	32
Functioning - close rel.	I have felt terribly alone and isolated		Hi	1
Functioning - close rel.	I have felt I have someone to turn to for support when needed	Pos	Lo	3
Functioning - close rel.	I have felt warmth and affection for someone	Pos	Lo	19
Functioning - close rel.	I have thought I have no friends		Hi	26
Functioning - social rel.	Talking to people has felt too much for me		Hi	10
Functioning - social rel.	I have felt criticised by other people		Lo	25
Functioning - social rel.	I have been irritable when with other people		Lo	29
Functioning - social rel	I have felt humiliated or shamed by other people		Hi	33
Risk/Harm to self	I have thought of hurting myself		Lo	9
Risk/Harm to self	I have hurt myself physically or taken dangerous risks with my health		Hi	34
Risk/Harm to self	I made plans to end my life		Hi	16
Risk/Harm to self	I have thought it would be better if I were dead		Lo	24
Risk/Harm to others	I have been physically violent to others		Hi	6
Risk/Harm to others	I have threatened or intimidated another person		Hi	22

(Pos = Positively phrased item)

SCORING

Total Score and Total Mean Score

Key points in the scoring of the CORE Outcome Measure are as follows:

- Each item within the CORE Outcome Measure is scored on a 5-point scale ranging from 0 (not at all) to 4 (most or all the time).
- The **total score** is calculated by adding the response values of all 34 items.
- The minimum score that can be achieved is 0 and the maximum 136.
- The **total mean score** is calculated by dividing the total score by the number of *completed* item responses (normally 34).
- However, in the case of **missing data**, the mean score can be calculated for the non-missing items. For example, if two items have not been responded to, the total score is divided by 32 (see below). We do not recommend re-scaling the total or non-risk scores if more than three items have been missed. Similarly we do not recommend re-scaling dimension scores if more than one item is missing from a dimension.
- The measure is problem scored, that is, the higher the score the more problems the individual is reporting and/or the more distressed they are. This makes scores on the "well-being" dimension a bit counter-intuitive but they are kept this way for consistency with the other dimensions.

Dimension Scores

The four dimensions of the CORE Outcome Measure can be identified by the letter adjacent to the column of boxes labelled "office use only" at the far right hand side of the measure. These are shown in Table 2 below. These boxes are for immediate hand scoring if required. Thus to gain a total score for the "Well-being" dimension, first write the values of the responses in the allocated boxes, then total the scores of the four boxes marked 'W' and write this score in the box marked "W" at the foot of the measure. The **mean scores for each dimension** are calculated by dividing the total scores by the number of *completed* item responses for each dimension; for "Well-being" the score would normally be divided by four, if one 'well being' item has been omitted, score should be divided by three.

Risk Items

These items cover suicidal ideation and harm to self and others. Where an individual scores more than '0' on any item marked 'R' (Risk), this should be flagged for further attention by the clinician. To calculate the mean total score minus risk items ('All minus R') first calculate the total score, minus the risk score, and then calculate the mean score by dividing this score by the number of completed item responses marked 'W', 'P' or 'F' (normally 28).

Table 2 - Identifiers and score ranges for dimensions of the CORE Outcome Measure

Identifier	Dimension	N° of items	Total Score Range	Mean Score Range
W	Well Being	4 items	0 - 16	0 - 4
P	Problems or Symptoms	12 items	0 - 48	0 - 4
F	Functioning	12 items	0 - 48	0 - 4
R	Risk	6 items	0 - 24	0 - 4
	Total Score	**34 items**	**0 - 136**	0 - 4

NORMATIVE DATA

In work to date, data have been collected on samples from two groups:

1. A non-clinical population of students from two different universities on a variety of different courses, and a sample of convenience of both staff and their friends and relatives (total n = 1,106) and
2. a clinical population comprising users waiting for or receiving a wide variety of psychological interventions in a wide variety of settings throughout Britain (total n = 890).

The **non-clinical data** came from the three samples. The first was of 691 respondents from a university. It comprised 304 (44%) women, 381 (55%) men with gender not given by 6 (1%). The age range for this sample was 17 to 43 with quartiles at 19, 20 and 23. The second sample was of data from 55 students at another university participating in a test-retest reliability study. Eight (15%) were men, 46 (84%) were women, and one not state their gender. Their ages ranged from 20 to 45 but the quartiles were 20, 21 and 22 years of age illustrating how 75% were 22 or younger. The last non-clinical sample was a sample of convenience, n = 360, of therapists, researchers and their other colleagues, friends and relatives. This comprised 251 (70%) women and 109 (30%) men with no missing data for gender. The age range in this sample was from 14 to 45 with two missing ages and again the age range is a young one with quartiles 18, 20 and 23.

The **clinical data** came from 21 sites. The majority were within the NHS but they included one university student counselling service and one staff support service. One service was employed by a general practice, another was entirely focused on primary care, others had wider spans of referrals. Service leadership and membership varied including medical psychotherapists, clinical psychologists, counselling psychologists, counsellors and psychotherapists. Theoretical orientation also varied with few pure behavioural or cognitive-behavioural services but many eclectic services, some with strong psychodynamic orientations. The data used were the first data from each individual provided that this came from pre-treatment or from the first treatment session. The numbers from each site varied from 10 to 196 (mean 42). Gender was recorded for 874 of the 890 (98%), 530 (61%) were women, 344 (39%) men. Age was recorded for 850 and ranged from 16 to 78 with mean 36, median 34 and quartiles at 26, 34 and 45.

Differences between clinical and non-clinical samples

The primary requirement of any clinical measure of distress is that it should show differences between the clinical populations for which it has been designed and non-clinical samples. Table 3 illustrates that the differences between the clinical and non-clinical populations are large and highly significant on all dimensions ($p \leq .0005$), i.e. less than a 5 in 10,000 chance differences as big as this occurred by chance.

Table 3 - Means and standard deviations for clinical and non-clinical samples

	Non-clinical (n = 1084)		Clinical (n = 863)		Difference	
Dimension	**Mean**	**S.D.**	**Mean**	**S.D.**	**95% C.I.**	**p***
Well-being	0.91	0.83	2.37	0.96	1.38 to 1.53	<.0005
Problems	0.90	0.72	2.31	0.88	1.33 to 1.48	<.0005
Functioning	0.85	0.65	1.86	0.84	0.95 to 1.09	<.0005
Risk	0.20	0.45	0.63	0.75	0.38 to 0.49	<.0005
All non-risk items	0.88	0.66	2.12	0.81	1.18 to 1.31	<.0005
All items	0.76	0.59	1.86	0.75	1.04 to 1.16	<.0005

**p values for Mann-Whitney test*

Gender Differences

There were statistically significant but not very large differences between men and women in our non-clinical samples. The differences in the clinical samples were generally non-significant or significant but small. These results suggest that gender should be taken into account when relating individual scores to clinical or normative distribution data but that effects of gender are small compared with effects of clinical *versus* non-clinical status.

Table 4 - Gender differences in CORE Outcome Measure scores for clinical and non-clinical samples

Non-Clinical Population						
	Male (*n* = 471)		**Female (*n* = 576)**		**Difference**	
Dimension	**Mean**	**S.D.**	**Mean**	**S.D.**	**95% C.I.**	**p***
Well-being	0.68	0.71	1.10	0.87	-.51 to -.32	<.0005
Problems	0.78	0.64	1.00	0.76	-.30 to -.13	<.0005
Functioning	0.83	0.62	0.86	0.67	-.11 to .05	.65
Risk	0.23	0.47	0.15	0.40	.03 to .14	<.0005
All non-risk items	0.79	0.59	0.95	0.70	-.25 to -.09	<.0005
All items	0.69	0.53	0.81	0.61	-.19 to -.04	.004

Clinical Population						
	Male (*n* = 338)		**Female (*n* = 515)**		**Difference**	
Dimension	**Mean**	**S.D.**	**Mean**	**S.D.**	**95% C.I.**	**p***
Well-being	2.22	0.98	2.41	0.97	-.33 to -.06	.004
Problems	2.32	0.92	2.28	0.87	-.08 to .17	.270
Functioning	1.92	0.87	1.84	0.85	-.04 to .20	.184
Risk	0.69	0.75	0.61	0.77	-.02 to .19	.030
All non-risk items	2.13	0.84	2.11	0.82	-.09 to .14	.522
All items	1.88	0.78	1.85	0.77	-.07 to .14	.380

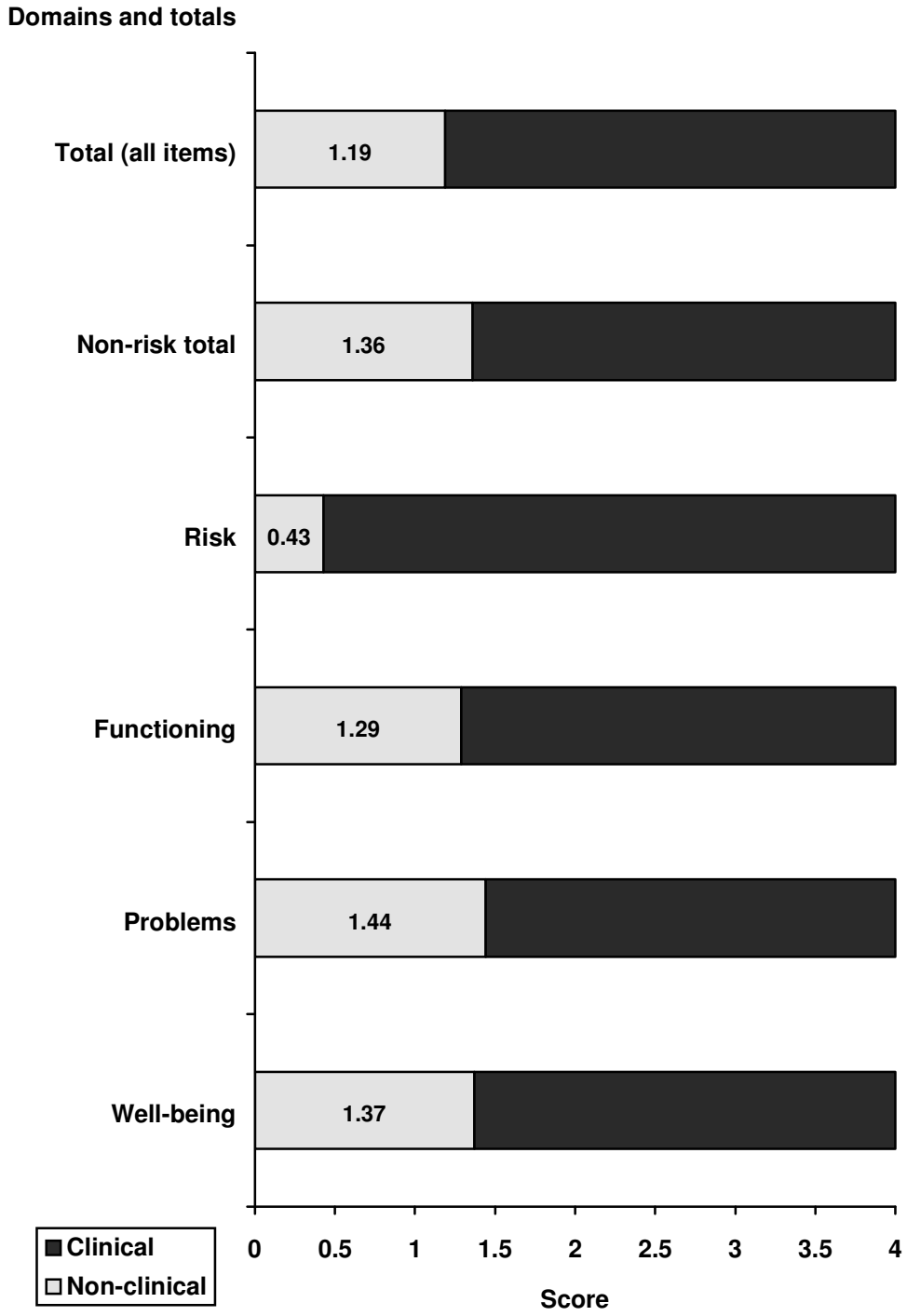
CUT-OFF POINTS FOR RELIABLE AND CLINICALLY SIGNIFICANT CHANGE

Jacobson and colleagues (Jacobson et al., 1988) have suggested methods for determining reliable and clinically significant change. Reliable change is that which is unlikely to have arisen just by the unreliability of measurement of the instrument. Clinically significant change is sufficient improvement to have moved the client to a score more representative of the general population than a clinical population. There are several methods of calculating both the criterion for reliable change and for clinically significant change. These are well summarised by Jacobson & Truax, 1991; Evans, Margison & Barkham, 1998; and within the CORE System Handbook (CORE System Group, 1998). Practitioners interested in determining the clinical significance of change scores from the CORE Outcome Measure can use the values from the large samples reported in the following Table 5 and the graphs overleaf.

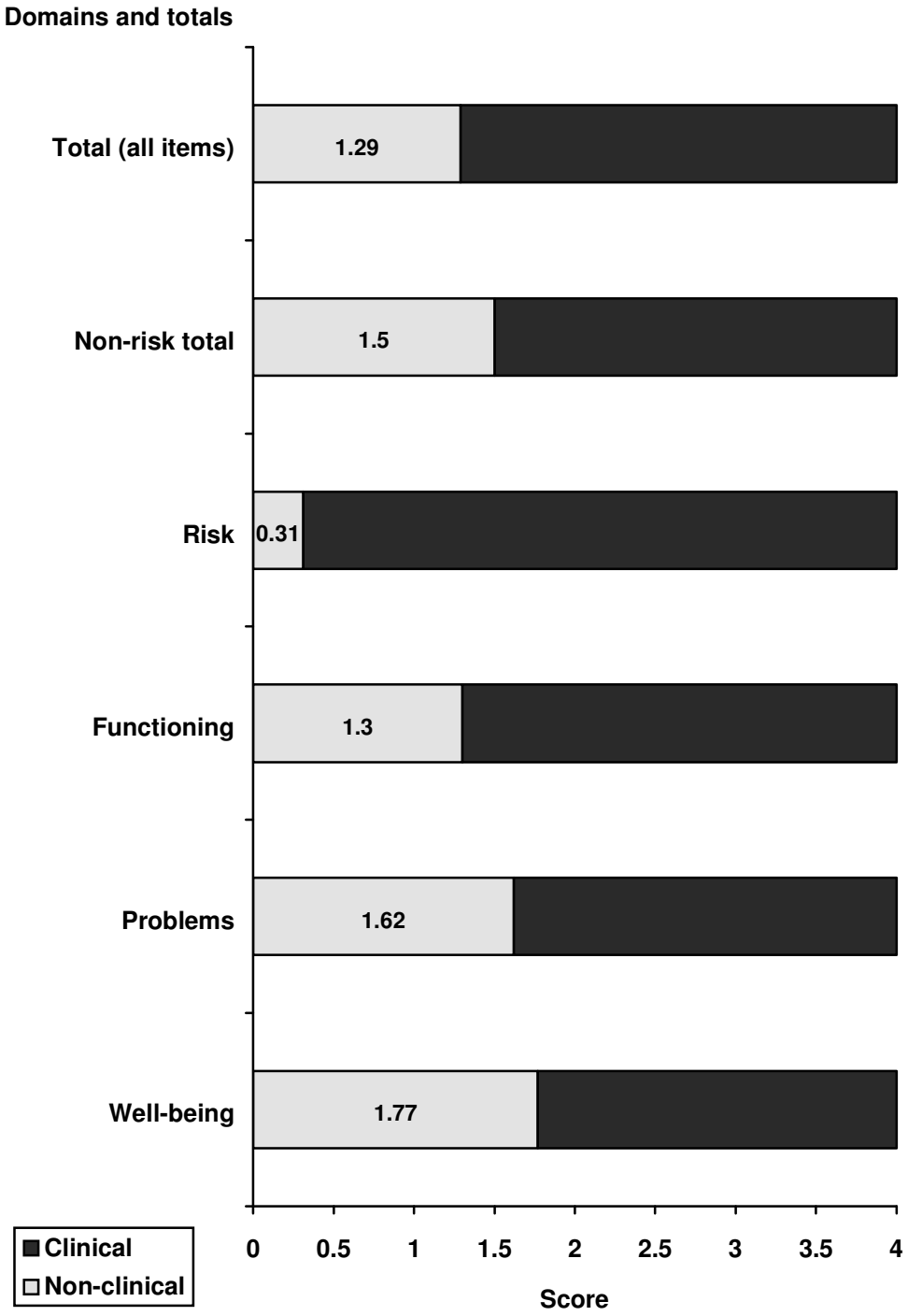
Table 5 - Male and Female cut-off scores between clinical and non-clinical populations

Dimension	Male	Female
Well-being	1.37	1.77
Problems	1.44	1.62
Functioning	1.29	1.30
Risk	0.43	0.31
All non-risk items	1.36	1.50
All items	1.19	1.29

CORE Outcome Measure
Cut-off scores: MALES - Non-clinical and clinical populations



CORE Outcome Measure
Cut-off scores: FEMALES - Non-clinical and clinical populations



SECTION C

CLINICAL
OUTCOMES in
ROUTINE
EVALUATION

ASSESSMENT
&
END OF THERAPY
FORMS

THERAPY ASSESSMENT FORM

Site ID

A Site ID will be pre-allocated to your service. All practitioners within one service should use the same Site ID. To differentiate between sectors or practitioners within a service, the sub-codes should be used (see below).

Client ID

It is imperative that each client within your service has a unique ID number and that this is written clearly within the boxes on all measures completed by/for that client. This ensures that the correct forms are linked up. It is preferable, but not mandatory, that the 'numbers only' part of the Client ID section is used (numbers are more accurately processed by the scanning software).

Therapist ID

The first sub-code (labelled therapist ID) should be used to identify the therapist who carries out the assessment. This code should be repeated on the 'End of Therapy' form if the practitioner carrying out the assessment subsequently delivers therapy.

Sub-codes

As all services are different, it may be necessary to audit aspects of your service which are not covered on the assessment/end of therapy forms. The sub-codes are therefore used to customise the forms to fit your service. For example one set of codes could be used to identify data for 'sub-sites' within your service or groups of clients attending a specific clinic.

Sub-codes may also be used where you have a substantial number of clients who do not comfortably fall within the categories for any of the sub-sections of the assessment/end of therapy forms.

It is important that the use of sub-codes are agreed within your site before data collection commences.

Referrer(s)

Three boxes are available to indicate multiple referral sources. From the list below, enter the main formal referral source in the first box. For example, if the GP referred the client to your service write '01' in the first box

0	1				

1 GP surgery/practice
2 Psychiatrist
3 Other doctor ***(e.g. gynaecologist)***
4 Other NHS Service ***(e.g. health visitor)***
5 Social Services
6 Voluntary Org. ***(e.g. MIND, RELATE)***
7 Education based service ***(e.g. student counselling)***
8 Legal profession ***(e.g. probation service)***
9 Private counsellor/psychotherapist
10 Family member
11 Friend or acquaintance
12 Self
13 Other

Age

Age, in years, at the first appointment. Age is used rather than date of birth for confidentiality reasons.

Male/Female

Tick the relevant box

Employment

Two boxes are available to indicate dual occupations. From the list below, enter the number next to the appropriate employment status(s) in the boxes provided. For example, if the person is a part time student and undertaking part time work, enter '6' in the first box and '2' in the second . If only one category is appropriate, use the first (i.e. left-hand) box.

6	2

1 Full time paid employment (>30 hrs per week)
2 Part time paid employment (<30 hrs per week)
3 Receiving sickness/incapacity/invalidity benefit
4 Unemployed
5 Full time student
6 Part time student
7 Retired
8 Houseperson
9 Other not specified above

Ethnic Origin	Two boxes are available to indicated mixed or dual origin. From the list below, enter the number next to the appropriate ethnic origin (s), in the box(s) provided. If only one category is needed use the left hand box. For example, if the person's ethnic origin is white (English) enter '8' in the left hand box [8] [ ] **1 Asian (Bangladeshi) 4 Asian (E. African) 7 Black (Caribbean)** **2 Asian (Indian) 5 Asian (Chinese) 8 White (English/European)** **3 Asian (Pakistani) 6 Black (African) 9 Other** Sites wishing to use a more extended range of codes than outlined above, should make use of the 'sub-codes' at the beginning of the Therapy Assessment Form.

Referral date	Enter the date on which the client was referred to your service and began to wait for an assessment/ therapy appointment.
First assessment date attended	The date on which the client first attended an assessment appointment with you. If the client does not have a formal assessment, leave blank, however, in the 'last assessment date' section below, write the date of the first session (see below).
Last assessment date	The date on which the client last attended an assessment appointment with you. • If the client attends for one assessment session only, enter the same date as for 'first assessment'. • If the 'assessment' and 'first therapy/counselling' session are indistinguishable from each other, write the date of the first session. This should be the same date as the 'date therapy commenced' on the end of therapy form
Total number of assessments	The total number of assessment sessions attended by the client. • If the client does not have a formal assessment session, but goes 'straight into' therapy/counselling, write '0' in this box.
Previously seen for therapy in this service	If client has previously undertaken a course of therapy provided by your service, tick yes. If they are new to the service, or have previously been seen for an assessment only, tick no.
Episode	Write in number of episodes of therapy undertaken by this client within your service. For example if this is the first time the person has been seen write '1'. If it is the second time they have been seen write '2'.
Months since last episode	How long is it since the client was last seen in your service? Round up or down to the nearest whole month.
Follow up/review appointment	If this is this an appointment following therapy to ascertain whether the client should attend a further episode of therapy, or be referred on to another service, please tick 'yes'

Relationship/ support	Please tick as many boxes as necessary to indicate the appropriate category. For example, if the client is a single parent with children aged 3 and 7, tick 'living alone' 'children under 5 years' and 'children over 5 years'.

Current/previous use of services for psychological problems	Tick as many boxes as necessary to indicate a) whether the client is currently attending another service apart from your own (concurrent), or b) has made use of your service, or other services in the past, and how long ago this was (less than or more than 12 months ago)

Medication to help with psychological problem(s)

Below is a list of medications which may have been prescribed to the client to help with psychological problems. Using this list, identify the category of the client's prescribed medication(s) and tick the appropriate box. If the client has been prescribed more than one type of medication, tick as many boxes as necessary.

Anti-psychotic/antimanic
(neuroleptics/major tranquillizers)

Benperidol (*Anquil*)
Carbamazepine
Chlorpromazine (*Largactil*)
Clozapine (*Clozaril*)
Droperidol (*Droleptan*)
Flupenthixol (*Depixol/Fluanxol*)
Fluphenazine Decanoate (*Clopixol*)
Flupenthixol Decanoate (*Depixol*)
Fluphenazine H (*Moditen*)
Haloperidol (*Dozic/Haldol/Serenace*)
Lithium Carbonate *Camcolit/Lisconum/Priadel*
Lithium Citrate *(Li-liquid/Litarex/Priadel)*
Methotrimeprazine (*Nozinan*)
Loxapine (*Loxapac*)
Oxypertine
Pericyazine (*Neulactil*)
Perphenazine (*Fentazin*)
Pimozide (*Orap*)
Prochlorperazine
Promazine Hydrochloride (*Sparine*)
Risperidone (*Risperdral*)
Sulpiride (*Dolmatil*)
Thioridazine (*Melleril*)
Trifluoperazine (*Stelazine*)
Zuclopenthixol (*Clopixol Acuphase*)

Anti-depressants

Amitriptyline H (*Lentizol/Tryptizol*)
Amoxapine (*Asendis*)
Citalpram (*Cipramil*)
Clomipramine H (*Anafranil*)
Desipramine H (*Pertofran*)
Dothiepin H (*Prothieden*)
Doxepin (*Sinequan*)
Fluoxetine (*Prozac*)
Fluvoxamine Maleate (*Faverin*)
Imipramine H (*Tofranil*)
Isocarboxazid
Lofepramine (*Gamanil*)
Maprotiline H (*Ludiomil*)
Mianserin H
Mirtazapine (*Zispin*)
Moclobemide (*Manerix*)
Nefazodone H (*Dutonin*)
Nortriptyline (*Allegron*)
Paroxetine (*Seroxat*)
Phenelzine (*Nardil*)
Protriptyline H (*Concordin*)
Sertraline (*Lustral*)
Tranylcypromine (*Parnate*)
Trazodone H (*Molipaxin*)
Trimipramine (*Surmontil*)
Viloxazine H (*Vivalen*)
Venflaxine (*Efexor*)

Anxiolytics/Hypnotics
(minor tranquillizers)

Alprazzolam (*Xanax*)
Busiprone \hydrochloride (*Buspar*)
Chloral Hydrate (*Noctec/Welldorm*)
Chlordiazepoxide
Chlormethiazole (*Heminevrin*)Diazepam
Diphenhdramine H
Flunitrazipam (*Rohypnol*)
Flurazepam (*Dalmane*)
Lorazepam
Loprazolam
Lormetazepam
Meprobamate (*Equanil/Equagesic*)
Nitrazepam
Oxazepam
Promethazine H
Temazepam
Triclofos Sodium
Zolpidem Tartrate (*Stilnoct*)
Zopiclone (*Zimovane*)

Brief description of reason for referral	This section complements the quantitative data in the next section and should be used to record the formal reason for referral (i.e. the problem for which the client is referred), or where the client is self-referred their description of the main problems/concerns.

Identified Problems/Concerns

Fuller details on each of each of the problem/concern areas can be found overleaf.

The profile of the identified clients problems and/or concerns should be recorded after the end of the formal assessment period. Where you do not undertake formal assessment, problems and concerns should be recorded at the end of the first session. In order to profile the problems/concerns two pieces of information are needed:

a) In the box to the left hand side of the category indicate the severity of any identified problem by using the severity rating below which rates severity in terms of the impact of the problem/concern on the client's day to day functioning. Day to day functioning relates to work/study, interpersonal, and the social functioning of the client. Problems/concerns not identified should be left blank.

b) For each of the problems identified, tick the appropriate box to indicate how long the client/patient has been troubled by this/these problem(s). Tick one box only.

It is recognised that some therapists find it unhelpful to focus on problems or use diagnostic terms. However, for the purpose of audit and evaluation it is important to have some record of the problems that brought a person into therapy

Severity	
1 causing minimal difficulty	problem reported as present, but only causing minor difficulty which does not affect day to day functioning.
2 causing mild difficulty	problem present and causing difficulty in one area of functioning but does not affect overall day to day functioning.
3 causing moderate difficulty	problem is causing significant difficulty in one or more areas of day to day functioning, and/or is moderately affecting overall functioning.
4 **causing severe difficulty**	problem causing severe impairment in all areas of functioning.

Identified Problems/Concerns - Categorisation

If you are unsure of where to categorise a problem/concern, please outline the problem in the box marked 'other'.

Depression

Include problems with mood, malaise, emotional problems, hopelessness, dysthymia, cyclothymia.

Anxiety/Stress

Include generalised anxiety, stress, adjustment, irritability, phobia, panic, obsessive-compulsive behaviour, dissociation.

Psychosis

Include schizophrenia, schizotypal, hallucinations, delusions.

Personality Problems/Disorder

Include personality disorder, sociopathic, psychopathic.

Cognitive/Learning Difficulties

Include dementia, Alzheimer's, memory loss/brain injury, learning difficulties, intellectual impairment, specific learning difficulties (e.g. dyslexia).

Eating disorder

Include anorexia nervosa, bulimia.

Physical Problems

Include sleeping, sexual problems, psychosomatic, factitious, Munchausen's.

Addictions

Include alcohol, drugs, gambling.

Trauma/Abuse

Include childhood and adulthood abuse/PTSD/ trauma in relation to specific event. Do not include abuse of others as these issues should be entered as risk issues (i.e. harm to others &/or legal forensic) &/or interpersonal &/or personality difficulties.

Bereavement/ Loss

Include death of significant other within the last 6 months. Bereavements of a duration in excess of 6 months are often categorised as depression.

Self esteem

Include loss of confidence in any area.

Interpersonal/Relationship problems

Include specific relationship problems (e.g. with partner/relative) and non-specific interpersonal problems (e.g. shyness, inability to form relationships).

Living/Welfare

Include financial problems, employment difficulties, housing problems, living conditions, lack of self care.

Work/Academic

Include motivation, concentration, performance, interpersonal (work/study related *only*).

Other

Problems which cannot be placed confidently in the categories indicated.

Risk

Please rate the severity for each of the identified risk areas. Client's responses on the CORE Outcome Measure should help as a guide to suicide, self-harm and harm to others. Legal/Forensic issues relate to criminal damage to property (e.g. arson, criminal damage etc.)

ICD-10 Codes

ICD-10 Codes have been included to give a finer level of detail to the presenting problems/concerns.

Full instructions for completion are contained overleaf.

ICD 10 CODES

ICD 10 codes have a prefix letter and then a main code of 2 digits and a more specific sub-code of 2 more digits. For mental health use there are two letters to use, F and Z. F-codes refer to mental disorders and Z-codes refer to a wide range of other non-illness features relevant to health care. Please write 'F' or 'Z' in the first box (labelled 'F/Z'). Pages 25-27 list the main headings to code, please write these codes in the next two boxes (labelled 'main code'). As many of the Z codes carry a sub-code, this should be placed in the last box (labelled sub-code).

More detailed information on completing the ICD-10 codes can be found in the 'World Health Organisation (1993) ICD-10 Classification of Mental and Behavioural Disorder: Diagnostic criteria for research'. The full version of the Z-codes is listed in the full 3-volume ICD-10 set.

Actions taken to cope/avoid problems	Tick whether positive and/or negative actions have been taken, then use the respective box to specify these actions. Positive actions might include talking to friends/relatives, relaxation, self help techniques, helping others, or seeking practical help. Negative actions might include increased alcohol/drugs, social withdrawal, violence/ aggression/ arguments, self-harm, illegal behaviour (e.g. stealing), gambling, absenteeism or over-dependence.

Assessment Outcome

This section identifies what happened to the client after the assessment session

Assessment only	The client attended the assessment session only. They may be suitable for therapy but did not wish to take it up or only an assessment session was required. There is no need to complete end of therapy form.
Accepted for therapy	As a result of your assessment, therapy sessions were offered.
Accepted for trial period of therapy	As a result of your assessment the client was identified as suitable for a trial period of therapy, and a number of sessions were offered.
Long consultation	The client was identified as suitable for a long consultation only, rather than a contracted episode of therapy.
***Referred to other service**	As a result of your assessment, the client was referred elsewhere for help.
***Unsuitable for therapy at this time**	As a result of your assessment, the client was identified as not currently suitable for therapy (e.g. in denial, not psychologically minded, unwilling to do the work etc.).
***If client is not entering therapy, give brief reason**	In the box provided, briefly describe the reasons why the client is not entering therapy with your service. This includes referral back to the GP, other psychological services (not identified by your Site ID), helping agencies or voluntary organisations.

END OF THERAPY/EPISODE FORM

Site ID	See guidelines for the 'Therapy Assessment Form'. Please make sure your site ID is written on all forms.
Client ID	See guidelines for the 'Therapy Assessment Form'. Please enter the Client ID from the therapy assessment form to ensure pre and post data are matched correctly.
Sub-Codes	See guidelines for the Therapy Assessment Form. These offer a further opportunity to customise the forms to your own service requirements. An example of a sub-code on the post therapy form could be 'form of discharge' (e.g. referred for group/individual therapy with codes for type of service). **Therapist ID:** please ensure that the therapist ID is entered on this form as well as the assessment form. This will differ where the practitioner undertaking the assessment differs from the person delivering therapy.
Date therapy commenced	This should be the date of the first **therapy** session with the client.
Date therapy completed	This should be the date of the last therapy session attended by the client.
N^{o} of sessions planned	Only complete if appropriate.
N^{o} of sessions attended	This should be number of appointments kept.
N^{o} of sessions unattended	This should be the number of appointments arranged but not kept, for any reason.

Type of therapy	Tick the box(es) which you consider is to have been the approach(es) you have undertaken with this client. Where your approach is not catered for by the categories indicated, please tick 'other' and describe in the box provided.

Modality of therapy	Tick the appropriate box.

Frequency of therapy	Tick appropriate box. If attendance has varied over the treatment period, please select 'not at a fixed frequency'.

Ending of therapy - unplanned If the therapy ending is unplanned, tick the box next to 'unplanned' and then tick the reason	**Unplanned due to crisis** e.g. an event prevents the client from attending any more appointments. **Unplanned due to loss of contact** e.g. client just doesn't return for any more appointments, with no reason given. **Client did not wish to continue** e.g. client does not feel therapy is helping and terminates future sessions planned. **Other** Outline reason in box provided.
Ending of therapy - planned If the therapy ending is planned tick the box next to planned *and* then tick the reason	**Planned from outset** Therapy continues up to the point agreed with the client from the start. **Agreed during therapy** Ending was agreed at any point after the start of therapy. **Agreed at end of therapy** Ending was agreed during the last therapy session attended. **Other** Outline reason in box provided.

Review of Presenting Problems	Firstly, for all problems identified on the assessment form, state the severity at the end of therapy in the left hand box using the scale below. Also rate the severity for problems which arose (emerged), or became clear after the assessment or first therapy session. 0 causing no difficulty 1 causing minimal difficulty 2 causing mild difficulty 3 causing moderate difficulty 4 causing severe difficulty Secondly, for each of the problems given a severity rating, tick the right hand box if this problem was a therapy issue, i.e. was addressed in therapy.

Risk	Please re-rate the severity for each of the identified risk areas

Motivation	Rate what you consider to have been the client's level of motivation to engage with the therapy process (i.e. commitment to treatment, readiness to change).
Working Alliance	Rate what you consider to have been the strength of the alliance with the client (include the bond established with the client, agreement on goals, tasks and methods).
Psychological Mindedness	Rate how psychologically minded the client was (i.e. the ability of the client to understand one's own, and empathise with others', feelings and use these to change their behaviour).

Benefits of therapy	The list provided is not exhaustive, but consists of the more common benefit responses. Tick the appropriate boxes which summarise what you consider to have been the important benefits of therapy for the client. Where benefits are different from the categories offered, please use the open ended box.

Change of medication	Tick the appropriate box.
Benefit to the client	Tick the appropriate box to indicate whether you think that the change of medication is likely to be beneficial to the client.
Details of change	Please tick the box which best describes the change of medication.

Has the client been given a follow-up appointment	Tick the appropriate box.
Number of months until appointment	How long is it until the client will be seen for a follow-up appointment? Round up or down to the nearest whole month.

ICD 10 CODES

ICD 10 codes have a prefix letter and then a main code of 2 digits and a more specific sub-code of 2 more digits. For mental health use there are two letters to use, F and Z (see below for details). F-codes refer to mental disorders and Z-codes refer to a wide range of other non-illness features relevant to health care. Please write 'F' or 'Z' in the first box (labelled 'F/Z'). Below we have stated the main headings which you might want to code, please write these codes in the next two boxes (labelled 'main code'). A more detailed breakdown into sub-codes is available in ICD-10. If you use these routinely within your service, these should be placed in the last box (labelled sub-code), however, the initial letter and first two digits are enough for most analysis.

F-Codes

F00 - F09: Organic, including symptomatic mental disorders	
F00	Dementia in Alzheimer's disease
F01	Vascular Dementia
F02	Dementia in other diseases (Pick's; Creutzfeld Jakob, Huntington's, Parkinsons, HIV)
F03	Unspecified dementia
F04	Organic amnesic syndrome, not induced by alcohol and other psychoactive substances
F05	Delirium, not induced by alcohol and other psychoactive substances
F06	Other mental disorders due to brain damage and dysfunction and to physical disease
F07	Personality and behavioural disorders due to brain disease, damage and dysfunction
F09	Unspecified organic or symptomatic mental disorder
F10 - F19: Mental and behavioural disorders due to psychoactive substance use	
F10	Due to use of alcohol
F11	Due to use of opioids
F12	Due to use of cannabinoids
F13	Due to use of sedatives or hypnotics
F14	Due to use of cocaine
F15	Due to use of other stimulants, including caffeine
F16	Due to use of hallucinogens
F17	Due to use of tobacco
F18	Due to use of volatile solvents
F19	Due to multiple drug use and use of other psychoactive substances
F20 - F29 Schizophrenia, schizotypal and delusional disorders	
F20	Schizophrenia
F21	Schizotypal disorder
F23	Acute and transient psychotic disorders
F24	Induced delusional disorder
F25	Schizoaffective disorders
F28	Other nonorganic psychotic disorders
F29	Unspecified nonorganic psychosis
F30 - F39 Mood (affective) disorders	
F30	Manic episode
F31	Bipolar affective disorder
F32	Depressive episode
F33	Recurrent depressive disorder
F34	Persistent mood (affective) disorders
F38	Other mood (affective) disorders
F39	Unspecified mood (affective) disorder
F40 - F48 Neurotic, stress related and somatoform disorders	
F40	Phobic anxiety disorders
F41	Other anxiety disorders
F42	Obsessive-compulsive disorder
F43	Reaction to severe stress, and adjustment disorders
F44	Dissociative (conversion) disorders
F45	Somatoform disorders
F48	Other neurotic disorders
F50 - F59: Behavioural syndromes associated with physiological disturbances and physical factors	
F50	Eating disorders
F51	Non-organic sleep disorders
F52	Sexual dysfunction, not caused by organic disorder or disease
F53	Mental and behavioural disorders associated with puerperium, not elsewhere classified
F54	Psychological and behavioural factors associated with disorders or diseases classified elsewhere
F55	Abuse of non-dependence-producing substances (e.g. laxatives, analgesics, antacids, vitamins, steroids)
F59	Unspecified behavioural syndromes associated with physiological disturbances and physical factors

F60 - F69: Disorders of adult personality and behaviour	
F60	Specific personality disorder (paranoid, schizoid, dissocial, emotionally unstable, histrionic, anankastik, anxious, avoidant, dependent)
F61	Mixed and other personality disorders
F62	Enduring personality changes, not attributable to brain damage and disease
F63	Habit and impulse disorders
F64	Gender identity disorders
F65	Disorders of sexual preference
F66	Psychological and behavioural disorders associated with sexual development and orientation
F68	Other disorders of adult personality and behaviour
F69	Unspecified disorder of adult personality and behaviour
F70 - F79: Mental Retardation	
F70	Mild mental retardation
F71	Moderate mental retardation
F72	Severe mental retardation
F73	Profound mental retardation
F78	Other mental retardation
F79	Unspecified mental retardation
F80 - F89: Disorders of psychological development	
F80	Specific developmental disorders of speech and language
F81	Specific developmental disorders of scholastic skills
F82	Specific development disorder of motor function
F83	Mixed specific developmental disorder
F84	Pervasive developmental disorders
F85	Other disorders of psychological development
F88	Other disorders of psychological development
F89	Unspecified disorder of psychological development
F90 - F98: Behavioural and emotional disorders with onset usually occurring in childhood and adolescence	
F90	Hyperkinetic disorder
F91	Conduct disorders
F92	Mixed disorders of conduct and emotions
F93	Emotional disorders with onset specific to childhood
F94	Disorders of social functioning with onset specific to childhood and adolescence
F95	Tic disorders
F98	Other behavioural and emotional disorders with onset usually occurring in childhood and adolescence
F99 - Unspecified mental disorder	

Z-Codes

Z33	**Pregnancy**
Z39	**Post-partum state**
Z55	**Problems related to education and literacy**
Z55.0	Low level literacy
Z55.1	Schooling unavailable
Z55.2	Failed examinations
Z55.3	Underachievement
Z55.4	Educational maladjustment and discord with teachers and classmates
Z55.8	Inadequate teaching
Z56	**Problems related to employment and unemployment**
Z56.0	Unemployment
Z56.1	Change of job
Z56.2	Threat of job loss
Z56.3	Stressful work situation
Z56.4	Discord with boss and workmates
Z56.5	Uncongenial or difficult conditions at work
Z56.6	Other physical and mental strain at work
Z59	**Problems relating to housing and economic circumstances**
Z59.0	Homelessness
Z59.1	Inadequate housing
Z59.2	Discord with neighbours, lodgers, landlord
Z59.3	Problems related to living in residential institution
Z59.4	Inadequate food
Z59.5	Extreme poverty
Z59.6	Low income
Z59.7	Insufficient social insurance or welfare support

Z59.8	Other (including isolated dwelling, loan foreclosure, problems with creditors)
Z60	**Problems related to social environment**
Z60.0	Problems related to life-cycle transitions (e.g. retirement, 'empty nest' syndrome)
Z60.1	Atypical parenting situation (e.g. single parent)
Z60.2	Problems with living alone
Z60.3	Acculturation difficulty (migration, social transplantation)
Z60.4	Social exclusion and rejection
Z60.5	Target of perceived adverse discrimination and persecution
Z61	**Problems related to negative life events in childhood**
Z61.0	Loss of love relationship in childhood
Z61.1	Removal from home in childhood
Z61.2	Altered pattern of family relationship in childhood (e.g. remarriage of parent, problem with new sibling)
Z61.3	Events resulting in loss of self esteem in childhood
Z61.4	Problems related to alleged sexual abuse of child by someone in primary support group
Z61.5	Problems related to alleged sexual abuse of child by someone outside primary support group
Z61.6	Alleged physical abuse of child
Z61.7	Personal frightening experience in childhood
Z62	**Other problems related to upbringing**
Z62.0	Inadequate parental supervision and support
Z62.1	Parental over protection
Z62.2	Institutional up-bringing
Z62.3	Hostility towards and scapegoating of child
Z62.4	Emotional neglect of child
Z63	**Other problems related to primary support group, including family circumstances**
Z63.0	Problems in relationship with spouse or partner
Z63.1	Problems in relationship with parents and in-laws
Z63.2	Inadequate family support
Z63.3	Absence of family member
Z63.4	Disappearance and death of family member
Z63.5	Disruption of family by separation and divorce
Z63.6	Dependent relative needing care at home
Z63.7	Other stressful life events affecting family and household (including sick person in family, ill or disturbed family members)
Z63.8	Other specified problems in household (including high expressed emotion, inadequate or distorted family communication)
Z64	**Problems related to certain psychosocial circumstances**
Z64.0	Unwanted pregnancy
Z64.1	Problems related to multiparity
Z64.2	Drug issues (not covered in disorders)
Z64.3	Seeking behaviours known to be harmful
Z64.4	Discord with professional counsellors, social worker, probation officer
Z65	**Problems related to other psychosocial circumstances**
Z65.0	Conviction without imprisonment
Z65.1	Imprisonment
Z65.2	Problems with release from prison
Z65.3	Other legal (e.g. child custody, arrest, litigation)
Z65.4	Victim of crime or terrorism
Z65.5	Exposure to disaster or war
Z72	**Problems related to lifestyle**
Z72.0	Tobacco
Z72.1	Alcohol
Z72.2	Drug use (other)
Z72.3	Lack of exercise
Z72.4	Inappropriate diet
Z72.5	High risk sex
Z72.6	Gambling and betting
Z73	**Life management difficulty**
Z73.0	Burn out
Z73.1	Accentuation of personality traits
Z73.2	Lack of relaxation and leisure
Z73.3	Stress
Z73.4	Inadequate social skills
Z73.5	Social role conflict (other)
Z73.6	Limitation of role due to disability

INFORMATION TO CLIENTS

In compliance with the Data Protection Act of 1998, it is necessary that clients give their explicit consent to the collection and processing of any identifiable data of a personal nature. They should also be informed of the reasons they are being asked to complete questionnaires, how the data will be used, who has access to the questionnaires, and whether or not this will affect their therapy. Clients also need to be assured that completing the questionnaires is voluntary, and that the information they give is confidential.

It is therefore required that clients sign an appropriate consent form, and be presented with an information sheet about the evaluation system when being asked to take part. Overleaf, you will find examples of an information sheet and consent form which will give you some guidelines as to what you should include. You may wish to alter these to be compatible with the details of your therapy/service, including an address for clients to contact if necessary.

CLINICAL
OUTCOMES in
ROUTINE
EVALUATION

Client Information Sheet

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This practice uses a standard evaluation system, which has been developed to help providers of counselling and other psychological therapies to deliver and develop the best possible services to clients seeking help for their difficulties and concerns. As part of the system, all patients are asked to complete a brief questionnaire before and after their contact with the service. These questionnaires assist us in understanding your problems, and ultimately, the degree to which we help you with those problems. We hope you will agree to complete the questionnaires, but would like to emphasise that participation is entirely voluntary and declining to complete them will not affect your counselling/therapy in any way.

About our evaluation:

◊ We would like you to complete a brief questionnaire before and after your contact with the therapy service. Your counsellor/therapist may also complete simple record forms relating to your therapy.

◊ Completing the questionnaires is entirely voluntary and you are free to choose whether you wish to complete them or not. **If you decide not to complete the forms this will not affect your counselling/therapy in any way, nor will anything you put on the questionnaire.** However, the more people who complete questionnaires, the more comprehensive the information is for improving the service for future clients.

◊ Your responses to the questionnaires help us understand more about the problems that counselling/therapy is required to address, the problems which counselling/therapy is most effective in helping, and the way in which our services can be improved.

◊ The processing of completed questionnaires is co-ordinated by The CORE System Group at the Psychological Therapies Research Centre, University of Leeds. The centre has a small team of researchers specialising in the evaluation of therapy services who help us to make the most of the information you give us, and assist us to report on the effectiveness of our service on a regular basis.

◊ The information from the questionnaires will be treated as strictly confidential, no names are used on any questionnaires, and no one other than the researchers and ourselves will have access to your responses.

THE PRE-COMPLETED INFORMATION IN THE TOP RIGHT-HAND SHADED BOX OF THE QUESTIONNAIRE IS FOR ADMINISTRATION PURPOSES ONLY

CLINICAL
OUTCOMES in
ROUTINE
EVALUATION

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CLIENT CONSENT FORM

I have read the information sheet provided and I agree to the fair and lawful processing of personal information for the purposes of analysis and research in line with the Data Protection Act 1998.

I understand that the CORE researchers based at the Psychological Therapies Research Centre, University of Leeds, will not have access to any personal data provided (eg name, address, date of birth) which makes the information identifiable to me and that I will not be identified in any way in anything that is written or reported about the research.

Signature ……..

Name (block capitals) ……..

Date …….

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All enquires regarding the CORE System should be addressed to:

CORE System Team
The Psychological Therapies Research Centre
17 Blenheim Terrace
University of Leeds
Leeds
LS2 9JT

Phone: 0113 233 1984/1953
Fax: 0113 233 1956
Email ptrc@psychology.leeds.ac.uk