Closing the loop: engaging with Clinical Outcomes in Routine Evaluation Data.

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Abstract

This work based project concerns the use of the CORE PC system within the Adur, Arun and Worthing Primary Care Counselling Service, which I manage. The system has been in use for 3 years and is currently used by some 200 services nationally. My objectives in this project were to establish and critically examine the use of CORE data within the service, ensuring that data collected is reflected on to inform clinical practice.

This is a very broad study of a previously unexplored area, and I have therefore taken a broad-brush approach. Using a methodology influenced by action research, and to a lesser extent the case study approach, I examine the process of feeding back and critically reflecting on the data produced to inform our clinical practice. I also reflect on the introduction and management of the system. Evidence is presented from action reflection cycles as well as focus groups and a questionnaire given to counsellors.

There are a number of outcomes to this project: I conclude that, notwithstanding the limitations of the instrument, CORE-PC can be used and experienced as useful in clinical practice by both counsellors and service managers. A tool such as CORE cannot be simply taken off the shelf and used uncritically however. We need to carefully attend to and manage the process of introducing and using CORE to ensure that the data is used in a thoughtful and sophisticated manner to inform our practice. I further conclude that making significant use of CORE (or any other audit data) and to extend its potential, has major implications for the *culture* of a service. We need to manage the process of introduction and use in order to encourage an environment where we can engage in critical discussions regarding the meaning and implications of the data. Attention to process is critical.

There is a tension at the heart of using CORE between its use as a performance management tool and its use as a developmental tool. This tension needs to be acknowledged and worked with rather than ignored. CORE PC allows for the creation of individual as well as service wide data. This brings many potential benefits and difficulties as we begin to develop the capacity to look behind the consulting room door at how any individual clinician is performing. If we are to really generate meaning from our data we need to be examining it in clinical supervision. This service is in the vanguard of making critical and sophisticated use of the data provided.

Abstract

Three themes are identified as important in creating the kind of learning organisation where CORE data can be engaged with and used to generate useful knowledge. These are leadership, especially in attending to the process of introducing CORE and interpreting data correctly, ownership and relationship.

Figure: A provides the reader with the layout of the document.

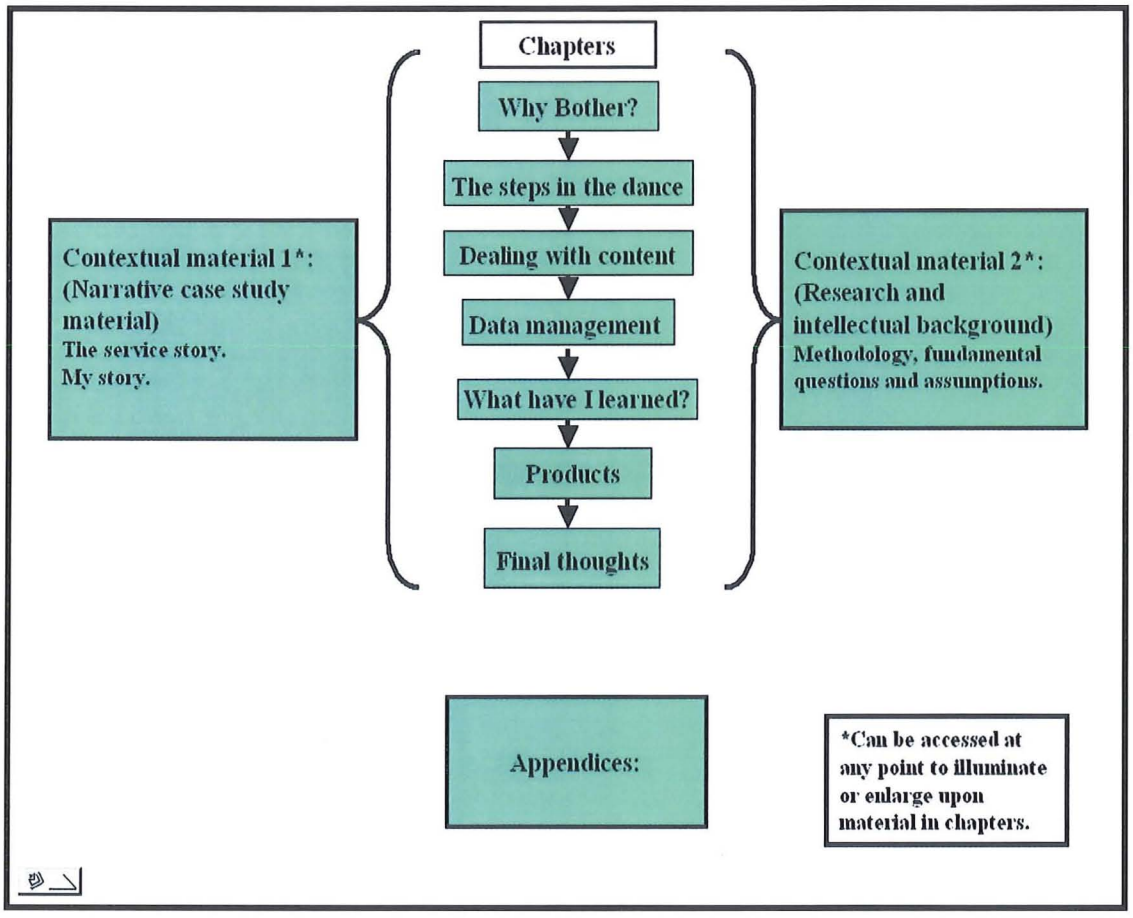

Figure: A The layout of the project

Chapter 1. Introduction, or Why Bother?

"Those who do not learn from history are condemned to repeat it." George Santayana (1905).

1.1 Introduction

Many years ago during my initial training as a probation officer I read a story in one of Donald Winnicott's books. He described talking to a teacher as part of a therapeutic consultation for a troubled child. The teacher was rather hostile and kept referring to his 30 years teaching experience as his authority. Winnicott acidly remarks that in his opinion the teacher did not have 30 years experience. Rather, he had one year's experience repeated thirty times! Some time later I drew on it whilst engaged in the political doctoral proposal for this project when the story again came to mind.

I have begun to wonder why this story is so appealing to me. I think that it is largely because it illustrates the ease with which we can fall prey to hubris. We believe that we are gathering 'experience' when in fact we are simply emptily repeating old habits and completely failing to gather and critically analyse evidence about what we are doing. I am reminded of the quip, familiar in analytic circles, to the effect that patients of Freudian analysts have Freudian dreams, whilst Jungian patients have Jungian dreams. We tend to see the world through the lenses of our pre-existing stories, our schema or in Bowlby's terms our working models. We assimilate but we do not accommodate. We do not always change our stories in the light of incoming data, rather we can tend to adapt the data to fit the story. As Sherlock Homes said to Dr. Watson in 'A Scandal in Bohemia';

"It is a capital mistake to theorise before one has data. Insensibly one begins to twist facts to suit theories instead of theories to suit facts."

Winnicott's story is also fascinating because it captures a central tension between accepting the individual's perspective and questioning it. This is the territory within which all psychotherapies operate, and it is a tension that is inherent in all clinical work.[1] The gap between what we think we are doing and what we might be construed as doing from another perspective is fascinating to me.

[1] Of course different models and different clinicians place the emphasis differently, but my contention is that all approaches seek to find some resolution to this tension.

The story illustrates a central part of my motivation to engage in this project. It seems especially interesting when we fall into the trap of failing to learn from our history in a profession whose key task is helping people to re evaluate their stories.
I am interested in how we ensure that we truly learn from our experience, rather than merely repeating favourite patterns in the false belief that we are somehow learning and developing. More than that, I strongly believe that we have a duty to ensure that the services we offer are effective and appropriate. To do that we need to be aware of the impact that we are having on our clients, and to know if and how what we offer can be improved.

One of the ways that we can begin to free ourselves up to truly learn from experience is to gather regular data that is not directly filtered by our selves. CORE is one tool that offers such an opportunity. We can get something that feeds in as if from the side, rather than coming through our personal set of distorting lenses. Of course there are still a myriad number of ways in which we can continue repeating our single year's experience. We can gather data and put it on a shelf or in a report. We can argue about the validity of the data to a point where we negate its value. Intelligent people can find any number of ways of carrying on as usual. The challenge of this project is to get beyond that, to a point of critical but genuine engagement with a different form of data that we are gathering in order to foster true learning, to ensure that we really generate thirty years of experience.

Of course, it is possible to fall into the same trap using audit data. CORE itself might be thought of as just another form of distorting lens. As is highlighted in 1.4 below, there are limitations on the data that it provides, and these must not be minimised or forgotten. We must maintain a spirit of active critical engagement with the data, acknowledging its limitations and ensuring that it is woven into our clinical thinking, rather than being passive and uncritical in our relationship to it.

In a sense I am sitting astride two worlds here. The first is the world of my original education as a psychologist, with its emphasis on number and a sceptical approach to data. The second is the world of my initial humanistic psychotherapy training, with its emphasis on, amongst other things, attending to process. I value both; clinical work

and certainly service management need to be guided where appropriate by hard data, and that data needs to be contextualised and used in a sophisticated manner that acknowledges and balances out some of its shortcomings.

We can all benefit from using feedback, and the CORE PC system gives us the possibility of receiving a new and real time feedback. It would however be very easy to turn the whole exercise into a form-filling nightmare from which no real value is gained. If we are to bother with such a system, then it follows that we should seek to gain the maximum benefit from it at all levels. This is, in my opinion, good for the organization as a whole as well as the individuals within it, and contributes towards creating an open system that is responsive to learning. My fundamental question is just what use can counsellors make of this data in their practice? My hypothesis is that what is gained will be a function of the way in which the process is managed. I will therefore be paying particular heed to process issues, as well as seeking to develop some general points about how the managers of clinical services make use of individual data with counsellors.

In order to locate the project in the literature, I will briefly comment on issues of outcome measurement before describing the development of CORE and linking it with existing thinking on clinical audit.

1.2 Outcome Measurement

At its heart, CORE is a self report outcome measure, based on client, designed to detect the change, or lack of change, accrued over a period of therapy. It is a measure aimed at producing evidence about the effectiveness of our work. In order to fully understand it, we need to locate it within the field of outcome measurement.

The search for the answer to the question, 'does psychotherapy work?' goes back to the 1930's (McLeod 1994), and is fraught with methodological difficulties. Robustly demonstrating that a certain type and level of change has occurred, *and* that this change is a result of an activity described as psychotherapy, is extremely difficult to do. The question is essentially a comparative one, requiring that we demonstrate in some way that psychotherapy is better than other approaches or no treatment at all.

Any effort to shed light on this area must consider both the internal and external validity of any study. Internal validity relates to the extent to which any study has dealt with competing or alternative explanations for the change (or lack of change) evidenced. External validity refers to the question about the extent to which we can reliably generalise any findings to other situations. Lambert Masters and Ogles (1991) usefully categorise the kinds of difficulty that we run across in seeking to establish robust truths about outcomes in psychotherapy. Internal validity might be limited or even nullified by problems with statistical regression, the tendency for scores to revert towards the mean on retesting. There might be issues of selection bias as clients are allocated to different groups in the study on a less than random basis, thus skewing the results of a study. We might experience differential attrition, as individuals from one group drop out more frequently than those in other groups, again skewing results. Finally, events external to the therapeutic process being studied might impact adversely on the results. External validity might be impacted by the use of measures more than once (test reactivity) or by the fact that individuals are participants in a study. Even when we have negotiated this minefield, it might be hard to generalise results from one setting to another. The classic approach in the search for robust data on outcomes, central to the randomised control trial, is to compare the treatment group with a control group not receiving treatment. Often those left on waiting lists are used as a form of non-treated control. This approach has been criticised (Kazdin 1994, Prioleau et al 1983, Basham 1986), with the latter two taking the view that such an approach fails to control for issues of patient expectations, and that this confounds the results derived.

These methodological issues might seem rather arcane to the practitioner, whose greatest concern is 'the poor success of RCTs in predicting outcome at the level of the individual case from data summarised at the level of group means.' (Margison et al 2000). However they impact directly on the problem of the generation of practice based evidence or PBE (see below).

Central to the issue of outcome measurement at a local level is the question of just how we *measure* change. Clearly in routine evaluation, as opposed to one off studies, we need a routine measure, and indeed this was an explicit part of the design brief of CORE (Barkham Evans et al 1998). Instead of seeking to compare outcomes with

some form of control group, we compare outcomes with normative data derived from relevant populations. Such data informs the development of scoring instruments, such that the scores derived reflect the individual's position in relation to a normative population.

The field of outcome measurement had a long tradition prior to the development of CORE (see Barkham et al (1998) for a fuller discussion of this area). Briefly, there were many rating instruments, such as the BDI and SCL-90, which were used successfully in clinical practice, either to inform assessments or on a pre post basis as *de facto* outcome measures. The large number of instruments in use became a problem however. Reviewing 1,430 outcome studies, Froyd et al (1986) found that 851 were used only in one study, and 278 provided no psychometric data. Mellor Clark, Barkham et al (1999) found a similar situation in the UK. Echoing Froyd et al, they concluded that the field of outcome measurement was 'in a state of disarray, if not chaos' (p368) with no standard instrument in widespread use. This made routine collection and comparisons of data between studies and between sites virtually impossible, and was a barrier to the development of routine data collection systems (DoH 1996. Roth and Fonagy 1996). Previous attempts at producing measures that could be used widely and routinely (Waskow 1975, Strupp et al 1997) had not succeeded. The Strategic Review of Psychotherapy Services (DoH 1996) suggested that links be established between clinical practice and research using outcome measures. This provided the impetus for the development of a standardised measure.

The development of routine measures adds another set of complexities in addition to the psychometric issues mentioned above. As Thornicroft and Slade (2000) note, in addition to being standardised, any routine measure needs to be acceptable to clinicians, and feasible for ongoing routine use. In practice this means that it is short enough to be acceptable to clinicians and clients and robust yet sensitive enough to provide data that is of clinical value. One approach to this problem was HoNOS (Wing et al 1998). Whilst there has been some evidence of its effectiveness (McLelland et al 2000), it has been criticised as not being sensitive enough to measure change in psychotherapeutic settings (Trauer 1999, Audin et al 2001). It thus appears not to pass Thornicroft and Slade's criteria for a routine measure.

1.3 The Development of CORE

1.3.1 Definition and description

CORE (Clinical Outcomes in Routine Evaluation) is based on a 34 item client self report questionnaire that assesses the psychosocial domains of;

- Subjective well being
- Symptoms
- Life/social functioning
- Risk (to self and others)

The Outcome Measure (OM, see Appendix 1) is designed to measure a pan-theoretical 'core' of clients' global distress, including subjective well being, commonly experienced problems or symptoms, and life/social functioning. This is based on Howard, Lueger et al 's (1993) work which links therapeutic change to the processes of remoralisation, remediation and rehabilitation. In addition, items on risk to self and others are included to aid and assist risk assessment.

Global level of distress is defined by the average mean score of the 34-items, compared with clinical thresholds before. (from CORE website). The OM is completed by the client pre and post intervention In order to provide further data, clinicians complete a Therapy Assessment form and an End of Therapy form at the start and end of the process respectively. Examples can be seen in Appendix 1.

1.3.2 Background and development of the measure

CORE was designed by the CORE System Group (CSG) at the University of Leeds (Barkham, Evans et al 1998, Mellor-Clark, Barkham et al 1999). Central to the thrust of its development was the need to introduce some rationality and consistency into the access to, and provision of, psychotherapeutic services nationally (DoH 1996. Roth and Fonagy 1996). This was to be achieved by the use of evidence from controlled trials on the psychotherapies to inform the design and organisation of services. This is generally known as evidence based practice, or EBP. This was seen as insufficient however. There are many reasons why an approach (let us say for example, brief interpersonal therapy with depression) that appears to be *efficacious* in trials, might not in fact be *effective* in a day-to-day clinical setting. We therefore need to generate good evidence about outcomes in ordinary clinical settings, where our findings are based on day-to-day practice, rather than specially established treatment regimes with selected clinicians and clients. This is known as practice based evidence, or PBE for short

(Barkham and Mellor-Clark 2000. Margison et al 2000). It was envisaged that PBE would be compared with evidence from controlled trials to generate a true evidence base for psychotherapeutic interventions. Thus the thrust behind CORE was not simply about measuring outcomes on a routine basis at a local level. It was also about developing large data sets derived from practice populations that could inform the field of outcome research.

As indicated in 1.2, no standardised measure existed, making comparison between outcomes at different locations, or indeed between different studies, exceedingly difficult, if not impossible. Thus the generation of PBE in practice rested on the development and use of a broad standardised outcome measure.The intention was to provide a UK normed measure that was free of the usual copyright and commercial pressures. The forms were and remain cost free. The only stipulation, brought about by experience (Mellor-Clarke personal communication), is that the integrity of the forms remains untouched in order to preserve their psychometric validity.

The funding for the initial development of the system was provided by a variety of organisations to the tune of £500,000 (Richard Evans, personal communication). The brief was to produce a valid and simple to use measure for routine clinical audit. This would allow for the generation of a very large database, and the development of benchmark data to provide reference points for services *vis a vis* their performance. Using this funding, the CSG "developed, piloted and implemented a co-ordinated quality evaluation, audit and outcome benchmarking system for psychological therapy services. This involved working closely with a range of stakeholder groups, representing psychiatry, psychotherapy, clinical psychology, and counselling from across the UK." (CORE PC website.)

An initial part of the development process involved a qualitative study of service commissioners (Chief Executives of Health Authorities) managers of psychology and psychotherapy services nationally. Overall the survey showed considerable support for the use of standardised measures, with 76% of purchasers indicating support for standardised measures across all psychological services. 78% of providers saw considerable utility in the use of standardised measures (Mellor-Clark et al 1999). A survey of 998 UK service providers replicated Froyd et al's (1996) findings, with 66% of

measures being used in single sites. Responses from both purchasers and providers indicated an overwhelming desire to see routine standardised data collected. This gave the green light to the development of a generally applicable outcome measure. The same survey showed that the areas clinicians were most concerned with in understanding outcome were symptoms, functioning and subjective well being. (Mellor Clark et al 1999). These areas were taken and used to inform the structure of the OM, ensuring that it is an instrument grounded in the actual practice of a range of clinicians.

The OM was designed by examining widely used measure such as the Beck Depression Inventory and SCL-90, and extracting items, which were then clustered and further examined. The final 34 questions were developed to elicit information on the four areas described in 1.3.1. Further information on the technical development of the measure is described in Barkham et al (1998), and is not repeated here.

The first wave of research presented data demonstrating the statistical validity of CORE, and its reliability as an assessment and outcome measure (Barkham, Evans et al 1998, Mellor-Clarke, Barkham et al 1999, Evans, Connell et al 2000, Barkham, Margison et al 2001). This led to widespread interest in, and use of, the instrument across a wide variety of psychological services, especially those offering counselling, with over 100 organisations using CORE routinely by 1999 (Mellor Clarke et al 1999). Further work using the rapidly expanding national database, has begun to produce evidence for the effectiveness (at least in the short term) of counselling in primary care settings (Mellor-Clarke, et al 2001).

Originally, completed CORE forms were scanned and analysed via the University of Leeds. Although the entire system was intended to be non-profit making, there was a significant per patient/per annum cost for this service. Indeed the cost lead to the service that I then worked for deciding not to use the CORE system routinely in 1998. Despite this cost, the University realised that it was making a loss on the enterprise, and withdrew in 1998. The intellectual copyright remained with the trustees (members of the CSG). The task of developing and marketing a lower cost PC version became the responsibility of CORE-IMS Ltd, a company run by John Mellor Clarke, in close collaboration with the CSG and Richard Evans.

The first PC version was made available in early 2002, and PC-2 was rolled out in mid 2003. The introduction of the PC version changed the way in which CORE could be used in a quite revolutionary manner. Previously data was sent away to Leeds, analysed and gathered into a report that came back some months later. With PC, the analysed data was potentially there at the touch of a button. There is no gap between entering raw data and generating results. One doesn't get a written report, and much more effort has to be put in to collating the various streams of information into a coherent shape, but the results are on stream constantly. The time lag is removed, and information is no longer out of date by the time we get it. This form of dynamic audit[2] is a new and challenging development, removing as it does the built in time lag associated with traditional audit.

In terms of analysis of the data, an alternative was to use SPSS. This was discounted because I was informed that it would be more costly than CORE-PC, also data input is more complex than with CORE-PC software, and it would have required time to establish the required analyses. SPSS also presents data in a manner that it less user friendly than the CORE PC software.

1.3.3 CORE and practice research networks.

Central to the CORE project is the concept of the practice research network. Simply put, these are "a network of clinicians that collaborate to conduct research to inform their day-to-day practice (Audin et al 2001, p242). They are seen as an ideal means of generating PBE and thereby narrowing the research-practice gap.

The development of CORE PC, and the rapid growth in the number of services using it meant that the CORE system rapidly generated the largest database ever accumulated in the field of psychological therapy. Services provided data under the old system on the understanding that it would be stripped of identifiers and added to a central pool. With the PC system, users were asked to contribute data at regular intervals in order to add to the national pool.

[2] I had struggled for some time for a suitable term to differentiate it from a traditional audit when I heard John Mellor Clarke use the term at the CORE primary Care conference in April 2004.

It will be seen therefore that CORE is an attempt to generate evidence about what we actually do in clinical practice, and that it sits astride the traditionally separate domains of research and practice. Although methodologically it has relied largely on quantitative approaches thus far, it has incorporated qualitative approaches, especially at the beginning. In its emphasis on practice and the change thereof, I do not think that it is too fanciful to see the CORE project as a very sophisticated form of Action Research.

1.3.4 Validity, reliability and sensitivity

The evidence that we gather is only of true value if it is derived from a measure that is valid (i.e. it measures what we are setting out to measure) and reliable (i.e. the score that is given approaches a true measure of the issue and will tend to be replicated should the instrument be completed more than once). With any routine outcome measure such as CORE, the key question is does it produce a valid measure of an individual's level of psychological distress, and does the score provided reliably differentiate between those who are troubled and those who are within the normal range? The best evidence suggests that it does (Evans et al 2002), with high test-retest reliability (0.87-.91) on all items bar risk.

If we are to know that there have been changes in an individuals score from pre to post therapy, we need to know that any difference in scores is genuine and does not result from some kind of measurement error. In order to determine this, we need a test of significance. This is basically a statistical way of determining the likelihood that a change is a true change, as opposed to an artefact. Jacobson and colleagues (Jacobson et al 1984, Jacobson and Truax 1991) provided a useful framework for providing pre-post data in a fashion that takes account of this issue, which they call the reliable change index or RCI. They use the standard error of the difference score ($s.e._{diff}$), which relates to the standard deviation of the population and the reliability of the measure. If the change measured for an individual is more than 1.96 times the $s.e._{diff}$ then such a change is unlikely to occur on more than 5% of occasions by chance.

'In practice this leads to a very simple way of representing change for a group of individuals on a two-dimensional graph, where the *x*-axis represents the pre-treatment score and the *y*-axis the post-treatment score on the same instrument. Every point on the graph represents an individual who has the corresponding pre-treatment and post-

treatment scores. The centre diagonal line represents all the points where there has been no change between before and after treatment (x=y). The 'tramlines' on either side of the diagonal represent the limits of 1.96 x $s.e._{diff}$, and so for anyone falling within the tramlines, a change could be attributed to chance. Those falling above the upper diagonal have reliably shown deterioration, whereas those below the lower diagonal line have reliably shown improvement.' (Margison et al 2003. p126)

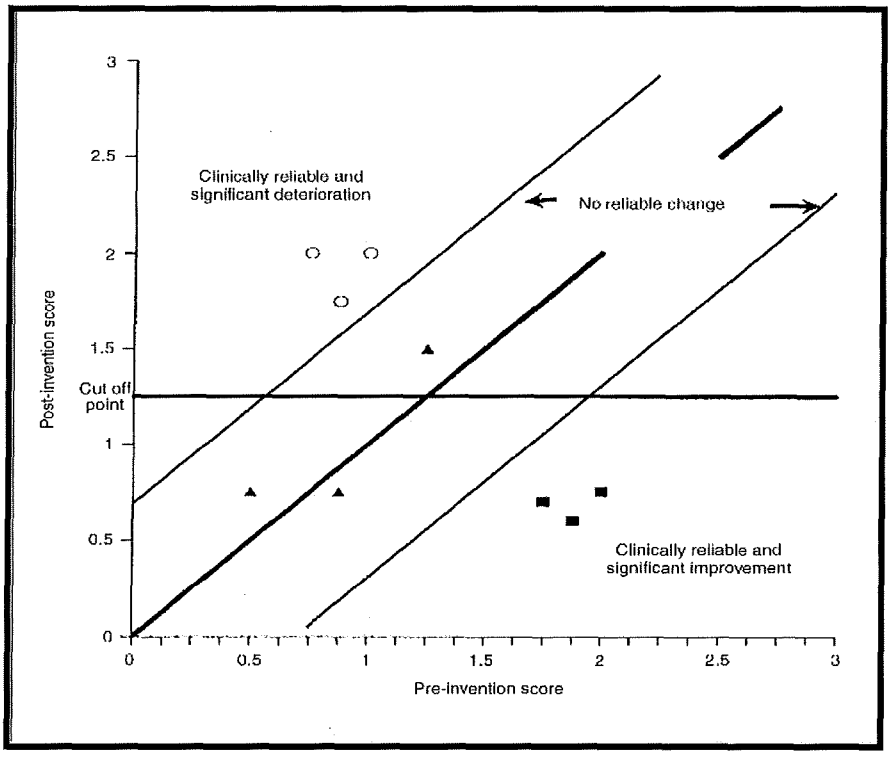

Figure 1-1 Pre-Post Scores with Indication of Reliability (from Margison et al 2003)

Figure 1-1 illustrates the way that Jacobson and Truax's (1991) thinking can be used to present pre-post measures. Thus we can be confident that in 95% of cases outside the tramlines, the change seen reflects a true change for the individual concerned.

This approach also highlights the importance of measuring the extent to which change has been clinically significant by determining whether the individual has moved from a score typical of a clinical population to a score typical of a normal untroubled population. The use of this approach in the CORE system allows us to estimate the level of clinical change for both individual and group, and be clear whether that change can be relied on (Evans et al 1998, 2002).

1.4 Critical Evaluation of CORE

1.4.1 CORE as a Self Report Measure

CORE OM is a transparent self-report measure, and it shares the strengths and drawbacks of any such measure. Self-report allows us to begin to get close to what someone is really experiencing, but at the cost of potential bias. There may be conscious attempts to skew the impression given in order to create a certain impression. The OM should therefore be interpreted with caution where there is any reason to suggest that an individual might have a motive to present in a certain way. This caution applies particularly to the risk items, which should be approached with some scepticism, especially in the context of criminal behaviour, or other behaviour that might be assumed to be embarrassing for the individual to report. The need for caution *vis a vis* the risk items is reinforced by its comparatively low test-retest reliability, which at .64 is much lower than the other items (Evans et al 2002). It is recommended that they be used as triggers for discussion with clients and not treated as a scale (Mellor Clark, Barkham et al 1999)

The very brevity that allows the OM to be acceptable in routine practice precludes the inclusion of response distortion scales embedded into instruments such as the MMPI-II and MCMI. We therefore need to remain clear that we are seeing very much what someone wants us to see. Bias may exist at a less conscious level, as individuals seek to ensure that they demonstrate being 'distressed enough' to merit a service. At the completion of therapy, it is not unreasonable to expect that positive or negative feelings towards the therapist might lead to skewed responses. The point at which an OM is completed is likely to have an impact. One might generally expect less declared distress if a measure is completed some while into a first session than if it is completed prior to seeing a clinician.

A self-report measure relies on the individual's capacity to report accurately on their experiences. We need to maintain an awareness of numerous caveats that might limit this ability. These range from simple misreading of instructions, to profound personality traits that can severely limit an individuals' ability to accurately report on their current state. It might therefore be of little or no value with populations where the ability to accurately self-report is limited, such as those experiencing acute major mental health problems.

Whilst no specific research exists in relation to the presentation of CORE, it is reasonable to assume that the manner in which the OM is presented to a client might markedly affect their response. OM scores might well reflect the attitude and expectations of the therapist, at least to some extent.

1.4.2 CORE as a Routine Generic Measure

A key issue with any measure is exactly what are we measuring? With CORE-OM it is important to be clear that it is designed as a robust brief and general measure of psychological distress. It measures self-reported current state, without seeking to comment on underlying personality traits. The connections between current state and underlying personality structures are complex and subject to much debate, and CORE-OM makes no statements about these connections. 'Improvement' in CORE terms is therefore a statement from the client about how they report their state pre and post therapy. This is very different from seeking to generate data on profound personality changes, as has been demonstrated using in depth personality inventories such as the MMPI-II (for example Gordon 2001).

The meaning of 'improvement' on the CORE OM in an individual case needs to be teased out using clinical acumen. The OM score tells us about the self reported state. In clinical usage it is therefore important that we consider this score alongside our knowledge of the individuals history and our thinking about their personality style. A low score might indicate that someone is untroubled, or that they are very reticent about declaring their troubles. Similarly, a marked change might seem less significant if it is in the context of a borderline personality disorder where there is a pattern of serious shifts from self-state to self-state across time.

Overall, we need to ensure that we maintain clear sight of the fact that the OM is a routine generic measure, and as such trades depth for ease of use and acceptability. It measures what is on the surface as declared by the client. Whilst it correlates well with BDI scores, it is not intended to identify specific psychological difficulties, far less underlying personality characteristics. It entirely ignores substance abuse for example. The development of problem specific spokes was originally envisaged to assist in work

in specific areas (Mellor Clark Barkham et al 1999) but to date these have not been developed.

The RCI (see 1.3.3), central to understanding the presentation and significance of pre-post CORE-OMs, has been criticised. Lunnen and Ogles (1998) found some evidence that it identifies those who make significant positive changes, but is less good at differentiating those who don't change from those who deteriorate. In practice when using this approach, we need to bear in mind that 5% of those who appear to have improved reliably might still have gained such a result by pure chance. This, and the measurement error inherent in all psychometric instruments behoves us to be cautious about interpreting the meaning of any score. As ever, we need to ensure that we interpret scores in the light of all known factors, rather than falling for the temptation to reify the data.

1.4.3 Use of CORE

The OM can be used as an aid to assessment, but in this area it would have strong competition from other tools. For example with depression the BDI is likely to produce more useful data, and in cases of suspected trauma, the TSI might be more useful. It is better placed as an outcome measure in single cases, due to its sensitivity, acceptability and its ability to indicate the level of reliability of change. The OM is unlikely to be of value where the task is to try and tease out personality styles, or to identify specific areas of difficulty (such as PTSD). About the former it has nothing to say, and regarding the latter, it is too general to do anything other than flag up the possibility of a problem.

CORE's great strength is as a system, used routinely to produce relatively robust data that can generate very large data sets, which can in turn be used to produce benchmark data (see 1.5.2). Standardisation helps produce results that are comparable, and it is from this that the greatest benefit to our practice is likely to be derived. Despite the caveats about the OM outlined above, my view is that this is a valid and worthwhile exercise to undertake, both for audit and to feed back the data into clinical practice. Data is always skewed. In practice the key issues are, is the data good enough to be potentially useful, and in practice do we bear in mind and correct for the skewed nature of the data?

In spite of the limitations of the CORE OM, CORE is the only system available that can both be used routinely with clients and developed into large data sets, which can be analysed at the service and clinician level. This is the crucial feature that makes it potentially useful in improving overall clinical effectiveness. It is the capacity of the CORE system to routinely collate and present data, making it possible to identify patterns in that data, which is the key to my decision to use this system. Other instruments such as the SCL-90, are extremely useful in clinical work, and can be statistically analysed for one off research purposes. What they lack is a developed package for analysing data on a routine across cases. However it remains important to maintain a critical relationship with the data, and to ensure that its limitations are counterbalanced by constantly interpreting it in the light of all available knowledge and understanding of the client, within the clinical relationship.

1.5 The broader picture: Audit and clinical governance

1.5.1 Audit

The term clinical audit is presently widely used (Cape and Barkham 2002, Parry 1992, Crombie et al 1993, Firth Cozens 1993). It has been defined as;

"The systematic critical analysis of the quality of medical care, including the procedures used for diagnosis and treatment, the use of resources and the resulting outcome and quality of life for the patient" Working for Patients 1989.

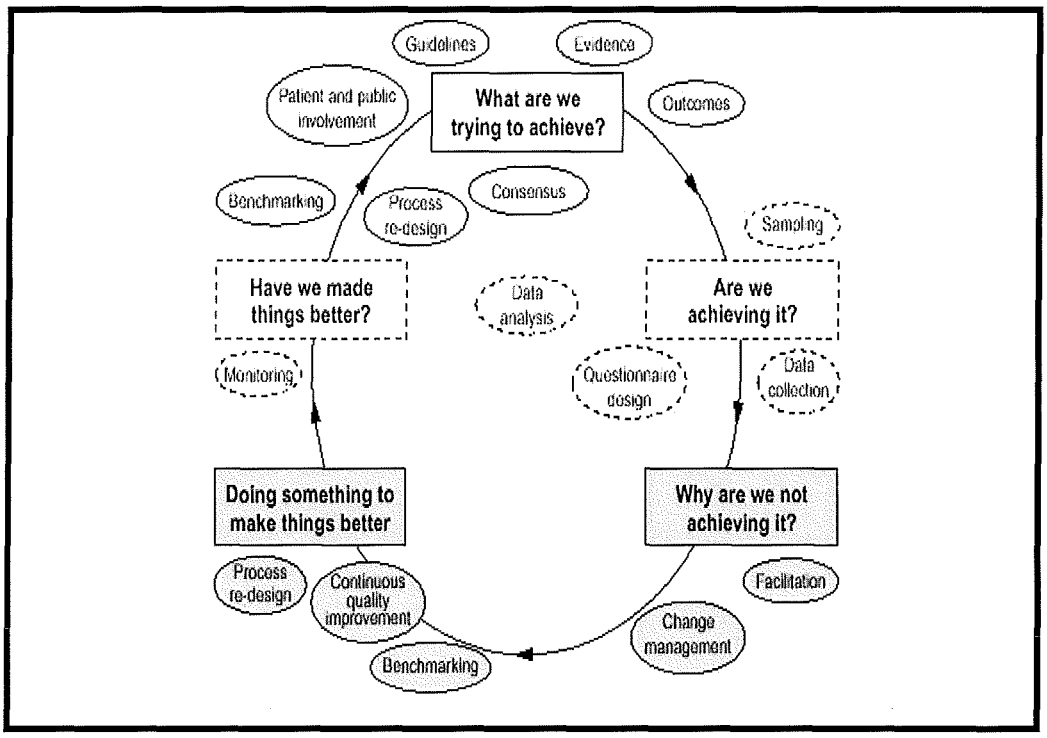

Figure 1-2 The clinical audit cycle (from CHI 2002)

As the above diagram illustrates, it is conceived of as a circular process consisting of setting standards, checking if we are achieving them and reviewing. By proceeding through these cycles, a check is made on how a service is performing, and standards are reviewed and re set in line with the evidence. It is of course not so simple in reality, as the neat cycles and reviews get lost or peter out (Berger 1998). The following quote summarises nicely:

"Clinical audit has a mixed history in the NHS, and for every success story there are just as many projects that have run into the ground without demonstrating any significant contribution to quality of services. Many of audit 's early adopters have lost the enthusiasm they once had. This legacy needs to be addressed if individuals and teams are to re-engage their hearts and minds in clinical audit. Many audit projects have foundered as a result of poor project design. Problems with clinical data have been particularly common. Data have often been of poor quality and inaccessible, or alternatively have been collected because of administrative convenience even where they are not accepted as relevant measures of clinical quality. In many cases the dataset has been simply too large to be workable within a busy clinical service weighed down with other priorities." CHI (2002) p9.

Perhaps this is because many audits gather a lot of data but give insufficient feedback (Parry 1992), and what is given is often directed towards external stakeholders. Even where feedback is given, we are loath to change our behaviour as a result of audit data (Oxman et al 1995). A recent review comments "Reviews of audit and feedback have come to different conclusions about their effectiveness in changing practice." (Cape and Barkham 2002.) It appears that we humans have considerable difficulty altering our habits as a result of information. There is no good reason to think that this applies any less to counsellors than to others.

1.5.2 Benchmarking

An outcome measure by itself is of limited audit value. What makes CORE an audit tool is the development of very large standardised data sets, from which benchmark data can be derived (Barkham et al 2001, Evans et al 2003). This allows for the comparison of service data with nationally derived data (see 3.2.3), thus introducing the capacity to assess performance against other services. This locates the CORE system firmly within the world of audit as well as outcome measurement.

1.5.3 Clinical Governance

This is a term that currently has considerable influence in the NHS. It was introduced in the 1997 paper 'The new NHS', which defined it as:
"A system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish. The basic components are a coherent approach to quality improvement, clear lines of accountability for clinical quality systems and effective processes for identifying and managing risk and addressing poor performance." Dept of Health 1997

Scally and Donaldson (1998) locate the development of the concept as arising from a reaction to the previous market based regime, thought to have placed professional standards second to financial constraints. Simultaneously, public confidence had been undermined by clinical failures. The concept owed much to the previously introduced notion of corporate governance.

The term is a rather cumbersome one, subsuming several processes, especially audit, under its umbrella. Overall it is an attempt to describe an organizational mindset in which quality and its improvement are seen as central. In this sense it has links to previous notions of quality management, explored previously in health settings (Maxwell 1984. Smith-Marker1987). This rests on the development of clinical audit systems and processes for monitoring clinical care, as well as policies and procedures for managing risk. All of this is in the context of clear lines of responsibility.

It will be clear that the concept of clinical governance is far reaching, being descriptive of structure, processes and attitudes. As Scally and Donaldson (1998) comment, "it requires an organization wide transformation; clinical leadership and positive organizational cultures are particularly important."

The relevance of the above to this project is twofold; firstly it illustrates that the current political agenda in the NHS is favourable (at least in principle) to efforts to gather and use data in service management. Secondly CORE stands as a potentially useful tool in the development of good Clinical Governance.

1.5.4 The benefits of audit

Taking a consistent and standardised look at our work offers the opportunity to validate the good work that we do, to finally show beyond reasonable doubt that our work is effective[3], not in our view but in the clients. It can show where we are strong and where we might improve, collectively as well as individually. Politically, good evidence about our impact is the best tool that we could have, a belief that I have confirmed in the course of this project (see Context docs 1 and 2). More than this, CORE potentially helps us become the antithesis of Winnicott's teacher and genuinely accrue 30 years of experience. All of this too forms a central part of my motivation, my passion, for this project. W e have to acknowledge as well that it might well shine a light on practices that are less than ideal. If we are to truly use the data provided, we must be willing to engage with this as well as with the positive.

[3] As measured by CORE-OM

1.6 Summary

In my view, reflecting on what we as clinicians do is imperative. However, the stories that we tell ourselves about what we do, whilst vital, are also suspect. This is for a number of reasons. Human memory is a very fallible (see Appendix 10), and we are all prone to faulty recall. Any reflection that relies simply on our memory is therefore going to be flawed. Even when our memories are accurate, we are all subject to the tendency to force what we see into our pre existing maps. Korzybski's (1958) wise words that 'the map is not the territory' are too easily forgotten in the day-to-day pressure to make sense of a complex and ever changing reality. We therefore need another way of examining what we do. However, in order to validly detect patterns, a measure needs to be used *routinely,* (to collect data across a wide enough spread of situations) and applied in a way that is *standardised* (to allow for comparisons to be made).

This view is by no means revolutionary in the present NHS climate. It is central to the concept of Clinical Governance. In this project I am therefore swimming with very powerful currents, and the work is located within a community of like-minded practitioners. This is important in giving the project a political base.
CORE has been specifically designed for this purpose, and as a package allows for this in a way that other potentially useful measures are not equipped to do.

There are problems however. With any instrument we might be tempted to see it as providing more than it actually is capable of providing. We need to ensure that in practice we constantly reflect on the true nature of the data being analysed. After all, data is always skewed. In practice the key issues are, is the data good enough to be potentially useful, and do we bear in mind and correct for the limitations of the data? In clinical practice we can maintain a balance by using the data as a part of our considerations, combining it with other sources of information and reaching balanced considered judgements as to its usefulness.

The OM is a transparent, self report measure open to deliberate or unintended distortion. In seeking to provide a measure of general distress, it cannot provide more than a general impression of self-reported state. It does this with reasonable reliability and validity, and can therefore be judged as good enough at this level, but we must be clear that the concept of 'outcome' in CORE terms has its limitations. On the other hand, the OM was designed

using data gathered from practitioners about what they looked for in assessments, and is thus grounded in the domain of practice as well as research.

The OM's limitations are more than offset by the ability of the CORE system to generate data sets that allow us to begin to allow us to take a different complementary perspective on our work. In this latter capacity CORE is unique. It is the combination of a good enough general outcome measure, with a system for making sense of the data, that make it a pragmatic choice with a better than average chance of providing us with something useful, at least until something better is developed.

The jumping off point for this project came with the introduction of the CORE PC version. The instrument has been validated, and used in a traditional audit process. What has not been done is to examine how we can make use of it as practitioners. We have no structured evidence about how this new toy can be used by clinicians and service managers. The canvas is in fact rather frighteningly blank. I have therefore chosen a research design that is broad and flexible, in order to allow for the greater possibility of generating practice relevant knowledge.

Where I am seeking to make an original contribution to knowledge is in exploring how we make use of this new opportunity. I am intent on creating a service in which we make use of the practice-based evidence that we generate. That is the action part of what I am doing, creating a learning organisation in which we collect and use evidence in the pursuit of practice relevant knowledge. From this I hope to identify pointers that might assist others in the same task in the future. Of course this inevitably means that at times I have to be satisfied with the outline sketch, not the draughtsman's detailed blueprint.

As explained in more detail in context document 3, this project uses a mixed methodology informed by Action Research. As outlined by Schon (1983);
" in real world practice, problems do not present themselves to the practitioner as givens. They must be constructed...In order to convert a problematic situation into a problem, a practitioner must do a certain kind of work.
Problem setting is a process in which, interactively, we name the things to which we will attend and frame the context in which we will attend to them". p 40.

A central task of this project is therefore to engage in "a reflective conversation with the situation" (Schon 1983 p130). From this reflective conversation emerge suggestions about ways of using CORE, problems with the instrument and its use and of course further questions. It is in developing this reflective conversation that my perspective as a psychotherapist comes to the fore. The skills of taking people with me, dealing with conflicting and often difficult material and managing process are all an important part of the weft and warp of this project and of me as its prime mover. It is that, often implicit, psychotherapeutic perspective that makes this work firmly a part of the psychotherapeutic world.

This project spans many worlds. It spans the clinical and the research worlds, as is the nature of this doctoral programme. I am however examining how we use a tool that itself spans those worlds. CORE has been developed in order for us to be in a position to develop Practice Based Evidence, to put alongside Evidence Based Practice Figure 1.3 locates CORE at the bridge between these two ways of generating knowledge, and shows where this project stands within the greater CORE project. I am fascinated by this bringing together of domains that have been separated for too long, and see CORE as currently the leading practical approach to doing this. Seen within these terms, my project is examining the generation and use of PBE generated by CORE.

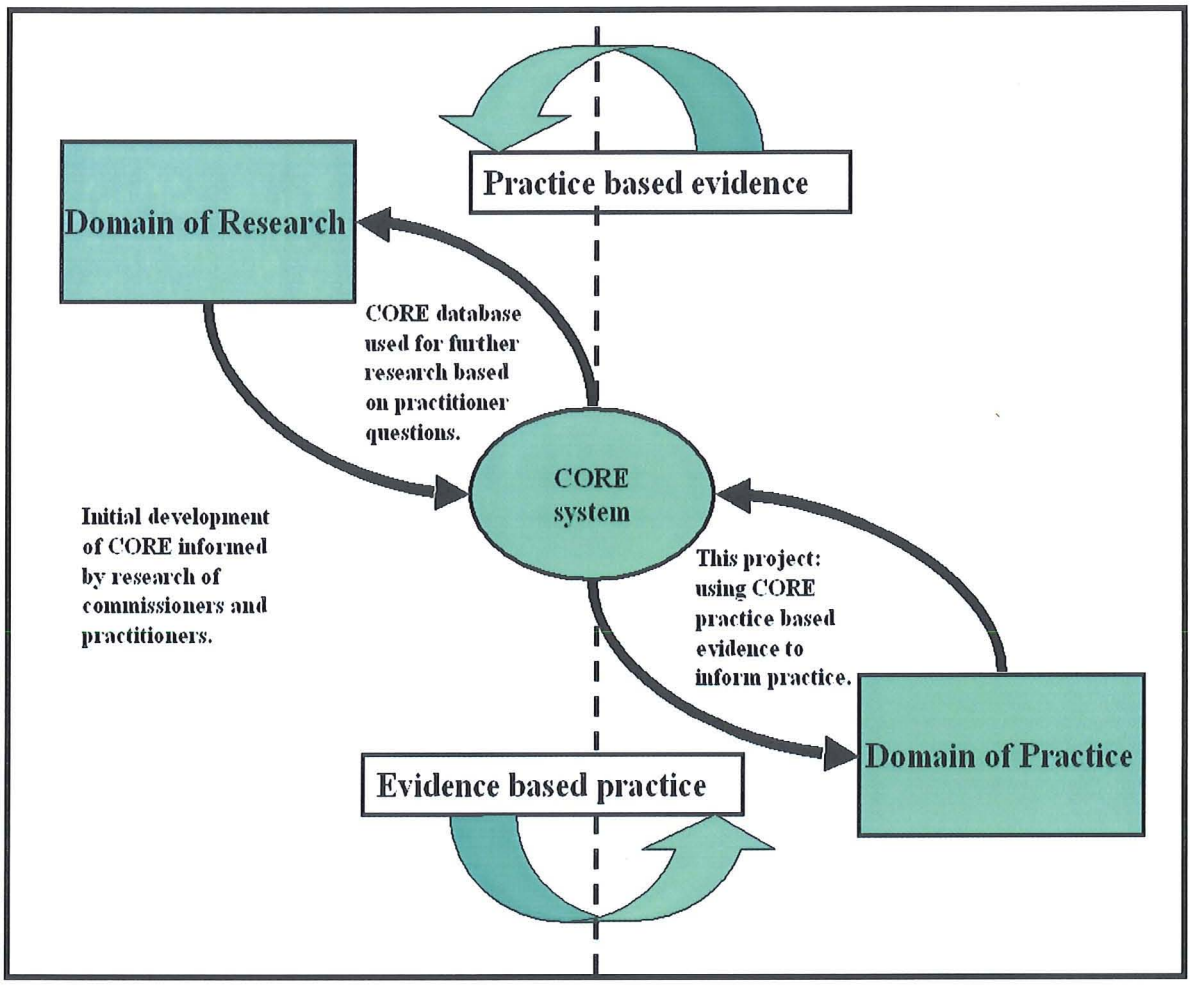

Figure 1-3 Domains of CORE

The project also spans the quantitative and qualitative research approaches. I examine the use made of the quantitative data that emerges from CORE PC software, using an approach that is broadly (but not purely) qualitative. Thus issues of quantity and quality are both firmly embedded in the enterprise.

Finally, the project spans the worlds of management and clinical practice, areas that have again remained traditionally rather separate.

Chapter 2. Steps in the dance

2.1 Process or management issues

At the point of acceptance of my doctoral proposal in November 2003, this project had already been through some vital stages. We had established the use of CORE, and counsellors were used to managing the process of having clients complete Outcome Measure (OM) forms. I had established a workable and sustainable process of ensuring that data input was achieved. The latter had required attention since it had become clear early in the project that data input was the weak link in the chain required to produce an up to date, useable database. In the early part of 2003 we were taking some 6 weeks to enter data. Consequently our information was not as up to date as it could be. Arranging for several members of the secretarial staff to take responsibility for entering data solved this. It also divided up what is a really dull task if done for too long.

2.2 Leadership and culture.

As I began to immerse myself in the project, I realised that I had already done a considerable amount to develop a 'core friendly' culture. I first started to become aware of it when my service had the introductory CORE workshop with John Mellor-Clarke and Richard Evans in early 2002. Their feedback, based on running similar workshops across the country, was that the counsellors seemed very enthusiastic and knowledgeable about CORE. At first I don't think that I realised the extent to which this was a result of my leadership. Furthermore, I did not see it as an integral part of the 'real' project. Somehow I placed my actions outside of the frame, viewing them as at best preparatory spadework for the true project. I think that this reflects the struggle that I had early in the project. I was still taking a narrow traditional view of my undertaking, seeing it as akin to standard research rather than as a true project. I think that this is a nice example of going through the reflection-action cycle backwards. I took action based on tacit knowledge, only really making my thinking explicit after the event.

In parallel to the organisational tasks related to CORE, I had done a considerable amount of introducing, enthusing and teaching. I had taken the project by the scruff of

the neck and began to make it happen. This began to sensitise me to the key issues of leadership and culture in introducing and making use of any audit system. I really began to understand this issue as I prepared to teach others, in this case my presentation to Brighton colleagues. It is so often the case that it is only when I am thinking of what I want to tell others that I really clarify what it is that I am thinking. I don't think that this is a unique experience.

So what are the qualities of leadership that I have used thus far? Central is *enthusing*. I have been told that I am very enthusiastic about what we can do with CORE. This fits with my internal experience. I can do this congruently because I strongly believe that taking constant well structured 'soundings' that can shine some light on what we are doing (as opposed to what we think that we are doing) is essential. This is balanced by a willingness to be upfront and *engage* with the difficulties and potential weaknesses in the enterprise. I am not convinced by naïve uncritical optimism, and I do not expect anyone else to be either. Knowledge is vital. I have immersed myself in the system, spending hours examining it, and then teaching and mentoring colleagues to help *inform* them and generate the level of technical fluency necessary to begin to make active use of the system (see appendix 2, A trip through the CORE system).

There is however, some value in thinking about what I have done thus far in phases; I think of an **Introductory phase,** in which the focus was getting the whole system established. This involved lots of practical work on CORE. We had discussions about how to manage the introduction of the OM in sessions, how to code certain parts of the counsellor completed forms etc. These conversations occurred in various fora, including in clinical supervision. At the time I had something of a tussle as to how far I thought this was appropriate, since it sometimes seemed that we were getting bogged down in minutiae and at risk of forgetting the clients. In fact I think that this represented a step that only later took on great significance. CORE had been allowed (and encouraged) to penetrate the bastions of clinical supervision. As argued below, I now see this as crucial to the development of a culture in which we truly engage with the data and make use of it.

I later learned that my service was somewhat unusual in that I ensured that the CORE file was networked and accessible from three PCs in the building. As with so much of

my early moves, at the time I did not see this as particularly noteworthy until I began to consider the issue of counsellor access (see below). From then on it became clear to me that network access is a crucial tool if one is to truly establish a database that is widely and regularly used.

Parallel to this set of tasks was the need to develop a head of steam, as I sought to generate a sense of vision about where we might go with CORE. As I consider this in retrospect, the parallel with clinical work strikes me. Clinically, one is often faced with the task of helping individuals generate different visions of how their life might go, as alternatives to the self-limiting and destructive visions that are so often a part of the problem. It is only by doing this that we can help the client develop appropriately positive self-fulfilling spirals. This phase concluded after the first round of 1:1 meetings, as I began to identify a broader problem.

After we had begun to meet to examine the data, I identified a need to broaden out the whole process, which I came to think of as the **phase of establishing wider access.** I was concerned that everything should not focus on me. I had access to the database, as did the secretarial staff, but the counsellors did not. This seemed wrong in principle. Information is power, and I did not want to unnecessarily concentrate power in my hands. There was a strong pragmatism behind this concern as well. Thinking systemically, this hub and spoke set up had a built in choke point, which was myself in the role of controller of access to data, and influencer of how that data might be seen and used. I did not want to negate this role, since as manager I properly had to take authority and responsibility. It was not sufficient however, since groups tend to function better where elements of roles and functions are shared. A web is stronger than a wheel, especially where information flow is concerned. People will only truly engage if they can get at it for themselves.

For some while there was a practical and ethical set of problems that prohibited me from moving forward on this. The way that the software was written allowed access to the entire database. This meant that anyone going in could see everyone's individual data as well as their own and the entire picture. I did not consider it appropriate that counsellors could 'peek over the garden fence' at others individual scores (and neither did they when I mentioned it to them). Also, the system allowed anyone in it to alter

data, which conjured up visions of a major catastrophe when someone pressed the wrong buttons, as well of course as being a green light for inappropriate 'tidying' of data by counsellors. I discussed these problems with Alex the software's designer. He wrote in the facility for limited access, in which people could be given a code that allowed read only access of their individual profile and the overall data, but not anyone else's data. Once the system had been amended in this way, I felt free to proceed. This is one of the ways in which this project has influenced the CORE system, as we have road tested it and suggested alterations.

The third phase can be thought of as **attempts at conversation**. Whether this is truly a phase is debatable, since the whole project can be seen as being about the development of informed conversations about our CORE data. However, the issue came to prominence with the 1:1 meetings, where for the first time we began to discuss the meaning of our data in any depth. It is inextricably linked with my comments under 'My developing roles...' below, since the act of conversation (as opposed to monologue) is based on mutuality and joint involvement. Such conversations serve as a means for broadening the sense of ownership of the project, as well as being in turn supported by that broad ownership.

In thinking about what I have done so far the image that comes to mind is of diving on a shipwreck in UK waters. Conditions change rapidly, and often one is faced with feeling a way around the wreck in almost zero visibility. You never quite know what you are going to find, but usually there is an incredible array of marine life from 2m eels to tiny plankton. Sometimes conditions mean that you cannot get where you want to go, and you have to adjust the plan to allow for circumstances. To prevent disorientation we use a hand line attached to a vertical shot line dropped from the boat. This allows us to get back to the boat at the end of the dive when its time to surface, and allows us to safely explore without getting (too) lost. What follows can be thought of as the shot line for this project.

In understanding what I have been doing it has been helpful to start to map out the key reflections and actions at different phases of the project. **Figure 2.1** below shows these action reflection cycles visually. The diagram should be read clockwise from the arrow

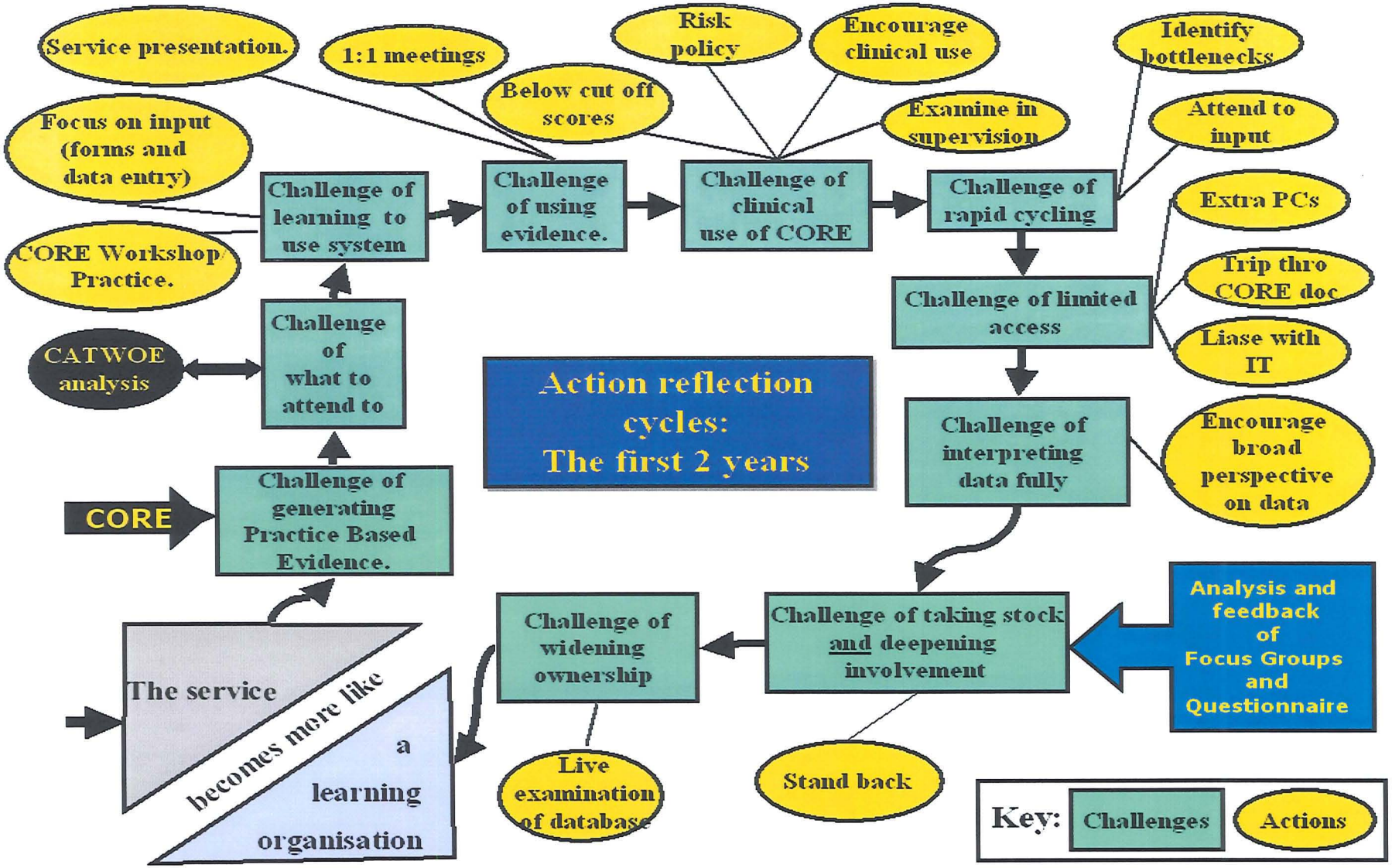

Figure 2-1 The Action Reflection Cycle

(Bottom left). Of course no diagram can capture the true complexity of the process. Events do not happen in a neat action-reflection-action pattern. I suppose this is what Schon meant by the term reflection-in-action. At times it seems like everything happens at once. Nevertheless there is some value in seeking to tease out the steps and offer some sense of the time line.

I have sought to encapsulate key nodes of attention, expressed as challenges, as a way of highlighting the key issue addressed at each phase. There never were single issues being considered at each point of course. Issues ebbed and flowed as I focused here and there on an ever-moving field, seeking to balance the numerous competing demands on me. Matters relating to the clinical use of the data are discussed in the next chapter.

The precursor to the project was the decision to routinely gather practice-based evidence and to use CORE as the means of doing so. Having taken this step, the next logical question is what am I trying to do with it? The challenge was what, of a myriad of possible things, should I attend to? As described elsewhere, getting to the point of articulating a good enough question was a complex process in itself, involving many action-reflection cycles. A key anchoring point was reached in summer 2003 when I used Checkland (and later Scholes') soft systems methodology (SSM) to analyse the task upon which I was embarked. SSM is a subset of the action research approach, requiring "Involvement in a problem situation and a readiness to use *the experience itself as* a research object about which lessons can be learned by conscious reflection" Checkland and Scholes 1990. p16.
Derived from Checkland's experience as a manager and later organizational consultant, it is an approach devised to help deal with complex 'swamp' type situations where in Schon's words there is a problem identifying the problem. There does need to be someone who thinks that there is a problem and feels that the situation needs to be managed in some way. There is an embedded assumption that some form of transformation is sought, which makes it firmly an action research approach. All of the above, and Checkland's emphasis on understanding the culture and history of particular situations from a variety of perspectives, meant that the approach had an appealing fit with the project I was embarked on. Of special relevance was their emphasis on what

they call 'issue based systems'. Contrasted to 'primary task systems' that relate to organizations structures, issue based systems are
"relevant to mental processes which are not embedded in formal real world arrangements" p32.
In other words they are attempts to understand and manage processes of learning as opposed to structural arrangements. Again this seemed highly relevant to my work with CORE.

In order to get under the skin of a situation they propose modelling it using a number of headings summarized in the acronym CATWOE. This stands for; Customers (those who stand to gain or lose by the sought after transformation); Actors (those who *do* the transformation); Transformation (the sought after change); Weltanschauung (broadly the world view that makes the sought after transformation meaningful to those seeking it); The last two letters stand for Owners (those who have the power to stop the transformation) and Environmental constraints on the sought after change. All of this goes to help develop a 'root definition', which is a statement of the desired situation expressed in active terms.

Applied to this project, the 'Customers' of this process were the counsellors and myself. We were the people upon whom there would be immediate impact. Of course the clients are also customers, since this whole project is predicated upon the assumption that they will receive a better service. It is not part of the research methodology of this work to directly address that however. Similarly referrers (GPs mainly) and the PCT as service commissioners are also customers in the ultimate sense.

Customers	**Counsellors and myself**
Actors	**Manager/counsellor/admin staff**
Transformation	**Unused data-data examined and reflected on –action taken**
Weltanschauung	**Feedback and reflection improves practice. The facts are friendly. We do not always do what we think we do.**
Owners	**Counsellors/PCT/ trust**
Environmental constraints	**Time limited as counsellors not employed**
Root definition	**A system to provide feedback , encourage reflection and appropriate action using CORE-PC data, in line with good professional practice in order to enhance that practice and develop good clinical governance**

Table 2-1 CATWOE analysis of the problem

Key Actors in the process are counsellors and myself, with admin staff also involved. Clients again are stage left, essential in providing the data and (I trust) receiving the benefits) but not being directly involved.

A key value of the CATWOE analysis has been in helping me to clarify what it was that I was seeking to achieve. The Transformation being sought is to turn unused data into information, through a process of examining it, reflecting upon it, and where appropriate taking action based upon that examination. In doing this, the practitioners and the service itself are fundamentally changed, as we become individually and collectively open systems, collecting and responding to data about what we do as opposed to what we hope we are doing. This is the heart of the project.

The Weltanschauung or worldview that informs my actions is further enlarged upon in contextual documents (especially 3, Methodology.) and in the initial chapter. Owners (defined by Checkland and Scholes (1990) as those who can prevent the transformation) are primarily counsellors and also myself. Again of course clients are crucial but not central in this view. At this stage the employment position of counsellors was seen as the major environmental constraint (this changed significantly later, see context doc 2).

The root definition is the statement summarizing the endeavour. I experimented with the phraseology, (see Appendix 11. RM 7a), but basically this paragraph captures what I was seeking to do as well as possible. At the time, it was very useful in helping me reassure myself that I did in fact have some idea about what I was doing.

The CATWOE model provided a very useful peg on which to hang the increasingly complex project. Using this approach I was able to begin to get some conceptual 'skin' on the problem, and produce a good enough definition of the task in which I was engaged. I was engaged in a process of systemic transformation in which the key task was the transformation of data into something useful and useable. The CATWOE analysis serves as the anchor point for this cycle. It also served as an anchor point for me at times of confusion. I was able to return to the definition from time to time when multiple demands and potential next steps threatened to drive me into either paralysis or the prospect of making random choices. In particular, I took comfort from Checkland's comments to the effect that, having worked in many organisations; he had never seen anything so complex as the NHS. When immersed in a mind-boggling complexity of role function and authority, it was good to know that it was not just my imagination.

Having installed CORE the first challenge to emerge was to learn how to use the system. We were all familiar with the forms because of our previous use of CORE. Nevertheless, having identified a few problems with forms at the point of data entry, I decided that it was useful to have a reprise. The introductory workshop served as a useful space to discuss some of the practical as well as conceptual issues relating to the gathering of CORE data. On a different level it also served as an important punctuation point in the project, marking the first step, and serving as a means of engaging the

interest and curiosity of counsellors. In retrospect this was essential in setting the tone of what followed.

There were a lot of "how do I...?" type questions in the period that followed. This felt a bit boring to me. I wanted to get to the more exciting bits. However I realised that if we developed good habits at this point, our data would be sounder. Better to take time and build solid foundations rather than rush ahead and regret my haste later. I therefore spent a lot of time in impromptu conversations and in supervision on practical issues. There was a forced interregnum between starting to gather data and having enough on the database to be worth looking at. I used this space to immerse myself in the system. It was very much like buying a new computer game, as I spent time finding out what button produced what result. The language that I used at this time was interesting, I thought and spoke of having a new toy.

As the database grew, addressing the question of how to begin using the data became the central challenge. I tussled with the timing of this. My formal research training led me to emphasise the issue of number. When would we have enough on the database to begin to provide valid results? This was not really an issue when looking at the overall database, since this grew rapidly. It was very much an issue when considering looking at individual performance however. I was very much aware of balancing a desire to move on and establish a culture of examining the data at individual as well as collective level, with ensuring that what we examined had some validity. The latter wasn't just an issue of scientific purism. The first meetings were going to be crucial in setting the tone of the whole enterprise. If counsellors felt that the data was dry or inaccurate then this could affect their view of the entire CORE system in an unhelpful manner. My thinking at the time is best illustrated by the following extract from a field note written shortly afterwards:

"I had generated a considerable amount of interest in CORE PC. In my experience such interest rapidly dissipates if individuals do not see anything concrete arising from their efforts. I was particularly concerned to ensure that Counsellors did not have the experience of simply filling in endless pieces of paper and never having any feedback. This has partly been addressed by my sending feedback on overall service performance as one way of completing the loop. It did, however, seem essential to begin to give them the information about their own individual performance that was now becoming

available thanks to CORE PC. My judgement was that doing this would continue to close the feedback loop and would in the long term help reinforce a positive culture about audit in general and CORE System in particular." (Appendix 8. FN 1).

In other words it seemed clear that early feedback was essential to provide reinforcement and begin the process of closing the loop. This was really the first overt acknowledgement of the need for rapid cycling, that I later came to see as crucial.

Having identified this issue, I made a presentation of the early service results at a service meeting held in December 2002 (see chapter 3, outcome figures). At the same meeting, I was keen to place the issue of 1:1 meetings on the agenda. There was considerable enthusiasm and interest at the idea of examining individual data. Again I had the tussle between purism and pragmatism. The question that bothered me was what is the proper size of individual database that allows for a valid analysis? I rapidly realised that this question was in fact rather redundant. As long as we acknowledged that patterns were likely to vary markedly, there was value in becoming engaged in the process of examining individual data. We agreed that anyone with over 25 clients on the system would contact me and arrange a meeting. The enthusiasm shown in the meeting was matched by action. By late January 2003, 7 of the 8 counsellors with the requisite number of clients had made an appointment. (Appendix. 11 RM 4, / Appendix 8. FN1.).

The decision to move ahead with 1:1 meetings was complicated by the delay in achieving ethics committee approval described elsewhere. I had intended to gain approval for the research and then start and record the 1:1 meetings as the central part of the study[4]. I was left with a choice; either postpone the meetings in order to allow myself to research them thoroughly, or prioritise the meetings and lose the possibility of collecting good data. It was a tough choice, but to me it would have been unacceptable to place my research needs over our need to begin to use the data in the management of the service. I therefore decided that I would continue with the meetings as part of my *management* and *audit* of the service. This led me to a second, related problem. If I did not have ethics committee approval I could not be seen to be formally

[4] In fact the delay caused me to rethink the overall design anyway, as described in context document 6.

collecting data for *research* purposes. That in itself would be unethical. I could not therefore directly involve counsellors in anything that had the label 'research', for example tape recording these meetings as I had at one time envisaged. There was however, nothing to stop me from making notes of my observations as service manager, for my own learning and development, and to help me in my task of developing service audit. If for any reason ethics committee approval was refused, then these notes could be destroyed.

This decision led to a third problem, which is that of informed consent. All good research involves participants giving their informed consent. Whilst counsellors were aware of the project and had shown considerable interest in it, including many spontaneous statements of willingness to be involved, they had not been asked to give formal informed consent as research participants. Given this, I wondered if my making notes was somehow dishonest or improper. I decided that it was acceptable on the grounds that anyone is free to make notes for their own use. It was not inconceivable that counsellors might be making notes about their meetings with me as part of a journal. In addition, as service manager I had a duty to ensure that we were offering our best service to clients irrespective of any formal research, and the notes were a legitimate part of this function.

This whole set of reflections did highlight for me just how grey the area between management, audit and research are in this project, and how careful I need to be to ensure that I do not blunder into an ethically compromising situation. This issue resurfaced with the questionnaire that I gave counsellors at a later date (see Appendix 9).

I began meeting with counsellors in the early part of 2003. The meetings had a varied tone. After the first 1:1 meeting, I made the following note;
"I realise that there were many unspoken questions that began to be articulated as I prepared for this meeting and during it. There were some practical issues e.g. the need to print off certain pages as reading a screen can be difficult. It was also important for the person to take away something from the meeting. The managerial nature of the conversation highlighted the issue of just what my role was in dealing with this. Am I a researcher or am I a manager?" (Appendix 8. FN 2).

I realised that I had discussed the meetings as a voluntary activity, emphasising their potential usefulness. This was utterly congruent, as I genuinely believe this to be the case. However, if we are to use CORE (or any other clinical audit tool) as part of service management, then the meetings could quite legitimately be a job requirement, becoming something that any clinician could be required to do. This is a core tension in the development and use of practice based evidence; to what extent is it a tool for development and to what extent is it a tool for management? The issue became much more focal at a later point, and within 15 months I was presenting at the CORE conference about 'Introducing Performance Management'. The rapidity of this progression is as much a comment on how little we know about the issue in clinical services, as it is a comment on the speed of my learning.

In addition to the above, the 1:1 meetings highlighted other issues. The theme of comparison was clear in many of the meetings, as counsellors wanted to know how they were doing. Potentially there are two comparators here, the service average and other counsellors individually. I was very clear that I did not wish to invite a league table mentality, and we had agreed at the December meeting that none of us wanted this.

One story illustrates the kind of benefit that counsellors can get from examining their data. I think of it as G's story. Early on we met and identified that a relatively high number of clients were dropping out just before completion of an otherwise successful piece of work. In thinking about this G responded that all clients will have a crisis at the end of any therapeutic process. We examined this and she realised that this was an assumption that really needed checking. I suggested that there might be a strong element of self-fulfilling prophecy (Merton 1948), with clients responding to her unspoken expectation of a crisis. She was quite troubled by this, and over the next while we had several more conversations about this assumption. A good year or two later she spontaneously referred to this incident and how it had helped her change her views about endings. As we examined the data by time period, there did seem to be some suggestion that her previously high drop out rate had reduced.

Early in the process of establishing CORE as a central part of the culture of the service, it became clear to me that there was a crucial issue concerning the extent to which we made clinical use of CORE material. I had a very clear image of the situation that I wanted to create, and conversely what I wanted to avoid. The use of CORE is simply a tool, a way of ensuring that we seek and respond to data about our work. This in itself is a means to an end, the end being a service that is relevant and responsive to clients needs and which seeks to meet these needs in an effective and efficient fashion. Conversely I could see how CORE might become something perceived as being for 'them', imposed by bureaucrats, and having no relevance to the real work that counsellors and clients do. I could imagine counsellors rather apologetically asking the client to complete the form, and then literally putting it to one side to start the 'work'. This was the route to making the use of CORE an empty box ticking exercise, devoid of any meaning to counsellor and client. I wanted something quite different. I wanted it to become part of a lively creative process of open reflection. In order to make this happen it was clear that we needed to make use of the material in the room with the client, rather than simply an after the event evaluation tool. Besides, the 34 item OM was potentially useful as part of an assessment, as well as being a way into conversations with the client about important areas of their life[5]. I wanted to ensure that this information was used by the counsellor and with the client as part of the developing conversation between the two. There is an important ethical issue here. I am opposed in principle to asking someone to complete a measure, especially one as evocative as the OM, without giving time for feedback on what has been said, and without seeking to generate a sense of meaning with the client. This is the route to opaqueness and a sense of things being done to people. The opposite is a route to openness and transparency throughout the system.

Making use of the responses to the initial OM in first and subsequent sessions was therefore crucial to setting an atmosphere of curiosity and engagement with the available data throughout the system. More than this, there is no point in our going through all of this effort if nothing impacts on our work with the client, and here was an opportunity from the start. I spent a lot of time saying these kinds of things to counsellors. There was some uncertainty, since making use of the material within a

[5] The value of having a structured assessment tool was underlined early on by Di's story (see chapter 3 and Appendix 5)

session required a step beyond simply giving the form. This itself had been difficult to adapt to for some counsellors, who felt strange asking people to complete written material early in a first session. Now they were being asked to use the answers as part of their conversation with the client in the session. This implied an ability to rapidly scan the form, get a sense of what it is saying and guide the client in discussion of this. Drawing on my previous experience of using psychometric measures, I gave several examples in supervision of how I might manage the process of eyeballing responses and discussing with the client. Perhaps the most important thing to emphasize was that we do not need to be 'expert' as in having all the answers. Indeed this is antithetical to what we are trying to achieve. Better to approach it in a spirit of curiosity along the lines of "I notice that you said ....". Once this was clarified I think a lot of the previous hesitation was overcome.

In order to underpin the drive to make use of CORE in clinical work I focused on the use of total, cut off scores and risk scores in the initial assessment. I proposed ways of using cut off and risk scores as a way of beginning to encourage and underpin changed practice. It would be facile to conclude that we have reached an end point in this regard. We have just begun to explore what is a complex area. There is evidence from conversations and more notably from the focus groups (see Appendix 5.) that these areas are being engaged with. We have started to make use of the tool and to reflect on how we do this. The clinical use of CORE in terms of cut off scores, risk and its use in supervision are discussed in the next chapter.

As the database began to grow and we got over the initial phase, I began to realize that there was a developing issue about the speed with which counsellors could access data. In designing a presentation for colleagues in a local service, the term 'rapid cycling' emerged for me (seeTable 2.2)

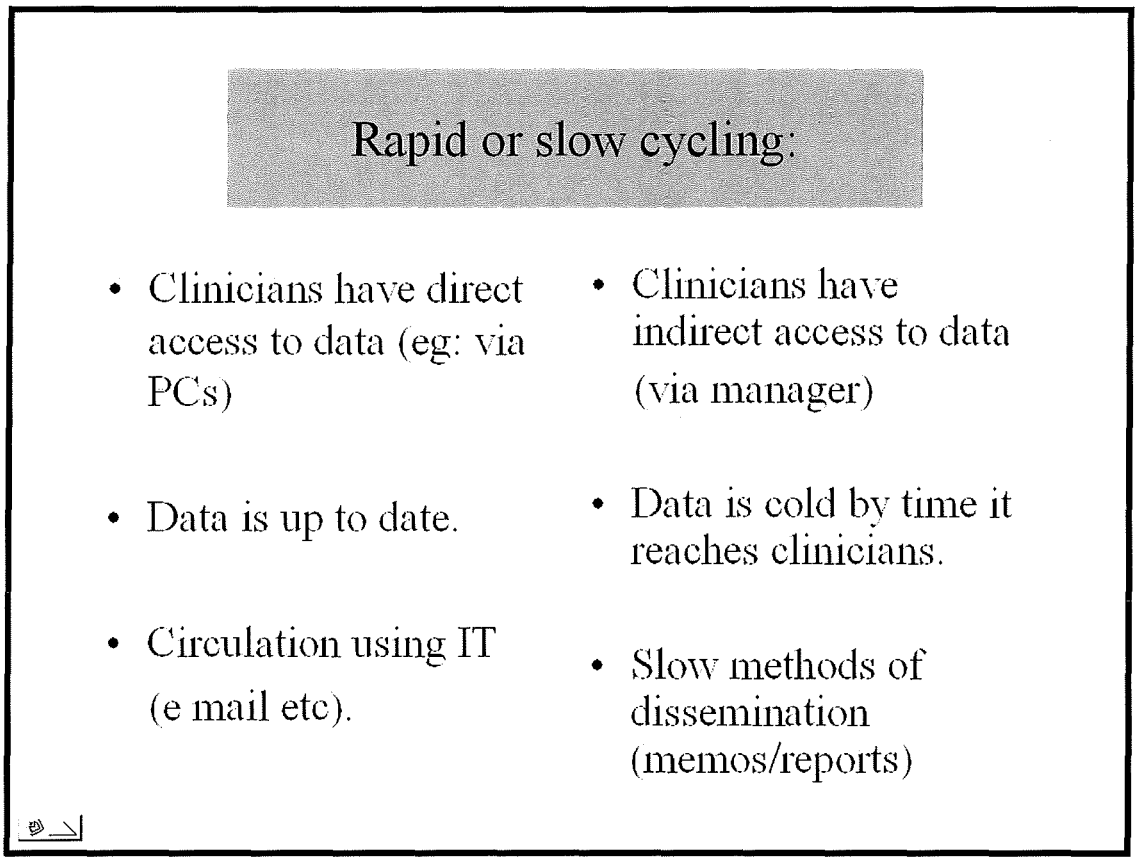

Table 2-2 Characteristics of Rapid and Slow Cycling

As it stood, counsellors were getting data that was some months out of date. This nullified a key feature of the CORE-PC system, which is the ability to create audit cycles that are rapid and up to date, as opposed to the old model where data is sent off and comes back months later. I took a step back and realized that to allow this to continue would mean losing some of the power of the new system. The more up to date feedback is, the more we are likely to be able to use it. I set to work identifying bottlenecks in the system for obtaining/processing and examining data. It emerged that service secretarial staff were under huge pressure with a growing pile of un-entered forms. I therefore rearranged the way in which this aspect of the work was managed to ensure faster entry.

In thinking about the rapidity of cycling it became very obvious that there was another serious bottleneck in terms of counsellors ability to access the database. Figure 4-1 in Chapter 4 illustrates this. Thus the challenge of rapid cycling was rapidly followed by the challenge of dealing with limited access. In fact the two are very much linked.

Although the CORE files were networked from the start, each PC including my own was unavailable to counsellor for most of the day. This created a situation where their only access to the data was via myself. This was not a problem in the early stages since I was leading people through the process, showing them how the system worked. I did not explicitly realise it at this stage, but I was beginning to tacitly acknowledge that this was no longer sufficient. If we were to really engage with the data, counsellors needed to be able to access it for themselves. I think that the principle here was 'information is power'. Counsellors could only engage if they felt some sense of ownership of the process. They would only develop a sense of ownership if they could have independent access to it.

I put a considerable amount of effort into ensuring that PCs were available in the building. This involved some fluency with the budget, and a considerable amount of organisation to get them trust passwords etc(see chapter 4)
Despite all this effort, there were still problems with getting counsellors to look at the CORE data. Questionnaire results (see context material 8) showed that some months after it had been possible, two thirds of those who responded had still not accessed the system. Time pressures and lack of technical fluency were the overt reasons given for this.

There remains a serious issue with access as follows; most counsellors work for the service in surgeries away from the main building. These are separate organisations from West Sussex Health and Social Care Trust. Their IT systems are different, and it is proving very difficult to find a way of allowing access from a surgery portal to the system that contains CORE. The same applies to trust e-mail facilities, which all go through this trust's intranet and are not directly accessible from surgeries. In order to deal with this I met with the head of IT and made a detailed presentation about my services broader IT needs including the above issues. I was promised that this could be sorted easily. Six months and many reminders later and I was still waiting. This is proving to be a major (and as yet unresolved) obstacle in ensuring easy day-to-day access to the system. The issue of limited access is therefore very much a live and troublesome one.

By this time I had generated some considerable experience of looking at CORE data with counsellors and I was becoming aware of a rather consistent pattern. This was the tendency to focus in on single aspects of data (typically outcome figures) to the exclusion of other relevant factors. This is encouraged in a way by the single screen nature of the software, which shows one aspect of the overall picture on each screen (see below).

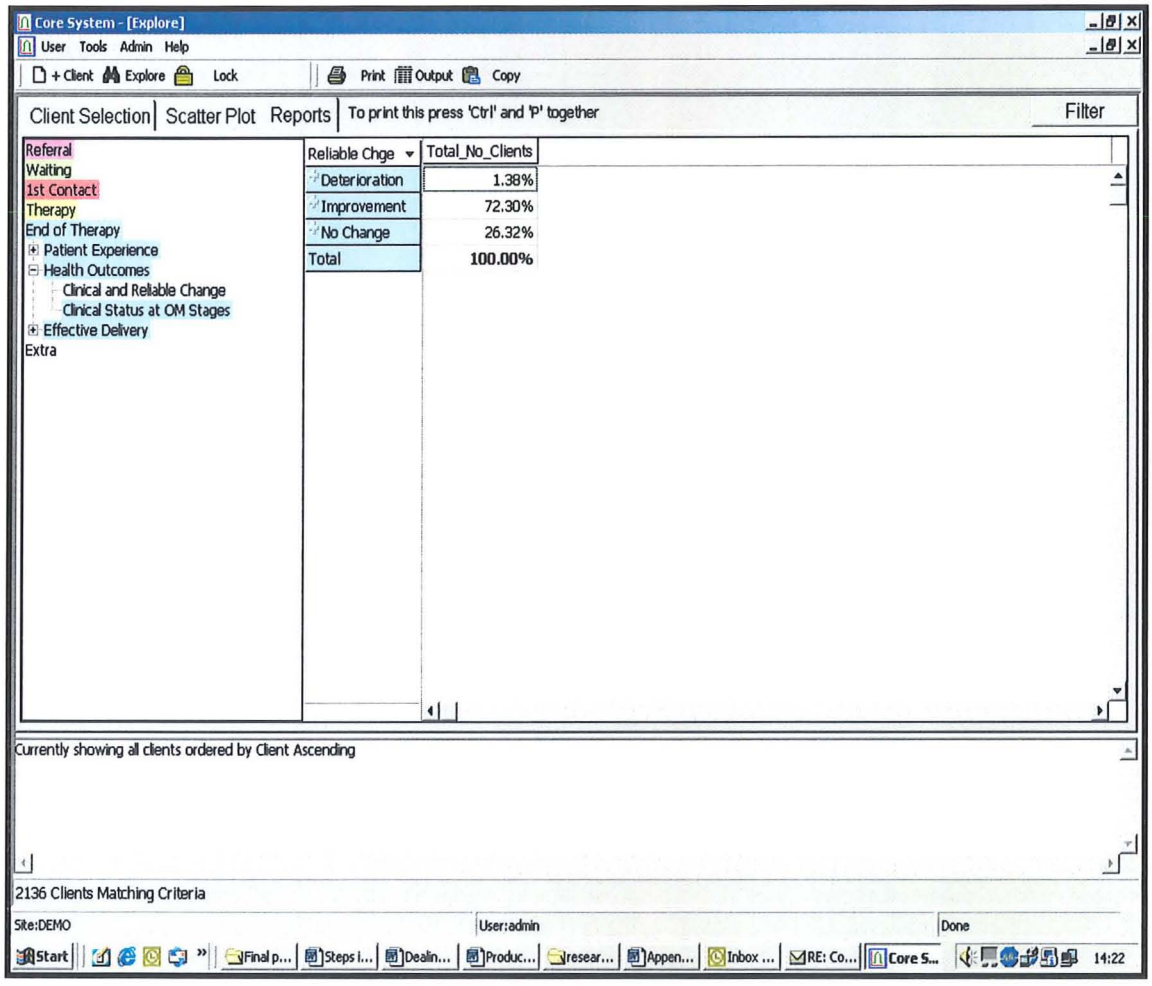

Figure 2-2 An example of a CORE system screen

I had experienced this tendency myself, and learned that it is always necessary to examine all aspects of the data before reaching even a tentative hypothesis about what it meant. In Fig 2.2, the screen shows our outcomes for the entire database. This is now some 2000 clients seen over a period of 2 years by many counsellors, including some who have now left. This is useful to a point, but to make more sense we might need to know other things. It might help to time slice the data, and examine say 6 month

periods for trends. We might need to examine the proportion of clients below the clinical cut off, the proportion of male to female clients etc in order to generate a valid impression about what is going on. This requires considerable technical fluency and mental dexterity. I became concerned that counsellors might miss some of the sophistication latent in the system by focussing on one aspect of the picture. This was illustrated when one counsellor was clearly unhappy at her lower outcome figures. When we examined other aspects of her data, it became clear that she was seeing more men and had a larger than expected number of clients below cut off at first appointment. Both of these meant that it was highly unlikely that the outcome figures would reach the service norm.[6] When I pointed this out her perspective changed.
In order to address this tendency, I spent some time emphasising the need to always examine the whole picture before developing hypotheses. This was done both in 1:1 meetings and a presentation that I made to counsellors.

This challenge of interpreting the data fully is of course something that is present with all data. Its value stands or falls on the interpretation that is made of it, and the action that follows from this interpretation. If we misinterpret what we are seeing, we stand to act inappropriately. Worse, there is the realistic possibility that we will persevere with those actions because we think that we are acting on the basis of 'facts'. Having a system like CORE is to be in possession of a two edged sword.

Interpretation is therefore of central importance throughout, and we need to constantly reflect on how we are interpreting the data if we are not to develop wooden thinking. I can see the possibility that we could become like Winnicott's teacher only with software, claiming to be learning but in fact only going through a few stereotyped reactions to our data. The challenge of interpreting data fully is therefore as much a constant theme as it is a phase. I describe it here because I think that it is something that is likely to come to the fore after we have gone through the first circles of learning to use the system and reflecting on what we are finding.

This entire project has been one of constant stock taking. The challenge came to a head in spring 2004 as I undertook a deeper analysis of the focus groups and the more

[6] Our data shows that men in general show a lower overall change, and if someone is below cut off at the start, they are unable to achieve clinically significant change.

recently issued questionnaire. These are dealt with in detail elsewhere (Appendices 5 and 9). In this process of concentrated analysis of different kinds of data a couple of things are worth noting here. The overall impression was that counsellors felt positive about the use of CORE, and there was evidence of some change of thinking/behaviour arising from its use. This was useful to me in confirming that the project was broadly on track. I had not lost the counsellors along the way. Methodologically this data provided a useful way of triangulating and checking my perceptions of what had happened to date. I could after all have been steaming along oblivious, seeing what I wanted and expected to see. As discussed in Appendices 5 and 9, there is still scope for bias in this data. The low return on the questionnaire and the fact that people knew that it was me who was seeing their responses limit the robustness of the data. In an ideal world it would help to have an uninvolved third party gather and analyse counsellors views on CORE. That is the strength of a more traditional research project, in which the researcher takes a role as uninvolved outsider, and conversely the weakness of this approach in which my passion/biases are central. Of course, such an uninvolved outsider would not have got to the position where CORE data was being used and experienced positively in the first place. That is the strength of the participative, action research derived approach that I am using.

Feeling confirmed in my basic position was very beneficial to me, coming as it did at a time of some difficulty (see context doc 2). In a way the process of gathering and reflecting on this data can be seen as a large actions reflection cycle spanning the first couple of years of the project. Perhaps inevitably it led to a new focus, albeit in an unpredicted way. Somewhere over the several months during which I was immersed in analysing the focus groups/questionnaires and drafting this document, I began to revise my view of my role in the whole. I will therefore address this process.

2.3 My developing roles as a participant participant

During the course of steering this project along its way, I have inevitably taken multiple roles and been through various phases. Initially there was what seemed to me at the time to be an interminable *milling phase*, in which I circled the problem without at times even knowing what the problem or focus was. Here I tried numerous lenses, as I sought to make sense of what I might do, and what I wanted to do, through the lenses of

various methodological approaches. This was at times deeply frustrating, and I was tempted to simply grab an approach in order to get on with it. Two things helped here. The first was Robinson's wise words:

"Progress in science is won by the application of an informed imagination to a problem of genuine consequence; not by the habitual application of some formulaic mode of inquiry to a set of quasi-problems chosen chiefly because of their compatibility with the adopted method." 2000. p.40.

The second was Dick's (1993) notion of moving from fuzzy questions to less fuzzy questions as we move through the phases of action research. Together these helped me to see that we can be flexible and allow our methodology to develop as our understanding of the areas of concern develops. Crucially we use the methodology rather than becoming its slave.

In negotiating this phase I think that two things are crucial. Firstly we do need to immerse ourselves in methodological considerations. We can only validly choose one approach if we have examined alternatives. Flexibility is not to be mistaken for intellectual sloppiness, and we do need to be willing to inhabit a relatively detached critical position. Secondly, and linked to the first point, we need to be clear about the limitations of our chosen approach as well as its strengths, and what we are seeking to achieve. For me this only really became clear as I prepared to present my doctoral proposal, as well as at a later time in the Goldfried seminar, when I realised that my interlocutor had a very different set of assumptions about research from myself. His ideas about what a piece of research should be seeking to achieve were valid and useful, but did not include the action component inherent in work such as this. I began to realise that in any project where system change and research are both elements the role of the central actor is fundamentally different. Just as in clinical work we need to be able to tolerate greyness and uncertainty, so in this type of research we need to tolerate emerging and shifting questions. Process awareness needs to be highlighted, as we seek to be aware of and respond to multiplicity of variables rather than controlling them out in pursuit of answers to a well-defined question.

Returning to my role in this phase, it can primarily be characterised as that of *initiator,* as I clarified my vision of what I wanted to achieve and began to move in that general

direction. Acknowledging the centrality of my drive to achieve something helped me to clarify and develop my methodology. In clarifying that I was not going to be a comparatively detached observer, but someone with an agenda, traditional research designs became redundant. Perhaps the nearest that I have come in the entire project to taking on the role of a traditional researcher was in this phase, as I researched the methodological options as part of the process of clarifying what I was intending to do.

The subsequent phase was characterised by the term *leadership.* I was seeking to push forward a system change, enthusing, managing, teaching and generally taking a central pivotal role in making things happen. Here the emphasis was on sleeves rolled up pragmatic work, whilst simultaneously ensuring that I maintained enough of a critical distance. This proved to be an extraordinarily difficult balance to achieve. The action side of the polarity required me to be a leader, a politician and manager as I sought to shift culture and ensure that human and other resources were correctly focussed and utilised. The research polarity required that I step back and reflect on the chaos.

A key task here was creating and maintaining the space within which this project could be moved forward. In the day-to-day clinical and managerial world, there is a constant pressure from other issues (Context docs 1 and 2 give some idea of these pressures). Central to maintaining this space has been this document. As I have gone through innumerable developing versions of this final text, I have used it to develop and clarify my thinking. This has then served to help me maintain a direction and momentum in the project. Perhaps the main disadvantage is that previous perspectives disappear at the touch of the save button, and I perhaps don't see quite how my views have developed. Maybe I should have made more use of my research memos.

What has emerged latterly is a realisation that I needed to start to step aside and widen participation in the process. This is the current stage of *encouraging wider ownership.* I have necessarily taken a central role, but I began to realise that I could become an obstruction unless I stood aside and allowed counsellors to take up the ball and run. This did not happen overnight, and indeed the realisation was clearer in the doing. I only named what I had done after meeting with my learning advisor some while in to the process. The process began as I addressed the issue of limited access to the database, and sought to encourage counsellors to access the material themselves. Individual access was

patchy, with some individuals proceeding to view the data and the majority not (Appendix 9.). The next step came as I ran the first live examination of the database (Appendix 11. RM 29). On reflection this was a small example of Robinson's 'application of an informed imagination', which took me even further than I expected.

The idea was to encourage and inform counsellors with a view to their proceeding to access CORE data for themselves. Using a live connection to the database removed a crucial step from the process. I no longer selected the pages to present, as had happened previously. Whilst I had ideas and considerable influence as to what we looked at, the entire database was now potentially available to be examined *as desired by the group.* This was a crucial step in my beginning to step aside as the controller of the agenda. Matters developed in the meeting, as I encouraged the adoption of a rotating chair for future meetings in order to explicitly pass more control and responsibility to counsellors. At the time of writing the group has met four more times and members are increasingly setting the agenda.

This process of letting go, whilst initiated by me, has not been entirely easy. I envisaged the group as being very focussed on examining CORE data. In fact the agenda has become much broader than this, with discussions and scheduled presentations on research topics beyond CORE. I found myself in something of a quandary, wanting on the one hand to keep mining the CORE seam, and on the other hand not wishing to grab the reins as soon as we took a new turn. I have deliberately stepped back, seeing it as more important to divest myself of some of the power[7]. I think that the great problem with any process or organisation that has strong leadership is how to mature from being leader -centred and charismatically driven, to a more mature level. I think that this is part of what Weber's (1947) description of charismatic organisations. The problem comes when the leader leaves the scene (either voluntarily or involuntarily, too often the latter) and the process becomes chaotic. This reluctance to leave is often connected to a reluctance to divest oneself of power, which as Lord Acton[8] famously noted, tends to corrupt.

[7] Of course I continue to have formal responsibility by virtue of my role as manager.
[8] letter to Bishop Mandell Creighton, 1887.

The challenge then is how to make the transition from something that is leader driven, to something that is embedded in the culture of the group or organisation. In terms of this specific project, this is the crux where, crudely speaking, we either develop into a 'learning organisation', or what is seen as Geoff's pet project slowly fades into history and has no lasting effect.

Crucial to making the transition to the former rather than the latter is to have others take the torch, and develop a broader ownership. Visually I think of this as a transition from a wheel and spoke process, where I occupy the central position through which all actions relevant to the process are mediated, to a web. The latter has more nodes, and is physically (and by analogy psychologically) more stable.

Coming back to the group moving on to a broader research agenda, I think that this highlights something central to this project. At first as indicated I felt a pull to bring us back to the true focus of this project, using CORE data. In a way however this would be to confuse aims with methods. CORE is simply a tool, albeit in my opinion a very good one. It allows us to take a structured look at what we do through one particular set of lenses. The true aim is to engender a culture that is genuinely questioning and reflective, where we collectively and individually seek data and transform this into information and useful knowledge. Thus, far from a broader agenda in some way diluting the process of using CORE, it is best thought of as taking the true spirit of the enterprise and acting on it.

I think that there is a crucial phase to be negotiated here. For this project, and I imagine for others, a key task is to embed the changes in the organisation so that they become in a way self-sustaining. Otherwise when the initiator runs out of steam progress is in danger of being lost. This is in many ways the key test. Have I lit a fire that will endure, or has it all been a brush fire, quick and dramatic but of little enduring importance? In terms of general learning I think that it is essential to acknowledge the importance of this transition and as far as one can to work towards it. It remains to be seen where we go from here. There are undoubtedly many avenues to be explored. The challenge will be to develop and maintain the momentum with myself in a less obviously central role.

Chapter 3. Dealing with Content

3.1 Content issues

This work is primarily about the processes involved in engaging with CORE data. It would however be rather an empty exercise if I were to ignore the content with which we were seeking to engage. In the time that we have been using the system, a number of issues or questions have arisen as follows.

3.2 Questions arising from the database

Outcome figures.

Number of clients below cut off at referral.

Use of risk scores.

Number of sessions and outcome.

Gender and outcome.

Effectiveness with categories.

Need to use CORE in clinical supervision.

Each of these can be seen as a mini action-reflection cycle, as we engaged with the data and took action on the basis of our reflections I will outline these in the chronological order in which they appeared.

3.2.1 Outcome figures

As the database begins to grow, one is able to start examining the developing patterns. Inevitably, the first place that we look is the outcome figure. We had had a previous tranche of data analysed and this had shown that we were generally effective. Nevertheless, I was very eager to see the figures as the database grew. For me the fundamental question was are we showing an effect. I wanted to know because this was the first hard data that I had ever generated, at least on more than single clients[9].

The early results were encouraging. I felt a great boost to know that we were showing a positive shift with over 70 % of clients. I fed this back to the counsellors as often as I could, and especially in an early meeting on CORE (Service presentation in AR cycles diagram chapter 2). The effect was positive, and I think that counsellors felt enthused and validated by the positive results. There were many comments to the effect that 'its

[9] I had used measures pre and post therapy with individual clients, but not on a routine basis across all clients.

nice to know that we do a good job'. I think that this early positive feedback was reinforcing for all of us. Had the early results been discouraging, I think that it would have become a lot harder to maintain a head of steam for the whole CORE project. In terms of my overall goal of ensuring that we engage with the data, this was a crucial positive first step. The first cycle was a positive one and this helped set the tone for further engagement.

3.2.2 Number of clients below cut off[10]

As the database grew, another question began to emerge from out of the mist. As I spent hours going through the system, learning what it could and could not show us, I noticed that the percentage of clients below the clinical cut off at first appointment was surprisingly high at nearly 30%. I watched the figure for a while, and it was clearly a stable percentage.

Having reflected on this, I was concerned for a number of reasons. As an NHS service in great demand and with a long waiting list, I felt obliged to ensure that we targeted our service at those who were declaring themselves to be significantly troubled. On the face of it, someone scoring under the cut off was stating that they were no more troubled than the traditional man/woman on the Clapham omnibus. In fact I was slightly exaggerating the problem, as I was at that time ignorant of the fact that even within secondary care services, 20-25% of clients referred were below cut off (Barkham, Margison et al 2001). This is a nice example of the research-practice gap in action. Even as someone steeped at that time in CORE, I missed this simple benchmark figure.

To me this issue was a crucial practical test of how we began to use the practice-based evidence that we were generating. I was not willing to have us simply ignoring this data (which comes direct from the client) and carrying on regardless. After all, if we disregard data, why collect it? I wanted to address the issue, and so I started raising it with counsellors by memo and conversation.

As we unpicked the issue, it became clear that of course the OM score at first meeting was one slice of data. I had no doubt that it was identifying some clients who were

[10] See section on CORE for a description of what this means.

effectively stating that they were untroubled, and who did not want or need a service. My concern was that rather than this being acknowledged and the case closed, they would continue on for counselling *because they were there.* I do not think that by and large counsellors are always as good as they could be at saying to people that they do not seem to need or want counselling. Rather they carry on, perhaps under a sense of obligation to 'help'. This impression has been confirmed in numerous discussions with counsellors in my service, where the problem of saying no has been widely acknowledged. On the clients' side, I think that there can be a level of passive acceptance, along the lines of 'the GP sent me and the counsellor is seeing me, so I must need it'. This runs counter to the ethos that I had sought to instil in the service (see Context Document 2).

There is another side however. The OM is an imperfect measure, and must not be reified. It is highly likely that clients might not score above cut off, yet might have a legitimate need for counselling. This issue was highlighted for me at the CORE seminar (see Context doc 10) where the term 'single issue clients' was used to refer to those who did not present a global high score because they had a single, relatively defined problem.

We therefore were faced with the old dilemma of how to interpret cut off scores *in use.* I was reminded of a quip that I heard early in my career from a consultant forensic psychiatrist, Pamela Taylor. Talking of Broadmoor patients, she said that we know that we could safely release half of them tomorrow with no real risk to the public. The problem is that we do not know which half. I suspected that we could use the below cut off scores to inform a decision to not offer a service to some clients. The problem was how to separate those who did not need a service from those who did. In action, I worked on an ethically acceptable compromise. As with the old legal adage that it is better for ten guilty men to walk free than for one innocent man to be convicted[11], it was clear that we should err on the side of caution and not denying a service to those who might merit it.

[11] I haven't changed the gender specific nature of the original adage.

The first step practically was to get counsellors looking at cut off scores[12] in or after the first meeting with the client. This required that they generate a total score from the OM and check it against cut offs levels. I provided a simple sheet with the scores on as an aide memoir for counsellors, with the suggestion that it be kept in their diaries. Having generated a score, it is a simple matter to see whether this is over or under cut off, and a more complex matter to decide what to do about it. The latter requires an assessment of the whole picture of which the OM score is a part. The fundamental question at this point is, to take or not to take.

In order to assist this process using the cut off score, I devised a policy that where the score was below, the counsellor could either not take the client or offer them a very short contract for three sessions. This could then be extended to the usual maximum of twelve sessions where appropriate. This procedure allowed a judgement to be made that someone might need counselling, whilst acknowledging the OM score and simultaneously minimising the risk that someone might inappropriately be denied counselling. I did not specifically audit the impact of the policy on cut offs. Having focussed on it in the late part of 2002, I was then subsumed by budgetary and organisational chaos as described in context document 2.

The key initial test as to whether the policy had made a difference to our practice would be that the number of sessions offered to those below the cut off at assessment would be, on average, lower than the number offered to those above. Whilst there has been some change in the numbers pre and post the policy, I am not satisfied that there is a significant shift. I think that this highlights the complex nature of decisions made about working with or not working with clients after assessment. It may also be that the OM score is not subtle enough to help us make a valid judgement.

3.2.3 The use of risk scores

The policy for sub cut off scores served as a template for the policy on risk that rapidly followed. The drive for this came from a number of sources. Clinical Governance requires that services have robust policies for managing risk. Locally, we had an inquiry going on into a nationally publicised case of a death. I was informed by my manager that

[12] CORE forms are entered on to the software system after the case is closed. To use scores clinically with the live case, we are left with hand scoring for the moment.

at one point, the client had had contact with a primary care counsellor[13] and that what had been discovered by the inquiry was not positive. There was a political need to ensure that we were watertight in advance of any findings. We had an experience in the service that served as a salutary reminder of the need to consider risk issues, and simultaneously of the fallibility of all risk prediction tools including the OM Risk score. I came to think of it as Di's story (see Appendix 5), and it certainly prompted me to ensure that we made the issue of risk central to our deliberations. In the face of all this, I did what I am best at and generated a solution. The OM provides a risk score, based on the questions outlined in Table 3-1, so why not make use of that as a tool for screening risk levels at assessment? I therefore drafted a policy and procedures document that incorporated the use of the risk score. To me it felt all rather obvious and frankly rather boring. Risk has been a central concept in my clinical work my entire career, largely I imagine because of my initial job in the Probation Service. The document seemed to require little thought and felt like it almost wrote itself. Perhaps because it seemed a little obvious to me, I did not see this as in any way connected with this project. This seems rather strange to me now, but at the time, it was just something that had to be done.

Risk/Harm to self	I have thought of hurting myself	9
Risk/Harm to self	I have hurt myself physically or taken dangerous risks with my health	34
Risk/Harm to self	I made plans to end my life	16
Risk/Harm to self	I have thought it would be better if I were dead	24
Risk/Harm to others	I have been physically violent to others	6
Risk/Harm to others	I have threatened or intimidated another person	22

Table 3-1 CORE Outcome Measure questions on risk

The actual construction of the policy was a pragmatic exercise intended to produce robust guidelines for practice. I wanted to make sure that we wove a process of

[13] Working under the previous ad hoc system.

explicitly reflecting on risk issues into the assessment of the client and any ongoing work. To me it was the process of explicitly reflecting that was the key to making the guidelines useful rather than simply serving as a fig leaf in times of crisis. In order to ensure that this reflection happened, I required that the CORE total and risk scores be recorded on the case file, and that scores above a certain level be discussed with me. Complying with these procedures made it virtually impossible to not reflect on risk. The problem with using a tool is summed up by Maslow's comment that 'if all I have is a hammer, I tend to treat everything as if it were a nail'. I could see that we could get too literal in our use of the CORE scores, ignoring other sources of data as we developed our impression of the level of risk in a particular case. I therefore ensured that the guidelines explicitly noted that we look at all the evidence, not just the CORE score. Di's story (Appendix 5) served as a salutary reminder of the limitations of all measures including this one. This is something that I have felt a need to repeat *ad nauseam* in discussions with counsellors.

As described in Appendix 5, this policy seems to have been experienced by the counsellors as broadly positive and supportive. It is perhaps the most concrete example of the way in which we have used CORE to influence our decision making as we go along, as opposed to in post hoc analysis. Our practice in this area continues to develop. I found that after an initial phase where counsellors were, if anything over diligent in discussing cases of potential risk, they have settled into a pattern that seems to me to be quite sensible. Now only the more pressing cases are brought between supervision sessions, and my experience is that the conversations that I have with counsellors seem very appropriate.

We cannot rest there however, and recently there has been another turn in the reflective spiral. Following an independent service review with John Mellor Clarke (something being offered to all service managers nationally, and initiated at least in part as a result of my suggestion from this project), we concluded that we are collecting good quality data overall[14], and included in this is good data on risk. Examining the data further however did highlight an area for further investigation. Of 462 clients seen in the previous 9 months, 43 (9%) were in the moderate to high-risk category based on their responses on the initial OM. When we examined counsellors' ratings of risk (completed

[14] We are obtaining an initial OM in 96% of all cases. The average nationally is 79%.

after the first session), there were 7 cases where the counsellor indicated that they saw no risk, despite the OM Risk score. There could be many explanations for this, but it is certainly worth exploring further as a way of continuing to find ways of using CORE in risk management.

There have been several turns along the way in this part of the project. As indicated above, I initially failed to make a connection between the guidelines and the real project. I just got on and produced them because I needed to. Then I realised that in fact there was a connection. Later in the light of the counsellors' responses both in conversation and in the questionnaire, I realised that they were far more positive than I was about the procedure and changed my feelings about it.

3.3.4 Number of sessions and outcome

Another aspect of CORE data that was of particular interest to me was the average number of sessions for which each client was seen. Politically this is very sensitive data, since in psychological therapies the number of sessions is probably the factor that has the single most important impact on service cost and waiting times. These factors in turn are the two that are most frequently used to judge the value and performance of a service. Perceived problems in these areas can threaten the existence of a service, as well of course as being damaging to clients and to staff morale. From day one therefore, this was data that I was especially interested in. The importance and sensitivity of these particular figures is underlined by the story of the misuse of the initial figure outlined in Context doc 2. As a result of this experience, I realised that I would have to be more cautious about the way that I fed back figures to the PCT. I also drew a clearer distinction between our use of the data within the service and our presentation of that data to other stakeholders.

The issue of session numbers continued to be of key importance for me as a manager, charged as I am with ensuring that the maximum number of clients receive the maximum benefit from the service. As explained in Context doc 1, I was able to raise the maximum number of sessions per client from 6 to 12 early in the history of the service. This proved to be a very important step, although not without its problematic consequences. I think that having the freedom to offer more gave an appropriate power to counsellors. Rather than having to offer a number of sessions limited by *them,* they

had space to exercise judgement. Most importantly, this is likely to be the best for clients. However, it is also important in maintaining the morale of counsellors who, one hopes, feel professionally respected. This in turn has a positive impact on the ethos of the service, and (so my hypothesis goes) this impacts on the service received by the client. Counsellors greeted the news of the shift positively. Inevitably, there was a drift upwards in the number of average number of sessions for which clients were seen. By late 2002/ early 2003, I was becoming concerned as the average was steadily creeping over six.

Because of the budgetary arrangement (partly explained in Context doc 1), this left my trust potentially being out of pocket on the deal. This in turn threatened the existence of the service, as the trust was under severe financial pressure and would not support any loss-making situation. It was therefore imperative that I address the issue. I spent a lot of time in meetings and memos explaining to counsellors the situation, and emphasising the need to collectively and individually 'balance the books'. I realised that I had not been clear about how the increase in potential sessions should be managed. Some of the counsellors, especially ones new to the service, were routinely offering 12 appointments to all clients. I clarified that we should offer an initial 6 with the possibility of a further 6 where this could be argued as clinically appropriate. As we tried this, I became aware that some clients were missing several of their initial sessions[15] and were still being offered more. Managerially this was not acceptable. I did not feel inclined to extend our contact with people who had not made maximum use of their first sessions at a time when the numbers waiting desperately for our service were growing. I legislated by asking that no one who had missed more than one initial appointment should be offered more[16].

I anticipated some resistance, and there were one or two problems. I had some very productive meetings with one counsellor who confessed (her words) to offering 12 routinely. She engaged with the issue and made some changes. Overall, however, the problem became one of over compliance. Having banged the drum and presented data etc, the average number per client began to fall. Then it continued to fall. A year later,

[15] For reasons that did not seem particularly sound.
[16] As is my habit I left room for clinical judgement. Counsellors could come and make a case where they felt it was clinically appropriate to extend despite lost sessions. I don't recall it happening.

and we were routinely seeing each client about 1.3 times less than in early 2002 when the problem arose (see Figure 3-1).

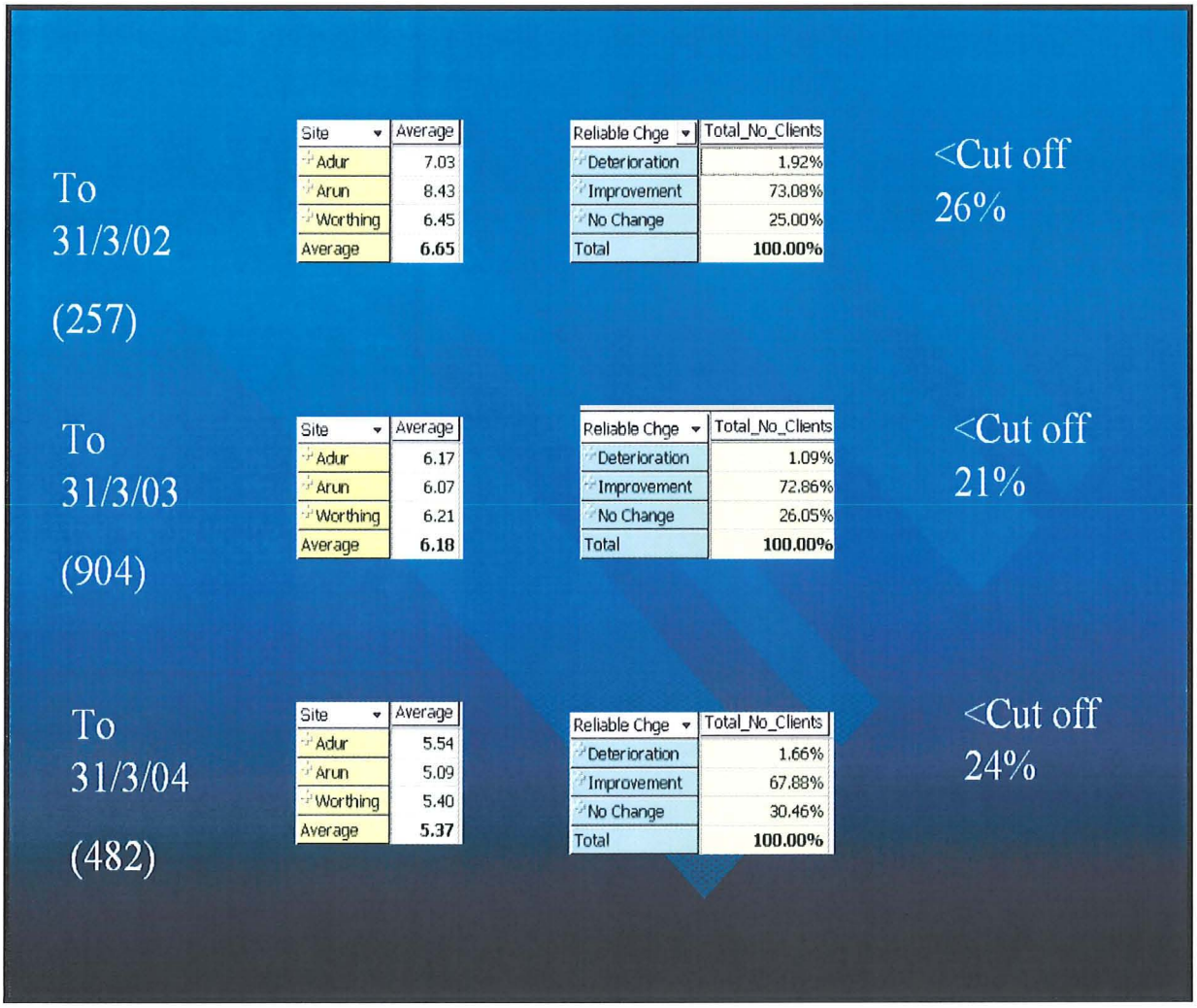

Figure 3-1 Average number of sessions and outcome

On the face of it, this was a great achievement. I did not want to accept this at face value however, and so I decided to examine the data more carefully. Comparing pre and post data, I saw that there was a reduction in our outcome figures. I began to worry that we had reduced sessions at the cost of providing a less effective service. In fact this apparent effect in fig 3.1 disappeared in time, and seems to have been ephemeral. Currently it seems that we are offering less sessions and being just as effective in CORE terms.

This highlights two of the difficulties in using CORE, namely how to keep multiple frames in mind and how to determine whether what one is seeing is a genuine meaningful (see chapter 4). The significant shift in session numbers also highlights the danger of the zigzag effect, where we realise that we are steering too far in one direction, overcompensate and then go too far the opposite way.

3.3.5 Gender and outcome.

From the start, our database has shown a consistent difference in our effectiveness between the genders, with men reporting significantly[17] less change than women. Other apparently important patterns in the data proved to be chimera, disappearing as rapidly as they appeared. I therefore kept track of this issue over a period of time, and there was clearly a pattern. Further checking revealed an apparent correlation between the gender of the client, gender of the counsellor and outcome, as presented in Figure 3-2.

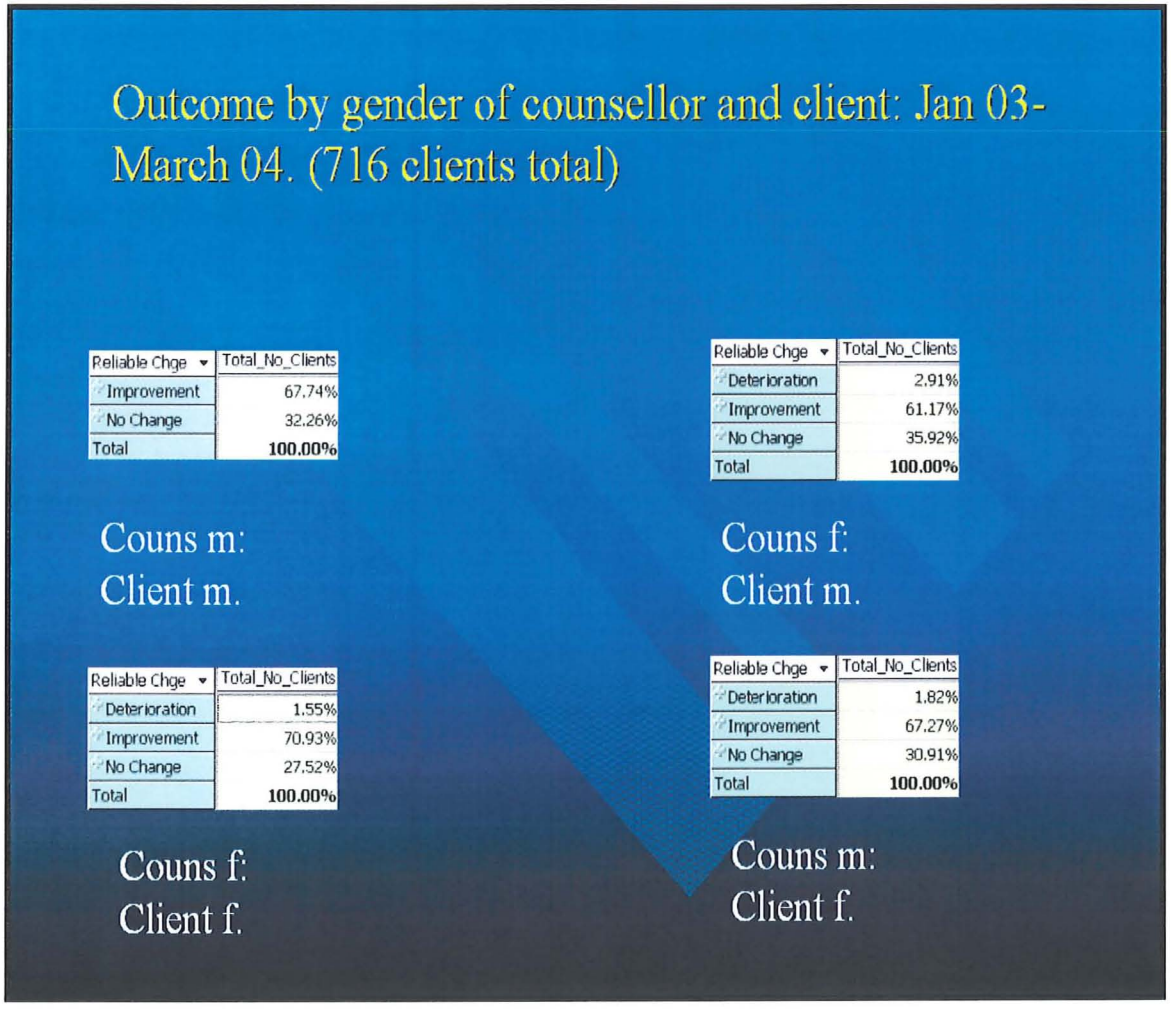

Figure 3-2 Outcome figures by gender

This issue has been passed on to the research project headed by Prof Barkham in a way that was at the time quite accidental. I had been puzzling about the meaning of the data that we were producing. It seemed clear to me that to explore it further would be a new

[17] I have not undertaken a statistical analysis, but have no doubt that the differences would prove significant based on eyeballing the data.

piece of research. I passed on the thought to Richard Evans and John Mellor Clarke and got a very positive response. Unknown to me they had just agreed with Prof Barkham to seek research ideas from practitioners in order to continue the process of learning from the data.

It remains to be seen just what we should make of this data. Within our service it seems to be a stable phenomena. We are beginning to explore the meaning of it and edge towards thinking about how we might best respond. It will be interesting to see the results of the research on the overall database, but at present, my hunch is that this will prove to be a very interesting pattern that needs a lot of further exploration and has many implications for the organisation of services. As ever the hard part will be interpreting the data and deciding when we have enough evidence to merit making changes in what we do.

3.3.6 Need to use CORE in clinical supervision

As we began to explore the use of CORE data, it became clear that there is no way that we can weave the use of CORE into the clinical work unless we discuss it in supervision. Thus, clinical supervisors need to be knowledgeable about the use of the CORE system in order to engage in the process of making use of it within supervision.

This highlights a very interesting area regarding supervision, relating to the traditional split between clinical and managerial supervision. Using CORE implies a blurring of this (rather artificial) boundary. I find it difficult to see how it is possible to maintain the difference between clinical supervision with its traditional leaning towards development, and managerial supervision with its primary emphasis on performance. CORE data inextricably links the two, for example providing information about data quality as well as outcomes. Whilst it might be possible to tease out areas of foci that were deemed appropriate for each form of supervision, I think that what is implied if we are to truly use CORE data is a new form of supervision that for want of a title could be referred to as clinical managerial supervision. This challenges the traditional culture (at least in the NHS) where clinicians will often have an arrangement whereby they work with an external supervisor, usually contracted on the basis of their particular modality of therapy.

There are, of course, major difficulties in the concept. Bringing the functions of clinical supervision and management entirely together runs the risk of dangerously placing all our eggs in one basket. We are likely to create a closed system, which is not healthy for anyone. There is, put at its simplest, a risk of too much concentration of power with everything that that entails. Practically, however, it is difficult to see how it will be possible to ensure that a diverse range of external supervisors to an organisation will be able to (a) access the data and (b) be familiar enough with the system in order to make use of it in practice. As ever, I think that we are in need of finding a compromise between these differing requirements. Two models come to mind:

It would be possible to develop a role of internal clinical supervisors. Such an individual would have to be linked in to the system, but would not carry day to day managerial responsibility. They would, of course, remain ethically and professionally bound to deal with poor performance (something that I do not believe is always adhered to in practice in the external supervisor culture). However there would be at least some separation between the clinical and managerial functions.

Another model that we are beginning to experiment with is the development of peer supervisory relationships. These begin to break down the concentration of power with the clinical manager/supervisor and allow for the use in practice of the expertise that has been developed within a group of practitioners. The appeal of this approach is that it flattens the hierarchy and begins to distribute the power. The downside is that, of course, it can be extremely difficult for peers within the same organisation to begin to raise, let alone deal with, issues of poor performance. I am therefore not convinced that this is an entire solution. It certainly, however, is a crucial step in the development of a culture of using CORE in practice, and of developing a sense of ownership and positive relationship to CORE (see Final Thoughts).

Chapter 4. Data and Information Management Issues

This entire project could be seen as the management of the process of transforming data into information (see chapter 2), and weaving this information into knowledge that guides our practice. In making sense of what I was doing in this process, I returned to and was assisted by soft systems methodology.

As I highlighted in my doctoral presentation, a key factor is humanising what CORE gives us. This is an active process connected to, but separate from the task of responding to the content of the database. What seems to be important is our *relationship* with the data (and by implication the process of gathering it). If we are able to create a sense of the data[18] as potential ally then we are well on the way. If on the other hand the data it is experienced as hostile, then we are set for an uphill struggle in making positive use of it. In doing this we need to help people see beyond the nuts and bolts of forms, screens and figures, and remember the reason that we are engaged in the process in the first place is to improve the quality of what we are doing. It is this ability to step back and reflect on what we are examining *and what it means* that is crucial.

Linked to this is the importance of developing a sense of *ownership*. We need to seek to create a situation where clinicians feel a sense of control and involvement, and believe that they are key stakeholders in the process.

4.1 IT and access to the Data

IT and its use are central to this project. I am primarily examining the ways that we can make use of the output of a software system. Early on however I became aware of just how reliant on me the entire process was. Counsellors came to my room and looked at the data on my PC with me guiding the process. This was necessary to begin with. Only I possessed the knowledge about how to do it. However, I could see that this was going to rapidly become a problem if I was not careful.

[18] I use the term in its broadest sense to refer to the entire CORE system *as used in this setting.*

Stepping back from the problem and mapping it out very much as in Figure 4-1, helped me to realise that there was a bottleneck. I realised that the block in access referred to in the previous chapter was reflected in the physical restrictions on access as outlined in Figure 4-1. It was vital that I deal with the issue, since truly engaging with data rests on the ability to actually get at it! The entire aim of the project would have been subverted if counsellors were left unable to see the database on a regular basis.
There is a huge amount implicit here, but broadly speaking I was working from the principle that the entire project rests on *involvement,* and that to be involved one needs information and a sense of control. I did not want to set up a situation where power was, or was seen to be, vested solely in myself.

In order to remove the bottleneck, I needed to increase the number of terminals that were functionally available to the counsellors. As I did this, I realised that I was somewhat out of step with them. They seemed to have developed a view that CORE was mine, and I needed to do a lot of work explicitly permitting and encouraging them to gain direct access to the system. I did this by face-to-face conversations and memos. There was a surprising amount of work in this mini project, as I arranged for the purchase of a new PC for the room used by the counsellors, had them all allocated passwords to use trust equipment (gaining *inter alia* e-mail addresses) and passwords to access the CORE database.

Many were not IT literate, and I had to spend a great deal of time teaching counsellors how to use the system. The Trip through CORE document (Appendix 2) was a vital part of this process. It was only the beginning however, and the issue of familiarity and use of IT will be around for a long time to come.

In terms of general learning, it is clear that direct access via multiple terminals is essential to help develop a sense of *ownership* of the data, and to allow for the rapid access to the data.

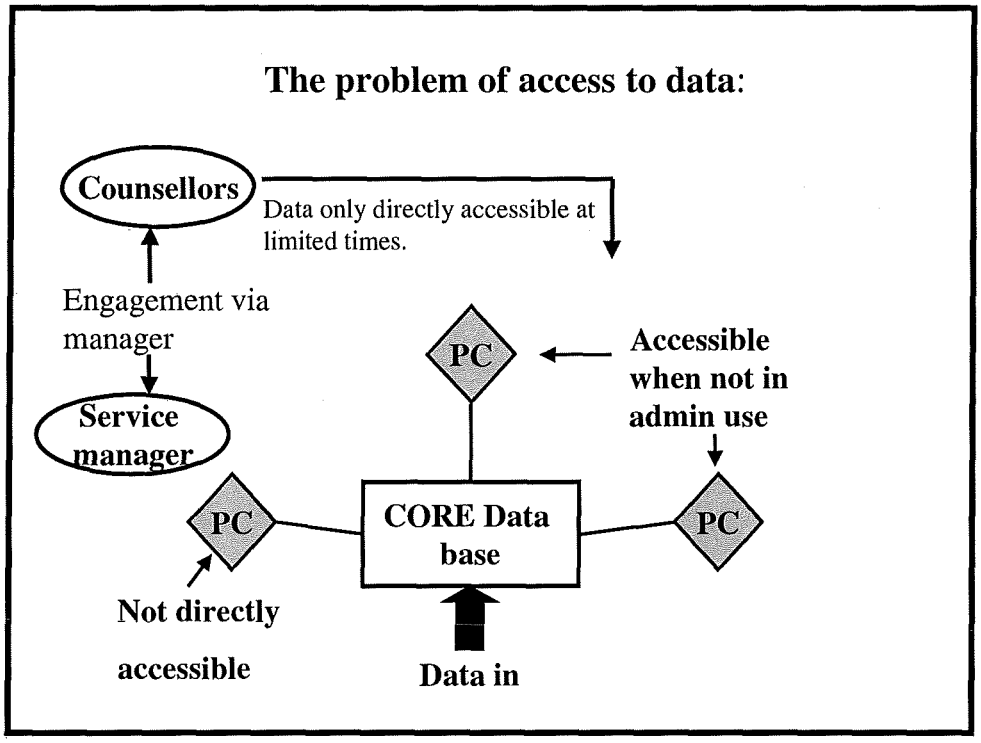

Figure 4-1 Counsellor access to CORE data

Developing access to the database in this way was in the service of what I came to think of as rapid cycling of data. It seemed clear to me that a central benefit of the system was the capacity to provide up to date data. It was only going to be up to date in any meaningful sense if people had access to it. The issue of access to data is ongoing as I work with counsellors to ensure that they have the skills and ability to be able to engage with the data.

4.2 The issue of data management

With a developing database such as CORE, one is presented with an ever-moving field. With a traditional audit, or the previous scanned CORE system, it is comparatively simple. You take a sounding, wait a while and then get some figures back. With this system, the figures are potentially there all the time, and change with every entry. The very speed with which the database develops becomes a factor in its management.
I began to experience a sense of fatigue at times with the sheer rapidity of the process and the multiple pathways that I could potentially explore. This highlighted what for me is a very genuine issue in the use of CORE or any similar audit system. Basically it is the problem of data overload. One gets so much that it is easy to try to chase after everything, eventually getting totally bogged down in detail.

Perhaps inevitably with CORE, there might be a fascination phase as one experiments with the new toy and sees what it can do. If this is not to be followed by disenchantment however, I think that it is important to find a way of relating to the whole thing that keeps the horse firmly in front of the cart. I did this by constantly coming back to the 'so what?' question, and reflecting on what I really needed to know and how it could help us offer a better service.

There seem to be a number of key areas in doing this; outcome figures are crucial, as is session number and cut off percentages. Gender is often important, and data quality (i.e. the number of forms entered as a percentage of total) always has to be at the back of the mind. As a way of managing this ever-shifting field, I developed the simple model outlined in Figure 4-2 below. It serves as a useful schema on which to hang the information and keep it manageable. In this respect the current layout of the CORE-PC software is perhaps not as helpful as it might be. Each aspect of the data is presented on a separate screen (see Figure 2-2 in chapter 2). This makes keeping a comparison between different aspects of the data, say outcome and gender, hard to keep in mind. In order to have all the data in front of one's eyes, it is necessary to go out of the software. I find cutting and pasting each screen onto a PowerPoint page a useful approach (see Figure 3-1 and Figure 3-2, chapter 3 for examples). This is cumbersome and introduces more chance of human error, and I have suggested that the software be altered to allow comparisons on a single screen.

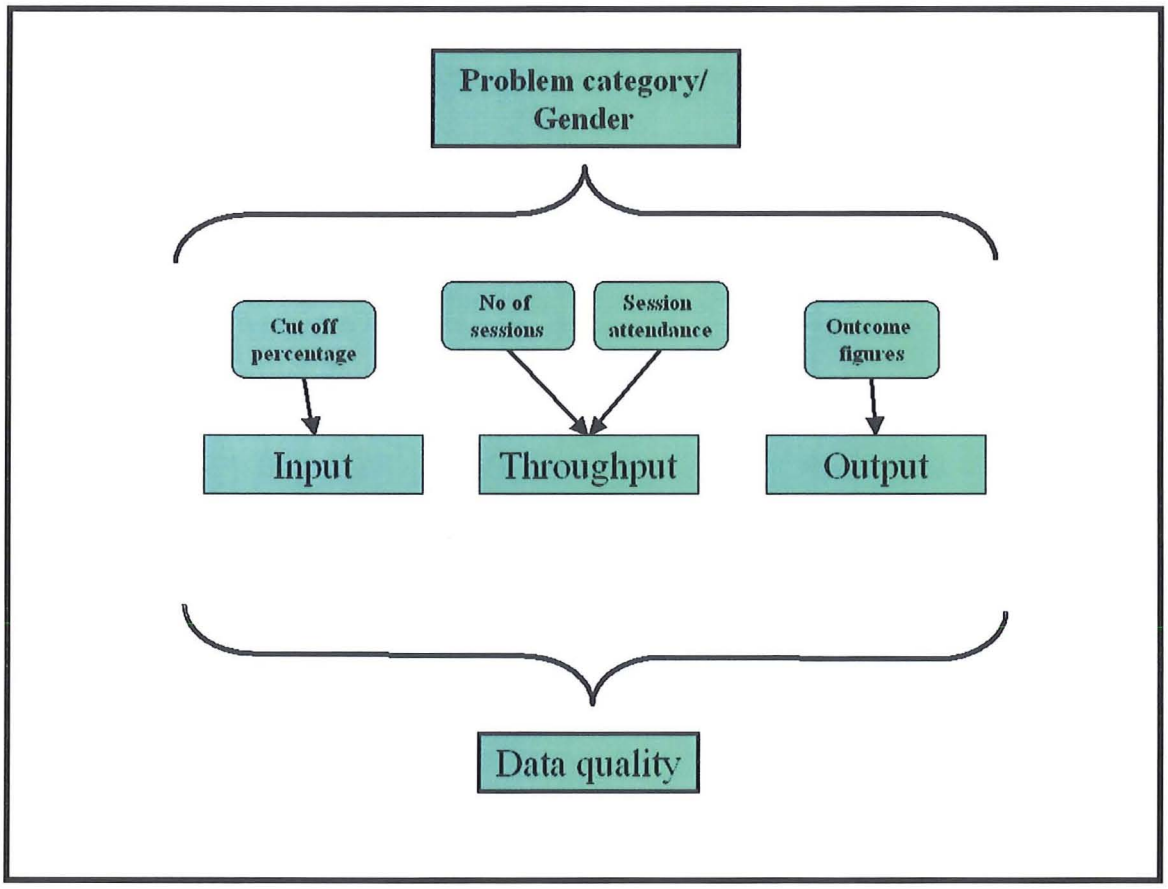

Figure 4-2 Model for managing data

4.3 The data entry problem

At the moment we only enter data onto the software after a case is closed. This is done for largely pragmatic reasons. Each episode of data entry takes about 10 minutes for an experienced person. If we were to enter data at the initial OM stage and then again after the second OM, we could almost double this time per case[19]. This would be very dispiriting for already hard-pressed admin staff. It would also require an admin system for ensuring that pre and post forms are linked.

The consequence of this is that making use of CORE data with a current client requires hand scoring of forms. This introduces the possibility of human error (especially where one is trying to do it quickly). More importantly though, it can be 'clunky'. It requires some dexterity to score an OM in a session without the process becoming awkward and unhelpful to the client. The trouble is that if we do not do this, then we might lose a valuable opportunity to reflect on what a persons responses mean. If we are intending to

[19] It would not exactly be double, but by the time the right screen has been brought up it would not be far short.

use CORE as a risk management tool rather than a *post hoc* risk audit measure, then we have to know the score as we go along.

There are no ideal ways of squaring this circle at the moment. We could hand score OM's after a session and have the information to hand for the next meeting, and indeed some counsellors sometimes do this. This risks losing the aliveness of meaning that is generated if we immediately reflect on responses. Most importantly, risk scores are too important to be left. We cannot have someone tell us that they have made plans to end their life most or all of the time in the past week and ignore this response. We need to respond there and then to this vital information.

We could enter data on current clients. This would have the advantage of allowing for risk scores to be identified and managed. As part of the good clinical governance of a service this is a very appealing possibility. However, it would not get round the need to address risk issues there and then. Until the technology develops, we are left with a slightly awkward, but to me necessary requirement to at least eyeball the OM with the client. As technology progresses I envisage a time when the OM will be completed online (for example with a networked palmtop) in a way that allows the measure to immediately be scored and simultaneously added to the database. Extreme scores could be flagged up in colour for the attention of clinician and client. This would remove the time lag and error factor as we eyeball and add up the OM, and would allow for a smooth transition to discussing the meaning of the person's responses, which is what it is all about.

4.4 Dealing with content

Dealing with the content of the database is the sharp edge of the project. Our response to what comes off the screen determines whether we do or do not truly engage in the process of making sense of, and using, the data. CORE shifts the whole concept of audit from a cycle to a fluid process that can be accessed at any time. This brings with it enormous problems. The picture is always moving, and it is hard to know how to best judge emerging patterns. Time slicing the data seems to be essential; otherwise we stand to miss important trends as they are evened out in the cumulative data. This time slicing might be arbitrary. For example, we might examine the percentage under the cut

off level every 6 months. The slicing might equally be of the database pre and post a change.

There is a huge risk of data overload and of simple misunderstanding as we cycle round the various pertinent aspects of a particular set of data. As a rule, I have found it helpful to focus on mean number of sessions/outcome/gender and percentages below cut off, cycling back to data quality and problem areas at presentation as needed.
Judgement is needed as to how best to observe patterns in the data. There is a risk, especially at the start, of over interpreting every eddy in the waters and attributing significance to patterns that prove illusory. Even watching patterns over time is not that simple. We have to factor in the issue of the co-variance of parts of the field. We might watch our outcome figures with one group, say depressed clients only to find that over a couple of time periods the balance of genders and cut off levels vary. This makes it extremely tricky to make any valid conclusions from what we are observing.
In terms of overall learning however, I think that as emphasised in chapter 2, we need to ensure that we take a broad perspective on the data and beware the pitfall of making interpretations based on part of the picture.

4.5 The process of transforming data into knowledge

As alluded to elsewhere, making use of CORE is a process that involves turning data into information into knowledge. There are no absolute differentiations between these concepts. For the purposes of clarity and brevity, data is that with which we are presented. As we seek to make sense of it we can think of it as information, and as we use it to guide our actions it can be thought of as knowledge.

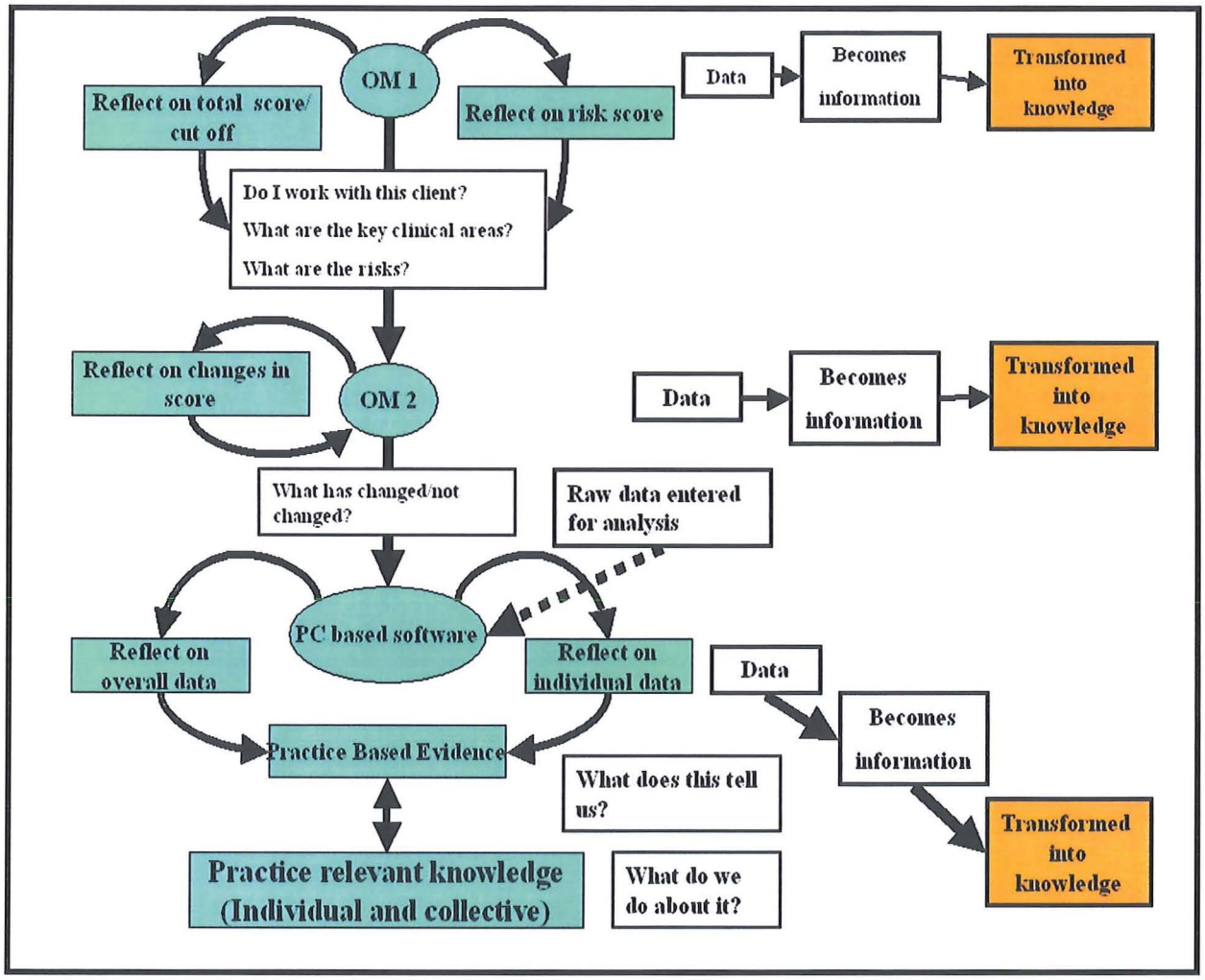

Figure 4-3 Routes for generating knowledge from CORE

As Figure 4-3 shows, there is scope for generating useful knowledge from CORE data at various stages of the process. When we use the initial OM to guide our actions and answer the question about whether to work with this client in front of us, we take the data of the scores and weave it in to our picture of the situation and how we should respond. When we collect a second OM and reflect on the changes (or lack of), again we can transform data into knowledge that guides our actions.

Both of these areas relate to the use of CORE with individual clients, before the data has been aggregated and analysed. As we move into the interpretation of aggregated data as it emerges from the software, we are faced with an even more complex reality. To take one example, the issue of our outcomes by gender (see chapter 3). First, we notice, or choose to attend to, an area of data that emerges as interesting for whatever reason. Then we have to see if we have a true pattern. Does it endure? There is no

absolute line to be crossed here, and we must exercise judgment as to what is good enough. As we do this we need to be developing professional conversations about what we are seeing and what, if anything, we might do in response. In doing this, we are making constant judgements about the reliability and meaning of the data. What are the other interpretations that might explain what we are seeing? Broadly, we need to balance the drive to use our data with the danger of overreacting and misinterpreting. As emphasised elsewhere, as a manager I am also making judgements about how to introduce potentially challenging findings without ending with people feeling persecuted or deskilled.

This is a massively simplified version of the processes that occur in transforming data into useful professional knowledge. We have been beginning to address the above issue for about 18 months and have reached no clear decisions. I think that this gives a small insight into the complexities involved in seeking to make real use of what CORE provides.

Chapter 5. What have I learned?

In this chapter, I will summarise the generalisations that can be made from my experience so far. I will use the term clinician here instead of counsellor as I am speaking beyond my service about the field generally. I also comment on what I have learned in the process.

Key concepts are leadership, management and the need to challenge the culture of the service. To me these are absolutely central from the start. If we are to use CORE and not have it as a kind of designer accessory, then we must pay heed to how the introduction and use is managed. Whilst the approach will vary according to local conditions and personal style, I think that ensuring that a service responds to CORE data requires that someone take a central role in driving it forward.

At the very least, if the introduction is mismanaged, and if clinicians are not broadly kept onside, there is scope for the whole thing to be seen as an unwanted irritant being imposed by others. If on the other hand we can help clinicians to see what CORE might offer, we can develop their enthusiasm and curiosity and in so doing create a far more positive atmosphere as we start the process. This is not to imply that we become spin-doctors however. I think that basic professional ethics require that we (and here I speak as a service manager) seek to be transparent about the pitfalls and dangers. I see nothing to be gained from ignoring criticisms. In my service, several opinions were expressed about the way that CORE can be used cynically as a management tool. I think that acknowledging the real possibility of this is only honest. It is a tool for managing services and we should not attempt to skate around this. Again, my view is that our espoused ethical standards require that we ensure that we offer our services as best we are able, and to do this requires management. The hard side of this is that we might (perhaps are likely to) shine light on practices that are simply not acceptable. I see no point in seeking to fudge this issue. It is anxiety provoking and speaks to the fears of probably all or nearly all of us that we might be found wanting in some way. This is not pleasant and we can expect anxiety. I have certainly felt it as I examined my data (and on occasions projected it on a wall in front of numerous colleagues). I think that we have to acknowledge the reality of this fear and again try to lead people into it, just as we as clinicians seek to help clients examine aspects of themselves that they

might rather avoid. If we do not then I think that there is a trap waiting. Sooner or later, we will start to see something in the data that is problematic. If we have not been upfront with clinicians that CORE is a management tool then there is a real risk that we are seen as suddenly shifting the goalposts, as we move from supportive conversations on CORE to more challenging uses. This is the basic tension at the heart of using CORE or any other clinical audit system to improve the quality of what we do. Figure 5-1 illustrates this tension.

As with any tool CORE has the capacity to be misused. Crucial to ensuring that it is a productive (and one would hope largely a positive) experience is the culture that we develop around it. It can be concealing, fear based and secretive, punitive and authoritarian, or it can be open, curiosity based and balanced. To help develop the latter, openness about the implications as explained above is crucial. Involvement, and a shared sense of ownership have to be central also. If the tool is seen to be the exclusive province of the service manager, this is likely to fuel many negative fantasies and prevent the development of a sense of ownership. Conversely, to really use the data, clinicians must have access to it. This requires attention to the ways in which data can be accessed and will probably involve thinking about IT hardware. One practical arrangement that has proved invaluable in my service is having network access to the database. This allows for input from various terminals, as well as allowing access by clinicians from various locations.

Apart from the practical benefits of having multiple points of entry to the system, it gives a powerful message that its contents are to be shared and is not the exclusive province of the manager.

I found it helpful to agree a rule early in the process that we would not name and shame, we would examine collective data in groups but I would not disclose individual data. If we do disclose aspects of our own data, the choice needs to be in our own hands. Beginning to collect data stirs up enough feelings of competitiveness and jealousy without adding to the process. Implicit in the above is the importance of our developing appropriate relationships with the data, and with each other as we seek to use it.

In considering the culture that supports a positive use of CORE, it is necessary to remind ourselves about its true purpose. It is not an end in itself, but rather a means to allow us to take a structured look at our work and learn from it. Therefore what we are aiming at is a culture that balances being supportive and non punitive, with openness to data and challenge. We are seeking in other words a truly reflective system that both seeks and responds to data.

5.1 Basic steps

It is easy to pay insufficient attention to getting the basics sorted right at the start. This is a danger since in the old adage, 'garbage in garbage out'. Our database will only be as good as the data that goes in to it. Attention needs to be given to helping clinicians get used to completing what can seem at first to be complex forms. In my service, we had a period where we were collecting them but had not yet commenced using the PC version. Even with this experience, we still had to spend time clarifying and agreeing how we coded certain items. An example is missed sessions on the End of therapy form (see Appendix 1). Where clients were seen for less than six sessions some counsellors were counting the remainder of the six as missed, even where these had not been booked. This lead to some counsellors appearing to have a vastly higher proportion of missed appointments than others. Such misunderstandings and differences in practice are inevitable, and time needs to be given to sorting them out.

A spirit of playfulness is important in learning how to make use of the software. In learning this, I watched my son with new computer games. He would sit and absorb himself, picking up functions rapidly by a process of experiment. For those of us who are older, it does take more time[20], and it has been helpful to remind myself and others that provided I stick within some very basic parameters I can do no harm to the database. Conversely, by playing with it I learn how to get what I want from it, as well as its quirks. Playfulness is not important solely in learning the nuts and bolts of the system. I think that it is vital that we allow, and indeed encourage such a spirit in our use of the data. The great risk is that we get bogged down, paralysed like a rabbit in the headlights as we face a myriad of choices about what to attend to and how to attend to it. I think that the most important thing is that we take charge of what is going on and

[20] This is more than just a folk tale. The norms of the WAIS-111 (the standard cognitive test in use) allow for a speed of processing in older adults that would be in the abnormnal range in young adults.

begin the process of reflecting, applying our informed intuition to what we are seeing. Within broad caveats, it doesn't really matter where we start. What matters is that we begin.

5.2 Clinical Use

Attention should also be given to the issue of how we introduce forms to clients, especially where clinicians are new to the use of psychometric measures. There can be a great deal of anxiety and not a little prejudice about this process. There is scope for individual preference, but by and large I do think that we must ensure that the form is completed relatively early in the first session at the latest, otherwise we are measuring from some time in to the process. Once we realise that this is going to have the effect of making individuals and the service look less effective, it becomes the logical thing to do.

Once the form is given, there is the tricky issue of how to deal with the responses given. To me the huge danger is that we put the OM aside and then get on with the 'real work'. I think that this attitude is dangerous and risks giving the message to clients that the forms are an imposition and of no direct value to them. To ask someone to complete an OM places on us a responsibility to feedback to the person what they have said and encourage a discussion as to what it means. Largely, I think this is what most people would expect. There is quite a skill in this and it can take some time before clinicians feel comfortable in doing this. The OM can be scored after a session or, with practice within it. We have experimented with the latter, largely so that the counsellor can check overall and risk scores as part of the assessment process. It has however proved useful to check extreme scores, since at times these are incorrect (the client has misread the form and not given a response that reflects their current state of mind.) Where the risk items are high and correct, it is almost invariably useful to begin to discuss what they mean. However we play it, I think that we must expect to make clinical use of CORE data, weaving the learning that the client and we generate into our assessment and our further work. It certainly seems to be helpful in identifying and managing risk issues, although there is a danger that we could over rely on it and miss other pieces of information.

In clinical use, one final issue has arisen. That is the importance of attending to disparities between the OM score and the clinician's overall impression of the client. We have found at times that there is quite a difference, with say a client declaring on the OM that they are not especially troubled but giving quite a different impression to the counsellors and/or the referring GP. This always seems to be an important area to explore.

5.3 Data entry

This is a vital area, since unless data is entered we have no database. It is a task that can be boring and dispiriting if it is done for too long or under too much time pressure. Each CORE set takes around ten minutes to enter onto the software. It is only reasonable (and one will get better work) if the task management is negotiated with whoever is doing data entry. Ideally, it needs to be broken up or shared. I have been very fortunate in having a group of admin staff that have shared the job between them and taught each other how to do the job. This aspect of the data management task will I hope become redundant when we move to system that allows for the client and clinician to complete the forms on a screen that will score and transmit the results to the database immediately. Until then, this is a potential bottleneck in the creation of useful data.

5.4 Access to data

If we are to respond to data, it needs to be up to date. Feedback is best given rapidly after the event. CORE PC opens the door to the rapid analysis of data, but if we do not access it then this potential is lost. This is what I have named rapid cycling. It is supported by the kind of open access described above. Again, this requires attention to IT systems and the flow of information as well as encouraging regular access and reflection on the data. This is probably best done in a variety of ways; To me creating a balance of managing the process and having people self-direct requires that we have some access for the self and some via the manager in 1:1 meetings. There are all sorts of other ways in which we can create spaces in which we can begin to have informed conversations about our data. Some counsellors in my service have experimented with meeting as buddy pairs to look at each others data. We have also begun to meet and examine the database live, using a laptop connected to the database and projecting the screen. This allows for the benefits of group discussion, and ensures that it is not the

manager who is filtering what is presented. The group can go anywhere in the software, with the exception at the moment of individual profiles.

5.5 Problems

As outlined in chapter 3, data overload is a very real danger with a rapidly evolving database, and developing some rules of thumb as to where to attend is probably useful. I think that it is important to keep reminding ourselves and others that we always need to examine the whole picture as we seek to make sense of the data (see G's story). Always look at the whole picture has become something of a mantra for me. We must also beware of reifying the data. CORE is a useful tool and produces much that is challenging and helpful. The whole picture contains CORE, but CORE is not the whole picture. In my service, Di's story (Appendix 3) illustrated this point for us very clearly.

There is a risk that we will seek to make sense of the data too soon. It almost certainly pays to let the database mature as we attend to the issues of data quality and input outlined above. It is not possible to place an exact number on what is a big enough database, but a couple of hundred would seem a useful guide before we start to look for meaningful patterns. As a rule of thumb, I suggest looking at collective patterns first as the numbers for individual clinicians grow more slowly. After one has a couple of years of data it becomes important to start to time slice the database and look for patterns emerging over time. This way one can identify a pattern, say that we have a lot of people who are under clinical cut off, discuss it and agree on action and then see what happens in the next period.

Finally, I think it bears repeating that getting a database established is hard, but is really the easy part. The real challenge is taking the data and doing something with it. This requires a long-term commitment and a willingness to wrestle with complex and challenging issues.

5.6 Tensions in the use of CORE

As summarised in Figure 5-1, if we think of CORE as a quality improvement tool, we are faced with a tension at the start. This is between its use as a developmental tool and its use

as a performance management tool[21]. The negotiation of this tension will probably prove crucial to the success or otherwise in embedding CORE into the culture of the service. If we emphasise the developmental at the expense of the managerial, we stand to have problems later when we notice something that requires managerial attention. We may feel that we cant use it as we haven't made it clear to clinicians that we will use CORE this way, or we use it and risk being seen as dishonest. On the other hand, if we overemphasise the managerial aspect of CORE, we stand to alienate clinicians and fuel every fantasy about it as something imposed by 'them'.

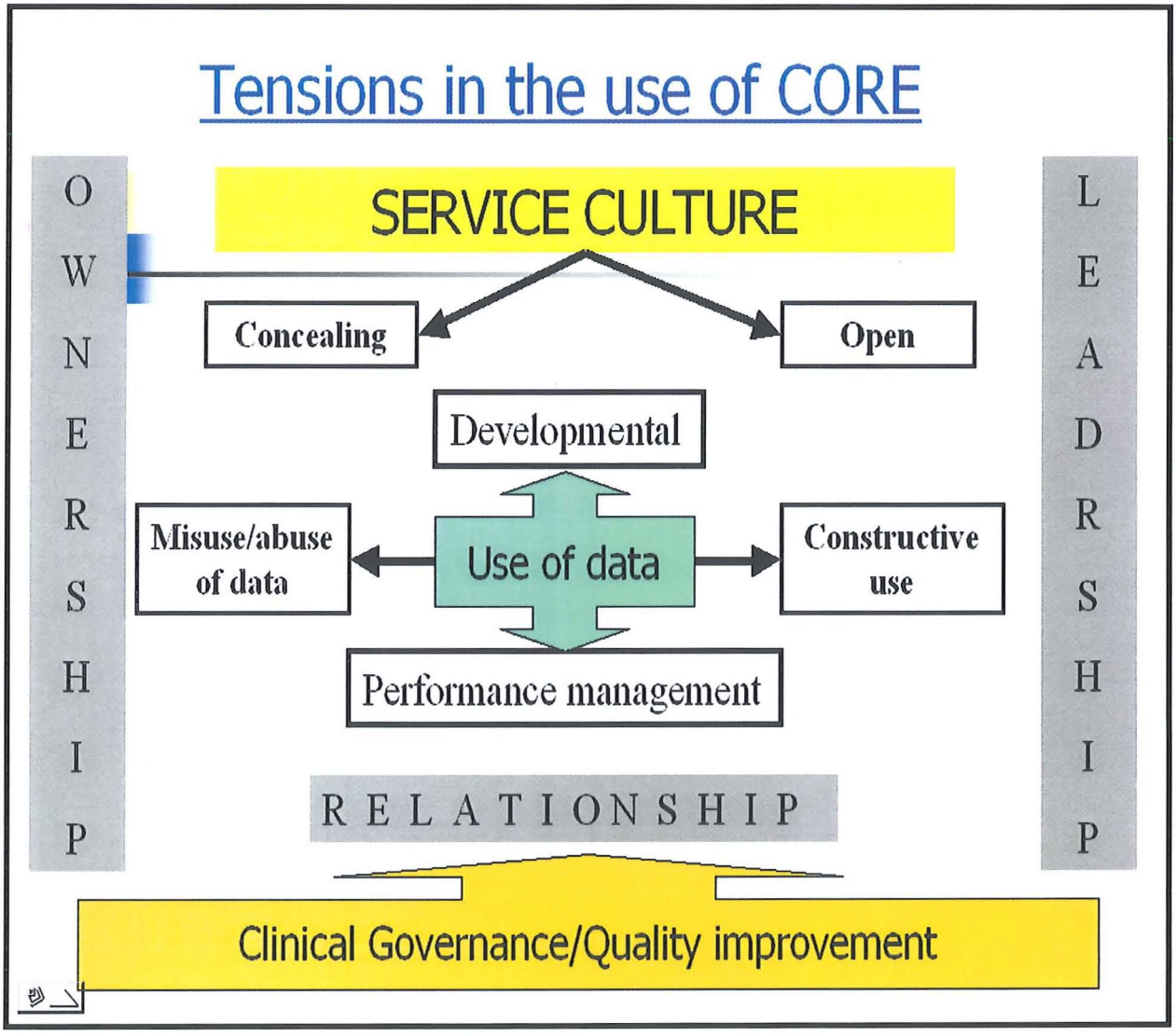

Figure 5-1 Tensions in the use of CORE

In any case, as soon as we acknowledge the potential for performance management we begin to be faced with some potentially uncomfortable realities. Performance

[21] The dichotomy is only useful up to a point. For example something identified from performance management might prove very developmental.

management requires that there be someone who undertakes it. This highlights the importance of the role of clinical managers. More importantly, it implies a manager who will start to look through the consulting room door in a way that has not previously occurred on a regular basis. That manager becomes an advocate for the service user in a way, which outside of investigating complaints, is rare.

Performance management changes the dynamics of the relationships around CORE. It introduces a power differential where the manager has the right and indeed the responsibility to draw attention to aspects of the data and in extremis require action. This is no different in principle from any management relationship. What changes is that now the manager has data about actual clinical performance. This raises the troublesome possibility of the fraudulent production of data, as clinicians seek to 'fiddle the figures'.

Performance management using CORE does begin to offer another route by which the voice of the service user is heard in the running of the system. A manager is well placed to lead the search to decode what the clients are telling us via our CORE data. This can supplement our continuing efforts to understand the voice of the client as clinicians. I do not believe that CORE is sufficient alone however and we need to find other ways of generating feedback, via satisfaction audit and perhaps specific research on the users impression of CORE. There is a tension at the heart of using CORE between its use as a developmental tool and its use in performance management. The different stakeholders in the CORE data, and the service that it derives from, have a right to be involved in the use of the data. Clinicians have a right to be involved and to use the data for their development and the manager has a right to use the data to best manage the service. Commissioners have a right to see the data in order to examine what they are getting for the taxpayers money, and the service user has a right to see their own and aggregate data to see how effective the service being offered is. As in any situation where there are multiple stakeholders, there will be times when there are conflicts of interest between parties. I think that this tension is inevitable, and perhaps the only thing that we can say is we should not try to avoid difficult issues. Specific cases will require judgements made in the light of local circumstances.

If we create the right culture, this tension can be creative. If we start by acknowledging the existence of potential tensions, we can begin to create a service culture that is open as opposed to concealing, and where we begin to increase the likelihood that we will use data constructively.

For the sake of snappily conveying complex ideas, three themes can be seen as crucial. *Leadership* sets the tone from the start, and plays a crucial role in the kind of service culture that is created. This has been explored elsewhere, but it is important to note that humanity is essential. The task of the leader can be seen to boil down to humanising CORE.

It is important to generate a widespread sense of *ownership* of the use of CORE. If it is solely seen as a managerial tool, clinicians are likely to miss some of the developmental benefits. If it is seen solely as developmental we are likely to avoid some important opportunities to learn from the feedback that we are being given. Coupled with this is the nature of the *relationships* that we develop with and about CORE. If we can relate to it as basically friendly and useful then we are well placed to learn from the data. If we experience it as cold and punitive then we are likely to learn little. We are back full circle to the importance of leadership in developing the right culture.

5.7 Becoming a Learning Organisation

The natural implication of my work is that to use CORE we must be willing to think in terms of organisational structures and processes. The current NHS jargon speaks of 'learning organisations'. If an organisation is genuinely to support learning in a meaningful way it needs to ensure that learning is put into action. This implies that the structure and processes of that organisation will be flexible enough to respond where appropriate to the developing PBE. This is perhaps the crux of the matter. Roles and structures within organisations, especially those such as the NHS, are highly defined and become ossified. Even where one can get beyond this and develop a level of flexibility, local circumstance often intervenes to constrain choice. For example in this service a lower number of male referrals seemed to be something that required attention. I hypothesised that perhaps one reason might be that we were not perceived as an available service. As a way of beginning to address this we could experiment with offering appointments outside of standard office hours, for example in evenings and at

weekends. It was my intention to develop this aspect of the service and at one point we had both an evening clinic with several counsellors working, plus a Saturday morning. The Saturday rapidly disappeared when the surgery began to close on that day. The evening clinic has been beset with problems because of the need to have administrative cover for health and safety reasons. I am still looking for ways forward with this. However, this is a good example of how creative ideas often founder on the rocks of local circumstance.

There is no end state marked 'learning organisation'. Rather it is best thought of as a willingness to reflect on experience and alter practices, and the systems that support practices, where appropriate. Perhaps we could paraphrase Schon's term and think of the 'reflective organisation'.

5.8 The CORE system

This whole project has been a form of road test of the PC system. It is a system that is constantly evolving throughout the period covered. This evolution is the result of many factors including suggestions that have arisen from my work.

Starting at the simplest level, I remain convinced after using the tool for a couple or more years that it is a very good thing. I cannot imagine how it would be possible to run a service without it. Of course, I have nothing to compare my experience with, since I have been using CORE since I began as service manager. However, I think it can be shown to have a positive impact in relations with many stakeholders;
External to the service, it impresses commissioners. I know that it is easy to be cynical about this, but without a budget, we can offer no service. My experience is that those who hold the purse strings are quite rightly impressed with the data that can be provided using CORE, especially data on session attendance, outcome and average number of sessions. Although I have not given a lot of attention to this area, it also seems helpful in providing GPs (and potentially other referrers) with feedback on how we get on with our clients. This can be through service data (sent in my case as part of an annual report) and individual CORE scores used in letters of closure.

Where the data is broadly positive, the use of CORE (or by inference any other valid audit tool) seems to be helpful in boosting morale as the belief that what we do is useful

is supplemented by hard evidence from the client. This improvement in morale has many facets including a sense of being protected by having a good assessment tool (see Di's story) and having the opportunity to reflect and change practice (see G's story).

Internally, it is a crucial management tool, allowing one to keep an eye on the profile of people coming in to the service (age/gender/problem type/OM score etc) and how we do with them (proportions accepted for counselling/number of sessions/session attendance/outcome). For clinicians as well as managers it can have a central role in risk management, and there is evidence of a more anecdotal nature that counsellors in this service find overall OM scores helpful as part of their assessment of the client. There is also anecdotal evidence that clients find examining their pre and post scores very useful. I have been asked to provide copies at the end of counselling so that the client can take these away, and others have reported in supervision similar interest. As explained elsewhere, we are beginning to explore the response of clients via our satisfaction questionnaire and other research. This is an area that could usefully be explored through further studies however.

There are difficulties in using CORE, especially arising from the rapidly changing nature of the data that emerges. Overload is a serious risk, as I believe is misinterpreting what one sees. There is a need to keep in mind many aspects of the data and it is easy to forget this in practice. For example,[22] I can be examining data for an area over two annual periods. In doing this, I might compare outcome figures whilst looking also at the gender and problem type balances in those periods. They seem more or less similar, so it might begin to look as if outcome figures have fallen slightly. Then I look at the average number of sessions. These are roughly similar, so I conclude that there is a slight trend. Unless it is massive, it is difficult, without some advanced form of statistical analysis that is beyond me (and I suspect most users of CORE) to say whether the trend is real or a measurement error. Then I realise that I haven't examined the gender balance in clients in the two periods. I look and find that there has been a slight increase in the number of men seen. I have shown fairly robustly that we are less effective with men. When I factor this in, I am no longer comparing like with like. The two populations are so different that any trend more probably reflects this than any decrease in our effectiveness per se.

[22] This is a conglomerate made up of many similar experiences that I have had.

This type of scenario arises constantly, and one is often faced with real uncertainty as to how to interpret that data in its entirety. In practice, it is easy to see how one might come to totally erroneous conclusions, and spend time pursuing red herrings. Given that there may be a tendency to reify the data, this could be hard to spot and correct.

The management of the process of establishing and maintaining the database is a large task. In particular there is I think a problem at the data entry stage. It is a boring repetitive task and likely to be a bottleneck in the data management process. As one of the key benefits of CORE PC is the rapidity with which data can be analysed, this is a real problem. Unless one has a really efficient arrangement, it seems likely that most data entry will end up being after the case is closed. This still allows for the rapid processing and interpretation of data, but the cycle is still being undertaken post hoc.

As outlined in chapter 3, using CORE in clinical work we are left with an awkward arrangement that requires hand scoring. We need to develop the system so that we can complete and score the OM on a computer, ideally adding this to the database as we go. I envisage a system using palm tops wirelessly networked that score and collect data as we go. This would allow us to extend the use of the system to our live clinical work and complete the transition from a very good audit system to a clinical management and audit system. If we move downstream in this way, I believe that this would further weave CORE in to what we actually do, and increase the chances of really influencing our practice.[23]

5.9 My own learning

Engaging in any kind of action research, where one is trying to make a change and simultaneously examine it, is hard work. I have been constantly balancing multiple and sometimes conflicting role demands, as I sought to do justice to being a manager and a researcher. At times I have had to be willing to make difficult choices, such as when I felt that I could not pursue the issue of the low return rate of questionnaires because of the risk of being seen to be abusing my position as manager. Balancing being an advocate for something and analysing how one is doing it is tricky in the extreme. At

[23] Events have moved on rapidly since this was written. As noted in the final paragraph of chapter one, we are now going to trial such a system. This work has played a minor role in these developments.

times it has been hard to know what to prioritise. For example my rationale for running the focus groups was about helping people get together and generate a sense of enthusiasm as well as creating a forum to unpick how counsellors were experiencing the process thus far. This felt awkward and I did not like the feeling that I might be operating with an undeclared agenda.

I have really struggled with the issue of involvement of others in the process. Not in principle, since I am very clear that it is best to seek to do this. In practice however, I have found it frustrating that at times they did not seem to want to be that involved. I have been disappointed at the low rate of take up of the facility to access CORE. Again, I have struggled with what is an appropriate response. As a passionate advocate, I wanted to harangue and chivvy people along, but as manager, I could not do that. I think on balance that I sometimes erred too much on the cautious side. However, as a male manager of a largely female staff, the possibility of being experienced negatively is very real.

One or two incidents have served as a reminder that like all of us, I lose my reflective capacities at times. I bracket things quite well, but sometimes this does not help. I kept the risk guidelines in a mental box quite separate from the project, only realising later on that it is in fact a central part of the whole. This was not too damaging and I corrected my error once I identified it. With the satisfaction questionnaire, I really missed an opportunity to dig deeper. Again, I corrected it later, but miss having some data to report here. The common factor between the two is that I saw both tasks as an imposition. I was irritated and went into automatic mode, operating from pre existing schemas rather than being really involved in the process. At these points, I was not a reflective practitioner.

At times, I have felt bogged down, as if I did not really know what I was doing. It is very hard with something like this to get a sense of perspective, and I have swung between thinking that I have not really achieved much, and verging on the grandiose. The latter was swiftly ended when I realised that even in my own wider organisation decisions were taken that seemed to negate the value of what I had done (see Appendix 13). This has changed somewhat since.

What does not come through in the action research literature that I have read is the sheer amount of time and effort that is required to clear the field in order to attend to the project. As described in Context Documents 1 & 2, the early days of the service were a constant struggle to establish the service and my position in it. I had just got settled when the issue of moving counsellors onto Trust contracts was thrust on me, forcing several months interregnum in the project. Frustrating as these feel, I noticed from this and previous forced interruptions that when I came back I made some shift in how I thought about what I was doing.

One of the key difficulties for me has been the balancing of my roles as researcher and manager. This was highlighted in the aftermath of the questionnaire when I was constrained from asking further questions. The issue of power and its abuse is central here. That goes for the use of CORE as well for my management of the project (as if they can be separated). It is a two edged sword that can be abused as easily as it can be used. At times, I have struggled with the dilemma of how to squeeze the most out of it without being experienced as persecutory of hard working counsellors. At such times I comfort myself with the reminder that really using this is very challenging to all of us, and is not going to happen overnight.

My own use of CORE data has been interesting. I toyed with sharing my developing data set as a way of modelling ways of using it (and to learn from it). This did not seem appropriate given my role in the service. I then took it to my own clinical supervision and really did not get far. It highlighted for me the importance of supervisors being fluent in CORE. At the managerial level I have had much more success, using Richard Evans in particular to bounce ideas around. From my experience it seemed vital to have then opportunity to reflect on ones data as a service manager, and it was from this suggestion (and no doubt others) that the idea of having workshops for managers to examine their data was born. This service profile (see chapter 3, page 52) with John Mellor Clarke was very helpful in letting me see the wood for the trees. On a more regular basis I am examining setting up a peer arrangement.

The process of writing this document has been interesting. I began to lay down draft chapters very early, beginning with the stories of Context Documents 1 &2. It was after the break whilst I attended to counsellors' employment status that I realised I wanted to

reshape the way that I presented what I was doing. This was when I hit on the idea of placing these pieces as context documents to add depth to the central chapters. Writing these pieces proved important however as it helped me to get clear what had happened and to clear the mental space to rethink what I had done regarding CORE. From this arose the diagram of the action reflection cycles (see chapter 1) that has become central to my understanding of what I have done. It has not all been positive however. I think that at times I have become so focussed on the writing that I have not been placing my energies in continuing to make things move forwards on other aspects of the project. On the other hand, I learn as I write, and without the space created in the writing of this document, it would have been much harder, maybe impossible to have kept myself on track.

Chapter 6. Products

The following are the products arising from this project.

6.1 Myself as a researcher and practitioner

I think it important to acknowledge at the start of this chapter that a central product of this project is my development as a researcher manager and practitioner. Space precludes further discussion, but suffice it to say that I think that this has been marked.

6.2 The development of a learning organisation

At its heart, this project has been about driving through the use of practice-based evidence, and generating some sense of how we might do that along the way. The central product of this enterprise has been the shaping of the Adur, Arun and Worthing Primary Care Counselling Service into a service that is characterised by a willingness to closely examine what we do. This should not be thought of as an end point. One does not tick the 'are we a learning organisation?' box, and then go on to something else. Rather it is a state of mind and a state of culture.

6.3 The dissemination of the work; presentations

I have made a variety of presentations, including to my service in December 2003, March 2004, and December 2004. A presentation was made to the Audit manager in December 2003, and to adult psychology colleagues in September 03 and January 2005. The latter have served to inform the wider trust about the work being undertaken, and have resulted in my taking a lead role in the use of CORE across psychological therapies in the Trust.

Externally to the Trust, I presented to Brighton and Hove Psychology Service in October 03. I have made two presentations at CORE events, a national workshop in November 2003 and at the CORE conference of primary Care managers, in April 2004.

The latter presentation came at a very useful time, as I was immersed in the process of analysing and writing up what I had done to date. It was fascinating how other

speakers on the day, also running primary care counselling services all over the UK, had had similar struggles and reached similar conclusions. For example, Belinda Wells mentioned the importance of engaging supervisors in the CORE system, seeing this as crucial to ensuring that the data is used. Dr Jenny McBride stressed the need to use CORE OM data in the clinical session, as opposed to putting it to one side for audit only. This reflects my position that to not use it gives a very odd message to the client.

It was widely acknowledged that it is essential to engage clinician's curiosity and enthusiasm. This was very much in line with my developing ideas, and this is a good example of how circular the process of disseminating ideas is; one learns as well as teaches.

6.4 The dissemination of the work; publications

CORE: What is it good for? The Counselling and Psychotherapy Journal. Vol 15 (7).August 2004. pp 18-21

CORE and Risk. The Counselling and Psychotherapy Journal. Vol 16 (2) Feb 2005.

These articles served to disseminate some of the general findings of the project. The journal was chosen for a number of reasons, including the fact that it has a wide circulation amongst those who self identify as counsellors. The first article produced a larger number of responses than any of the previous papers I have published. The second article was delayed, for reasons that are unclear to me and is due to appear as this document is submitted. Whilst these papers reached a part of the potential audience for this project, it is unlikely to have reached many psychologists and psychotherapists, who read other journals.

6.5 Research question on gender and outcome

As outlined in chapter 3, the most consistent finding from our database has been the difference in our effectiveness with male and female clients. At my suggestion, Professor Michael Barkham has now taken this up. He is leading a two-year study using the national database (currently some 25,000 client data sets). The focus will be on practitioner-derived questions, and this was the first such question to be passed on to his team. This is a good example of how a piece of work like this identifies further specific research questions for further examination. It also neatly exemplifies the

circularity of the entire CORE project as implied by Figure 1.3 CORE was designed as a result of a piece of formal research, I and others have used it to produce practice based evidence, and now a question arising from that evidence will be examined using a traditional research design.

6.6 Feedback and changes to CORE

I have been in constant contact with the CORE team regarding the use of the PC system. This contact has led to a number of developments in the system. Some of these have been of a comparatively minor variety, suggesting revisions to page layouts and clarifications of tables and the like. More significantly, I was involved in shaping the individual feedback template that summarises an individuals CORE data. A significant shift in the use of CORE was having the software amended to allow for counsellors to see there own and aggregate data and not any one else's. This allowed for the crucial shift of counsellors being given direct access to the system.

Perhaps the most important development of the system is currently in hand; this will use broadband or mobile phone technology to input data direct to a web-based database. This will remove one of the main drawbacks to the current system, which is the onerous task of data entry. It will also allow for scoring, and comparisons with benchmark figures to occur automatically, removing the slightly 'clunky' process of scoring OM's by hand. Most importantly, it opens the door to the live use of CORE data in the clinical work (7.2.1).

My work has been one of a number of threads that has led to this development. I am quite sure that it would have happened irrespective of what I have done, but it is fair to say that my feedback and thoughts have played a role in this new project. My service will be the first to trial the new system, which promises to take CORE to a new level and begin to allow us to really weave audit data and clinical work together as never before. Figure 6-1 gives a visual indication of the products of this project. I have not included my development in the diagram. Feedback to the PCT and its impact on service size etc is commented on in Context Document 1.

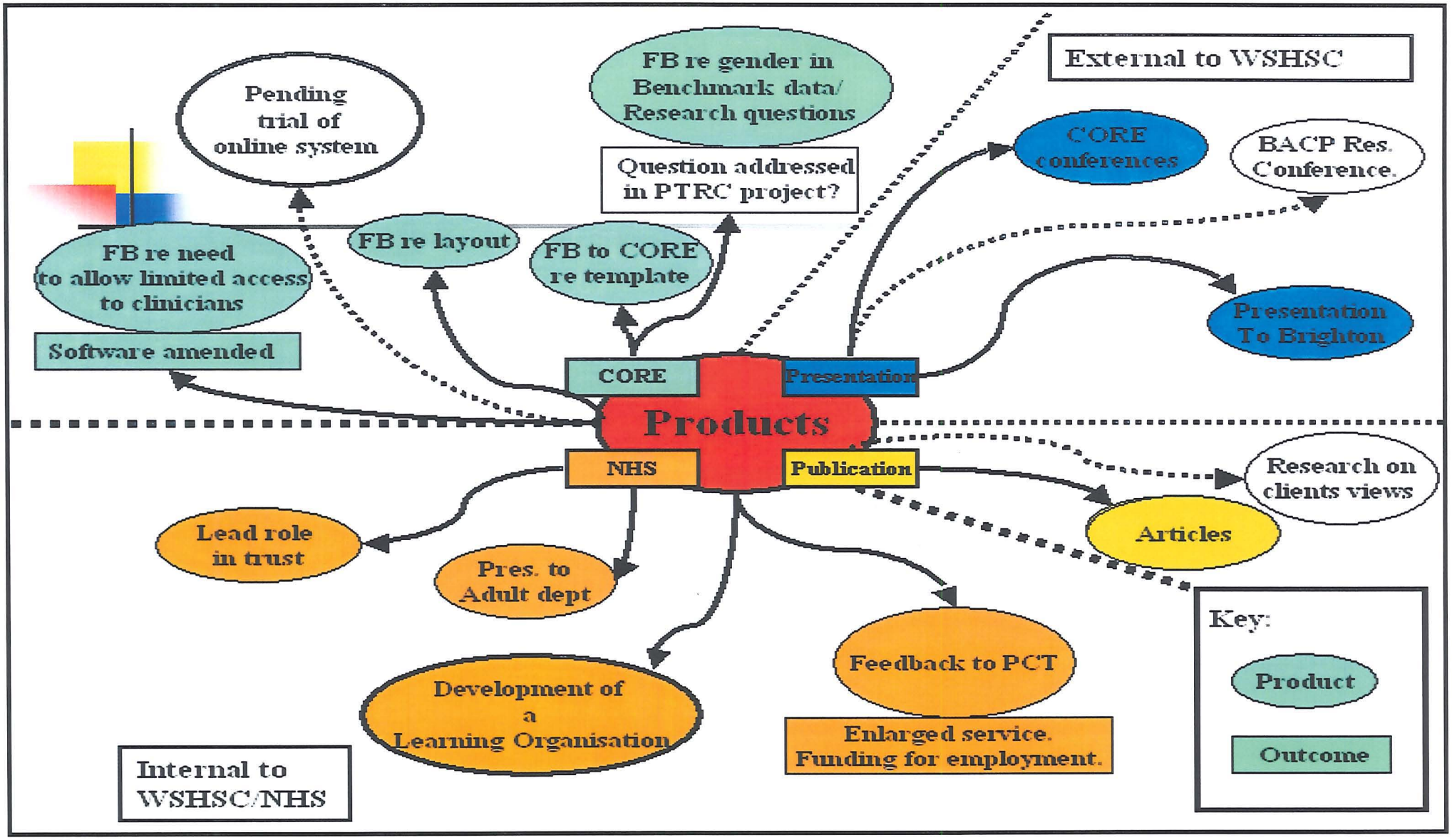

Figure 6-1 Products Arising from the Project

Chapter 7. Final Thoughts

"Human knowledge doesn't accumulate like the bricks of a wall which grow regularly, according to the work of the mason. It's development, but also it's stagnation or retreat, depends on the social, cultural and political framework." Rigoulot, quoted in Applebaum 2003 p5.

7.1 Evaluation of the Project

7.1.1 Introduction

In my doctoral proposal I identified a number of criteria by which I would judge this project:

- There is clear evidence of critical analysis.
- The product is coherent, and shows evidence of appropriate reflexivity.
- I have discovered something worthwhile (for myself and others).
- I show what my evidence is, and what I have done with it.
- The work is written in such a way as to be open to challenge.(cf: Popper 1959)
- I have articulated what I have discovered in a way that is useful for others.
- I have done that in a useful forum.
- I can show awareness of the limitations of my work.

So how have I done? In answering this, I will first address the initial criteria and then in greater depth focus on the issues of limitations. Perhaps the key question here is how do I know that I have not simply become like Winnicott's teacher? How do I (and others) know that I have not been simply using CORE to support pre existing views and practices? Perhaps the best way of examining this question is to look to see if I have found evidence that ran contrary to my expectations, and evidence of my changing direction as a result of my findings. In other words have I demonstrated true reflection in action?

The counsellors' views of the risk guidelines, evidenced by the questionnaire results, were contrary to my expectations. As a result I altered my view of the importance of those guidelines, and indeed came to realise CORE's value in supporting risk management. This can be seen as evidence of reflection in action, and provides evidence of learning as opposed to simply skewing evidence to 'prove' pre existing prejudices. There is clear evidence of critical analysis throughout this work. I have

shown my evidence, gathered by various routes, both structured (focus groups, questionnaire), and unstructured (observation and reflection).

This leads to the next question, is the product coherent? It was always going to be messy and have an odd shape, but that is accounted for by the methodology chosen. In undertaking what I have come to think of as an action research case study (for the sake of a snappier description) I have been firmly in the swamp, working with the multiplicity of variables rather than trying to control them out. The coherence of the project comes from the consistent focus on developing our ways of using practice-based evidence. In CATWOE terms it is about the transformation of unused CORE data into useful information. Perhaps more accurately it is how we take the data (raw CORE scores), turn them into processed data (produced by the software), and crucially how we engage with that and turn it into information to generate knowledge that is useful in the pursuit of offering a better service.

I have articulated some of what I have been discovering within the service in numerous discussions and workshops. I have used my learning to engage in numerous conversations about the future improvements of CORE, in particular helping shape management tools that are being developed to support its use. I have presented my thoughts at national conferences, local meetings and in written form. I am of course aware of and keep mindful of my bias and vested interest in believing that this has been experienced as useful to others. The spontaneous feedback that I have received on the articles and comments from presentations do support this positive view of CORE-PC however.

Finally, is this work open to challenge? This is perhaps the Achilles heel of any approach using a pure or partially qualitative methodology. In seeking to generate something with ecological validity we sacrifice an element of replicability. It becomes more difficult for an external person to be in a position to properly challenge[24]. I have sought to avoid the pitfalls inherent in an extreme qualitative position, especially by seeking to generate islands of data through the focus groups and questionnaire. It has to be acknowledged however that these do no more than scratch the surface. This work was envisaged as a

[24] This is of course not the whole story. The internal consistency of the work and logical flow of conclusions from the evidence presented can be challenged.

conglomerate. The problem is that a conglomerate may end up neither one thing nor the other.

7.1.2 Strengths and limitations of the project

Whilst the focus of this project has been on the process of using routine audit data, there is a risk that the whole project becomes a house built on sand, if the instrument used is shown to be so limited as to provide worthless, or even misleading, data. It would be possible to argue that CORE data is limited because the measure only examines self-reported general distress, and that therefore any process of reflecting on it is compromised. I believe that this would be to overstate the problem however. Despite the limitations outlined in 1.4, it is my contention that the CORE system (as opposed to simply the OM as a stand-alone measure) provides us with good enough data in a useful manner (and this project has led to some improvements in the way that data can be made use of). Merely measuring distress at the start and end of counselling might be limited, but it is better than nothing. In the domain of practice we have to make compromises between rigour and usability.

Where any data is being used, the key is to interpret that data in a sophisticated manner with a clear eye on its limitations, and in so doing ensure that we only reach conclusions that are merited. In clinical practice we place our routine audit data alongside our other knowledge of the client in order to reach sophisticated clinically informed judgements about what we are seeing. This is by no means an easy process. For example I have noticed that on occasions in discussions about risk scores we have begun to talk as if they formed a scale, even though this is not merited (Mellor-Clark, Barkham et al 1999). This highlights the danger of ignoring the technical limitations of any system when we use it routinely.

In a piece of work that seeks high ecological validity, context is everything. This project has taken place within a broader environment that was favourable to CORE (the PCT included it in the original commissioning document). Counsellors were largely reasonably positive about CORE. This is partly a function of my approach as is described elsewhere. However there were no people who were strongly against. The results of our initial data were broadly positive and could therefore quite honestly be fed back in this light. Any or all of these factors may well not apply in other services.

This may seriously affect how any system for routine outcome measurement, including CORE, is received and how it can best be used.

A project like this is a story of compromise. The tension between rigour and relevance runs throughout. Choosing to balance action and research immediately places limitations on what one produces in terms of how much one can generalise. Similarly the choice to move away from the neater research design of 1:1 interviews focussed on counsellors experience of CORE, led me into much muddier waters. The great benefit of these waters however is that one stands to create knowledge that is practice based. The great difficulty of keeping things practice based is how to remain in contact with the wider world of research, and avoid becoming so locally focussed that the capacity to create some valid general truths is lost. This is where the location of this project in the wider world of CORE is vital.

The entire CORE project can be seen as straddling the traditional gap between research and practice, (see Appendix 1 and chapter 1). One way that it has sought to remain practice relevant is through the development of practice research networks (Audin, Mellor-Clarke et al 2001). This project has links to the network of clinical service managers using CORE.

I use a largely qualitative methodology, but draw on quantitative data that itself is based on the rigorous, largely quantitative research that underpins the production of that data. We export our data to the growing national CORE data pool. This in turn is used to produce benchmark figures for services to use. A product of this project has been the identification of questions that stand to be addressed as part of research on the national database. There is therefore a cycling between the greater CORE project and my project. It is not too fanciful to see what I have done as an action research informed study that is part of the greater action research study of developing using and researching a system for generating practice based evidence. The action research connection goes even further. Any routine outcome measurement system, including the CORE system can be seen as a way of providing structured data that feeds in to our action reflection cycles. It is being a part of this much larger collective effort that prevents this project from being an interesting, but ultimately not very productive work. It is located within a dynamic and cutting edge project that is reshaping the face of psychological therapies nationally.

This work can be challenged in other areas. The analysis of focus groups was very basic. I could have gone much deeper in teasing out ideas and multiple voices regarding CORE and its use. In an ideal world I would have run more groups and perhaps got others to come in and ask more searching questions. It would also have been useful to follow up the questionnaire with more searching questions. Unfortunately this is where hard pragmatic choices had to be made about where to focus my energies. I must be clear that the results, whilst useful in this context, are barely a scratch on the surface. This is quite consistent with the methodology and aims of the project, but is frustrating. I certainly see it as vital that we continue to explore the impact of CORE usage on clinicians, probably using simpler guiding questions in order to produce a more focussed light on that area.

Another key area that is so far largely unexplored is the perspective of the client. Again this is perfectly defensible in terms of the stated aims and methodology, but it is not something that can remain properly unexplored for long. We are currently addressing this gap via our satisfaction questionnaire. The results from this further research fall outside of this project, but I think that it is fair to say that they are at least in part actions taken as a result of the reflections involved in this project. There is a lot more to be explored about how clients respond however. I would for example like to examine how clients and counsellors experience the initial CORE OM and make sense (or perhaps don't make sense) of it together.

Another particularly significant outcome of this project might be to explore some of the issues of gender balance of referrals to the service. I think that there is a whole fascinating set of questions about how we make services relevant to men. I had all sorts of ideas about an out of office hours service, talking to GPs about their decisions to refer and so on. I have identified an interesting pattern in terms of our outcome figures with male and female clients (see chapter 3). This has been discussed with Prof Michael Barkham and his team are going to examine it further as part of their mining of the national database. We are reflecting on how we respond to this as a service.

Summarised, the central tenet of this project is that reflecting on data about service and individual performance (in this case CORE data) appears to be a worthwhile activity. It would be potentially feasible to use a number of instruments, but the CORE system

has the advantages of being able to be used routinely in practice, and of providing large data sets which provide benchmark data to assist in this reflection. To show that it is worthwhile we have firstly to show that it is possible to engage with the data and how this might be achieved. Secondly, we then need to produce evidence that this engagement is productive.

I believe that taken as a whole this project provides ample suggestive evidence to show that it is possible to enthuse clinicians to become interested and involved in making sense out of CORE data. To do this in my service required a considerable emphasis on leadership and management. It is reasonable to speculate that this is a truth that can be safely generalised to other situations. This leadership has spanned a wide spectrum of activities: it includes managing the nuts and bolts of form filling and data entry, teaching counsellors how to navigate the system, ensuring that they have access to it, identifying paths of exploration within the data, engaging in discussions to construct meaning out of what is found, and encouraging further exploration. It also includes taking responsibility for the tricky and inescapable issue of performance management, with all of its necessary but difficult policing functions

My experience suggests however, that the second part of the issue, relating to the development clinical practice, requires a great deal of effort. Data does not magically transform itself into improved practice. It takes effort to humanise it and make meaning out of it, and more effort to decide what we should do as a result. Then we need to try and do something different! I think that my experience illustrates just how hard it is to go beyond collecting data. It is incredibly easy to conflate aims with methods, and relax once one has a nice well-run database. It would not necessarily be an entirely futile exercise were we to stop at this point however. One could reasonably predict that some benefit might accrue as a result of the very act of collecting data, as is implied by the classic Hawthorne study (Roethlisberger and Dickson 1939) and Merton's (1948) work on self fulfilling prophesies. The atmosphere engendered by collecting some data on our work might have an effect on how we think about it and how we conduct ourselves. Perhaps this benefit would occur in the same way that studies of new treatments often show unusually positive effects. The development of a collective sense of enthusiasm percolates down through the system and has a positive effect on the work undertaken. Of course where there is a prevailing hostility to CORE, then the effects might be negative. It all comes down to how its done, and that

in turn comes back to my emphasis on leadership and the management of the process. In other words we cannot afford to be passive in the process, we need to seize the initiative. There is an interesting piece of research that could be done here, taking a service before and after the introduction of CORE, and measuring in some way the prevailing culture.

The focus groups and questionnaire analyses provide evidence that counsellors can find the process useful and can identify specific benefits to their practice. As noted in my doctoral proposal and chapter one, we have to be sceptical about self-report, and I cannot claim to have produced evidence that practice actually is altered. This needs further exploration. Despite this caveat the data is very positive. The experience in my service indicates that we can begin to create a learning organisation that engages with and responds to CORE data, transforming it into knowledge that counsellors see as potentially being of practical value. The existence of this study can act as a beacon to other service managers and clinicians engaged in the same process.

7.2. Critiques and critical discussions

Perhaps the greatest surprise after seven years of CORE in use is the complete dearth of critiques of the entire CORE project. A search of Psych Lit using the terms critique and problems in relation to CORE, repeated several times in 2004/5, found no articles. It seems that critical discussions are taking place at the level of services and conferences, but have yet to develop into articulated published critiques. Certainly my experience of presenting this work to the BACP research conference reflects this (see 7.4.1 Services using CORE). Whilst in some ways this might be taken as indicating an absence of serious concern, such an attitude risks becoming dangerously complacent. We need to continue to develop critical debates about both the fundamental assumptions behind CORE and its use in practice. These include (but are not limited to) continuing to reflect on just what the OM measures, and when and how we might best administer it. We also need to seriously examine how the use of CORE as a performance management tool can be balanced with the validity of the data produced, and the openness of the system to data manipulation. If we develop a culture where CORE scores are seen as crucial, either to clinicians livelihood or to decisions regarding provision of services to clients, there are serious ethical issues to be wrestled with. The likelihood of clients feeling pressured in their response to OMs is ethically

and practically worrying, since it stands to fundamentally pollute a system intended to improve practice, and leave us in a position where we can have no faith in the data that we are gathering. We are back to the importance of the process of how we make use of CORE data, and the service culture that we develop around it.

One critical issue to be dealt with is that of data attrition. It is easily forgotten that at best CORE data relates to a subset of any services' clients. We obtain a first OM on those who are referred and turn up for a first appointment. In this service 28% or so of clients referred never opt in, and of those offered an initial appointment, some14% do not attend. By the time we come to the second OM, around 30% of those who commence treatment have dropped out. These figures are fairly typical nationally. It therefore behoves us to be clear that CORE tells us nothing about those whom we never see, and very little about those who drop out before the agreed final session.

7.3 Impact of the project

This leads nicely to the issues of the impact of this project and the dissemination of what I have found. How do others come to be impacted in a positive way by what we have done in this service? It would be easy to lose sight of the fact that the major product of this project is the Adur Arun and Worthing Primary Care Counselling Service. As I hope I have clearly outlined, this service had a hard initial few years. At times its existence was under threat. I am convinced that the early expansion of the service was made considerably easier by the existence of impressive data as to our effectiveness. Negotiations with commissioners, whose bottom line is efficiency, was made considerably easier by my being able to provide them with figures about how we were performing. My post takes a large slice of the overall budget, and at one time questions were being asked as to whether this was necessary. I have only flimsy direct evidence from reported conversations, but my belief is that this cost was accepted because I was seen as someone who provided good evidence that the PCT was receiving value for money.

A major impact of this project therefore has been in influencing commissioners, operating in a climate of cost pressures and multiple demands on resources, and ensuring that money comes in to counselling as opposed to going somewhere else. I

make no apologies for emphasising this product, since without it there might not be a service within which the other products have emerged.

7.4 The Place of this Project in the Wider Field

7.4.1 Services using CORE

During the course of this project, and partly as a result of it, a practice research network of service managers using CORE has developed. This network presented a symposium at the BACP Research conference in May 2005, including a paper on this project. The response from an audience including Prof Glenys Parry and Prof Michael Lambert was overwhelmingly positive. As a result the network is going to collaborate with Prof Lambert, visiting the USA to exchange ideas on how we might develop routine outcome management (see 7.4.3 CORE and outcome management).

7.4.2 Studies offering some support.

This work's emphasis on leadership and ownership receives some limited support from other studies. In a general study on unsuccessful efforts to establish clinical audit in a psychodynamic unit, Adelman (2003) reports a poor response rate, linking this to the negative views of senior staff. Without commenting on the validity of these senior staff's views on the project described, it seems clear to me that their work shows that without positive leadership from senior people, any project aimed at using audit/outcome data is unlikely to succeed. Lucock et al (2003) note the importance of clinician ownership of the use of CORE. Gilbody House and Sheldon (2003) emphasise the importance of a robust IT and administrative infrastructure to support the use of routine outcome measures, supporting the emphasis placed on these factors in this work. Although not highly emphasised as a specific factor in this work, Marks (1998) supports the view that it takes time to embed routine gathering and use of clinical data into a service.

This project has been located in the practice-based polarity of the Practice Based Evidence-Evidence Based Practice typology. Developing this concept, Barkham and Mellor-Clark (2003) identify 4 interlinked domains of research activity; efficacy, effectiveness, practice and service systems research. The first two are defined in 1.3.1. Service systems research addresses issues of large scale organisational and funding, (eg Brower 2003), whilst practice research, a term that best describes this project, is the analysis of results within a service. Barkham and Mellor-Clark emphasise that each

approach is in itself insufficient, and clearly explicate the circularity of the whole process. The binding of practice and research can only be achieved through collaboration in practice research networks developing and analysing very large data sets. It is therefore important to look up and out at the wider world of CORE and outcome management.

7.4.3 CORE and outcome management

The use of CORE data in service management has been the subject of some attention in recent years (Evans et al 2003, Lucock et al 2003, Gardiner et al 2003). The former showed how a service can drill down into its data in order to examine aspects of service delivery. Lucock et al show, using a very different approach from that described here, how CORE can assist in enhancing therapists' reflections on their practice, supporting the general conclusions from this project.

A fascinating possibility is the use of repeated measures to graphically illustrate the trajectory of the client and identify problems in the working alliance (Lueger et al 2001). Lambert and colleagues (Lambert, Whipple and Smart 2001, Brown et al 2001, Lambert Whipple Hawkins et al 2003), using the 30 item Life Symptom Questionnaire to feed back data to clinicians during the course of treatment, are producing some interesting results using this type of feedback. Similarly Duncan and Miller (2004 a, b. Miller and Duncan 2004), using a system called the Partners for Change Outcome Management System, report improvements in practice, including reductions in drop out rates. Here the data is derived from a 4 item Session Rating Scale designed to measure the therapeutic alliance on a session-by-session basis.

This transition to steering clinical work and services using routine outcome data is probably the current most important issue in the field. Okiishi et al (2003) have produced powerful evidence for what they title the supershrink effect. Their data shows massive differences in improvement rates between therapists with no correlations found with orientation etc. They present some ways of responding to these findings, including having more successful therapists supervise others. If we accept their conclusions, and they are in line with others (eg Wampold 2001, Miller, Duncan, & Hubble, 2002), this work suggests that routine outcome measurement is likely to highlight major differences between practitioners. This underlines the importance of

getting to grips with performance management as emphasised in this work and by others (Miller et al 2004).

7.4.4 Risk and OM

Whewell and Bonano (2000) found that the OM risk measure was helpful in work with Borderline patients. This offers some support for the findings presented here regarding use of risk scores. Barkham et al (2005), using aggregated data from 49 NHS services including this one, have shown that OM scores can reliably differentiate between primary and secondary care patients. This data raises the possibility of using OM data to inform decisions about whether someone might best be dealt with at primary or secondary level.

7.4.5 The political arena

Politically there have been developments nationally related to outcome measurement, with the publication of best practice guidance (NIMHE 2005). This document, the product of a working party, paves the way for mandatory outcomes measurement in NHS mental health services. The tool for this measurement is to be HoNOS, or a measure that can produce similar data. Its conclusions are very much in line with those of this project, including an emphasis on the involvement of all stakeholders, the importance of feedback, and a need to develop IT skills. Unfortunately whilst highlighting the production of CORE benchmarking data as an example of its highest level of benefit, the document makes no other mention of CORE. This poses a major political challenge for future widespread use of the instrument.

7.5 The Challenges

CORE (and whatever follows) throws down the gauntlet in several areas of practice. Perhaps the biggest challenge is to the notion that we can continue to practice without seeking to reflect in a structured way on what we are doing. What follows is the challenge of integrating the generation *and use* of practice based evidence into our professional cultures.

It challenges us to rethink our ideas about clinical work; it challenges the traditional idea of clinical supervision as separate from management, and challenges service managers to become more pro active in really examining what happens behind the consulting room

door. When what happens appears to be in some way problematic, it challenges us to really become the advocate for the clients. This poses professional and ethical dilemmas. Questions arise about how valid the data generated is, and what weighting we should give it.

The existence of tools like this has enormous implications for the continuing professional development of clinicians. It is potentially useful for work based learning, both for those entering the profession and those who are post qualified. Its role in the assessment of trainees remains to be explored. CORE is very much a two edged sword. One aspect of it offers a great deal as a developmental tool, helping us become better at what we do, whether we are beginners or post qualified clinicians. The other aspect is its potential as a performance management tool. This is probably the more troublesome, implying as it does its use within relationships characterised by power and authority. This highlights the importance of thinking about who uses the tool and in what way? We can use a hammer to bang in nails on which to hang beautiful paintings, or to hit people over the head.

As soon as we introduce the notion of performance management we are changing the field. We are by definition introducing the reality of power based relationships and authority. I don't think that it follows far behind that once this reality is perceived, then the temptation to skew data becomes very real. Then the question becomes can we really make much use of data that is collected directly by those who stand to gain or lose from it? Even if we put this matter to one side, using CORE in performance management remains a challenging prospect.

CORE brings to the fore the issue of accountability, and challenges us to truly be accountable for what we do, to our clients, to our funders, to our managers and to ourselves. This requires that we create systems in which we are able to really learn. The next phase of development of the system promises to be both helpful and challenging in equal measure in this respect.

To respond to these challenges requires a determination to find ways of managing ever-shifting complex streams of data and turn them into information in the service of useful knowledge. Along the way we will need to continue to challenge and change our cultures, where developing evidence suggests that this might be necessary. The

problem will remain how to avoid falling into the trap of arranging for data to be collected and then relaxing, thinking that the job is done. It is not. It is really only just beginning.

Context Documents

1 The story of the service

1.1 Establishing the service

What is now the Adur, Arun and Worthing Primary Care Trust Counselling Service came into being in April 2000. This marked the commencement of a contract between what was then the Worthing Primary Care Trust and the Department of Clinical Psychology of the Worthing Priority Care NHS Trust. The awarding of this contract took place after a period of competitive tender, during which organisations were asked to bid to run a new managed service. The service was to take over from the previous *ad hoc* model whereby various individual counsellors had contracts with individual surgeries, and access to a service was very variable.

The contract set key parameters for the service, including the fact that it was to offer short term counselling (initially up to 6 sessions) for clients referred from GPs. It was also to be audited using the CORE system, and counselling was to be undertaken by qualified counsellors, or those in advanced training. Although there were subsequent headaches about funding CORE, the decision to require its use in the initial tender document proved crucial, enshrining CORE in the service from the very start. The person who should take most credit for this is the then commissioning manager Sue Parton. I played a role in the decision via discussions in which I suggested its use.

Two of the driving forces behind the move to a managed service were the desire to ensure proper Clinical Governance and the establishment and maintenance of quality standards in the delivery of the service. The former is a term much in vogue in the NHS.

There is as ever another level to the story. At the time, I recall being surprised at the energy and thought that had gone into setting up a managed counselling service, but I gave it little more thought. I subsequently came to the conclusion that it was a reaction to the death of a local patient, which was for a time quite newsworthy[25]. Late in 2004 the report from the inquiry into this death came out. I saw that it had been commissioned in January 2000, almost exactly the time that the PCT had begun the rush to a managed service. It seems that this service arose from a classic organisational process; crisis

[25] She was killed by her father, who successfully pleaded diminished responsibility. Both parents subsequently vehemently attacked local NHS mental health provision.

followed by adverse publicity followed by an inquiry and a desire to reorganise, so that when the report comes out we can say that we have learned and changed.

Work on the contract was undertaken by the then Director of Clinical Psychology, with myself contributing. It was agreed that I would take over the day to day running of the service upon commencement, pending being regraded and appointed to a substantive post to manage it. As is often the case in the NHS, the decision to award the contract was made only shortly before the commencement date. The service therefore began in something of a rush, with existing counsellors being transferred to the new system as a job lot. This understandably led to a high level of anxiety and some resentment on the part of counsellors, and a great deal of work had to be done to allow them to see the benefits of the new arrangement.

1.2 Early issues

The first year was naturally a period of bedding down, as the service began to settle into shape. There were several crucial aspects to this.I decided that every counsellor would attend a small group run by me for clinical supervision. My thinking was to ensure that we developed a common sense of purpose as a service. I was concerned to ensure that as far as possible we developed an ethos of commitment to offering short-term interventions for clients. I could see the dangerous possibility that a time limited approach was seen as second best. If this ethos got established from the start, it could pervade everything we were to do and lead to clients getting shortchanged. I therefore knew that I had to find a way of disseminating this attitude, and supervision was perhaps the most obvious route. Also, these counsellors were unknown to me, and it was crucial that I be in a position to ensure good and consistent clinical standards in the service as part of my commitment to clinical governance. The final aspect of placing counsellors in groups was to develop a sense of community and cohesion. Primary Care Counselling can be a very isolated job. In retrospect I think that these small groups have proved crucial in giving people a sense of belonging, and allowing for the interchange of information and ideas.

I was aware of the potential problem of becoming too closed a system, and in particular of counsellors having supervision from their manager. Each had external supervisors and counsellors rapidly formed a peer supervision group that the service supported and I did not attend. I was therefore happy that on balance the arrangement was a good one.

Auditing was a new concept to almost all of the counsellors, myself and the department of psychology. There was therefore a great deal of work undertaken in educating the counsellors and myself about the nuts and bolts of the CORE system. A crucial part of this was instilling an ethos of seeing CORE as desirable, rather than viewing it as an imposition that was there only to keep others happy. I was very aware of the possibility (not least because of my own reactions to paperwork) that the entire process could be seen as an unwanted imposition, designed to keep 'them' happy. I feared that this would have a deleterious effect in a number of ways. I think that there is a problem with clinicians getting clients to complete measures if the clinician does not feel broadly positive about that measure. The clients could (with some justification) feel that their time and effort was being wasted. On a different note, all that we know about the self-fulfilling prophecy (Merton 1948) suggests that a negative attitude in the clinician could adversely affect the outcome of the measure.I worked very hard at this, especially in forwarding the idea that CORE forms given at the start of counselling should be used as part of the assessment process, and not simply 'got out of the way' and put to one side once completed.

This was an aspect of how I worked that I did not initially pay much heed to. It was just an implicit part of how I dealt with the situation. I began to see how important it was following later comments made by John Mellor Clark and Richard Evans after they had given the introductory workshop to my service. They indicated that compared to many groups they had taught, the counsellors in my service seemed very enthusiastic and committed to CORE. Apart from been very gratifying, these comments helped me to begin to understand the key role that I had to play as manager in developing the ethos of the service.

The decision to simply roll over existing counsellors into the new service left me with an ethical problem, in that several of the existing people did not possess appropriate qualifications. I therefore had to be clear with them that they could continue on condition that they took active steps to gain BACP accreditation, and a time frame was agreed in each case. One member of staff indicated that she would be retiring in 18 months, and I agreed that she would be allowed to continue until this time.

There was a major structural issue that was to dog the first 2-½ years of the service. I was not given any formal role in running the service, as I made it clear that I would only

take on such a position when given a B grade psychologist post. In the event, this took far longer than the 6 months that I was assured it would take at the outset. I was therefore left running the service with no formal role beyond a verbal agreement with the head of department that I was to undertake the day to day management whilst he held budgetary control. The lack of a formally acknowledged role, and more importantly the lack of allocated time for the job, caused me considerable difficulty (see later).

1.3 Ensuring the future.

Two crucial events marked the transition from the first rather chaotic phase to the next level. We got the first audit results back on the first 166 clients seen. These were very positive, with over 66% of those seen reporting clinically significant or reliable change in a very short number of sessions. Both the commissioners and the counsellors received this information very positively. It showed that the service was effective and efficient. In retrospect I think that the service's future was secured by these results.

As is almost always the case however, there was a less productive outcome to this feedback, which did not become clear until two years later. The audit showed that the above results were achieved in a mean number of sessions per client of 3.13. As part of my analysis of the results, I reported this figure back to the PCT.

I did not realise that this figure was taken and included in the costings for the service. All calculations for the next two years were on the assumption that clients would be seen for an average of 3.13 sessions. Our average number of sessions per client in fact increased to around 6. It took many hours of analysis and some misunderstandings before I realised that the initial snapshot had become a concrete feature of the budget.
On reflection, this is a very good example of how audit data can be seized on and used in ways that are not merited. My reporting of this early figure was not entirely negative in its consequences however. We had a session limit of 6 imposed in our first service level agreement. I felt that this was too tight, and we needed clinical flexibility to go beyond. The *quid pro quo* was that I as service manager ensured that we balanced the books and kept the average at 6 sessions. I was able to argue that this could be done on the basis of this initial very low figure. As a result, after a year or so of the service I raised the agreed maximum number of sessions that any individual client could be given to 12.

The second event was with the counsellor who had been allowed to practice on to retirement. I became aware that she was not attending supervision, and at one point had not presented her work for several months. I therefore wrote and reminder her that she was required to attend. Following this she attended once before absenting herself again. She then contacted me to ask if she could continue to work for the service as she wished to delay her retirement. I refused to allow this on the grounds that I had stretched a point in the first place, and following her non-attendance at supervision I was not confident that her clients were receiving a proper service. She therefore left the service on the agreed date.

This was a significant experience for me, being the first time that I had had to exercise managerial authority in order to protect both clients and the integrity of the service. Ensuring that the above individual moved on from the service at the initially agreed time was an important practical step in line with the spirit of both of these concepts. As with so many such experiences, its significance was only clear in retrospect.

1.4 Expansion

Having successfully established the service, the next phase was one characterised by expansion. Here a note about the context is important. At that time, my trust (responsible primarily for secondary mental health services) covered the area that was served by three Primary Care Groups, Adur, Arun and Worthing PCGs. These were clusters of surgeries with some local budgetary control. A single Primary Care Trust superseded them in April 2002.

In anticipation of the forthcoming Trust, it was generally agreed at Health Authority[26] (HA) level that it was logical to seek to roll out the managed service into the two other Primary Care Groups. There were some considerable political problems with this, largely due to the historical independence of GPs. Whilst they made up the largest and therefore dominant group on Group boards, individual surgeries did not seem to consider themselves bound by group board decisions. Health Authority decisions seemed to carry even less weight for them. There was thus a tussle between the H.A, the PCG Boards and GP surgeries, with no one seeming to be clear about where authority lay.

[26] The Health Authority was responsible for commissioning services, and was replaced in this task by the new Primary Care Trust.

I was asked to present the case for a managed service to one PCG Board prior to them making a decision about whether or not to come into my service. In doing this I drew heavily on my experiences in steering and influencing committees within UKCP, as documented in my Review of Prior Learning. Although subject to some sharp but understandable questioning, my task was made very easy by the CORE data. I was able to present them with the figures, which showed that the service as run in Worthing PCG was effective and efficient, as demonstrated by very sound data. I was in any case pushing at an open door as the chair of the board was very much in favour of a managed service, as she indicated in a discussion prior to the meeting proper. The board made an immediate decision to go with a managed service and to put more money in, in line with an argument made by myself and a colleague at the HA to the effect that their area was comparatively underprovided. This PCG entered a managed service arrangement in April 2002, just as the three groups merged to become a single Trust, and exactly two years after the start of the service.

My experience in presenting to the other board could not have been more different. I presented exactly the same argument, and was apparently quite persuasive, as judged by feedback from the board and colleagues also at the meeting. After that, nothing happened. It seemed that the issue got tied up in a number of local problems, some of which had nothing to do with counselling. About six months later I was invited to a meeting with a representative group of GPs, many of which were known to be anti the idea, and who had been metaphorically hopping up and down about moving to a managed service.

Despite dire predictions, the meeting again went quite well. There was however a clear effort to engage me in discussions about a single individual counsellor who was working in that area (for more background, see 'Why bother'). I had to work hard to be clear that I would not discuss individuals and would stick to a general argument about the merits of a managed service. After some further delay, a decision was made to enter a managed service, with one surgery opting out. This area joined in September 2002. I had the rather embarrassing situation of having to say that I could not move matters forward as my own position had not been clarified and I had no time to work on the new part of the service. In retrospect this was not a bad thing, as absorbing two new areas in a short time proved rather difficult, and the six-month gap between them proved essential.

1.5 Consolidation and using CORE

The arrival of the third area meant that the service was now provided across the whole of the new PCT area, with the exception of one surgery. It also coincided with my finally being appointed on a 0.8 contract to manage the service.

This was the first time in over 2 ½ years of the service that I had an appropriate and properly agreed time to dedicate to the work (I had one day a week on secondment from Nov 2001, which was inadequate). The process of being appointed as Head of Service was long and complex. This process is described and commented on further in context doc 2.

There were still problems however, as due to mismanagement of the budget renegotiations[27] there were insufficient funds to pay for me, and I was expected to do a large amount of clinical work. It had also been agreed with my employers that the service needed a full time head, but this case had not been made to the PCT during negotiations, despite my being told that it was being dealt with. This process, which dragged on over many months, was extremely stressful for me, as all the plans and agreements that I had been working with for a long time hung in the balance. The fact that it occurred at a time when the service more than doubled in size added to the stress.

As outlined above, the tender document that counselling would be audited by using CORE. Such an audit was to be undertaken by the Health Authority, with the service providing the data to be sent away for analysis to Leeds University under the old system. This was duly done and the first 166 clients audited. After this the budget ran out and the whole thing ground to a sudden halt. This was the first of many CORE budget difficulties.

This presented me with a problem. I had worked hard at establishing CORE as a central part of the culture of the new service. Not least was the effort of helping counsellors become familiar with an array of paperwork to be completed. I realised that this could be easily lost, and we could slip backwards if I was not careful. The clouds, having

[27] Having been centrally involved in all previous negotiations, I was excluded by the stand in manager who took over when my head of service went sick. I was finally called in at the last moment when the PCT demanded that I be involved.

parted, could close in again if I was active in preventing this. I believed this to be undesirable as once systems coalesce around certain patterns, they can be hard to change. Having got audit in as a part of the culture at the start, I was not going to slip back. Therefore I encouraged counsellors to continue to collect Outcome Measure data in the full knowledge that it was not being processed. I simultaneously negotiated the funds to pay for an annual licence to use the newly available PC version of CORE.

All of this was an early example of Portwood's (2003) view that the implementation of projects requires attention to budgets (both temporal and financial). Furthermore this requires that we be *involved.* Here and at later stages, my involvement was in financial planning and negotiations of a kind that were very new to me. The nearest analogous situation that I had were my UKCP activities.

1.6 Instilling a service ethos

From the very start of the service, I was aware that it was going to be vital to instil a positive ethos in the service. Central in this was the decision to place counsellors in small supervision groups (see earlier).
I was very aware of the possibility that the time limit on sessions could be viewed as a terrible handicap, with the feeling of 'if only we had more time...' pervading the culture in a very destructive and negative way. I therefore sought to emphasise the positives of time-limited work

I realised that it was essential that we be a proactive group rather than a reactive one. We needed to define what we did, for GPs, clients and ourselves. There is a huge danger in primary care counselling that counsellors are used as an inappropriate dumping ground for GPs tricky (ie emotionally taxing) patients. The phrase that came to mind was the counsellor as GP's handmaiden, very much in the traditional doctor-nurse mould, (gender is a significant issue here as the majority of counsellors are female, and historically at least, the majority of GPs male). The counter to this was to be clear and articulate about what we offered clinically. I saw this as resting on several things. Firstly there was the importance of developing an area of focus for the work, and secondly there was the development of a rapid and positive working alliance. I emphasised these issues, distilled from my experience and the research, repeatedly. What follows from this is the need to make good assessments at the start of contact with the client. Are we

able to help the client articulate a focus for counselling in the assessment session, and can we cooperate safely together to work on it? What follows in turn from this is that sometimes the answer will be no, and we therefore have to find ways of explaining this to the client and the referrer. The whole issue of saying no has been a big feature in our collective development of a proactive service culture.

It has been even more of an issue because I am also committed to making the service relevant to more than the traditional YAVIS[28] clientele. As a primary care service we are in a position to make psychological help available to people who might never get through the multiple practical and psychological hurdles that prevent people getting to other services. I wanted to ensure that we did not just take the 'worried well', but were relevant as a local service. The implication of this was that I would accept referrals where I might have some doubts, on the assumption that the client would meet with the counsellor for a genuine assessment as to whether counselling was safe and appropriate. Overall, this implies that they might need to say no more often. Obviously there is an ethical balance to find here, between inappropriately denying a service to people who might use it, and taking unacceptable risks and wasting a clients and the referrers time.

1.7 The belated issue of contracts for counsellors

Since the start of the service, I had been uncomfortable about the nature of the contract between counsellors and the Trust. Counsellors seemed to inhabit a no man's land between being employees and sub contractors. This caused me some difficulties in knowing just what it was legitimate to ask them to do beyond seeing clients. I was also concerned that their liability in the event of a lawsuit or complaint was very unclear. I had managed to arrange for criminal record and had asked about providing them with honorary contracts in order to create a formal contractual link with the Trust.

In a period of chaos for personnel, with the old Priority Care trust dissolving and the new trust emerging, forms relating to honorary contracts were lost twice. In a period of over a year I received countless assurances that the matter was being dealt with and would be resolved swiftly. I accepted these assurances and did not pursue matters, since my manager informed me that the department had had major sickness problems. Eventually

[28] The traditional psychotherapy client has been described as Young, Attractive, Verbal, Intelligent and Successful (Schofield 1964).

after another broken promise, which coincided with another personnel problem, I was advised to complain.

I met with the Head of Personnel and Director of Finance. She informed me that honorary contracts were not possible where a fee was being paid. She proposed another approach, later contradicted by the finance colleague. The matter was dragging on. Just before going on Christmas leave a series of e-mails arrived from which it was clear that under Inland revenue rules the counsellors were employees, and should be treated as such. It later emerged that the trust was being audited by the IR and was afraid of any anomaly being pounced on.

I had a lousy Christmas. I had looked forward to a simple process of budget renegotiation. For the first time the budget was going to remain more or less the same, and I would not have to enter complex negotiations with the PCT. This news scuppered all of that. Once again I faced a difficult period of negotiation, with all the uncertainty that this implied. I knew once more that if I did not get it right, then my job was on the line. A series of meetings with personnel and finance was arranged in the early New Year and eventually we agreed that I would have to transfer counsellors on to trust contracts. This had to be done by the new financial year or the trust faced penalty charges from the IR.

The positive side was that after 2 years of seeking clarity I now had an answer, albeit only because of the threat of outside involvement. The down side was that making someone an employee costs at least 16% extra. I had to negotiate a budget from a cash strapped PCT, negotiate with counsellors and ensure that I had people in place for 1st April, all without disrupting the service.

I knew that I faced a major leadership challenge in which I would have to take several groups along with me. I began to let the counsellors know what was happening straight away. Apart from being the way that I would want to be treated, I knew that we all need time to adjust to changes, and if I wanted a successful outcome I needed them to feel as OK as was possible about it. Throughout the process I tried to keep them informed by memos and conversations. I also met each one twice, once to go through the situation and its implications for them, and once to go through the final offer. As part of this process I asked for an indication as to whether they were interested in becoming

employees. I felt it important to keep clear that this was a matter of choice, not something automatic.

I contacted the PCT as soon as I knew that the matter was on the cards. I knew that it was vital to make sure that they were not sprung late in the day with a nasty surprise. I was extremely worried that they would not be able to act swiftly enough given their previous track record. I also booked in meetings with them in advance of any decisions being made on my trusts side.

The first phase involved devising a proposed budget with my finance contact. This necessitated setting a salary scale that would ensure that my counsellors received the same recompense for the work as before. I also had to fight hard to ensure agreement that anyone who wanted to be employed would be. I wanted no barrier placed in their way due changes beyond their control. I also had to negotiate sufficient leave provision within the contract, since as technically new employees they were initially threatened with being offered a low annual figure.

Throughout this period, I was stretched into new and unanticipated directions. I had to really sharpen my grasp of finance. Figures were banded about and changed with mind-boggling regularity. I spent a huge amount of time going through options with my partner Gail who fortunately has an extremely mathematical brain and was a part qualified accountant in years gone by. She taught me to use Excel spread sheets, despite initial reluctance on my part. I think that becoming able to use them was the single most important factor in helping me to a successful outcome without my brain melting in the process. I was able to generate cells that took overall figures and broke them down into who would do what and how much it would cost. Whenever a figure was altered (and they altered with astonishing rapidity as we played with options, looked at next years as opposed to this years cost and so on) I could add it in and see all the other cells shift at the touch of a button. It was joy. Without it I would have got lost, and I am convinced that this project within a project would have come off the rails.

I was also caught between being an advocate for the counsellors and being a hard headed manager who wanted the most for the least. Even on a good basic salary, it appeared that counsellors would not receive as much money as they were doing under the old arrangement. I spent a considerable time examining the figures and the basis on

which they were calculated. It became clear to me that their were two parameters, that of the self employed and that of the employed. I came to see them as two languages, Greek and Chinese[29], each understandable within itself, but if one tries to use a Greek alphabet to understand Chinese one only gets confusion. I ended up satisfying myself that taken overall, the new deal was fair. Counsellors would not get as much up front but including payments made into pension funds, sick pay etc, the equation balanced.

As I was doing this, I did wonder at times if I was merely trying to convince myself in order to feel better about offering them a worse deal. My test-in-action for this is to see if I can articulate a rationale for what I am saying, and then to metaphorically walk around it and see if it is sound. I went back again to the issue and felt convinced. The external validation of this comes from the fact that we pay quite a lot more than some similar services. In trying to convey this to counsellors however, I did at times feel rather like a dodgy time-share salesman however.

Negotiations with the PCT went in the end a lot more smoothly than I anticipated. I think that they took the message that this was a *fait accompli*, forced upon us by external powers. The prime negotiator was a finance person, and in that world the IR have a status just below that of a deity. This worked in my favour, since I think that he was clear from the start that this was not up for negotiation. It was a matter of how we made the figures add up. Within the negotiations, my newfound fluency with Excel again paid dividends, as I was able to demonstrate almost to the penny just how the extra money would be used to provide an efficient service. There was a last minute problem as the PCT placed a limit on what they would fund, necessitating me cutting an hour from what I was intending to offer each counsellor in order to balance the budget.

As I step back from this, it is clear that this is a case where the classic iceberg metaphor fits nicely. My actions were based on a huge pyramid of personal and service history. As a service we had solid data showing how effective we were. As with the earlier enlargements of the service (see context doc 1) it is clear to me that this was crucial in us being seen a central and valued local service. There was never any evidence to suggest thought was given to *not* providing the extra funds. Of course it was not just our history that ensured this view prevailed. The way in which I entered the negotiation was crucial.

[29] Both are alien to me.

Using my clinical skills and previous experience in UKCP, I sought to express the problem as one for *us*. Using inclusive collaborative language helped me to orient myself, and helped set the frame and tone of the discussions. I also rather played up the external enemy, the Inland Revenue. The truth is that my Trust had been rather inefficient in not sorting this before, but it was also true that we were being compelled to act, and so this is the part that I emphasised. It is a trick that every dictator knows well. Unite the nation against the external enemy. Stalin was a master. Smaller groups tend to unite as well in the face of a common enemy, and it was this clinical wisdom that I drew on to manage the process (as far as it was in my power).

This highlights an interesting, and at times troublesome tension for me between honesty and strategy. Contained within this is the issue of power and its seductiveness. Lord Acton's words, that power tends to corrupt, and absolute power corrupts absolutely, have always been dear to my heart. I felt the thrill of power (and anxiety in equal measure) as I set my goal and determined to achieve it. I was aware however of how easy it would be to simply prioritise the end and steamroller my way to it.

My position *vis a vis* the counsellors was highlighted. I was acutely aware that my role had shifted significantly. I had always seen clearly that I was a manager. It is one of the reasons that the service had run so efficiently and effectively. However, the fact that we had discussions about contracts and salaries led to a shift in how I was perceived. It is somewhat odd when one considers that I had previously taken the most managerial of actions in getting rid of Mr O (see chapter 2). This had passed with barely a murmur as far as I knew. The only comments that I got were of congratulations from one counsellor who had worked with him, and commiserations at having to take such difficult action from two others. Perhaps the key difference was money. There was considerable disquiet at what was generally perceived as a cut in salary. This was made worse by the need to reduce the total hours of activity that I had intended to offer. This led to a reduction in each person's contract. Oddly enough, had I kept quiet about this then there would probably have been less resentment. At a time when they were struggling with feeling badly treated this news fed the feeling that they were being badly treated. Had I simply told them of the final hours that were available, they might have felt better. Again it is the tension between being open and being strategic. In the greater scheme of things though I would rather risk the former.

Because of the way that the figures added up, I had to reduce one counsellor's hours by 2 over what it would have been. Another counsellor who had been doing similar hours ended up with a slightly larger contract. I did this on the basis that she had been seeing 7 clients per day. I had previously told her twice that I did not think that this was acceptable on a long-term basis. Forced with making a choice I decided to use the opportunity to end something I was not happy about. She was very upset at what she perceived as a lack of fairness, and claimed no recollection of my telling her that she was seeing too many clients in a day.

The issue of money rumbled on, with repeated allusions to disquiet about being paid less. I alternated between feeling some empathy at this and getting quite irritated at what I perceived as an unwillingness to see that they were being treated fairly.
Another issue that rumbled was leave entitlement. I played into the problem by glibly quoting 7 weeks as the total that they would get. In fact it was just short of this figure. The difference, whilst small, played into a sense of being shortchanged with some people. As was entirely predictable, there was a period of confusion as people adjusted to the minutiae of being employees. Leave forms and training requests were two areas that caused particular problems, especially for the administrator who had to keep on top of the records. I found myself immersed in a new set of paperwork, having to sign forms for seemingly everything.

Overall, there are, as one would expect ,costs and benefits to having counsellors as employees. The costs are in terms of extra bureaucracy and a relative inflexibility. If someone wants to alter their hours (and previously this happened a lot) we need to amend their contract. The extra work per person makes me now think that we need to move away from having counsellors working very low hours. It is very hard to factor in CPD time, meetings etc when someone only does 6 hours per week. They rapidly end up having the equivalent of several weeks TOIL owing.

The benefits are I think slower in surfacing, but are there. There is added security and status from being trust employees that is vital. Counselling has always been something of an add on the mental health provision. Being employed on the same basis as say CPNs or psychologists is I think a message to both counsellors and colleagues that they are a part of the furniture. In practice it makes linking with those colleagues easier, for example I now encourage counsellors to attend training days run by the psychology

service. I see employment status as being another step in the development of firm foundations for the service. Crudely speaking, I think it is going to be a lot harder to get rid of 14 employed counsellors than 14 independent contractors.

1.8 Swimming in a sea of change

It is important to underline the atmosphere of constant change within which this project has taken place. At the time of submission of this document, my trust is in the run up to a merger with the East Sussex Trust. This will be the second change in the macro structure in three years. On the commissioning side PCGs became PCTs. Each organisational change results in massive changes in procedures and personnel. I am about to work with my fifth manager in three years. On the PCT side I have worked with five commissioning managers, and a sixth is about to become involved. Out of a staff that now totals fourteen counsellors, six have moved on and eleven have joined the service[30] Three of the original six counsellors remain. This is a vital part of the field within which I am driving this project forward. Of course change is not a bad thing. I would much rather have healthy systems where the waters are steadily replaced, rather than a stagnant pool. This level of change though makes it not so much a swamp that I work in as a roaring mountain torrent, cascading down over the rocks with an awesome and unstoppable power. Perhaps that makes me a white water rafter.

2 My story

2.1 Overview

Understanding the context of any study is essential if the reader is to develop a full and rich understanding of the process. It is generally agreed that in good qualitative research[31], the perspective of the researcher and the context must be fully explicated (Stiles 1993. Elliot Fisher and Rennie 1999. Kirk and Miller 1986). This chapter contains aspects of both.

The story speaks to elements of my perspective (at a more personal professional level). It also provides a backdrop to the project and I trust gives a sense of the seas through which it all had to be piloted. This is all in the service of providing a;
"full and integrated descriptions of an experience or situation under study"

[30] The difference is accounted for by the growth of the service.
[31] Whilst this is not a pure piece of qualitative research, the point still holds.

Polkinghorne (1991) p164. The story of my attempts to create a secure base for the service and myself is therefore an essential part of the whole. This story is interwoven with the development of the service described in context doc 1, and is the personal context in which (and at times against which) I was working.

When the whole idea of bidding for a service was proposed by the then local health Authority in January 2000, I immediately saw an opportunity to be involved in an exciting development, and to achieve a better position for myself. I saw this as the opportunity to create a consultant psychologist position (known as a B grade within the NHS). I discussed this with my manager John le Lievre, Director of Clinical Psychology, and was very clear that for me this was an essential part of the package. I was reassured by the promise that a regrading would be backdated to the date of initial submission, and that I would be paid accordingly once the matter was finalised. I made a formal submission in July 2000, after struggling to get clear guidelines as to what I had to do. I was assured that the matter should be fairly swift.

The immediate problem was that given the relative newness of counselling psychologists within the NHS, there was no local precedent for placing one on the B grade. It is hard to obtain figures, but my understanding is that at this time, there were only about 3 or 4 counselling psychologists on such grades nationally. There was however a well established set of guidelines used for the appointment of clinical psychologists to consultant posts. This involved liaison with a member of the national assessors list, who would offer advice on the structuring of the post and the job description. Once this had been agreed, the assessor would act as external examiner in the formal interview that was necessary to complete the process of appointment.

The first problem came in getting someone from the list who not only felt competent and willing to act as external assessor, but who was also open minded.
My manager reported contacting several who felt unable to be of assistance. One notable individual asked why a clinical psychologist could not be appointed, asking my (clinical psychologist) manager why 'we' were allowing 'them' (ie counselling psychologists) to take such posts.

Two pieces of evidence suggest to me that this is more than an isolated example of prejudice. In a completely different department, a manager reported (after taking

advice from an assessor) that the rules stated that I was completely ineligible for a B grade post, unless I retrained as a clinical psychologist. Even when I demonstrated that this was inaccurate, I was still told that I could not be regraded. This is in my opinion a good indicator that one is dealing with prejudice and not rational and open-minded approach. Even recently[32], I have seen advertisements for clinical and or counselling psychologists (it is usually in that order) where the pay scale offered is lower for the latter.

It took many months to find an appropriate assessor. I was of course very worried that we might get a closed minded colleague who could scupper my plans. If an assessor said no, there was little if anything that could be done about the matter. In the end Dr David Whitlow agreed to assist. He had experience of the process with another counselling psychologist colleague, and was reported by my manager as being 'sympathetic'. I agreed to his appointment (not that I had a lot of options). Later I was pleased to meet with a colleague, who reported that he had been very rigorous and fair in her interview process.

Matters proceeded slowly, because at that time, the plan was to have me work some time as Head of the counselling service, and some time as a senior clinician in the adult mental health service. This was a compromise position achieved largely because my manager did not want to lose me, and there were insufficient funds to be full time head of counselling. The implication of this was that we had to agree two job descriptions, so everything took twice as long.

By the middle of 2001 (ie over 12 months in to what had been expected to be at the outside a six month process), the job descriptions were agreed. We were due to proceed to appointment. After discussion with my manager, the assessor helpfully agreed that a formal interview would not be necessary, provided he could be supplied with two references. One was to focus on my suitability for the managerial post, and the other should demonstrate that my clinical skills were of a high enough level. For the latter I asked my manager in a forensic post (mentioned above) where I had been employed for a day a week for some two or more years. She readily agreed. I thought that the matter was more or less settled, and was distressed to hear some while later

[32] Psychologist appointments memorandum. July 2003.

that the second reference was not considered adequate for the purpose. When I finally saw a copy of the reference some while later it was about six lines long, despite the clear request that it be detailed[33].

The assessor made it clear that he did not see anything of concern in the reference, but that he could not proceed to appointment with such limited information. Having taken advice, he decided that a formal interview should take place. Owing to a national development, he took the view that a second assessor should be involved in the process. A date was set for interview in December 2001. This was changed to January 2002 at the second assessors request.

I had many conversations with my manager about the fact that it was difficult to run a growing service with no time to do so. I was in the bizarre position of working with the Health Authority about expanding the service into other PCGs , whilst having no formal role in my own organisation! I finally told him that the matter could not continue. There were funds available to pay me to manage the service and it struck me as absolutely ludicrous that they were not being used. We agreed that I would transfer a nominal one day a week to focus on the service as a stopgap measure until the regrading was completed. I was told that this was a matter of him completing a form and sending it to the personnel department. Some while later he told me that he was advised that this had been deemed to be a new post. Equal opportunities procedures demanded that this post be advertised and an appointment made after open competition. I therefore had to wait until a formal advertisement was made in the Trust's internal appointment bulletin and apply. I felt utterly disrespected and disregarded by this. I was having to apply for a post that I had built up, with no formal recognition, over a long period. What had been my legitimate attempt to have this marked by an increase in status had suddenly been transformed from a regrading into a competitive application. I felt utterly dispirited, and seriously questioned whether it was worth pursuing the matter. If this was how the NHS rewarded innovation and commitment, why bother?

[33] This manager, having given me the information described above, had later offered me B grade work of a very unsatisfactory nature. Some short while after the reference incident, she verbally gave me notice in a quite incorrect manner. I was eventually made redundant by her, even though I had already announced that I would probably be leaving anyway.

The post was advertised on a very short-term contract to the end of the then current financial year. This was my manager's way of following procedure whilst ensuring that it would not interest anyone else. I 'applied', and was relieved that no one else did so. When the paperwork came through I was still on my current grade. Relations with my manager were getting strained. I felt like I had to walk on eggshells around him as he was clearly very ill. I had the terrible dilemma of not wanting to make his life harder, but wanting to push him as I felt very worried about how little he was doing to fight my corner. He was having a lot of time sick, and was not around when this came back from the Trust's personnel department. I liased with them and said I would only take the post if it was on B grade and at a higher pay point. With no further discussion the contract came back as I had asked. I was therefore in the bizarre position, having been told very clearly that I could not possibly be appointed to a B grade until the agreed procedure was completed, of being appointed (on secondment) with little or no apparent fuss.[34] It was by now November 2001.

Again, I thought the end was in sight, I had some form of contract, albeit insufficient, and I had an interview scheduled for January. Less than a week before the date of interview, I was told by a rather sheep faced and apologetic manager that the second assessor had refused to agree the job descriptions. I was furious and deeply disappointed, especially as I had a letter from the first assessor clearly stating that the descriptions were agreed. I argued that if the correct procedure had been followed, and a decision made, this could not be overturned at the last minute by another person. My view was that she had been invited to interview me, not review the entire matter. I could not get a clear picture, and felt trapped by forces outside of my control. I could not afford to fall out with my manager, and it was not appropriate to contact the assessor directly since this would run the risk of appearing to be canvassing. I was told that the interview would be put back for a while until the second assessor was satisfied with the paperwork. I was left in limbo, with no clear rights and no clarity as to what was happening.

Some while after, I was told that the second assessor had withdrawn from the process. I never got a reason. A further date for interview was scheduled in April 2002. Dr Whitlow agreed not to seek to replace the second assessor in view of how badly I had

[34] I had clarified some while earlier that Trusts can appoint who they like to a B grade post. It is an employment matter and the assessors have no real authority beyond offering advice.

been messed about thus far. Some three weeks before this date, my manager, who had been suffering from serious ill health for some time, went on long-term sick leave pending neurological surgery. From first April, the old trust dissolved, and we became part of a new larger trust with a different structure. The existing SLA lapsed on 31st March and my temporary secondment lapsed on the same date.

I was left utterly high and dry, with no manager, contract, nor contract for the service[35]. A deputy took over in nominal charge of the department. A new area manager came in to post locally. The deputies refused point blank my request that she stand in for the head of service in order that my interview could take place. Her view was that matters should be dealt with 'properly'. I demonstrated to her that they had been, by showing the correspondence with Dr Whitlow, but to no effect.

I faced the realistic possibility that I was going to be unceremoniously dumped after two years in limbo. I realised that I had to change gear and attitude. I had up to now been willing (not happy) to let matters proceed slowly. In retrospect I perhaps should have pushed harder earlier, but the one time I went to really confront my manager about how slowly things were going, he was in distress having just received very bad news about his condition. I began an urgent campaign of persuasion, which included letters and meetings with the person who I perceived as having the most influence (the new locality manager). I got good news and bad. He agreed that the regrading for the counselling post was OK in principle (subject to a new SLA and funds being available). However, he and the deputy took the view that the adult mental health part of my week could not proceed. This despite my having the job description agreed by both the service manager and the external assessor. This was never conveyed to me directly. It was just that whenever I raised the issue, the topic would be steered back to the other post.

The deputy, who had a particularly unfortunate management style, informed me that I was to leave the negotiations with the PCT to her and the area manager. The clear implication was that I would just make a mess of it, as only she and he really understood such things. This was despite the fact that I had been involved since the start, and had increased the size of the service already. Along the way, she told me that

[35] It was agreed with the PCT that we roll over the contract until it could be re negotiated and signed.

my post would have to go to open competition under trust equal opportunity policy. When I formally questioned this I was told that I had misunderstood. Matters drifted despite my best efforts, and it was June before the contracting meeting with the PCT was arranged. I felt in an impossible position. I could not have the confrontation that I wished to have with the deputy manager as she held the cards in respect of the regrading interview. I knew from colleagues that she would be quite ruthless if she wanted to be. When I did raise issues, the response was aggressive and defensive. At the very last minute (1 ½ hours before the meeting) I was sent a copy[36] of the new draft agreement between the new trust and the PCT, which was being agreed by the deputy and locality managers on behalf of my service. I noticed that it contained 14 major errors that they had not picked up. This was perhaps not surprising, as they had not spoken to me about how the service ran in the 3 months that they had been 'dealing' with the matter.

I must admit that I got a great satisfaction in going through the items one by one in the meeting and watching the complete bemusement on the face of the deputy manager. Had I not become involved, they would have agreed an SLA that was seriously flawed, for example having the number of sessions that the service offered wrong. Unfortunately the key issue, funding to employ me to manage the service, was not raised. In the meeting, it became clear that despite assurances, they had given the matter no thought at all. I was faced with a strategic dilemma. I could raise the issue, in which case I risked publicly humiliating my managers. This was tempting, but it would also make us look utterly incompetent in front of the PCT. I therefore kept quiet, knowing that I was once again left without the position that I had been seeking to secure for myself. After the meeting I raised the issue of my post. I was finally told that I could be appointed to 8 sessions on the basis that I would be doing a large amount of clinical work.

It went on like that. By now the new head of psychology for the trust was in post, and I knew that there would be a handover from the deputy soon. My rescheduled interview took place in September, after considerable pressure on my part. This had included taking the extreme step of writing direct to the assessor to complain about the lack of a clear date for the interview. I expected, and got, a very proper response to the effect

[36] From the PCT. I never got one from my own management.

that he could not compel the trust to act, but shortly after that I was informed that the deputy had spoken to him and that the interview was scheduled.

I was successful in interview, and finally placed on a permanent contract in September 2002, some two and a half years after I started day-to-day management of the service. It was hard to feel much pleasure at achieving this. In the same month, the service expanded and clearly required full time management (which had in any case been agreed within my trust some months before). I had four days, and was expected to spend half of them seeing clients to fund my post.[37] The positive was that I now reported to the head of psychology.

The above story was occurring in a period of chaos and change for the department as a whole. Prior to September 2002, I was still in employed in the clinical psychology adult mental health section. This department went through a period of utter turmoil as John le Lievre went on long-term sick leave just prior to the emergence of the new trust, which brought the complete reorganisation of all services.
The only full time clinician within the department, who became sick with severe mental health problems, followed him within a month. She was eventually deemed incapable of working and left the trust. The remaining part time clinician experienced a severe trauma and also went on sick leave.

I was therefore left as the only remaining member of my department, at a time of major organisational transition, trying to ensure the future of a growing counselling service, with no proper time for that job, whilst still being expected to hold together an adult mental health department that had effectively ceased to exist.

There was considerable disquiet among my administrative colleagues, who did not know if they were going to be made redundant. Just when it looked as if things could not possibly get worse, my main administrator for the counselling service badly broke an arm in a fall and had to be off work for several months. This coincided with an influx of new work from the newly absorbed sectors.

[37] The service was running on an odd contract whereby we received funds on a per contact basis.

My task became one of survival, as I sought to deal with considerable confusion and despair, unsure at times whether I would have an acceptable job at the end of the process. It was clear to me that I could be completely swamped by this morass unless I was very careful. I took a decision to be ruthless. I could not alter the fact that the adult mental health service was in meltdown, and no matter how hard I worked I could not make a significant impact on the waiting list. With no management input[38], I took the decision to focus solely on running the counselling service.

After my regrading interview, the last formal action that I took within the adult mental health service was to manually sort over 200 case files into piles for allocation once a new structure had been decided upon and people employed.

I was concerned for my future position. I had been landed with an impossible task. I could not achieve clinical targets and manage a larger service. I therefore wrote a forceful document to outline this, and sent it to the locality manager and head of psychology. I wanted to cover my back when things went wrong.

My next priority was to ensure that it was agreed that I needed to be full time, and negotiate a revised SLA with the PCT that would sort this out for the next financial year. The first part of this was rapidly achieved, and it was agreed that the locality manager would continue to lead on contract negotiations. At the first meeting with the new head, I made it clear that I thought that the contract and my position were unacceptable. The next six months became a morass of confusion and yet more frustration. I tried to ensure that we arranged early meetings with the PCT to begin negotiations about the next years budget. The new PCT[39] was an organisation in chaos. My contact person went (there were four people in the first three years of the service.)

I realised that up until now, there had been a structural problem. The personnel involved on both sides in contracting negotiations were not senior enough to make and carry through decisions. As part of dealing with the situation outlined in 'expansion' above, I met with the Director of Primary Care and Commissioning to discuss how we

[38] The deputy who was now nominally responsible was extremely busy, but also did not believe in discussing matters with colleagues, and was wont to instruct people to act in certain ways without finding out the facts. She was in any case busy securing her place in the new hierarchy, as she delighted in telling us.

[39] NHS changes meant that the old Health Authority and associated PCG's disappeared and were replaced by the Primary Care trust at the same time as my trust changed in April 2002. There was therefore complete organisational upheaval on both sides, with major staff changes.

would deal with the situation. I used this as an opportunity to develop a new contact who would by virtue of his role be in a position of some power. Whilst this was very productive, a personal tragedy limited his work role for a considerable time afterwards. This played a major role in allowing the chaos and lack of clear leadership in the PCT to continue.

The process of renegotiation dragged on, but in a bizarre manner. My attempts to get a clear structure and understand exactly how the decision would be made by the PCT were unsuccessful. Despite considerable effort, no one could tell me how a decision would be made, by whom and by what date. My efforts to generate a clear game plan with the locality manager met with clear promises that he was committed to the service and to my being fulltime, but little concrete action.

A serious part of the problem was his personal position. He had come to the new trust from a previous one that had ceased to exist. He was on a one-year transfer, during which time he unsuccessfully sought higher posts. I heard on good authority that he had fallen out with the chief executive. It gradually emerged that he was going to be made to take early retirement at the end of the financial year. I was therefore left with two new organisations in states of chaos and transition, where the one person upon whom I relied was going to be getting ready to leave during the period when I would need him to be fighting my corner. We discussed this latter issue and I receive his personal assurance that he was committed to ensuring the future of my service, and my post before he left.

We attended a contracting meeting with the PCT in the February at which the locality manager was supposed to present a detailed proposal for the next SLA. He didn't have it done, but matters were agreed in principle about the size of the contract and funding for my post. He agreed to prepare a detailed budget within the week. The meeting was an unpleasant affair, quite markedly different in tone from previous ones. At the very start, I was told that there were 'problems' with our performance. I was shocked as these had never been mentioned previously. I was given no details until I asked to see them. What I saw were tables of figures in a shape I did not recognise and could make no sense of. I basically did not have a clue how to respond. My locality manager, who had much more experience of this kind of meeting, was quicker off the mark. He made

the point that there seemed to be some misreading by the PCT of their own data, and that in fact we were performing exactly as required (see below).

After the meeting he again gave me his personal assurance that he would deal with the matter before he left (now a worryingly short time away). He then went underground as far as I was concerned, never being contactable.The deadline came and went, as did the date for his leaving. His PA told me that he had done something and sent it to another person in the trust for comment. I tracked it down and found that what he had in fact done was virtually nothing other than a few uncosted figures, identical to those he had given the previous meeting. Again I had been left high and dry with promises broken. After so many problems I found this let down almost too much to bear.

By now the PCT were pushing hard for a draft budget. Once more I saw my future in the balance. Without agreement, there was a realistic possibility that the service would be scrapped or that my part in it would be lost.

I contacted my finance department and arranged a meeting to draft a budget, more or less from scratch. The person I met with was furious that the previous locality manager had not involved him in discussions. We drafted a budget in double quick time and dispatched it to the PCT. It was probably the steepest learning curve in my career, as I went from no budgetary experience to speak of, to arranging a budget of £286 k in five working days.

The awaited agreement from the PCT did not arrive. What came instead were hostile e-mails from the PCT head of finance raising the questions about our performance that had been raised in the meeting. This was especially galling as he had not attended the meeting, or raised these problems at any time in the previous year. I was able to find the crux of the problem. This was that as mentioned in Context doc 1, an early CORE audit had shown a mean number of 3.13 sessions per client seen. This had been taken and used in the budget to calculate costs, unknown to me. It was a wonderful but bothersome example of how data gets misused, and how figures get set in stone in a way that is not merited. I found myself being expected to justify why we now took 6 sessions to see clients to someone who had no knowledge of counselling (and who was I suspect rather hostile).

Once I had identified the source of the misunderstanding, I could show quite clearly that our performance was in fact almost exactly as required (I was within a few percentage points of target figures and in budget). It did highlight an issue of our poor compliance with activity recording however. Two counsellors had not submitted figures. One gave me backdated information and the other never complied, leaving the service a short while later. I amended our procedures so that invoices were paid only after they had been reconciled with activity sheets, thus preventing this from occurring in the future.

Inevitably winter turns to spring, and as the new trust began to settle, so some of the worst of the chaos and uncertainty began to recede. Central to my realisation that times were changing was my performance review in May 2003 (mentioned elsewhere). For the first time I began to feel recognised and managed myself. Negotiations with the PCT dragged on, but eventually they signed the SLA in August (for a financial year that had begun as usual on 1st April). The significance of this was that this budget contained the funds to employ me full time. I had been working full time since April with the agreement of my manager in the expectation that the SLA would be signed swiftly. She would not however formally employ me on the extra sessions until it was signed[40].

2.2 A post hoc analysis.

So how does this lengthy and involved tale of woe relate to my project? This is a question that I have asked myself on many an occasion. I think that it shows just how much time one has to put into surviving in basically unhealthy organisations. I am truly in Schon's swamp, and in this period, I was in a very deep and smelly part. It is difficult to offer quality to clients and staff, when one is being badly treated oneself, and I have had to work hard to ensure that my feelings didn't leak out in an inappropriate manner and colour counsellors' views. I was very worried that if this happened, it would poison the entire feel of the service. This would almost certainly have a negative impact on the quality of service received by clients. Apart from professional standards, my other reason for not wanting this was that if the service declined, my position would become even more tenuous.

[40] She was under pressure to find £100k from the overall budget, and redundancies were a possibility.

This set of experiences confirmed painfully my previous learning that decisions are not made in organisations on the basis of logic, and that often (as with the B grade fiasco) people carry on as if they were following clear and agreed rules, but in fact they are not. On the positive side, I know that the service survived because of its effectiveness, and the personal good name and good will that I had developed. I have two pieces of evidence for this; In the early days of the new trust the new area manager asked the chair of the PCT (a local GP) about my service. I had made a presentation to a PCG Board of which she had been chair and after that they came in to my managed service. He e-mailed me to say that she was most complementary. If she hadn't been I suspect that the matter would have been dropped there.The second piece of evidence is comment from a contact at the PCT who told me that, after my colleagues had excluded me from re-contracting meetings, they had demanded that I be present on the basis that I was (and I think my quote is accurate) "the only person who knows what he is doing". Later she told me that at one point the PCT had given serious consideration to pulling out of the contract with the new trust, and that they had only stuck with it because they knew that on a day to day basis they worked with me, not my colleagues.

2.3 The themes of the story.

I can identify a variety of themes or features in this story. The first is the importance of my bracketing this wearing series of experiences in an effort to keep them from inappropriately affecting the culture of the service. In doing this I drew heavily on the expertise that I have developed over the years as a clinician. Such a putting of things to one side is a process that is of course recognised in the qualitative research literature (eg: Glaser and Strauss 1967). I do not delude myself that the service culture remained completely untainted by the wider context. My focus on the issues described above meant that there was little time for service meetings and other such activities, and at one point the identity of the service was becoming very diffuse. On a day-to-day basis, bracketing was not a simple or sufficient process. Rather, I experienced a series of oscillations between bracketing and immersion in the experience in which I engaged critically with questions in a manner described by Moustakis (1990). It was only in this way that I managed to cover all of the requisite tasks and maintain my emotional health.

The second issue concerns the importance of leadership. I was initially seeking to exercise a leadership role whilst being given little myself. Neither was I given a formal role that recognised that fact. It was nevertheless vital that I do this in order to establish what I saw as a positive culture in the organization. I tried to respond to the lack of clarity and trustworthy behaviour that I experienced by being very clear and wary of letting anyone down myself. At times, this lead to me being a little over cautious, as I added caveats to promises in the fear that I would build up unrealistic hopes that I could not fulfil.

There is a great deal in the above about chaos and change, and how one finds a way to deal with it. Partly this is about survival, but it is also about using the openness that such periods bring. In crises, organisations can unfreeze, and opportunities arise. The usual level of homeostasis tends to be reduced. The point is made by the oft-quoted Chinese symbol that represents both crisis and opportunity. I am tempted to say that the initial stages were largely about survival, but that is to ignore the fact that in the first two years of the service the service more than doubled in size.

The massive changes described were turbulent waters, but at no point were they of sufficient magnitude to prevent the basic down hill flow. My job was to make use of that flow. This was basically a political task, as I sought to develop alliances, push through my ideas and generally use what limited power I had. In doing this, I drew heavily on my UKCP experience of persuading and influencing. There were two major tools in this struggle. The first was budgets. This is a subject that has always struck me as having the appeal of a dead slug. I had minimal experience of managing a small budget from another previous post, as well as my private practice and domestic life. It was not a topic that I felt at all skilled in however, and I could easily have ignored it. However it was clear to me that to do so would be fatal, since everything is (quite rightly, as it is taxpayers money that is being spent) costed tightly. I realised from the start that to secure the service's future I would have to ensure that we ran tightly to budget. To do this I had to get myself familiar with budget sheets, and some of the language (prior to this, I assumed that the letters SLA referred to some obscure terrorist group). This basic familiarity paid off when I was let down by my locality manager. I had just enough grasp to allow me to take the correct steps to ensure that a very able and helpful Director of Finance drafted a budget in record time.

The importance of budgets and their management was underlined by an incident with an independent psychological service provider in my area. She had been complaining for a long time that she was not properly managed. With the PCT's blessing I spoke to her about my managing her in some way, but we were not able to reach an agreement. The matter was left to drift by the PCT despite their concern at the lack of appropriate Clinical Governance. Mid way through a financial year, they noticed that this provider had used up her entire budget without discussion or agreement. Her service was promptly stopped and client work terminated. Despite acrimonious letters, the service disappeared and many clients who had been on her waiting list had to be sent elsewhere. Many endured a long wait for help.I was angry that this situation could have been allowed to occur, especially as everyone knew that the arrangement was not working. It does stand as a stark illustration of the fact that managing the budget is more than a paper exercise. It has a direct impact on the service received by the client, and is thus an integral part of my overall task. This example hardened my resolve to work demonstrably within budget as a way of ensuring that the service to clients, and my position, were protected. In this way, I turned the budget from a potential enemy to be 'got around' into a friend and ally in my cause.

The second major tool in my political campaign was data, as provided initially by the first CORE audit and later by the PC system. I used this ruthlessly to make an argument for our effectiveness and (linked to the issue of budgets) our efficiency. The story of the misuse of the mean contact figure was a salutary lesson in how careful one has to be in doing this, as all data can be misunderstood and misused. Politics has been described as the art of the possible, and there is a side of this that appeals greatly to my pragmatic side. In a traditional research approach (Schon's high ground) such issues would usually be excluded from the frame, unless they were the specific subject of study. In the swamp however, they are a vital part of the weft and warp of the project. This is a point made by Portwood (2003) and Checkland and Scholes (1990) amongst others.

There is another crucial theme in this story that can best be thought of as the tension between health, survival and sickness. At times I had a strong sense of just 'getting on with it'. This is what I do best, getting my head down, being self reliant and getting on

with it. I drew inspiration from reading about people who had been through things that my generation[41] can barely imagine. This helped me to keep it in perspective at times. Stoicism is in my culture and family, and in any case, I'd been through a lot worse, and I was by the sea! The drive to and from work along the seafront, and the fact that I can walk on the pier near my office served as vital refreshers. Nevertheless, there were times when I despaired of ever getting things on a relatively even keel. In retrospect the worst phase, when I was let down by the locality manager, had problems with the PCT and simultaneously had been made redundant from a one day a week job elsewhere, turned out to be the darkness before dawn. After a period of six months working full time and being paid for 8 sessions, the contract was signed and I received back pay as agreed. I also was successful in having my manager agree that I would be put up the pay scale to where I would have been if my regrading had gone as it should. This seemed to me to be a very important and symbolic line under the messes of the previous period. I felt that this act recognised what I had gone through. Once I had this, I could let it go.

3 Methodology, fundamental questions and assumptions

3.1 Introduction

"The situation is complex and uncertain, and there is a problem in finding the problem" Schon 1988.

It would probably be possible to produce an entire dissertation on the process of clarifying the focus for the work, and of refining my methodological approach. I had comparatively little problem in defining the overall problem, it was to find out how we could make use (or possibly couldn't make use) of what came out of the CORE system. Breaking this down into a series of mini problems proved to be a lot more difficult.

My interest in the area arose from the confluence of a number of factors. I had for some time been interested in the question of how we develop audit systems for clinical work. This arises from a long held belief that for all of us there is often a gap between what we say we do and what we do in practice. From this it follows that in order to really understand what we are doing, and the impact (or lack of impact) of our efforts,

[41] In the privileged parts of the world.

we need to collect routine data. It is only by this process that we can generate practice-based evidence about what we are doing. The latter concept was highlighted by Parry (2002) in a seminar that I attended in the very early days of registration. If I am leading a service, I want to know that it is doing a good job. My starting assumption is that unless we can demonstrate in some coherent and intellectually defensible manner that what we do has a positive impact, we have no right to continue to do it.

There is of course considerable scope for debate about what constitutes evidence, and how this can be assembled or generated. My starting point, as outlined in my doctoral proposal, is that a wide variety of types of evidence might be added to the pot, provided that they meet certain conditions that might be summed up as demonstrating intellectual rigour. By rigour I mean that the question has been subject to a critical analysis that is coherent, internally consistent and which produces an argued and evidenced perspective on the topic at hand. Helpful texts in this regard are Lincoln and Guba (1985) and Stiles (1993).

The ease of defining my initial overall problem, contrasts with my subsequent difficulty. The process of articulating and formalising the final initial question has been long and at times tortuous. Indeed it is somewhat inaccurate to use the term 'final'. For a long time I was seeking to articulate a clear testable question as specified in all basic research texts. I was clear that I wanted to address the issue of how we used the data[42] that we generated, but it was difficult to get beyond that. It was in reading around the literature during this time that I clarified that I was engaged in exploratory research, where questions are by definition less clear.

For some while, I felt like this reading was preparatory, and preceded the 'real' study. I began to feel frustrated at the 'delay' caused by amongst other things seeking ethics committee approval. I felt torn about beginning to meet with counsellors to start looking at their CORE data when I didn't have an agreed question or methodology. I was however clear that I could not put matters on hold whilst I sorted this out. It was a matter of priorities, and my priority is to manage the service in order to ensure that we provide the best possible service to the troubled people who seek our help. I also felt

[42] In a way, the term information is more accurate, since what comes out of CORE is analysed data. However this becomes the data for the next cycle, and so looked at in this way the term is legitimate.

that if we collected data and didn't use it, the whole thing would stall, and it would be hard to get moving again.

Looked at in this light, there was as it were no contest, and so I began, and in doing this I realised that my priorities were action. I wanted to make a difference. The considered reflection was an implicit part of this, but at the end of the day it was there to support action, not as an exercise in itself. This firmly linked my enterprise with the action research tradition. It was only slowly that I came to realise that my tussling with the problem was part of the problem. The realisation that going from initially fuzzy questions to clearer questions (Dick (1993), Dick and Dalmau (2000)) is a part of the process, and not something that has to be achieved before the process begins, was an important step. The processes that I had been through to date were in fact the early cycles of the entire research process.

3.2 Creating is harder than criticising

The final chapter in the process of clarification came as a result of the Goldfried (2003) seminar during (and after) a rather confused and troublesome discussion about my proposed work. I experienced a rather 'cross purposes' conversation, in which I felt pressured to clarify a formal hypothesis type question. It was on unpicking this experience that I realised we had been talking from two different perspectives. As an expert in the traditional paradigm, Goldfried was trying to establish a clear initial question in order to allow the study to begin. I realised that I was not using such an approach, but was interested as much in the process of clarifying the questions (plural) *and* in changing the system that I was in. I had already got to this place, and indeed articulated it in my doctoral proposal, but it was only by engaging in this discussion that I came to really understand what my position was (and was not).

3.3 My epistemological position

I have been greatly helped in my understanding of the overarching conceptual and philosophical issues in research by McLeod (2001). He outlines two major traditions or approaches, the *phenomenological* and the *hermeneutic*. Briefly the former encourages the setting aside of presumptions and aiming for a comprehensive description of the 'thing itself'. Terms such as 'in dwelling' in the phenomenon imply an almost meditative element to the process.

Hermeneutics on the other hand is, in one way at least, an opposite concept in that there is assumed to always be an element of interpretation in any perspective. McLeod goes on to conclude that qualitative research in psychotherapy involves elements of both positions. At this point, I think that I come down rather more on the hermeneutic side of the fence. I think that we can do much to set aside our preconceptions, thereby clearing a space to allow for us to engage with a topic or entity in a relatively uncluttered fashion. I do not think that this engagement can ever be considered to be truly free of interpretation however. At the most basic level the human brain is an organ that constructs a view of the world. Whilst self awareness and techniques such as 'bracketing' can help (we use them all the time as clinicians, and I have used it in this work), I am sceptical of arguments that imply that we can set all preconceptions completely to one side as we 'engage' in some fashion that is totally uncluttered by these preconceptions. This is not to imply that I take a radical constructivist view, since to me such a position seems untenable. If one takes that position to its logical conclusion in a *reductio ad absurdam* style, then we must simply accept that every reality is valid. Then we cannot logically seek to tease out generalities, and most importantly we have no yardstick to deal with conflicts between realities. I do not find this intellectually acceptable. Rather, I take what Mahoney (1989) called a critical constructivist position. In a nutshell this accepts the existence of an external reality, and seeks simultaneously to understand subjective realities as being. On a pragmatic level I see clear value in accepting the notion of an external reality[43]. Put at its simplest, the best available evidence is that if we shoot someone, they are likely to bleed, irrespective of their experience of the event. In any case I worry about the implications of the relativist position, as I think it can, in certain situations, encourage solipsism and a narcissistic concern with the self. I have had many clinical examples where, in my view, the fundamental problem was an unwillingness to engage fully with an external reality. An example being the complete denial by many sex offenders of the demonstrable truth of their offending.[44]

McLeod (2001) helpfully outlines the necessity for our methodology to be based on an epistemological position. Epistemology is best defined as the area of philosophy

[43] Whilst acknowledging that this might not be a complete truth. For example it is pragmatic to accept a Newtonian view of the world for day-to-day purposes, and assume that lines are straight, even though we know that on the grander scale this view does not hold true.
[44] This is not to deny the meaning of this denial for the individual, and the need to work with that clinically.

devoted to describing how people come to know things or believe them to be true (Barker,Pistrang and Elliot 1994). This itself has to be based on some view of the fundamental nature of reality (the ontological question). Hamlyn (1970) outlines four fundamental epistemological positions. These are; 1) the *correspondence theory*, where a belief is true if it matches reality. 2) The *coherence theory*, whereby something is deemed to be true if it is internally consistent. 3) The *pragmatist* or *utilitarian* position, holds that a belief that produces practical benefits is true. 4) Finally the *consensus* position holds that truth is intersubjective and looks for shared beliefs rather than troubling itself with comparison.

As Barker et al (1994) note, there are problems with each of these approaches. They suggest adopting what they refer to as a 'pluralist epistemology'. Whilst I am broadly in support of this, it will be clear from the above that my position pays more heed to Hamlyn's first and third positions. I have seen too many examples of theories that have great internal consistence (and not a little face validity) but which appear to bear no relation to the world as I see it. Similarly, where consensus is taken as a yardstick, I think of nazi Germany or religious groups. There may be great benefit in seeking to elicit and specify a groups views of reality, but that does not mean that I am prepared to accept this as the sole criteria of 'truth'.

One further issue is vital in specifying my overall philosophical position. This is a strong scepticism on my part, based on my cultural background.

3.4 Final choice of approach

My decisions about an epistemological and methodological approach are best illustrated by an analogy. Within martial arts, there is a great concentration on the learning of basic forms. These can be single techniques or combinations (known as kata). These are practiced repeatedly, even at high grades. Many who begin training take the view that these techniques are what they should use in the event of a physical confrontation. The error of this view is best illustrated by a story from my own (unfortunately rather limited) days of training. The head instructor of the club, Dr Andy Hathaway recounted, with not a little schadenfreude, how he had been talking to another student who had encountered a burglar in his home late at night. The student (as reported by the instructor) told how, upon seeing the burglar, he had 'adopted an

aikido stance'[45]. At this, the burglar picked up a chair and hit him over the head with it, before getting away with his possessions. Fortunately the injuries were minor, other than to his pride.

The injury to the students pride was however compounded when he recounted this tale to the instructor. Hathaway's response was to comment that the burglar clearly knew more about aikido than the student! He went on to explain that the whole idea of technique is secondary in such a situation. First you move, and as you do so, the opportunity to use elements of techniques might arise from within the context of movement. One should improvise, and not be trapped in a mentality of technique. Techniques are what we learn in order to condition the body to move in a powerful and controlled manner. They are not to be repeated in rote fashion. In picking up the chair, the burglar had used an aspect of the situation to his advantage.

Of course Hathaway was not implying that we throw out all that has been learned in practice. That would clearly be silly. The trick is to extract the *essence* of what has been learned, such as powerful movement, coordination, balance, zanshin[46] and suppleness, rather than be stuck with empty forms that will not fit a rapidly evolving situation. The story illustrates nicely a problem with methodology in research. Training, whether in martial arts or research methods, can be seen as being akin to a controlled experiment. We isolate variables in order to be able to examine a defined aspect. If we know that our training partner is going to attack right-handed to the forehead, this allows us to use a certain block and counter ideally suited to such an attack, and to learn by doing so. In applied settings such as described above, the rules are different. We do not control the variables and must be much more fluid in our responses, or else we get hit on the head by a chair. If we stand in front of our metaphorical opponent (the research problem) in an uncontrolled situation, we can paralyse ourselves by an overemphasis on technique. We risk putting the cart before the horse by emphasising method. I am reminded of the quip attributed to Maslow, to the effect that, "if all I have is a hammer, I tend to treat everything as if it were a nail".

[45] In technical terms this is known as hanmi, and is emphasised constantly in aikido training.
[46] This translates roughly as 'remaining spirit'. It implies a sense of focus and aliveness in any action, as opposed to merely going through the motions.

So what does this mean for my work? I think it is about extracting the essence of meaning from methodological writings, without seeking to adopt a rigid 'stance'. Two quotes illustrate this point nicely:

"Progress in science is won by the application of an informed imagination to a problem of genuine consequence; not by the habitual application of some formulaic mode of inquiry to a set of quasi-problems chosen chiefly because of their compatibility with the adopted method." Robinson. 2000. p40.

"One of the greatest methodological fallacies of the last half century in social research is the belief that science is a particular set of techniques; it is rather a state of mind, or attitude, and the organisational conditions which allow that attitude to be expressed". Dingwall (1992).

What Dingwall and Robinson are arguing against has been referred to as 'methodologism' (Salmon 2003). He defines this as applying an epistemology that research is good if it has been conducted according to certain methods, leading to researchers and referees 'ticking off' work against accepted guidelines. Salmon also makes the important point that approaches such as grounded theory are ways of thinking, and not tools to be 'used'. The latter implies a reification of the idea, and leads to conceptual problems.

From the above and others (such as McLeod 2001) there seems to be a clear consensus (especially within the qualitative arena) that we use the literature on methodology, rather than becoming a slave to it. There is in other words a requirement for *flexibility* in our approach. This flexibility is not simply limited to our initial selection or adaptation of a methodology. It allows for the development of that methodology as we progress through the research. It also allows for flexibility in what we count as data. I am with Glaser and Strauss (1967) in seeing no fundamental conflict between qualitative and quantitative approaches. Data is data. We might appropriately choose to use either, or elements of both, depending on what we are seeking to achieve.

For example, this project explores the questions that arise in using quantitative CORE-PC data. The thrust of the study is qualitative, as I seek to understand the process. However, it has been useful to include some quantitative data as a way of highlighting elements of the picture, even if it is something as simple as basic percentages.

The yardstick is in other words essentially a pragmatic one, as Elliot, Fischer and Rennie (1999) state:

"Ultimately, the value of any scientific method must be evaluated in the light of its ability to provide meaningful answers to the questions that motivated the research in the first place." p216.

To some extent the initial choice of methodology has to be guided by the state of our current knowledge base. This is the informed part of Robinson's 'informed imagination'. Mahrer (2003) disputes the existence of a coherent knowledge base in psychotherapy. Whilst his position holds a certain truth in that the base is not by any means coherent nor in places consistent, I think that he overstates his case. There is to my mind a value in seeking to assess the state of knowledge in an area of the field, and using this to develop ideas about future directions in our research. Simultaneously, I think that we must acknowledge that the state of current knowledge is akin to a swirling mass of leaves, clustering in one or two piles, but with little coherent shape. It is certainly not a nice neat pile of swept up leaves with a clear and enduring shape.

I described in my doctoral proposal how I moved from conceptualising the project as a discrete piece of research on counsellor's experiences of using CORE-PC data, to a much messier design. This process occurred as I went through the events described in chapters 2 and 3. It was only as I immersed myself in the complexity of the systems and processes related to the service and my role in it that I began to realise just how complex a job I was involved in. As I came to the end of this particular process, I came across the following quote, which sums up the situation that I was faced with.

"In the varied topography of professional practice, there is a high, hard ground where practitioners can make use of research based theory and technique, and there is a swampy lowland where situations are confusing 'messes'...Problems of the high ground, are often relatively unimportant. In the swamp are the problems of greatest human concern... "(Schon (1988). p42.)

My shift to this position was, I think significantly influenced by the personal swamp described earlier. I came to realise that far from putting these issues to one side as I got on with the 'real' research, they were centrally and fundamentally a part of the whole. One could not understand the process of using CORE within my service without understanding my story as manager and the story of the service and my fight to establish and preserve it. I do not pretend that this is a clean and simple change of view. I still hanker after a nice simple design with a clear strategy and linear progress. I do have doubts about the validity of what we achieve in action research type studies. Generalisability seems to be sacrificed to achieve environmental validity and fit. On

the other hand, I am passionately convinced that I want my work to be useful, and there is no doubt that if we are going to be useful, we have to enter the swamp. Overall, the project can be thought of as using CORE-PC data to develop a reflective process in individual counsellors and in the culture of the service as a whole.

3.5 The problem revisited

Having worked on this project for some considerable time, I began to realise that I was making many tacit assumptions. I was assuming that;

- Audit is a good thing because there are often gaps between our stated beliefs and what others might infer about our beliefs from the way we behave.
- Using data is an active process (it does not happen automatically).
- There is a problem in changing our behaviour.
- Such activities lead to professional development.
- The service received by clients can be improved by the above.
- There is a less palatable assumption that some counselling practice might not be terribly effective, and that audit data might highlight this.

I will address these in turn.

In one focus group a participant, himself an ex manager, commented that he had been surprised upon coming into counselling to find that so much was taken on trust. "coming from a managerial back ground its one of the things that I've always found very odd that you come into an area of work which is highly personal and there's lots of potential, but *you could be doing anything almost* ..and its about having a way of knowing what you are doing...so to me this is very important ..this development....it does give you something to help you hopefully to know what you're best at and what you you're less good at" FG 2, page 5. (italics added.)

This highlights for me a point that has troubled me from the start of my training. How do we know that what we are doing is effective, and how do we improve what we do? This is what audit is all about, knowing what we are doing, [47] as opposed to knowing what we think we are doing. The importance of this is directly linked to what can best be described as the performance gap. Human history is replete with examples;

[47] Or more accurately, having data about aspects of what we are doing, assuming that the measure is valid.

"No man in history did more for human liberty than Thomas Jefferson, author of the Declaration of Independence and of Virginia's Statute for Religious Freedom, among other gifts to mankind. Few men profited more from human slavery than Jefferson. " Ambrose. 1996 (2003) p.18.

I start from the assumption that for all of us there may be a difference between what we do and what we say we do. This is in direct accord with the tradition of academic psychology, which for years ignored self-report as an invalid form of evidence on these grounds. My reading of much of the work on qualitative methodologies is that they are very much a reaction to this state of affairs. Unfortunately, they often fail to differentiate between the fundamental position, and some of the unfortunate consequences of a rigid adherence to that position. They make the opposite mistake of ignoring the performance gap. It is not logical to state that, because people don't always act in accord with their stated beliefs, we should ignore their inner world. However, neither is it logical to suggest that we should concentrate on inner worlds to the exclusion of behaviour, since this risks missing the fundamental value of the traditional perspective. Far better in my view to take a middle position, in which we can be interested in our own and others experiences from a somewhat sceptical position. By cycling between observed behaviour and self-report, we are best able to begin to tease out the complex multiple layers of meaning in any situation. This is an area explored by Argyris and Schon (1974, 1989), and is a fundamental part of the reason that I draw heavily on action research approaches in this project.

If the point needs further illustration, the case of Stephen Ambrose (quoted above) is illuminating. He is widely acknowledged as a brilliant popular historian, and was a key mover in the development of the oral history tradition, in which the words and stories of combatants from the Second World War were woven into historical text (Ambrose 1992,1994, 1997). I have found his work exceptionally moving and informative, and his approach has interesting parallels with the kind of qualitative approaches that inform this work. He is interested in people's stories as parts of the greater story, and he acknowledges his own position *vis a vis* those stories. Shortly before his death however, he acknowledged that he had been guilty of failure to attribute parts of his text to other authors (BBC News 7th Jan 2002/28th Feb 2002).

My second assumption is that even when we have gathered data on what we do, we cannot assume that it will be used. Again, history is replete with examples of catastrophic failures to use the information that we have available. Perhaps the greatest such example, in terms of human life and misery, is Stalin's refusal to accept the reality of Hitler's intentions in 1941. Despite overwhelming evidence, including that gained from one of the most effective spy rings in the history of espionage, Stalin simply refused to accept that Hitler intended to attack, imprisoning his own agents as 'abetters of international provocation' (Conquest 1991).

"The consequences to the Soviet Union were catastrophic, including losing 30% of ammunition, 50% of food reserves and, by 1942, 3.9 million soldiers constituting a huge portion of the Red Army taken prisoner" (Amis 2003).

Stalin's response to this was not to reflect and change his perspective, but to go for more of the same, imprisoning those who had escaped nazi capture as malicious deserters

Apart from its obvious significance, the above has particular resonance for me since in my family Stalin, whilst seen as rather authoritarian, was viewed as 'Uncle Joe' who won the war. In common with many (Amis 2003), this led to my underestimating for many years the full madness and horror of his regime. This serves as another personal reminder that we all filter information according to our fundamental beliefs.

This tendency to ignore or otherwise distort information plays a central role in my third assumption, that we sometimes have difficulty in changing our behaviour as a result of feedback. It is not an automatic process that individuals and systems will adjust their behaviour even if the evidence gathered indicates the need. Thus;

"Effective systems for collecting outcome data will be rendered meaningless unless there are also robust methods for ensuring that the data are used to answer the questions that the service wanted addressed in the first place. This means ensuring that the data collected are analysed, interpreted *and made use of within the service."* Sperlinger 2002. p11. Italics added.

Making use of the data seems to be a hard process. A classic study by Oxman Thomson Davies and Hayes (1995) analysed the evidence from 102 trials of different interventions aimed at improving clinical practice in health professions. This included 31 studies of audit and feedback. Effectiveness across different types of clinical behaviour as measured by these studies ranged from zero to moderate, with only one

study showing a (desired) significant change in the prescription of generic drugs as a result of feedback (Gehlbach, Wilkinson and Hammond (1984)).
As ever, these results need to be carefully interpreted, since many of the studies cited were 'one off' studies rather than assessments of systems that were seeking to develop continuous feedback loops.

This has been an issue within this project. I was initially envisaging the final written product as being a rather linear text. Having spent a considerable amount of effort on writing about the service, my part in it, and even an earlier version of this section, I sent what I had to my supervisor and learning advisor. Their comments indicated that the text was useful, but really supportive to a central part that was as yet missing.[48] For a long while I stopped overt production. I really did not want to change the path that I was on. Far easier to simply carry on the same familiar way. Indeed, 20 years earlier that is exactly what I did with a Masters dissertation, when the feedback from a supervisor suggested that the structure was wrong. I passed, but didn't learn much. This time, after the period of block and time engaged in other work matters, I came back to a file with hard written pages that I knew I did not want to lose. I also knew that there was something crucial to this project in them. I further knew that how I had started to put it together was old habit not new learning. I also knew that within the culture of this doctorate, it wouldn't pass. Then I had a moment of shift. I mapped out the written submission visually (see chapter 1) and realised that this did not need to be a traditional linear text. These sections could be presented as contextual documents that would allow the reader to develop a rich sense of the context of the project without obscuring the central issue. I found a way of developing my professional frame and associated practice in the light of data.

The story of Winnicott's teacher (chapter 1) serves as an antithesis of the professionalism and professional development that truly engaging with CORE data is intended to further. How much better to remain open, gather data from multiple sources, reflect on it, make sense of it and use it. That is the route to truly gaining thirty years of experience. That the client will benefit if counsellors and the service as a whole make use of the data generated seems axiomatic. Of course it isn't really, and there are several assumptions nested within this assumption. There is the assumption

[48] This is my distillation, in retrospect, of several conversations both face to face and e mail.

that professional development leads to altered practice, that this altered practice impacts in a significant manner on the client, and that this impact is positive. These are fascinating questions but are not within the scope of this work. The furthest that I go down this road is the inclusion of the question on CORE within the research questionnaire of my student, and within the revised client satisfaction questionnaire. My final assumption is perhaps the most challenging in every aspect. It is easy to concentrate on the positive aspect of gathering CORE data, just as it is often easier to focus as clinicians on the positive aspects of a client's psyche. Far harder to acknowledge *with and to them* that they might sometimes be bad partners/parents or even citizens. So it is with CORE. We quite properly focus on the developmental aspects of engaging with the data, but this begs the question about what we do when the evidence is persistently indicative of poor performance.[49] However I feel almost compelled to address the issue, to not do so seems naïve and evasive, and certainly intellectually untenable. It is something that I have always felt strongly about. It would take far too much time and space to articulate a coherent story as to why, and even then I am not sure what validity that story would have. Partial aspects are contained in my doctoral proposal. My first job as a probation officer required an ability to have direct discussions with people about aspects of their life that were deemed to be less than acceptable by others. I have certainly have no doubts about the reality of poor practice as the story of Mr M and Mr O, illustrate. These stories and the issues raised above are discussed further in chapter 2.

[49] This itself begs the question as to whether CORE data can be properly held to be capable of demonstrating poor performance, but this discussion is about the fundamental question.

Appendices

Appendix 1: The CORE Story and Forms

Definition and description

CORE (Clinical Outcomes in Routine Evaluation) is based on a 34 item client self report questionnaire that assesses the psychosocial domains of ;

- Subjective well being
- Symptoms
- Life/social functioning
- Risk (to self and others)

The Outcome Measure (OM) is designed to measure a pan-theoretical 'core' of clients' global distress, including subjective well-being, commonly experienced problems or symptoms, and life/social functioning. This is based on Howard, Lueger et al 's (1993) work which links therapeutic change to the processes of remoralisation, remediation and rehabilitation. In addition, items on risk to self and others are included to aid and assist risk assessment.

The main purpose of the tool is to offer a global level of distress defined by the average mean score of the 34-items that can be compared with clinical thresholds before and after therapy to help determine clinical and reliable change. (from CORE website). The OM is completed by the client pre and post intervention (see example below) In order to provide further data, clinicians complete a Therapy Assessment form and an End of Therapy form at the start and end of the process respectively. Examples can be seen below.

Background and development of the measure

The CORE Outcome Measure (OM) and supporting forms (Therapy Assessment form (TA) and End of Therapy form) were originally designed by the CORE System Group (CSG) at the University of Leeds (Barkham, Evans et al 1998, Mellor-Clarke , Barkham et al 1999). This followed a suggestion from the Dept of Health Strategic Review of Psychotherapy Services, that links be established between clinical practice and research using outcome measures (UK Dept of Health 1996). Central to the thrust of this argument was the need to introduce some rationality and consistency into the access to, and provision of, psychotherapeutic services nationally. This was to be achieved by the use of

evidence from controlled trials on the psychotherapies to inform the design and organisation of services. This is generally known as evidence based practice, or EBP. This was seen as insufficient however. There are many reasons why an approach (let us say for example, brief interpersonal therapy with depression) that appears to be *efficacious* in trials, might not in fact be *effective* in a day-to-day clinical setting. We therefore need to generate good evidence about outcomes in ordinary clinical settings, where our findings are based on day to day practice rather than specially established treatment regimes with selected clinicians and clients. This is known as practice based evidence, or PBE for short (Barkham and Mellor-Clarke 2000. Margison et al 2000). It was envisaged that PBE would be compared with evidence from controlled trials to generate a true evidence base for psychotherapeutic interventions.

The problem was that no standardised measure existed, and thus comparison between outcomes at different locations, or indeed between different studies, was exceedingly difficult, if not impossible. The generation of PBE in practice rested on the development and use of a broad standardised outcome measure. An initial part of the development process involved a qualitative study of service commissioners (Chief Executives of Health Authorities) managers of psychology and psychotherapy services nationally. Overall the survey showed considerable support for the use of standardised measures, with 76% of purchasers indicating support for standardised measures across all psychological services. 78% of providers saw considerable utility in the use of standardised measures, although only 33% thought that they should be used across all services. This gave the green light to the development of a generally applicable outcome measure. The intention was to provide a UK normed measure that was free of the usual copyright and commercial pressures. The forms were and remain cost free. The only stipulation, brought about by experience (Mellor-Clarke personal communication), is that the integrity of the forms remain untouched in order to preserve their psychometric validity.

The funding for the initial development of the system was provided by a variety of organisations to the tune of £500,000 (Richard Evans, personal communication). The brief was to produce a valid and simple to use measure for routine clinical audit. This would allow for the generation of a very large database, and the development of benchmark data to provide reference points for services vis a vis their performance. Using this funding, the CSG "developed, piloted and implemented a co-ordinated quality evaluation, audit and outcome benchmarking system for psychological therapy services. This involved working

closely with a range of stakeholder groups, representing psychiatry, psychotherapy, clinical psychology, and counselling from across the UK." (CORE PC website.)

The OM was designed by examining widely used measure such as the Beck Depression Inventory and SCL-90, and extracting items, which were then clustered and further examined. The final 34 questions were developed to elicit information on the four areas described above. Further information on the technical development of the measure is described in Barkham et al (1998), and is not repeated here.

The first wave of research presented data demonstrating the statistical validity of CORE, and its reliability as an assessment and outcome measure (Barkham, Evans et al 1998, Mellor-Clarke, Barkham et al 1999, Evans, Connell et al 2000, Barkham, Margison et al 2001). This led to widespread interest in, and use of, the instrument across a wide variety of psychological services, especially those offering counselling, with over 100 organisations using CORE routinely by 1999 (Mellor Clarke et al 1999). Further work using the rapidly expanding national database, has begun to produce evidence for the effectiveness (at least in the short term) of counselling in primary care settings (Mellor-Clarke, et al 2001).

Originally, completed CORE forms were scanned and analysed via the University of Leeds. Although the entire system was intended to be non-profit making, there was a significant per patient/per annum cost for this service. Indeed the cost lead to the service that I then worked for deciding not to use the CORE system routinely in 1998. Despite this cost, the University realised that it was making a loss on the enterprise, and withdrew in 1998. The intellectual copyright remained with the trustees (members of the CSG). The task of developing and marketing a lower cost PC version became the responsibility of CORE-IMS Ltd, a company run by John Mellor Clarke, in close collaboration with the CSG and Richard Evans. The first PC version was made available in early 2002, and PC-2 was rolled out in mid 2003.

The introduction of the PC version changed the way in which CORE could be used in a quite revolutionary manner. Previously data was sent away to Leeds, analysed and gathered into a report that came back some months later. With PC, the analysed data was potentially there at the touch of a button. There is no gap between entering raw data and generating results. One doesn't get a written report, and much more effort has to be put in

to collating the various streams of information into a coherent shape, but the results are on stream constantly. The time lag is removed, and information is no longer out of date by the time we get it. This form of dynamic audit[50] is a new and challenging development, removing as it does the built in time lag associated with traditional audit.

CORE and practice research networks

Central to the CORE project is the concept of the practice research network. Simply put, these are "a network of clinicians that collaborate to conduct research to inform their day-to-day practice (Audin et al 2001, p242). They are seen as an ideal means of generating PBE and thereby narrowing the research-practice gap.

The development of CORE PC, and the rapid growth in the number of services using it meant that the CORE system rapidly generated the largest database ever accumulated in the field of psychological therapy. Services provided data under the old system on the understanding that it would be stripped of identifiers and added to a central pool. With the PC system, users were asked to send their data at regular intervals in order to add to that pool.

It will be seen therefore that CORE is an attempt to generate evidence about what we actually do in clinical practice, and that it sits astride the traditionally separate domains of research and practice. Although methodologically it has relied largely on quantitative approaches thus far, it has incorporated qualitative approaches especially at the beginning. In its emphasis on practice and the change thereof, I do not think that it is too fanciful to see the CORE project as a very sophisticated form of Action Research. I have to acknowledge though that I do not think that this suggestion would necessarily be readily accepted by either the key actors within CORE or the AR community.

[50] I had struggled for some time for a suitable term to differentiate it from a traditional audit when I heard John Mellor Clarke use the term at the CORE primary Care conference in April 2004.

SAMPLE

CLINICAL
OUTCOMES in
ROUTINE
EVALUATION

OUTCOME MEASURE

Site ID

letters only | numbers only

Client ID

Therapist ID | numbers only (1) | numbers only (2)

Sub codes

Date form given (D D / M M / Y Y Y Y)

Age

Male ☐ Female ☐

Stage Completed

S Screening
R Referral
A Assessment
F First Therapy Session
P Pre-therapy (unspecified)
D During Therapy
L Last therapy session
X Follow up 1
Y Follow up 2

Stage

Episode

IMPORTANT - PLEASE READ THIS FIRST

This form has 34 statements about how you have been OVER THE LAST WEEK.
Please read each statement and think how often you felt that way last week.
Then tick the box which is closest to this.
Please use a dark pen (not pencil) and tick clearly within the boxes.

Over the last week	Not at all	Only Occasionally	Sometimes	Often	Most or all the time	Office use only
1 I have felt terribly alone and isolated	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ F
2 I have felt tense, anxious or nervous	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ P
3 I have felt I have someone to turn to for support when needed	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0	☐ F
4 I have felt O.K. about myself	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0	☐ W
5 I have felt totally lacking in energy and enthusiasm	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ P
6 I have been physically violent to others	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ R
7 I have felt able to cope when things go wrong	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0	☐ F
8 I have been troubled by aches, pains or other physical problems	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ P
9 I have thought of hurting myself	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ R
10 Talking to people has felt too much for me	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ F
11 Tension and anxiety have prevented me doing important things	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ P
12 I have been happy with the things I have done.	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0	☐ F
13 I have been disturbed by unwanted thoughts and feelings	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ P
14 I have felt like crying	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ W

Please turn over

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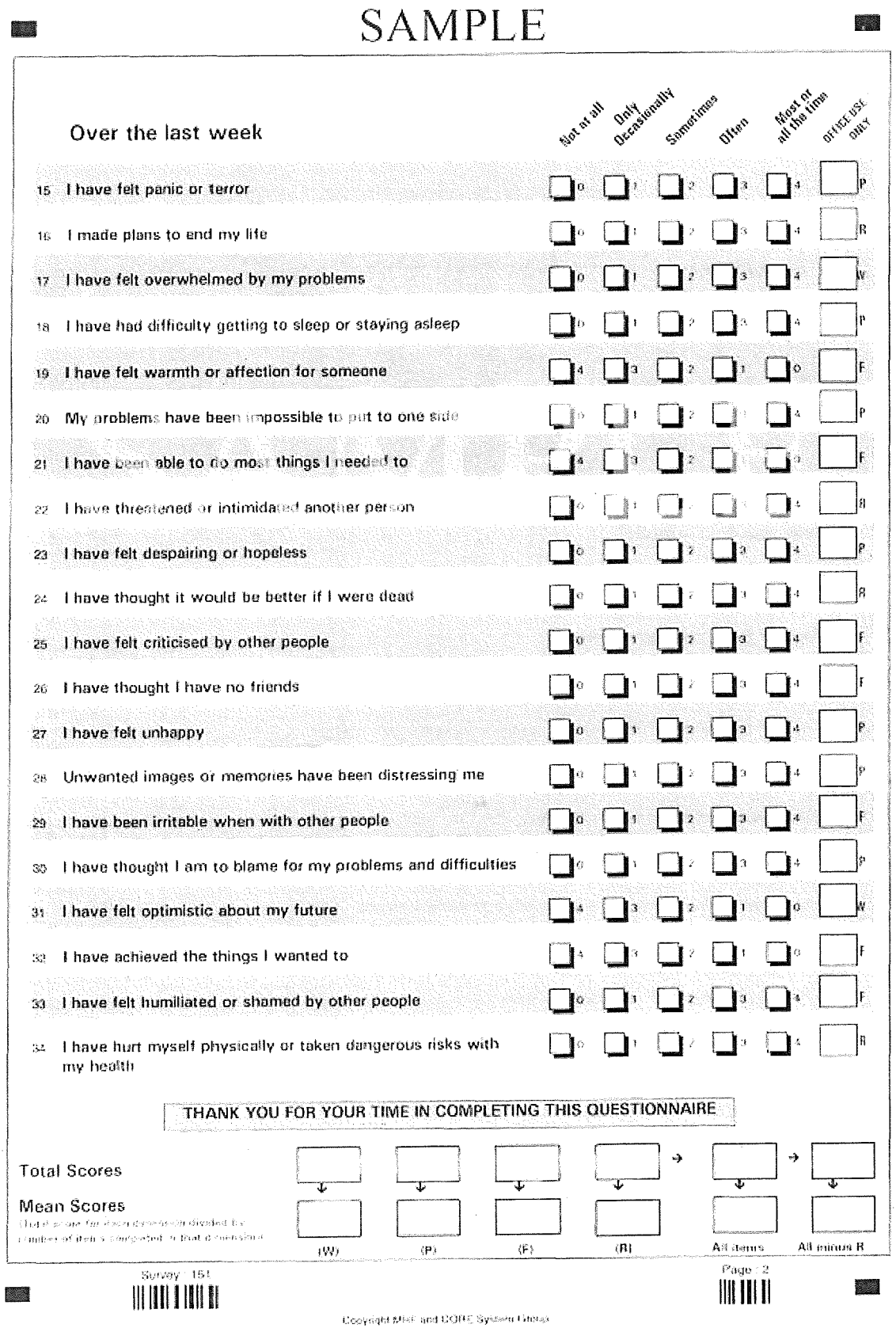

Figure App 1: 1 CORE Outcome Measure

SAMPLE

CLINICAL OUTCOMES in ROUTINE EVALUATION

THERAPY ASSESSMENT FORM v.2

Site ID

Client ID (letters) (numbers)

Sub Codes Therapist ID SC2 (numbers) SC3 (numbers)

Referrer(s)

Age

Male Female

Employment

Ethnic Origin

Referral date D D / M M / Y Y Y Y

First assessment date attended D D / M M / Y Y Y Y

Last assessment date D D / M M / Y Y Y Y

Total number of assessments

Previously seen for therapy in this service? Yes No Episode

Months since last episode

Is this a follow-up/review appointment? Yes No

Relationships/support *Please tick as many boxes as appropriate*

- Living alone (not in caring dependents)
- Living with partner
- Caring for children under 5 years
- Caring for children over 5 years
- Living with parents/guardian
- Living with other relatives/friends
- Full time carer (of disabled/elderly etc)
- Living in shared accommodation (eg lodgings)
- Living in temporary accommodation (eg hostel)
- Living in institution/hospital
- Other

Current/previous use of services for psychological problems?

Please tick as many boxes as appropriate

		Concurrent	< 12 mths	> 12 mths
Primary	GP or other member of primary care team (eg practice nurse, counsellor)			
Secondary	In primary care setting			
	In community setting			
	In hospital setting on sessional basis			
	Day care services (eg day hospital)			
	Hospital admission < 10 days			
	Hospital admission > 11 days			
Specialist	Psychotherapy/psychological treatments from specialist team (sessional)			
	Attendance at day therapeutic programme			
	Inpatient treatment			
Other	Counsellor in eg voluntary, religious, work, educational setting			

Is the client currently prescribed medication to help with their psychological problem(s)? Yes No

If yes, please indicate type of medication:

Anti-psychotics (neuroleptics/major tranquillizers) Anti depressants Anxiolytics/Hypnotics (minor tranquillizers) Other

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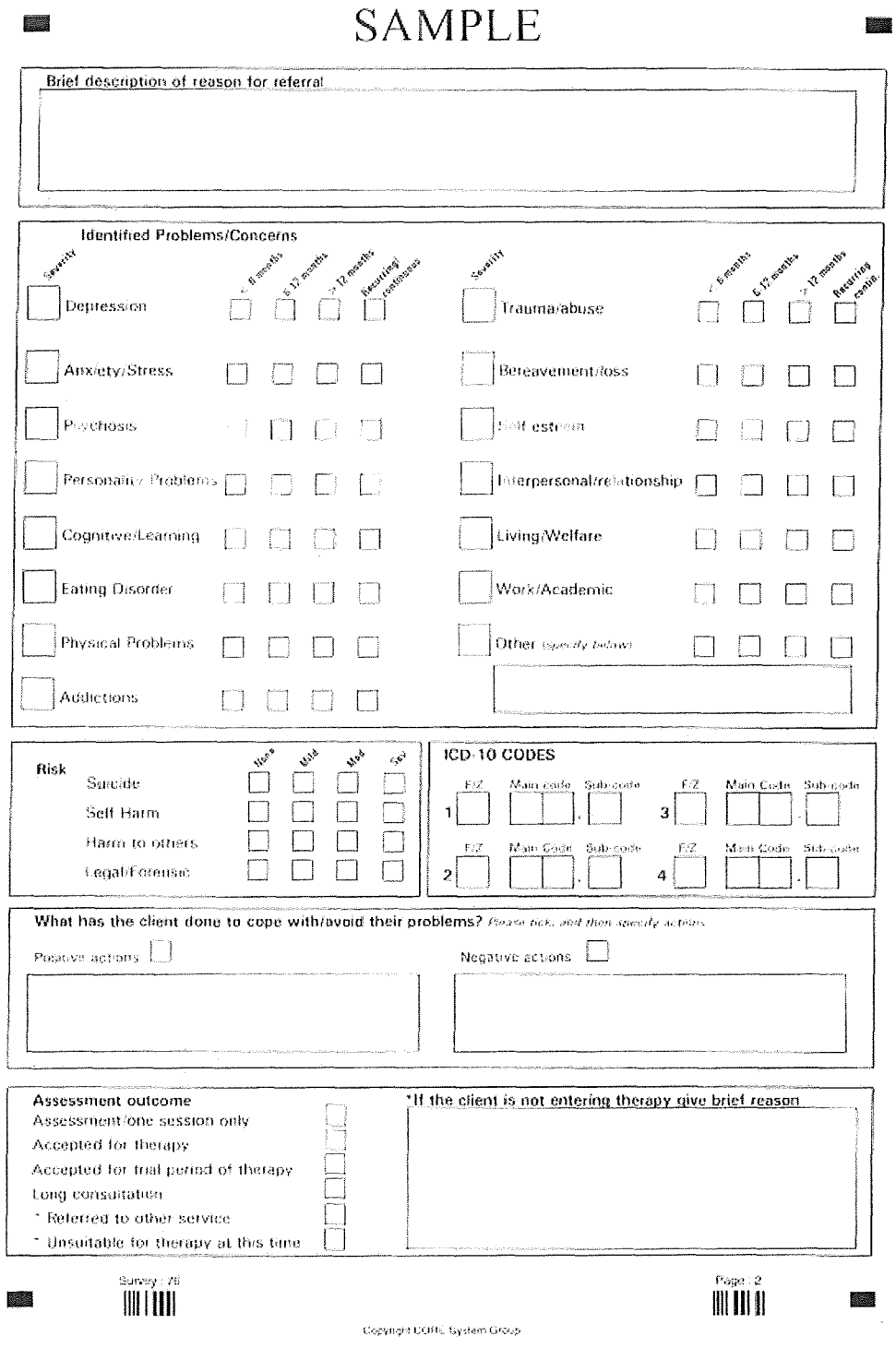
SAMPLE

Brief description of reason for referral

Identified Problems/Concerns

Severity | < 6 months | 6-12 months | > 12 months | Recurring/ continuous

Depression
Anxiety/Stress
Psychosis
Personality Problems
Cognitive/Learning
Eating Disorder
Physical Problems
Addictions

Severity | < 6 months | 6-12 months | > 12 months | Recurring/ contin.

Trauma/abuse
Bereavement/loss
Self esteem
Interpersonal/relationship
Living/Welfare
Work/Academic
Other (specify below)

Risk

	None	Mild	Mod	Sev
Suicide				
Self Harm				
Harm to others				
Legal/Forensic				

ICD-10 CODES

	F/Z	Main code	Sub-code	F/Z	Main Code	Sub-code
1			.	3		.
2			.	4		.

What has the client done to cope with/avoid their problems? (Please tick, and then specify actions)

Positive actions

Negative actions

Assessment outcome

Assessment/one session only
Accepted for therapy
Accepted for trial period of therapy
Long consultation
* Referred to other service
* Unsuitable for therapy at this time

*If the client is not entering therapy give brief reason

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Figure App 1: 2 Therapy Assessment Form

SAMPLE

CLINICAL OUTCOMES IN ROUTINE EVALUATION

END OF THERAPY FORM v.2

Site ID

Client ID

Sub Codes — Therapist ID

Date therapy commenced

Date therapy completed

Number of sessions planned

Number of sessions attended

Number of sessions unattended

What type of therapy was undertaken with the client?

Psychodynamic	☐	Person-centred	☐
Psychoanalytic	☐	Integrative	☐
Cognitive	☐	Systemic	☐
Behavioural	☐	Supportive	☐
Cognitive/Behavioural	☐	Art	☐
Structured/Brief	☐	Other	☐

What modality of therapy was undertaken with the client?

Individual	☐	Family	☐
Group	☐	Marital/Couple	☐

What was the frequency of therapy with the client?

More than once weekly	☐	Less than once weekly	☐
Weekly	☐	Not at a fixed frequency	☐

Which of the following best describes the ending of therapy?

Unplanned	☐	**Planned**	☐
Due to crises	☐	Planned from outset	☐
Due to loss of contact	☐	Agreed during therapy	☐
Client did not wish to continue	☐	Agreed at end of therapy	☐
Other unplanned ending	☐	Other planned ending	☐

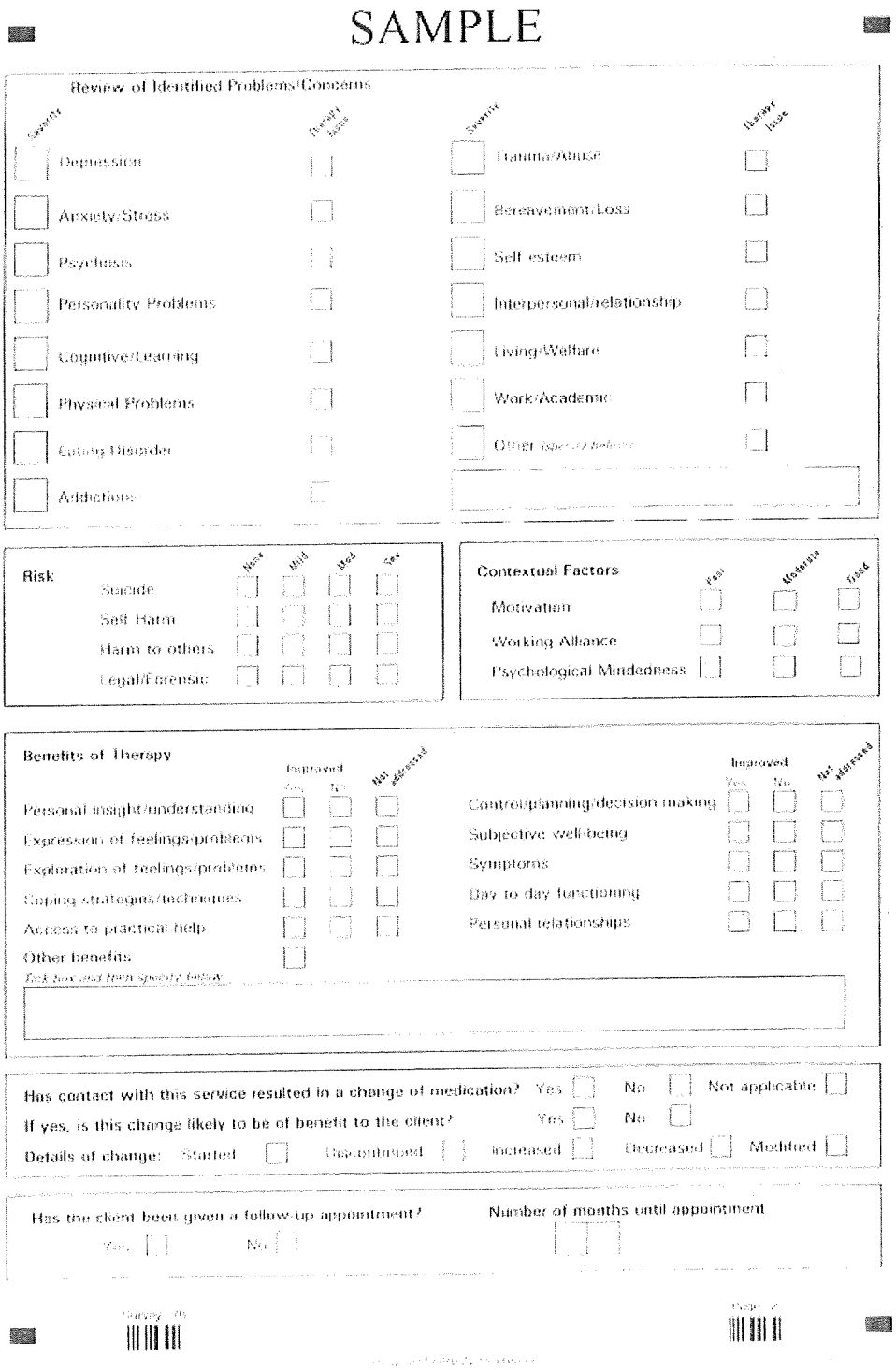

Figure App 1: 3 End Of Therapy Form

Appendix 2: A trip through the CORE system.

Starting Up

Once you have opened the system, you will get a blue screen. Press **Explore,** and you will get this;

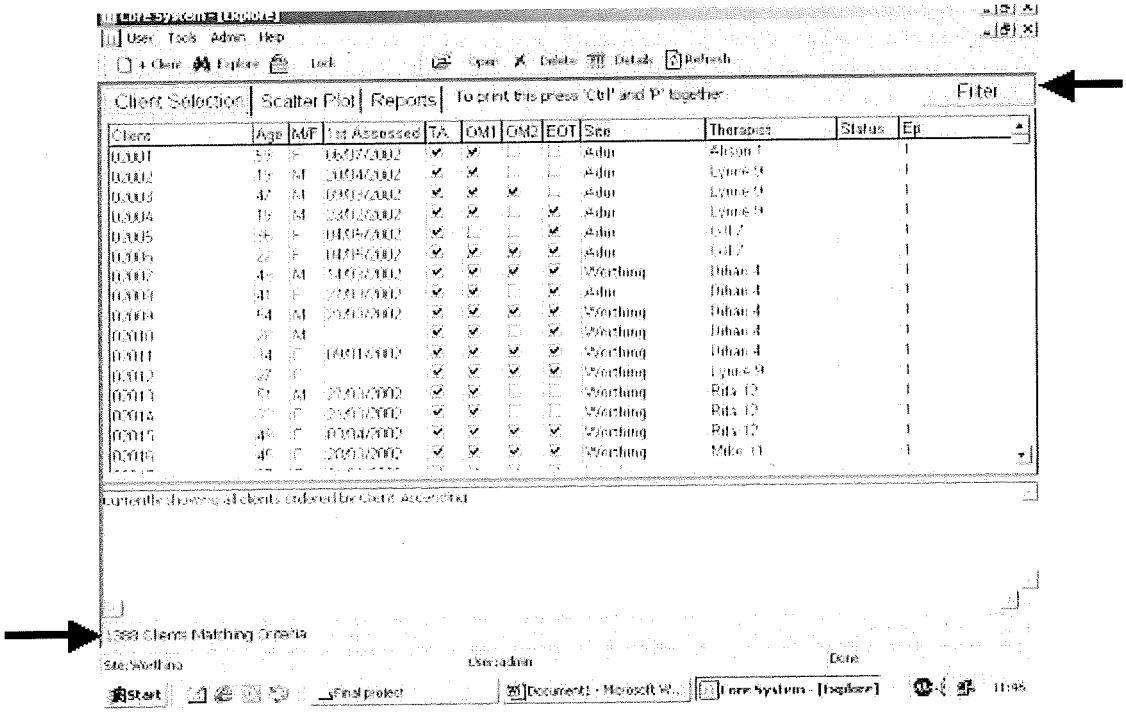

Figure App 2: 1 The first screen (showing the entire data base)

Figure App 2: 1 lists all the clients on the data base. The number is in the bottom left (see arrow)

Always check the number here: it tells you if you are looking at the whole data base or a smaller sample such as your own figures.

Choosing the data to look at.

The first choice is to decide if you want to look at the whole data base (everything that is on the system) or a part of it, such as your own data/male clients/female clients/those with depression at the start etc.

To look at a specific group, such as your own data, you need to go to **filter** (top right arrow). This gets you to this screen

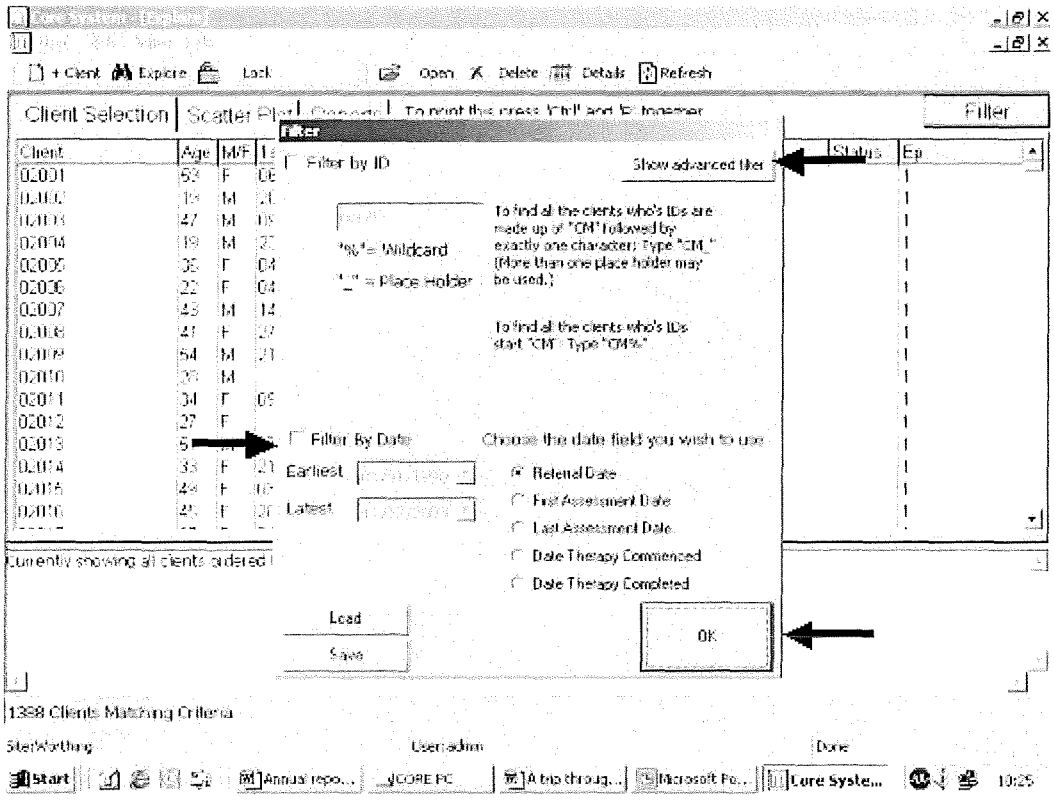

Figure App 2: 2 The first filter level for dates.

Here you can filter by date. To do this click the icon (see left arrow). You must also choose whether you want date of referral/first assessment etc. see list bottom right of middle screen). This gives you the clients in any date period selected. You could for example look at the last years figures (and then by changing the date filter, compare them with a previous years figures). If this is all you want, click OK (bottom right arrow)

To choose other options click on show advanced filter (top right arrow) to get to Figure App 2: 3. You can still filter by date, and can also filter in other ways as well. To get your own data up, click on the therapists button in the right hand list and then on your name when it comes up. To apply this click OK.

You will notice that you come back to the original screen, with a lower number in the bottom left box. To take a filter off, reverse the process and click on the tick to remove it. Click OK and when you come back to the first screen, check that the number has gone up. It usually loads as you watch. As you look at the data, you can skip backwards and forwards between filtered data (say your own figures) and the entire service data. But do make sure that the screen changes. I often click and open another screen and immediately return to the one I want in order to change from filter to non filter or vice versa.

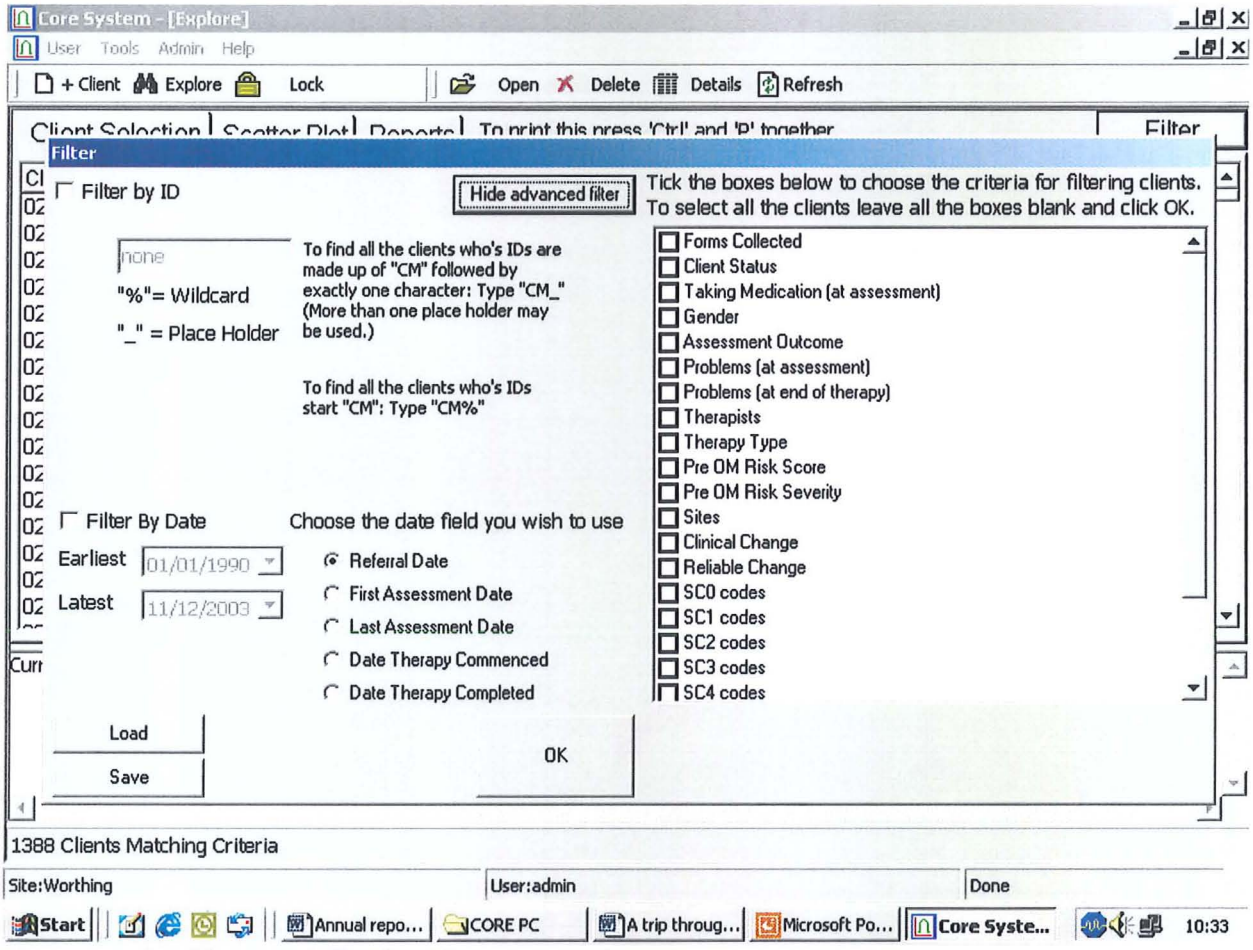

Figure App 2: 3 The second filter level for your own data etc.

Examining the data further: To examine a particular client, double click on their line. This gives you this screen;

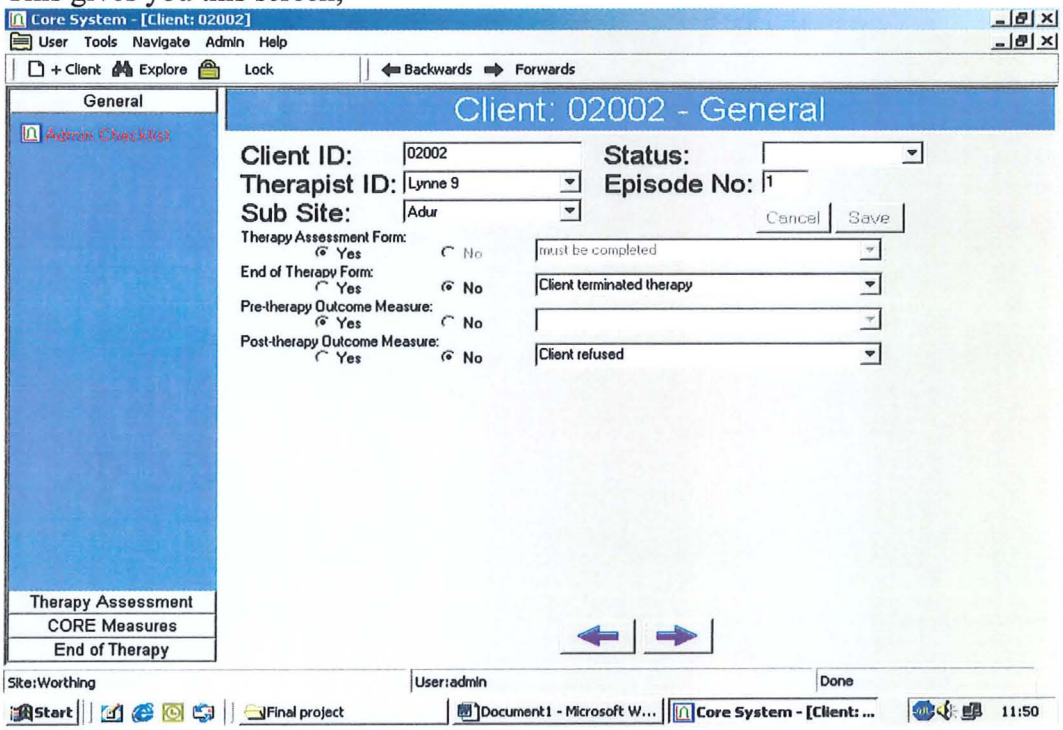

Figure App 2: 4 The screen for a particular client.

Navigate through this section using the purple arrows above. One of the most interesting is the pre-post graph (below).

This allows you to see at a glance the scores at the start and end of therapy for the client you are looking at. To return to the first screen at any time, click on the lower of the 2 crosses at the top right of the screen.

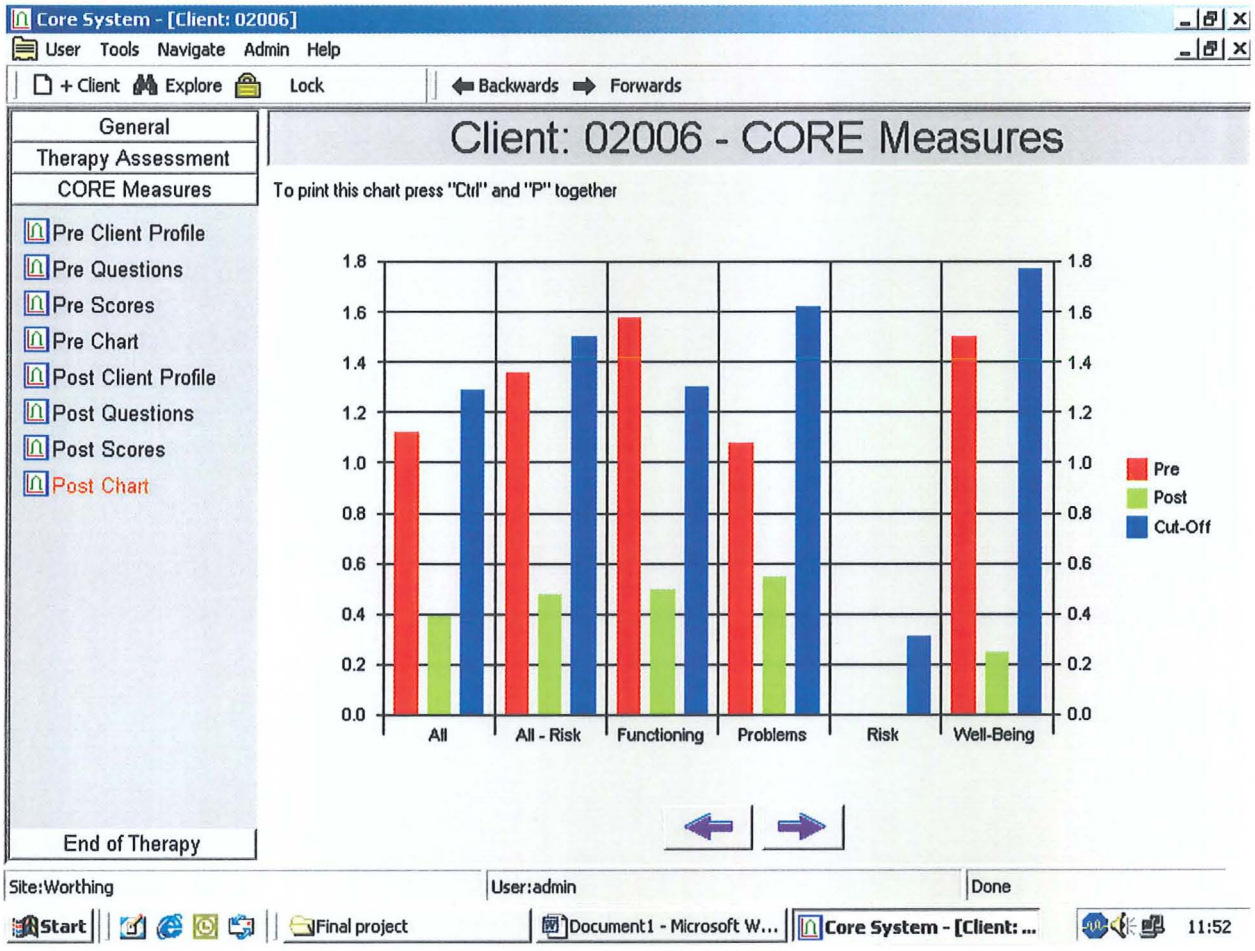

Figure App 2: 5 Graph showing pre and post scores for a particular client.

From the main screen, you can get a synopsis of your client by pressing the details icon

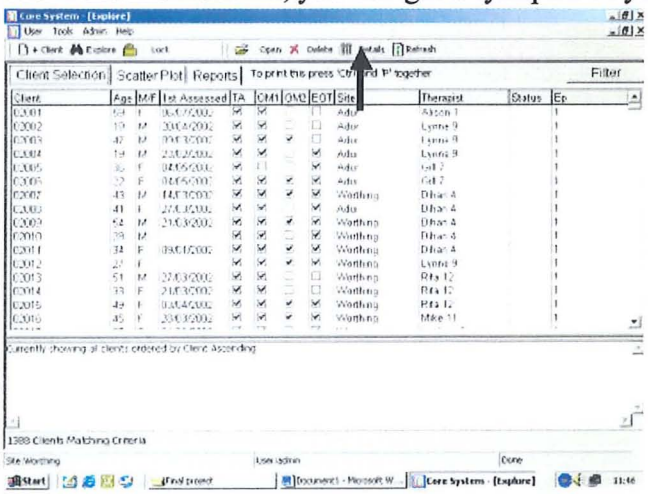

Figure App 2: 6 Details icon

This gets you a summary of your client (see below).

Assessment Summary Report

Client Information

Client ID	Age	Gender	Referral Date	Reason for Referral
02015	**49**	**Female**	**16/01/2002**	**Depression. Stress at work.**

Risk Assessment

Risk Type	Risk Level

Problem Assessment

Problem	Severity	Duration

Pre-Therapy Outcome Measure Scores

2.5 1.77 1.58 1.62 1.82 1.3 0.17 0.31 1.52 1.29 1.81 1.5

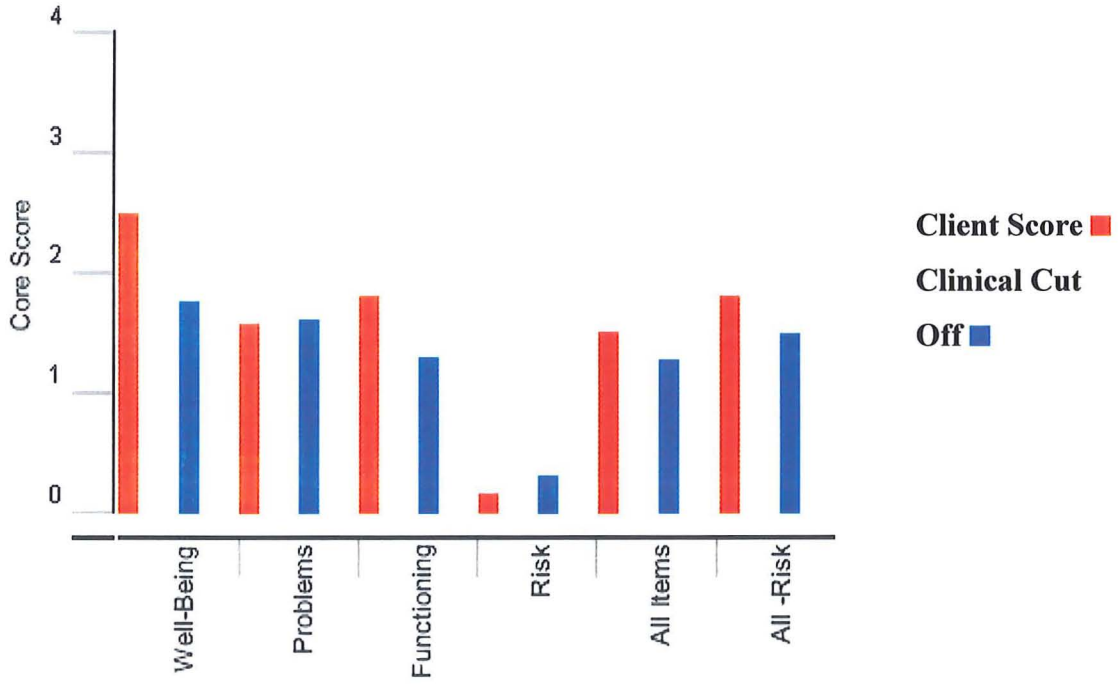

Figure App 2: 7 Assessment summary report.

You can also get data on the client at the end, by clicking on the tab at the top of the page (not shown). Again, you return to the first page by clicking the cross at the top right.

From the first page you can get a graph of outcomes by clicking the scatter plot icon.

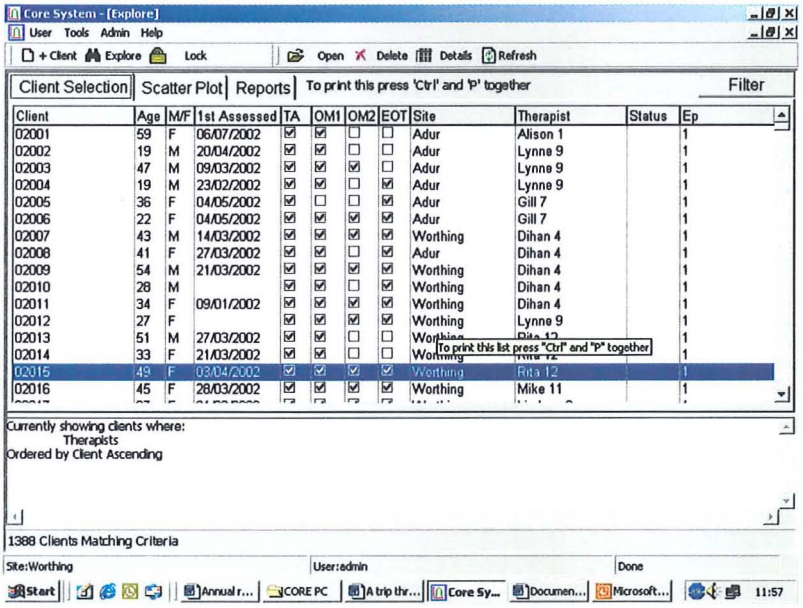

Figure App 2: 8 Scatter plot icon.

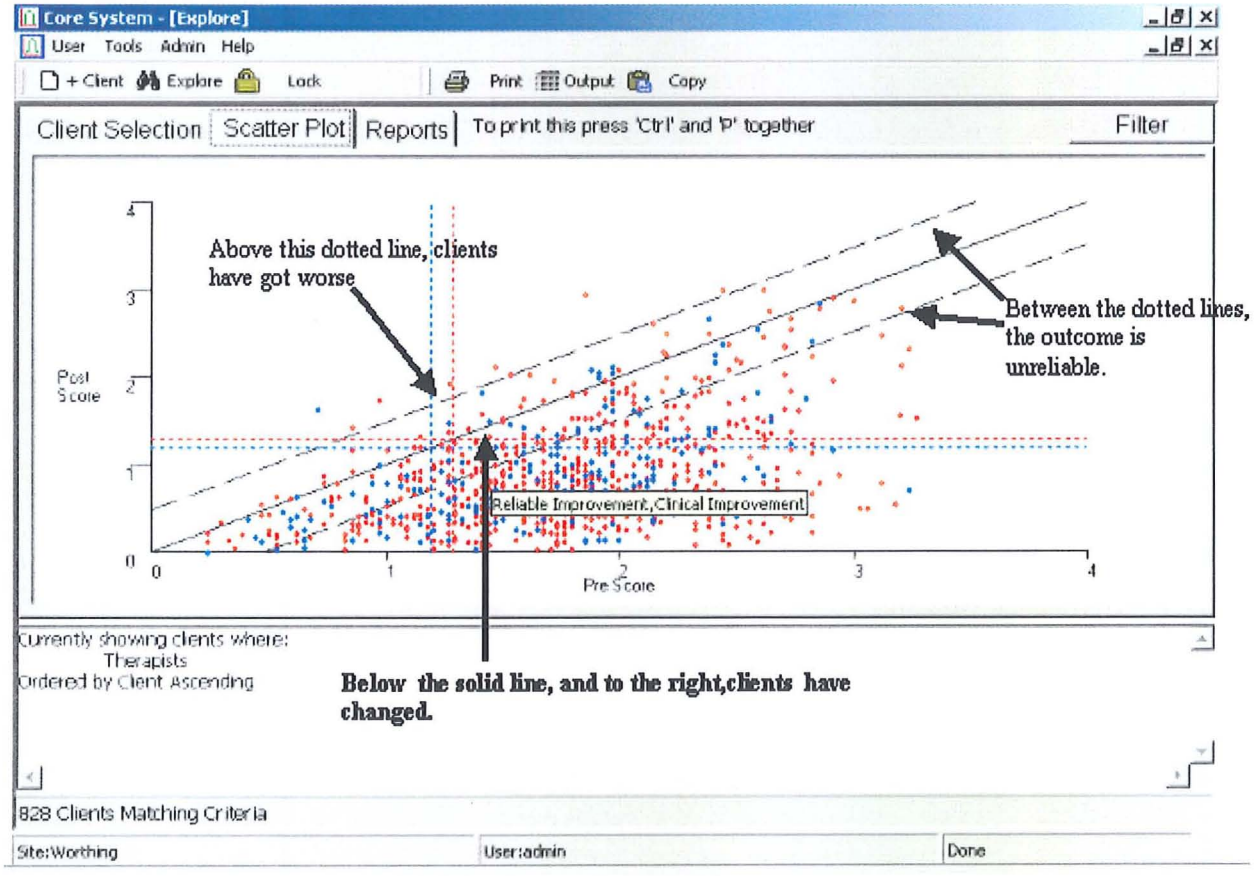

Figure App 2: 9 The scatter plot.

If you place the pointer on a client (red dots for female, blue for male) if gives you their CORE number. Double click and you get to their details as shown earlier.

Place the icon in a space (as illustrated) and it tells you what you are looking at.

Click the icon next to the scatter plot, and this gives you the reports page. Initially this gives you a series of headings on the left, each with a + sign next to it. Click on these and a further set of options drops down.

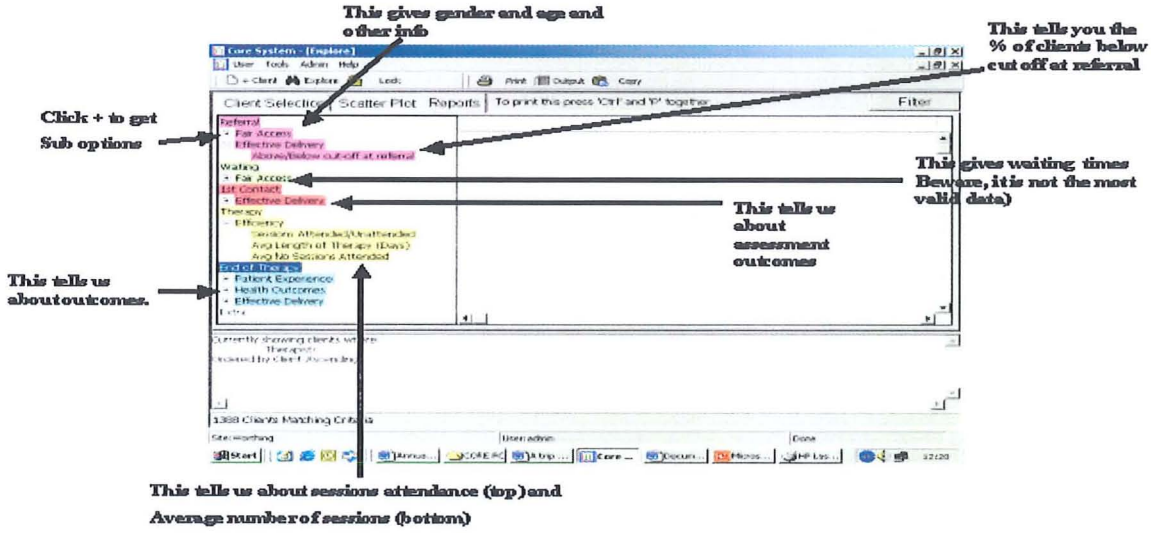

Figure App 2: 10 The options explained.

Each of these options gives information about different aspects of service performance. Fig 10 explains. Data quality info is in the effective delivery icon at the bottom, and extra gives info on problem types.

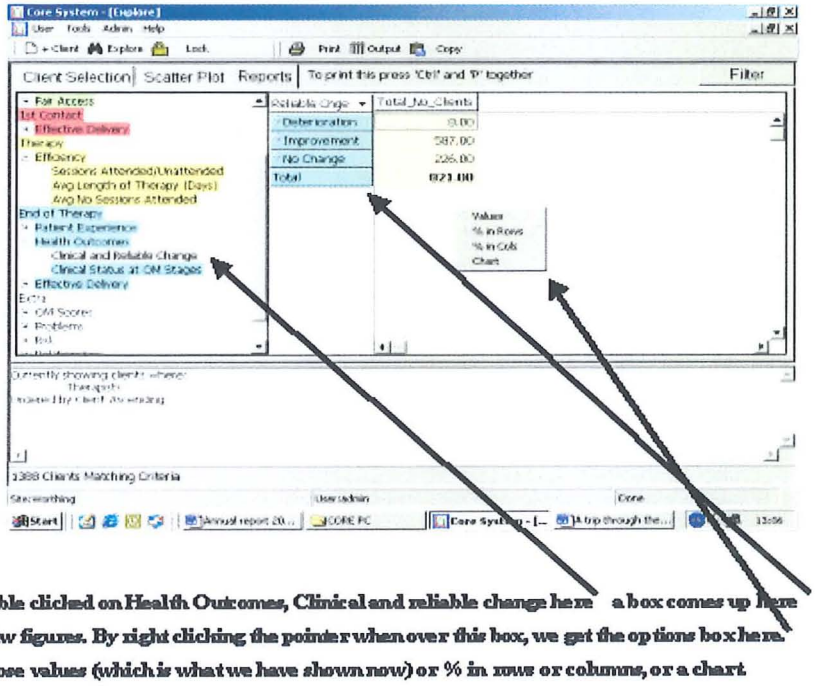

Figure App 2: 11 Altering the display.

I have found that percentage in columns is the most informative. For some data, like problem types, chart is also helpful. For example, if we go into extra: problems: problems at assessment, we get data on the types of problems people were deemed to have at first meeting.

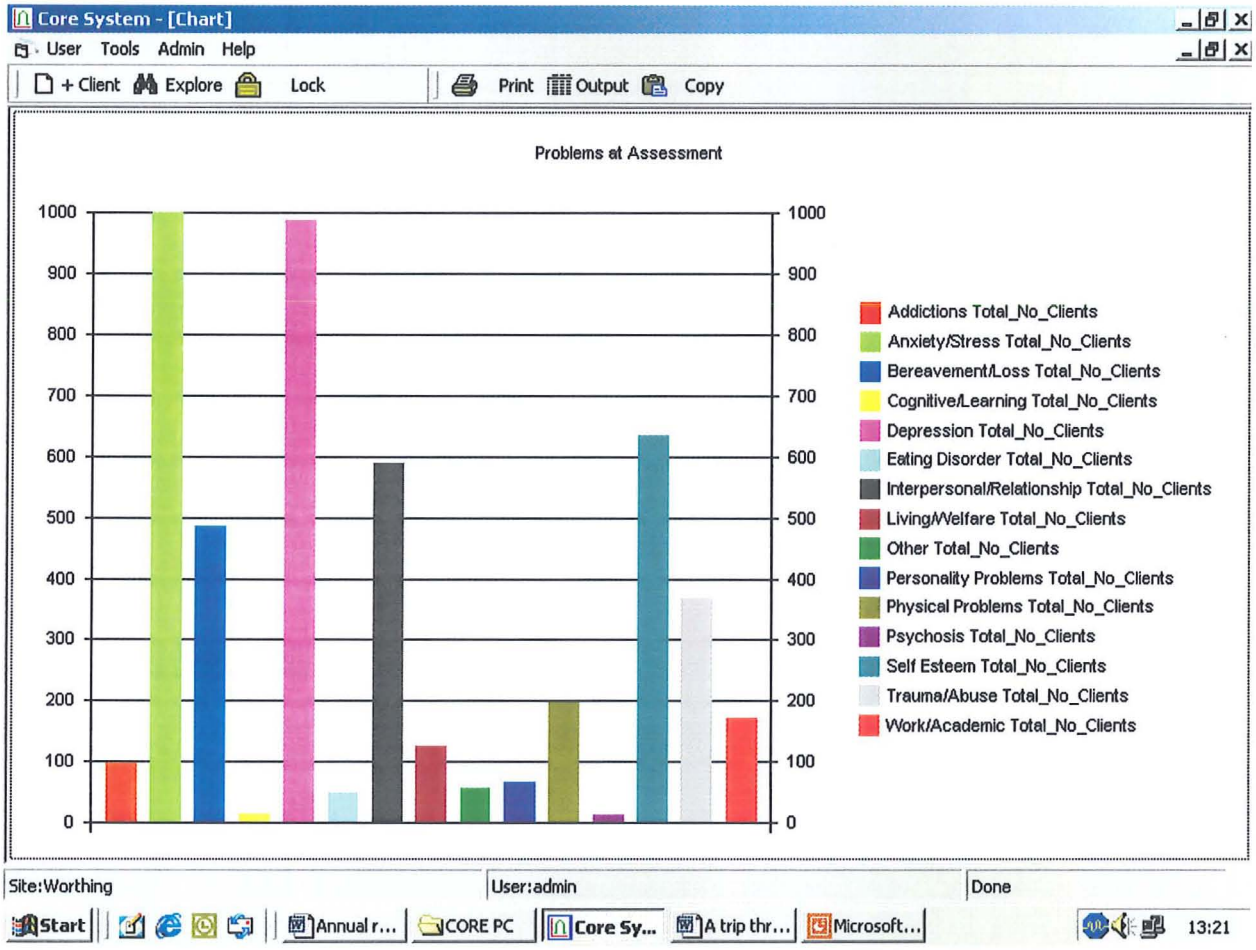

Figure App 2: 12 Extra/Problems/Problems at assessment/chart.

NB: remember that you can print at any point by pressing Ctrl/P together. The print option also sometimes works.

You can also copy onto a word document. I find the easiest way is Ctrl/Print scrn together and paste onto word. You can then edit the picture as required.

There is more, but I think the best way is to just try!

Geoff Mothersole. 11/12/03

Appendix 3 Transcript of focus group 1.

Coding notes: Green = comments on risk policyYellow = gen comments on core

Transcript of focus group 1
27th October 2003-11-04

Present:
GM chair, Tony, Gina, Mike, Dihan, Patti, Mary

Group self selected and remained downstairs as others went upstairs to be in the self directed group. NB: This group contains all the men in the service.

Geoff: sets the scene and gives initial exercise.

M do we then stick it to our foreheads (laughter)

G yeah, yeah…instead of that I'd be interested in what you came up with and what your associations were to begin with

D well mine was a lotus flower, because its used to help people learn and grow, but underneath the water there is the mud, which is the hard work, the data and the unseen stuff — **Nice image**

M funnily enough I've got a lotus flower her too and underneath it I've also got like a rose, which starts out as a bud but is also changing all the time…I like the lotus flower because it brings out the spiritual side..

D that's exactly where I was coming from

G a sense of something emerging.. — **Growth**

M something very young

G and the unseen

D I think that's as important as what you could see..

M mines come out as an oak tree, something solid and reliable and functional..and does it produce acorns (yes) it produces acorns and leaves so there's a sense of something valuable… — **Solidity**

G mine was an owl..a provider of wisdom but that's just the image…slightly elusive..not seen during the day, so if you look at it in so much depth (pauses)

G then…

G well if you see an owl during the day then it will be bad luck, and I was thinking if you shine too much light on the core form that you know…that

PAGE
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ORIGINAL

years, there is a more standardisation of the results that individuals are getting….there's like a convergence which you get as a consequence of feedback…

G we are all using it very, very differently at the moment but I don't know how people are using it, and if we talk more about it we might start using it in more similar way

T I think that what comes out of these discussions is that we all sort of become aware that we are all using it differently, and that we might …you know what's the significance of those differences..it's' very speculative…but over time, we might start to use it differently and the global results that Geoff gets might be different in some way
And you take looking at our service compared t the global figures the national figures, you are automatically giving some comparisons about how we are against some benchmark, but then we could all amongst ourselves do that ..there could be some notional benchmark of this service that we could all hover around if you like, and over time perhaps converge towards it..

eg of lack of common ownership of data

G there certainly seems to be some value for me in talking about sharing the ideas and getting a sense of what other people do…I'm wondering about the convergence bit…sometimes it's the differences that are interesting..that others use the tool in a creative way or in a creative manner that can itself be particularly enlightening…

G how do you use core with your clients…I mean what is it like when you use the core with them when you first meet them

P I find it fairly useful, but maybe I look at it in a different way but I actually can get a sense of where the client is, because in short term work you have to assess fairly quickly, it's not like in psychodynamic , you cant go on for months just finding out bits and pieces and getting a picture, my sense is that you've got to..looking at it as a puzzle you've got to start getting the container, the edges in place, and the assessment from core can be like building that container, can I work with this client in a way that's safe…if they're coming out with a high risk score it's not really a safe area to be for myself or the client, so I kind of use it as an assessment tool

G so one of the ways that you do that is you look at the risk factors…do you look at any of the others particularly

P yes, I go through the whole thing, I actually skim through it initially, and if I pick up high scores I go through that statement

Use of risk score

G do you do that with them before you do anything else?

P Yeah I do actually, what I do is I show the client the GP letter, because they've had no assessment. Where I work elsewhere..
often , initially when I started the presenting problem on the GP letter had moved to another problem, and I'm kind of going in with one thing and kind of 'hang on a minute, I've come because of this'…so I actually start with the GP letter and say has it changed since your GP wrote because some of

Clinical usage

them have been here for about 3 months before they're seen, so circumstances do change, so I start with that and then going with the core.

G Its interesting actually hearing about how other people use it because I ..

General discussion

G its useful to hear bout where you do/do not find it helpful clinically

M One area is where the score is under the clinical level, so when the questions, if that comes out in the overalls score, I'll, you know, and that ask 'have things improved since you saw the GP?', you know, and that gets the story going . Or you might find that they've been put on a heavy dose of anti depressants and then you can start to hypothesis that it's the medication that is actually making the emotions less raw and therefore the score lower so then you can decide whether you are going to continue to work with them or not with a low score using core…its very effective like that.

Clinical use

Apart from the fact that having actual erm solid data there does give you some performance feedback for yourself, which coming from a managerial back ground its one of the things that I've always found very odd that you come into an area of work which is highly personal and there's lots of potential, but you could be doing anything almost ..and it's about having a way of knowing what you are doing…so to me this is very important ..this development….it does give you something to help you hopefully to know what you're best at and what you you're less good at…I expect we all know in some way what we're good at and what we're not good at but…

Explanation for below cut off Score

Reasons for core audit

G Do you look at kind of individual answers to the questions in terms of their you know, the work you're doing with certain people…like I was interested in a certain answer to one of the questions on the core form which gave me a black and white substantial answer to something that we would discuss in the session..

M yes yes…and the risk factors also, it's very important to ask them about the question..you've said this , but what does that mean?'

It can mean all sorts of things, you know, and is the score as bad as it looks, sometimes it's a lot worse than it looks. Yea, it gives you hard data to use. So you tick the box and you can say that "You've said here …" and they respond very positively.

D Sometimes you get the problem as well to distinguish so that if there is a risk factor. The question about wanting to end their life and if they have ticked that, that would be for me, as you were saying, like containment, am I the one that is going to be of service to this person or is this going to be a psychiatric problem. And the other way I also use it is one of the ways you have already spoken about, is the person more anxious, traumatised or depressed. I have noticed that I have used it for looking at what ….. skills I'm going use. We can head from an outcome. Given that we have a very

short space of time I'm looking at, uhm, what am I going to use to move this person forward given that they scored high on depression and low on anxiety. I know sometimes it's the same but I've noticed that as a discriminating factor that's when I use it most I think.

GM So depression, anxiety. **containment**

D Yes

GM And there's something about using it in a screening sense, you're saying 'well is it us or is it psychiatric?'

D Yes, they are my first hurdles.

GM Yea, but also focussing that sense of 'what are we going to be doing together', it sounds like addressing several levels.

D Yes, several levels at once. Because you've only got a short space of time. Only a number of weeks to do it so it's a bit like, you know … I think that's where, you know when you saying about the owl, I think the owl bit comes, for me, right at the beginning and it's quite intense this information I've got. I got to make something of this, but it's really intense, and then you get more of … just thinking about your metaphor.

Gn Because actually the CORE does feel a bit like that doesn't it, because the questions are like this focus beam, all these different bits and for me, because in my last job I asked them to finish it before they came and in fact I didn't discuss it with them at all and I would look at it but I wouldn't have done anything about it unless there were things that really that, you know, leaped out at me and so it's a learning process for me now. An so I have 34 of these and I'm beginning to find that I do look to certain questions, you know, there are certain questions that are more helpful to me than others. But I'm also quite shocked with some people that I have had three or four sessions with them and I look at the CORE form again and I think 'my God!' they have ticked this before and I haven't picked up on it. So it's really interesting to hear how you would look at that and oh yes they've put it in black and white. And they respond really well, you know, when you get the form and you say 'Look you've done, you know, you've ticked this like this and answered this question this way' and how they respond very positively to that.

GM So there's …, Gina, that sometimes later on looking back at what the CORE form had told you and thinking 'Good heavens I hadn't noticed that' or there's something there that I hadn't initially at least picked up on not overtly picked up on.

Gn Yea. That perhaps if I'd picked up on it in that way because they've been talking, it's not such a strong message as actually having to answer that question. That if I had picked up on it, I mean whether I would have done it when I had actually got the form back and looked at it, but at the moment it still feels as if I'm doing quite a lot, you know, working on the clinical cut-off, you know, like this is the first time they've come for

counselling. I'm doing so much.

GM There's a lot of skill development I think in kind of précis-ing what it's telling us, just thinking what does that mean and there are several processes going on at once. Personally I found that really quite complex.

D Then there is the whole thing about the fact that this form for some people as well. And some people say oh well I'm used to forms this is how society runs, and other people I get a little sense of my manner has to be … That's why I initially and still use a consent form because I want them to be able to say look this is for you, you can do it or not. Look this is the form, could you sign a form to say do you want to fill this in. To get over that, oh it's a form about my feelings. Just a thing I've felt that I've thought no I like that idea of a consent form because right from the beginning they are working as much as I am working. And that consent form does it for me, personally.

GM But I think in what you just said Dihan that sense of 'this is for you' and I know I was really clear that I had to believe that I believe that it is potentially of some value to the individual as well as being of value as an audit in the general sense.

Informed consent

Gn Being so explicit about that, that actually it is their choice, do you get people who turn round and say no I don't want to do that?

D I don't think I've had anyone who's said that.

My You mean complete the CORE Form?

Gn Yes

MY One thing, I don't know if anyone else has had this experience, I always stress that that first session is an assessment session to see if counselling is the best thing for them, and it's their decision at the end of 50 minutes whether they can work with me. And they visibly relax at that point because they're very nervous, and I usually check and see how they're feeling about coming to counselling. Some of them are so enthusiastic, others are quite angry at having to wait and we look at that and I say that there is a bit of paperwork to go through and I've noticed certain people's faces visibly drop. I have had some people who are dyslexic and so now if I see their expression I say are you able to fill in the form and quite a few people say "well actually I can't, I'm dyslexic". And so I have to read out the erm .. things. But some people might think they would like to fill in the form when actually they can't. That's the problem. And that's cropped up in at least 4 of my assessment sessions and they are quite happy when they know it can be read out to them. They can think about it.

GN And that would be different again, you know, reading it out rather than saying to you ….

GM Mmm, seems more public doesn't it …

GN Some of the questions – I get a lot of people struggling with these questions and they say "Oh God, these questions are very…(tails off)

MY There's one where a lot of people say "what does this actually mean" I think it's the 'unwanted images and thoughts' and they want to know exactly what that means. But I think that CORE form does focus them, it makes them re-think about where they are and I think it's quite an important point. And of course the risk factor which I look for personally.

Client problems with form

GM What about examples then of either why you found it useful or possibly why you haven't found it useful clinically where there is a sense of direct link, if you like, between the CORE and the person who you are working with.

MY I have sometimes found that the score is very low but the person is actually more distressed. I don't want to generalise too much but I think for me they would underplay how they are feeling, personally that's what I have found, and often when you get into therapy that's a huge issue.

T I have found that it's significant if you get a score that seems very incongruous in how the person is and what they are talking about . Their … report and their verbal report ……. And talking about that straight away seems pretty important, because often it seems to uncover something like the person's process of how they present to the world.

GM Yes

T And the fact that they want to present as o.k. but in actual fact they're not o.k. And they have this struggle to come out with mixed messages I suppose, which is one way of looking at it. That's happened on a few cases. It's an interesting thing to identify quite quickly normally when you're working ….. so that's been quite useful.
And then there was a comment you made yourself once about it being like a short cut …. Being like a short cut to find out how .. their feeling is. Some people don't know where to start and it just makes things flow quite quickly.

Form focuses client

P I've also had a couple of clients which have spent most of the session, which says something about me as well, filling in the form – that's an exaggeration – but it feels like, you know, you can't get into the work and it's almost about their, sort of, compulsive behaviour, you know, they're really digging into each question and then making flippant remarks, you know, and I feel myself thinking 'I don't think I want to work with you'. You know, by their reaction to the form and their flippancy and then finally you add up the score and they've actually come out really high. But the flippancy of answering one and, you know, the length of answering one you think they are going to put 0 or 1 and they are going to come out at 20 or 30 and, you know, two of them once came out at 70 to 80. But already my feelings about that client have been like, ooh, you know, why is she here, she's really irritating me and, you know, she's dismissing the whole thing almost, so I think that's quite an indication of I would have worked with that client because of the way they were reacting.

Score under estimates problem

GM Something about the process by which they are engaged with it that is telling you a lot of information.

P Yea, and it quickly hooks in with my transference issues and then, you know, sort of like ... negative transference that is going on then I think hang on .....

MY I think that's very valid. Some people just tick them through very, very quickly and some people are so painstaking and it's almost as if they're struggling to understand themselves. And some people even say "I don't know, I don't know number 4, I don't know .....

Client style

Obsessing/ being flippant

GM So again, it's highlighting for me the issue of how it's done as well as what's done. How is this person relating to it.

MK It's interesting I've heard so far that you get the OM form done in the session and I don't, I get it done in the waiting room. Because I worked on the basis that, umm, that I could actually influence the – start to influence the score by doing it in the session. And when do you do it? Do you do it right at the beginning? Or halfway through and so rather than .. because sometimes people just want to blurt it all out right away from the start and so I felt well in order to get a measure of all that tidal wave or whatever there might be there if there is one, not always, is to not actually minimise my , umm, my contact with them, to just introduce the form in the waiting room and asking them to do it there and to explain why. And that works quite well here because the waiting room invariably doesn't have more than 1 or 2 people in it.

P I was going to ask about the practical.....surgery

MK But when I'm in a surgery, I'm only in one surgery and again it's usually quiet when I'm there, so that works alright but if there's a surgery involved then I ...

Client style

GM So you kind of adjust it ....

MK I will adjust it if I feel that it's a bit too embarrassing. But I've not had anybody refuse and my perception is that it seems to be working o.k. I'm not entirely always, you know, fairly quite hard to do it that way, but I've felt that was probably the most effective way of getting the score.

MY So do you actually leave them with the form for a few minutes and then come back in 10 minutes or something?

MK Yes, that's right, or 5 minutes. I say 5 minute. 5 minutes I've worked it out is the usual time.

GM There are so many different ways of working it.

MY I always say, you know, please answer it as honestly as you can and take time about it. I say there's no rush about this at all. And if there's anything you don't understand just ask. And that's when that particular one

comes up again and again, uum, but I can see what you're saying.

GM Can we just, uum, move on to the question about risk guidelines because I think that's kind of connected but perhaps in some ways slightly separate. It would be interesting to know what your experience so far has been on that. It's a fairly recent innovation, I forget when it was now – June or something.

MK That's the ..... (five?) is it?

GM Yes, it's kind of using .. scanning the paperwork looking at what the risk score is. If it's above the kind of slightly arbitrary figure of 5. Thinking about it – discussing it.

GN Was it arbitrary? Is 5 arbitrary?

GM It's fairly arbitrary. It reflects a score of 1 or more on, umm, most of the 6 questions. So it means that somebody is indicating something other than 0 on a substantial number of them. But it was a comparatively arbitrary number, was not entirely pulled out of the air.

GN I kind of feel that – I mean the risk thing falls into two categories doesn't it 'harm to yourself' and 'harm to others'.

GM Yes, absolutely.

GN And I think that there are – are there three questions that are to do with harming yourself and two for harming others?

GM Three and three.

GN Three and three. Oh, alright. 'Cos, umm, it feels like if somebody puts 1 for them, it, umm, feels that quite often that they are quite minor. You know, like if you say I've threatened to intimidate him for some reason and put 1 and it comes out they've had a row with their sister or brother.

MK Or a row with the kids.

D Or smacked their child.

GM Mm, mm

GN Yea, but it feels like if they put 2 or more, you know it almost sounds like it's 2 or more on any of the items then that would be then that would be, kind of, something that would alert me to be more mindful of what I should do.

MY If I actually see that they've actually marked the umm, umm, 'physically violent to others' , 'hurting myself', I ask them directly about that situation in the first session.

GM Sure.

MY I just see what .... Often it's not, it's just angry feelings towards somebody but there are times when people have attempted suicide they feel very vulnerable.

D I think that clarification is important because I've had people say ' I've thought about doing it' and I've actually said well actually the question asks .. You know about the physical violence, the question actually asks specifically ... and I think that clarification is really important.

ALL Yes, yes

GM But I think what's particularly interesting is what's that process of kind of explicitly reflecting on it, if you like, and having guidelines. I mean how does that work, how does it not work perhaps.

GM O.k. What I'm interested in is how having a set of guidelines written down, I think it's about 3 pages wasn't it, of how we might react to or use the risk scores. How is that compared to status quo, if you like. How is that compared to what you were doing previously. Is there any difference or is it ...

GN Well I re-read those guidelines the other day and I realised that the first time I read it I didn't take in properly, 'cos I didn't know for a start that actually we should notify you, I think, or a supervisor, I'm not quite sure what it said now, if the score was over 5. And I thought Oh God I've got loads of people who've got a score over 5 and I haven't notified, umm, you. Umm, but that actually I did have in my mind that the guidelines were very helpful in terms of knowing or just reiterating the fact that if somebody has got risk scores, and I always look at them, to make sure that I have done things that I need to do in order to feel safe that uum that working with me is containable and that there's nothing else I should be doing in order to make sure that they're safe.

GM So you kind of go round like a loop and think about ...

GN And the guidelines were useful but I wouldn't but I quite like, well I don't know whether I quite like, but actually just the little kind of checklist of things. In my old job we had a form we'd fill in so actually it was documenting all the things that were quite important to document.

GM Right. Sure.

MY On the first new page now that we have now where we put the time, date and that ...

GM Yes

MY Well I've started to do is if I've noticed they're very high I've actually scribbled on there 'Noted very high risk'. I'll check it out with them and if I don't think it's too worrying then, uum, but I mean there have been people who are at risk from suicide and, I don't know, but I negotiate a contract

with them really. You know the fact that they've arrived at counselling and so if all the reasons for not to try anything again, you know, this is a new era – it's just about negotiating with them.

GM But that again sounds like a very explicit process. That's on the table as it were.

P But it is quite … I've had clients that have acted out as I would say in some harm or suicidal overdoses, and yet when they've filled in their CORE form, the risk has been - they've filled in 0. So I still feel it has to be addressed. The GP's recommended, you know, this person has overdosed in June or whatever and I'm seeing them in December or something or, you know, even though they're saying in the last week they haven't had suicidal thoughts or they haven't self-harmed but they still have that potential to do it.

Value of risk guidelines

GM Mmm, sure.

P So that's when I find the risk score a bit, uum, you know, I'll put down 0 or they'll put down 0 and then I'll just think well actually they probably are quite a high risk really. Six months ago they were still open to acting out.

MY One thing I do if I feel they're at high risk, I check out their relationship support system. They've got 50 minutes with us and the rest of the time they haven't got access to us, so it seems a bit tough to try and draw a contract with them that's even down to the Samaritans. Their friendships and family support systems is what they can do if they feel really low. That's what I personally do.

D I think I'm a bit, well, hyper-vigilant. Two years ago a client came and I'd seen her twice and she'd filled in the CORE form and then she was prosecuted for manslaughter of her 13 year old son and we looked at the CORE form and there was no evidence at all that I could have picked anything up. But if I hadn't have had that CORE form I think I could have been in quite a mess actually. I know that's my point of view but … I think I put myself through enough as it was, every single thing she said, every single thing I looked on that form over and over again saying what did I miss? But in terms of legal matters I don't know. They had it that – they had that form too in the court so they could also make ….what I'd written, the CORE forms, so they obviously had .. it was evidence as well.

Following procedure

GM But in that case, I remember so well, it was evidence of lack of evidence. It was, where I was sitting that the real value for you seemed to be something about the fact that look see what's there, look there's the form, it wasn't there. There was no sense that you'd missed something – it just wasn't there.

Use of risk score

D I just went through it for about 6 months in my head, umm, and it was the last thing that I would have thought she would have done. Because when we talked about you love him, what about love and support? As soon as we talked about that she had scored that she, umm, … you affection for somebody … the child, oh yes my son. She had all this stuff going on "my

son, I have my son", and of course I thought, No support. Interestingly enough what I also do for somebody who hasn't got any support .... I always say o.k. then we can address that your GP becomes your support. I always do that. I've done that for donkey's years. For her I remember saying that too. And it hadn't made sense. But I didn't really look at the little boxes before when I first started but I tell you definitely – and I'm on the phone aren't I "This person's got 13".

GM You are, yes.

D Because it was such an experience.

GM Yes, it really focussed it for you didn't it?

MY I think people are guarded when they do fill this in if there was anything like violence. I mean there was a young woman – single parent – who had huge issues about Social Services removing her children from her. So she was very careful to fill in ... you know ... 'I've been physically violent to others' as low, although she was very angry towards her children but she was going to make damn sure that wasn't down. Because she was concerned about, you know, losing her children. So the risk areas are quite tricky aren't they.

GM Yea, both in the telling and in the not telling.

MY Exactly, exactly. Geoff, in the 'Legal and Forensic'

Di's story

GM Where do you get that from ....

MY ..... a bit more because I rather get stumped at that one. Because I think that this person could easily end up in court over something and is that ... I'm not sure whether that's a legal possibility.

GM Yea, by definition that would be legal.

MY But in what way.

GM It's just asking you to speculate about what the risk is on a legal forensic or otherwise you can go out and commit a crime basically.

MY But in the form we had explaining, it was doing damage to property or something and that seemed to be what was the example.

GM Yes, it's anything that's going to bring them to the attention of the police and/or courts of law, which in our case is usually very, very low. By definition, you know, we aren't a service that works with the kind of people with that headline problem.

MY But if we think that they are then we should put that down.

GM Sure.

MY Because there is a certain percentage of mine where there is drugs or violence that we should put down then.

GM Sure.

MY Right.

MK But it doesn't come out the other end does it., necessarily.

GM I want to re-focus slightly here and again more generally think kind of coming out from the risk issues to CORE as a whole. A kind of whole process, if you like, of gathering the data, the stuff we've looked at this morning and having access to it now yourself on an individual basis. I mean I would be interested to hear what thoughts, feelings, reactions you have to the notion of how it might help. I mean how to you imagine that might be helpful, I'm using 'helpful' in kind of the broadest sense of the word really. I mean you said something earlier Mike about the sense of getting some idea of how you were performing basically.

Clients take strategic approach to disclosing risk issues

MK Yea. I was thinking about, you know, that particular areas of work where one seems to struggle a bit or not quite sure of umm.
I mean very often you have to be selective really. People come along with multiple problems sometimes, the whole of their life apparently is an absolute waste of time and then you've got to sort it out in 6 sessions and you help them to sort it out in 6 sessions. So in a way if they're workable or not ..... You've got to find something you can work with so I guess that we actually – I know I do, I tend to say well I could produce some useful work on assertiveness here, for instance, something I could do to help this particular person. Umm, so yeah, I'm quite interested to see whether the data threw up any particular areas where perhaps I'm not so strong. And also, from the service point of view, what areas of distress are we not really addressing. Umm, there's nothing in the form about addiction, I don't thing. I recently had a client and suddenly you find he's both drug and alcohol addicted.

ALL Its on the ....

MK Yea, but not on the other end though. Umm, and that seems to be - not that I know quite what the question would be – you know, but that's a bit missing. Yea, and so there may be areas of work we find the form actually helps us to identify either individually or from a service point of view that we don't address particularly well.

GM Yes. It's about addressing the gaps.

MK Yes

GM Bridging the gaps.

MK Mm, yea, I think there is scope for things like people who have got ongoing anxiety problems to have groups and stuff like that. Umm, whether or not that should be run by this service or elsewhere, umm I suppose is up

to the fundholders really. Certainly, you know, sometimes, perhaps, we would be using our time more effectively if we did have groups. Seeing 4 or 5 people might be quite useful.

GN Yes. Sometimes people are more suitable for that. Like anger, you know, anger.

MK Anger's a key one for me. (Laughing) not for me personally, but for the clients.

GM Sounds like there's a real resonance for that one. 'Cos that was the issue I was thinking of as well, although not particularly through CORE but it come to mind as kind of a complete gap in provision. The way we look at people with anger problems. So, yeah, there's a sense of we might be able to use this date to kind of, if you like, to identify a problem and marshal an argument.

MK Marshall an argument with statistical data.

D …….. a marshal arts class. Sorry.

(Laughter)

MK That's right (still laughing) yeah.

Gap in form?

MY But I'm sure we all have a certain type of patient who we enjoy working with much more than others.

MK Mmm.

MY And for me personally, it's not so much the difficulty but the person .. their approach to their life and the counselling that makes all the difference.

All Mmm

MY You get people who are a dream to work with and, like you said Mike, about people whose lives are completely in chaos and every week it's almost like day to day stuff and you're sort of unravelling all that 'cos you feel that ultimately the value is working in the little psychological baggage, not the day to day practical stuff. Which some of them are almost begging you to help them with.

GM Mmm, mmm

MY And that's really hard. You know, you could work for just so long. And you just have to pick out … what they can take away really.

GM Mmm

GN I wonder if the CORE is useful, you know, in terms of helping you highlight that somebody's life is so chaotic that actually they are not in a position to make use of what our strengths are.

ALL Yes, yes

GN You know, actually saying look we've come together to look at the kind of psychological, umm, foundations on which all this chaos is kind of like heaping up. And actually maybe there is some other kind of setting where you can address the .....

MY But isn't that the .... view that we have to be able to help them so they ..... unravel .....

GN Yea, unravel

GM So what would we be basing that on, on like the kind of like the CORE score, you know? Because I've often wondered well what about those people .... 80 or 90 ... who seem to be getting a huge amount of pain and chaos and ...

T But I think there is some value in looking at the individual categories of the measures because you've got the well-being, the problems and the functional. And I mean, I haven't really done it much yet but I'm starting to think in terms of well possibly if their problem score is very high but their functioning score is quite low it might indicate that they've got a lot of problems in their life which they are already functioning quite well in. Or maybe their functioning score is quite high ..... therapy ..... a change of circumstance but you can change how they cope with the circumstance. Perhaps the value of looking at the individual indicators like the well-being .... A person might have a particularly bad sense of well-being yet they might not think that their problems are particularly bad. It's kind of what might that mean for that person. Maybe it's a first indicator of an area to go and explore as to why the well-being score is bad when the problem score is not particularly bad. Or if it was the other way round, what might that mean.

GM So there's something in there about using what the CORE ..... and our other perceptions and kind of comparing and contrasting in a way. And picking up if there are themes or inconsistencies you need to explore.

D Because you're using all these cues all the time aren't you. You know, Like what you said about the way they fill in the form, their appearance, their lack of eye contact. So you've got something. Quite a few cues that either will be reflected on this form or not. And then it's the 'or not' that's like the mud. It's just as important as the ...

GM Yes

MY Because we have the so much bigger picture that what's on the ...

Use of core to screen

GM But what about that notion that Mary was raising that seemed to be something about looking at well 'what do I do well and what don't I do so well' and maybe adjusting ....

P Well I was just thinking going back to the previous question about looking at our own data on the computer. Well I went through it with you and I saw areas where I found I could improve on and I thought that was quite beneficial. You know, a type of client that I thought I was doing o.k. with, and actually I was on my score, but I could see there was scope for improvement because another type of client I was actually doing quite well with, and that type I was struggling with so it was sort of like you know I think to have that …… makes you sort of address your own bit in the room and what's going on. And also what more training you can do 'cos you know you can never get complacent about, you know, doing more training or more development ourselves and what is going on with our own stuff as to how we're working with these clients. I just thought I'd say that 'cos I thought that was important.

GM But again, there's something really important in there I think, about taking what it's telling us and thinking o.k. what are my developmental needs, what are my training needs or to think….. how I work on that kind of problem.

P Yes.

GM I certainly think it's got a huge value there.

Break while tape is turned over.

MY ……. really, and I find it so hard ….. don't know how to express themselves or who aren't psychologically minded. But I mean with the … CORE…… to enable you to get someone to express themselves. Because that's hard, they either can or they can't. And also to be psychologically minded …… I know that's where I come unstuck.

MK You are only able to go as far as the client is able to go really.

MY But then can you turn around at the end of an assessment session and say 'not suitable for therapy because unable to express themselves and no psychological mindedness'. It's almost like, I don't know, it goes against the grain.

GM How does it tie down to .. how would CORE inform us on that one? I mean would it inform us on that one? Thinking about the first session. Were they, for a better description, psychologically minded or suitable for counselling or however you want to express it.

MY It's also only our opinion ….

GM Well it's what we're paid to do …

Laughter

MK I think when there's an under-clinical score, bearing in mind that I do realise that an under score doesn't mean to say they haven't got problems

realise that an under score doesn't mean to say they haven't got problems, so I then I don't .... people automatically so .. I had one the other day, a chap and err I just – he scored about 26 – and I just thought oh I'm not too sure about this one and so we talked it through and in the end I thought he just had some – I think he actually improved – I've found he's actually developed coping skills that were going to help him with the problem he was talking about. And I just put it to him in the end "Do you think perhaps you've got the skills now. You've done this, you've done ..." so it was, what do you call it, careers advice I slipped in because it was related to the work he did. So I put it in. And (quote) "Oh, Oh yes that's good" and, you know, he'd put himself in a stressful situation and then realised that's what he'd done and I just said that to him and that was enough really. Because then I said do you need to see me again "No I don't think I do". So we came to an agreement that he didn't need me any more, rather that 'right you're out the door mate'. But it is difficult, I think inherently I feel that we all feel that we've got – we're the ones who can always make the difference. And therefore we've got to stay with this client

Use of fb To reflect on pratcice

MY .... high score and you're aware that it's going to be difficult working with this person.

MK That's the other side of the coin isn't it.

MY But it's not so much to do with intelligence 'cos you can do wonderful work with people who have quite a low intelligence. You know, imaginative stuff. It's not that, it's something else.

GN Well counselling does have a culture doesn't it? You know, like the way we're talking in this room is not the kind of way a bunch of people would be talking in a different room. In a different kind of set up. And sometimes I do find that a real challenge. I think God, listen to myself, honestly!

Laughter

GN It's true.

MK I think, like, in certain err model backgrounds you know the whole concept of assessment is taboo. And if you come through that type of training then to actually even be thinking about assessment actually takes a lot of getting over. And I think that's part of – but the CORE thing can actually give you something more external can't it to look at and think well hang on a minute I'm paid here to do a certain job and you know ..... bring that into play here.

GM So what are the features that we're looking at I think it would be really helpful to kind of name those. What bits of the CORE profile are we looking at when we're thinking assessment and questioning the issue about is counselling appropriate or not. I mean I guess there are various ones that come immediately to mind.

MY Ability to express themselves.

GM How would you be ringing that in CORE.

MY A certain amount of self-knowledge to start with.

GM Right. I don't see how you would get that from the CORE answers.

MY No, no you wouldn't get that from the CORE answers.

GM Right. O.K.

MY Well they might struggle to fill it in in the first place. You'd pick that up.

GM Yes, there might be an element of that process.

General hububb

P I think they find reading the question right, what you're asking Geoff, but are you asking what benefit ...?

GM No, I'm just interested in this notion of making an assessment and how the kind of CORE data that we have on a first interview, where would that fit in to that process. You know. Would you be thinking of, for example, the overall score, below the cut-off, err the risk score is something else that comes to mind.

MK For me it's the overall score, and the risk factors – really that's where it mainly comes into play I think.

ALL Exactly, yes.

GM And the bit that you kind of hit on there Mary was something about the process, the way in which the person ... it's a bit more nebulous but it could be quite enlightening I think.

T I actually think it's very enlightening. I don't do it too obtrusively but I do actually try and look at how the person goes about it. And study the way they ..... Because there's one client who sticks in my mind whose clearly very depressed with a huge amount on his mind and he was very distracted and took a long time to fill the form in. And his whole demeanour and manner in which he approached it was giving out a loud signal. There was another client who again took a long time to do it but because they got confused. They kept asking me questions and would tick a box and then not be sure, then ask for clarification and then tick the other end of the range. And the whole thing was chaotic. And it was telling me that this person is very chaotic. You know, they were kind of acting out a little sample of what they're like in their world just by using this form.

GM Yes, sure.

T I wouldn't say it happens on every person, some are completely unemotional but there are some who do give you quite big signals.

GM Absolutely.

D What about the odd one that's been so distressed there's no way I'd ask them to fill in the form. Although actually, that person has usually been someone who I immediately re-refer back straight away to the GP. Because of their level of distress. When I think about it. This lady was suicidal and there was no way I was even going to go there with the CORE form. I've had a couple actually – not that they've refused – but it's the fact that I wouldn't even say ' by the way there's a form'. It would be the clients that would come in and on the day have actually told me "I feel like going out and putting my car round a lamppost", and you think well aren't you glad you came here.

GM That's where your priority is.

D Yes, and you think, I think I need to talk to somebody else about this. I guess that's quite stark.

MY So you refer them back to their GP?

D I'd ring their GP. Well I've been fortunate in the fact that I work at a GP surgery, so I usually just collar a GP and say I've got a client here who needs some help pretty quick. That's because I'm in a GP surgery so I'm fortunate there.

P Would you use a GP even if the client wasn't at that surgery?

D Yes, if they were suicidal.

P Alright, yes.

GM Needs must

MY Would you explain to the patient what you're doing? Because you're concerned about their welfare.

D Yes, yes.

MY What if they got very distressed at that. They came to you for help and then ...

D They came for help and that's it .. I think they were telling me "Sod the counselling I'm going to put my car round a lamppost". I think at that point ....

MY But there is an expectation there like a light at the end of a tunnel.

GM I think you're raising an interesting question. I think it's an ethical one but perhaps not to go into too much detail now.

D It's rare and I'd use my professional judgement because the other thing that happens to me quite a lot, and other people have voiced it, is that you get people with high scores, I'm feeling a bit ambivalent, do I keep going or do I pass this person on. And it's that feeling of I'm holding all this concern for this person, and if it's to me dead obvious, I think I'm not holding all this on my own. I don't work on my own, we're all part of a team. Whether I ever hear or see the GP at all, for me it's not losing sight of the fact that I'm not the only one in with this person. It's my support system as well as they have a support system. So at those times I've thought I'm not carrying this concern all on my own.

GM So there there's a sense of rapid assessment. Like I'm not even going to bother with the paperwork because there is something so important that it prioritises above everything else.

D And thankfully it's rare.

GM Sure, absolutely.

D But then it makes you wonder about the types of referral from the GPs. All those sorts of questions are begging.

GM I'm really interested in picking up this notion about how it might

be unhelpful, I mean how this whole process of, you know, clients and filling in forms and all the rest of it, and then kind of getting the feedback that we were looking at this morning. I mean where do you think that might potentially go awry. Where do you think that might be less helpful than helpful.

T Are you asking how can the information be unhelpful, is that what you're saying?

GM The information itself or what we do with it or the implications behind it, I mean yes it's a fairly broad ranging question.

Long pause

D I think if you're very self-critical there may be an element where you could actually use it to beat yourself up.

GM Yes, yes. Picking out the figure that best shows how poor we really feel with ..... yes absolutely. Personally I think there's a huge scope for that if we kind of go down that road with it.

D It was interesting as well, what he said, the guy who came to talk to us about it. The figures of effectiveness shown were how you were on the day. I'm not really gobsmacked really I thought ...

GN I don't understand.

D ..... *(the name of the person)* he spoke about the effectiveness and apparently counselling .. it was how the counsellor felt on the day.

GM Right. John was referring to some other research that had been done that was showing that how the counsellor's mood on the day correlated with how effective the session was, reached by all sorts of different means.

GN Oh, right.

GM Which was stark and somewhat enlightening.

T I suppose that would imply that we need to fill out the CORE form for ourselves really ...

Laughter & amusing comments

GN Actually I do have a thought when I watch people filling out the CORE forms, thinking I must fill this CORE form out myself every so often.

ALL *General agreement & talking over each other*

MY Like some days you're aware you're more passive and some days you're energised, you're more challenging. You're almost looking for different things depending on how you're feeling.

GN Yes, I didn't have a very good day on Friday and I thought, Ooh I haven't done very good work today so it's funny hearing you say about the mood of the Counsellor on the day. Because I had a new person and I thought, ooh I don't know if she'll come back. But I think that was about me and not about her. I think if she'd seen me earlier in the day or on another day, I think it would have been really different.

P I suppose it's about our own projections isn't it? What's going on in the room. Perceptions of what we're projecting in our own stuff, projected on to the client and the client work.

GN Yeah

P I was just thinking that if we were quite anti the CORE ... stuff ...

Laughter

P Like, I actually do want to see you but you're pissing me off because, you know, I've got to fill this form in before we get down to work or something. I suppose ....

GM Certainly there's a danger ... we haven't pro-actively gone down that route, but I think the whole thing could become a nightmare if it was done along the lines of "Look we've got to get this paperwork out the way" ... it's a message we're giving to clients that is so weird.

P Yeah, it's like we're don't care about the CORE data so don't worry about it yourself. And then you don't get a true understanding of the client.

T I think when I was beginning – because I started here – it was a placement when I was a trainee – my very, very early sessions, I was very conscious of CORE ..... it actually, in fact, ran counter to some of the teaching that we had. And I felt that I had this, sort of, opposite set of err, err, guidelines and rules about how I should be approaching a session. And I felt quite anxious and uncomfortable in those early sessions as to how I do this. And it took my some while – some weeks – to settle down and I had to sort of – I put a lot of conscious effort into thinking how can I integrate this into the flow of it all. And for me it was about the flow.

Misuse of data by couns

GM Yeah

T You meet the client and it's like the second by second by second of an unfolding of the relationship, of the engagement, or something. And how could I take CORE simply like something that was a distraction, like a junction that would break the flow. How could I use it to like increase the flow. So gradually I – so now I don't feel worried, I think it's o.k. and I feel now that I know when it's the right moment to mention the CORE form.

General agreement.

T My aim is to do it in the first two or three minutes but sometimes it might actually be the first fifteen minutes. If that's the way it turns out to be. But I don't let it hang me up too much, as long as I do it relatively soon. But I like to feel that it hasn't disrupted this engagement process because if you get to the end of the first session and you haven't got any relationship, you're unlikely to see them again anyway.

GM That's right. But I really like that image of it becoming part of the flow rather than an obstruction. If it's part of what we're doing then if it's weaved in there rather than like something that gets in the way.

P It kind of came at the right time for me to do CORE forms, because I have been working in education as a college counsellor, and every year we had to justify our unit budget and there was no actual data that said that we retained students on seats. Which is what they wanted, you know. So it sort of came at the right time because every year – I was there for six years – you kind of, you know, write these reports saying what a wonderful job we're doing in the unit etc. but actually it would always come back with 'ah but do you know how many students stayed' on at college due to the fact that they came to the counselling unit. Which we didn't. So when I came here I thought, you know, that would be good actually, I don't have to justify ..... with huge annual reports, you know. You've got it there.

GM I do.

Laughter

GM It's certainly an easy job when you just have the figures there.

P Yes it is, yeah.

GM So anything else in terms of worry about the unhelpful – this issue that struck me as terribly important about like kind of using the information to 'beat ourselves up' which I think many of us, if not most of us, are familiar with. Anything else that comes to mind?

P I would imagine, as human beings, we're sort of looking at what we're good at and what we're worst at. It's those two extremes that we ..... be most fascinating. For me personally, both sides. Not just one or the other. We might have a pretty good idea but we might be wrong of course.

GM Indeed.

P So we might have a few surprises.

GM I suppose one of the things that struck me just in looking at it so far is that I think it's quite easy to get hold of a piece of information and not see it in context. And you kind of see and you think, oh God, I'm not as effective as other counsellors. And then not look back to well actually I'm dealing with people who might be arguably more trouble, for example.

General agreement.

GM Just because of the random throw of the dice of chance in the year when the figures were gathered. I suppose to me, it's not necessarily unhelpful but the way we use it, if we're not keen and clear ..... always come back to the context. Then I think we could get some unhelpful kind of impressions of what we're doing. When we are, actually, fairly accurate.

MY I never thought about the aspect of comparing with other people so much, seeing what it would bring out.

GN Oh yeah, and the idea of our Manager having more data on us ... ...

General murmer

P It also brings out the sibling rivalry

Laughter

P No, I'll stay clear of the sibling rivalry. I'm quite happy to know what I do not what anyone else does.

GN But it's true isn't it. It could be used as a management tool.

GM Absolutely

GN I mean could it be? And is it robust enough? You know, that's the other thing. You might get someone who is really coercing their

the other thing. You might get someone who is really coercing their clients in a way. "Fill this out, this evaluates counselling" you know

"we've done 6 sessions and now this is the end, you know, but be honest .... "

Laughter

GN But others are a bit more humble in the way they operate, you know. But they might be the one who is axed as a result of the Manager having this information so ...

D Oh, my goodness ...

MK Oh no ...

GM Yes like any tool it can be used in a really crude and destructive way.

GN Or, also, further up the chain, it can be used by the PCT to say "Sorry, you're not doing well enough. 72% of people have improved. But what about the 1% of people who have deteriorated, what about that 25% of people who didn't change".

GM And, just to give an example, rather naively in the early days when they did the first CORE audit right at the start, they came up with a ridiculously low number of sessions that we were seeing people for. I didn't realise, until 2 years later, they took this number of sessions and put it in the budget. So they were expecting us to be seeing and counselling clients for 3 sessions. And there were all sorts of questions about the budget. I couldn't work it out and then I realised they were making the assumption that we were seeing each client for three sessions. So this was the feedback they'd been given.

GN And we are a service within the NHS so we do have context but there is tension as counselling as an activity that goes against that grain. You know, when we actually see people we go 'yup you can come into our service because you've got a problem and we'll fix it for you and off you go and here are some pills' you know just doesn't work. It doesn't work like that. And CORE might be having one of those as one of its presumptions or assumptions.

GM Sure

T If you think how much stress league table cause other professions like teaching and there are probably others, they are published in newspapers.

All General agreement

GM Very punitive ...

T It's terrifying, I mean I don't think anyone is suggesting it but potentially this type of mechanism could be used and that worries me.

GM Yes, because I remember signing on with a GP when I moved area and they said "Oh well we might not take you one it depends how ill you've been" you know how ill you're likely to be. I was a very healthy person so I thought what about people – "no you're not coming on our books because it costs us ..... and affects our performance records.

ALL General agreement

GM Yes terrible isn't it. Cart put before horse.

GN So there are political downsides to the Core.

T Probably not many people know that there is such a measure like this for counselling, it's so new. If you give it five years on and the amount of press there is about counselling and money you do get some negative articles in newspapers about ... and counselling and so-forth. Once it becomes more widely known that there is this measure out there, there might be people start going looking for it. I mean are our figures published in a public sense or not, I don't know?

Anxieties About Comparison etc

GM The overall service figures are fed through to the PCT, so far...what's the word? ... in a very filtered fashion..... effectiveness figures and all the rest of it, and it has been a very positive process. In the sense that I give them the data and say give me more money and they say fine here it is.

MY ... beginning to get more money because we're doing particularly well? Because we're already quite proud of certain areas where compared to the national average we do very well. So already there is that ..... going on.

GM ..... who does what with the information is always terribly fraught and needs to apply to us as it always did.

Pause

GM Now we've just got 5 minutes left and I'd really like to give some space to the question on what else you'd like to get from looking at the Core data. It's a speculative exercise in a sense. Some of you sat and looked at your individual profile and all the rest of it, but what do you imagine getting something back? What comes to mind?

GN I'd like a report every 6 months on paper isn't that terrible?

GM Why terrible?

GN Well terrible because it would be really practical and sort of fit in to the way I audit my practice over the years. Or maybe once a year or something. But I'd also like to have something that I could feed back to my GPs in the practice that I work in. Er you know on a personal level the people I meet in the corridor and you know just some way of feeding back about how many people I've seen and how many people have actually found it useful.

GM Yup, yup absolutely.

MY Confirmation of validation.

GM There's also that thing – that rather messy slide I showed you this morning also highlighted the number of people you see. The number of first appointments, effectively.

GN Although sometimes that looks kind of paltry really in a sense you know ... You think God I've done a year's work and that's ....

ALL Laughter

GM Again everything you highlight begs questions. OK something concrete there, now what else? We talked earlier about highlighting CBT issues basically of learning needs and training needs.

MY I think we're at a very interesting point at the moment, to be involved in counselling. It's quite special to be involved now at this great transition stage isn't it, where it's all going to be accounted for.

GM I certainly think things are changing hugely.

MY And we don't quite know how it's going to be changing.

GM No, that's right.

MY We're all just ploughing forward and hoping for the best.

GM Well, and we're also part of changing it. That's the bit that excites me that we have control over that. If you like we're the people although never totally in control, we're the people who can define the turf or at least have our mark on the turf.

MY And presumably the people who don't like this will opt out of the profession now.

GM I don't know. I wouldn't like to predict. Certainly there are areas that will become very, very important.

P They probably won't opt out, they'd probably have to do more training to come up to certain standards. That's something that will

come from Core really, good standards will be seen, shown and adhered to really.

GM Certainly, I hope so.

MK Geoff, in terms of what it tells us do we categorise the problem areas of the clients?

GM Yeah, yeah

MK What sort of categories are they?

GM Oh, Anxiety, Depression, Trauma, Personal blah, blah

MK And that's taken from the OM is it?

GM Um, it's taken from the Therapy Assessment Form

MK Only?

GM Yes. And that again is showing us a whole interesting heap of data because now we can start to look at how effective we are with particular headline groups – whatever that means.

MK Yes, that goes back to what I was saying.

GM Yes

MK It doesn't mention Anger as a specific – I often use the spare box for anger because I think there are certain people who have just got this issue.

MY Personality Problem.

MK No I think that's more subjective

GM We can pull out all those areas and start to look at how selective the groups are

D I'm quite interested in the effectiveness of the clients who are on anti-depressants in counselling and those that aren't.

GM Absolutely. Again, we can do that. You can filter and see how effective we are one with the other. I kind of looked at that briefly and there wasn't a massive difference, which surprised me actually, I thought there might be. But you can look at all these questions collectively as well as individually.

P And also how long they have been on anti-depressants before they come into counselling. Because if it's over 3 months, you know the anti-depressants could have kicked in their world appears quite different.

GM Yes. There you go.

GM Time is up. So can I again thank you. I really appreciate you giving this time and I hope you also found something useful. That was certainly my intention, this isn't a research project in the traditional .... It's about collectively thinking about making a difference and using some of the ... so I hope to continue the discussion. Would you put your stickers, your post-it notes. I'll make sure I've got them all in that folder. I'll get the other group in, just very briefly for a just a 10 minute plenary just sharing what people want to share and then we will stop for today.

T & GM Discussion about whether tape should be kept running.

GM ....do appreciate it. I think I was saying before that as well as a traditional research project I think this is about a kind of sense of how do we move forward and how we actually make something happen rather than the old model of researching and then going away and analysing data ..... So I mean it could be useful to just give a few minutes for anything we want to share umm anything that arose for you. There is no expectation on my part that there are things but I would be interested ... We are being taped by the way, just to be clear about that ...

Gill Your question doesn't reflect, you know, we didn't get the opportunity to discuss where the material goes from here, you know, how you use it. Maybe there'll be another opportunity to say how it can be used. I know that's your brief but maybe it could be ours as well.

GM So how to take the whole issue forward. I certainly would anticipate at some point – it's a bit of a cyclical process – it's like I go away and think about it and then come back to you and share some ideas and something will emerge if you like, as a next step. Probably some sort of questionnaire ... to follow up, and keep mining this idea about what do we do from here. But I would anticipate at some point trying to get a group, or groups, like this back together and think o.k. so six months on, or however far on, where are we now? What do we do about it now? So there is certainly a sense of process, you know, in my mental map of the exercise.

CAR It's like you said – it makes us question things doesn't it? And ask ... to look at things.

GM Brilliant

CAR And perhaps that's where we're meant to be at this stage.

GM To me absolutely. To me that is absolutely what this is all about and if we go away questioning, and enquiring, and puzzling, and thinking well hang on a minute what about that? what about this?

PAGE
MISSING
IN
ORIGINAL

Transcript	Comments:
GM: sets scene, begins tape and retires from room to run other group.	
The group begins with the specified exercise.	
Y are we supposed to discuss these or just stick them on the wall?	
S well shall we stick them up or perhaps we could?	
Y Oh!	
G Isnt that interesting …(inaudible)	
Y yes	
C Perhaps we could..	
G definitely the same sorts of …	
Group put up post its and compare.	
S an owl? (one of the images)	
G yes	
S interesting..	
S Because we cant see, shall we just each read our own out..	
V and then discuss it…	
Agreement and some laughter followed by some general fumbling.	
V (inaudible)	
Y shall we just go round?	Great
S I have mine as an owl..wise fragile..an inquiring mind, and sometimes vomits horrible bits…	metaphor
Laughter of recognition	
C That' good.	
G Ive got an owl too….wonderful wise and it provides a watchful overview and sees all around.	
V I had mine the other way round….I have mine as grass, its boring, its predictable, it's a tool , its something, something that we all need to have.	
Y A rose..a tight bud to begin with, opens up to different dimensions…but	

doesn't reveal all!

A I put a Marigold, I was thinking that at first sight, not very attractive but utilitarian and very useful.

Comment: I think I agree.

C I put a fox cub, it could be new and exciting and also unsure about trusting data to be used in an accurate and helpful way.

Y Yes.

Inaudible

C I suppose one of the reasons I'm sceptical is the misuse of statistics. I've had experience of statistics, which were misused.
I think its good to measure things, and also necessary, for research and things, erm can be misused and lose the subjective

Y yeah

C and that data can be, I think it can be misused…has to be in the right hands…and how subtle is it…
I immediately look at how big a drop it was, and whether it was, you know, the clinical drop…how big it was percentage wise..what was changing..I would be much more interested in looking in a much more complicated way, refined way

S I think that potential's there though that makes it that much more interesting…it worries me this wonderful thing that data becomes fact, that then becomes another truth, and all it can do is get us to ask more questions I think.

Counter 100

Y I guess my concern is how I use it. For me the worry is how its interpreted out when it gets out, away from me, and and that is a concern and I think and I think we all sort of picked that up..so there's a big part of me that's thought well I'm not going to worry about what's out of my control which is really …were I younger I wouldn't have done.

Public nature of it

Control issue

C (inaudible) ..experience of it being misused

Y Yes and If I were younger I wouldn't have that view.

S Is it younger or is it something else?…is it about confidence

General comments: about knowing who we are and 'career prospects'

V I don't see it that way at all, I think it's a tool about keeping us in this job because that's what the government wants, they want to see figures, they don't want …they want to see if it works or it doesn't work …if we can

prove it, it safeguards our career.

A There are sanctions...I also believe (inaudible)

V I mean I was dead against it when I was first introduced to the idea...to just go to somebody...something just in black and white...it's difficult..it just gets my impatience.

Y mm, yes its difficult ...but it has a lot of importance.I don't think there's anything else that can do it. I'd like to take up your point about the positive aspect, because again like you when I first came across this mainly I thought it was to be used to analyse and it would be all pointed down to me, ummm that made me feel a little bit anxious especially coming from the teaching profession where all this stuff about SATS and tests I suppose were really being used to bad mouth the teaching profession very largely...umm..whereas the impression is that especially at the moment it is being used in a positive way with the analysis., Data's being used to prove a more positive point but maybe, maybe because I'm comparing it with something that really was very negative I'm feeling positive about it at the moment in what it does show, but my image of the rose opening up I think you know that's been my take on it, it does open up new dimensions around the client ummm but I think, you know, as we've all really been saying surely it just doesn't reveal everything, it just doesn't reveal what goes on in the sessions and what goes on in the relationship...

S I think that's really interesting about opening up, with the client...about the focus with the individual client particularly on what's changed and the importance of change and the meaning the client attached to that change, for example I read earlier on about a client who became more irritable and from the CORE point of view that would be negative, but she said "I really need to be more irritable and that's my path...to be more assertive..and the meaning she attached to that was so valuable"

A It's almost coming out of a repressed need isn't it?

S Yeah yeah...but when people feel big change as well they get very frightened...I photocopied some for clients, they wanted to take it home and share it with a partner ... I found it very positive.

C Having said that I am concerned about statistics, I still try to use it regularly. I had someone recently who'se got really excited and I showed her the before and she said "was that me"? you know, so I think, I think it can be useful.

G and also the point that lots of people have made about how they put one thing and you find another, when they've put 4's and then they've said they didn't have problems...it can be used creatively there...

C but I'd quite like to see that bit more integrated...it's quite easy to think although we know there's other...this is what we're concentrating on. I'd like to see more, some way to include the contradictions...I'm just concerned that things might be too simplistic...

Y so maybe it needs to have something..even a tick box for the counsellor to put whether this is felt to be a true representation or something that could be worded in a straightforward way to bridge at least some of the gaps..cos I've often felt the need to write something at the end, cos I think this isn't a true reflection the client said that and ticked that box because she's recently become pregnant and therefore tearful or something.

C yeah it's a difficult thing isn't it because it presumes that if you're in pain it's a measure of your psychological well being

G so really you know the bit where you fill in 1 2 3 and 4 ..really wouldn't that be helpful if that was changed and therefore you had a space there to relate to the other score …it would somehow tie up more closely or more logically in the way that you were saying ummm

C Using the same box almost?

G yeah

C that would be interesting ..also in reality that's mainly what we do I mean when we go through it at the end, we discuss it with the client…we are actually making our own assessment..you know, we are looking at it and considering it, it's just more integrated in what actually happens.

S for me it's like at the micro level the client we use it as a tool and I find it very helpful at times, and then there's the political issue of audit or relevance in a way..I think it's important to try and keep them separate really

G yes

S the information going to the outside world that's not you know rich enough to tell the story.

Others: that's right

S the might be changed if only we could say more.

C the fact that we've got it and can use it creatively in our own way with our clients feels positive and you know and I feel OK about that but the anxiety for me is what will be made use of .is it really too crude to measure what needs to be measured? They're 2 things aren't they?

G There's this big divide between the 2, between the subjective and the objective or the objective and the subjective…

A I think that's why I raised the point about the looking after myself because then I will doubt when I see discrepancies or this score is so much worse because (inaudible)

V Isn't it about us needing to prove that we are on the problem

A that we look after ourselves. If something's making you anxious because it seems a huge discrepancy between, not so much if it's gone down, but if its gone up, and I um want to explain that ...cos then I've got it out from my anxiety.

V Do you think if the second part is done, is that better for you, is that how you see it?

C I had that I worked somewhere where I was asked to assess people...someone who needed counselling and I did do that and then they counted DNA's and used it against me and that made me really anxious umm yes...

A Lies damn lies and statistics.

C that's right

A so we need to keep some scepticism.

S its anxiety...I know the intellectual part of me, rational part of me is OK, but there is this anxiety about being correct and also ...

V But if I had constant high results then I'd obviously have to question myself, but if there's the odd one then that's part of life and would it be unrealistic to expect that I rescue every patient...

G I think that highlights a difficulty in giving a very objective view which is absolutely appropriate..there's different statistics that are still subjective and therefore I think that's right you know

Counter 300

G When you talk about it in this way with colleagues it feels very comfortable, but you know what is the point, where is it used. Does that make sense?

That's funny because I wasn't actually thinking that specifically which is strange isnt it?

Y Yes, one of the things that I certainly point out is the questionnaires are confidential that they are known only as a number on them, so that kind of relieves their anxiety , so what relieves ours?
For them, they are known just as a number umm, we know that it's actually going down under our name.

Key issue of Public view and Judgement.

V Are your, do your feelings of performing

Y But strangely I'm sorry while you were talking I wasn't completely listening, I was also thinking that umm I'm thinking that I'm not, the bit that I don't get anxious about necessarily is the client's goes up instead of down, that doesn't concern me quite as much as the one's that DNA actually, cos I see that as my greatest failure. I don't know if other people feel that because

also that is measures statistically…

C I think that what is interesting is that it's changed the way I look because I know that I have a high rate of DNA's with clients. If I know they're clients for example that are very disorganised, borderline suicidal that often don't turn up, I know that I find it very difficult with those clients to say "right. You've not come for 2 sessions, off you go"…I find it very difficult to , to let go if you like…and I know that they'll come upon my statistics as possibly having a high rate of DNA's ….and I think the whole sort of tightening up has made me think about it and possibly checked my practice, but possibly lately I have nt had a lot of those clients, but other times I get loads, and I think "is this a fair measure"

Fair measure is an important concept For C.

G and yet that's subjective too because do you count it as DNA if the client has had an accident, you know, it doesn't seem really fair. I had huge DNA figures because say somebody had agreed to come 12 sessions and then we agreed to during the course to work for six I put all the others as DNA's

Shocked noises!

C What about the client who had ME or arthritis, and those sorts of clients are functioning in a very difficult way aren't they? And those sorts of clients do need support…it's all those sorts of issues that makes me think about, what's the service for , how many sessions do we keep if they are not attending, what about the waiting list, you know, it makes you think about all these things or brings them into the light , but you don't want those people to squash that…
But then a lot of me says with people with ME aren't going to turn up, what can we do? It's such a difficult issue isn't it?

Good metaphor Bring to light Tension between w/list and clients space

S One of the questions is about those of us who have looked at our data…how many people have?

3 indicate yes.

G Horrible….well horrible and fascinating ….my DNAs for a start were I mean, you know…

C that's a really good example, I mean if someone were insensitive, they could say well look at all these DNA's

G well with me it was an issue for supervision, S's in my supervision group…it was so supportive..

S I did it when the numbers were very low….25…and a couple of clients had got worse, and that distorted it and I though, "I'm not a very good therapist" It was more important to question why I was working with these particular clients, but of course we didn't look at any of that, and it may touch into my wanting to rescue, working with people individually where you might think, "hold on how important do you think you are". I had someone who had a swallowing problem, 40 years worth, and I thought I

could sort him out...they're the more interesting questions, actually to begin to look at some of the feedback you're getting but for me its what do you think of him, I don't know Geoff. I don't know him ,I don't think he knows me, and it's all about. It isnt the whole picture of me...

C As you say, it's not knowing..we're in the same group, and if you said that to me, I would have said, "oh S, I know you do a brilliant job" you know what I mean?, because we know each other, we could have looked, as you had...

G but how do you know, this is what CORE's all about, that's the question. We can assume, you can imagine, use you insight, intuition, everything, but how do you know?

A This is what it did for me...

G and the only person that can tell you is the client..

C but then you see, we're back to the thing assuming that picking your score, whatever it was, we're now knowing, the danger is, we've proved it was as you thought because we're being sacked you see, where we haven't actually proved it, if we look more closely we actually see this is whats happened...and that's what we learn from it, not actually that you're not a very good counsellor.

V People are talking about how we are, is that what CORE is about? Isnt it about more than that , about counselling full stop, does counselling work?

A big question.

V that's not how I see it, I don't see CORE as measuring how good I am, I see it as a measure as to whether it works.

C I'm not sure if I was like you, I got my individual, you know, you don't respond...if you get your own individual score as it were, measurement, it's very hard not to see it as a reflection

Y and there's the difficulty you see, because counselling for me is about relationship and maybe CORE doesn't effectively measure the relationship

A I'm with you, the relationship

G yes, and er I also feel, I've talked to Geoff about this, we could do with a measure to actually kind of measure after the counselling is ended would be really helpful you know, to actually send clients, and of course whether they'd return it or not...or the doctors to do it

Y because this is what all this long term follow up, 3 months and 6 months is all about

G yes because so much is dependant on what's going on with the client

before they come to you in a short term way, I mean certainly I've always said to clients 'last week last week', but it seems like one doesn't have to..but by sticking to the last week is very subjective isnt it.

Seems to be a quest for a measure that is objective and subjective

C isnt it a bit depressing, I read some research a while ago, that if you measured things six months later, there isnt actually such a change

Several comments on this

Y when the client fills in the you know , end of therapy form, they are in the room with you aren't they, the relationship is still continuing...if you measure it 3 months 6 months down the line with another questionnaire, the relationship is no longer there

C they want to please you...as any psychologist knows, your'e sitting in the room with them

V so what are you saying then?

Y I'm not sure really, well if you want, well part of me was thinking that it would actually be quite interesting if the GP at the point of referral was to give the questionnaire to the client, because that's when they are first presenting as having a tremendous problem. Often by the time we se them 3, 3 1/2 months down the line things maybe got better, anti depressants have kicked in big time, or the problem may have just gone away and they think Ive waited all this time I might as well just come along anyway, erm but that would be interesting as an experiment but also this idea of a follow up, you were saying that research shows that a lot of people are no better off after 3 or 6 months ...what I think I was trying to say was that part of the reason for that could be that when we do the end of therapy form
They are still engaged with us and feel better because we are in the room, whereas 3, 6 months down the line, that no longer exists..that support, just that body in the room

Critique of the scientific basis of measure ment

Very critical of evidence

S there's this huge body of what helps people change...I was looking at the research on brief therapy practice which was looking at asking our clients what actually prompted them to change, at least 40 % of them had life changes and it may be an auntie I haven't talked to a long time gives me a ring, or you get a new job or you have a new dog or something and you go out walking and you feel better..there's all sorts of reasons how things change and one of the things that was underlying was that its what we do in the room with the client

C you could say that what we might do is obviously discuss their relationships with other people, obviously whether or not a dog would help and so you focus on living their lives as well as

G how do you measure the severity of the problems because that almost sounds like erm it's a sort of ...short term difficulty rather than something a deep psychological wound or doesn't it? To say right I felt so much better when I went out for a walk..it's almost like saying well

S but on a day to day basis…very small changes can be very helpful

A If the counsellor relationship is focussed and you were in other relationships as well, then they do begin to talk to other people…with a bit of encouragement, how to put a question or how to say for example " when you said that I felt rejected" rather than "you reject me" and things change as a result of that …I don't know what I'm saying either.

Counter 400 Continued discussion about what change is about

C this is fascinating topic, but maybe we should get back

V for me, CORE helps me because I can be quite…it gives me structure…it's self sufficient and it finishes the counselling…it kind of gives me an outline. But I'm thinking what do I find helpful about it well I hate filling in all the forms, the extra adding up, and I don't know whether I spend that much time analysing it, I think, its something I have to do, erm so we at the end can compare a patient

Eg: of helpfulness

…

G I had a schizophrenic client who had been in erm hospital and now in the community it's the first time she'd talked about how she felt about her illness, how she was treated in the units, she needed to say that, absolutely needed to say it, and erm she did really good work. But somehow when she filled in the CORE she would not keep to the last week , she didn't have learning difficulties but she missed out on her education and she was answering exactly as it had been throughout her life. She needed to put that on paper…so she had this really high CORE score

Score not representing clients current state

C cos you know that that is something particular, cos you'd really worked well

G she'd really appreciated and valued the work…and I was surprised

V and there's no box to tick there

C did you go through it with her

G yes, and she just needed to do it, saying I feel better but…it was really odd actually I would have loved another session to open up what was going on.

A a follow up?

G no because we hadn't planned a follow up, it would have looked very messy, you know , boundary issues really…also I'm finding with follow up sessions, quite a few people are not coming, so I'm not going to

A I've only just started doing them

S It can be very interesting…there's always issues..until we get to 6 and deal with endings.

G And I guess that's the point of psychodynamic goals and I guess that's what CORE does you see…it sort of refreshes you …refreshes…we start to look at different approaches again

S I like the point about that.. there's something much more..more clear about that

A (talks about DNA's) and how CORE helps

G It's very holding in this way to know that you've got sort of… for clients somehow.

C how much of that though is about CORE and how much is it about being in a managed service**?**

G Well, there you go…

C I think there are lots of questions..the thing is, things like the limit of the sessions you know, or all sorts of things, we're answerable …and it also gives us a justification, like especially if GPs refer people…wen I first arrived I wasn't sure how many times to offer them an appointment if you see what I mean? The fact that you've got a structure in a managed service is just as significant.

We lost how you would have felt if you got the feedback, you know you were saying about erm your reactions to visiting the data..

V I was very positive.

A (talks about session numbers averaging out

Factual confusion

G Ive been feeling terrible

A You've been trying to do too much though G, its so much simple than you've allowed it to be.

G I know, but I was given a whole pack and told "'do it like this" and Im always so good and do it like I'm told, and I did it like Im told, and actually I don't see how you cant do it like I was told if you are going to check the clinical cut off, so there's a very grey area for me saying well, we're working towards this clinical cut off, but nobody else seems to be doing this mean

Changes

C We had another bit of paper, because first of all we had this thing with the mean didn't we..(agreement) and I was doing means..and much later I was doing something else which gave numbers and not means

S 41 and 44

C yes …but first of all we didn't have that

G yes…if I could have explained it as law of averages…it was a good learning curve, so I don't think it was a disaster, that it was below this service's figures…but had I not been able to talk to S

V I'm waiting for the 100s, because I am looking for a kind of average picture because I wouldnt want to do it with 20…it might give me a poor idea..my picture's absolutely fantastic and then when , the next time round you may be "ooh" you know, so I'm waiting

C and I feel like you, because in our supervision group…it would be nice to look at it in a much more whole way, and there are some positive things, like when he said that 25% of people don't shift or 15% of people don't turn up, you think "oh, its not just me then" I feel better, its quite useful

G well actually I think the most valuable thing about CORE is the discussion groups

C yeah, I think you're right (others indicate agreement)
C but can we put it back to CORE though or is it part of being a managed service, and I think being a managed service means we have more contact with each other..

G I think its something about having the overview, the erm the

V isn't it about giving us erm a framework to work to again..

G yes, yes, I think that's what it is about and like we all come from different back grounds erm and it sort of

Y It's kind of like the computer is sitting there and erm there's a bit of each of us in there…(laughter) we've all been kind of amalgamated into it…shoved together and these statistics churn out…

Nice metaphor

S and the contact will be deeply reassuring…

V has anybody ever felt handing out the CORE sheet, outcome measure in the last session and felt "oh my god, I don't want to do this"

General agreement (4 audible strong yes's)

V I'm thinking about one particular patient, was so angry, and he…I so expected he would throw the CORE back at me….he wouldn't fill it out in the room, he took it home with him…

C We are allowed some discretion aren't we, there's this box (talks of client where it wasn't working in session 2/3…I thought it would be an imposition, very difficult for her

Acknowledgment of value of data

G, but I mean the process is.. It's useful, any data is useful, it gives you a ..and not to withhold..

C We're not talking about the data, as about having to ask this elderly lady

who was fairly out of it and I did feel that it wasn't helpful

G Fair enough

S and it is very intrusive…I remember early on doing it, and you just know that when people come into the room they've rehearsed what they , they're ready to talk and I've given this form and I've looked up and I just saw tears running down and I thought…."I cant" — And the Reality of getting it!

V and then I had a client who was dyslexic who I was concerned about ..and the struggle that he might have in deciphering the stuff, because you're having to in reality read the sentence and then read something else at the top and it's actually quite hard

G I think there's a very high number of clients with dyslexia and in my private practice I've particularly noticed a lot of alcohol and depressives who have had problems at school and are not diagnosed, so I'm always very aware of them….if we're not careful it fails before we've even started the process, it sets up that "I've got to read this

S so, should we ask ourselves the question how we found the risk guidelines? — Risk issue

G Brilliant…I really appreciate them

C (clarifies what they are..)

General discussion about the memo/I didn't get it etc It's useful

C I think it's great I agree…I do remember now, it's a lovely support isn't it, from being self employed to having a structure and following a guideline, it gives you a back up — support

G back up, and it's like you know, we're all very experienced counsellors aren't we, we've all been doing it for a number of years, so its very easy to not, to feel gosh how can I ask, or I shouldn't be concerned, I should be dealing with this, and yet when I went on holiday and talked to Geoff about it, it was so good.. — Permission to speak

Y questions when guidelines introduced, refers to not having had them

S I think if Geoff were here now, he wouldn't be saying "it must be done like this" he'd be OK with it…I mean I was really worried at first, that I'd phone Geoff and have to make a report — Big brother aspect

Y I certainly discuss it with clients if there's even a score of 1, erm then I ask what that's about , I don't know if that's what everyone else does?

G I think what we need to be aware of is if something goes wrong, I think this is, I thought we had to tell Geoff , initially that's how I read it ..if you want to protect yourself , you need to be aware that if anything does happen, you have had the support from the manager…it sounds over protective but I — Self protection

think nowadays we have to protect ourselves…it's no good us saying well, you know, "you'll be alright" if anything did happen we need to erm

C follow the procedures..

G follow the procedures

G so I think it's very very supportive

V I find too..I know if I tell Geoff, it makes me feel pretty safe

Discussion of GPs clinical responsibility

G but it's still on me…

C they do, but we also have clinical responsibility

V I make it clear…that if their life is in danger or someone close to them, then …

Discussion about confidentiality

C there's a question mark isn't there…I remember Geoff said at one point that we are part of a thing, so if I'm discussing with a GP that's one thing, but if I'm discussing with someone else that's completely different. (Refers to experience of talking to different bodies and says how complex it is)
It isn't black and white

G there's common sense, this BACP solicitor said "buckle up" there is no court in the land would criticise you if you saved someone's life

C it depends on the contract, if you say, I will discuss with the GP if you tell me this and that, then that's the contract that you've made…which I've learnt the hard way (laughs) you're then free to discuss it

Tape ends 70 minutes.

G bottom line is what is in the client's best interest, and erm I don't agree with you (about gp having a right to info) it's what about who has access to all this information…

General discussion about confidentiality and breach of.

Y I rely heavily on the supervisor

G I spoke to a doctor this week, and she was wonderful…I had actually spoken to the client , so I'm not saying for one moment not to, what I'm saying is every case is different and that's why I appreciate being able to talk it over with Geoff, without wondering if it's serious enough to do it…

Y yes it's more significant I suppose because of the CORE form …we may

Follow procedure

This shows how much confusion there is about Confident-iality

Initial contract.

have concerns in other , but it's there in black and white in the form, whatever it might be, which which we need to respond to which perhaps in a different place and time there wouldn't be such a need to do so, or it wouldn't be so obvious.. there wouldn't be black and white evidence suggesting that you might need to take further action or speak to somebody

How CORE Highlights the issue of risk

Question of clinical value of CORE measure.

Y what Id say in answer to that question is I think it has very limited clinical value when it is used in the first session apart from possibly throwing up certain elements which can be discussed there and then with the client…I think the clinical value comes at the end of therapy and I think it has clinical value both for us as counsellors and also for the client potentially because like everyone has been saying, they can take it away….and in terms of actual clinical value overall…

V …you can use it…where someone has put 4's say…and there's a contradiction.with what they say..

C "I'm confused, because down here you've put…." You know

V CORE is a subjective experience for the client…but looking at it out there in the wider picture…that's when we start to to question..our figures

Y yes, you've put that very nicely..

V so 59% recover…what does that mean ?

S (inaudible) that's when you get one's better than the other, or more valid than the other..and there'e lots of things that mean we get to be more questioning about that, what it means…

G and I suppose that…sorry to interrupt…just to follow on, I suppose the very fact that it opens up, raises up questions probably means that it is of clinical value

S yes and I remember on my research module that evaluation just as ks more questions and out of those questions you actually might get research questions

C talks of situations where researchers contradict each other…and they employ lots of researches and I don't think that is too fantastic, that's the sort of anxiety….that's the worry isnt it?

V the wider question to me

S its not like we're in control…(agreement)

Y whats the worst thing that can happen?

Paranoid fantasy..

C we get the sack..(laughter)

V and you get these workers coming in what is it, with a years training and erm that solves the problem

That we'll be sacked..

C and in theory if we get the sack because they've done something statistical...for something that's unfair...not for the right reasons

Fairness

V its also very trusting isn't it, I mean, who is to say that counsellors don't just manipulate

Manipulating the system

Y yes...that's true isnt it? (laugher) we're all looking suspiciously at each other....I don't have the time to go to that trouble

C what is manipulating? Ive had situations where I notice people have missed questions and I say "I notice you've left that...basically she couldn't decide what to answer....I put one or two and it averages out...was that reasonable...do you know what I mean?

Y you're meant to leave them though Carol..

C repeats above

S and they take out the potential score....there's a way of doing it..

C oh I'lll do that then...

Ways we can influence scores

S I think what's more manipulative if I'm really honest is in the last session I can start whipping up..tell me more about that...and what has changed....now would you like to do you're CORE form?

C or "lets see how much better you've got..."

S should we do the CORE forms right at the beginning of the end of that last session without saying how are you , or should we give them to take away...puts them off

Y I insist that they complete them...it's the teacher in me and I don't do it often...but it's like " you're not getting out of here till you do your CORE form

C sometimes people haven't done very well...how do we acknowledge that? Without being to focussed on the positive and the change...it feels hypocritical

Dealing with poor scores

G we have insight that very often clients don't have we've got psychological insight tat they don't have...like a flight to health

Y I must say I do try very hard...to tell the clients at the start , this is a way of us finding out what sort of people counselling helps, so I do try really hard to put it on an individual level

Discussion of ways of working

G we say we work in different ways, but fundamentally I think we've got an understanding of the way we work…but I'm realising that there are so many many different ways of doing it…and they're all valid

Issue of standards

S but at the same time there is are constraints on the way that we should do things

V but when you're looking at figures there's no room..

G yes S is right…I get them to fill in the CORE at the end of the session and by then they might be feeling much better, and it does make a huge difference…so sometimes it pisses me off a bit…

Y I know if I don't get the form filled in at the start of the first or last session, I feel anxious …I'll never get the thing filled in and ten I'll be in trouble with Geoff or the rest of the world and I cant concentrate on what they're saying and I'm being less than a good therapist…you know from that point of vies its better to get it out of the way even though it doesn't feel like a good way of working sometimes

Anxiety

G you could argue that CORE has got a very huge presence in the room compared to another person…its very powerful..

G Today has raised as many questions as answers…but I think that's very healthy

C Its great that we hear what others do

V I liked your words earlier..I cant remember exactly what you said…that it turns our subjective experiences into objective factual things …I think that is very true

S yes for me that is true….and I've got less anxious about it

Importance of discussion space

G and I must confess..if I hadn't been able to take the risk and be honest with you, it would have been very different..

V CORE has always been part of my experience during training and since

Is it easier if we don't have to change habits?

Appendix 5: Background to the focus groups

The use of groups in this project

The idea to use focus groups in this context arose after a forced interregnum caused by the need to seek permission from the LREC prior to initiating the formal part of the project. I began to question the original idea of having 1:1 interviews with counsellors to elicit their reactions to examining CORE data.

There was a strong element of pragmatism in my decision to move away from individual interviews, since the transcription alone would have been a huge task and would not have been a good use of resources. I also began to realise that such an approach would place too much emphasis on the individual's experience, whereas my project is as much about change in the service as we made use of the data.

Given that the counsellors formed a natural group that was central to the enquiry, it became clear that it made more sense to make at least a part of the enquiry using that group. Whilst it is common for the researcher to create the grouping focus group studies, there is no logical reason to prevent use of the approach with a naturalistic group Kitzinger (1995).

Pragmatism was far from the sole reason however. As service manager my primary concern is to work to improve the service in the spirit of Clinical Governance. Whilst 1:1 meetings would provide a good forum within which issues of service improvement could be discussed, this would by its very nature be an individual process. I was seeking to develop a culture for thinking about and using CORE, and any group discussion on that subject was potentially of benefit in developing such a culture.

Meeting in focus groups provided a potential means of developing coherence within what is, on a day-to-day basis, a very isolated group of individual practitioners.

The very fact of getting counsellors together to discuss a work related issue would I thought be helpful for the service as a whole, almost irrespective of the research side of the activity. I wanted people to have a chance to talk about the subject, share their learning so far and their ideas for the future. The groups could serve as a vehicle for developing the group, almost irrespective of the research component.

This aspect of focus groups is acknowledged in the literature, as the following indicates; 'The benefits to participants of focus group research should not be underestimated. The opportunity to be involved in decision making processes (Race et al 1994), to be valued as experts, and to be given the chance to work collaboratively with researchers (Goss & Leinbach 1996) can be empowering for many participants. If a group works well, trust

develops and the group may explore solutions to a particular problem as a unit (Kitzinger 1995), rather than as individuals.' (Gibbs 1997).

The issue of power is a central part of the context of this project. I am very aware that I occupy the position of manager. I am the controller of livelihoods, at least within my service. This cannot be ignored, and will clearly influence my questions, and my perceptions, as well as the responses of counsellors. Giving counsellors the opportunity to discuss their views in a group setting seemed a good way of at least partially beginning to deal with this issue. There is some supporting the literature that supports the notion that people feel more able to be critical in groups (Watts and Ebbutt 1987).

In hindsight, I think that my decision to use groups was the result of a tacit, later explicit, understanding that central to the whole enterprise is the culture of the service. Only by engaging collectively in questioning conversations about CORE and the ways that we use it, would we truly engage with the data. This is true to the action science aspect of this work, especially Freedman's (2001) ideas about developing communities of inquiry within communities of practice.

History and definition of focus groups.

The use of focus groups is usually traced back to Merton and Kendall's (1946) concept of the focussed interview. Merton and colleagues began to use groups to assess people's views of media programmes, and the approach now has a long history in market research (Morgan 1988).

Crucial to the approach is the use of group interaction (as opposed to individual interviews conducted in a group setting);

'Focus groups are a form of group interview that capitalises on communication between research participants in order to generate data' (Kitzinger 1995).

The key characteristic, which distinguishes focus groups, is the insight and data produced by the interaction between participants. Much more comes out of the discussion than can be gained in 1:1 interviews or other means.

A second defining characteristic is the use of open ended, exploratory questions that give the group a 'good enough' focus, whilst leaving considerable scope for exploration and elaboration by participants.

Hence Powell and Single's definition of a focus group as:

'a group of individuals selected and assembled by researchers to discuss and comment on, from personal experience, the topic that is the subject of the research'. (1996: 499)

A focus group therefore is a collection of individuals that pre-exist (as say, work colleagues) or have been brought together to discuss a particular topic, issue or concern. A facilitator chairs the group providing a framework and structure to the group, using open-ended questions to promote discussion.'

The running of the groups.

The idea of having 2 parallel groups came relatively late in the planning. In my Learning Agreement oral presentation I was encouraged to think about having someone else facilitate the group rather than taking on too many roles myself.

This suggestion came as a surprise, rather surprisingly. Once I though about it, it was eminently sensible. I had fallen into an old habit of steaming ahead relying on no one but myself.

I was unable to find someone to run the group at what was very short notice (the date for the group was only just over a week ahead). I briefly considered rescheduling, in order to find someone to run the focus group for me, and had this simply been a research project I would have done so.

I was very aware that time was an important factor however. We had been using CORE for 18 months and had completed a first round of individual meetings to examine the data. I did not want to postpone the opportunity for discussion and ideas for further action, as I feared a loss of momentum. A project of this nature needs driving forward if it is not to stall in the mire of institutional inertia and homeostasis. It was clear to me that I needed to prioritise action over design.

The above suggestion did set me to questioning however, as I realised that I did not have to be the one facilitating the group. Reviewing the literature on focus groups helped me to clarify that the skills required to facilitate such a group are those that should be possessed by any competent counsellor. I was worried at the potential size of the group. The consensus in the literature (Kitzinger 1995, Morgan 1993) is that groups of around 6 are ideal, and allow for individuals to have space to speak in some depth. I stood to have a group of around 12 (allowing for the inevitable drop outs from the staff group of 15

including myself). This number would be unwieldy, and would potentially lose a lot of valuable data as people would not have much space to speak. I therefore took the decision to run two groups in parallel, asking for a volunteer to chair the second group on the day. In terms of pure research such a move stood to lose focus in the second group. I had a list of questions available to participants, but of course my own internal map was far more developed, and much of my exploration would be guided by my tacit knowledge. I could not expect that an un-briefed chair, even with a list of questions, would necessarily be in a position to pursue matters in the same depth. On the other hand, the opportunity to discuss matters in my absence (allowing of course for the reality that I would listen to a tape of the group) might allow for an even more open discussion, where I was not consciously or unconsciously influencing responses. In fact, having 2 groups would allow for me to make comparisons about the tone of responses, and check to see if there was evidence of unhelpful bias in the group that I was to chair.

These groups took place at the end of a service half-day training event focussed on CORE. The initial slot was devoted to a presentation by myself on a) the general thrust of my project and the service and b) some of the headline findings about the service's performance. This was woven in with discussion of the issues as we went along.
Key issues emphasised in the presentation were; the challenge of using data as opposed to gathering it, the new possibility of having direct access to data by password and the effectiveness of the service as demonstrated this far by the data. Of 14 counsellors, one apologised in advance due to childcare problems and one announced that she would not be able to stay for the focus groups. Another had to leave a half hour early owing to a previous commitment.

What I wanted to achieve.

At the time of running the groups we had been using CORE for 18 months. Most counsellors had met with me at least once to examine their data, and we had had risk guidelines based on CORE in use for over 6 months. It therefore seemed like a good time to build in a stock take.

There were several aspects to this. I wanted to know what counsellors thought and felt about CORE generally. I particularly wanted to know about how they experienced the risk guidelines. In addition I wanted to think with them about where we went next. How would we continue to use it?

These questions were of course being asked within the context of my strategic agenda to develop a culture of using CORE. Underlying this is my profound belief that we *should* do this in order to minimise the gap between our espoused theories and our theories in action. I had a very strong agenda biased towards positive assumptions about the entire process.[51] These are not detached research questions, but are part of a project about which I feel passionate and in which I have a considerable amount of investment, not least because it is part of this doctorate.

Participants were given a list of questions (Table App 5: 1) to cover in the time allotted (1 ½ hours). They were asked to begin with a simple task of finding an association between CORE and a bird/flower or other object. The purpose of this exercise was to initiate reflection in a way that elicited implicit as well as explicit meanings. They were asked to then give a brief 'because ' statement that linked their association with CORE PC. The thinking behind this approach was to encourage creative associations that would engage people and lead to involved and informative discussion. A picture or metaphor is indeed worth a thousand words.

[51] I do not believe that this anything other than the norm. The great strength of the qualitative approach is that it encourages being explicit about preconceptions and expectations. The fact of the impact experimenter bias on outcomes is known to every psychology student, yet gets forgotten. For example most of the apparently superior outcome for cognitive behavioural approaches disappears when the allegiance of the researcher is factored in (D.Shapiro personal communication. May 2002)

Focus group questions
What does CORE mean to you? **If it was an animal/bird/flower, what would it be?** **(write down on post it...give a phrase that explains the image.. and hand in).** **Discuss.** **How do you imagine it might help?** **How might it be unhelpful?** **If you have looked at your data, what reactions do you have to the process?** **What would you like to get from looking at CORE data?** **How have you found the Risk guidelines?** **What is your experience of CORE's clinical value?**

Table App 5: 1 Questions for the focus groups

Analysis of focus groups

As is widely acknowledged, the analysis and interpretation of qualitative material is generally extremely time consuming.

The transcribing of these 2 groups occupied 3 work days and produced over 50 pages of transcript (appendices 3 and 4). I transcribed the group in which I had not been present. This seems to be a good way of immersing myself in the product of this group. My group was transcribed by an extremely diligent secretary. Apart from relieving me of an onerous task, having someone else transcribe my group helped prevent any unconscious censorship on my part.

I spent a lot of time examining the transcripts and allocating labels to comments made. These comments are added in a separate column to the right of the text. At this point I began to feel rather guilty, since this did not seem to match the rigour implied in the grounded theory literature. Unusually for me I dealt with this by leaving the transcripts for some time. I would come back to them rather reluctantly, have another look and add one or two more comments, but not feeling that I had really 'analysed' them. I reread what for me is the most useful text (Strauss and Corbin 1990) and was comforted to find that what I had done was in accord with their initial steps of coding and categorising.

Although they see these as often two separate phases, I tended to go straight to the latter. This concerned me a little once I realised it, might be that I was simply placing pre existing categories on the data, and not allowing myself to see it afresh. However context is vital here. I am not an outside researcher coming to a new situation about which I know nothing. I am an insider, soaked in the area that I am examining. My tacit clinical and local knowledge means that I will move rapidly to categories.

The key to ensuring the validity of these categories lay in questioning and looking for exceptions. In doing this I realise that first time round, I had generated an almost exclusively positive set of comments. Clearly it was important to approach this with some scepticism, and I therefore looked for more negative comments.

The images

Table App 5: 2 summarises the counsellor's images of CORE. The instruction suggested images such as animal bird or flower and the predominance of such images is therefore not surprising.

Image	Associations
Lotus flower	Starts as a bud and changes all the time.
Lotus flower	Helps people grow. Under the water there's mud.
Oak tree	Solid reliable and functional. Produces acorns.
Owl	Wise fragile. An inquiring mind.
A Bird	Soars very high. Has a view of everything. Picks out Details and zooms down.
A mountain	Solid quite firm and hard. It's measurable, you can Measure the distance you've come.
Owl	A provider of wisdom. Slightly elusive.
Owl	Really good vision, also a narrow field. Intense..
Rose bud	Tight. Opens up but doesn't reveal all.
Marigold	Not very attractive at first sight. Utilitarian and useful.
Grass	Boring predictable. Something we need.
Fox cub	New exciting and unsure.

Table App 5: 2 Summary table of counsellors images and associations to CORE.

Given the instruction, the actual images are perhaps less revealing than the associations to them. The following categories emerge from my viewing of the above. They are based on a textual analysis, (FG 1 pp 1-3. FG 2 pp 1-3) and on my recall of the manner in which images were discussed:

Category	Image
Solidity/tangibility	Oak tree/Mountain
Worthy but dull	Grass/Marigold/Oak tree
Illuminating	Bird/Owl (2)/Mountain
Change/growth	Lotus flower (both)
encouraging	Rose bud
Elusive/not	Owl (1)
revealing all	lotus flower(2)

Table App 5: 3 Categories derived from images.

There is a sense from this that counsellors see CORE as something that is useful and solid but not especially exciting. However they see the possibility of insight arising from it and it is associated with a sense of encouragement of change and growth. Associated with this is a sense of the not quite graspable, that CORE does not reveal all.

What does not come through from the above is a sense of the less pleasant side of what CORE represents;

"I have mine as an owl..wise fragile..an inquiring mind, and sometimes vomits horrible bits..."**(FG 2 p2)**
and
"I put a fox cub, it could be new and exciting and also unsure about trusting data to be used in an accurate and helpful way." **(FG 2, p3)**

The latter is not so much an image of CORE as an image of the counsellor in relation to CORE. The point comes across strongly however.

After the exercise I noted my image for CORE, it was an octopus **(RM 18).**
Until I took up diving I had never really seen octopi as at all worthy of attention. I'd caught them and eaten them, but never had the opportunity to watch them. Then I spent

some time on a coral ref in the northern Red Sea watching a beautiful red specimen glide in slow motion across the edge of the reef. Its motion was almost impossible to comprehend. It seemed to expand and contract, one tentacle leading, rather than move in a conventional sense. Later I watched a similar scene off the Spanish coast, as a huge specimen with a head the size of a small rugby ball flowed effortlessly across the rocks, oblivious to the three divers hung in the water above it.

It was that sense of fascinating but extremely hard to describe movement that captures something of my fascination with CORE. You know that you are studying movement, but it is not quite like anything you have ever seen before. Stretching the metaphor further, people often have an initial dislike or even fear of octopi that can prevent them from seeing just what incredible creatures they are.

The exercise provided a forced choice in suggesting a plant/animal/flower as the image, and this of course tends to limit and prescribe the range and quality of responses. They could of course have said 'triffid' 'poison ivy' or something similarly negative, but I think that it is fair to conclude that, at least in this culture, the instructions biased responses toward the positive. Overall however the images provide an insight into the rich and textured perspective that counsellors have on CORE as a whole.

Perspectives from the remainder of the group.

Table App 5: 4 summarises my view of the major categories arising out of the comments made by members of the group. The intention is to highlight major elements of their perspectives. The list was derived by repeated reading of the transcripts, with some being generated on first reading and others later. Examples were then extracted from the text. At this point the transcripts were re read and exceptions sought.

Category	Speaker and text	Location	Comment
Control	Y: For me the worry is how its interpreted, out when it gets out, away from me.	FG 2 p3	
	S its not like we're in control...(agreement)	**FG 2 p 16**	Tape shows general Agreement here.
Public	**Y: For me the worry is how its**	FG 2 p3	

nature	**interpreted,**		
Anxiety	**Y: so what relieves ours?**	FG 2 p7	'Ours'
	For them, they are known just as a		refers to
	number umm, we know that it's		anxiety.
	actually going down under our		
	name.	**FG 2 p 16**	
	Y whats the worst thing that can		
	happen?	**FG 1 p28**	
	C we get the sack..(laughter)		
	T If you think how much stress		General
	league table cause other		agreement
	professions... It's terrifying, I mean		on tape.
	I don't think anyone is suggesting		
	it but potentially this type of		
	mechanism could be used and that		
	worries me.		
Pragmatis	**V: I think it's a tool about keeping**	FG 2 p3	
m	**us in this job because that's what**		
	the government wants		
Fairness of	**C: and I think "is this a fair**	FG 2 p7	
measure	**measure"**		
Structure	**V: it gives me structure...it's self**	FG 2 p10	
	sufficient and it finishes the		
	counselling...it kind of gives me an		
	outline.		
Interesting/	**G put it all together , put it in a big**	FG 1 p3	
provocativ	**pot and we'll come out with all**		
e/	**these interesting things that we**		
stimulating	**might interpret, that might inform**		
	our work.	FG 1 p3	
	T so it's a question of take an		
	overview and see what might be		

interesting ...and go and look at that and it might not tell you anything at all interesting , and then you go back and look at something else that might be interesting.	**FG 1 p6** **FG 2 p13**
Gn the questions are like this focus beam.	
G, "but I mean the process is.. It's useful, any data is useful"	**FG 2 p18**
V "I liked your words earlier..I cant remember exactly what you said...that it turns our subjective experiences into objective factual things ...I think that is very true"	

Table App 5: 4 Counsellors perceptions of CORE: Major categories

Overall the images provide an insight into the rich and textured perspective that counsellors have on CORE as a whole.

There is evidence of appropriate scepticism about the validity of what CORE shows: **(see G Y and S from middle pp 9/10 FG 2).** This includes an acknowledgement that it is a tool that is open to either direct manipulation or indirect influence by the counsellors:

V "its also very trusting isn't it, I mean, who is to say that counsellors don't just manipulate"

Y "yes...that's true isnt it? (laugher) we're all looking suspiciously at each other.." **(FG 2 p17)**

and regarding the ways counsellors might influence clients in completing the OM;

S I think what's more manipulative if I'm really honest is in the last session I can start whipping up..tell me more about that...and what has changed....now would you like to do you're CORE form?

(FG 2 p17. See also general discussion at this point.)

and;

GN I mean could it be? And is it robust enough? You know, that's the other thing. You might get someone who is really coercing their clients in a way. "Fill this out, this evaluates counselling" you know ,we've done 6 sessions and now this is the end, you know, but be honest .... "

(FG 1 p26).

Overall however there is also strong evidence of an acknowledgement of the need to produce good data;

M "its one of the things that I've always found very odd that you come into an area of work which is highly personal and there's lots of potential, but you could be doing anything almost ..and it's about having a way of knowing what you are doing...so to me this is very important ..this development....it does give you something to help you hopefully to know what you're best at and what you you're less good at"

(FG 1 p 5.)

V "I liked your words earlier..I cant remember exactly what you said...that it turns our subjective experiences into objective factual things ...I think that is very true" **(FG 2 p18)**

But this needs to be balanced;

C "I suppose one of the reasons I'm sceptical is the misuse of statistics. I've had experience of statistics, which were misused.

I think its good to measure things, and also necessary, for research and things, erm can be misused and lose the subjective"

(FG 2 p3.)

A "Lies damn lies and statistics." **(FG 2 p6)**

There is evidence of the clinical use of CORE;

P "I find it fairly useful, but maybe I look at it in a different way but I actually can get a sense of where the client is, because in short term work you have to assess fairly quickly"

(FG 1 p4.)

M "One area is where the score is under the clinical level.." **(FG 1 p5)**

Y "what Id say in answer to that question is I think it has very limited clinical value when it is used in the first session apart from possibly throwing up certain elements which can be discussed there and then with the client...I think the clinical value comes at the end of therapy" **(FG 2 p16)**

There are however some problems in introducing CORE;

MY "I say that there is a bit of paperwork to go through and I've noticed certain people's faces visibly drop. " **(FG 1 p8.)**

GN "Some of the questions – I get a lot of people struggling with these questions and they say "Oh God, these questions are very...(tails off)". **(FG 1 p5).**

There are also some problems in the way clients complete forms;

T "they want to present as o.k. but in actual fact they're not o.k. And they have this struggle..." **(FG 1 p8)**

P "I've also had a couple of clients which have spent most of the session, which says something about me as well, filling in the form.... it's almost about their, sort of, compulsive behaviour" **(FG 1 p9)**

V "and then I had a client who was dyslexic" **(FG 2 p13)**

Reactions to the Risk guidelines.

Comments assigned to some categories also speak to other categories. Where this is the case the other category is noted in the comments column.

Category	Speaker and text	Location	Comment
Positive	G Brilliant...I really appreciate them	**FG 1 p14**	
Support/ stucture	C I think it's great I agree...I do remember now, it's a lovely support isn't it, from being self employed to having a structure and following a guideline, it gives you a back up. G I appreciate being able to talk it over with Geoff, without wondering if it's serious enough to do it...	**FG 1 p14** **FG 1 p14**	**Positive**

Giving permission to speak	G back up, and it's like you know, we're all very experienced counsellors aren't we, we've all been doing it for a number of years, so its very easy to not, to feel gosh how can I ask, or I shouldn't be concerned, I should be dealing with this, and yet when I went on holiday and talked to Geoff about it, it was so good..	**FG 1 p14**	**Positive**
Protective	G I think what we need to be aware of is if something goes wrong [..]if you want to protect yourself , you need to be aware that if anything does happen, you have had the support from the manager...it sounds over protective but I think nowadays we have to protect ourselves. P ..looking at it as a puzzle you've got to start getting the container, the edges in place, and the assessment from core can be like building that container, can I work with this client in a way that's safe...if they're coming out with a high risk score it's not really a safe area to be for myself or the client, so I kind of use it as an assessment tool.	**FG 1 p14** **FG 2 p4**	
	GN Umm, but that actually I did		

Containment	have in my mind that the guidelines were very helpful in terms of knowing or just reiterating the fact that if somebody has got risk scores, and I always look at them, to make sure that I have done things that I need to do in order to feel safe that uum that working with me is containable and that there's nothing else I should be doing in order to make sure that they're safe. See also D below	**FG 1 p12** **FG 1 p6**	**Positive** **Protective**

Table App 5: 5 Counsellors reactions to risk guidelines

In the swamp of day-to-day clinical work, it is hard to truly separate the use of the risk scores from all the other data within the field. It does seem however that risk scores are used as an explicit part of the process of decision-making.

D "The question about wanting to end their life and if they have ticked that, that would be for me, as you were saying, like containment, am I the one that is going to be of service to this person or is this going to be a psychiatric problem" **(FG 1 p6)**

MY "But I think that CORE form does focus them, it makes them re-think about where they are and I think it's quite an important point. And of course the risk factor which I look for personally." **(FG 1 p8)**

The positive tone of comments noted above correlates with the observed behaviour of the counsellors that I noted in the weeks and months after introducing the risk procedure. **FN (10th Sept 03)** notes that I had had many phone calls about risk matters raised by the policy. This is evidence of adherence to the policy, and my impression is that this has continued since. A note added later to the same source notes comments from a supervision group in October that the policy was experienced as very helpful. This basic triangulation suggests that the focus group comments can be taken as a sound representation of the

counsellors' views, and that these views are matched by their actions in speaking to me about risk matters.

I was surprised at the positive nature of the comments. In drafting the procedure, I had felt that I was undertaking a rather boring but necessary task of no great worth. Indeed I had initially conceived the procedure as somehow separate from the 'real' project that I am undertaking. I think that this is because risk issues are a very much ingrained into my way of working, from probation days and later work with offenders. I underestimated the impact that the procedure would have, and the extent to which having simple but robust guidelines can be experienced as supportive.

The contrast between my initial view and the results is indicative of their reliability. This was clearly not a case of me hearing what I wanted to hear. Of course it might be a case of the counsellors telling me what they thought I wanted to hear. However the presence of some negative comments about CORE generally suggest that this was not a strong factor.

One further matter relating to risk came out of the focus groups. It does not easily fit with the rest of the analysis, and I had been previously involved with the situation. I came to think of it as Di's story, and include it here as it is largely her own words.
D "I think I'm a bit, well, hyper-vigilant. Two years ago a client came and I'd seen her twice and she'd filled in the CORE form and then she was prosecuted for manslaughter of her 13 year old son and we looked at the CORE form and there was no evidence at all that I could have picked anything up. But if I hadn't have had that CORE form I think I could have been in quite a mess actually. I know that's my point of view but ... I think I put myself through enough as it was, every single thing she said, every single thing I looked on that form over and over again saying what did I miss? But in terms of legal matters I don't know. They had it that – they had that form too in the court so they could also make ....what I'd written, the CORE forms, so they obviously had .. it was evidence as well.

GM But in that case, I remember so well, it was evidence of lack of evidence. It was, where I was sitting that the real value for you seemed to be something about the fact that look see what's there, look there's the form, it wasn't there. There was no sense that you'd missed something – it just wasn't there.

D I just went through it for about 6 months in my head, umm, and it was the last thing that I would have thought she would have done. Because when we talked about you love him, what about love and support? As soon as we talked about that she had scored that she, umm, ... you affection for somebody ... the child, oh yes my son. She had all this stuff going on "my son, I have my son", and of course I thought, No support. Interestingly enough what I also do for somebody who hasn't got any support .... I always say o.k. then we can address that your GP becomes your support. I always do that. I've done that for donkey's years. For her I remember saying that too. And it hadn't made sense. But I didn't really look at the little boxes before when I first started but I tell you definitely – and I'm on the phone aren't I "This person's got 13".
GM You are, yes.

D Because it was such an experience."

FG 1 p 6/7.

The story became central as a reminder of the importance of considering risk issues, and simultaneously the fallibility of all risk measures. Here it was clear that the client had not wished to reveal what was truly going on. For D however the very fact that the OM showed this proved extremely comforting. She had in black and white the clients answers to specific questions, and was not left to worry that she had omitted to ask something. Although the story ended tragically (the mother killed herself in prison) the very existence of a structured measure taken at assessment was protective of the counsellor. Had she been called on to do so, she could prove that certain questions were asked, and that she acted in good faith on the basis of the information provided.

Critique of my analysis:

In noting my conclusions from these groups, I think that it should first be noted that the analysis is necessarily not as detailed as it might otherwise have been. Were this a research project based solely on the groups, I would have spent a lot more time on the analysis of the data. I would almost certainly have considered the issue of who ran the groups. An external person might have been better placed to ask more provocative and potentially enlightening questions that me as an insider. As what I described in my doctoral proposal

as a participant participant, I cannot pretend that I have not had a profound influence on the material produced. Indeed I want to have an influence. I am not after some detached research outcome here. I want to produce a group that is interested, stimulated, informed and critical as part of my overall goal of using CORE data. This stems from the very nature of my project. This could become a fig leaf for uncritical thinking however. I think that my stumbling rather late in the day on having a second group does give some space for the emergence of other views. In a sense the second group acts as a form of control. Had it been markedly different in tone, it might support the hypothesis that my presence was preventing certain issues from being raised. Of course the participants knew that whilst I was not in the room, I was going to be listening to the tape, so this hypothesis is questionable. Nevertheless, the fact that there is no noticeable difference in tone between the two groups, and that in both critical thoughts about CORE were raised, does offer some support to the position that my presence has not negated the value of this exercise.

In Strauss and Corbin's (1990) terms I have restricted myself to the stage of open coding, the naming of parts. They note that transcripts can be subjected to analysis by line, paragraph or at the level of the entire document. I do not present line-by-line analysis, although the transcripts have been read in this fashion. In generating categories I relied on my capacity to emerge these from the text rapidly and I trust accurately. Strauss and Corbin talk of the importance of theoretical sensitivity in the researcher. They see this as the ability to 'see' what is latent in the data, using our experience and knowledge to our advantage rather than to obscure our vision. Here I think that I am strong ground, as I use clinical skills to tease out what lies beneath and name it, very much as I would do in work with clients.

What I do not do is advance to the stage of axial coding. This was a pragmatic and slightly frustrating choice. In a nutshell I do not wish to allocate the time or energy to this process, since it would distract from the primary action focus of this project.
Here I am at the heart of one of the primary choice points in this enterprise. I could quite validly, and I think usefully, have embarked on study using grounded theory to generate such a theory about the use of CORE data. Instead I chose to take a more complex messy action research guided path, aimed at generating practical as well as intellectual knowledge. The further development of a grounded theory remains as a road to be explored another time, either by others or myself.

In making this choice I come back to my initial goals. I want to create a service in which CORE audit data is used. In doing this I wish to generate what I referred to in my learning agreement as islands of hard data to supplement the case study, narrative and reflective material. I believe that this analysis, with all its limitations serves as such an island.

Conclusions.

So what does all of this add to the overall project?

Broadly I think that it confirmed my view that the counsellors were overall very positive about CORE and its possibilities. There are of course concerns as predicted. These are entirely realistic since CORE data does hold up the possibility, indeed the likelihood that some individuals will come under adverse scrutiny. There is also a service tradition of challenging and dealing poor performance, either at the point of entry to the service or later.

The comments on the Risk policy and procedure were surprising. I had expected that it would be seen as a necessary but rather irritating piece of bureaucracy. In fact the counsellors seem to find it a very helpful process. The fact that this was not what I expected lends weight to the findings. These are perhaps the most concrete findings of this project, and show how CORE can be used in a very practical fashion. The process of reflecting on the scores and discussing where appropriate is the first example of clear changes in counsellors behaviour as a result of using the system.

At a process level the groups were useful in helping provide a space for the sharing of ideas and concerns about CORE and its use. They also served as a useful marker to me, helping me to confirm that overall counsellors were interested and engaged. This was vital for me since at times along the way, I did worry that I was getting out of step with counsellors, and that my enthusiasm and interest was not shared.

Appendix 6: Risk Policy and Procedures.

Adur Arun and Worthing Primary Care Counselling Service

Risk: Policy and procedures.

Preamble:
This document specifies what actions shall be taken to recognise and manage risk as it relates to clients and staff of the service.
The Primary Care Counselling service is not a service intended for assessing or working with high risk individuals. With the vast majority of counselling clients there is no appreciable risk of anything untoward occurring. However, an element of risk is inherent in every clinical decision. It cannot be totally eliminated. The level of significant risk and consequent damage can be minimised by careful reflection and appropriate action.

The procedures below are intended to assist in that process, by encouraging reflection on all relevant aspects of a situation. There is however no substitute for well-informed clinical judgement.

Types of risk:
Risk can be best viewed as falling in three areas;

There is the risk posed by a client to himself or herself. This might be by suicide, self-harm or other self-damaging behaviour such as substance abuse.

There is the risk posed to specific others, or society in general. This might be through violent or aggressive behaviour. It might be through reckless behaviour such as driving whilst under the influence.

Thirdly, and linked to the above, is the risk posed to ourselves and and/or colleagues.

A useful question to focus the mind is "*who* is at risk of *what*, and *how likely* is it to happen?

If there is a *specific* threat in the *immediate* future, then urgent action needs to be considered. Immediate and serious risks override all other clinical priorities beyond the health and safety of clinicians and others.

Most risks however are not so urgent as to preclude appropriate consultation. There are very few situations that cannot wait whilst we seek such consultation.

Risk Policy.
The service shall work within the spirit of the prevailing Trust policy on risk management at all times.

- **The level of risk posed shall be specifically assessed in all cases.**

In the vast majority of cases this means that, having reflected on the information available from the client, the referrer and CORE OM, the clinician sees no evidence of any risk posed by the client to self or others.

- **A key tool for this assessment shall be the CORE Outcome Measure.**

6 questions are risk related. 4 relate to risk to the client's self, and 2 relate to the risk posed to others. This gives a potential risk score of between **0 and 24** (0-6 for risk to others, 0-16 for risk to self). Common sense suggests that the higher the overall risk score, the more concerned a clinician should be.

- **Where a client scores more than 0 on any risk item, the clinician shall attend to this.**

This should include asking about plans to self-harm and exploring the issue of harm to others as appropriate. Remember however that the CORE OM only asks about the week prior to the time of completion. It may well be appropriate to ascertain the longer-term picture.

- **Where a risk score is greater than 5 in total, or where a client responds with an answer of 4 to any risk item, the matter must be followed up with the client. It should then be discussed with the Head Of Service at an appropriate time.**

There is no simple cut off point in CORE for determining what poses a significant level of risk.

- **In reaching an overall judgement about risk, a client's history should be explicitly taken into account.**

It is well demonstrated that statistically, the best predictor of future suicide or violence is a past history of attempted suicide or violent behaviour.

- **The existence of a significant risk in a counselling client should be taken as indicating a need to review whether the provision of counselling is safe and appropriate.**

- **Where a significant identified risk makes counselling inappropriate or unsafe, it may be necessary to suspend or terminate counselling.**

Such action will of course be rare. It will, in all but the most extreme circumstances, be a course of action that is only undertaken after agreement has been reached with the Head of Service.

Procedures.

- **The total CORE OM score and risk score shall be recorded in client's notes.**

This demonstrates that the clinician has reflected on the situation, and shows what action is taken. Usually such note shall be made during or immediately after a first meeting with the client.

- **Any significant identified risk shall be discussed with the Head of Service.**

In an urgent situation, in the absence of the Head of Service, the counsellor shall consult with the Head of Psychological Therapies, or any available senior colleague within the Trust.

- **Where a client is deemed to pose a significant risk, then the GP and relevant others should be informed.**

Examples are a client who has a plan and/or stated intention to attempt suicide.

- **Any information about use of weapons and/or information about significant use of violence by the client should be recorded, and the information passed to others involved professionally with the client.**

- **As far as is safe, concerns about risk should be explicitly discussed with clients.**

- **Where it is considered unsafe to discuss the counsellors concerns with the client, this will, in all but the most exceptional of circumstances, indicate that counselling is not a viable option.**

Risk and breach of client confidentiality.

The prevailing guidelines within the NHS[52] specifically state that information may be passed on to others concerned with a patients care or treatment. It is accepted that professional need to communicate and cannot and should not be bound by inappropriate concerns about confidentiality. This general principle certainly applies to the communication of information to a GP or other NHS staff member regarding a clients risk level.

Geoff Mothersole.
Head of Primary Care Counselling Service.
June 2003.

References.

The Protection and use of Patient Information. Guidance from the Department of Health. 7 March 1996

[52] Dept of Health 1996.

Appendix 7: Consent form and Information sheet

CONSENT FORM

Title of Project:

Closing the loop: engaging with CORE-PC data

Name of Researcher:

Geoff Mothersole

Consultant Counselling Psychologist.
Head of Primary Care Counselling Service
West Sussex Health and Social Care NHS Trust
16 Liverpool Gardens
Worthing
BN11 1RY

Please initial box:

1. I confirm that I have read and understand the information sheet dated ..... for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. ☐
3. I understand that sections of any notes or tape transcripts may be looked at by responsible individuals from Middlesex University/Metanoia Institute. I understand that this will be for the purpose of audit and examination only. I give permission for these individuals to have access to this material, which will be anonymised. ☐

1. I agree to take part in the above study. ☐

Name of Counsellor	Date	Signature
Researcher	Date	Signature

1 for counsellor, 1 for researcher;

Information sheet.

Study title: Closing the loop: engaging with CORE-PC data

You are being invited to take part in a research study. Before you decide it is important that you understand why the research is being done, and what it will involve. Please take the time to read the followinfg information carefully and discuss it with others if you wish. Please feel free to ask me if there is anything that you are unclear about or need to know in order to give your informed consent to participate in the study.
As you know, we are one of a growing number of organisations nationally who are using the CORE-PC system to audit our work. For the first time, this system allows for real time analysis of service performance. It also allows for the generation of CORE profiles for individual clinicians. It is this latter area that is a particular focus of this study.

Purpose of study:

The study is an exploratory analysis of the ways in which we can make use of CORE data. It aims to examine the process of gaining and making use of feedback in order to provide some beginning pointers as to how this feedback might be used.
You are being invited to participate as one of the counsellors providing an input to the service. Participation in the research is entirely voluntary, and if you do agree to participate and then wish to withdraw, you can of course do this at any time.

What is required:

The request for this study is to participate in group interviews (focus groups) that will be run at various stages. During these groups you will be given the opportunity to reflect on your experience of looking at the CORE PC data. Groups will be tape recorded. The content of these groups will be examined and themes identified.
You will also be invited to complete a questionnaire.
Tapes will be stored securely and without identifying data, and will only be heard by the researcher, transcriber and responsible examiners. They will be erased once the project is completed.

At a later stage of the process the initial analysis of these themes may be shared with you. You would then have the opportunity to comment on the authenticity of the draft, and to request amendments. Of course responsibility for the finished analysis rests with the researcher.
This is a piece of action research. The intention is to do something that makes a difference to how we do things. It may well be that ideas emerge from the process of the research that will suggest other approaches.
Thank you for your time.
Time spent in attending groups can legitimately be counted for CPD purposes.

Geoff Mothersole. June

Appendix 8: Field notes

INITIAL FIELD NOTES (1)

First Round of Meetings

Data entry using the CORE PC System commenced in earnest in late 2002. At around this time the half-day induction session was arranged with John Mellor-Clark and Richard Evans at which Counsellors were reminded of the basics of the CORE System and the relevant features of CORE PC. Following this data entry commenced and, after initial technical problems, we rapidly achieved a database of some 500 individuals.

My original (largely implicit) plan has been to formalise my research proposal and then commence a round of initial meetings with Counsellors at which we would begin to look at the CORE data. As is so often the case circumstances have intervened. This is largely in the shape of the local Ethics Committee. Following various national scandals procedures have been tightened and it became clear that I cannot take any steps without prior approval from that Committee. Unfortunately, it was not possible to get approval from the Committee until I got University approval. This in itself was not possible to achieve until two relevant papers had been submitted. Deadlines for these submissions were many months ahead. It therefore became rapidly obvious that it would not be possible to commence formally researching in the anticipated manner for many months.

I was, therefore, faced with the choice of putting on hold all meetings with Counsellors until I had the relevant approval. This seemed to be a serious case of putting the cart before the horse. The meetings were, in my opinion, essential if we were collectively to make good use of CORE data to improve the service. To my mind it would be unethical and really rather silly to not have meetings that were potentially useful to individual counsellors and therefore the whole service simply in order to meet my research needs.

In addition to the ethical issue there was a very practical issue. I had generated a considerable amount of interest in CORE PC. In my experience such interest rapidly dissipates if individuals do not see anything concrete arising from their efforts. I was particularly concerned to ensure that Counsellors did not have the experience of simply filling in endless pieces of paper and never having any feedback. This has partly been addressed by my sending feedback on overall service performance as one way of completing the loop. It did, however, seem essential to begin to give them the information

about their own individual performance that was now becoming available thanks to CORE PC. My judgement was that doing this would continue to close the feedback loop and would in the long term help reinforce a positive culture about audit in general and CORE System in particular.

At a service meeting in late 2002 the issue was discussed and there was considerable interest expressed in receiving individual feedback. At this meeting there was, of course, some acknowledgement of the potentially rather exposing aspect of this, although this was largely articulated by myself. At this meeting it was proposed by myself that we begin the process of making the data available. Common sense suggested that there was no point in individuals making special time to look at the figures when their personal database was very low. An arbitrary figure of 25 cases and above on the database was therefore suggested and agreed unanimously.

Following the above meeting a memo was sent round to the individuals with the 25+ cases. They were invited to contact me and make a time to meet up. The memo was sent to 8 of the then 12 Counsellors working various hours for the service (7F1M) the other 4 had less than 25 clients on the database (1M3F).

The response was rapid and positive. Within 4 weeks of the memo inviting contact, 7 of the 8 had contacted me requesting a meeting.

NOTE:

It is interesting to note that at this point the request was expressed in voluntary terms. This highlights a serious managerial question about the extent to which this kind of feedback becomes seen as a job requirement as opposed to an optional extra.

The above response rate is rapid considering that in some cases it probably took over a week for the memo to reach the individual's attention.

NOTE:

The above is reasonable prima-facie evidence that the exercise was viewed in largely positive terms.

Field work notes: 1/5/03

Letter of resignation from LR commenting on the interest in core.

Following the first round of CORE feedback a spontaneous discussion occurred in a super vision group with 3/5/and 13.

"I want to be kept on my toes, but not fall over" 5

this comment was made about core and expresses nicely the tension that I was describing between being challenged by core feedback and becoming persecuted by it.

A great deal of interest was expressed in having access to the data on a regular basis.

Following the core management workshop on 1/4/03, I was able to say that we can now access overall data and our own, without 'peeking over the garden wall' at our neighbours scores. There was agreement that this would not have been a good thing, too exposing.
We can now look towards having counsellors access the data at their own desire on a pc here. Open and regular feedback in the hands of the counsellor

Openness

Access to data

Demystifying it?

Judgement/are we good enough?

This greeted as a good thing.

3 expressing questions about the value of the data

"what about those who get worse?" This seen as a general issue. Are we judged on our failures?

22/03/03

FIELDWORK NOTES (2)

The Initial Round of Meetings	**Notes**
MS	
1. This meeting was conducted in a very business-like manner. It is probably relevant that MS is an ex-manager and seemed to approach the exercise with a managerial perspective. Questions were business-like and angled to performance and audit.	
Note: *I realise that there were many unspoken questions that began to be articulated as I prepared for this meeting and during it. There were some practical issues e.g. the need to print off certain pages as reading a screen can be difficult. It was also important for the person to take away something from the meeting. The managerial nature of the conversation highlighted the issue of just what my role was in dealing with this. Am I a researcher or am I a manager?*	transparency voluntarism
2. Meeting conducted in a way that left me feeling as if I was the person doing 'to' the Counsellor as opposed to them being an active participant. Surprising as comparison showed outcome figures to be very high in comparison with the mean. Few questions.	comparison
3. There was a feeling of the underlying question being "am I good enough". An interesting process was the immediate focussing on the negative aspect of the feedback. This was discussed in the meeting and a more balanced view taken.	
4. Again focus on comparison. Particularly strong outcome figures comparatively.	comparison surprise
8. A very active and involved discussion. Compare with (2). Clear satisfaction with feedback.	satisfaction
7. Meeting cancelled owing to urgent commitments on my part.	
6. No contact.	
5.	

Very interesting meeting. Worried at her low effectiveness figures. Invited to be interested not beat self up. Led to discussion of her expectations that clients will have a

Good eg of feedback loop leading to questioning and ? Action

Crisis at the end. Is this a self fulfilling prophecy?
Acknowledged that she does not underpin change where client wobbles and doubts it. Will look at this.
C: ? why figures so low. I expect a crisis in last session
M:
C: But if that were true for everyone, then it would affect all figures
M: Idea of self fulfilling prophecy as hypothesis
C: Maybe I don't acknowledge change enough

Field work notes: (3) Sept 10th 2003

Re risk policy

Numerous t/cs from couns.

GPJ called and stated that she wouldn't have called but for the policy requiring it.

Very helpful and supportive to have the chance to discuss these cases where there is a significant risk element

NB: in writing this I realise that I somehow had not considered the risk procedure as a part of the project as a whole

It seemed to be a 'bureaucratic' thing and was in a different mental box.

Of course it is a part of the complex whole that is under the umbrella 'using core data'

Later: Oct 03.

Comments from counsellors (3 of them) in supervision group that the policy had been useful. It allowed them the freedom to call and discuss cases where before they might not have bothered

FIELDWORK NOTES (4)

The Second Round of Meetings. Oct 2003---

Notes

14. Asked to meet and look at CORE. Very interested and appeared excited. Lots of questions. Acknowledged the reality of examining own data

own data.
Spent a lot of time going through the system and showing what it could do. Pleased with own results.

FIELDWORK NOTES (4) Nov 03

Notes

The second Round of Meetings

AG Asked to meet just after CORE meeting and focus groups.

Effectiveness figures rather low
? Illness/low no above cut off

PG Also asked after meeting. V interested in whole thing.

ST second meeting. Used feedback form. Very interested in looking at the whole thing further.
Discussed IT and how to make data more accessible.

Field work notes: Dec 03

Discussion with LJ re the use of core in the trust.

She wants me to come to her areas and speak about audit and enthuse people. Otherwise it doesn't get off the ground. She is very keen and we examined her individual profile.

Meeting with Liz F and Adelle H from audit.

Showed them the system. Very impressed and want to use it widely in the trust. I explained some of the budgetary problems. It feels a bit odd as I do not want to set up a problem with Mary/Peggy. But I do think it essential that we use it widely.

The task is to disseminate the use of core more broadly in the trust.

Methods: audit ctte/ clin gov agenda/CHI.

Appendix 9: The questionnaire to counsellors

Development of the questionnaire.

The idea of a questionnaire arose after a period of questioning the potential usefulness of engaging in taping interviews with counsellors.

I needed a way of eliciting their experiences and thoughts without focussing the entire study on that area.

Having previously used questionnaires in my UKCP work, this approach immediately struck me as having several benefits; it is relatively straightforward to administer. It can be analysed both quantitatively and qualitatively, and was thus in line with the spirit of methodological pluralism that underpins the project. Finally, the activity of considering the questions and completing the questionnaire could be seen as a further opportunity to engage the counsellors in the process of making meaning out of the data, and being active in the meaning making process.

Before proceeding, a number of issues had to be considered.

Questionnaires rely on a basic level of literacy and familiarity with forms

Give the nature of the group that this questionnaire would be given to, there were no obvious problems in this area.

As McLeod (1999) comments, "this method relies on the ability of the person (completing the questionnaire) to report ...with at least a moderate degree of accuracy" p65.

Given that the questions were to be about the counsellors own views and experience, this criteria was met. There was no reason to consider that they would have significant reason to be so concerned about how their responses would be seen, that they would provide significantly inaccurate responses.

Initial design of the questionnaire.

As with the overall project, the design of the questionnaire depended on just what questions I wished to address. It was therefore necessary to specify its purpose.

The broad areas that I wished to address were:

- The counsellors experience of looking at CORE data so far.(ie: their thoughts about the process).
- What they had learned, if anything. (ie: the outcomes thus far).

- Their thoughts about what would be helpful as next steps.

The process was seen as a part of a spiral, whereby the results would be fed back to further discussion and the identification of next steps. In this sense the very act of inviting responses to a questionnaire was part of ensuring continued engagement in the debate.

Identifying these principles occurred during the process of the initial designing trialling and amending of the questionnaire. It was really only in the process of actually designing and looking at the drafts that I clarified what I was doing.

Several principles were important in the design. The first is to take care of the respondent, and not get in the way of their being able to communicate their thoughts and experiences (Barker, Pistrang and Elliot 1994). This means keeping it as short as is reasonable (McLeod 1999). I can certainly resonate with this. I have received many questionnaires in the post over the last few years, and I have to admit that some, even though they looked interesting, ended up unanswered.

Care was taken to ensure that wording was reasonably neutral and did not inappropriately suggest answers. Whilst I was of course hoping for broadly positive responses (that indicated commitment to the process) I had to ensure that I allowed space for 'negative' answers.[53]

Questions were specific and sought to address single issues.
I decided to include Likert scales as part of the design. The inclusion of such scales, which effectively constrain the respondents' answers by requiring that they ring one of five given responses, introduces a different form of data into the project. It is possible to analyse responses in a quantitative manner as well as a qualitative one.
This is a step that is entirely consonant with the philosophical and methodological position outlined earlier. It also increases the potential for triangulation. The specific questions address the overall perception of CORE at the present and in anticipation. Responses are thus highly germane.
The art with such scales is to make the scale long enough to get some differentiation of answers, but not so long as to be meaningless. The general rule of thumb is to have about

[53] Which of course are not really negative at all. Every response tells us things if we can but understand what.

five points (Barker et al 1994). This helps prevent the problem known as the 'central tendency' where responses tend to cluster in the middle of the scale.

Such scales can be unipolar or bipolar. A unipolar scale seeks responses on one construct in varying degrees. In this context, a unipolar scale would have asked if counsellors found the experience not at all helpful to very helpful.

A bipolar scale ranges from one construct to its opposite. Such scales made intuitive sense in this context, since I wanted to allow for a range of responses. The initial version of the questionnaire included an example of each, a fact that was not picked up until I did some further reading.

With any such scale, there is a choice as to whether to include a neutral or mid point. I am convinced by the argument that *not* to include such a mid-point, and thereby to force a choice to one end or the other of the polarity is too coercive. This is not in the spirit of this piece of research, and I therefore included a mid point.

The Likert scales were reversed in the original version, so that two had the positive polarity at the left and the others had the positive polarity at the right. This is a standard measure taken to prevent the establishment of unthinking response sets during the process of completing the questionnaire. Its value is that the individual usually has to stop and consider their response rather than assuming that the 'good' or 'bad' answer is always in one place.

A first draft was trialled on a friend who, as a Senior Lecturer in a University, had experience of teaching research to practitioners in an allied field. This revealed that I had unwittingly ignored the possibility that counsellors might already have identified areas that they had learned from. Two questions about the identification of helpful/unhelpful issues thus far were added.

In revisiting the general look of the questionnaire, I had a small but pleasing flash of what Robinson (2000) named 'informed intuition'. I had recently found out how to use text colours and highlighting on my PC. It occurred to me that the aesthetic appeal and capacity of the instrument to maintain interest and attention could be enhanced by the use of colour. I therefore experimented with various schemes until I hit on something that seemed good enough.

Simultaneously, the order of some of the questions was altered. This was to produce a natural flow in which counsellors were asked to reflect on their fears prior to a first meeting, comment on that meeting, and then on the impact of that meeting.
After the initial design described above, the questionnaire was placed on the back burner pending finalization of the Learning Agreement and the running of the first focus groups. As with the pause for ethical approval, this proved to be fruitful.

When I came back to it, I realized that I had designed it rather narrowly with a focus on the 1:1 interviews. Having taken stock I had identified a number of mini cycles that had been completed (R M 18). The original drafts of the questionnaire were too general and addressed questions that were more of a pure research nature. I needed something that produced knowledge that could inform my next steps.

My questions needed to be tapered and made more specific. Early drafts asked for comments on the experience of using CORE as a whole. Whilst this was not entirely dropped from later drafts, I realized that I wanted feedback on some specific areas that had already emerged as nodes of interest within the overall enterprise.

I wanted to follow up on counsellor's views about the risk guidelines. This was a very specific area in which we had made use of the data and I wished to have another data source to complement the focus groups. Having developed specific guidelines I

Secondly, I had met with a number of the counselors to begin the process of looking at their data. With the introduction of the feedback template in CORE-PC 2, such meetings could become more focused and challenging, and I wanted to test the waters before proceeding.

Thirdly I had realized that a bottleneck in the overall process was counsellor's access to data direct. Having arranged for this access, I wanted to know whether they had used the facility and if so, how they had found it.

The final version of the questionnaire.

The final version of the questionnaire was laid out in scan able format by the trust audit department. This gave it a better layout and removed the necessity for manual data entry. Unfortunately my bright idea about the use of colours had to be dropped, as the trust did

not have colour printers. Also, the alternating layout of the four Likert scales was altered in the translation to scan able format, something that I did not notice until after I had distributed it. I took the decision that nothing was to be gained from recalling the copies, since any bias that this minor error introduced would be more than offset by the benefits of avoiding further delay. Were the questionnaire to be used again this would be amended. Figure App 9: 1 shows the final version of the questionnaire. A copy of the analysis of the questionnaire provided by the trust audit department can be seen at the end of the chapter.

Results of the questionnaire.

The process of disseminating and collecting the questionnaires was rather an odd one. The idea had been on the stocks for some considerable time by the time it was finally given out to counsellors. I had held off from using it because I wanted to analyse the focus groups, generate some areas of focus from that, and incorporate these in the final questionnaire as a way of drilling down further into specific areas of interest. Unfortunately the issue of counsellors employment situation became paramount (see Context Document 2), and before I knew it, some five months had passed. I realised that there was a danger of the whole issue becoming stale, and decided to give it out, with a preparatory talk, at the training day on CORE in early 2004 (where we examined the database live). I wanted to make sure that I had chance to let counsellors know what my rationale for doing it was. To send it out cold with just a memo would, I thought, run the risk of not engaging them. I wanted to ensure that they saw it as part of the cycle of reflection and action, and that it would guide our next steps.

After one month I had only received 7 responses. A couple of reminders by memo and individual conversations brought in a couple more. I was disappointed and a little worried by what I saw as a poor response rate. I had anticipated that all bar one or two would reply, whereas I had a 60 % final response rate.

I found myself in a difficult position, torn between my interest as researcher/owner of the process, and my role as manager. I felt that I could not properly go too far in chasing people up. They had (as was outlined clearly by the research Ethics Committee and the consent form (Appendix 7) an absolute right to withdraw from the study at any time and not be asked to give reasons. I had to prioritise this over my frustration and curiosity, and ensure that I did not abuse, or risk being perceived as abusing, my power as manager. This is a good example of the limitations that the role of participant participant places upon one as an involved researcher with multiple roles.

It all seems a little odd given that, had I been calling what I was doing 'audit' I could, as manager ask for and expect compliance. As the questionnaire went out as part of something with the title 'research', I felt compelled to err on the side of caution and not risk acting in a way that went against the central ethical requirement of voluntary involvement. Of course, I could have sought guidance from the ethics committee on the matter, in order to ensure that whatever actions I took were clear and above board. Informal soundings (a colleague who was taking a place on the committee) led me to believe that they would take a strict view on the matter. I therefore decided not to do this on the basis that the likelihood of gaining permission was low, and the benefits of gaining permission and obtaining further responses did not merit the additional effort.

I think that what happened is that my questionnaire got subsumed in the story of moving counsellors over to contracts of employment. In giving out the questionnaire at this time, I had thought that I might get a better response rate as counsellors were now being paid to undertake extra client duties. Under the previous arrangement such requests had seemed like something of an imposition, as counsellors were not being paid for anything other than seeing clients. In the event, I think that my timing was poor. Probably I should have held fire for a while to let things settle. Counsellors were very preoccupied with the transition, getting used to new requirements of being trust employees. This inevitably involved lots of paperwork, and I assume that my questionnaire did not stand out as priority in this. Also, there was some bad feeling about salaries, with one counsellor in particular feeling very bad about what she was receiving under the new system.

The first question to reflect on is what if anything can we conclude from 9 out of a possible 15 responses? In the world of questionnaires, this is considered to be a good response rate, but where the overall numbers are low (as here) it poses problems. Percentages should be treated with considerable scepticism, since any individual's answer constitutes 11% of the total and the slightest variation in how any one person answered a question could lead to markedly different final results.

What of the 6 who did not respond? Were they making a coherent statement that should be listened to, or would they have answered in a broadly similar manner had chance events or other circumstances not prevented them from responding? This is always a problem when seeking to collect people's views. In this case it is probably reasonable to speculate that those who did not respond were on the whole less positive, but this is nothing more than educated guess work.

Despite the above caveats, I think that some very general trends can be inferred from the responses to the questionnaire. 1:1 meetings largely confirmed initial fantasies and were seen as positive both in terms of the meeting itself and what was gained.

There are clearly problems with the process of allowing counsellors to access data for themselves, with two thirds indicating that they had not done so in the 6 months that this had been technically possible. The responses seem to indicate that allocation of time is an issue for some, and technical fluency clearly plays a role. This suggests that the issue of competence addressed via the 'trip through CORE' document might need further attention. The issue of time might be less of a problem with counsellors as employees, since they have paid time to undertake such legitimate activity. By far the soundest results from this part of the project are the views about the overall value of using CORE (questions 6/7). All 9 respondents indicated that they had found CORE useful, and each indicated that they had already identified something specific that either is or could be helpful in practice. This is very strong evidence that cuts to the heart of what I am seeking to achieve. It suggests that counsellors are able to identify examples of examining the data and extracting practice relevant knowledge. This is not the same as evidence that they actually are doing something different. That is outside the bounds of this project and would constitute a separate (and interesting) research study. What it does do is offer strong support for the central hypothesis that engaging with the data is a worthwhile activity. It goes a considerable way to showing that we have begun to engage with CORE data, and that this has been done in a way that counsellors find positive.

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Making use of C.O.R.E Data

This questionnaire is designed to gather your thoughts and reactions to the process of examining your CORE profile so far. It is also intended to provide information about how we might make use of the data in the future.

I hope that by closely examining ways of making use of the data, we will be able to ensure that the process is a positive one. I would appreciate your full and frank responses to the following questions.

Section A - Meeting To Examine Your C.O.R.E Data

1) When you first examined your C.O.R.E data, were your initial fears/fantasies met?

Yes ☐ No ☐ Unsure ☐

Comments: _____

2) How would you describe the process of meeting to examine the C.O.R.E data?
(What did it feel like for you to look at your own data?)

Very Positive ☐ Broadly Positive ☐ Mixed ☐ Broadly Negative ☐ Very Negative ☐

Comments: _____

3) How would you describe the outcome of the meeting in terms of what you gained about C.O.R.E?

Very Positive ☐ Broadly Positive ☐ Mixed ☐ Broadly Negative ☐ Very Negative ☐

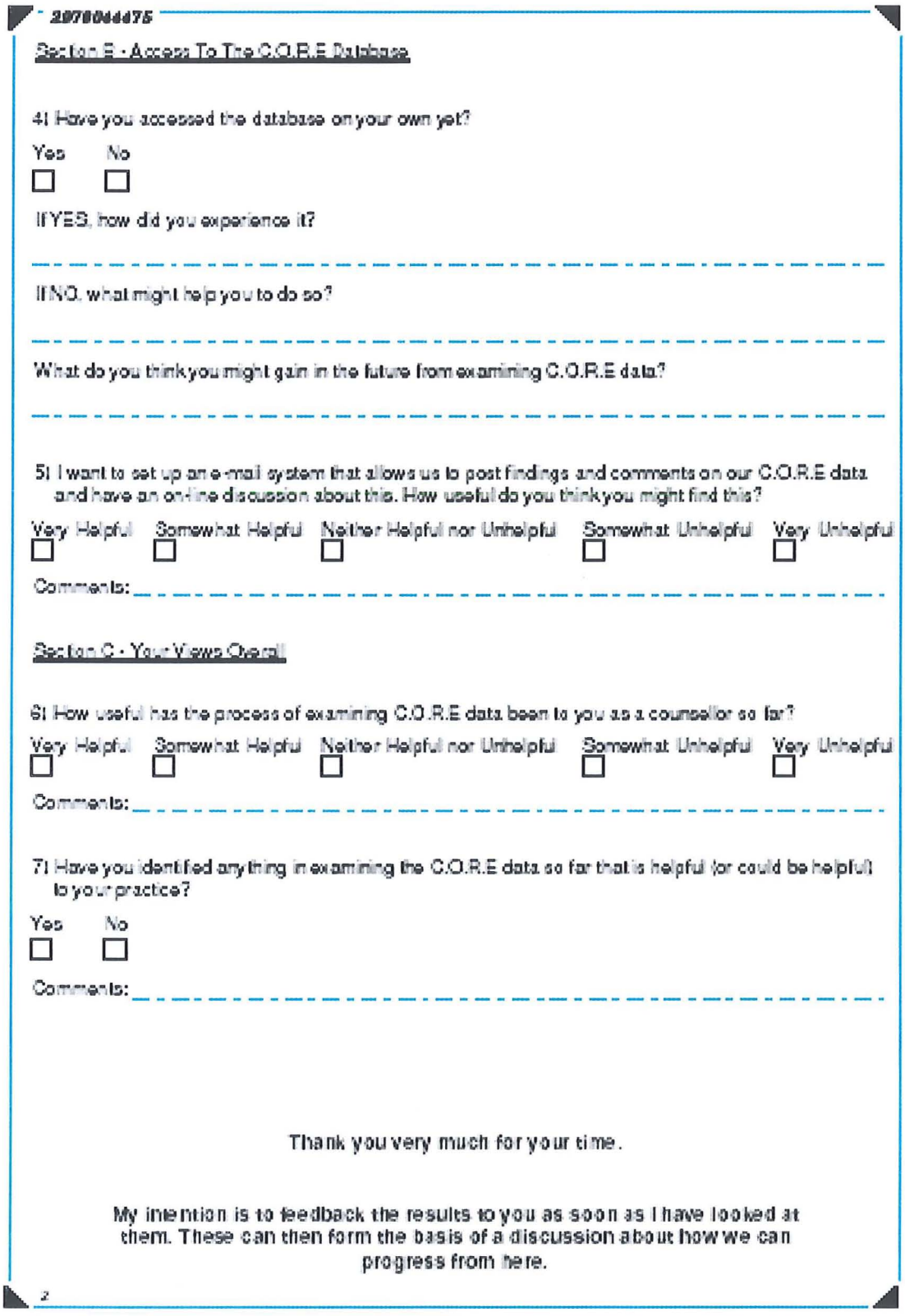
Please give 2 or 3 'why's' for your overall impression of the above:

(1) _____

(2) _____

(3) _____

PLEASE CONTINUE ON NEXT PAGE



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Section B - Access To The C.O.R.E Database

4) Have you accessed the database on your own yet?

Yes ☐ No ☐

If YES, how did you experience it?

If NO, what might help you to do so?

What do you think you might gain in the future from examining C.O.R.E data?

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5) I want to set up an e-mail system that allows us to post findings and comments on our C.O.R.E data and have an on-line discussion about this. How useful do you think you might find this?

Very Helpful ☐ Somewhat Helpful ☐ Neither Helpful nor Unhelpful ☐ Somewhat Unhelpful ☐ Very Unhelpful ☐

Comments: ---

Section C - Your Views Overall

6) How useful has the process of examining C.O.R.E data been to you as a counsellor so far?

Very Helpful ☐ Somewhat Helpful ☐ Neither Helpful nor Unhelpful ☐ Somewhat Unhelpful ☐ Very Unhelpful ☐

Comments: ---

7) Have you identified anything in examining the C.O.R.E data so far that is helpful (or could be helpful) to your practice?

Yes ☐ No ☐

Comments: ---

Thank you very much for your time.

My intention is to feedback the results to you as soon as I have looked at them. These can then form the basis of a discussion about how we can progress from here.

2

Figure App 9: 1 Final version of the questionnaire.

The client satisfaction questionnaire.

Although it is not central to this project, it is worth mentioning that shortly before the above questionnaire was sent out, I devised and used a satisfaction questionnaire at the request of the PCT. It was sent to 180 clients who had finished counselling in the recent past. 66% were sent to female clients and 33% to male, this representing the gender balance of our clientele.

The request was dropped on me at comparatively short notice. I was frankly rather irritated at what I saw as something of a hoop jumping exercise imposed by the PCT in order to fulfil their obligations to address user involvement.

I had done a similar exercise in a previous post, so I rapidly drew on that, drafted a questionnaire with the able help of a Masters student, and sent it off to a large sample (180) of completed clients.

The results were very positive, with a return rate of just below 50%, and overall a very high level of satisfaction with the service and counselling received.

I was impressed at just how well we were perceived, as were the counsellors, PCT, and GPs to whom I circulated the results.

In acting speedily however I missed an opportunity to truly reflect and learn. I did not take the opportunity to inquire about how clients experienced the CORE questionnaire.

Looking back I find it surprising that I missed such an obvious opportunity. To miss the chance to begin to seek the views of the people who are central to our whole profession seems quite astonishing.

I suppose my irritation didn't help. Basically I became Winnicott's teacher (see chapter 1) and simply repeated past actions emptily, rather than truly reflecting and being open to learning. I suppose it is an illustration of just how easy it is to slip lazily into familiar patterns.

The key issue with mistakes is to learn from them however, and once I had realised this error I was able to take some steps to fill the gap. I added a question to the questionnaire that is now routinely given to all clients on completion of counselling. I also was able to add the same question to a questionnaire going out to a large sample of completed clients as part of my student's Masters research. The results are not at hand at this point, but it will be interesting to start to scratch the surface of this crucial area.

West Sussex Health and Social Care NHS
NHS Trust

Audit Report

Chapter 2. DIRECTORATE OF NURSING

Chanter 3. CLINICAL AND SOCIAL CARE GOVERNANCE

May 2004

Audit Of Staff Perception Of The C.O.R.E Data System

Introduction

As part of a continuous process of quality improvement, the Adur, Arun and Worthing Primary Care Counselling Service in collaboration with the Clinical Governance Team devised a staff questionnaire in order to establish their perception of the C.O.R.E (Clinical Outcomes in Routine Evaluation) Data System. The Audit was conducted during May 2004.

The C.O.R.E system is a nationally validated tool for auditing and measuring outcomes of psychological therapies. Using pre and post measures and clinician completed forms, a database is developed for the service. This gives profiles of both service performance and individual clinical performance. These can be compared against a growing national database gathered from NHS and other psychological services. The Adur, Arun and Worthing service has one of the largest databases, and is at the forefront of learning how to make use of the practice based evidence that it provides.

Data Collection

All of the Adur, Arun and Worthing Primary Care Counselling Service staff that use the C.O.R.E Data System were sent a questionnaire for completion and return. A copy of the questionnaire can be found in **Appendix 1**.

Analysis

There were 9 surveys in total returned and analysed. The tables below detail the responses to the questionnaire.

Section A – Meeting To Examine Your C.O.R.E Data

1a) When you first examined your C.O.R.E data, were your initial fears/fantasies met?	Count	%
Yes	7	78%
No	1	11%
Unsure	1	11%
Total	**9**	**100%**

1b) Comments:
I resented it for months. I felt it interfered with the counselling relationship.
Yes, in that it would reflect my work and no, I was pleased with what I saw in my work.
C.O.R.E makes me feel more secure within my profession.
My initial reaction was positive, I felt it was a good assessment tool.
Anxiety about performance/measuring outcomes.
I felt data reflected my efforts.
Overall improvement, figure was lower than anticipated.

- 78% of responders felt their expectations were met with regard to the C.O.R.E system.

2a) How would you describe the process of meeting to examine the C.O.R.E data?	Count	%
Very positive	3	33.5%
Broadly positive	4	44.5%
Mixed	1	11%
Broadly negative	0	0%
Very negative	0	0%
Not been possible	1	11%
Total	**9**	**100%**

2b) Comments:
Yes, it was a good experience, better than I thought and it was shown with sensitivity.
An interesting and supportive exercise.
This has not really been possible.
It was very interesting, things I thought would be the case weren't and vice versa.
The second time felt much more positive.
Figures were explained clearly.
Helped me to identify areas to work on and incorrect entry of data by me.

- 78% of responders described the process of meeting to examine the C.O.R.E data as a positive exercise.

3a) How would you describe the outcome of the meeting in terms of what you gained about C.O.R.E?	**Count**	**%**
Very positive	5	55.5%
Broadly positive	3	33.5%
Mixed	1	11%
Broadly negative	0	0%
Very negative	0	0%
Total	**9**	**100%**

3b) Please give 2 or 3 'why's' for your overall impression of the above:
a) It is very useful in observing my strengths and weaknesses. b) It is important to see the strength of the service overall. c) It is good to meet as a group to build team work.
a) It made me look at my weaknesses and strengths. b) It helped me to assess my training needs. c) Greater understanding of the forms.
a) Opened up possibilities for use of C.O.R.E. b) Validated work already done on this. c) Clarified problem areas and uncertainties.
a) It confirmed my hypothesis that C.O.R.E could be the tool to add credibility to our work. b) It made me aware of all the variables that influence data. c) There is scope for so much more, how differently the form is used.
a) I was impressed at the specific level that could be looked at. b) It was good to compare our data with averages. c) I found it very rewarding to compare clients outcome measures to see significant change.
a) Good feedback. b) Felt very supported by you. c) Challenging and interesting questions raised.
a) Insights in to all C.O.R.E can offer. b) Liked the scatter plot presenting data. c) Stimulates questions of factors influencing the outcomes.
a) Interested to know how I compared with last year. b) New interest in computers and a focus for using one. c) Surprising results in categories such as eating disorders.
a) The feedback was helpful and supportive. b) The results got in the way of the feedback. c) My confidence was undermined – questions left hanging, "is it me? Or is it the data?"

- 89% of responders described the outcome of the meeting and what they gained from it as positive. Comments made included, the fact that it was helpful to observe ones strengths and weaknesses and to see what can be produced from the C.O.R.E system.

Section B – Access To The C.O.R.E Database

4a) Have you accessed the database on your own yet?	Count	%
Yes	3	33.5%
No	6	66.5%
Total	**9**	**100%**

4b) If YES, how did you experience it?
In group of three – beneficial to share information and discuss findings.
Sadly I was unable to look at it in detail due to problem.
Confusing at first but good when I got the hang of it.

4c) If NO, what might help you to do so?
With another colleague or manager!
Time!!
Probably have more time.
Feeling more confident about computers and good access.
Training on fundamentals and practice. No immediate access.
More time.

4d) What do you think you might gain in the future from examining C.O.R.E data?
Keep my performance up to scratch.
Continue monitoring of my work.
Information on personal work and possible areas for development. Overall comparisons on wider scale.
I would like to look at strengths and weaknesses.
Continuing to look at my own strengths and weaknesses.
Reflecting on practice, areas of strengths and weaknesses.
Ongoing measure of effectiveness.
More specific areas of strengths and weaknesses.
Re-evaluation of my practice.

- Only 33.5% of responders had accessed the database on their own. Of the 66.5% who had not accessed the database on their own, some stated more time would give them more opportunity. When asked what they think would be gained in the future from the C.O.R.E system some stated the continuous monitoring of their strengths and weaknesses.

5a) I want to set up an e-mail system that allows us to post findings and comments on our C.O.R.E data and have an on-line discussion about this. How useful do you think you might find this?	Count	%
Very helpful	3	33.5%
Somewhat helpful	4	44.5%
Neither helpful nor unhelpful	2	22%
Somewhat unhelpful	0	0%
Very unhelpful	0	0%
Total	**9**	**100%**

5b) Comments:

I am computer illiterate, but might find others ideas helpful. My husband can access e-mails for me.
I can get access to a computer.
We are colleagues so let's share interesting findings.
I think it would be good to talk to others more regularly.
Unsure about the online discussion.
I would like more skills in computer use first.
Useful to share ideas, but will the time spent be justified?

- 78% stated that the setting up of an e-mail system to post finding and comments on would be of help. Of the 22% that felt it was neither helpful nor unhelpful had worries regarding their computer skills.

Section C – Your Views Overall

6a) How useful has the process of examining C.O.R.E data been to you as a counsellor so far?	**Count**	**%**
Very helpful	6	66.5%
Somewhat helpful	3	33.5%
Neither helpful nor unhelpful	0	0%
Somewhat unhelpful	0	0%
Very unhelpful	0	0%
Total	**9**	**100%**

6b) Comments:
It is important to me to get good C.O.R.E results.
Reassurance that am providing adequate service. Greater awareness of issues arising from group discussions.
It makes me more confident about my work.
I think it is an excellent tool.
Gives good objective feedback.
Given me confidence that figures backup subjective views of progress with client groups.
Clarifies risk, informs my practice causing me to constantly question and reconciling objective results from information subjectively but by clients is difficult.

- 100% of responders felt the usefulness of the C.O.R.E system with regards to their position as a counsellor was helpful and is of great help to their progress as a service.

7a) Have you identified anything in examining the C.O.R.E data been to you so far that is/could be helpful to your practice?	**Count**	**%**
Yes	9	100%
No	0	0%
Total	**9**	**100%**

7b) Comments:
Assess carefully, aim for number of sessions, which will have maximum benefit.
The group discussion 14/03/04 helped look at how we as individuals interpret the forms. The parallel

process is how each client interprets the question.
Identifying possible areas in future for CPD.
I am more inclined to extend sessions with females.
I would like to look more specifically at the client's issues to see if there are some, which are more difficult for me to work with. I was surprised that the average number of sessions offered was not above average. 92% success rate (significant change) I feel I must be doing something right.
A good general measure of my work.
My interest in risk assessment increased since working with C.O.R.E.
Recognition of the degree that my attitude regarding completion of care can influence the outcome.

- 100% of responders felt that the C.O.R.E system is helpful with regard to their practice.

Outcomes and Recommendations

Signs of Good Practice

- 78% of responders described the process of meeting to examine the C.O.R.E data as a positive exercise.
- 89% of responders described the outcome of the meeting and what they gained from it as positive.
- When asked what they think would be gained in the future from the C.O.R.E system some stated the continuous monitoring of their strengths and weaknesses.
- 78% stated that the setting up of an e-mail system to post finding and comments on would be of help.
- 100% of responders felt the usefulness of the C.O.R.E system with regards to their position as a counsellor was helpful and is of great help to their progress as a service.
- 100% of responders felt that the C.O.R.E system is helpful with regard to their practice.

Areas for Improvement

- *Of the 66.5% who had not accessed the database on their own, some stated more time would give them more opportunity.*
- Of the 22% that felt the setting up of an e-mail system to post finding and comments on was neither helpful nor unhelpful had worries regarding their computer skills.

Adelle Hedges
Clinical Audit Project Manager
13th July 2004.

Figure App 9: 2 Audit department report on questionnaire.

Appendix 10: The role of seminars in the project.

This section weaves the seminars attended into the overall project, showing where they helped me clarify or elaborate matters related to this project. Other connections appear elsewhere in the text.

The seminars have always seemed to occupy a rather awkward place in the doctoral programme. I can fully see the value in meeting with the 'great and the good' within the field of psychotherapy, and have greatly appreciated the opportunity to meet with individuals, about whom I had previously only read. Irrespective of this programme, this would have been valuable CPD activity. Indeed, it was because of my interest in attending two upcoming seminars that I registered midway through the academic year.

My problem comes in how one is supposed to incorporate the work for, and learning from, the seminars into the final project. Perhaps inevitably, I have found some seminars much more germane than others.

The first seminar that I attended was that of Sinason (2002), addressing the fascinating topic of dissociative disorders.

As I noted at the time; "This is a controversial and fascinating topic that cuts to the heart of what we can and cannot know from our clinical work.

I approached the topic of dissociation with a mixture of fascination and suspicion. I have found the concept of dissociation extremely useful in explaining some of the things that I have seen clinically, especially in abused or traumatised people. What I have always struggled with is the associated concept of DID, in which self-states are said to be completely separate and possessed of their own personal characteristics. Whilst I have no problem with fragmented and contradictory personality structures (typified by Borderline Personality Disorder, and best explained by the TA concept of ego states) I do not find the concept of entire separate personalities intellectually convincing. It seems to me that there is too much evidence of confabulation and suggestibility (cf: Gudjonnson 1992).

To say that I found the seminar troublesome is an understatement. I was concerned at what I took to be a cavalier approach to evidence on the part of the seminar leader. It is clear that she is a crusader for this cause, and has great energy and passion for it. Unfortunately this leads to an appearance of assembling facts in order to support her pre-existing thesis, rather than taking a critical look at the evidence both pro and anti her position.

There was a complete lack of an engagement with critical issues, for example the problem of how one begins to differentiate between someone who may have been ritually abused and someone presenting with a factitious problem. My questions about the implications of the work of Gudjonnson (1992) on suggestibility, and the Wilkomirski case were not met with direct and convincing responses. There was no acknowledgement of the fallibility of memory in 'normal' (ie: not abused) participants, eg Braun et al (2002)

.

I found this seminar to be intellectually unsatisfactory and worrying in its implications. For example the statement was made that most sexual offenders have been sexually abused. This does not fit with my understanding of the literature[54]. There are problems with such a view. It is a cause of great concern to victims that they too might become abusers. Abusers themselves like to present themselves as victims as a way of avoiding responsibility. The whole notion of humans as simply replicating their own problematic history seems to dangerously minimize the issue of choice and free will, and is untenable to me as a total explanation of human behavior. Most importantly, the thrust of the seminar seemed to be that we accept stories from our clients as gospel, and do not seriously entertain the worrying possibility of confabulation and error in their narratives. In view of the work of Loftus (for example1995/1997) and others on memory, I cannot accept this position.

Sinason appeared to me to exhibit a level of zeal that I found discomfiting. I missed any evidence of an ability to critique her position. This does not fit well with my view of what a researcher should demonstrate. Passion and commitment are central to the completion of any project, and have certainly played a central role in my work. However, they need to be leavened with a strong dose of critical thinking and scepticism. One should always be able to acknowledge the alternative explanations for the known facts, and show logically why one prefers one's own theory.

Within the seminar, I saw no evidence of this process. Indeed, I saw no evidence of anything that I would call a fact. Sinason alluded to clinical evidence, but could not point to anything that I would consider adequate evidence to back up such serious claims. When I pushed her on this matter, she spoke of how we tend to find it hard to accept the awfulness of ritual abuse. This is true, but in 25 years of listening to awful stories of rape

[54] I was at the time of this seminar working in a nationally renowned centre for the treatment of offenders, including sex offenders, and could reasonably consider myself to be well informed on this issue.

torture and murder I have come to accept what humans can do to each other. I have stood in Umschlagplatz in Warsaw, and I do not have a problem with the fact of human destructiveness and cruelty. What I have a problem with is someone who keeps telling me something but can produce no evidence to back up her claim.

My concerns are not unique to myself. Afterwards I did some more research on the issue of normal memory and false memory, and found the following:

"It's depressing to find someone who has a position at leading London hospitals who is so cut off from what research methodology is, and what rational evidence is," La Fontaine, quoted in the Daily Telegraph, 22/3/02.

Now of course, this newspaper has its own agenda, and mocking anything that smacks of woolly liberalism is high up in its order of priorities. However, I think that on this occasion its sceptical position is in line with the state of research. Consider for example the work on so called flashbulb memories. These are those events that have high emotional valence, for example the day Kennedy was shot (for the older ones of us) or the Challenger disaster. Studies consistently show that whilst we might have strong memories and believe that they are accurate, when examined over time, a large percentage of us will change our recollection, and *show no recognition of this* (Brown and Kulik 1977, Schmolk Buffalo et al 2000, Neisser and Harsch 1993). Other work shows how easy it is to create false memories in healthy people (Wade, Read et al 2002, Mazzoni and Memon 2003). All of this suggests that we all become sceptical about our own memories (van der Wettering Bernstein and Loftus 2003).

Sinason shows no awareness of this massive and (to me) persuasive evidence base. It might be that she has a powerful argument as to how her views can logically coexist with this evidence, but I see no evidence of this.

The above stands as an example of how I do not wish to be in relation to my evidence. Central to me is retaining the ability to *critique my position*, and to relate my views to the totality of evidence. Perhaps there is a natural tendency to become rather over fond of our own ideas. I later saw some, much milder, evidence of this in the Mahrer seminar. Maybe we all have a tendency to become at times like Winnicott's teacher (see chapter one). Putting the content of this seminar to one side, I realise that I am convinced where people engage with counter arguments and either offer logical rebuttal to them, or amend their views in the light of new evidence. Such an attitude was evident in the last seminar that I

attended, de Zueleta's day on attachment and trauma. Covering the broadly the same territory, she specifically acknowledged the troublesome issue of false memory incorporating it into her thinking and way of working in a fashion that I found much more ethically and intellectually satisfying. This is the fundamental attitude that I am trying to instil in my service in using CORE data, and it is have sought to conduct the entire project. The evidence on the fallibility of human memory serves to underline the point made in my learning agreement, about the importance of acknowledging the gap between what we say we do and what we actually do.

The second seminar was Parry's (2002). Even at the pre reading stage this captured something central to this entire enterprise. As I noted at the time;
"I found this paper interesting in its summation of the state of play to date. Perhaps the most challenging section is the final one, which is effectively about how we use the evidence. It seems to me that Parry is making the essential point that all the research counts for nothing unless we change what we do as a result. As a service manager this is the central issue. There is no point in collecting evidence unless we use it. Her statement that 'many audits gather data but give insufficient feedback' is in my experience accurate. The focus of my research into the use of CORE will be on exactly how to take what it provides and use it to shape a better service."
This comment is one that I have found myself repeating both in presentations and to myself, since this is the point at which my work begins. How do we ensure that we use audit data, rather than collecting it, feeling satisfied, but then doing nothing with what we have collected? It is absolutely central to my project.

This statement had an impact because I saw in this presenter something that I missed in the previous seminar. I saw Bromley's (1986) 'quasi judicial approach' in action, as Parry carefully presented the evidence in a logical and coherent manner that supports this and her other conclusions. I was in a nutshell *persuaded.* In terms of the genesis of this project, I saw a genuine expert identify and name an issue. My work to be was therefore *located.* It was not simply something that arose idiosyncratically out of my concerns. This in turn suggested that addressing this area would have wider value to the broader community of practice.

A second useful clarification arose from this day relating to the order of development of any research. Parry outlined her first rule of research, namely that we should not bother

with methodology until the basic research question has been identified. This was to prove extremely helpful in the next months as I went round in seemingly endless circles seeking to identify what my basic area of interest was. It didn't prevent me from getting bogged down in methodological questions at times, but it did help me to ensure that I kept coming back to the issue of question.

The primacy of the question was reinforced in the Shapiro (2002) seminar. He took the idea further, as he outlined the importance of 'gaming out' the implications of the possible answers to the initial question, with a view to checking if these answers will be of any value. This made a lot of sense to me. I was (and continued for some time) struggling with the concept of project as emphasised in this programme, contrasting it with my more traditional ideas about research project. Central to this is the issue of the value of the enterprise to the wider community of practice. Here was Shapiro, from a very traditional research background, addressing the same issue of the relevance of one's findings. I continued to struggle for some time with how I could incorporate research ideas within the concept of project, but this was a useful point of contact between the two areas that I had previously seen as hard to connect.

From this seminar, I also sharpened my ideas about what research is. I note from the day that research is a structured critical inquiry into a defined area...that seeks to begin to answer questions and/or frame new questions. The process is a cyclical one, consisting of identifying questions, reflecting on them and identifying new questions. This wasn't a radical new concept to me, but it served as a helpful reminder that I was not expected to engage in some once and for all process. My work would, indeed should, lead to further questions. This became central to my thinking, and was incorporated into my subsequent doctoral proposal document.

I decided to challenge myself with the next seminar, Mair (2002), since the title of poetic writing was not one that would naturally appeal.
I certainly found the day a struggle. The creative 'unblocking' exercises were familiar to me from my initial training, and strike me as useful at times of blockage perhaps, but not sufficient in themselves. Divergence and creativity is vital, but for an entire project, one also needs convergence and rationality.

I had just come back from a diving holiday in the Red Sea, where I had dived with hammerhead sharks. As a result of one exercise, I wrote a poem about it. This was quite fun in itself, and the idea of diving with sharks provides an interesting metaphor. It is quite frightening, but maybe not as frightening as we might expect. One could make connections to the notion of diving down to see what lies beneath that this project entails, but in all honesty that seems to be forcing things rather. All told, I cannot make any significant connections between this seminar and the project.

Mahrer's (2003) seminar provoked a response in me similar to the Sinason day. Throughout the morning he referred repeatedly to 'meetings with dead philosophers', refusing to elucidate despite repeated questions from members of the audience, keen to understand if this was a metaphor or some other clever way of making a point. I do not think that I was alone in finding the morning teeth grindingly difficult. I mused along the way about the process of appearing to be just that elusive step ahead of the audience. It is something that I have come across in some writings, especially of the psychoanalytic tradition. Sometimes it seems to me that the writer/speaker is deliberately keeping the audience in the dark in order to remain the unchallengeable expert.

As with the Sinason seminar, I was reminded of how easy it is to become too comfortable with one's perspective, and to lose that crucial sense of critical engagement. This was odd given that a key part of his message was that there are always problems with any research, the question is just what are they? I take this as another reminder of the need to remain realistic about our products. One of Mahrer's clearer points was his view that there is no body of knowledge in the field of psychotherapy. This seemed to me to be a gross overstatement, which accepted at face value seriously misrepresents what we do know. In the end I came up with a simile of a pile of leaves to represent the state of our knowledge. Mahrer is correct in implying that we do not have a nice neat pile of leaves. It is messy, and there are lots of odd bits blowing around in the wind, but we do have a definable pile of leaves. Where I think that he is correct is in underlining the danger of reifying the state of knowledge, and becoming uncritical.

Apart from the above, I took his idea of entering into a 'creative relationship' with that which is being studied, seeking to free myself up from unnecessary blocks and allow creativity to play a central role. This concept came back later when I read Robinson's

(2000) words about science involving the application of an 'informed imagination', and is central to my understanding of what I am doing.

In early 2003, I attended a seminar for service managers using CORE, run by John Mellor Clarke and Richard Evans. This provided a unique opportunity to engage in discussions with peers about the ethical and practical issues connected with the use of CORE. The central part of the day was the use of a service case study as a way of engaging with the realities of using CORE. This highlighted the ethical and professional issues inherent in starting to use CORE or any other audit data on an individual level.

One factor that seems to be common in all services is the enormous variance in individual profiles on many factors. For example, a service might on average accept 95% of those seen for an assessment session into counselling. However the range between counsellors might be huge. Counsellor a might offer further counselling to 99% of those seen for an assessment meeting, and counsellor b 60 %, *from the same pool of potential clients.* This latter point is crucial, since even where one might expect the input (in this case clients seen for an assessment appointment) to be the same, there can be great variations. For example in my service, all clients are allocated on a random basis to counsellors, with the odd exception of someone who wishes to see or not see a specific counsellor who they have seen before. Even here however there can be surprising variations in say, the number of clients below cut off, or even the gender balance of the clients seen. So we need to check carefully that the client groups actually do match. If they do however, then an interesting question arises about the variation in performance. Why is one counsellor taking nearly everyone, and another taking a lot fewer? At this stage, one does not even have to assume that there is a problem, but we need to be asking the questions, since a client who by chance ends up with counsellor a is virtually certain to be taken on, whereas if they were referred in a parallel universe to counsellor b, this would be a lot less likely. Such randomness is unacceptable if one is seeking to run a service that is equitable and makes decisions according to rational criteria.

This seminar enabled me to engage in discussions with peers about these kinds of issues, that arise from our efforts to use CORE data. One area in particular that was clearly a widespread area of concern was the use of CORE as a performance management tool. This confirmed thoughts that I had been having for a long while about its potential utility in this area, as well as some of the difficulties that we face as we introduce this. Most

importantly these conversations confirmed that I was engaged in an area that is cutting edge, and is of real practical concern to colleagues managing psychological services. In this sense the seminar served as a waypoint, confirming that I am on a useful path. Beyond this the seminar was an important marker of, and change in, my presence in the developing CORE practice research network. Being there and contributing on the basis of the work that I had done to that point, was a crucial step in my transition from fringe participant to a more central figure. Within a year of this seminar, I had been involved in discussions about the developing individual performance template and reporting template, as well as three seminars as presenter with John Mellor-Clarke.

In retrospect it was the doorway to important forums for the dissemination of my work and for my further learning. Being a part of this practice research network is central to this project. It legitimises my activity, and helps me ensure that I am connected to others engaged in the same process. I am ploughing what can feel at times like a lonely furrow, and this group is a source of feedback, stimulation and support.

In the week after my learning agreement presentation, I attended a seminar with Marvin Goldfried (2003), excitingly titled 'Building a better bridge between research and practice'. Again the centrality of the question was emphasised. Perhaps the most useful part of the day came in a rather puzzling interchange as I tried to convey what I thought I was doing in my work. Marvin kept trying to suggest interesting ideas for more focussed research questions, each of which would have been a perfectly good basis for further study. What we didn't get clear between us was that I am engaged in a project that is as much about action as about research, and that it is of a very exploratory nature. So often as clinicians we assume that clients clarify things by being understood. In my reflections afterwards, I realised that I had clarified what I was doing by being misunderstood! I had still felt a little guilty that mine is not 'proper' research. However after this, I had a deeper understanding of what I was engaged in, and how it is different from but equal to more formal research processes.

This seminar also helped me to clarify another interesting part of my work. I spoke at one point of clinical audit, and he made a remark that indicated to me that the word had strong negative connotations for him. Certainly murmurs in the group suggested that this was the case for other participants. This reminded me of an interesting incident on the first day of this programme, in which I had experienced similar negative reactions and glazed looks

from some other students and a tutor. At the time I had filed the incident away, unsure whether there was something of general import, or whether it was simply an idiosyncratic reaction. The reaction in this seminar suggested that there was something here. It might be an issue of culture, since in the NHS the term audit is fairly widely used. However it now seemed clear to me that, at least in certain situations, the language I was using was not helpful. It placed a block between my potential audience and me. I therefore decided that in the future the term ' generating practice based evidence' might be more user friendly! Already mentioned above, the final seminar that I attended was the day by Felicity de Zueleta (2004) on attachment and trauma. In addition to the content, the day had a certain significance for me in that a colleague whom I had supervised from the start of her professional training, and who had now registered for the doctorate, attended. It was another reminder of the speed at which we all move along.

There was an unplanned symmetry in that the topic of this day was similar to the first seminar described above. My experience of this day was however markedly different. I saw an open inquiring mind in action, prepared to engage with complex issues and present her knowledge in a discursive and intellectually open fashion. I was reminded of Robinson's phrase about the application of an informed imagination. I saw an interplay between sound evidence and a willingness to be open and creative in practice. At both the conceptual and practice levels, it seemed that she was willing to integrate on the basis of reflection and evidence, as opposed to ploughing on recreating her single years experience in lieu of true learning. It was a good example of the inquiring spirit that I am seeking to foster, and all without a single mention of CORE. This underlined an important truth (also discussed in meeting with my academic consultant at about this time) that CORE is simply a tool that I happen to be using to seek to generate evidence.

Appendix 11: Research memos.

Worthing Priority Care NHS
NHS Trust

Memorandum

Date: **21 June 2002**

To:

From:

Subject: **Research memo 1**

What is the question? And what will I have to give up to focus on it. These are the problems at the moment.

How do we use CORE PC in a PC Counselling setting?

This will be a piece of qualitative work exploring the use in my service. The overall focus is on how to develop it as a feedback/audit tool for counsellors.

My agenda:

- **to show how to really squeeze the max out of CORE**
- **to involve counsellors in a cooperative venture (but its still mine!)**
- **a cynicism that do we really make best use of it. Systems are homeostatic.**
- **Fear of null findings.**
- **I might be exposed**
- **I am afraid of statistics**
- **Is qual research proper.**

Proposal

Study the introduction of a core pc system and how we explored the use of it for counsellors.

Grounded theory analysis.

How to gather data...Delphi technique (McLeod 99 p94)

Memorandum

Date: 27 September 2002

To:

From:

Subject: research memo 2

If the topic is to study the impact of CORE on counsellors:

Take base rate of their figures on filling in core forms.

Then give each counsellor a core feedback session...what their figures are re clients/ what their data collection is like...

Review their performance in filling in forms.

Hypothesis: That the very fact of focussing on their results will increase the no of filled in forms (cf Hawthorne effect). Maybe that the lower performers will actually be de motivated.

Tape group discussion/and interviews re CORE and its potential for f/b

Examine for themes.

Undertake review and re interview later.

Research memo 3

I have hit a problem in that I will have to have ethics ctte approval internally before I can start.
I can only get this after I have university approval, and I cant get this till I submit the RAL doc. Potentially this puts the study back 6-9 mths.

I feel really dispirited.

Jan 2003-01-22

Idea of having feedback agreed with counsellors at meeting of 18th Dec. General interest and commitment was expressed

Asked all counsellors with over 25 on core to contact me for a meeting as agreed.
8 contacted. 6 replied (1 sick)

Mike: 22/1/03.
Felt rusty and unsure. Very exploratory.
Printed some off before we met to give better view of figures.

Mike ex manager and very interested and experienced in such things

Rita
Seemed wooden and rather off beam. Interested. Very good figures comparatively.
Issue was low level of completion of forms.

Sheila
Anxious about it. Very keen to see where she is falling short. We discussed the need to not take only negatives

NB the issue of confidentiality is coming up strongly. I would like to have counsellors able to access the system at will and get their profile/the services profile. However, they would also be able to peek at others figures.

Can we set it up so someone can see the overall figures and their own, but not someone elses

Memo 5. 5th Feb 03

The priority is making a difference. I want us to use the process not for it to become a boring research study with no obvious value.

So are we back to a study of management using core rather than the impact of feedback?

Worthing Priority Care NHS
NHS Trust

Memorandum

Date: **15th May 2003**

To:

From:

Subject: **Research memo 7**

Today I had my first annual performance review with Mary John.
I anticipated it as a boring bureaucratic exercise.

In fact it was a really useful opportunity to say how things have gone and get feedback.

This was very positive, with Mary commenting how I have dealt with a very complex stressful situation very well. He commented how I had kept all the counsellors involved and interested, and how motivated I am. This is good. I felt like I got what I try and give counsellors. It highlights what I have missed for so long.

More negatively, I am upset that Richards wife is dying. I realise that I have thought of him as very central support to what I am doing.

3 things re the project

- John MC wants me to write something for a special edition of CPR journal on use of CORE
- Also he spoke to me about me being involved in the management training.
- I am writing a policy on risk, and using CORE as its core.

29/5

I continue to circle around this idea of the question.
Do I go for the system as a whole and address the issues of change management etc.

If I do, then an action research methodology is OK. But what is the data. AR seems to be short on the sharp end about how to gather and analyse hard data.

On the other hand if I look at the counsellors experience I end up doing taped and transcribed interviews. This seems like a very hard slog and doesn't appeal.

What do I do??

Memorandum

Date: written 30th May/ work done earlier on card

To:

From:

Subject: **Research memo 7a**

Checkland and Scholes SSM.

Customer	**Counsellors/me**
Actors	**Manager/counsellors.**
Transformation	**unused CORE data-----CORE data examined and reflected on—action taken.**
Weltanschaung	**Feedback and reflection improves practice. The facts are friendly. We do not do what we think we do.**
Owner	**Counsellors/manager**
Environmental constraints	**Time limited cos counsellors not employed.**

Root definition:

"A system to provide feedback, encourage reflection and appropriate action using CORE-PC data, in line with good professional practice, in order to enhance that practice and develop good clinical governance."

I have hit a problem in that I will have to have ethics ctte approval internally before I can start.
I can only get this after I have university approval, and I cant get this till I submit the RAL doc. Potentially this puts the study back 6-9 mths.

I feel really dispirited.

Worthing Priority Care NHS
NHS Trust

Memorandum

Date: **30th May 03**
To:

From:

Subject: **Research memo 8**

2 months into the current year and we still haven't got the budget sorted.
This year it stalled at the desk of the PCT Financial guru. Concerned at 'efficiency' savings that we cannot realistically be expected to meet as our contract is of a different nature.

The process has been circular, with no one seeming clear who agrees the contract and gets it written up.

Yet again it is clear that if I don't sort this no one will.

Just like the budget proposal that I got done in a week after that wanker pamment left me in the lurch.

So today I got Mary j to agree with Jeff P that we go on the basis of the cut budget and haggle about the remaining 5600 later.

NB: This is the kind of systemic chaos that is a constant part of the background (and often foreground)

How do you plan anything in this mess?

As if that weren't bad enough, my PCT contact left and was not replaced for a month. This left me with extra work to place in surgeries and no one to do this (the PCT have always done it in the past)
I therefore had to write and meet loads of surgeries to cajole room space. I did it quite quickly to my surprise.
The plus side has been that I have met more people and got my face known more.

Memorandum

Date: **30th May 03**
To:

From:

Subject: **Research memo 9**

- **7/5/03 We have the practice based evidence. So what do we do with it?**
- **14/5/03.**
- **I emphasise action and outcome**
- **I am sceptical of self report**
- **This is a piece of change work**

Questions as at today

- The use of CORE-PC as a tool for individual feedback to counsellors in a Primary Care Counselling setting.
- The value of the core pc system in generating individual feedback to counsellors: a qualitative study.
- The value of core pc feedback in clinical governance: Implications for service managers and counsellors.
- What is the experience of counsellors and service managers in using CORE data for feedback? An analysis informed by grounded theory.
- Closing the loop: making use of CORE-PC data in a Primary Care Counselling Service.
- The use of CORE-PC data as a Quality Improvement tool.

Memo 9a

As I reads the literature on complex systems, especially Checkland and Scholes (1990), I think more in terms of the entire system that I am working with.

The project is one of system change, this links with NHS speak on becoming a 'learning organisation'

The study is how do we use CORE feedback to further the service as a learning organisation.

CATWOE analysis (Checkland)

Customer	Counsellors
Actors	Couns + Manager
Transformation	To use data for ind feedback
Weltanschaung	Professional ethics/CPD/practice based evidence/learning organisation/clinical governance
Owners	Counsellors/manager/overall trusts in principle
Environmental Constraints	Time of counsellors/budgetary constraints/lack of good will

Root definition	A system for using practice based evidence by examining individual core pc data in order to improve professional practice and further professional development. This is in the service of creating a learning and questioning organisation in which specific attention is paid to using audit data to improve the service. This in itself is in line with the spirit of the NHS Clinical Governance agenda.

Memorandum

Date: **30th May 03**

Subject: **Research memo 10**

Products for this project:

- Meet with counsellors and discuss findings
- Change system
- Paper for John MC
- Risk guidelines (eg of change)
- Workshops…being expert on service management.
- Audit lead for Cons Psych group in Trust.

Memorandum

Date: **10th June 2003**

Subject: **Research memo 11**

Conversation with Kate re my project proposal:

- Just because it's a good story doesn't mean its true
- Cf: van Goghs ear/Fragments.
- My key struggle is to identify a good enough rationale for the project;
- Not too tight as to strangle creativity/flexibility
- Not so loose as to leave me wandering aimlessly
- It is a study that is informed by AR

- However I need to go beyond AR to ensure that I have some islands of data to take a bearing on

- Eg: focus groups/ questionnaires to supplement the reflective and case study material.

- Allows for triangulation also use ex counsellors to check if people are saying things because I am their manager (ie issue of power)

- Pointers for others about how to get the best out of it.

Research memo 14: 29th October

After the ½ day on Monday on CORE TJ is desperate to get into the system and look at it for his masters research.

I have set up access codes for 14 counsellors that allow for them to get their own data and the service data but not anyone else's.

TJ tried and could not get in.
All logical options were examined to no avail.
At home transcribing tapes, I got a frantic call. We went through all other codes and every one worked, but not this one.

This is a small eg of the level of simple practical yet essential tasks that are required to be managed in order to really use the data via modern systems.

Today I also sent out a circular e mail to gp's and practise managers, this didn't work either!

Memorandum

Date: **27th June 2003**

Subject: **Research memo 12**

CORE, what is it good for? An evaluative study of the use of CORE-PC data in a Primary Care Counselling Service using a mixed methodology.

The issues are:

How do we engage with core data? What do we do with it? What is the experience like for counsellors? What is it like for service manager? What lessons do we learn in the process? New title?

Issues that pose problems:

- Van Gogh's ear

- Memory research
- Hawthorne effect/self fulfilling prophecy.

These are 2 problems with a narrative approach.

Methodology:

An evaluative study (Barker et al 2002 p199ff)

Using aspects of AR (change/cycles/CATWOE)

Aspects of case study

Research memo 14: 29th October

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Memorandum

15: 27th October 2003-10-27

The focus group idea developed from a single group run by myself to having 2 parallel groups.

This arises from a comment made in the LA oral presentation by JEW that it might be better to have someone else run the fg's..this led me to rethink.
Pragmatically I couldnt hold the proces and find another person, but I plit the groups and had one run as a self run group

why not? counsellors have those skills in abundance

also, it allows me to compare the groups, does having the manager in them make a difference? a form of triangulation.

The fg's lead to the questionairre as a follow up/triangulation.

maybe 1:1 interviews to mine the info.

Memorandum

RM 16

Date: **24th Oct 03**

Last week I passed the oral presentation of the LA.

Feedback: very strong presentation and project.

Not enough emphasis on how project might shape CORE…didn't like 'gold standard' image.

Also…get so else to do focus groups for me….problem with this as to hold it now would lose momentum.

Developed Q's for groups 1 on 27th Oct.

Need to get reactions about CORE. Creative association technique to get beyond explicit to implicit associations.

Memorandum

RM 17

Date: **4th Nov 03**

Focus groups: **The idea of having 2 groups came late in the day.**
A number of reasons fed in to the decision:

Why not have someone chair a group as counsellors have all the skills required to run a group?

2 groups= more data/more chance for counsellors to talk about core and think about it.

GPs e mail

This is another circle….we have some data..why not feed it back to those who refer

Technologically e-mail lists are easy and fast and allow for a kind of contact not previously available

It is another way in which we can make use of the data

Memorandum

RM 18

Date: **6th Nov 03**

There are several loops that we've been around so far:

1) What to do with the below cut of people (late 2002)

This began in supervision as we noticed some people below cut off.

Early audit showed a % were in this area , therefore provoking the question should they get NHS treatment?

This led to policy that we offer either no service or, if there is a good reason tom think that there might be a clinical issue, then we offer up to 3 sessions

Thgis can be extended to the 12 if required

Idea is to introduce a question into the clinician's mind where they explicitly reflect on the issue

2) Individual interviews re the core system and ind data (from mid 2002)

We met after the first intro day on core with those who had 25 + on the system.

This service to introduce the mechanics and begin to look at the data (see field notes)

3) Clinical use of core Di's story (ongoing)

This story occurred before we had the PC version but has become a part of the service

culture...told in the focus group by DM

A clear eg of the protective use of core.

4) Use of risk scores.....risk guidelines (Early 03)

We have begun to explore explicitly what we do to assess risk. CORE helpfully provides a risk score, and we need to attend to this as a matter of good practice and in line with requirements of Clin Gov.
This led to the development of risk guidelines which appear to be seen overall as helpful/supportive of good practice

5) Feedback to GPs of audit data via e mail (Nov 03)

The PCT are meant to circulate data to GPs but don't. New technology allows us to send files round direct to GPs

6) Individual access to the data base (from Nov 03 because of a new version of core)

The new version allows for people to get their own data and the service's and not each other's…it is now therefore possible to give password access to the system

NB only one person has asked for the password in the first 2 weeks despite being mentioned at the meeting and in memo since.

7) Use of the summary ability /second round of 1:1 interviews (This is the next phase from Nov 03)

introduced at the CORE day 27th Oct, the idea of summary performance review capability.

These phases are interlocking areas of use of the system. It is of interest that 4 did not initially seem to me to be related to this project, and 5 had not occurred long before I did it, except as a general idea.

Memo 19

Contd

Interim summary

I am feeling in danger of becoming confused. Rather as when I was little nd was out on a hill or mountain in the rain and mist. You walk along for ages and are unsure where you've got to. Then from out of the gloom looms a hilltop.

So where have I got to?

In Schon's terms I began not even knowing what the questions were. I spent a lot of time circling this one, reading and trying to clarify the question/s are.

Fuzzy questions merged. I knew that I wanted to show how we could use audit data, but what does that mean?

In addition to the factors outlined in memo 18, I am constantly reminded of the prosaic but essential matters that take up time, and upon which all else is based.
I need to pay constant attention to;

- Budgetary issues. (ensuring that there is a service to audit)
- Keeping counsellors occupied (client flow and efficiency)
- My own position (the regrading story/the Pamment story/relationships with the PCT) this has required considerable work.
- Ensuring the data base. Getting counsellors to provide data/entering it on the system/protecting the data base (the crash!)/ keeping up to date with new systems (PC 2/performance review pages)
- How what I am doing ties in with the wider field (Clinical Governance/The NHS as a Learning Organisation/ Leadership in the NHS)

These factors are vital. In a traditional research study they would be seen to be variables to be negated or controlled. In my work they are an essential part of the whole, part of the story. We are in Schon's swamp here.

The day to day use of data derived from clinical audit requires constant attention to the fundamental issues.

This story so far has relied on leadership. I have worked long and hard to develop a culture of interest in CORE as opposed to it being viewed as alien.
This has drawn on my ability to persuade and enthuse, and to help people get beyond what is often initial skepticism about alien concepts such as audit and anything to do with computers.

The extent of this challenge was outlined on the very first day of the program, when there were various expressions to the effect that audit is a questionable concept, and 'I don't like computers'. Later on the Goldfried seminar, he also commented about his associations with the word being connected with dull things like accountancy. I would therefore see my struggle as being to change a very powerful cultural factor in counselling generally. In this service I have been greatly assisted by the fact that we used CORE from the start (with an 18 month gap). Nevertheless the counsellors came from a traditional background where virtually no routine audit or outcome evaluation took place.

So where do I go for inspiration on leadership? The performance review in May 3 was helpful here (much to my surprise). If I was being led then I am better placed to lead. There is generally a dearth of management training generally though. I realise that I have drawn heavily on Richard Evans unique combination of business, psychotherapeutic and CORE knowledge to think through the task at hand.

In terms of Schon's reflective conversation with the problem, this has begun. I have identified some of the mini problems (Use of risk scores/sub clinical clients/where to send data), and have moved from fuzzy to clearer questions.

A number of other questions loom out of the mist;

- How do different counsellors perform, and how valid are the judgements that we can make on this data? This is the $64k question.

- How do we account for individual preferences and differences in performance with different headline presentations in clients?

- What use can we make of the performance review capacity in version 2?

- How effective are we with male and female clients respectively (we appear to be less effective with men, and they attend fewer sessions, so what?).

- What feedback does this have on CORE as a tool. This was emphasised in my LA presentation. In fact I had already thought of it and then lost it temporarily. To date I have fed back the need to have a system of access that allows counsellors to see their own data and service as a whole data but not each others.

I asked counsellors about their associations with CORE…what is mine…an octopus. Complex and it is extremely difficult to describe its motion

Memo 20. Nov 11th 03

Amendments to CORE

- Filter by cut off
- Filter by age
- On appraisal form, give average number of sessions taken
- Blue box format hard to follow..needs to be changed.
- Make summary sheet available to counselors

Problems with CORE:

- People read it as a for ever account..they forget its one week.
- Some Q's misread? Check further this

These are some of the obvious changes that our first round of use has brought up.

My impression is that the meeting of 27th Oct has stirred up some interest.

2 people have met to examine their figures (AG/PG) and I am to meet ST soon

2 have got their password, (AG/TJ) and TJ is really using it.
On the positive side, everyone is now on the system, and the lowest number is about 8 and growing…

The project.

There is a very complex tussle at the heart of this.
Do I go into details about figures…for example,

- we seem to be reducing the number of sessions we offer overall, but maybe reducing our effectiveness as well.
- We see men for less sessions / male counselors seem more effective with men/ overall we are less effective.
- Arun seems to refer less below cut off/ outcome figures in Adur are lower

How do we engage with this? To even get this fact across to counsellors would take a morning seminar, this would seem impractical.

I have spent hours with the data and I get confused, so how is someone with less time to deal with this?

This is a feature of management…to digest the data and make suggestions.

The defining criteria is the use of the data, not the data itself. It is not an outcome study.
But even so it is hard to make a clear differentiation, since the use of it depends on what the data is and just how we interpret it, so back to square one!

As manager I feel near to data overload at times..so many ways I could go, how do I choose?

Memo 21. Nov 03.

Take up of passwords. Now 6 in 2 weeks.

C/Y/M supervision group as ked to go through core system together.
Interesting and they got very excited at what it could do.

Lots of 'so we're not going to be sacked yet then…' comments

NB: Use this phrase as heading

ie: a level of anxiety at looking at own data.

I am surprised at the level of computer illiteracy with some people.

They thought it might be good to look in groups

Set up buddy system?
Examine in pairs

Memo 22. Nov 14th 03.

A new issue emerges as counsellors start to get access to the data

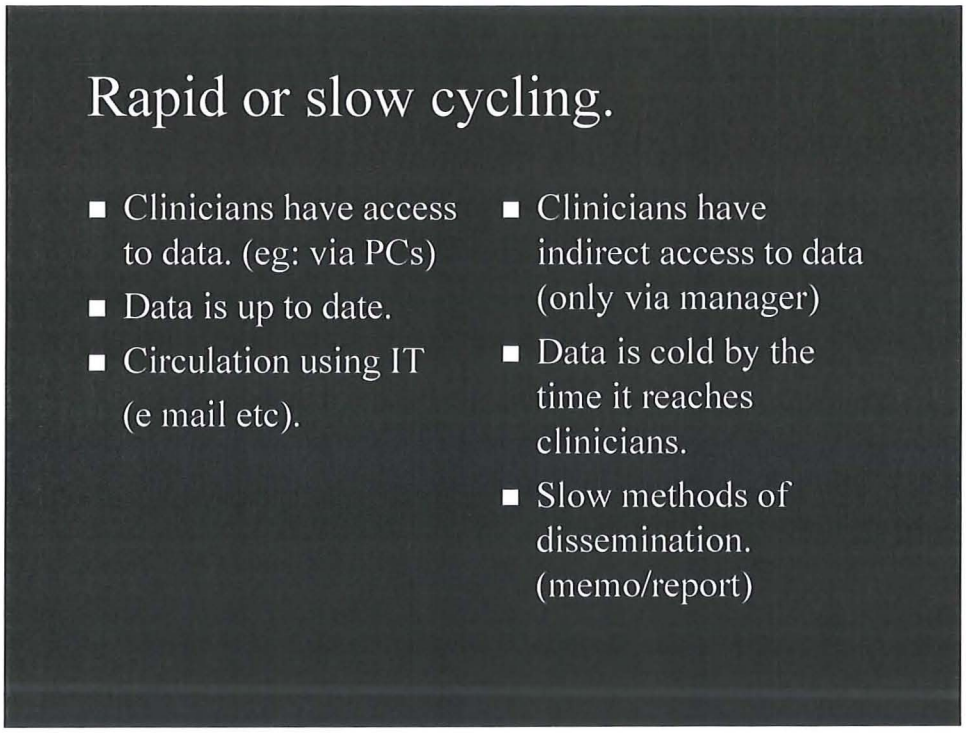
- Need to get trust user name which also gives them e mail and library access online

- But what happens when we have seen the data? How do we communicate with each other
- Could do memos. But this is from me/central and not organic. It is also slow
- Need a way of bouncing ideas around quickly to capture the moment
- E mail/web based
- Call to IT helpdesk re web or similar solution

Memo 23. Nov 20th.

Several areas are emerging as the focus

- Risk management : how we manage risk using core…add to q'airre
- Gender: our effectiveness and sessions with m/f clients
- 1:1 feedback to counselors.
- IT project.
- There is a bottleneck here in that unless we use IT we cannot get the core data in front of the counselors rapidly



- Overall we are talking about major culture change if we are to use core properly.
- This requires leadership.

Memo 24. 27th Nov

On Tuesday I ran a workshop with John MC for Brighton service. In doing so I clarified a lot of my ideas.

- Central is IT. John referred to counselors with palmtops and no paper…
- Later met with ST re her CORE and had a similar conversation

So the importance of having a good IT system is now foreground….this involves rapid cycling of data….an ability to get and discuss data and threads of analysis and communicate with colleagues quickly about this.

Key to all this is access…which means PC terminals.
Counsellors need to have access to data as easily as possible.
So a new PC in the couns room, and talk about access via GP terminals.

Then a bombshell…I had been moving on apace in the belief that I was developing a node of expertise in the trust about core and clinical audit.
I joined the audit clin. gov pillar group. I have taught for core on the basis that we would get a reduced licence fee for the trust as a whole.
I had talked to PE and MJ about the idea of using core in the clin psych service. My assumption was that I would be a part of this process…I had agreed with PE that she would come back and talk more about core. In a burst of enthusiasm I talked to her and was told that she will be using a home made programme written by JE locally.
I am shocked that this is happening, because a) no one talked to me about it, and b) I wonder about the legal side (copyright). It seems to be a wonderful example of the right hand not knowing what the left hand is doing. It makes sense now that PE had not got back to me about core. I wonder also if it was part of the reason that JE was hostile when we met with MJ over a year ago, maybe he was writing the software then.

Maybe it is a salutary reminder that I am a small fry in a large and complex pool. Certainly I shouldn't be shocked that organizations make decisions with which one doesn't agree. The bottom line is £.

I was tempted to go off all guns blazing. Spoke to JMC to inform him. It puts me in a very awkward position. I am responsible to the trust but I do not wish to sell him short.

At this stage I was still thinking about stopping it on the grounds of copyright, as JMC indicated might be the case.

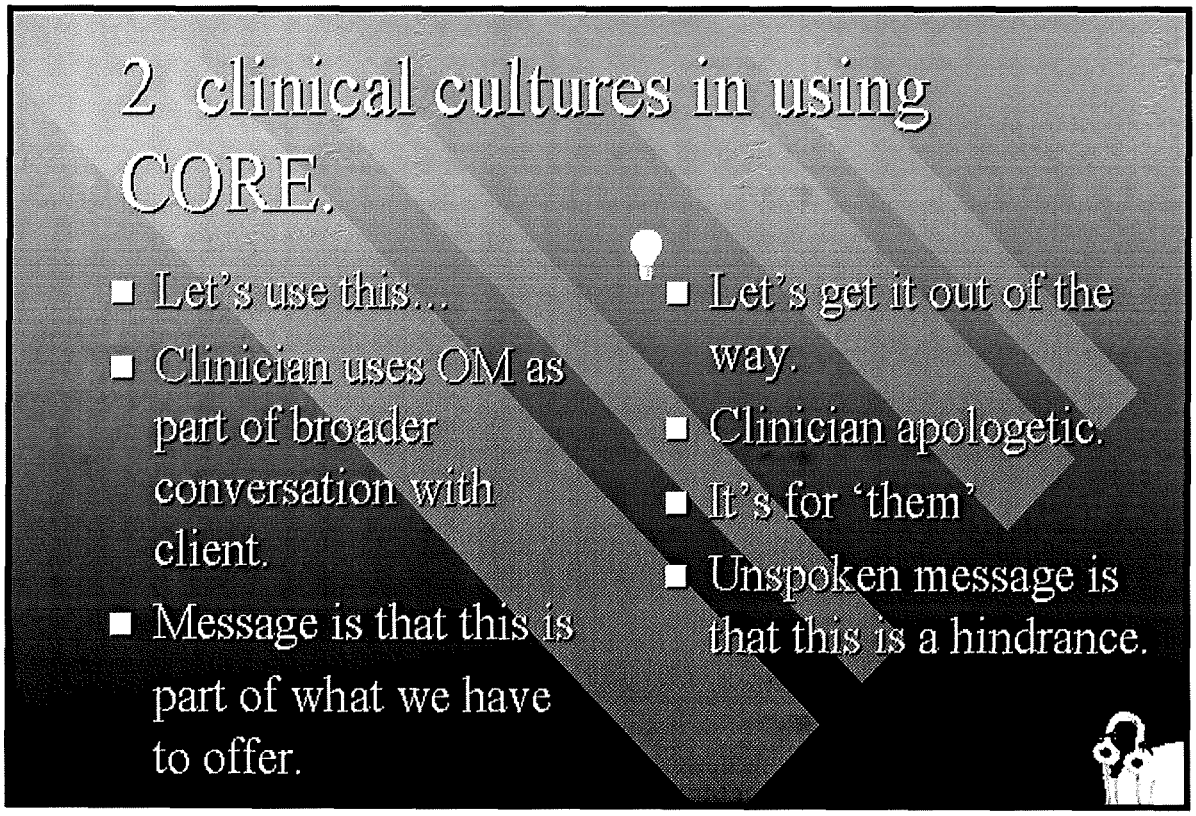
Then spoke to RE who counselled a different approach. Go slow and watch it collapse. Projects like this require enormous support and go wrong. When JE is unable to give this, and they cannot get the reports that I can get. If I keep showing what core can do, then eventually the message might get through. It does in the meantime put me in a bad position. I cant share the benchmark data as they will not be cooperating with it and adding data. Their software wont be compatible and wont allow for data transfer. Neither can I help with core (but the impression that I have always had from PE is one of mixed contempt/disinterest...like she doesn't rate me or want to work with me).

It is a worrying reminder of how rapidly plans can be derailed, and how fragile projects are, especially where £ are concerned.

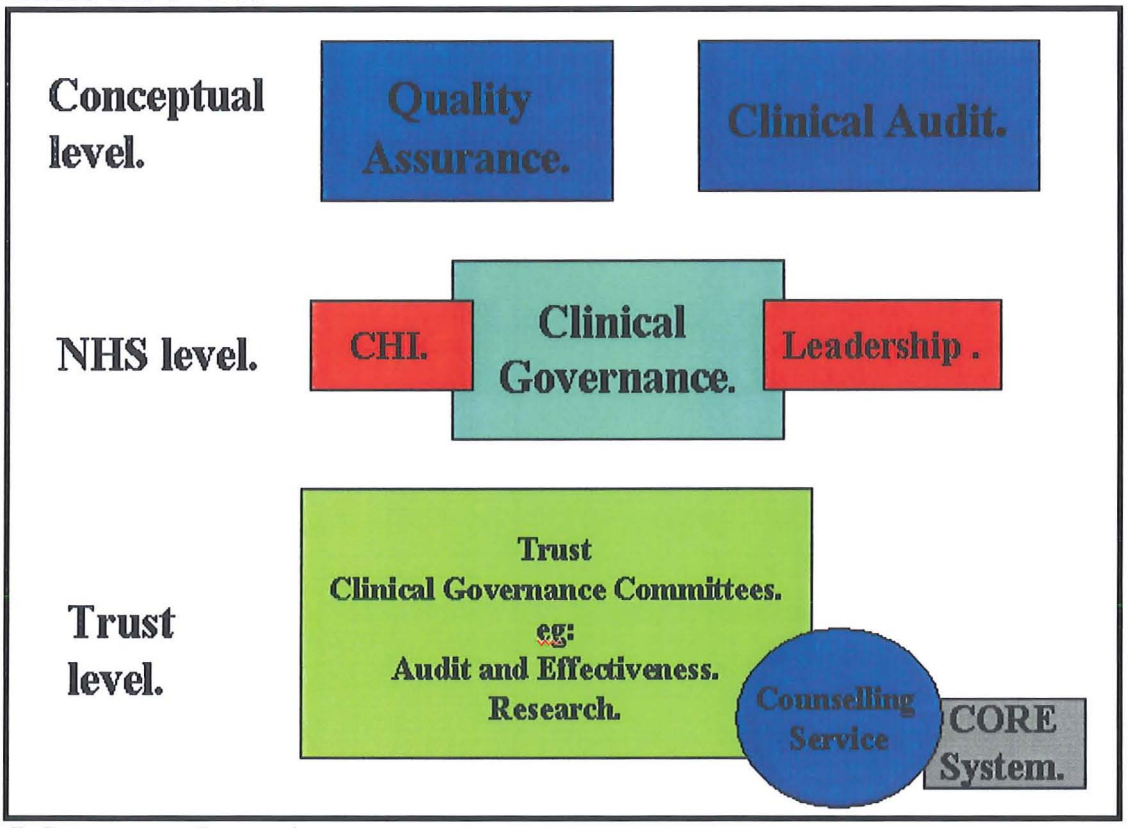
In the meantime, I have mapped out the requirements for IT systems to present to Ian Puttock/Mary John

IT requirements diagram.

This system allows for a proper database, with potential for referral/allocation online. As part of this, I want to set up a way of accessing CORTE data and rapid cycling what we find.

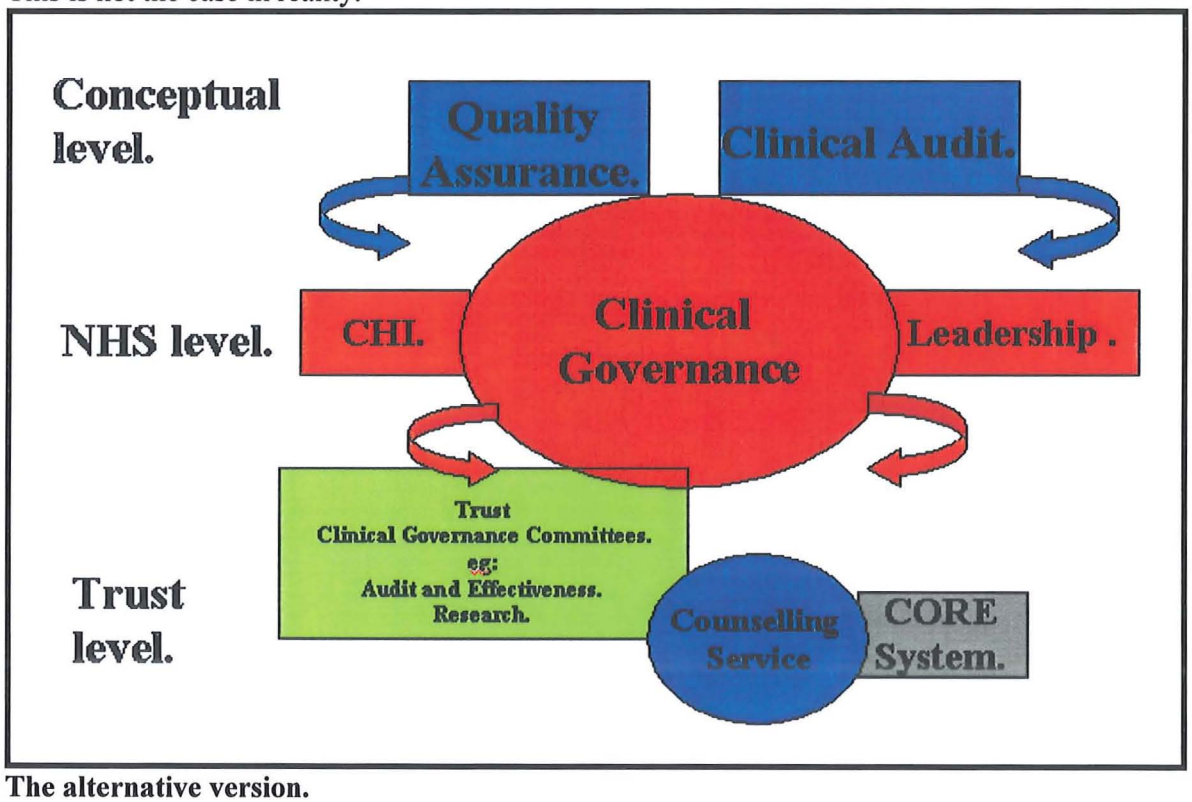


Memo 25. 8th Dec



Influences on the service

This is a static diagram, boxes have nice defined shapes and clear edges.
This is not the case in reality.

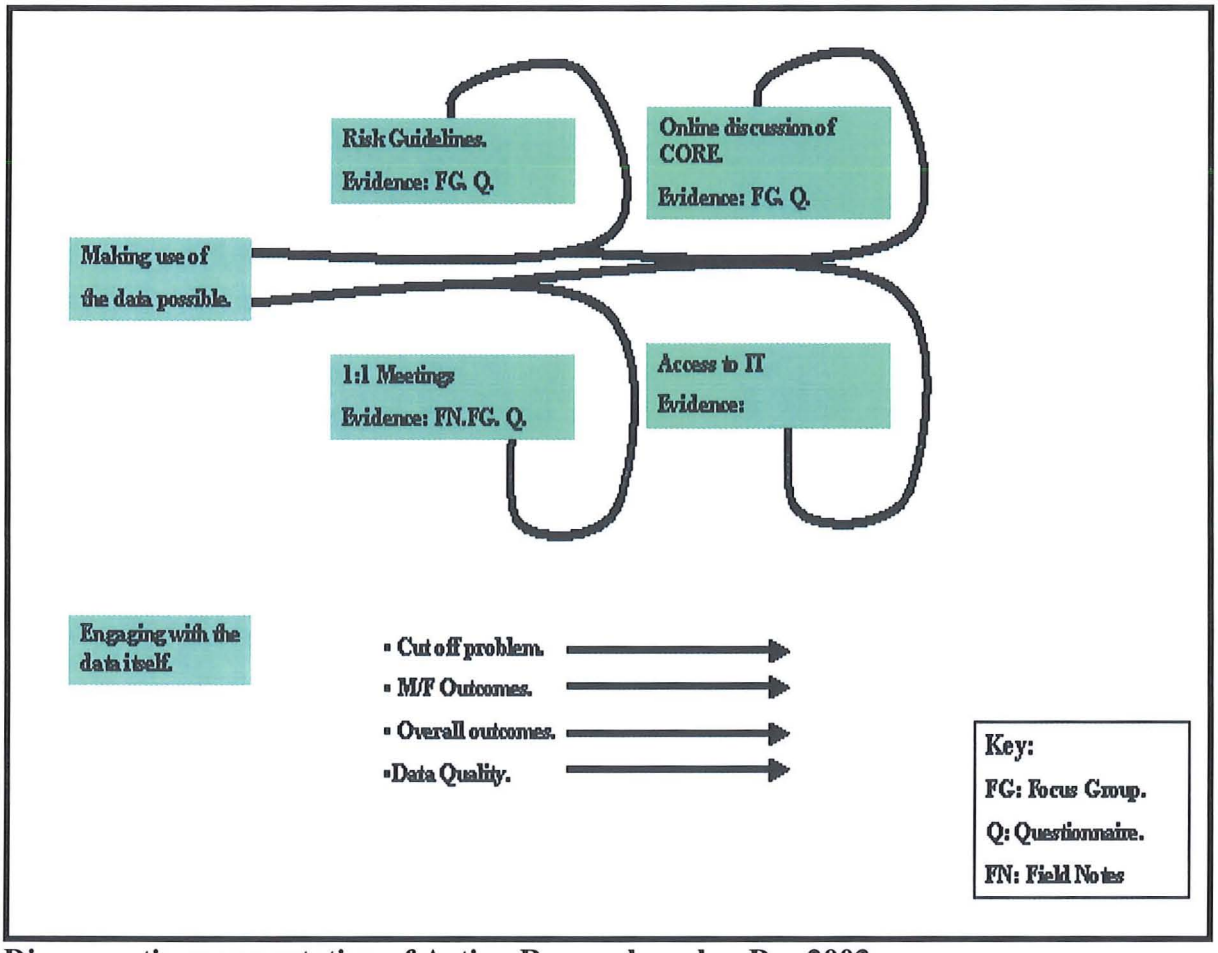


The alternative version.

This is a diagrammatic illustration of the influences on the service and how CORE plays a role as a tool in the development of clin gov.

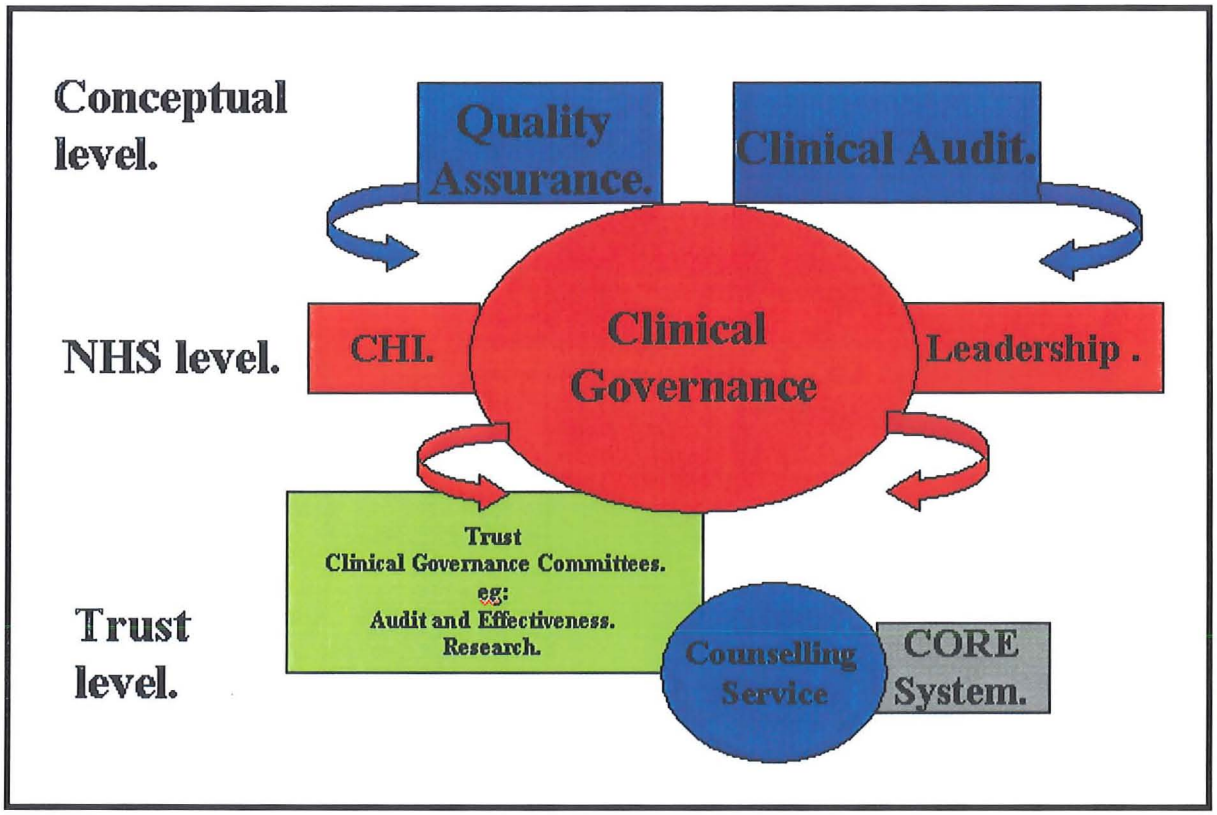
NB: The commonest error in audit is to confuse the activity (ie holding the audit) with the outcome ie improving the service as a result of the audit.

Memo 26. 8th Dec



Diagramatic representation of Action Research cycles. Dec 2003.

This diagram shows the cycles engaged in during the first phases of the project. To an extent these can be thought of as actions that made use of the data possible, and engagements with the data itself. This typology is flawed however since the risk guidelines make direct use of the data in its raw form.



Memo 28. Feb 04

After a period of stalling following supervision I am getting back on track.

It is this whole issue of the product that is the problem.

Satisfaction q airre came back with very good results…

I then realize that I did not ask a question about core

However TJ is sending a questionnaire out and will add a question about their experience of core

Agreed with JMC to teach on workshop in April and discuss papers re use of core in service management

Is this product?

Memo 29. Mar 04

Idea for making CORE data accessible

Service meeting to examine core. Using lan line to link to data base and project onto screen for live examination of data.

This allows for live unfiltered examination of data as a group and makes use of modern technology.

Idea for research: 2 by 2 matrix of m:f couns/ m:f clients to look at the effectiveness of each pairing.

Memo 30. Mar 04

The first meeting to examine the database live.

Gave out questionnaire.

At times a difficult meeting. Employement agenda and satis quaetionnaire intruding.

At end a suggestion that we have a group to meet regularly and examine the database.

Booked on the spot

Memo 31. Mar 21st 04

In an effort to get more perspective on how clients see the core I have added a question to tonys research. We will also add the same question to our ongoing satis qairre.

This should generate some sense of how they see it.

I am not sure it is part of the project or not?

I suppose it is in the sense that it is another way of making sense of the data in the very broadest sense.

Research memo 33 16/4/04

Insights into forced breaks.

Every time there is a break in my project I have a major rethink.

For example when I had to wait for the LREC and felt frustrated, I went away from the idea of 1:1 meetings and analysis on to the broader project that I am now doing.

In the break to get counsellors on contracts I did no work (consciously) on the project. I had been tussling with feedback from a supervisor and how to shape the final project and presentation.

Coming back to it in late March I moved all the stories I had written so far and came up with the idea of contextual documents (I rather like that phrase...is it mine?). This allows for the true new bit of this work to be kept central and for the rest to serve as context to give a rich textured case study .

It also interests me that I move the actual project and the write up along in parallel. Each feeds off the other in a spiral. I have begun to really understand what I am doing by writing. First the stories...the service, my regrading and intellectual background. This has somehow feed me up to get to the steps in the dance...the AR cycles and what I have discovered.

In remapping the way that I will present the project, I have remapped the way that I conceptualise it, and what I think that I am doing. I need a frame. I always like a broad map, even if it changes.

Re the questionnaire, it is not looking like a useful contribution to the project. Only 7 back and its over a month since I gave it out.
Is it the timing? Counsellors have just gone to contracts and are getting a lot of paperwork. They may also be angry with me over the cuts in income. Or just generally bored with it?
I did just give it out and didn't have much of a lead in to it....did this sell me short?

It will be interesting to see the response to the articles that I have circulated...I am worried that I wont get anything back at all.

Re my core data how do I feel about my own data...well I am glad the outcome is good..wont sack myself yet.

However my OM 2 % is the lowest in the service. I felt a bit of a hypocrite when I saw this..asking others to get it right and not doing it myself.
I don't think that its just flannel to say that this is explained by my deliberately seeing clients who have been waiting/are slightly tricky...I therefore offer a lot of single sessions, so don't get second OMs.
This is a useful sensitiser to how we need to be aware of all aspects of the situation before we can truly manage.

Re my changes as a result of core the reduction in outcome as average numbers go down is making me rethink my ideas about short term therapy....there is a dose related effect

But what to do about it?

Also the gender issue is interesting. We are clearly less effective with men, but again what do we do....questions questions...

34 22nd April 2004
To be of use, CORE must pervade the culture of the entire organisation.

It is no good simply trying to use it as an add on, to produce some figures. Its use has to be integrated into the weft and warp of the day-to-day work.

At assessment it can be used to inform the decision about whether to see a client, and what to focus on. Central to this is the identification and management of risk (Risk guidelines)

At the end it can be used to take stock of where the individual client has got to.

At service level it can show that we are being effective. It can then be used to drill down and look at what specific groups we do/do not have an effect with (Male female scores)

Managerially it is central in showing the state of the service. This is useful externally (story of service) but is an area where there is greatest risk of misuse of figures (story of session nos)

Individually it can be part of performance management as we look at just how we are doing. Nos seen/data qual/impact etc.

The knack is to ensure that it pervades all aspects of the service. Not use it and put to one side either with client or as a service.

NB Talk of creating and using practice based evidence not audit as it has negative connotations

eg tutor/Goldfried/other students

34a: 27/4/04.

Recommendation following my experience, it seems clear that clinical supervisors need to be knowledgeable about the use of the CORE system in order to engage in making use of it within supervision.

This highlights a very interesting area regarding supervision. This relates to the traditional split between clinical and managerial supervision. Using CORE implies a blurring of this (rather artificial) boundary. I find it difficult to see how it is possible to maintain the difference between clinical supervision with its traditional primary emphasis on development and managerial supervision with its primary emphasis on performance. CORE data inextricably links the two, for example providing information about data quality as well as outcomes. Whilst it might be possible to tease out areas of foci that were deemed appropriate for each form of supervision, I think that what is implied if we are to truly use CORE data is a new form of supervision that for want of a title could be referred to as clinical managerial supervision. This challenges the traditional culture (at least in the NHS) where clinicians will often have an arrangement whereby they work with an external supervisor usually contracted on the basis of their particular modality as therapy.

There are, of course, major difficulties in the concept. Bringing the functions of clinical supervision and management entirely together runs the risk of dangerously placing all our eggs in one basket. We are likely to create a closed system which is not healthy for anyone. There is, put at its simplest, a risk of too much concentration of power with everything that that entails. Practically, however, it is difficult to see how it will be possible to ensure that a diverse range of external supervisors to an organisation will be able to (a) access the data and (b) be familiar enough with the system in order to make use of it in practice.

As ever, I think that we are in need of finding a compromise between these differing requirements. Two models come to mind:

It would be possible to develop a role of internal clinical supervisors. Such an individual would have to be linked in to the system but would not carry day to day managerial responsibility. They would, of course, remain ethically and professionally bound to deal with poor performance (something that I do not believe is always adhered to in practice in the external supervisor culture). However there would be at least some separation between the clinical and managerial functions.

Another model that we are beginning to experiment with is the development of peer supervisory relationships. These begin to break down the concentration of power with the clinical manager/supervisor and allow for the use in practice of the expertise that has been developed within a group of practitioners. The appeal of this approach is that it flattens the hierarchy and begins to distribute the power. The downside is that, of course, it can be extremely difficult for peers within the same organisation to begin to raise, let alone deal with, issues of poor performance. I am therefore not convinced that this is an entire solution. It certainly, however, is a crucial step in the development of a culture of using CORE in practice.

Memo 35 7 May 04

CORE has role in CPD. We can set up internal groups as per my service to examine results/do further research etc.

It is therefore a good tool for CPD.
Also has a teambuilding function and cost benefits for CPD.
It can be a focus for conversations about our work Almost any tool could be useful. To reflect on our work is a good thing.

CORE is also a good database for research at a local level as well as the poled national level. Eg TJ.

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