Introducing a routine outcome and feedback measure in an Australian university counselling service

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Abstract

This paper describes the introduction of the Outcome Questionnaire-45 (OQ-45) as a routine outcome measure within an Australian University Counselling Service, and outlines the rationale, implementation and practical considerations involved in its administration. The use of accompanying software (OQ-Analyst) to collect and analyse data electronically, and to generate instant feedback reports to counsellors is also explained. Preliminary outcomes in terms of feasibility and acceptability, clinical status of presenting clients, effectiveness of counselling and feedback to counsellors will be discussed.

Keywords: outcome measures, university counselling service, Outcome Questionnaire-45, feedback, benchmarking, student mental health

Background

Most, if not all, Australian universities provide counselling services for students and about half that number also provide counselling to university staff, according to a survey of 28 out of a total of 37 publicly funded Australian universities (Situational Analysis - Counsellors on University Campuses, 2007). Yet there is very little data available concerning the levels of distress or extent of mental health problems of students presenting to university counselling services in Australia, beyond anecdotal reports by counsellors. In part, this is due to the absence of standardised screening measures being used routinely as part of the intake process. Similarly, little is known about the effectiveness of counselling in university settings in Australia, whether to improve retention, which has been of particular concern in recent years, or the overall well being and mental health of students. Once again, this is in part due to the absence of outcome measures to monitor clients' progress in response to counselling and the impact of counselling on academic performance. While some Australian university counselling services report using outcome measures or measures of therapeutic alliance (personal communication; ANZSSA Bulletin Board[1]), it is not known how many do so routinely or in a systematic way. This is not the case elsewhere, where standardised measures are used extensively, if not nationally, enabling cross institutional comparisons, national benchmarking and collaborative research between university counselling services, mental health and primary care services.

In the United Kingdom (UK), the CORE System (Clinical Outcomes in Routine Evaluation - see www.coreims.co.uk) was developed between 1995 - 1998 as a standardised set of measures to be used as an outcome, quality, evaluation and clinical audit tool for psychological and counselling services throughout the UK (Barkham, Mellor-Clark, Connell, & Cahill, 2006). CORE consists of two main measures - an outcome measure CORE-OM, which is a 34 item self-report questionnaire completed by a client pre- and post-counselling and includes items covering subjective well-being (four items), symptoms/problems (12 items) and life/social functioning (12 items); and an assessment measure CORE-A, which

[1] [1]An email list server for members of the Australian and New Zealand Student Services Association Inc.

consists of two forms completed by a practitioner: the Therapist Assessment Form (TAF) and the End of Therapy Form (EOT) and collects demographic information about the client and descriptive information about the presenting problem and/or diagnosis (Evans, Connell, Barkham, Margison, McGrath et al., 2002; Evans, Mellor-Clark, Margison, Barkham, et al., 2000).

In the UK, CORE is used extensively within the National Health Service (NHS) and other public and private sector services, including university counselling services (Barkham, Gilbert, Connell, Marshall, & Twigg, 2005). CORE-PC is a computer software program that enables electronic data collation, management and reporting. The establishment of a National Research Database, with data pooled from participating services, has enabled the development of national benchmarks and facilitated research in a wide range of areas (Mellor-Clark, Curtis Jenkins, Evans, Mothersole, & McInnes, 2006). These have included comparison of effectiveness of different forms of therapy (Stiles, Barkham, Mellor-Clark, & Connell, 2008; Stiles, Barkham, Twigg, Mellor-Clark, & Cooper, 2006), dose response i.e. how much treatment a client needs to reach recovery (Barkham et al., 2006a) and benchmarking against practitioners and services in terms of effectiveness and outcomes (Mullin, Barkham, Mothersole, Bewick, & Kinder, 2006).

Recent research within the university sector in the UK using CORE found only marginally lower levels of severity of mental health problems in students presenting to university counselling services compared to an aged matched sample presenting in NHS primary care services, and similar levels of risk to self (Connell, Barkham & Mellor-Clark, 2007). The authors' conclusion that university counselling services should be afforded the same level of resources as primary care for the provision of mental health services would be difficult to sustain in Australia where comparisons of this kind are not easily substantiated.

In the United States (USA), the OQ-45 (Outcome Questionnaire) and the OQ Family of Instruments (see www.oqmeasures.com), were developed in the early 1990s as standardised measures to track client progress and outcomes in counselling and psychotherapy. It is used extensively throughout the United States across a wide range of clinical settings and in university counselling services, as well as on several continents in 17 different languages. Like CORE-OM, the OQ-45 is a global self-report measure of client distress and functioning, rather than a diagnostic tool, that includes subscales for symptom distress, interpersonal relationships, functioning at work or school and an overall score. Unlike CORE-OM, it is designed to be used on a session by session basis to track change in response to treatment, and more specifically, to identify clients who are not progressing and are at risk of dropping out.

Research over ten years involving five randomised clinical trials (RCT) (Harmon et al., 2007; Hawkins, Lambert, Vermeesch, Slade, & Tuttle, 2004; Lambert et al., 2001; Lambert et al., 2002; Whipple et al., 2003) has shown that providing feedback to Counsellors on their clients' progress on a session by session basis, significantly improves outcomes for clients who are deteriorating (Harmon et al., 2007; Hawkins et al., 2004; Lambert et al., 2001; Lambert et al., 2002), and successfully predicts clients who are not on track for recovery and are at risk of drop out in 85-100% of failing cases (Hannan et al., 2005). Interestingly, this pioneering research was conducted within a university counselling service - Brigham Young University, Provo, Utah. Research using the OQ-45 has focused on improving therapeutic outcomes through the use of feedback to therapists (Lambert et al., 2001; Lambert et al., 2002) and feedback to clients and therapists on clients' progress (Harmon et al., 2007; Hawkins et al., 2004); the use of Clinical Support Tools (Harmon et al., 2007; Slade, Lambert, Harmon, Smart, & Bailey, 2008; Whipple et al., 2003); identifying clients at risk of treatment failure (Hannan et al., 2005); and measuring variance in therapist effectiveness (Anderson, Ogles, Patterson, Lambert, & Vermeersch, 2009; Okiishi et al., 2006).

OQ-Analyst, like CORE-PC, is a computer software program that was developed to be used in conjunction with the OQ-45 to enable electronic data collation, management and reporting. When administered electronically to clients, the OQ-45 can be scored and analysed by OQ-Analyst, and an electronic feedback report generated within seconds for both

counsellor and client. The client's score is plotted against a clinical cut off and known norms for a range of clinical populations (e.g. community mental health, employee assistance program, inpatient and outpatient mental health) based on national American data. For example, scores above 63 are deemed to be in the clinical range with higher scores on the OQ-45 representing higher levels of distress and poorer functioning. It is not known how well norms given for specific clinical populations correspond to equivalent Australian populations, but they provide an indication of increasing severity of distress and poorer functioning that can be useful for clinicians. Empirical and rational algorithms, developed and tested in the five RCTs mentioned above, enable predictions to be made concerning whether or not the client's progress is 'on track' and generate feedback to the Counsellor in accordance with the predicted outcome.

Counsellors whose clients are 'on track' to recovery would be given feedback to this effect and a prediction would be given as to how many sessions this might take to achieve, based on algorithms derived from the dataset accumulated over the period of research using the OQ-45. Counsellors whose clients were not progressing as expected, or clearly deteriorating, would be given feedback encouraging them to review their work with their client, possibly engaging the client in this process and to consider increasing the frequency of contact or changing their approach to better suit the client's needs.

In Australia, routine outcome measures were selected and tested for use in the public mental health sector as part of the National Mental Health Strategy in 1992 (Pirkis, Burgess, Kirk, Dodson, & Coombs, 2005). The measures introduced were chosen because of their suitability for use in services for people with severe mental illness with a focus on the kind of impairment associated with conditions such as schizophrenia. The use of these measures is mandated and each State and territory is required to submit data to a national database under the National Outcomes and Casemix collection (NOCC) protocol. It is expected that these measures will be administered at a minimum of three monthly intervals as well as at intake into and discharge from services. These measures provide useful information about the impact and effectiveness of public mental health services in general (Eagar, Trauer, & Mellsop, 2005) and have the potential for routine monitoring of client response to treatment (Andrews & Page, 2005). However they are not designed to provide high frequency or timely feedback to clinicians about individual client outcomes, in the way the OQ-45 and OQ-Analyst does.

Rather than a single measure, a suite of clinician and consumer rated measures were adopted for use with particular service settings and age groups e.g. child and adolescents, adults and aged persons (Fourth National Mental Health Plan, 2009). However, for adults and aged persons, different consumer rated measures are used across the States and territories, resulting in the lack of a uniform national measure (Outcome measurement in mental health services: Factsheet 2). Even if there was a national consumer rated outcome measure suitable for adults, it is unclear how useful it would be applied to other settings such as university counselling services, given the focus on severe or chronic mental health within the public mental health sector.

As stated previously, some Australian university counselling services report limited use of outcome measures, mainly the OQ-45 or the Outcomes Rating Scale (ORS; Miller, Duncan, Brown, Sparks, & Claud, 2003) which was developed as a brief alternative to the OQ-45. Similarly, some report use of measures of therapeutic alliance, mainly the Session Rating Scale (SRS; Duncan, et al., 2003). However how many services or counsellors use them routinely or in a systematic way is not known.

In this paper we describe the introduction of the OQ-45 as a routine outcome and feedback measure to monitor client progress on a session by session basis within an Australian university counselling service. We describe the rationale, implementation and practical considerations involved in its administration. The use of accompanying software (OQ-Analyst) to collect and analyse data electronically, and to generate instant feedback reports to Counsellors is also explained.

Rationale

Some of the reasons for introducing standardised outcome measures as part of routine practice within a university counselling service have already been alluded to. These include:

- to obtain objective baseline data concerning the level of distress of clients presenting
- to enable comparison with other known populations e.g. mental health populations
- to establish benchmarks or norms for a particular service or client population e.g. international students, indigenous students
- to enable cross institutional comparisons across the sector
- to measure the effectiveness of counselling based on client progress, irrespective of clinical approaches or interventions undertaken.

Further reasons might include:

- to determine the number of sessions needed for clients to recover i.e. to improve to within the non-clinical range, and
- to allocate resources in response to client need based on objective measurement and feedback on progress.

At this university counselling service there were additional reasons, some pragmatic, for choosing the OQ-45 over other established measures. As a 45 item self-report general screening tool, the OQ-45 is easy to administer and takes only a few minutes to complete. It has proven reliability and validity and has been shown to be sensitive to change over short periods of time (Lambert et al., 1996). Hence it suits the short-term framework of counselling within a university service. It has advantages over a diagnostic scale such as, for example, the Beck Depression Scale, because it is a global measure of client distress and functioning across a range of subscales - symptom distress, interpersonal relations, social role functioning and gives an overall score - rather than a measure of severity of a single symptom, such as anxiety or depression.

The OQ-45 has advantages over the Outcome Rating Scale (ORS; Miller, Duncan, Sorrell, & Brown, 2005) as it has the capacity to identify critical items such as suicidality, substance abuse or potential for violence, which the ORS does not. This can be illustrated by the fact that the ORS is a four-item visual analogue self-report scale, which involves the client marking a point on a 10cm linear scale to indicate how they have been feeling in four areas of their life (overall, individually, interpersonally, socially). Whereas the OQ-45 as a questionnaire asks clients to rate the frequency of specific critical items on a five point scale from ‘Never’ to ‘Almost Always’ e.g. “I have thoughts of ending my life’; “After heavy drinking, I need a drink the next morning to get going’. So while the ORS is quicker to complete than the OQ-45, it cannot provide specific information about risk factors as the OQ-45 can.

There was some attraction in the fact that the OQ-45 was developed and researched in successive randomised controlled trials within a university counselling service at Brigham Young University, which is a similar size to this University, and that it is a client self-report tool. The fact that the OQ-45 was being used routinely by the Psychology Clinics in our own and two other metropolitan public universities, and likely to be used more widely in psychology clinics across Australia, made it an attractive choice from the point of view of possible cross institutional comparison and research collaboration. Lambert’s consulting to the School of Psychology over a number of years, meant that he was available to consult with the Counselling Service to discuss relevant research findings, its use and possible implementation. Finally, used in conjunction with the accompanying software (OQ-Analyst), benefits of the OQ-45 could be derived immediately in the form of instant analysis and feedback to counsellors on clients’ progress in counselling. Compared to the frustrations of using pen and paper forms which then have to be scored and entered into a database and analysed at some future point, the electronic option was far preferable. An earlier pilot undertaken within the Counselling Service in 2002 using pen and paper versions of the OQ-45, ORS and SRS was a valuable introduction to the measures, their use and differences in

their utility. It also highlighted the significant advantage of electronic data collection and analysis through OQ-Analyst, and the immediate value that could be derived from instant feedback on clients' initial distress and progress in response to counselling.

Implementation

Discussion took place within the Counselling Service for over a year before a decision was reached to introduce the OQ-45 as a routine outcome measure, administered as part of the intake process and at each subsequent session with the counsellor. Considerable thought was given to how this could be facilitated across campuses, where there were differences in intake procedures, with some campuses having full or part-time administrative assistance, and other campuses where the counsellor operated as a sole practitioner with no administrative support. Counsellors were encouraged to adopt a method of administration that would work best on their campus. In this way counsellors were given some ownership and control over the process. Administrative staff were briefed on the introduction of the OQ-45 within the Counselling Service and the rationale for its implementation explained. Their input was sought into how it could be introduced to clients and administered on each campus and how they could assist counsellors in implementation, especially those working as sole practitioners.

Initially consideration was given to administering the OQ-45 only to counselling clients who presented with personal problems and to exclude clients presenting with academic or other university related enquiries. However given that underlying personal or relationship difficulties often emerge with clients who present ostensibly with academic or other university related matters, we decided to administer the OQ-45 to all counselling clients. We were also interested in helping counsellors to identify clients at risk, given that it is not always possible to screen for risk in a single consultation. There was some concern that clients presenting in a distressed state may be reluctant to complete the questionnaire. Counsellors and administrative staff were encouraged to use their discretion in such cases, however it was noted that information about the client's level of functioning, distress and risk could be missed if it were not administered.

Ethics approval was sought and obtained and clients were required to provide written informed consent prior to completion of the OQ-45. Participation was voluntary and clients could elect not to complete the questionnaire at any time without affecting their access to counselling. Students aged 17 years or under were not required to complete the questionnaire.

Clients completed the questionnaire in electronic format either on a hand held palm pilot or computer in the waiting room or counsellor's office. On larger campuses this was facilitated by administrative staff. On smaller campuses where there was no or part time administrative assistance, counsellors administered the questionnaire. Presentation of the questionnaire to clients varied across campuses but in general it was offered as part of the Counselling Service's ongoing efforts to evaluate and improve its services to clients.

The financial outlay for implementation using OQ-Analyst involved an annual license fee to purchase the software license, based on the number of full time equivalent counsellors using the software and a modest fee to cover technical support during the installation process, and in house IT expenses to set up the OQ-Analyst on a secure part of the University server to enable access from multiple campuses. Several palm pilots were also purchased.

Concerns about using the OQ-45

Initial concerns about the use of the OQ-45/OQ-Analyst in the Counselling Service centred on access and 'fit' with the culture of a university counselling service. Counsellors had some reservations that completing the OQ-45 may complicate the intake process, or emphasise a mental health focus, rather than the wellbeing and development objectives of the service. There was some concern that the terminology used in the software (patient/therapist, treatment, clinic) reflected a medical model rather than a service model which seemed more appropriate for an Australian university counselling setting. There was also concern about the limitations of using a single measure and generalisations that could be drawn from it.

The software has the capacity to compare outcomes of different counsellors which has been the subject of recent research interest (Anderson, Ogles, Patterson, Lambert, & Vermeersch, 2009; Miller, Hubble, & Duncan, 2008; Okiishi, Lambert, Eggett, Nielsen, & Dayton, 2006). However this was not an objective in introducing the OQ-45 within the Counselling Service. While it is recognised that there may be variance in clinical effectiveness amongst counsellors, multiple factors affect client outcomes, including most notably the client's level of initial distress or disturbance, as well as motivation or readiness to change, which are outside the counsellor's control. The main objective for introducing the OQ-45/OQ-Analyst into the Counselling Service was to improve counselling outcomes overall, through providing feedback to Counsellors, especially for clients who are deteriorating or at risk of dropping out.

In working through these concerns, counsellors supported the introduction of the OQ-45/OQ-Analyst with the focus being on improving the quality of counselling services while maintaining a client centred approach, that is, to enhance the counselling process by seeking feedback and information *from* clients, not merely to collect or analyse data *about* them. As the OQ-45 is a client self-report tool that offers information and insight into a client's current circumstance counsellors' concerns were ameliorated. Additionally, it has been made explicit in all written information and in the day to day practice of the service that participation is entirely voluntary, with no issue or consequence for those clients choosing not to answer the questionnaire.

Training

Counselling and administrative staff were trained on site, individually or in small groups, in the operation of OQ-Analyst - entering clients into the database; administration of questionnaires using palm pilots or computers via Kiosk, a shortcut on the desktop - and shown sample feedback reports to counsellors demonstrating the utility of OQ-Analyst. A local User's Manual was developed for staff to help troubleshoot any problems which could be encountered using the software, and which supplemented the online OQ-Analyst User's Guide. A protocols document was also developed for staff that outlined the rationale for introduction and administration of the OQ-45, information on security (access levels and user roles) and guidelines for implementation. The OQ-Analyst software was installed on a development server for several months prior to going 'live' to enable staff to try out the software with 'dummy' clients. Once 'live', staff were invited to contact the first author concerning any difficulties encountered, which were usually of a technical nature (login, synchronisation of palm pilots, uploading questionnaires from palm pilots etc), and solutions to common problems were reported in an email to staff.

Security

For multi campus universities such as ours, the OQ-Analyst software is designed to run in a local area network to allow access from multiple computers. The application was installed on a secure part of the university server. Access to the database was via a username and password and was governed by a two-tiered security model comprised of access levels and roles. A user's access level determined the pages, subpages and action available to them and information displayed within OQ Analyst. A user's role controlled the rules permitting them to see a customised group of clients and excluding them from viewing others. Staff were allocated access levels (standard, administrative, executive, system administrator, not assigned) and user roles (clerical, clinician, supervisor and corporate) according to their position i.e. counsellor, administrative officer, supervisor etc and need to access relevant information. In practice this meant that counsellors as clinicians could access their own clients' records but not those of other counsellors; supervisors could access their own clients' records and the records of clients seen by counsellors or interns whom they supervised; and administrative staff could add clients into the database but not access questionnaires or reports relating to clients.

Practical considerations

Having used the OQ-45 and OQ-Analyst for well over a year now, we have developed a preference for administering it electronically using Kiosk - a shortcut to the database which can be installed on a networked computer - rather than hand held palm pilots. In our experience it is more time consuming to administer the questionnaire on a palm pilot, as it relies on administrative or counselling staff to login and pull up a blank questionnaire for each client and then upload the completed questionnaire to the server so that it can be accessed by the counsellor. In addition, portable devices such as palm pilots lose charge if they are not plugged into a computer or charger, which presents problems on smaller campuses which may only be staffed part time. In contrast, Kiosk allows clients to pull up an electronic questionnaire when they login to OQ-Analyst directly onto the computer where it is installed and it is uploaded to the secure server immediately when they press 'submit'. This means that regular clients can 'help themselves' by completing the OQ-45 while they are waiting for their appointment with the counsellor, if they have access to a computer in the waiting room.

Outcomes

In this paper we report preliminary findings based on the first year of implementation (September 2008 - August 2009) of the OQ-45/OQ-Analyst within the Counselling Service. So what have we learned?

Firstly, it is both feasible and acceptable to utilise a routine outcome measure within a university counselling service. There has been general acceptance and compliance with administering the OQ-45 on a session by session basis, from both staff and clients of the service. Over 73% of clients (1017 completions out of a possible 1388 clients) completed the questionnaire at the initial session. This is likely to be an underestimation as clients were entered into the OQ database at the time of making an appointment and some clients failed to attend the initial session. However 96% of repeat clients i.e. clients who attended more than one session, completed the questionnaire at each session. Reasons for non-completion included technical reasons (e.g. computer failure, failure of palm pilots, the server being down), administrative reasons (e.g. not being offered the OQ-45 because they arrived late or were too distressed to complete it on the first presentation) as well as clients' declining to complete it. Owing to the complexity of administering the OQ-45 across multiple campuses, involving many different staff and intake procedures, it is not possible to give a precise breakdown of the reasons for non-completion. The higher rate of completion for return clients suggests that clients did not object to being asked to complete the questionnaire on a session by session basis. The apparently lower rate of completion for clients at the initial session may be a reflection of differences between clients who present for only one session and repeat clients.

Secondly, using the OQ-45 has not changed the focus of the counselling service. It remains a short-term, solution focussed service, aimed at enhancing student persistence, decision-making and success with university studies or work. Approximately 95% of clients attended between one and six counselling sessions, with 561 clients (55%) attending only one session and 456 clients (45%) attending between 2 and 18 sessions.

Thirdly, baseline data for clients presenting to the Counselling Service suggest that over two thirds of clients (69%; *N*=697) are in the clinical range i.e. had initial OQ scores above 63. Over one third of clients (40%; *N*=404) had initial OQ scores of 80 or over, which represents moderate to severe levels of symptoms. In order to interpret this finding it will be necessary to compare baseline scores with known benchmarks for similar populations in Australia and elsewhere using similar outcome measures. However it would appear to confirm counsellors' anecdotal experience of high levels of distress in clients presenting to the counselling service.

Fourthly, preliminary analysis of outcome data suggests that most clients benefit from counselling. A comparison of mean scores on the OQ-45 for repeat clients (*N*=456) at the first and last presentation of 79.96 (*SD*=23.2) and 72.78 (*SD*-23.92) respectively, showed improvement in well being over time, indicating a small effect size of .30 as measured using Cohen's *d*. This finding is similar to a North American sample of clients (*N*=164) presenting

to a university counselling service where therapists received immediate OQ-45 feedback (Slade et al., 2008). As this is not a controlled study we cannot demonstrate improved outcomes compared to treatment as usual, but only compared to published outcomes from controlled studies. Further analysis is required however before meaningful interpretations can be made concerning our findings. These will be presented in a subsequent paper.

Finally and perhaps most importantly, there have been immediate benefits to both counsellors and clients in terms of enhancing the counselling process. Counsellors have integrated the use of the OQ-45 into counselling sessions in various ways so that clients see the use of the questionnaire in action and understand how it informs the counselling process. The OQ-45, used in conjunction with OQ-Analyst, has proven to be an invaluable clinical tool for counsellors. Through feedback to counsellors at the initial consultation and in subsequent sessions, it has alerted counsellors to clients who are at risk of suicide or self-harm, substance abuse or violence, and who are not progressing as expected and are at risk of dropping out of counselling prematurely. Other potential benefits are only beginning to be realised. These include the capacity to identify specific client populations that are presenting with greater distress than others.

Discussion and Conclusion

To demonstrate that it is both feasible and acceptable to introduce a routine outcome measure on a session by session basis within an Australian university counselling service is a significant outcome in itself. It has been a significant achievement to successfully implement a routine outcome measure in a university counselling service delivered across six sites in a multi campus university, where there are varying levels of administrative support.

Several factors influenced the successful implementation of the OQ-45 within the Counselling Service. The most important factor was the cooperation and commitment of counselling staff. All counselling staff were committed to the introduction of the OQ-45 within the counselling service. The support and assistance of administrative staff and the overall support of management were also critical to its successful introduction. The decision to implement the OQ-45 using an electronic format, rather than pen and paper, ensured that data was collected and analysed immediately. Using the OQ-45 in conjunction with OQ-Analyst meant that there were immediate benefits to counsellors from the feedback generated about their clients' level of distress and functioning, critical items such as suicidality, and their progress on a session by session basis. This was in contrast to a previous attempt to pilot the use of outcome and other measures using pen and paper data collection, where it took several months for aggregate data to be analysed and reported back to counsellors, and information about the progress of individual clients was not available for use in the session.

Other factors that facilitated the implementation of the OQ-45 included the decision to administer the questionnaire as part of the routine intake process and to offer it to all clients of the counselling service at every session. Incorporating the OQ-45 into the intake process meant that it was seen as an integral part of the service, not an 'add on'. Offering the OQ-45 to all clients simplified administration and avoided 'second guessing' who should be given it e.g. clients who were presenting with personal difficulties rather than academic or other university related matters. Choosing an appropriate outcome measure for use within a university counselling service involves striking a balance between what is acceptable to clients and counsellors in terms of relevance and ease of administration, and what is being sought by its introduction. A brief, single measure that has general applicability to the client population is likely to be more acceptable than a suite of measures or a single diagnostic measure. The choice of measure might vary depending on whether the objective is monitoring client outcomes or simply benchmarking. Baseline scores are useful for benchmarking of initial distress and comparison with other populations, as the use of CORE in the UK has shown (Connell et al., 2007). Briefer measures such as the ORS and SRS might be perceived as more user friendly, but lack the features of longer measures such as the OQ-45 to specifically highlight critical risk items.

There are limits to the utility of a single outcome measure such as the OQ-45. It is not a

substitute for clinical judgement. Occasionally we have found that clients appear to be over- or under-reporting their distress on the OQ-45. The OQ-Analyst recognises this phenomenon and alerts counsellors to possible reasons this may occur. For example, clients who are attending at the behest of someone else, or who are "cut off' emotionally, may score unusually low on the OQ-45, whereas the counsellor may assess them as highly disturbed and in difficulty. Similarly, clients who score very high on the OQ-45 may be presenting a "cry for help" but be assessed by the counsellor as less distressed. Overall, our experience has been that used in conjunction with clinical experience, particularly in our short term service, the OQ-45 and feedback from the OQ-Analyst can enhance the counselling process and maximise the impact of a single counselling session. Feedback from clients about the process and content of the questionnaire has been positive, with the majority of clients of the service electing to complete it.

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