

Progress Monitoring Measures: A Brief Guide

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There is much evidence to suggest that psychotherapy is effective, however, it is far from flawless (e.g., Lilienfeld, 2007; Stuart, 1970). As the field of mental health changes, there has been a recent movement in routine practice toward the use of standardized measures to track client progress and to collect feedback about treatment response (Lambert & Shimokawa, 2011). The use of standardized tools can help practitioners identify when clients are not progressing in therapy and have been linked to better outcomes for nonresponsive clients than when these measures are not used (e.g., Shimokawa, Lambert, & Smart, 2010). The purpose of this article is to introduce a group of such tools, referred to as progress monitoring (PM) measures, and to highlight features relevant in selecting and implementing a PM measure in practice. Areas covered include domains assessed, target populations, administration, scoring, feedback and interpretation, cost, training and privacy. While there exist numerous outcome and assessment measures (e.g., Froyd, Lambert, & Froyd, 1996), this article focuses specifically on seven popular progress monitoring measures for adult mental health populations, that are brief, comprehensive and easily accessible tools designed to be used to monitor change throughout the therapeutic process.

Keywords: psychotherapy, progress monitoring (PM) measures, feedback, outcome, progress tracking

Research suggests that 5–10% of clients in psychotherapy experience deterioration, and up to 50% demonstrate no reliable change during treatment (Hansen, Lambert, & Forman, 2002; Lambert & Ogles, 2004). As clinicians do not accurately detect when clients are worsening (Hannan et al., 2005; Hatfield, McCullough, Frantz, & Krieger, 2010), it may be important to supplement clinical judgment with additional tools. Tools that can help clinicians identify clients who are not responding to treatment and that improve therapeutic outcomes may be referred to as progress monitoring (PM) measures. These measures are used to carry out continuous assessment of client change and to give the clinician systematic feedback about treatment response (Lambert & Shimokawa, 2011). In contrast to pre-post assessments, PM measures are completed by the client on a routine basis, and feedback is provided to the clinician throughout the therapeutic process.

The practice of tracking client change during therapy has been studied by research teams around the world and is referred to in varying ways, including Client-Directed, Outcome-Informed therapy (CDOI; Miller, Duncan, & Hubble, 2004), Patient Reported Outcome Measures (PROMs; Barkham et al., 2010), Feedback Informed Treatment (FIT; Miller & Bargmann, 2011), client feed-

back (Lambert & Shimokawa, 2011), and behavioral health assessment and outcome (Kraus, Seligman, & Jordan, 2005). The term “progress monitoring” has been chosen for this article due to its emphasis on the continuous nature of assessment that occurs throughout the therapeutic process as opposed to outcome measures, which are generally used in the context of termination. Research has led to the creation of numerous psychometrically sound measures that can be integrated into practice, each with the goal of helping practitioners improve clinical decision making and ameliorate treatment outcomes.

As the changing landscape of mental health demands for greater accountability and demonstrable treatment outcomes, the use of PM measures to track progress may become increasingly prevalent and as such information regarding these measures is timely. The purpose of this article is to provide the individual clinician, and community-, counseling- or hospital-based practices with an introduction and brief guide to some of the popular PM measures. This review is not intended to be exhaustive, but rather to highlight issues important in selecting a measure and to provide relevant information on each measure. Based on an examination of key features of measurement systems (e.g., Evans, Mellor-Clark et al., 2000; Hawkins, Lambert, Vermeersch, Slade, & Tuttle, 2004) and current usages (e.g., Hatfield & Ogles, 2004; 2007), the following have been used as inclusion criteria: (a) pantheoretical; (b) brief administration time; (c) appropriate for use with an adult outpatient population with a broad spectrum of presenting problems; (d) designed for routine administration (e.g., session-by-session or other regular interval); (e) comprehensive (i.e., provides a broad overview of a client’s functioning, as opposed to only focusing on symptoms); (f) aids assessment and treatment planning (e.g., provides alerts and/or benchmarking information); (g) sensitive to clinically significant change (as measured by a reliable change index; Jacobson & Truax, 1991); and (h) information available regarding relevant psychometric properties. Although other areas will be examined, an elaboration and critique of psychometric prop-

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Table 1
Selected References Reporting Psychometric Properties and Sensitivity to Change for Progress Monitoring Measures

Measure	Reference
BASIS-24	Eisen, Gerena, Ranganathan, Esch, & Idiculla (2006); Eisen et al. (2004).
BHM-20	Kopta & Lowry (2002).
CORE-OM	Barkham et al. (2010); Evans et al. (2002).
OQ-45	Lambert, Hansen, & Harmon (2010); Lambert, Morton, et al. (2004).
PCOMS	Bringhurst, Watson, Miller, & Duncan (2006); Duncan et al. (2003); Miller & Duncan (2004).
Polaris-MH	Grissom & Lyons (2006).
TOP	Kraus, Seligman, & Jordan (2005); Kraus & Castonguay (2010).

Note. BASIS-24 = Behaviour and Symptom Identification Scale-24; BHM-20 = Behavioural Health Measure-20; CORE-OM = Clinical Outcomes in Routine Evaluation-Outcome Management; OQ-45 = Outcome Questionnaire-45; PCOMS = Partners for Change Outcome Management System; TOP = Treatment Outcome Package.

erties and sensitivity to change for each PM measure is beyond the scope of this article; a list of selected articles that report relevant information is provided in Table 1. Moreover, in order to ensure wide accessibility, PM measures were only included if information was readily available through scholarly works, websites, and direct contacts with the companies or agencies who manage the reporting functions. The final list of PM measures reviewed includes the Behaviour and Symptom Identification Scale-24 (BASIS-24; Eisen, Normand, Belanger, Spiro, & Esch, 2004), the Behavioural Health Measure-20 (BHM-20; Kopta & Lowry, 2002; formerly Behavioural Health Questionnaire-20), the Clinical Outcomes in Routine Evaluation System-Outcome Management (CORE-OM; Barkham et al., 1998, and CORE-5; Barkham et al., 2010), the Outcome Questionnaire-45 (OQ-45; Lambert, Hansen et al., 1996), the Partners for Change Outcome Management System (PCOMS), which is comprised of the Outcome Rating Scale (ORS) and the Session Rating Scale (SRS; Miller, Duncan, Sorrell, & Brown, 2005), the Polaris-Mental Health (Polaris-MH; Grissom, Lyons, & Lutz, 2002; formerly the Treatment Evaluation and Management), and the Treatment Outcome Package (TOP; Kraus et al., 2005).

Description and Domains Assessed

The general purpose of a PM measure is to provide the clinician with a quick test of a client's "vital signs" of psychological functioning and to help practitioners track changes in treatment progress (Lambert & Shimokawa, 2011). Although there are variations among measures, they generally target three main domains: (1) symptoms, (2) well-being, and (3) functioning (see Table 2 for a list of domains). Symptoms range from depression, anxiety and substance use to panic, psychosis, violence, mania, and sleep. Well-being encompasses factors such as emotional distress, motivation/energy, and life satisfaction. Functioning covers a range of areas such as a client's perceived performance in work/school, sexual, and intimate or interpersonal relationships. Measures range in scope, from very general to specific (Owen & Imel, 2010). For example, the ORS, which is part of the PCOMS, was initially

developed as a brief alternative to the OQ-45 (Miller, Duncan, Sorrell, & Brown, 2005) and includes only four visual-analogue questions that clients respond to by marking a tick along a 10-cm line (Anker, Duncan, & Sparks, 2009). As such, the domains covered are fairly broad (Miller et al., 2005). In comparison, the TOP and OQ-45 with 58 items and 45 questions, respectively, are much more comprehensive instruments (Kraus & Castonguay, 2010). In addition to key subscales, the following measures include questions that assess client risk of harm to self or to other: BASIS-24 (Eisen et al., 2004), BHM-20 (Kopta & Lowry, 2002), CORE-OM (Barkham, Gilbert, Connell, Marshall, & Twigg, 2005), OQ-45 (Lambert, Hansen, & Harmon, 2010), Polaris-MH (Grissom & Lyons, 2006), and TOP (Kraus & Castonguay, 2010). In conjunction with tracking progress, PM measures are generally designed to alert clinicians when a client is not progressing as expected (see Table 2).

PM measures are intended to be pantheoretical (e.g., Grissom & Lyons, 2006; Kraus & Castonguay, 2010; Lueger & Barkham, 2010). Recent studies suggest that practitioners with diverse theoretical orientations including CBT, insight-oriented and eclectic, have integrated these measures into their practice (Hatfield & Ogles, 2004; 2007).

Populations

PM measures reviewed are targeted for use with adult clients (18 and older) struggling with a wide variety of mental health issues. Several systems also offer alternate versions of their measure for other clientele such as children, adolescents, groups, college students, and substance-abuse populations (see Table 3). All of the measures reviewed are available in English; the CORE (French version in progress CORE IMS, 2012b), OQ-45 (de Jong et al., 2007), PCOMS (Hafkenscheid, Duncan, & Miller, 2010), and Polaris-MH (American Psychological Association [APA], 2011d) are also available in French. Additionally, many measures have been translated into other languages (see Table 2). Practitioners should note that there are certain populations for which measures are not recommended; for example, the developers of the BASIS-24 caution against the use of these measures with clients suffering from serious cognitive impairments, such as dementia or mental retardation (McLean Hospital, 2012a).

Administration

PM measures vary in the amount of time they require for completion, from approximately 2 min for the PCOMS (Miller et al., 2005) to 10–15 min for the Polaris-MH (APA, 2011d). Generally, measures are administered to clients, either in paper and pencil form or using an electronic version, before meeting with the therapist. There are slight variations in the administration of several measures. For example, the BASIS-24 (McLean Hospital, 2012a) and OQ-45 (APA, 2011b) measures can be administered using a face-to-face or telephone interview, the TOP can be administered via fax (APA, 2011f), and the Behavioural Health Laboratories (BHL) and the CORE Net provide clinicians using the TOP and the CORE, respectively, with the option of sending an e-mail reminder to clients prior to their session ("One-Click Assessment"; BHL, 2012d; CORE IMS, 2012d). Finally, the PCOMS is a two-part measure, with the client completing the ORS prior to the session and the SRS at the end of the session (Miller &

Table 2
Key Characteristics of Selected Progress Monitoring Measures

Measure	Language ^a			Administration (items/minutes)	Domains assessed	Alerts	Benchmarking	Cost	Contact
	FR	SP	OT						
BASIS-24	— ¹	✓ ¹	✓ ¹	24/10–15 ¹	1) depression and functioning; 2) interpersonal relationships; 3) self-harm; 4) emotional lability; 5) psychosis; 6) substance abuse ¹	— ¹	✓ ¹	\$60 USD (\$59.82 CAD) ^b instruction guide; Annual license: \$395 USD (\$393.81 CAD)/year single-site license; \$95 USD (\$94.72 CAD) subsequent sites; Additional cost for Web-based system ²	http://ebasis.org/ ; (617) 855-2948
BHM-20	— ³	✓ ³	✓ ³	20/2 ⁴	1) well-being (emotional distress, motivation/energy, life satisfaction); 2) symptoms (depression, anxiety, drug/alcohol abuse, risk- harm to oneself and other); 3) life functioning (work/school, intimate relationships, nonfamily relationships, life enjoyment); 4) global mental health ⁴	✓ ⁵	— ⁶	\$115 USD (\$114.66 CAD)/clinician for sites that are do not charge clients (3 clinician min.); No additional charge for maintenance or technical support; Contact for price quote ³	http://www.celesthealth.com/ ; (443) 798-5797
CORE-OM	✓ ⁶	✓ ⁷	✓ ⁷	34/5–10 ⁸	1) subjective well-being; 2) problems (depression, anxiety, physical aspects, trauma); 3) functioning (relationships, general functioning, social); 4) risk (risk to self/others); CORE-5: 1) anxiety; 2) depression; 3) functioning ⁸	✓ ⁹	✓ ¹⁰	Paper version free of charge; £10 (\$15.77 CAD) CORE Trial packs; Contact for price quote for additional services ¹¹	http://www.coreims.co.uk/ ; 44 (0) 1788 546019
OQ-45	✓ ¹²	✓ ¹²	✓ ¹²	45/5–10 ¹²	1) symptom distress; 2) interpersonal relationships; 3) social role performance; 4) total ¹³	✓ ¹²	— ¹²	License: Paper version range from \$50 USD (\$49.85 CAD) (student) to \$7000 USD (\$6979 CAD) (state) plus shipping and handling ¹⁴ ; Software license \$250 USD (\$249.25 CAD)/clinician ¹⁵	http://www.oqmeasures.com/ ; (801) 649-4392
PCOMS	✓ ^{16,17}	✓ ^{16,17}	✓ ^{16,17}	8/2 ¹⁸	ORS: 1) individual (personal well-being); 2) interpersonal (family, close relationships); 3) social (work, school, friendships); 4) overall (general sense of well-being). SRS: 1) relationship; 2) goals and topics; 3) approach and method; 4) overall ¹⁸	✓ ^{16,17}	✓ ^{16,17}	Paper version free of charge; MyOutcomes \$225 USD (\$224.32 CAD)/year for sole provide; contact for price quote for group/large agency ¹⁹ ; FIT-Outcomes €134 (\$175.69 CAD) for single license user (discounts when >10 clinicians) ²⁰	http://www.scottmillier.com/?q=node/6 ; (250) 763-4775

(table continues)

Table 2 (continued)

Measure	Language ^a			Administration (items/minutes)	Domains assessed	Alerts	Benchmarking	Cost	Contact
	FR	SP	OT						
Polaris-MH	✓ ²¹	✓ ²¹	✓ ²¹	—/10–15 ^{21,22}	Polaris-MH: 1) subjective well-being; 2) symptoms (depression, anxiety, phobia, obsessive-compulsive, somatization, panic, PTSD, alcohol severity, drug severity); 3) functional disability (personal, social, vocational); 4) behavioral health status; 5) mental health and health screens; 6) strengths; 7) motivation. Patient Update: 1) subjective well-being; 2) symptoms; 3) functional disability; 4) behavioral health status; 5) mental health and health screens; 6) treatment progress/satisfaction; 7) therapeutic bond ²²	✓ ²¹	✓ ²¹	Contact for price quote http://www.polarishealth.com/; (215) 359-3901	
TOP	— ²³	✓ ²³	✓ ²³	58 (can vary based on modules included)/10–15 ^{23,24}	1) depression; 2) violence; 3) quality of life; 4) sleep; 5) sexual functioning; 6) work functioning; 7) psychosis; 8) mania; 9) panic; 10) suicide ²⁴	✓ ²³	✓ ²³	Free basic service; Monthly fee: Range from \$24 USD (\$23.93 CAD)/ clinician to \$90 USD (\$89.73 CAD)/clinician depending on services; Additional costs based on additional services ²⁵	http://Bhealthlabs.com; (508) 281-6737

Note. BASIS-24 = Behaviour and Symptom Identification Scale-24; BHM-20 = Behavioural Health Measure-20; CORE-OM = Clinical Outcomes in Routine Evaluation-Outcome Management; OQ-45 = Outcome Questionnaire-45; PCOMS = Partners for Change Outcome Management System; Polaris-MH = Polaris-Mental Health; TOP = Treatment Outcome Package.
^aAll measures are available in English; — = not available; ✓ = available; FR = French; SP = Spanish; OT = other. ^bConverted on February 18, 2012 based on current exchange rate of 0.9970 (Bank of Canada, 2012). ^cFrench version in progress.
 See the following references: ¹APA, 2011a; ²McLean Hospital, 2012f; ³J. Starfill, personal communication, January 25, 2012; ⁴CelestHealth Solutions, 2008a; ⁵CelestHealth Solutions, 2008b; ⁶M. Kopta, personal communication, February 8, 2012; ⁷CORE IMS, 2012b; ⁸Barkham et al., 2010; ⁹CORE IMS, 2012f; ¹⁰CORE IMS, 2012a; ¹¹CORE IMS, 2012c; ¹²APA, 2011b; ¹³Lambert et al., 2001; ¹⁴OQ Measures, 2012d; ¹⁵OQ Measures, 2012e; ¹⁶APA, 2011c; ¹⁷APA, 2011e; ¹⁸Miller & Duncan, 2004; ¹⁹L. Kasden, personal communication, February 16, 2012; ²⁰S. Bargmann, personal communication, February 16, 2012; ²¹APA, 2011d; ²²Grisson & Lyons, 2006; ²³APA, 2011f; ²⁴Kraus & Castonguay, 2010; ²⁵BHL, 2012c.

Table 3
Selected Related Measures

Measure	Related measures		
	Child/Adolescent	Group	Other
BASIS System	—	—	BASIS-32 ¹
BHM-20	—	—	BHM-43; Psychotherapy Readiness Scale; Therapeutic Bond Scale ²
CORE System	Young People-CORE ³	—	Learning Disabilities-CORE; General Population-CORE ³
OQ System	Youth-OQ 2.01; Youth-OQ Self-Report 2.0; Youth OQ-30.2; Youth OQ-12 ⁴	OQ-Group Readiness Questionnaire; OQ-Group Questionnaire; Group Climate Questionnaire ⁵	OQ-30; Severe OQ; OQ-10; OQ-Assessment for Signal Clients; Brief Psychiatric Rating Scale; OQ-Wellness and Resilience Assessment Post-deployment ⁶
PCOMS	Young Child-ORS; Young Child-SRS ⁷ ; Child-ORS ⁸ ; Child-SRS ⁹	Group-SRS ¹⁰ ; Child Group-SRS ¹¹	Relationship-RS ¹²
Polaris-MH	Polaris-Child Welfare; Polaris-Youth; Polaris Child and Adolescent Needs and Strengths; Smart-Wraparound ¹³	—	Polaris-Domestic Violence; Polaris-Chemical Dependency; Polaris-Recovery Outcome Management System ¹³
TOP	Child TOP ¹⁴ ; Adolescent TOP ¹⁵	—	TOP-Substance Abuse; TOP Satisfaction and Alliance; TOP Treatment Program Satisfaction ¹⁵

Note. BASIS = Behaviour and Symptom Identification Scale; BHM-20 = Behavioural Health Measure-20; CORE = Clinical Outcomes in Routine Evaluation; OQ = Outcome Questionnaire; PCOMS = Partners for Change Outcome Management System; Polaris-MH = Polaris-Mental Health; TOP = Treatment Outcome Package.

See the following references: ¹McLean Hospital, 2012c; ²CelestHealth Solutions, 2008a; ³Barkham et al., 2010; ⁴OQ Measures, 2012g; ⁵OQ Measures, 2012c; ⁶OQ Measures, 2012b; ⁷Duncan, Miller, Huggins, Sparks, 2003; ⁸Duncan, Miller, & Sparks, 2003a; ⁹Duncan, Miller, & Sparks, 2003b; ¹⁰Duncan & Miller, 2007; ¹¹Duncan, Miller, Sparks, & Murphy, 2011; ¹²Duncan & Miller, 2004; ¹³Polaris Health Directions, 2008c; ¹⁴Kraus, Boswell, Wright, Castonguay, & Pincus, 2010; ¹⁵BHL, 2012b.

Duncan, 2004). Although the same version of the measure is generally used throughout treatment, there are abbreviated versions designed for session-by-session use for the Polaris-MH and the CORE-OM, referred to as the Patient Update and Brief Patient Update (Grissom & Lyons, 2006) and the CORE-5 (Barkham et al., 2010), respectively. Additionally, for the TOP, there are separate modules that the therapist can decide to either include or omit at each administration (Kraus & Castonguay, 2010).

Scoring, Feedback, and Interpretation

Different PM measures have different scoring procedures. Some of these measures, including the BASIS-24 (McLean Hospital, 2012d), the BHM-20 (Academy Communications, 2006), the CORE-OM (Leach et al., 2006) the CORE-5 (Wright, Bewick, Barkham, House, & Hill, 2009), the OQ-45 (Okiishi et al., 2006), and the PCOMS (Anker et al., 2009; Miller et al., 2005) can be scored manually by the practitioner or with the assistance of a computer program (e.g., Microsoft Excel or Statistical Package for the Social Sciences). Hand-scoring can be time consuming—from 2 min in the case of the PCOMS (Miller et al., 2005) to approximately 20 min for the BHM-20 (Academy Communications, 2006)—and may require manual computer data entry. Another option available to practitioners is the combination of PM measures (electronic or faxed paper-and-pencil versions) with an Internet-based scoring and reporting system. This technologically advanced method of scoring allows practitioners to receive detailed results in “real-time” or within seconds of sending in data. These systems provide information regarding client change by comparing the client’s

scores during treatment, either (a) to preestablished cutoffs (CORE-OM; K. McCrea, personal communication, February 15, 2012), (b) to the client’s intake scores (BASIS-24; J. Berkowitz, personal communication, February 15, 2012), or (c) to dosage curves (BHM-20: M. Kopta, personal communication, February 8, 2012; PCOMS: Health Factors Inc., 2011; Polaris-MH: Grissom & Lyons, 2006; OQ-45: Finch, Lambert, & Schaalje, 2001; and TOP: D. Kraus, personal communication, February 14, 2012). Dosage curves—first designed by Howard, Kopta, Krause, and Orlinsky (1986)—illustrate the relationship between the number of psychotherapy sessions and client’s improvement. The creation of dosage curves allows the systems to identify when clients’ scores begin to deviate significantly from the expected recovery curve, indicating that clients may be experiencing deterioration in treatment or no change.

Because clinicians generally cite “adds too much paperwork” and “takes too much time” as the top reasons not to use assessment and outcome measures in practice (Hatfield & Ogles, 2004, p. 487), combining measures with centralized scoring systems is a time-saving option that eliminates paperwork and provides almost instantaneous client results regarding the client’s status in treatment, when practitioners need them—at the beginning of the session. The following section summarizes the feedback that practitioners receive when PM measures are combined with such systems. The systems are presented in alphabetical order.

Combining the BASIS-24 with Webscore 2.0 from McLean BASIS Plus provides client reports involving (a) graphical results of a client’s overall score and scores on all six subscales at the

various time points that the measure was administered and (b) the client's rating of each item at these different time points (McLean Hospital, 2012c). These reports can help practitioners identify individual client's symptoms and functioning challenges at intake and highlight areas of change during the course of treatment and at follow-up (McLean Hospital, 2012c). However, this system does not provide practitioners with alerts regarding clients' progress in treatment (APA, 2011a).

The BHM-20 is combined with either CelestHealth-MH (designed for mental health and college counseling settings) or CelestHealth-MD (designed for medical settings). Client reports generated by CelestHealth-MH provide practitioners with the client's overall score and scores on each subscale (M. Kopta, personal communication, February 8, 2012). These scores are presented in combination with a color that represents the client's level of distress: green for normality, yellow for mild distress, orange for average distress, and red for severe distress (Irvine, 2011). The report also illustrates clients' expected dosage curve and the individual client's scores relative to the curves as treatment progresses overall and on each subscale. When client scores deviate from the predicted dosage curve, practitioners are notified visually on the graph (M. Kopta, personal communication, February 8, 2012).

CORE-Net reports also provide color-coded severity scores, with green representing mild distress and red representing severe distress. CORE-Net uses the client's overall scores on the CORE-OM (pre-measure) to establish initial level of severity. During treatment, CORE-Net provides a graphical representation of the initial score and progress throughout treatment (CORE IMS, 2012f). Reports also indicate whether the client is "off-track" (i.e., has completed at least three treatment sessions and two measures, with no reduction in scores) (K. McCrea, personal communication, February 15, 2012), has experienced clinically significant change (i.e., scores have shifted from the clinical range to the nonclinical range), and/or shows a reliable change (i.e., a 5-point change in score; CORE IMS, 2012f; CORE IMS, 2012b).

The OQ-Analyst software is also a web-based scoring system that uses colors to indicate client status. This system has been combined with the OQ-45 to provide practitioners with fast (3–5 s) results regarding client progress in treatment (OQ Measures, 2012a), including whether clients are ready for termination (white), making expected improvement (green), deviating from the expected rate of change (yellow), or having a high probability of a negative outcome (red). Recommended steps that the practitioner may consider, such as termination, reviewing the client's treatment plan, or taking intense and immediate action, are also included in the report (OQ Measures, 2012e). The interpretations and recommendations are based on the client's overall score on the OQ-45, but client reports also include (a) client scores on three subscales, (b) client ratings to critical items (including suicide, substance abuse, and violence), and (c) a graphical representation of the relation between number of sessions and the client's OQ-45 scores throughout treatment relative to the client's predicted dosage curve. In the intake report generated by the OQ-Analyst, the client's score is illustrated in relation to normative comparison group scores (OQ Measures, 2012f). The OQ-45 can also be combined with clinical support tools, which can further aid practitioners in deciding on the course of actions to take based on the client's scores on the OQ-45 (Harmon et al., 2007).

The PCOMS is linked with two different centralized scoring systems: FIT-Outcomes and MyOutcomes (Miller, 2012). FIT-Outcomes and MyOutcomes both use initial scores on the ORS to generate an expected dosage curve for the client. If the client's future ORS scores deviate from this curve, practitioners are warned that the client is not progressing as expected, and the curve is presented as a graph. This report also presents the client's score on each ORS question and the overall ORS score at each session administered. A client's score on each SRS question, the client's overall SRS score at each time of assessment, and a warning of potential alliance problems (i.e., if scores drop within a specific range) are also available in a report (Health Factors Inc., 2011; FIT-Outcomes ApS, 2012a). In addition, MyOutcomes provides practitioners with a number of suggested activities based on scores, and at intake, clients are asked questions regarding drugs, alcohol, and harm, which may lead to identifying potential risks in the reports generated (Health Factors Inc., 2011).

The last two measures, the Polaris-MH and the TOP, do not appear to be available for manual scoring, separate from a centralized scoring system (APA, 2011d; 2011f). Data from the Polaris-MH can be sent either electronically (report returned immediately) or by fax (ranging in the time reports are returned, depending on customer agreement) to Polaris Health Direct, where the client's scores and clinical characteristics are used to create a predicted dosage curve (L. Toche-Manley, personal communication, February 2, 2012). During treatment, progress is compared to this expected pattern of response to determine whether the client is benefiting from treatment (Lueger, 2006) and is presented in a detailed client report. Aside from the client's predicted pattern of change, the intake report includes screening (e.g., general health, chemical dependency, and harm to self/other), information on previous mental health treatment, client treatment motivation attitude, the reason that the client is seeking treatment, the client's scores on each domain and subscale relative to other people in treatment, and a section highlighting strengths (Polaris Health Directions, 2008b). The Patient Update (version used during treatment) provides reports that graphically illustrate progress relative to the predicted dosage curve and provide screening for inauthentic responding, harm to self/other, chemical dependency, therapeutic bond, medication, changes in symptom severity, functioning or feelings, and areas in which the client has made the most progress and areas of greatest concern (Polaris Health Directions, 2008a).

Data from the TOP can be sent either electronically (report in ~3 s) or by fax (report in ~14 min; Kraus & Castonguay, 2010) to BHL. Similar to other systems, BHL provides practitioners with reports that illustrate the client's progress in treatment using color-coded alerts, with red symbolizing client deterioration or symptom exacerbation and yellow symbolizing a risk that the client may end treatment with a poor outcome. Reports also provide a comparison of the client's scores on a number of subscales relative to the general population and highlights statistically and clinically significant changes on each subscale throughout treatment. Additionally, reports provide information on the client's previous mental health treatment and on general medical issues, suggest possible reasons that clients are not progressing as expected in treatment, and provide practitioners with a number of recommended actions. The reports also provide unique features such as potential Axis I, Axis III, and Axis IV considerations, including possible Diagnostic and Statistical Manual for Mental Disorders-Fourth

Edition diagnoses (BHL, 2012d). Based on the results of these reports, the TOP provides practitioners with access to a “library of catalogued evidence-based principles and therapies tied to each TOP outcome domain,” which can guide subsequent treatment (Kraus & Castonguay, 2010, p. 156).

Through the combination of PM measures with centralized scoring systems, practitioners can access aggregate reports that provide information on the general characteristics of clients receiving treatment and/or benchmarking information at the practitioner or agency level. All of the PM measures discussed thus far can provide practitioners with aggregate reports that group client data (e.g., average number of sessions and demographic information) based on a variety of factors (e.g., client age, therapist, or site) selected by the practitioner or agency. These systems can also group the client’s data to elucidate the average level of progress in treatment or provide a “snap-shot” of client average change for a practitioner or agency (BHL, 2012a; CelestHealth Solutions, 2008b; K. McCrea, personal communication, March 23, 2012; Health Factors Inc, 2011; McLean Hospital, 2012b). For example, using Webscore 2.0 (with the BASIS-24), practitioners are able to access data on their clients’ average level of distress on each subscale at intake and at various time points throughout treatment (McLean Hospital, 2012b). Reports generated by CelestHealth (for the BHM-20) can also provide practitioners with the client’s average intake score compared to the client’s most recent scores. These reports include the percentage of clients who fit into the following categories: recovered, improved, deteriorating, and no change (CelestHealth Solutions, 2008b). Similarly, CORE-Net provides information regarding the proportion of clients who fit into categories: positive termination/recovered and improved (K. McCrea, personal communication, March 23, 2012). MyOutcomes (used with the PCOMS) can provide practitioners with a graphical representation of the client’s average trajectory of change (Health Factors Inc, 2011), whereas FIT-Outcomes provides practitioners with the client’s average raw change score, the percentage of clients reaching their target, and effect size scores (FIT-Outcomes ApS, 2012b).

PM data of different states or provinces, organizations, practitioners, and clients can be compared so that the quality of psychotherapy can be evaluated. These comparisons have been called benchmarking (Lueger & Barkham, 2010). At the organizational level, data from PM measures can provide information regarding the quality of the different services that they provide (Lueger & Barkham, 2010), and practitioners can use feedback measures to assess the effectiveness of their services relative to national benchmarks. The following measures can be combined with their respective centralized scoring systems to provide benchmarking reports: the BASIS-24 (APA, 2011a), the CORE-OM (CORE IMS, 2012a), the PCOMS (APA, 2011c, 2011e), the Polaris-MH (APA, 2011d), and the TOP (APA, 2011f) (see Table 2). Although the OQ-45 does not provide practitioners with benchmarking reports (APA, 2011b), this measure has been used in research to compare the scores of practitioners (Okiishi et al., 2006). Further, the BHM-20 does not currently offer benchmarking options, but there are plans for this feature to be added in the future (M. Kopta, personal communication, February 8, 2012).

Cost, Training, and Privacy

PM measures have been designed to be accessible to the individual clinician as well as to hospitals and counseling and community centers at a reasonable cost. Typically, a sample of the measure can be viewed on the website (e.g., BASIS-24; McLean Hospital, 2012d), and for several systems, including the CORE-OM/5 (Barkham et al., 2010), PCOMS (Miller & Duncan, 2004), and the TOP (Kraus & Castonguay, 2010), basic usage is free of cost. Other systems require fees for various applications, such as a licensing, set-up, technical support or customer service, software, client reports, or benchmarking (refer to Table 2 for costs). All systems offer some form of training to help clinicians integrate PM measures into practice. For example, pertinent information is available through a user’s manual or instructional video. Additional training can be acquired through customer services, private training, or conference sessions.

Because developers of measures are aware of the sensitivity of the data, safeguards have been taken to ensure confidentiality. Generally the PM measures developed in the United States, including BASIS-24 (APA, 2011a), Polaris-MH (APA, 2011d), TOP (APA, 2011f), PCOMS (APA, 2011c, 2011e), and OQ-45 (APA, 2011b), comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which stipulates that various administrative, physical, and technical precautions must be taken in order to protect client information and maintain strict confidentiality (U.S. Department of Health and Human Services, 2012). The BHL (2012b) states that clients, therapists, and agencies can use the TOP measure without providing any client identifying information. Other measures offer different precautions to ensure the safety of data. For example, BHM-20 uses Secure Socket Layers for personal data, and upon request, all information kept on the secure databases can be deleted at any point (J. Stanfill, personal communication, January 25, 2012). Systems used in conjunction to the CORE-OM/5 system have formal accreditation from the British Standards Institute (ISO/IEC 27001; British Standards Institution, 2012), which indicates that the system is up to code regarding internationally accepted standards for information security (CORE IMS, 2012e).

Other Measures

Although this is not an exhaustive review of available PM measures, our aim was to provide a snapshot and to highlight practitioner-relevant and practitioner-accessible information about several popular measures. Other available measures include the Schwartz Outcome Scale-10 (SOS-10; Blais et al., 1999), which is a brief and psychometrically sound instrument used to assess psychological health (Young, Waehler, Laux, McDaniel, & Hilsenroth, 2003). At this point, there is no easily accessible website supporting the SOS-10; thus it was not included in this review. Additionally, the Psychological Outcome Profiles (PSYCHLOPS; Ashworth et al., 2005) is a promising new measure that aims to capture patient-generated outcomes using a combination of questions and freetext boxes for clients to rate their issues (Czachowski, Seed, Schofield, & Ashworth, 2011). This measure is idiographic, and there are no population norms to which client progress can be compared. Finally, there are PM measures that cater to specific populations. For example, the Counselling Centre Assessment of Psychological

Symptoms-62 (CCAPS-62; Locke, et al., 2011) can be used in conjunction with the briefer CCAPS-34 (Locke, Mcleavey, et al., 2011) to assess and track progress in clients seeking services at college mental health centers.

Conclusion

Popular PM measures are generally fairly short, pantheoretical, psychometrically sound instruments that provide practitioners with valuable data regarding changes in a client's functioning and symptoms (Lueger & Barkham, 2010). PM measures have much to offer, but they are not intended to replace clinical judgment. They can provide practitioners with additional information regarding the client's progress (or lack thereof) that may be helpful in informing treatment decisions (Hatfield & Ogles, 2007). Given that every treatment is not successful for every client, progress monitoring is an important tool in the repertoire of practitioners who aspire to build their client work on a strong evidence base.

Résumé

Bien des données suggèrent que la psychothérapie est un traitement efficace, mais elle est loin d'être parfaite (voir Lilienfeld, 2007; Stuart, 1970). Au fil des changements qui surviennent dans le domaine de la santé mentale s'est dessinée une tendance, à titre de pratique courante, qui consiste à avoir recours à des mesures normalisées en vue de suivre les progrès des clients et d'obtenir une rétroaction au sujet de la réponse au traitement (Lambert & Shimokawa, 2011). L'utilisation d'outils normalisés peut aider les praticiens à reconnaître que leurs clients ne progressent pas dans leur thérapie. Elle a été liée à de meilleurs résultats parmi les clients non réceptifs, comparativement à un non usage de ces mesures (voir Shimokawa, Lambert & Smart, 2010). Le but de cet article est de présenter des mesures pour le suivi des progrès (SP) et de mettre en relief les caractéristiques à retenir en vue de leur sélection et de leur réalisation. Les sujets traités incluent les domaines évalués, les populations cibles, l'administration, la notation, la rétroaction et l'interprétation, les coûts, la formation et la confidentialité. Bien qu'il existe de multiples mesures des résultats et d'évaluation (voir Froyd, Lambert & Froyd, 1996), cet article porte précisément sur sept mesures de suivi des progrès populaires utilisées parmi les populations adultes et qui constituent des outils brefs, exhaustifs et facilement accessibles pour le suivi des changements qui surviennent au cours du traitement thérapeutique.

Mots-clés : psychothérapie, mesures de suivi des progrès (SP), rétroaction, résultat, surveillance des progrès.

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