Brief Process Rating Scale

BPRS

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March 2024
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About the BPRS

principles of process rating

Process Rating and the BPRS

Process rating refers to the means of rating treatment delivery. The Brief Processing Rating Scale(BPRS) is a tool for measuring the amount and the quality of components of addiction treatment delivered. It was adapted from the UKATT PRS which was developed and validated in the UK Alcohol Treatment Trial for the purpose of measuring the delivery of the two trial treatments and testing their distinctiveness. Following the UKATT finding that both treatments worked equally well, Motivational Enhancement Therapy (MET) and Social Behaviour and Network Therapy (SBNT) were combined into Integrated SBNT (iSBNT). The BPRS takes the strongest items from the UKATT PRS and is aligned to iSBNT, however, because iSBNT combines the practitioner skills that have evidence for effectiveness in changing addictive behaviours, the BPRS can be applied more generally to assessing interventions falling under the umbrella of network based, cognitive behavioural approaches.

Adapted from the UKATT PRS...

Validation of a Scale for Rating the Delivery of Psycho-Social Treatments for Alcohol Dependence and Misuse: The UKATT Process Rating Scale (PRS) Tober G, Clyne W, Finnegan O, Farrin A and Russell I in collaboration with the UKATT Research Team (2008) Alcohol & Alcoholism 43: 675–682
doi.org/10.1093/alcalc/agn064

Introduction

Client facing sessions need to be recorded for supervision and process assessments. Video recorded session are ideal - suitable governance arrangements will need to be agreed and permission given by the service user. It is not necessary to show the service user's face. In settings where video recording is impractical audio recording is usually possible.

(1) Supervision is an essential element in maintaining good practice and in monitoring protocol and manual adherence.

(2) Process assessment by a trusted independent rater is the basis of process research, and enables the agency/individual/team to assess standards of practice including therapeutic technique, therapeutic alliance, specific and non- specific aspects of treatment, which might affect outcome. The BPRS can be used for these purposes.

The person who is seeking help for their addiction problem is referred to as the focal person - FP and those people supporting the focal person are referred to as network members - NMs.

i) Score therapist behaviours

In general, BPRS items refer explicitly to therapists' behaviours, not the FP's behaviour or the FP's response. Frequency scores are given for attempts to do a particular thing; quality scores are given in line with the criteria specified for each item.

ii) Score therapist facilitation

Although the rater's task is to score the therapist's behaviour, often the FP or an NM initiates a behaviour which is measured on an item, with only limited therapist involvement.
Scores should reflect the degree to which the therapist facilitates the behaviour being measured. Facilitation refers to the therapist actively encouraging or prompting the client in a specific activity, rather than to a passive acceptance of the FP's behaviour on the part of the therapist.

iii) Score frequency and quality

The BPRS measures the extent to which therapists engage in the behaviours being measured, and the quality with which those behaviours are performed. The extent of the therapists behaviour is measured in frequency, either time spent, such as a lot of time discussing the client's support network, or the number of instances of an item, such as lots of instances of individual feedback as drinking/drug taking consequences. The quality rating refers to the depth and level of engagement achieved by the therapist. Examples are given for each item. Each time an item is rated, it is rated for frequency and quality.

iv) Avoid haloed scores

The BPRS is designed for the purpose of describing the therapist's behaviour in the session. In order to use the scale correctly, it is essential that the rater scores what actually occurred, and NOT what OUGHT to have occurred. Therefore, the rater must be sure to apply the same standards for scoring an item regardless of:

(1) what type of therapy the rater thinks he/she is scoring
(2) what other behaviours the therapist engaged in during the session
(3) what scores were given to other items
(4) how skilled the rater believes the therapist to be
(5) how much the rater likes the therapist
(6) whether the rater thinks the behaviour being scored is a good or bad intervention

v) Use of examples

We have given examples of therapeutic dialogue to illustrate the item and the guidance for scoring. Account of the whole session needs to be taken when giving a frequency and quality rating. Examples include both 'strong' dialogue that would work well and 'weak' dialogue to show what should not be used.

vi) Making distinctions

BPRS items vary in scope of what they cover. For example, #1 Maintaining Session Structure and #2 Consistency of Focus on Target Problems need to be assessed throughout the session and then scored.
Other items will occur at different points during the session and can be scored as one offs or as a repeating item.

Items are designed broadly to be mutually exclusive within each section; the rater should be careful to score each item distinctly - in scoring each item, the rater should consider the extent to which the behaviour specified in that item occurred, including how well the behaviour was performed and should not consider other similar behaviours.

vii) Specific instances required for scoring

In order to score an item greater than "0", the rater must hear a specific example of the relevant therapist behaviour. The rater must be careful not to score behaviour as having occurred if he/she thinks it probably occurred but cannot think of a specific example. Some examples heard may be specific to the item being scored even when different from the example written in the item description.

viii) Substantiating scores
The starting point for scoring each item in the scale is “0”. The rater should assign a score greater than “0” only if he/she hears examples of the behaviour specified in the items. The rater must be able to substantiate the scores he/she assigns to every item.

ix) Score every item
This scale is designed so that every item can be scored for every therapy session. Do not leave any item blank. All items can be scored on frequency. However, quality cannot be scored if an item has been given a score of “0” for frequency. If this is the case the computerised scoring will skip the quality rating - N/A should be written if using a rating sheet for quality.

x) Read items each time they are scored
We recommend that the rater read each item as written in the manual, each time it is scored, to prevent rater drift. Because of the complexity of the BPRS items, it is essential that the rater be completely familiar with all the items in the manual as well as the tally sheet, mentioned below, before scoring each item.

xi) Watch and take notes before scoring
Entire sessions will be scored. Therefore, do not score any items on the scale until the entire session has been watched. We recommend that the rater take notes whilst watching the session. The rater should use a tally sheet (example at end of manual) on which all of the items to be scored are listed. Next to each item create columns in which to record frequency and quality. Each time an item occurs it is marked in the space provided for frequency and a score is placed in the space provided for quality. As the BPRS requires the rater to make many fine distinctions, it is essential that the rater watch the session carefully and does not attempt to do other tasks while watching tapes.

At the bottom of the tally sheet is a section for additional notes. This space should be used by the rater to note any other significant observations such as picture/sound quality and the resulting difficulty in performing the rating.

xii) Transferring Tally Scores to the Rating Sheet
When transferring the frequency and quality scores from the tally sheet across to the rating sheet (see website page), the rater needs to remember that the frequency tally refers to the extent to which the therapist carried out each specific item across the whole of the session. The rater also needs to remember that the quality scores relate to how well the therapist's behaviour was performed within each specific item across the whole session. The rater should not for example give a rating of "3" for frequency because 3 instances of the item were observed.

The tally sheet should serve as a guide to the frequency of an item. The rater should also read the value labels of the frequency scale and use their judgement based on their training and experience to make decisions about a specific score.

xiii) Rate whole numbers only
Insert the numbers for each rating in the appropriate space.

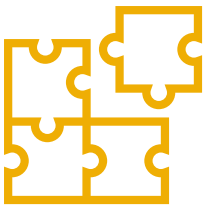
xiv) Confidentiality
All video or audio recordings and rating scores are confidential material. When rating at home ensure that no one else sees the videos or the ratings. Do not leave the rating material unattended. Do not discuss the content of sessions with anyone other than the relevant practitioner/supervisor and/or peer supervision group. This is to ensure the confidentiality of all clients and therapists.

Scored BPRS items

Scoring

Each item is to be rated on frequency - the extent to which the therapist carried out a task...
To what extent did the therapist..... ?
Not at all =0
A little =1
Somewhat =2
Considerably =3
Extensively =4

Each item is also rated on quality - how well did they do the task...
How well did the therapist perform the behaviour within each item?
Not at all well = 0
to
Very well =4



1) Maintaining Session Structure

To what extent did the therapist attempt to structure the session?
There may be some overlap between this item and the next one which is related to it. This item taps into the extent to which the therapist maintains the overall structure of the session: ensuring that the session begins and ends on time, that no more than five minutes is taken for the introduction and another five for the summing up, that the content of the session occurs during the time in between.

Some behaviours that are not measured will be used by the therapist to maintain session structure. For example: introducing specific session topics, explicitly redirecting the conversation back to the session topic, selectively responding to the client's discourse, keeping to time, asking open ended questions or yes/no questions, or suggesting something like "we can return to that issue in another session".

To score this item the whole session needs to be considered.
Frequency:
Time spent by the therapist maintaining the structure of the overall session must be considered.
Quality:
How well did the therapist maintain the overall structure of the session.

This item is distinguished from item # 6, Consistency of Problem Focus, as that item is a specific way of maintaining structure. This item focuses on the overall structure of the session.

2) Consistency of Focus on Target Problems

To what extent did the therapist attempt to keep the session focussed on target problems?

This item refers to the extent to which the therapist attempted to keep the session focussed on target symptoms or problems, usually alcohol and/or drug use, by specifically refocusing the client or attempting to relate what the client was discussing to a target problem, or by discouraging discussion of issues clearly unrelated to the target problem and by redirecting dialogue when it strayed off tasks, by organising the session so defined tasks were covered.

Frequency:

A high score would be given if the therapist focussed on, and when necessary refocussed the FP's dialogue continually to the target topic being discussed.
A low score would be given if the therapist either did not or only occasionally attempted to refocus the FP to the target topic being discussed.

Quality:

A high score would be given if the therapist consistently connected the FP's dialogue to his/her alcohol and/or drug use or other identified target problems throughout the session with the effect that the FP focussed on their drinking.
A low score would be given if the therapist attempted to refocus the client's dialogue but allowed the client the latitude to discuss issues unrelated to the target problems.

Examples:

Therapist: "I see you have some strong feelings about your boss, but I'm not sure how you see them as related to your drinking." (high score)
FP: "I thought about getting a part time job to fill my time now that the children are that bit older and I don't need to be around so much"

High score

Therapist: "Do you think there is a link then between your spare time and your drinking?"
FP: "I suppose it is possible but I like the idea of getting a job but it would have to be in an office and I would have to learn to use a computer as my husband wouldn't let me work in a shop or be a waitress"

Low score

Therapist: "So you want to get an office job?" (low score)
This item is distinguished from item #1, Maintaining Structure, which focuses on the global structure of the session.

3) Take home tasks

To what extent did the therapist plan or review concrete tasks assigned during the session to be carried out outside of the session?
This item refers to the extent to which the therapist set homework, planned the practical details of a homework task, or reviewed a previously assigned task. The nature or type of task assigned by the therapist is not relevant to this item: any task assignment which is planned to be supportive of positive behaviour change is relevant.

Frequency:

A high score would be given if the therapist spent a significant amount of time planning the details of a homework task and/or reviewing a previously assigned task.
A low score would be given if the therapist spent little or no time on planning or reviewing homework tasks.

Quality:

A high score may be achieved if the therapist reviewed in detail the purpose of the homework task, discussed the practical details of conducting the task or reviewed in detail how a previously assigned task went.
A low score would be given if the therapist just mentioned a task the client might carry out or just mentioned in passing whether a previous assigned task had been conducted and how it went.

Examples:

High score
“Last week you were going to find out about the possibility of joining a sports club, how did you get on?”

Low score
“You didn’t go in the end then?”

This item could include activity since the last session but only when this was a task assigned as homework by the therapist.

4) Feedback of negative consequences

To what extent did the therapist provide personalised feedback about the client's drinking or drug use or elicit specific negative consequences of drinking or drug use that are experienced by the client?

This item refers to the extent the therapist explores the negative consequences of drinking in the context of what the client has said about themselves and their drinking or drug taking behaviour. The therapist may provide objective evidence, (e.g. lab reports, psychological assessments, results of pre-treatment assessments) to the client and clearly explain and discuss the results.

Discussion of the negative consequences of drinking or drug use for people in general, that is, without specific reference to the client's own drinking or drug use and the consequences for the client, is not included in this item, for example: "The more that people drink the more likely they are to damage their health".

Frequency:

A high score would be given if the therapist discussed with the FP the various negative consequences caused by their drinking (e.g. physical, emotional, relationships, employment), based on objective evidence.

A low score would be given if the therapist merely mentioned a few negative consequences either as they come up through the session or are presented from the therapist's assessment of client records or does not mention any.

Quality:

A high score would be given if the therapist clearly explained the purpose of the test and the results in detail and discussed the implications with the FP.

A low score would be given if the therapist gave objective test results but did not discuss in any detail the implications of the results.

4) Feedback of negative consequences

continued

Examples:

High score

“So it’s these two areas (referring to test results) that seem to be the main problem areas. Tell me something about the problems you are having?”

“We’ve just gone over your results for gamma GT and tolerance. Now let’s look at some more of these results”

Low score

“Now you have got your test results, let’s move on to……”

"The results show that you have done a lot of damage due to your drinking”

This item is distinguished from item #8, Ambivalence, which focuses not only on the negative consequences of drinking, but also includes the positive aspects of drinking, to increase the client’s awareness of his/her ambivalence about changing their drinking habits. Item #8 does not have the concrete, specific evidence needed for this item. This item refers to the therapist presenting concrete evidence about the consequences of the client’s drinking. Inquiries from the therapist about the client’s views or concerns would be rated elsewhere, for example, item # 5, Eliciting Client Concerns about Drinking.

5) Eliciting concerns

To what extent did the therapist attempt to elicit concerns from the client about drinking or drug use?

This item refers to the extent the therapist focuses on what bothers or concerns the client about their drinking or drug use. This includes therapist inquiries as to the problems resulting from the client's drinking or drug use. What are the client's concerns as opposed to other people's concerns about the client? If the client focussed on other people's concerns, she/he should be redirected to focus on her/his concerns or perception of problems and how important these concerns are to the client.

This item is specific to the therapist eliciting concerns from the client (typically using an open question). It does not refer to the client agreeing with a concern expressed by the therapist.

Frequency:

A high score would be given if the therapist made attempts to elicit the FP's concerns about their drinking or drug use and problems related to or resulting from drinking or drug use.

A low score would be given if the therapist did not attempt or only tried once or twice to elicit concerns from the FP about their drinking or drug use and problems related to it.

Quality:

A high score would be given if the therapist consistently asked questions in detail about drinking or drug use, and /or about problem areas related to it, which resulted in the FP exploring how her/his drinking or drug use may be affecting any aspects of her/his life.

A low score would be given if the therapist attempted but was not successful in eliciting concerns about drinking or drug use, or elicited some concerns without discussing them in detail.

5) Eliciting concerns

continued

Examples:

Therapist “Tell me your concerns about your drinking.”
FP “My wife really believes it is a problem, so she’s always on my back about it.”

High score

Therapist “It sounds like your wife is concerned about your drinking. How do you feel about your drinking?”

Low score

Therapist “Do you have any concerns about your drinking?” (low score)

This item is distinguished from item #8, Ambivalence, which focuses on the client’s ambivalence about drinking and therefore includes material on the positive aspects or benefits the client experiences from drinking. This item is also distinguished from item #4, Drinking-Feedback/Negative Consequences, which focuses on feedback regarding the negative consequences of drinking/drug use. It is also distinguished from item #2, Consistency of Problem Focus, which refers to the way the therapist re-focuses the client’s dialogue to the session topic or problem.

6) Social Support for Change - general

To what extent did the therapist stress the importance of social support in changing drinking or drug use behaviour?
This item refers to whether the therapist stressed social support as a key factor in achieving change and advised the client of the benefits of social support for achieving successful change. This will involve discussion about how other people can be supportive in achieving change. This item does not concern discussion of social contacts who may be supportive of the client but are also supportive of current drinking, e.g., drinking friends who are nice and helpful people. This item does not include support from the agency providing treatment.

Frequency:

A high score would be achieved if the therapist spent a significant amount of time exploring and discussing the importance of social support.
A low score would be given if the therapist spent little or no amount of time exploring and discussing the importance of social support.

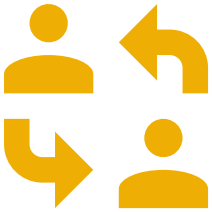
Quality:

A high score would be achieved if the therapist thoroughly and actively explored and discussed the importance and benefits of social support.
A low score would be given if the therapist does not mention or briefly mentions the importance of social support.

Examples:

High score
"You're all working really well together, it's important for Stuart's abstinence that he has people around him who can support the changes he's trying to make."
Low score
"It's nice to have people around you who are supportive."

This item is distinguished from item #7, Involvement of Others in Behaviour Change, which concerns individuals who may be supportive. Rather, the current item refers to discussion of social support for change in general.



7) Involvement of Others in Behaviour Change

To what extent did the therapist initiate the planning and actual involvement of other people in working towards behaviour change with the client?
This item addresses whether the therapist makes specific suggestions about or reviews the involvement of others in behaviour change and the extent to which specific individuals and things they might do are discussed.

Frequency:

A high score would be given if the therapist spent a significant amount of time planning the involvement of named people in working towards behaviour change, or planning specific instances of the actual involvement of named people in working towards behaviour change.
A low score would be given if the therapist did not plan the involvement or actually involve others in the FP's behaviour change. If the therapist involves other people present in the session, but does not involve them specifically in planning or setting tasks for supporting behaviour change (for example, the therapist discussed the FP's level of drinking with their partner) then a low score would be given.

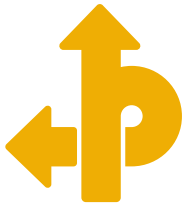
Quality:

A high score would be achieved if the therapist planned in detail the involvement of a supportive individual with that individual, or discussed the involvement of another supportive person with the FP, or reviewed the involvement of specific others in supporting behaviour change. A high score would be given if the therapist discussed the details of the others' involvement in detail.
A low score would be given if the therapist did not plan in detail the involvement of or actually involve others in the FP's behaviour change. If the therapist discussed the involvement of others in broad, general terms, but did not make specific suggestions about the involvement of others then a low score would be given.

Examples:

High score
"What can <NAME OF NETWORK MEMBER> do to help you to refrain from drinking on Friday night?"
Low score
"You might find other people could help you out with that"

This item is distinguished from item #6, Social Support for Change, which reflects more general investigation of social support, not specific to particular individuals.



8) Ambivalence

To what extent did the therapist focus on the client's ambivalence about their drinking or drug use or about changing it?
This item refers to the extent to which the therapist tried to increase the client's awareness of potential mixed feelings about drinking or drug use, and encourage exploration of both the positive and negative consequences. This item may also refer to the client's mixed feelings about pursuing or maintaining his/her drinking or drug use goal.

Frequency:

A high score would be given if the therapist made a high number of references to the pros and cons of the FPt's drinking or drug use or plans to change.
A low score would be given if the therapist made few or no references to the pros and cons of the FP's drinking or drug use or plans to change.

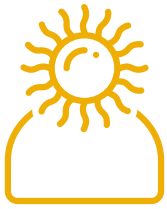
Quality:

A high score would be given if the therapist facilitated a full discussion of the FP's ambivalence, including helping the client become aware of both the positive and negative consequences of his/her drinking or drug use.
A low score would be given if the therapist simply noted the FP's mixed feelings about drinking or drug use.

Example:

"You take drugs to stop feeling anxious but you also think that if you were to stop you would feel less anxious about the consequences"
High score
"Drinking seems to be useful to you in a number of ways. At the same time you've mentioned some things that are of concern. In particular the effect that drinking has on your marriage. Tell me what that feels like."
Low score
"So you think alcohol is harming you but you enjoy it too much to stop drinking"

This item is distinguished from item #5, Eliciting Client Concerns about Drinking, which concentrates specifically just on concerns, and from item #4, Drinking–Feedback/Negative consequences, which looks specifically at the negative consequences of drinking.



9) Eliciting optimism for change

To what extent did the therapist attempt to elicit optimism for change from the client?

This item refers to the extent to which the therapist attempts to focus on the positive consequences and outcomes for the client and those close to them if the client were to change, or has already changed their drinking or drug use. When the client mentions the negative consequences of changing their drinking or drug use, they may discuss these with the client, but will also refocus the client to the positive consequences of changing.

Frequency:

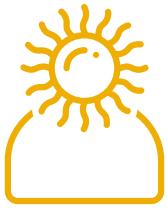
A high score would be given if the therapist attempted a number of times to elicit optimism for change.

A low score would be given if the therapist did not attempt or merely tried a few times to elicit optimism for change from the client.

Quality:

A high score would be given if the therapist consistently asked questions or discussed in detail the positive consequences of changing the FP's drinking or drug use, and /or the positive consequences in other areas that will result from changing their drinking or drug use, and manages to elicit from the FP the positive ways in which their life may be different if they change their drinking or drug use.

A low score would be given if the therapist asked questions about change but without focussing on the potential positive consequences of change, did not manage to elicit optimism for change, or elicited optimism about change but did not explore this in detail.



9) Eliciting optimism for change

continued

Examples:

Therapist: “Last time we discussed some of the changes that have happened in your life because of the way you have been drinking recently, and you said that you are not happy with how things are any more. To start today, tell me about some of the things that would change if you were to change your drinking. ”
FP: “I don’t know really.”
Therapist: “Well, last week we talked a lot about how you have less time for your kids than you used to. Why don’t we start there. How might things be different with your kids if you were to change your drinking?”
FP: “I’d have so much more energy and interest in what they were doing. I’d be a proper dad again”

High score

Therapist: “What would being a proper dad be like?”
Therapist: “What do you think might be different if you were to change your drinking?”

Low score

FP: “I wouldn’t see so much of my friends if I had to stop drinking”
Therapist: “Okay, anything else?”
FP: “I suppose I would have more money”
Therapist: “Anything else?”

This item is distinguished from #2 Consistency of Problem Focus, which focuses on the therapist re-focussing the client’s dialogue to the session topic or problem.

10) Therapist is Task Oriented

To what extent did the therapist actively discuss specific plans designed to bring about behaviour change in the client and/or other people close to them?
This item refers to the orientation of the therapist. It is concerned with the therapist being oriented towards the future, suggesting active and practical ways to bring about positive change in future drinking, drug use and related behaviour. It is different from the approach based upon the idea that insight into beliefs and feelings towards alcohol, drugs and the consequences of their use, background factors and reasons for drinking, or problems resulting from drinking can bring about positive change.

Frequency:

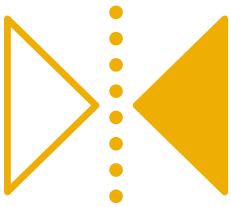
A high score would be given if the therapist spent a significant amount of time in planning activities or strategies which concerned working towards or supporting positive change, or discussed tasks assigned in previous sessions.
A low score would be given if the therapist did not initiate or suggest planning activities or strategies which concerned working towards or supporting positive change, or discussed tasks assigned in previous sessions or merely mentions these.

Quality:

A high score would be given if the therapist discussed in detail previous or currently assigned tasks and was explicitly involved in planning tasks aimed at positive change, or discussed in detail the level of success of previously assigned tasks.
A low score would be given if the therapist did not discuss or merely mentioned previous or currently assigned tasks without explicitly planning tasks aimed at positive change, or did not discuss in detail the level of success of previously assigned tasks.

Examples:

High score
“We can identify and write down high risk situations that could lead to relapse and decide how you could avoid/cope in the situations that we identify. Let’s do that together now”
Low score
“You might want to give some thought to risk situations for drinking”



11) Reflective Listening

To what extent did the therapist reflect back what the client had said in order to communicate understanding of the client's comments and concerns?
This item refers to what extent the therapist communicates understanding of the client's thoughts and feelings through the use of reflective statements. Reflective statements made by the therapist express empathy using language that accurately clarifies and captures the meaning of the client's communications.

Frequency:

A high score would be given if the therapist frequently used reflective statements.
A low score would be given if the therapist rarely used reflective statements.

Quality:

A high score would be given if the therapist effectively communicated understanding of the FP's underlying concerns and feelings.
A low score would be given if the therapist's style was empathic, so the FP felt understood, but the technique of using reflective statements was not explicitly employed, or a therapist simply repeated the last words of the client.

Examples:

FP "I don't want to get back into drinking, and I'm frightened that I will if I don't distract myself"
High score
Therapist "You're feeling worried at the moment that you might start drinking again"
Low score
FP "I don't want to drink again but it might happen"
Therapist "You think it might happen"
This item is distinguished from items which refer to the therapist eliciting specific thoughts and feelings from the client.

12) Collaboration

To what extent did the therapist convey that the treatment is a collaborative effort?
This item refers to the extent to which the therapist emphasises that others are working together with the client, this does not have to include the therapist him/herself.

Frequency:

A high score would be given if the therapist spent a significant amount of time or made a high number of statements relating to the collaborative nature of the treatment.
A low score would be given if the therapist spent little time or only made a few statements that related to the collaborative nature of the treatment.

Quality:

A high score would be given if the therapist conveyed to the FP in some detail, that they are not alone in making decisions and plans about their future drug use or drinking behaviour, and that others are working with the FP on their treatment.
A low score would be given if the therapist merely mentioned in passing or did not convey in any detail that the treatment/treatment session is a collaborative effort.

Examples:

High score
"I'm just wondering how others could help you work out what to do when you feel stressed about your cravings"
Low score
"We can decide to refer you to a psychiatrist who will deal with that"

This item is distinguished from item #6, Social Support for Change, which refers to the way the therapist might stress the importance of having support for change, and from item #7, Involving Others in Behaviour Change, which refers specifically to tasks designed to recruit other people to help.

Unscored BPRS items

Context setting items

The BPRS finishes with a few context setting questions which are not scored. It is important for the supervisor to have a feel of how the session being assessed unfolded and for the practitioner to be able to keep a meaningful record.

Who was present

Apart from the therapist and client how many other people attended this session?
0=none 1= one 2= two 3=three 4+ = four or more
2. Did the other people contribute?
0 = No 1 = Yes

Session content

Tick as many options as you think reflect the content of the session...

- Feedback results
- Action plan
- Communication skills
- Coping skills
- Social support
- Relapse prevention plan
- Substance misuse Education
- Increasing Pleasurable Activities
- Employment
- Giving Advice

Untoward events

This question taps into whether anything unusual or counter to good practice happened in the session...

- Was the client distressed/crying/upset at any stage of the treatment session?
- Did the therapist at any time absent themselves from the session - answering a phone or leaving the room?
- Anything else?

Tally sheet

Use a Tally Sheet or from result4addiction use the BPRS scoring link to make notes while you are watching or listening to a client-facing session. When you have finished, use your notes to complete the BPRS rating on the website. Score all the BPRS items (0-4) for both frequency and quality...

Session management

1) Maintaining Structure
2) Consistency of Problem Focus

Specific tasks

3) Homework
4) Drinking - Feedback/Negative Consequences
5) Eliciting Client Concerns about Drinking
6) Social Support for Change - General
7) Involvement of Others in Behaviour Change
8) Ambivalence
9) Eliciting Optimism for Change

Therapist style

10) Therapist as Task Oriented
11) Reflective Listening
12) Collaboration