



Article

Applying the ‘East Kent Outcomes System’ (EKOS) in music therapy

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ABSTRACT

This paper examines the current expectations for measuring clinical outcomes within the healthcare system in the UK, and introduces an application of the East Kent Outcomes System (EKOS) (Johnson & Elias 2010) as a means of measuring the clinical effectiveness of music therapy. The aim of the article is to describe how the system was implemented within Nottinghamshire Healthcare NHS Foundation Trust and to demonstrate its use within music therapy practice. The application of EKOS is illustrated through a case study with a client in the Intellectual Disability Service. Examples are given of how the data gathered can be used for reporting the effectiveness of music therapy, along with implications for the future use of the EKOS within the music therapy profession.

KEYWORDS

music therapy, outcomes, evaluation, clinical effectiveness, assessment and treatment, EKOS

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INTRODUCTION

Music therapists are expected to provide effective treatment and care, reflect on their work, and demonstrate evidence-based practice. They are under pressure to achieve good results, meet contact targets, and prove that they are good value for money for managers and commissioners. They therefore need to be able to measure what they are achieving, or their outcomes, in their everyday work.

This paper aims to examine the current expectations for measuring clinical outcomes within

the healthcare system in the UK, and to discuss the East Kent Outcomes System (EKOS) as a measurement system. The paper begins with a contextual outline of music therapy outcome measurement across the contemporary healthcare landscape. The development and implementation of the EKOS within the Intellectual Disability Service of Nottinghamshire Healthcare NHS Foundation Trust will be described. The potential for using data generated from the system to create reports for service managers or commissioners will be shown, and a case study will illustrate how the EKOS is used to set therapy aims and objectives

and evaluate the work. Finally, the paper will conclude with some critical reflections of the EKOS and considerations about how it may be utilised within the music therapy profession.

CONTEXT

Following a review of the healthcare system in the UK, Lord Darzi (2008: 50) advised that “Every provider of NHS services should systematically measure, analyse and improve quality”. He stated that clinicians should demonstrate the effect of their care and treatment by measuring clinical outcomes, and the information gathered should be used to continuously improve their services. The *Mental Health Outcomes Compendium* also recommended that clinical analysis should be undertaken through outcome measures, which they defined as “The positive changes, benefits, learning or other effects that result from the work that clinicians do” (National Institute for Mental Health in England 2008: 6). More recently NHS England (2014: 8) aims to improve the future quality of services “by measuring what matters, requiring comprehensive transparency of performance data and ensuring this data increasingly informs payment mechanisms and commissioning decisions”.

Whilst these documents refer primarily to services within the NHS, it is clear that their recommendations could and should also be applied to all places in which music therapists work, such as schools, forensic units, hospices, social health and care settings, and in private practice. The regulatory body for music therapists in the UK, the Health and Care Professions Council (HCPC), states in their *Standards of Proficiency for Arts Therapists* that in order to maintain safe and efficient practice (and indeed registration) therapists must “be able to assure the quality of their practice” (HCPC 2013: 11). It recommends that clinical monitoring and evaluation should be achieved by gathering information through qualitative and quantitative data, and by using recognised outcome measures in conjunction with the service user.

In 2009, Nottinghamshire Healthcare NHS Foundation Trust’s Associate Director for Allied Health Professions (AHPs), Catherine Pope, raised the need for more rigorous measurement and evaluation, and she was driven to find a suitable system that could measure our clinical outcomes. It needed to be accessible to all the therapists across the Trust, who comprised of arts therapists, speech and language therapists, occupational therapists and physiotherapists. The services within which the

therapists worked were diverse and included Child and Adolescent Mental Health Services, Forensic, Intellectual Disability, Mental Health Services for Older People and Adult Mental Health, all of which had both inpatient and community pathways.

The music therapy teams within the Trust are situated within the Adult Intellectual Disability and Forensic Services. When we researched the literature, there was very little evidence available in terms of music therapy specific outcome measures, either generally or more specifically to our clinical areas. Wigram (2006: 93) wrote that “One of music therapy’s fundamental problems is the lack of formalised and standardised assessment tools and outcomes indicators”. He criticised the lack of reporting of any such tools within the literature, thus resulting in poor reliability or validity, so “it remains difficult for us to provide concrete evidence for either the relevance of music therapy interventions or their outcome effect over time” (Wigram 2006: 93). More recently, Miller (2014: 12) states that

“There is a growing body of research, using a variety of measures, which increasingly provides evidence for the efficacy of the arts therapies [...]. In routine practice the use of measures, and reporting of results, seems not to be so common”.

Music therapists have begun to adapt pre-existing tools to create music therapy outcome measures such as Lawes (2012), and Lindeck, MacKeith and Burns (2011), but these have limitations in that they were developed for children and so were not appropriate to use with the adult population groups within the Trust. Similarly and more recently, some outcome measures have been devised specifically for music therapy. These include the Music in Dementia Assessment Scales (MiDAS) (McDermott, Orrell & Ridder 2015) and a questionnaire to measure Interest in Music (IiM) (Gold et al. 2013). However, as these are for music therapy in dementia and adult mental health respectively, they were not appropriate for clients with intellectual disability. We therefore needed to find a method of monitoring and evaluating our work that was relevant and meaningful for our services.

APPLYING THE EAST KENT OUTCOMES SYSTEM

The music therapists in the Intellectual Disabilities Service had some previous experience of trialling an outcome measure for people with an intellectual disability, as we had been invited to be part of the

UK CORE-LD pilot in 2008. This was an adapted version of the '*Clinical Outcomes in Routine Evaluation – Outcome Measure*' questionnaire which covers wellbeing, problems/symptoms, life functioning and risk to self and others (Brooks, Davies & Twigg 2013). It was used with people who had a mild to moderate intellectual disability who were not in crisis, and it was administered twice – once at the beginning and again at the end of therapy so that it could be seen if there was any change over this time. The form consisted of a series of 17 questions about how the person feels. Examples included asking if the person had felt lonely, sad, frightened or unhappy. They were also asked if they had felt like hurting others or themselves, or if they had difficulty making friends or sleeping. The scoring system was a simple three point scale in which the client ticked one of three boxes: 'Not at all', 'Sometimes', or 'A lot'.

The process proved to be a useful experience for us as a team, as it gave us some insight into the benefits and difficulties of how information could be collated about a person's wellbeing and their progress in therapy. However, whilst the tool aimed to be an accessible assessment of a person's feelings, we found that it was limited only to those clients who had capacity to understand the text, reflect on their feelings, and complete the scoring system. This therefore excluded those who had a severe or profound intellectual disability. The guidelines also excluded those people who might have been in crisis. The requirement was that all of the questions would be asked in each session and for some, this hindered the natural flow of therapy.

Following this all of the therapists in the Trust were invited to attend some training days on a few other outcome measures to ascertain their potential in our services. The first of these was the Therapy Outcome Measure (TOM). It was led by Professor Pam Enderby, a speech and language therapist based at the University of Sheffield. This tool enables professionals working in health, social care and education to describe the abilities and difficulties of a client in four domains which are described as impairment, activity, participation and wellbeing, and their changes are monitored over time (Enderby & John 2015). It comprises an 11-point rating scale, which is based on specific clinical conditions, and it scores a person's ability from 'profound' to 'normal'. Whilst it seemed a relatively easy tool to use, as arts therapists we felt that it was not sensitive or descriptive enough to capture the more subtle changes that might take place within our work.

In contrast was the East Kent Outcome System (EKOS) (Johnson & Elias 2010). This could be used across all the AHPs in different services of the Trust and it seemed well suited to a more descriptive method of analysis. It appeared to be a simple and meaningful system which aimed to reflect evidence-based practice and good therapy planning. We were attracted to its collaborative focus, which allowed the client and/or carer to be involved in setting and reviewing therapeutic aims. The EKOS had the potential to either be used for individual clients or group therapy, and by either a single professional or a multi-disciplinary team.

Local evidence was available as Murphy and Logan (2009) had conducted a study in Nottingham using the EKOS for their multi-professional team. Their aim was "to identify and test the feasibility of using a generic outcome measure for all members of the multi-professional team" (Murphy & Logan 2009: 482). The EKOS was chosen as the framework to achieve a single set of notes and outcome measure across four intermediate care teams. Methods included collecting clinical information from case notes over the period of a year. Data from each summary record was stored and analysed using an excel database. This included: the number and type of aims set per patient; the number of aims achieved; the time taken to achieve the aims; the health benefits that were associated with the aims; and any contributing factors that might have affected the aims. Conclusions were that the use of the EKOS appeared to be an easy and acceptable way for care teams to record aims relating to patients, and to measure how many are achieved. However, they identified the limitations as being: 1) EKOS is not a standardised measurement system, 2) each service set its own generic overall aims so outcome measures could not be compared across services, and 3) there is a scoring system that calculates an overall outcome for each aim, but there is no method for weighting aims.

IMPLEMENTING THE EAST KENT OUTCOMES SYSTEM

Following these training events, the music therapy team, along with other therapists in the Trust, decided to use the EKOS as a means of measuring clinical outcomes in their work. Further teaching with Maggie Johnson, Lead Speech and Language Therapist in Kent Community Health NHS Foundation Trust, took place in spring 2010 so that all staff had a good understanding of the tool, and

meetings were held for profession-specific groups to plan the way forward for each of their teams. The Trust arts therapists met bi-monthly to devise a list of common aims that would be suitable within our clinical work, and we trialled some case studies together. Follow-up sessions were then held in autumn 2010; these were useful in that we were encouraged to bring case studies to work through, along with any questions, difficulties or issues that had been identified. After this we felt more confident to roll out the tool across our services and so from spring 2011 it was piloted with each new referral. Initial drafts were sent to the trainer via email, in which she gave valuable feedback to further deepen our understanding. We set up an evidence-based resource on the shared drive of our computer system so that the completed forms that had been marked by the trainer were available to all as a guide.

Throughout this period, regular liaison took place with the other therapy teams within the Intellectual Disability Service. We were able to support each other by sharing examples of how we were using the system, and within the music therapy service we brought cases to our monthly team meetings for discussion. The EKOS audit tool (Johnson & Elias 2010) was used to monitor how the therapists were using their data so that good standards and consistency were maintained.

Our application of the EKOS was therefore developed and fully rolled out at the beginning of 2012. During the first year, 49 EKOS plans were completed within the music therapy team, with 92% achieving a good outcome (Johnson & Elias 2010).

DESCRIPTION OF THE EAST KENT OUTCOME SYSTEM

The outcome system is described as not being an outcome measure in itself; rather it “provides a framework for producing and evaluating individual treatment plans which draw on evidence-based clinical practice” (Johnson & Elias 2010: 6). It is a simple two-page form that is based on therapy goals, and it aims to be a summary of what is planned for and achieved during the course of the work. It is a collaborative process between the therapist, client and/or carer. If the client is able to, they can think jointly with the therapist about why they are attending therapy and what their aims might be. The form can then be completed together so the purpose of therapy is clear to all involved.

Once the referral is made and an assessment is completed, the therapist is ready to begin drafting

his or her treatment plan. It consists of the following main sections:

Client needs group: This is a list that can be created uniquely by each professional group. It categorises the different types of client, for whom the therapist would expect similar aims, outcomes and level of service provision. The music therapy team based theirs on the most common reasons for referral (for example self-expression, anxiety, challenging behaviour, etc.) as it was felt that this information would be most relevant to the service and would provide meaningful data for managers and commissioners.

Health benefit: This is the broad category of overall anticipated health gain for the service user. The categories are set by EKOS and are shown in Table 1.

Health benefit	Definition
1. Reassurance provided	To give reassurance that no problem has been identified.
2. Problem resolved	To resolve a problem to an acceptable level.
3. Facilitated development	To achieve full potential by facilitating development or growth.
4. Restored function	To achieve full potential by restoring function as fully as possible after injury, disease, trauma, etc.
5. Function preserved	To preserve function or minimise deterioration.
6. Modified / adapted regime	To enhance the client's quality of life by adopting alternative methods of functioning or making adjustments to live with and compensate for chronic conditions.
7. Harm avoided	To remove or minimise the risk of harm to the client or others.
8. Health promotion	To promote better health through anticipatory care and health education.
9. Supported	To support client with pain, grief, anger, guilt, etc.
10. Information provided	To provide information regarding a specific issue.

Table 1: Health benefits set by EKOS

Reason for intervention: This is a useful summary of why the client has been referred.

Therapy package and timescale: A self-explanatory section in which individual or group sessions are named along with the proposed

timescales for therapy.

Consideration of consent: It is important to demonstrate that issues of capacity and consent for therapeutic intervention have been considered and evidenced. If the client lacks capacity, a best interests decision should be made and recorded here.

Service user's views/comments on intervention: The method is designed to be a collaborative process with the client, so that if they are able, they are encouraged to reflect on and discuss why they are attending therapy and what they would like to achieve. These boxes therefore provide an opportunity if appropriate to capture their thoughts before and after the intervention.

Overall aims: The aims of the intervention are linked to the health benefit, and they identify the long-term purpose of the intervention. They are specific to each profession, so a list of aims applicable to arts therapists was devised as a result of many months of work between the various arts therapies teams across the trust. These were based on existing methods of goal setting that were already being used in the teams, which had been informed by models such as Bruscia (1987) and Baxter et al. (2007).

It is usual that every service that uses EKOS develops their own aims, treatment protocols, etc. so the following list therefore comprises the most common groups that our therapists were working to. These were relevant across both adult and child services, which included Intellectual Disabilities, Child and Adolescent Mental Health Services (CAMHS) and Forensic.

- A – Assessment and treatment aims
- B – Emotional issues
- C – Relationships
- D – Communication
- E – Psychological development/personality
- F – Behaviour
- G – Other.

Each section (A-G) has between one and three specific aims within it; these explain the reasons for therapy and more than one can be identified at any time. Examples include: A2: To identify the key issues and aims for the client; B1: To enable the client to increase their ability to express emotions; E2: To foster self-esteem and self-confidence etc.

Baseline: When an aim has been selected, a description of the current baseline is given (for example, what is happening now?). This is a measurement or judgement noted before the intervention, against which change can be measured.

Objectives: The objectives are then set. These are directly linked to the aims and they describe exactly what the therapist is working towards achieving. For instance, this might be a specific skill, behaviour or situational change. The objective must be SMART (Specific, Measurable, Achievable, Realistic and Timely) so that it is possible to state clearly whether or not it has been achieved.

Treatment plan: This details the therapy approaches and techniques used towards meeting the objectives, thus demonstrating how the therapy is to be delivered.

Final evaluation: Evidence of how the objectives have or have not been achieved is detailed in the final section. From this the outcomes can be recorded. They are then added up and given as a percentage on a four-point scale as shown in Table 2, with 'good' outcomes ranging from 70-100% and 'poor' outcomes being less than 70% achieved.

When the recorded outcome is 'poor' (i.e. partially or not achieved), it is necessary to note the reason for this by choosing up to two possible contributory factors from a designated list as follows in Table 3.

Additional discharge information: This section provides an opportunity for any other relevant information related to the client's discharge to be documented. This could include further recommendations/signposting to other services and so on.

REPORTING AND FURTHER EVALUATION OF DATA

Once the therapist has evaluated the effectiveness of the intervention and recorded the outcome, the overall percentage of good outcomes can be a useful performance indicator for the service as a whole. Examining the reasons for poor outcomes is also beneficial for monitoring therapy trends across the team. For example, if they are therapist-orientated (such as setting aims that are overambitious or inappropriate) this might have implications for further training or support, whilst if the reasons are to do with a lack of support from staff, this can be positively addressed.

The Nottinghamshire Healthcare NHS Foundation Trust currently uses an electronic patient records and management system called 'Rio'. This is a web-based electronic care record system which was created as part of the National Programme for Information Technology in the NHS. Rio was designed for health and social care organisations that needed a single source of

information about patients or clients. In our Trust, all professionals involved with a patient can access their electronic records and add information to the system such as weekly progress notes or completed assessments.

The EKOS is formatted into the Rio system so that the completed data can be extracted and reported on. This is particularly advantageous when teams are required to compile reports and communicate their outcomes to managers and commissioners. Examples of data that can be used are: what are the most commonly used health

benefits or aims, what are the numbers within each client needs group, percentage of good outcomes, reasons for poor outcomes, number of EKOS forms completed by each team member, and so on.

For example, in 2014-15, 45 EKOS plans were completed in the music therapy team. The data showed that overall 96% of these had good outcomes (i.e. more than 70% of their objectives were achieved). Figure 1 shows the breakdown of these by *health benefit*, so that those with the highest outcomes were facilitated development, function restored, harm avoided, and supported.

Good outcomes		Poor outcomes	
<i>Fully achieved</i>	<i>Mostly achieved</i>	<i>Partially achieved</i>	<i>Not achieved</i>
100% objectives met	70 -100% objectives met	<70% objectives met	0% objectives met
All objectives are met.	3 out of 4 4 out of 5 5 out of 6 6 out of 7	6 out of 8 7 out of 9 7 out of 10	1 out of 2 2 out of 3
			No objectives are met.

Table 2: Calculating the overall outcome

Possible contributory factors influencing outcome: Record if outcome less than 70% (please tick up to 2)		
Poor attendance	Overambitious aims / objectives	Transferred to another service/team
Therapist absence	Deteriorating health	Lack of agreed support
Slower progress than expected	Delay in planned delivery of care	Lack of involvement (client)
Unable to complete the course	Inappropriate aims / objective / intervention	Unforeseen life event
Deceased	Unmet need – funding of equipment	Unmet need – service gap

Table 3: Possible contributory factors influencing poor outcome

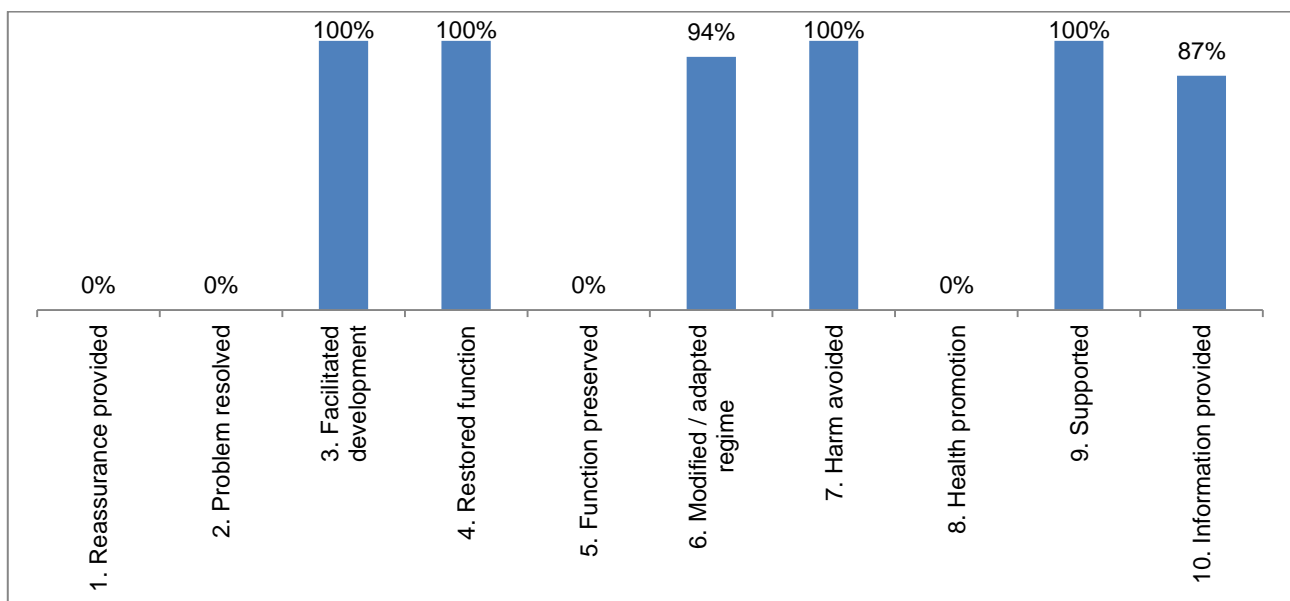


Figure 1: Percentage of good outcomes by health benefit

CASE EXAMPLE

This brief case example aims to demonstrate how the EKOS can be used in music therapy practice. It is based on a case from the Intellectual Disability Service in Nottinghamshire Healthcare NHS Foundation Trust.

The Intellectual Disability service

The service provides specialist health care for adults with intellectual disabilities and complex needs such as additional physical health problems, additional mental health problems, or serious risk issues. Assessment and treatment is delivered within a stepped model. Routine assessment and treatment is delivered within nine multi-disciplinary and multi-agency Community Learning Disability Teams across Nottinghamshire. More intensive assessment and treatment, where there has been an increase in risk or deterioration in mental health, is delivered by two multi-disciplinary Intensive Community Assessment and Treatment Teams (ICATTs). The most intensive assessment and treatment for people who have an intellectual disability and associated challenging behaviour and mental health issues is delivered in the inpatient Assessment and Treatment Unit (ATU). Music therapy is currently available within the ICATTs and the ATU, with referrals being made by colleagues within these teams.

Mark

Mark, whose name has been changed to protect his identity, was a 30-year old man with autistic spectrum disorder who was living in a community home for people with intellectual disabilities. He was admitted to the ATU due to an increase in anxiety and possibly depression. Mark was referred to music therapy to help him express and explore his emotions, decrease his anxiety and improve his general wellbeing.

Assessment

Mark attended four assessment sessions which were recorded and analysed through clinical notes and video recording. He was able to stay for the whole 30 minutes each time, but he seemed quite tense, grimacing frequently, rolling his head from side to side and talking repetitively about topics such as birthdays and other clients. As he became familiar with the therapist and the sessions, however, he appeared to relax. Video recordings showed that he smiled more naturally, gave

increased eye contact and focused more on the music rather than the repetitive speech. Mark was also noted to be compliant each week, as he would wait for the therapist to choose an instrument and begin playing it. However, when given a gentle verbal prompt, Mark was able to make choices for himself and lead the improvisations. The methods used in the assessment encompassed both relational and music-centred techniques (Wigram et al. 2002) to assess the development of a therapeutic relationship alongside the potential for musical interaction.

The music therapy department's assessment tool (Saville 2000) was used to record the findings from these initial sessions. In this tool, musical, interpersonal, sensory and physical observations based on Bruscia's model of Improvisation Assessment Profiles (Bruscia 1987) were documented and these were written up in an assessment report.

Treatment

The findings from the assessment formed the basis for the treatment phase of therapy, which consisted of ten further sessions over a three-month period, covering his discharge from the ATU through his transition back to his community home. Information from the assessment gave the baseline for the EKOS treatment plan which could now be implemented. This is illustrated in Figure 2 and the process was as follows:

- a. The 'client needs group' was identified as 'anxiety' due to Mark's primary presentation.
- b. The 'health benefit' was 'problem resolved' as it was felt that once he moved through the transition back to his home, his anxiety would decrease.
- c. The timescale was decided as three months which would correspond with Mark's pending discharge from the ATU through the transition back to his community home.
- d. Two main aims were identified: i) To enable Mark to manage difficult feelings during transition from ATU back to his community home, and ii) To foster self-esteem and self-confidence.
- e. The baselines were matched against the aims, detailing how Mark was presenting at the beginning of the treatment episode.
- f. The objectives were set by thinking about how musical and relational techniques could be used to achieve the aims: i) Mark to sustain a relaxed

dialogue about his transition to community during each session, ii) Mark to lead 50% of the improvisations during each session, iii) Mark to choose instruments independently in three successive sessions.

- g. The aims and objectives for the therapy were considered within an integrative framework, so that early mother infant theories relating to affect attunement (Stern 1985), holding and play (Winnicott 1971), and containment (Bion 1962) informed the social and musical activities and interactions (Saville 2007). Due to Mark's anxiety and autistic presentation the therapist aimed to focus on containing his emotional state, encouraging relaxation and developing more autonomy and reciprocity. These techniques were detailed in the treatment plan, thus demonstrating the small steps that were to be implemented each week throughout the intervention.

Outcomes

At the end of therapy the outcomes were as follows. They were evidenced through case notes and video analysis and documented on the EKOS form with a 'Yes' and some accompanying text:

1. Mark engaged positively, and he continued to be interested in the instruments and our musical relationship.
2. Mark seemed to cope well with the discharge back to his new home, and he told the therapist all about it in the following sessions. He was noticeably happy and relaxed, playing easily and coping well with the change in routine of coming to the sessions.
3. Mark's attention and concentration was much improved when he was encouraged to play in structured ways – for instance "Follow my beat – 1, 2, 3". Otherwise when not so engaged he would talk repetitively to himself.
4. Mark's confidence increased so that he was able to choose instruments independently and take the lead in over half of the improvisations. He showed his pleasure after these by smiling.

Mark also coped well with the ending of therapy – he acknowledged this appropriately in the final sessions and he left with a sense of achievement and confidence.

DISCUSSION

This paper has examined the use of an outcome measurement system within a music therapy team for adults who have an intellectual disability. The expectation to monitor, evaluate and improve the quality of clinical services within the contemporary climate implies that robust methods of measuring outcomes should be routinely embedded into everyday practice, and the EKOS is a system that can enable clinicians to achieve this.

It was a challenge to find a form of measurement that suited our needs within Nottinghamshire Healthcare NHS Foundation Trust due to the limited resources and literature available regarding outcome measures. However, our experience of participating in the UK CORE-LD pilot along with training on TOMS and EKOS informed the therapy teams of best current practice and helped us decide to apply the EKOS within our services.

The system has several limitations in that firstly it requires in-depth training to fully understand its principles and methods. To ensure reliability and consistency within and across teams it is recommended that therapists should maintain and monitor their standards of its use through audit, supervision and peer discussion (Johnson & Elias 2010).

Secondly, whilst the system is not an outcome measure in itself, it provides a framework in which evidence from clinical practice can be documented. Rather than being a standardised system, it is more of a method for evidencing aims and objectives within therapeutic treatment plans.


Thirdly, the system has the potential to be a useful collaborative experience between client, carer and therapist, thus allowing for an early discussion of the expectations of therapy as well as giving an opportunity to reflect on the outcomes. However, this is naturally dependent on the capacity of the client to understand the purpose of the therapy and/or the written text. In our services, which include mental health services for older people and child and adolescent mental health services as well as intellectual disability, we provide an accessible version of the tool for clients in which the aims of therapy are detailed in a format that is much easier to understand.

In terms of the benefits of the EKOS, it is a fairly simple process which provides a clear structure for planning and evaluating therapeutic interventions. It

is based on existing good clinical practice and it enables the therapist to critically reflect on and develop their work. The flexibility of the EKOS allows each professional group to apply it within their individual services, whilst also providing a consistent, systematic method of analysis that enables comparison across clinical teams.

It is beneficial that data can be extracted from Rio reports so that information is available to analyse at all levels, from therapists through to managers and commissioners. The individual therapist, for example, might see trends emerging regarding favoured health benefits or reasons for

poor outcomes, which might be useful to explore in supervision to check for consistency or good practice. Team managers might wish to produce annual service reports with data such as how many treatment plans were completed and what percentage of these had good outcomes. This information can be displayed through charts and graphs, which are a quick and concise way of communicating the value of the service alongside accompanying text or case studies. This is vital for commissioners who appreciate succinct evidence of an intervention they are purchasing.

Intellectual Disability Service Music Therapy Treatment Plan		Nottinghamshire Healthcare  NHS Foundation Trust		
Name: Mark	Client needs group: IDD: Anxiety Health benefit: Problem Resolved	Consideration of consent: Mark can consent to attending music therapy sessions.		
DOB: 1.1.1982	Reason for intervention: Anxious client not relating to here and now, displaying rigidity of thought and play.	Intervention in best interests? Yes		
NHS No: 1234567890	Therapy package & timescale: 1:1 MT. Weekly sessions following assessment. Continue for 3 months.			
Service user views on Intervention (What are their aims?):				
Mark is keen to come with the therapist to the music therapy room and he looks forward to his session each week.				
Overall aim(s):	Baseline:	Objective:	Outcome:	
			Y / X	Evidence
1. To enable Mark to manage difficult feelings during transition from ATU back to his community home.	Mark appears tense, grimacing frequently, rolling his head and talking repetitively about certain topics unrelated to the here and now.	Mark to sustain a relaxed dialogue about his transition to community during each session.	Y	Mark expressed his feelings about his transition calmly each week, and coped well with the change in routine of coming to the sessions from home.
2. To foster self-esteem and self-confidence	Inflexibility within musical interactions – Mark copies but does not improvise.	Mark to lead 50% of the improvisations during each session.	Y	Mark took the lead in over half of improvisations each week and demonstrated enjoyment when the therapist followed his playing.
	Mark is compliant when choosing musical instruments.	Mark to choose instruments independently in three successive sessions.	Y	Mark was making independent choices of instruments after 4 weeks.
Start date: 1.2.12	Planned evaluation date: 4.4.12	Date discussed with client: 1.2.12	Client's signature (if appropriate): Mark	
Name: Rhian Saville	Designation: Lead Clinical Specialist Music Therapist	Date & Time: 1.2.12	Signature: Rhian Saville	

Treatment plan (small step programme of intervention):			
1. Provide weekly 1:1 MT sessions on Wednesdays at 2pm in MT room. 2. Provide similar structure to sessions each week. 3. Encourage Mark to choose instruments independently. 4. Encourage Mark to join in simple turn-taking and counted musical activities. 5. Help Mark to relax and engage in reciprocal musical and verbal dialogues. 6. Encourage Mark to talk about his transition.			
Evaluated on: 4.4.12	Date evaluated with client: 4.4.12	Client's signature (if appropriate): Mark	
Overall outcome:	Fully (100%)	Mostly (>70%)	Partially (<70%) Not (0%)

Possible contributory factors influencing outcome: Record if outcome less than 70% (please tick up to 2)			
Poor Attendance	Overambitious	Transferred to another service/team	
Therapist Absence	aims/objectives	Lack of agreed support	
Slower progress than expected	Deteriorating Health	Lack of involvement (client)	
Unable to complete the course	Delay in planned delivery of care	Unforeseen life event	
Deceased	Inappropriate aims/objective/intervention	Unmet need – service gap	
	Unmet need – funding of equipment		
Service user's comments on intervention			
Mark said he felt calmer and happier after coming to music therapy.			
Additional discharge information if required:			
Recommendations made to home staff regarding building and sustaining positive relationships and reducing anxiety.			
Name: Rhian Saville	Designation: Lead Clinical Specialist Music Therapist	Date & Time: 4.4.12	Signature: Rhian Saville

Figure 2: Example of a completed EKOS Plan [Form adapted from East Kent Outcome System (EKOS) (Johnson & Elias 2010)]

Further applications

The EKOS is a simple and attractive system in which information about therapeutic aims, objectives and clinical outcomes can be captured and analysed. There are possibilities for it to be used in many other clinical or educational settings where therapists are interested in demonstrating evidenced-based practice. This can be done by either using the original EKOS templates (Johnson & Elias 2010), or by applying the tool and referencing EKOS (Johnson & Elias 2010) as the source. In either case, training would be necessary to ensure consistency of use and to maintain reliability.

The EKOS has been used successfully by all therapists across Mental Health, Intellectual Disability and Forensic services in Nottinghamshire Healthcare NHS Foundation Trust since 2010. There is a need for more methods of outcome measurement within the music therapy profession and so it is hoped that this system has the potential to be used with a wide variety of client groups in the future.

Conflict of interest

There are no conflicts of interest to note.

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