OBJECTIVES

1. Participants will be able to understand the rationale for consistent feedback.

2. Participants will be able to identify a feasible method for obtaining consistent feedback.

3. Participants will be able to describe strategies for responding to specific client feedback.

4. Participants will be able to understand how feedback operationalizes the concept of “client-centered”.
WHAT MOTIVATES THERAPISTS

We all know that the main reason we Social Workers got into this business is… NOT!
WHAT MOTIVATES THERAPISTS

We tend to value the helping nature of our profession. We really do like seeing people improve their lives in some way.

Staying personally involved and developing/learning guards against burnout. It also helps with recovery process of the client and the therapist. (When client and therapist are both involved in their own recovery, outcomes are enhanced.)

Expansion of therapeutic breadth assists us in being able to respond and relate in a client-centered / directed fashion. Rigid loyalty to a therapeutic model can be a barrier.

Current growth is also important. (86% want to get better!)

A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.
DO WE VALUE “PERSON-CENTERED”? 
STRENGTHS-BASED APPROACH

Client Strengths and Resources: Helping Clients Draw on What They Already Do Best

Jacqueline A. Sparks and Barry L. Duncan

STRENGTHS-BASED APPROACH

• Clients are the engine to change as their cooperation and collaboration (engagement) is critical to change being realized.

• Solution-focused perspectives looks for those exceptions to the problems without ignoring the problems and attempts to increase frequency of adaptive/ effective cognitive and behavioral activities.

• Clients who feel valued by therapist generally engage more fully (Roger’s Unconditional Positive Regard). However, this is not all that is necessary: a match between goals and therapeutic activities are also key.

• Clinicians maintain a belief in client’s ability to change.
MODEL VS. EFFECTIVENESS

With few exceptions, partisan studies designed to prove the unique effects of a given model have found no differences.


Considered to be the most sophisticated comparative clinical trial ever conducted:

- Four approaches (CBT, IPT, Drug, Placebo).
- *No* difference in outcome between approaches
- The client’s rating of the alliance at the second session the best predictor of outcome across conditions.
- Tx model accounted for (0-2% of the variance...)

PROJECT MATCH

The largest study ever conducted on the treatment of problem drinking with three different treatment approaches studied (CBT, 12-step, and Motivational Interviewing).

FINDINGS

• *NO* difference in outcome between approaches.

• Client’s rating of the therapeutic alliance was the best predictor of:
  • Treatment participation;
  • Drinking behavior during treatment;
  • Drinking at 12-month follow-up.


Does therapy work?
Are your clients getting better?
How do you know?
THERAPEUTIC EFFECTIVENESS

It is often reported that the average treated person is better off than approximately 80% of the untreated population.

HOW WELL DO THERAPISTS JUDGE OUTCOME?

What do you think was the result when 143 clinicians were asked to rate their own job performance from A+ to F?

143 TOTAL PARTICIPANTS

- A+ or Better: 67%
- A to C: 33%
- Less Than Average: 0%
REAL WORLD EFFECTIVENESS

• Therapists’ effectiveness ranges widely. Routine clinical care often is as low as 20% where in RCT the efficacy is as high as 67%.

MORE ON EFFECTIVENESS

• Early drop outs: 47% for adults and 60% adolescents

HOW EFFECTIVE ARE THERAPISTS IN IDENTIFYING THOSE AT RISK FOR DROP OUT?

Michael Lambert and associates in 2005 did a study in which there were 40 therapists (20 licensed and 20 interns) with 550 clients in the study. They used the OQ 45.2 to measure outcome, but did not give the feedback to the therapists.

40 of the clients actually deteriorated.

Throughout the study they periodically (after 3 sessions) asked the therapists whether or not the clients were getting better, staying the same or getting worse.
HOW EFFECTIVE ARE THERAPISTS IN IDENTIFYING THOSE AT RISK FOR DROP OUT?

The therapists identified three, but were only right one of those three times and that one was identified by an intern.

The Algorithms (OQ 45) predicted 85% of those who had a negative outcome.

False alarm signals were given at a 2:1 ratio.
Examined case notes of clients who deteriorated to see if therapists noted worsening at the session it occurred.

- Clients who scored 14 points worse there was documentation 21% of the time.
- Clients who scored 30 points worse there was documentation 32% of the time.

SO, DO YOU THINK WE NEED FEEDBACK?!
Factors Accounting for Successful Outcome

- **Spontaneous Remission**: 40.0%
- **Client/Extratherapeutic**: 15.0%
- **Models/Techniques**: 15.0%
- **Placebo/Hope/Expectancy**: 15.0%
- **Common Factors Relationship**: 30.0%

JEROME FRANK (1973)  
COMMON FACTORS

1. An emotionally charged, confiding relationship with a helping person

2. A healing setting

3. A rationale, conceptual scheme, or myth that provides a plausible explanation for the client’s symptoms

4. A ritual or procedure that requires the active participation of both client and therapist and that is believed by both to be the means of restoring the client’s health
Client/Life Factors (86%) (includes unexplained and error variance)

Feedback Effects 21-42%

Alliance Effects 36-50%

Model/Technique: Specific Effects (Model Differences) 7%

Model/Technique: General Effects (Rational & Ritual), Client Expectancy (Placebo), & Therapist Allegiance 28-?%

Therapist Effects 36-57%

Treatment Effects 14%
EARLY CHANGE

The general trajectory of change in successful psychotherapy is highly predictable in that most change occurs earlier rather than later.

Change in Treatment

EARLY CHANGE

Between 60-65% of people experience significant symptomatic relief within one to seven visits
That increases to 75% in six months
To 85% in a year
Major Point: after 7 visits, it generally takes more effort for smaller gains.

Some clients do take longer, but the mythology never dies

N=4676; 77% attended 8 or less, and 91% 12 or less

Note that even for the clients who take longer, change starts early…just is flatter

ALLIANCE

Orlinsky, Ronnestad and Willutzki reviewed 1000 studies indicating a powerful effect of alliance.

The client’s assessment of the alliance is more predictive of outcome than therapist’s/ practitioner’s.

MODELS AND TECHNIQUES

- NREPP has more than 300 listed EBPs
- When placebo, hope and expectancy are controlled for by applying an inert experimental design where positive expectancy is fostered, there is a reliable effect size almost as great as the bona fide treatment model.
- When alliance is added, it closes the gap even further.

BUT, MODELS ARE IMPORTANT

Model is important in that it has to resonate with the client and the practitioner. EBPs provide an organized way to explain problems and potential strategies for remedy. Practitioners will likely deliver service with increased consistency when they understand and have an allegiance to the model.
THERAPEUTIC RELATIONSHIP/ ALLIANCE

• Alliance is highly predictive of outcome, but the client’s assessment of the alliance is more predictive than the practitioner’s assessment.

• Alliance is not what we do before applying the EBP. **Alliance is the treatment.** Alliance is formed within the context of a therapeutic model.

• First impressions are important. **Assume that the encounter is meaningful to the client from the very first contact.**
(a) agreement on the goals of therapy,
(b) agreement on the tasks of therapy and
(c) development of an affective bond.
MODELS APPLIED WITH CLIENT VOICE PRIVILEGED

• Without a theory, there can be no relationship.

• The relationship is based on the client’s belief that the therapist is competent to help and cares enough to help.

• Effective therapists are going to create some expectancy that treatment is beneficial and that a particular model works. So, the therapist’s credibility with the client is highly important to positive outcomes and is largely effected by the therapist’s ability to match the approach with the client’s culture and theory of change.
PRACTITIONER FACTORS

• Outside of the client, the practitioner is the most robust influence on outcome.

• The practitioner’s contribution to alliance explained largely why some get better outcomes and have fewer dropouts than others.

• Getting systematic client feedback can improve performance. Without feedback it is too easy to overly rely on one’s own assessment of alliance and benefit based on the practitioner’s experience of the encounter.
HOW CAN WE KNOW IF WE ARE GETTING BETTER AND IF OUR CLIENTS ARE GETTING BETTER?

Measure!
SO, HOW DO WE GET BETTER?

1. Use measurement tools to obtain feedback as feedback helps 80–90% of therapists improve their outcomes, especially those who were less effective to start.

2. The feedback helps practitioners to identify those at risk of dropping out or deteriorating which gives the practitioner a chance to make adjustments in the approach.

3. The adjustments may be targeted at the alliance or the strategies depending on the feedback. The major reasons clients drop out is poor fit with practitioner and poor outcome – it’s not working! This real time feedback gives the client a better chance for early change which is a predictor of positive outcome.
THE HEART AND SOUL OF CHANGE PROJECT

Founded in 2009 by Barry Duncan, Psy.D. to disseminate the clinical tools, Partners for Change Outcome Management System (PCOMS). He is one of the developers and he is the developer of the clinical process of PCOMS.

PCOMS attends to culture, diversity and outcome one client at a time.

www.heartandsoulofchange.com
PCOMS is a-theoretical & therefore additive to any therapeutic orientation, including other EBPs; PCOMS applies to clients of all diagnostic categories.
A CASE FOR PCOMS (RCT 1)

In a randomized clinical trial (RCT) with couples, they found that those who gave their therapist feedback about their benefit and “fit of services” on two four-item scales reached clinically significant change nearly four times more than the non-feedback couples.

So, the potential reward is seeing your clients getting better more often and even more quickly while you continue to grow and learn from them and become a better therapist/practitioner!

Feedback condition was significantly better across therapists.

<table>
<thead>
<tr>
<th></th>
<th>Feedback</th>
<th>Non-feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre – tx ORS</td>
<td>18.08</td>
<td>18.58</td>
</tr>
<tr>
<td>Post – tx ORS</td>
<td>26.35</td>
<td>21.69</td>
</tr>
<tr>
<td>Difference</td>
<td>+ 8.27</td>
<td>+3.11</td>
</tr>
<tr>
<td>Follow-up</td>
<td>28.28</td>
<td>24.60</td>
</tr>
</tbody>
</table>

Therapists who were least effective without feedback (TAU) benefitted the most from feedback (PCOMS).
The purpose of this study was to replicate the findings in RCT 1 with a sampling of clients in couple therapy in the United States.

Couples in the feedback condition improved 8.58 points (out of possible 40) vs. 3.64 points for the TAU group.

More couples both on individual and couple levels in the feedback condition achieved reliable change (increase of 5 points) and clinically significant change (increase of 5 points and crossing the clinical threshold of 25) than in the TAU group.

Clients in feedback condition were more likely to experience reliable change in fewer sessions. 50% of clients in the feedback condition demonstrated reliable change by 7\textsuperscript{th} session (graduate training clinic) or 9\textsuperscript{th} session (university counseling center).

PCOMS ALSO EFFECTIVE FOR SUD GROUP TX (RCT 4)

In a study of active military with sample meeting criteria for substance use abuse or dependency, the clients in the feedback condition reached clinically significant change nearly twice as often.

Clients with no change were greater in the TAU group.

In the categories of deterioration and reliable change the differences were not significant.

Schuman, Donald L.; Slone, Norah C.; Reese, Robert J. and Duncan, Barry (2014) “Efficacy of Client Feedback in Group Psychotherapy with Soldiers Referred for Substance Abuse Treatment” *Psychotherapy Research*
MAJOR FINDINGS IN FEEDBACK RESEARCH

- Providing feedback and use of feedback improves outcomes for the clients predicted to be at risk of deteriorating or dropping out.
- When feedback is utilized with those at risk, they had more sessions than the TAU group.
- Clients on track, use of feedback resulted in fewer sessions than TAU.
- Feedback can assist practitioners in providing the right dosage of service for the specific client; therefore, maximizing efficiency.
Meta-analysis by Lambert & Shimokawa (2011) of PCOMS (the ORS and SRS)

Those in feedback group had **3.5 higher odds** of experiencing reliable change

Those in feedback group had less than **half the odds** of experiencing deterioration

PUBLIC CMHC STATS

Claude (2004) compared the average # of sessions, cancelations, no shows, and % of long-term cases before and after using Outcome Measures. Sample: 2130 closed cases seen in a public CMHC.

- Average # of sessions dropped 40% (10 to 6) while outcomes improved by 7%; cancelations were reduced by 40% and no show rates were reduced by 25%.

- There was an estimated savings of $489,600. Such cost savings did not come at the expense of client satisfaction with services—during the same period satisfaction rates improved significantly.
CLIENT FEEDBACK IN GROUP TX (RCT 5)

- University Counseling Center from Jan 2012 to Dec 2012
  84 clients completed the study
- 43 - feedback condition and 41 - TAU condition
- Dx was not factored in, but common problems were anxiety (68%), stress (64%) and depression (58%)
- Use of psychotropic medications was not factored

CLIENT FEEDBACK IN GROUP TX (RCT 5)

Findings:

1. Feedback group enjoyed larger tx gains than the TAU group (0.28).

2. Feedback group experienced reliable change (32.6% vs. 17.1%) and clinically significant change (41.9% vs. 29.3%) more often than TAU group.

3. Feedback group attended an average of 1.5 more sessions than did the TAU group.

4. There were no significant differences between the groups for premature termination which was extremely low in both groups – may have been due to the setting and emphasis on expectation of completing the study.
WHAT DO WE NEED IN AN OUTCOME MEASURE?

- Very brief! Takes less than 5 minutes to administer, score and interpret.
- Applicable to all service settings.
- Applicable to all treatment methods.
- Applicable to all treatment populations.
- Has viable support that allows for quality improvement.
- Provides a means for transparency and accountability.

Outcome Rating Scale (ORS)

Name ________________________Age (Yrs):____ Sex:  M / F
Session # ____  Date: ________________________
Who is filling out this form? Please check one: Self_______ Other_______
If other, what is your relationship to this person? ____________________________

Looking back over the last week, including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels. If you are filling out this form for another person, please fill out according to how you think he or she is doing.

Individually
(Personal well-being)

I------------------------------------------------------------I

Interpersonally
(Family, close relationships)

I------------------------------------------------------------I

Socially
(Work, school, friendships)

I------------------------------------------------------------I

Overall
(General sense of well-being)

I------------------------------------------------------------I

The Heart and Soul of Change Project

www.heartandsoulofchange.com

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ORS ADVANTAGES

- Designed to be used every session
- Brief
- Helps the client identify goals
- Is to be worked into the therapy itself
- Focuses attention on the client’s goals – privileges the client’s voice
- Starts collaborative experience from the beginning
Session Rating Scale (SRS V.3.0)

Name ________________________ Age (Yrs):____
ID# _________________________ Sex: M / F
Session # ____  Date: ________________________

Please rate today's session by placing a mark on the line nearest to the description that best fits your experience.

Relationship

- I felt heard, understood, and respected.
- I did not feel heard, understood, and respected.

Goals and Topics

- We worked on and talked about what I wanted to work on and talk about.
- We did not work on or talk about what I wanted to work on and talk about.

Approach or Method

- The therapist's approach is a good fit for me.
- The therapist's approach is not a good fit for me.

Overall

- Overall, today's session was right for me.
- There was something missing in the session today.

The Heart and Soul of Change Project

www.heartandsoulofchange.com

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SRS ADVANTAGES

• Designed to be used every session
• Brief
• Is to be worked into the therapy itself
• Focuses attention on the client’s goals – privileges the client’s voice
• Designed to help the clinician identify and correct any alliance ruptures before they negatively affect the outcome
• Reflects the client’s assessment of the alliance
BETTER OUTCOMES NOW (BON)

PCOMS is empirically demonstrated to dramatically improve outcomes and efficiency across client populations and settings.

Get Measures ☞

Heart and Soul of Change

Your all in one

On Becoming a Better Therapist

BETTER OUTCOMES NOW
ORS/SRS IN BON

Outcome Rating Scale (ORS)

Individually
(Personal well-being)

Interpersonally
(Family, close relationships)

Socially
(Work, school, friendships)

Overall
(General sense of well-being)

First: 6.1
Last: 34.3
Change: 28.2
Progress To Date: [Graph with colors and progress indicators]
Meetings: 4 in 426 days

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PROCESS

1. Introduce the ORS
2. Solicit their cooperation
3. Score the ORS
4. Connect the score with their experience
5. Use that data to develop tx plan/ focus
6. Toward the end of the session, introduce the SRS
7. Solicit their cooperation
8. Score the SRS
9. Check on any scores that are less than 9
IDENTIFYING THOSE AT RISK FOR POOR OUTCOME

If early change is not taking place (3-4 sessions) based on the ORS, you will want to discuss that as the client is at greater risk for deterioration or dropout.

If there is no improvement after 6 or 7 sessions based on the ORS, it indicates a need for a serious discussion about the lack of benefit being received.

If the SRS scores are not 9 or over on each item by 3-4 sessions, a serious discussion about the “fit” needs to take place.
WHAT TO DO WITH FEEDBACK

HAVE A DISCUSSION WITH THE CLIENT!

1. Alliance
2. Motivation
3. Social Skills Training
4. Additional Evaluation/medication
You may need to involve another treatment provider, support service, self-help services, collateral supports, etc.

Without some indication of benefit, the ethical question has to be considered as to continuing the service.
When ORS score has (1) increased 6 or more points from baseline, (2) is over 25 and (3) scores begin to plateau or change little, what would be a reasonable and ethical course of action?

A. Reinforce the progress made.
B. Begin to decrease frequency of appointments.
C. Terminate.
D. All of the above.
E. I do not know.
When clients are improving as planned, connect their progress with their own change in thinking, behavior, etc. Taking ownership and increasing their confidence in their ability to manage their own life is what we want to see.

If progress has been made and the ORS scores plateau, that is a time to begin to discuss decreasing the frequency of visits and/or termination.

Using the scores can help the therapist ensure the proper utilization. Under-utilization, the client does not get the help they could use and over-utilization fosters dependency.
1. What does the client say in terms of the score?
2. Is the client engaged? SRS?
3. What has the therapist done differently?
4. What other resources can be rallied? Family, self-help group, PCP, etc.
5. Is it time to fail successfully?
1. Administer the ORS each visit.
2. Ensure the client understands that the tool will be used to bring the client’s voice into the decision-making process and will be collaboratively used to monitor progress.
3. Ensure the client gives a good rating; i.e., a rating that matches the client’s description of their experience.
4. Ensure the client’s marks on the ORS are connected to the described reasons for service.
5. Use outcome (ORS) data to develop and graph individualized trajectories of change.
6. Use the trajectories to determine which clients are making progress and which ones are at risk for a negative or null outcome.
PCOMS FIDELITY TOOL

7. Use ORS scores to engage clients in a discussion in every session about how to continue or empower change if it is happening; or to change, augment or discontinue tx if it is not.
8. Administer the SRS each visit.
9. Ensure that the client understands that the SRS is intended to create a dialogue between the therapist and client that is intended to tailor the service – there is no bad news on the measure.
10. Use the SRS to determine if the client feels heard, understood and respected.
11. Use the SRS to discuss if the service is addressing the client‘s goals for treatment.
12. Use the SRS to discuss whether the service approach addresses the client‘s culture or worldview, or theory of change.
APPLICATION

PCOMS is applicable to virtually all behavioral health populations and is intended to be integrated into the provider’s preferred model(s); thus, is of interest to a wide variety of providers.

Consumers will be interested in that providers using PCOMS expressly engage/involves the client and values their ideas and preferences in the therapeutic decision-making throughout the treatment episode.
1. Deteriorating: Clients who have dropped 6 points are considered to be at risk for terminating prematurely or having a poor outcome. Discuss possible reasons, review the SRS to ensure alliance is on track, and consider changing the treatment approach, frequency, mode or therapist if deterioration is not quickly abated.

2. No Change: Clients who have not shown a reliable change after 3 sessions are at risk for dropout or negative outcome. Review the SRS, and consider changing the approach, frequency, or mode of treatment. If the client has not demonstrated reliable improvement after six sessions, seek consultation, supervision or referral options.
INTERPRETATION AND USE OF ORS

3. **Reliable change**: Clients who have shown a change of 6 points are on the right track. Reinforce changes and continue treatment until progress begins to plateau, whereupon reducing the frequency of sessions and/or termination should be discussed.

4. **Clinically significant change**: Clients who have shown a change of 6 points and have crossed the cutoff are likely no longer struggling with the problems that led to therapy. Consolidate change, anticipate potential setbacks, and consider a reduction of the frequency of sessions or termination.
INTERPRETATION AND USE OF SRS

• If rating is poor (under 36) and stays the same or decreases, it is a predictor of poor outcome.
• If rating is poor, but is increasing or reaches 36 or higher and stays there, it is a predictor of good outcome.
• If clients give a poor rating and then give little explanation, thank them anyway. All feedback is to be appreciated!
• If clients give a good rating (36+), it is a predictor of good outcome (although it may be weaker predictor than if it starts lower and then goes up).
ORS USE WITH DIFFICULT CLIENTS

- Accept that it may be a struggle
- May have to decline, if early on
- Avoid the labels, listen to the person
- Remember people do change
- Empathy, appreciation, genuineness, and trustworthiness will go a long way
- Remember that everyone is motivated for something
MULTI-CULTURAL COMPETENCE/SOCIAL JUSTICE

Inequity of power is inherent in the behavioral health system. At times services can be unintentionally discriminatory or a barrier to tx. Providers themselves cannot change their gender or ethnicity and that alone can be negatively perceived by clients. Awareness, mindfulness and sensitivity is to be employed to minimize such.
MULTI-CULTURAL COMPETENCE/SOCIAL JUSTICE

Actively and consistently getting feedback keeps the therapist in step with the client and requires the therapist to challenge personal biases; keeps therapist flexible and learning about the local knowledge of not only that client’s culture, but that specific client’s views of their culture; feedback determines or shapes the interventions and strategies used to reach that client’s goals in light of client’s preferences.

Thus; PCOMS operationalizes “client-centered” and attends to social justice one client at a time!
APA RECOMMENDATIONS

- Clinical decisions should be made in collaboration with the client, based on the best clinically relevant evidence, and with consideration for the probable costs, benefits, and available resources and options.

- Services are most effective when responsive to the client’s specific problems, strengths, personality, sociocultural context, and preferences.

- The application of research evidence always involves probabilistic inferences. Therefore, ongoing monitoring of client progress and adjustment of treatment as needed are essential.
SUMMARY

We need an early warning system to alert us when someone using our services is at risk for early drop out or is not benefitting.

The only way we are going to know if we are on track with a particular client is if we are obtaining feedback.

PCOMS provides a feasible mechanism as a clinical tool to provide that feedback.

www.heartandsoulofchange.com