
Feedback Informed Treatment:
Making Services FIT Consumers
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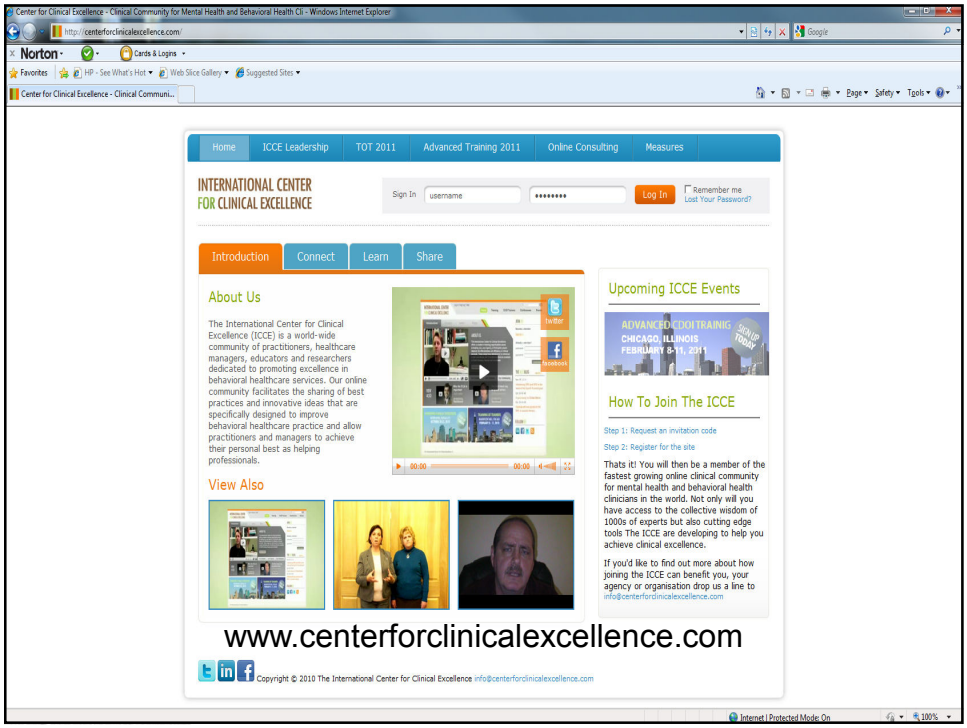
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Worldwide Trends in Behavioral Health
"Do More with Less"
•Increasing caseloads, regulation, and documentation;
•Funding challenges;
•Demand for accountability.
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Lambert, M.J., Whipple, J.L., Hawkins, E.J., Vermeersch, D.A., Nielsen, S.L., Smart, D.A. (2004). Is it time for clinicians routinely to track patient outcome: A meta-analysis. Clinical Psychology, 10, 288-301.

The Evidence

- *In most studies of treatment conducted over the last 40 years, the average treated person is better off than 80% of the untreated sample.*
- *The outcome of behavioral health services equals and, in most cases, exceeds medical treatments.*
- *On average, mental health professionals achieve outcomes on par with success rates obtained in randomized clinical trials (with and without co-morbidity).*

Duncan, B., Miller, S., Wampold, B., & Hubble, M. (eds.) (2009). *The Heart and Soul of Change: Delivering What Works.* Washington, D.C.: APA Press.

Minami, T., Wampold, B., Serlin, R., Hamilton, E., Brown, G., Kircher, J. (2008). Benchmarking for psychotherapy efficacy. *Journal of Consulting and Clinical Psychology, 75 232-243.*

The Evidence:

Three "Stubborn" Facts

- *Drop out rates average 47%;*
- *Mental health professionals frequently fail to identify failing cases;*
- *1 out of 10 consumers accounts for 60-70% of expenditures.*

Aubrey, R., Self, R., & Halstead, J. (2003). Early non attendance as a predictor of continued non-attendance and subsequent attribtion from psychological help. *Clinical Psychology, 32, 6-10.*

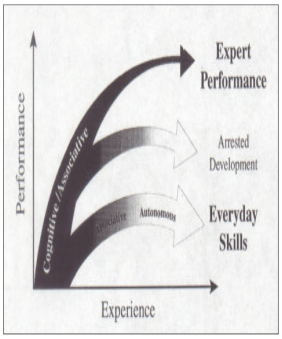
Chasson, G. (2005). Attrition in child treatment. *Psychotherapy Bulletin, 40*(1), 4-7.

Harmon, S.J., Lambert, M.J., Smart, D.M., Hawkins, E., Nielsen, S.L., Slade, K., Lutz, W., (2007) Enhancing outcome for potential treatment failures: Therapist-client feedback and clinical support tools. *Psychotherapy Research, 17(4), 379-392*

Lambert, M.J., Whipple, J., Hawkins, E., Vermeersch, D., Nielsen, S., & Smart, D. (2004). Is it time for clinicians routinely to track client outcome? A meta-analysis. *Clinical Psychology, 10*, 288-301.

The Evidence:

- The effectiveness of the "average" helper plateaus very early.
- Little or no difference in outcome between professionals, students and para-professionals.

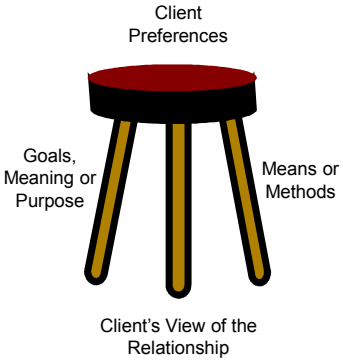


Ericsson, K.A., Charness, N., Feltovich, P. & Hoffman, R. (eds.). (2006). *The Cambridge Handbook of Expertise and Expert Performance* (pp. 683-704). New York: Cambridge University Press.
Nyman, S. et al. (2010). Client outcomes across counselor training level within multitiered supervision model. *Journa of Counseling and Development, 88*, 204-209.

The Impossible Profession

Seeing More:
What to "Watch"

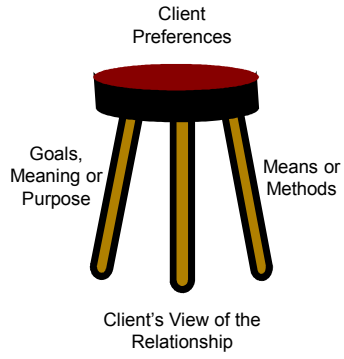
- Research on the power of the relationship reflected in over 1100 research findings.



Norcross, J. (2009). The Therapeutic Relationship. In B. Duncan, S. Miller, B. Wampold, & M. Hubble (eds.). *The Heart and Soul of Change*. Washington, D.C.: APA Press.

Seeing More:
What to "Watch"

- Baldwin et al. (2007):
  - *Study of 331 consumers, 81 clinicians.*
  - *Therapist variability in the alliance predicted outcome.*
  - *Consumer variability in the alliance* <u>unrelated</u> *to outcome.*



Baldwin, S., Wampold, B., & Imel, Z. (2007). Untangling the Alliance-Outcome Correlation. *Journal of Consulting and Clinical Psychology, 75*(6), 842-852

Seeing More:
What to "Watch"

"Clinical implications include:

(1) therapists monitoring their contribution to the alliance;

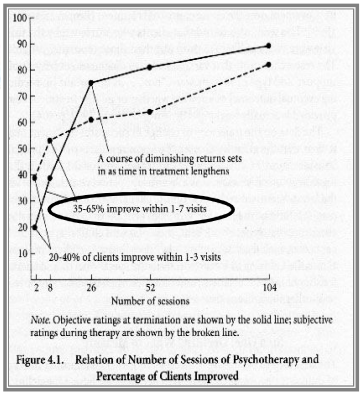
(2) providing feedback to therapists about their alliances; and

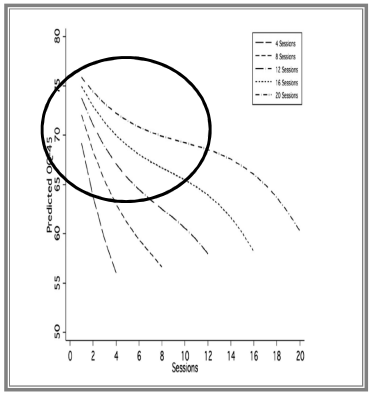
(3) therapists receiving training to develop and maintain strong alliances."

Baldwin, S., Wampold, B., & Imel, Z. (2007). Untangling the Alliance-Outcome Correlation. *Journal of Consulting and Clinical Psychology, 75*(6), 842.

Seeing More:
What to "Watch"

The Course of Progress in Successful Care

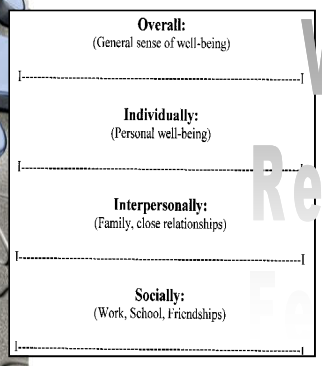


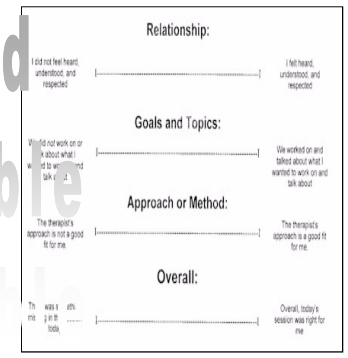


Howard, K. et al. (1986). The dose-effect relationship in psychotherapy. *American Psychologist, 41,* 159-164

Baldwin, S. et al. (2009). Rates of change in naturalistic psychotherapy. *Journal of Consulting and Clinical Psychology, 77*, 203-211.

Seeing More:
Another approach





Valid
Reliable

The O.R.S

The S.R.S

Feedback Informed Treatment
The Evidence

•Currently, 13 RCT's involving 12,374 clinically, culturally, and economically diverse consumers:

- *•Routine outcome monitoring and feedback as much as doubles the "effect size" (reliable and clinically significant change);*
- *•Decreases drop-out rates by as much as half;*
- *•Decreases deterioration by 33%;*
- *•Reduces hospitalizations and shortened length of stay by 66%;*
- *•Significantly reduced cost of care (non-feedback groups increased).*

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Miller, S.D. (2010). Psychometrics of the ORS and SRS. Results from RCT's and meta-analyses of routine outcome monitoring and feedback: The available evidence. http://www.scottdmiller.com/?q=blog/1&page=2.

Feedback Informed Treatment

The Evidence

•FIT is being used with broad and diverse group of adults, youth, and children in agencies and treatment settings around the world including:

- *Inpatient*
- *Outpatient*
- *Residential*
- *Prison-based (mandated care)*
- *Case management*

Bohanske, B. & Franczak, M. (2009). Transforming public behavioral health care: A case example of consumer directed services, recovery, and the common factors. In B. Duncan, S. Miller, B. Wampold, & M. Hubble. (Eds.) (2009). *The Heart and Soul of Change* (2nd Ed.). Washington, D.C.: APA Press.

What Works in Therapy

Consumers:	Clinicians:	Payers:
Individualized care	Professional autonomy	Accountability
Needs met in the most effective and efficient manner possible (value-based purchasing)	Ability to tailor treatment to the individual client(s) and local norms	Efficient use of resources
Ability to make an informed choice regarding treatment providers	Elimination of invasive authorization and oversight procedures	Better relationships with providers and decreased management costs
A continuum of possibilities for meeting care needs	Paperwork and standards that facilitate rather than impede clinical work	Documented return on investment

FIT Fits

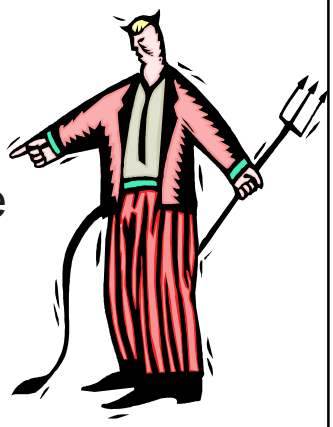
•In the Task Force's recent report (APA, 2006), the following definition for EBPP was set forth: "Evidence-based practice in psychology (EBPP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (p. 273; emphasis included in the original text). Regarding the phrase "clinical expertise" in this definition, the Task Force expounded the following (APA, 2006; p. 276-277).

•Clinical expertise also entails the monitoring of patient progress (and of changes in the patient's circumstances—e.g.,job loss, major illness) that may suggest the need to adjust the treatment (Lambert, Bergin, & Garfield,2004a). If progress is not proceeding adequately, the psychologist alters or addresses problematic aspects of the treatment (e.g., problems in the therapeutic relationship or in the implementation of the goals of the treatment) as appropriate.

Presidential task force on evidence-based practice. (2006). Evidence-based practice in psychology. *American Psychologist, 61*(4), 271-285.

Feedback Informed Treatment

"The devil is in the details…"



Three Steps for becoming FIT:

1. *Create a "Culture of feedback";*
2. *Integrate alliance and outcome feedback into clinical care;*
3. *Learn to "fail successfully."*

Step One:

Creating a "Culture of Feedback"

Outcome Rating Scale (ORS)

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

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.

- When scheduling a first appointment, provide a rationale for seeking client feedback regarding outcome:
  - *Work a little differently;*
  - *If we are going to be helpful should see signs sooner rather than later;*
  - *If our work helps, can continue as long as you like;*
  - *If our work is not helpful, we'll seek consultation (at week 3 or 4), and consider a referral (within no later than 8 to 10 weeks).*

The Outcome Rating Scale (ORS):
Seeking Feedback about Progress

- *Give at the beginning of the visit;*
- *Client places a hash mark on the line.*
- *Each line 10 cm (100 mm) in length.*

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

- *Scored to the nearest millimeter.*
- *Add the four scales together for the total score.*

Child Outcome Rating Scale (CORS)

Name _____Age (Yrs):____
Sex: M / F_____
Session # _____ Date: _____

How are you doing? How are things going in your life? Please make a mark on the scale to let us know. The closer to the smiley face, the better things are. The closer to the frowny face, things are not so good.

Me
(How am I doing?)

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

Family
(How are things in my family?)

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

School
(How am I doing at school?)

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

Everything
(How is everything going?)

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

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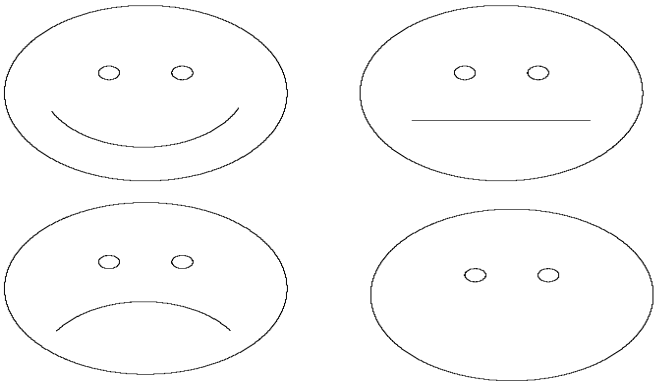
Young Child Outcome Rating Scale (YCORS)

Name _____Age (Yrs):____
Sex: M / F_____
Session # ____ Date: _____

Choose one of the faces that show how things are going for you. Or, you can draw one below that is just right for you.



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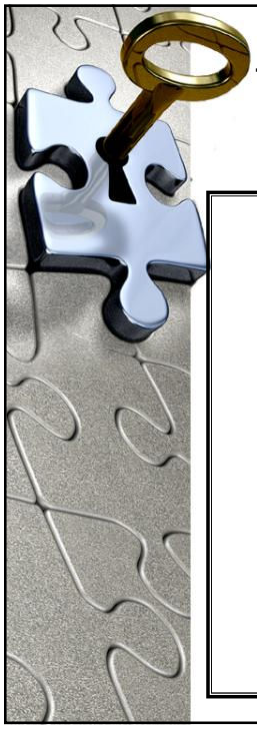
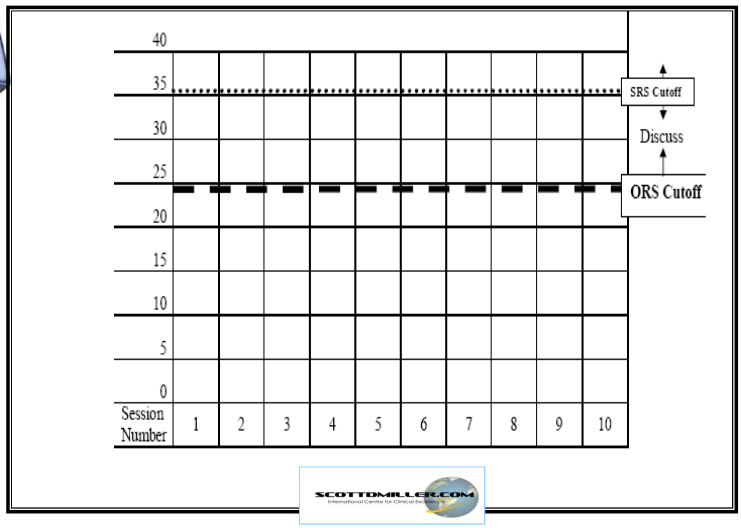


The Outcome Rating Scale (ORS):
Seeking Feedback about Progress



Step One:

Creating a "Culture of Feedback"

Outcome Rating Scale (ORS)

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

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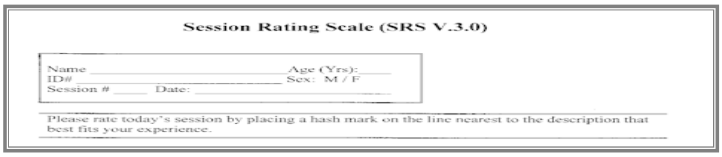
  - *If we are going to be helpful should see signs sooner rather than later;*
  - *If our work helps, can continue as long as you like;*
  - *If our work is not helpful, we'll seek consultation (session 3 or 4), and consider a referral (within no later than 8 to 10 visits).*

Step One:

Creating a "Culture of Feedback"



Session Rating Scale (SRS V.3.0)

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

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

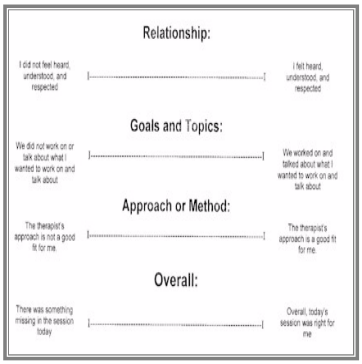
- When scheduling a first appointment, provide a rationale for seeking client feedback regarding the alliance.
  - *Work a little differently;*
  - *Want to make sure that you are getting what you need;*
  - *Take the "temperature" at the end of each visit;*
  - *Feedback is critical to success.*
- Restate the rationale at the beginning of the first session and prior to administering the scale.

Seeking Feedback about the "working relationship"

Session Rating Scale (SRS V.3.0)

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

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



- *Give at the end of visit;*
- *Each line 10 cm in length;*
- *Score in cm to the nearest mm;*
- *Discuss with client anytime total score decreases or falls below 36.*

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Child Session Rating Scale (CSRS)

Name _____Age (Yrs):____
Sex: M / F
Session # ____ Date: _____

How was our time together today? Please put a mark on the lines below to let us know if how you feel.

Listening

_____ did not always listen to me. — I---I — _____ listened to me.

How Important

What we did and talked about was not really that important to me. — I---I — What we did and talked about were important to me.

What We Did

I did not like what we did today. — I---I — I liked what we did today

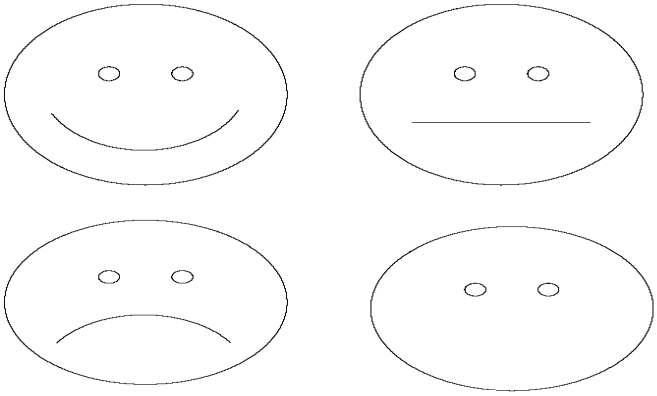
Overall

I wish we could do something different. — I---I — I hope we do the same kind of things next time.

Young Child Session Rating Scale (YCSRS)

Name _____Age (Yrs):____
Sex: M / F_____
Session # ____ Date: _____

Choose one of the faces that shows how it was for you to be here today. Or, you can draw one below that is just right for you.



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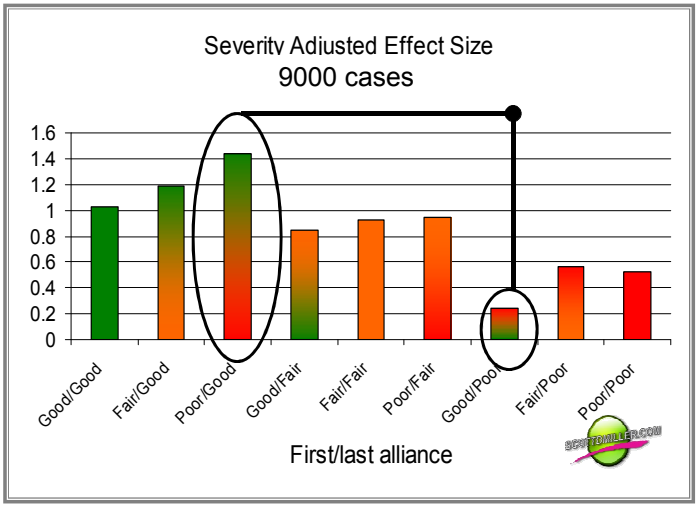
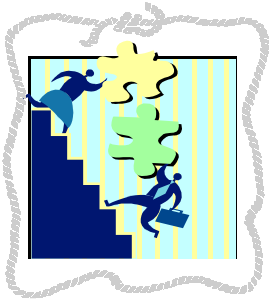
Supercharging the "Culture of Feedback"



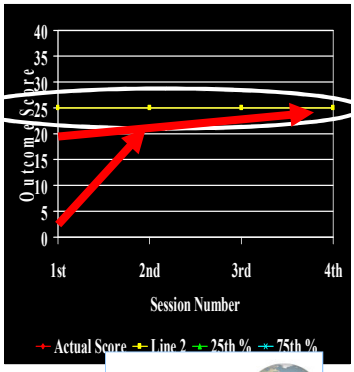
Step Two:
Becoming FIT

Integrating Feedback into Care



Step Two:
Integrating Feedback into Care

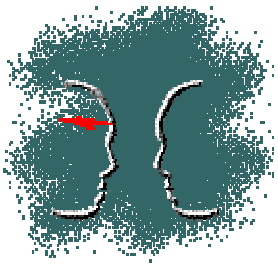
- The dividing line between a clinical and "non-clinical" population (25; Adol. 28; kids 30).
- Basic Facts:
  - *Between 25-33% of clients score in the "non-clinical" range.*
  - *Clients scoring in the non-clinical range tend to get worse with treatment.*
- The slope of change decreases as clients approach the cutoff.



Step Two:

Using the "Clinical Cut-off" to Inform Care

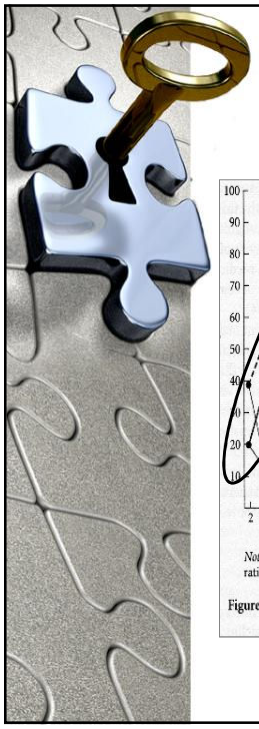
- Because people scoring above the clinical cutoff tend to get *worse* with treatment:
  - *Explore why the client decided to enter therapy.*
  - *Use the referral source's rating as the outcome score.*
  - *Avoid exploratory or "depth-oriented" techniques.*
  - *Use strength-based or focus on circumscribed problems in a problem-solving manner.*



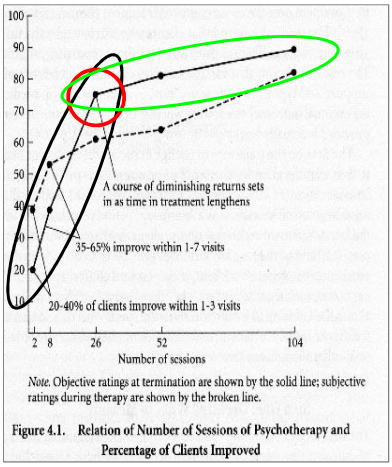
Step Two:

Becoming FIT

Integrating Feedback into Ongoing Care



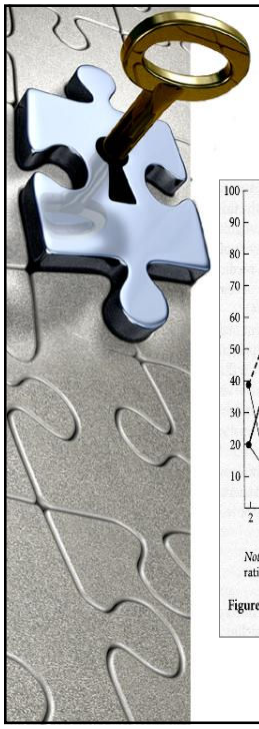
Step Two:
Integrating Feedback into Care



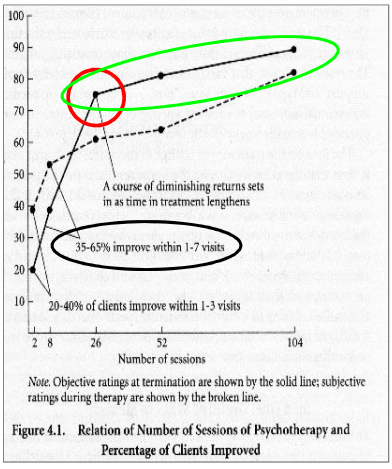
Note. Objective ratings at termination are shown by the solid line; subjective ratings during therapy are shown by the broken line.

Figure 4.1. Relation of Number of Sessions of Psychotherapy and Percentage of Clients Improved

- Do not change the dose or intensity when the slope of change is steep.
- Decrease dose or intensity as the rate of change lessens.
- See clients as long as there is meaningful change & they desire to continue.



Step Two:
Integrating Feedback into Care



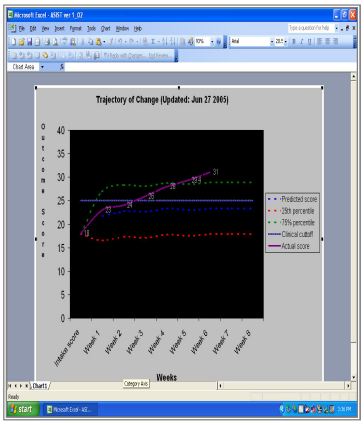
Note. Objective ratings at termination are shown by the solid line; subjective ratings during therapy are shown by the broken line.

Figure 4.1. Relation of Number of Sessions of Psychotherapy and Percentage of Clients Improved

- Consider changing the focus, type, dose or intensity when the slope of change is flat, uneven, or decreasing early in care.
- Consider changing the type or adding additional services if the slope of change is uneven or flat.
- Change the type, location, and provider of services.

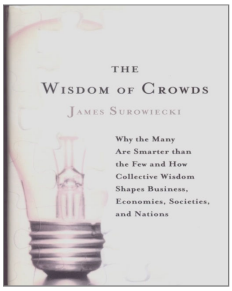
Step Two:
Integrating Feedback into Care

- Computer-generated "trajectories of change":
  - *Uses a normative database and linear regression to plot client-specific trajectories;*
  - *Depicts the amount of change in scores needed to be attributable to treatment.*



Step Two:
Integrating Feedback into Care

"Therapists typically are not cognizant of the trajectory of change of patients seen by therapists in general… That is to say, they have no way of comparing their treatment outcomes with those obtained by other therapists."



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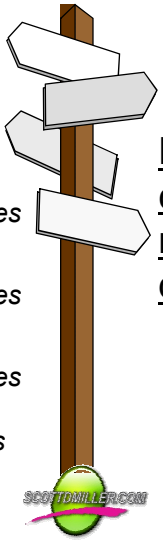
Wampold, B., & Brown, J. (2006). Estimating variability in outcomes attributable to therapists: A naturalistic study of outcomes in managed care. *Journal of Consulting and Clinical Psychology, 73* (5), 914-923.

Step Two:
Integrating Feedback into Care

- Happens on a weight judging competition:
  - People paid a small fee to enter a guess.
- In 1906, 85 year old British Scientist Sir Francis Galton attends a nearby county fair;
- Discovers that the average of all guesses was significantly closer than the winning guess!

Integrating Feedback into Care

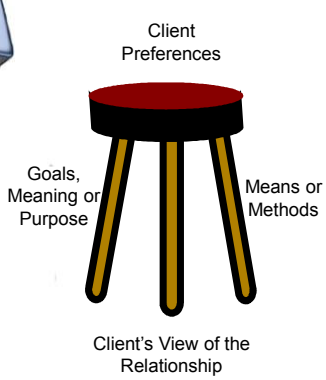
- Outcome of treatment varies d
- *ities*
- *ities*
- *ities*
- *offered.*



Directions for change when you need to change directions:

- What: 1%
- Where: 2-3%
- Who: 8-9%

Integrating Feedback into Care



1. *What does the person want?*
2. *Why now?*
3. *How will the person get there?*
4. *Where will the person do this?*
5. *When will this happen?*

Miller, S.D. et al. (2005). Making treatment count. *Psychotherapy in Australia, 11*, 42-61.

Integrating Feedback into Care

Collaborative Teaming & Feedback

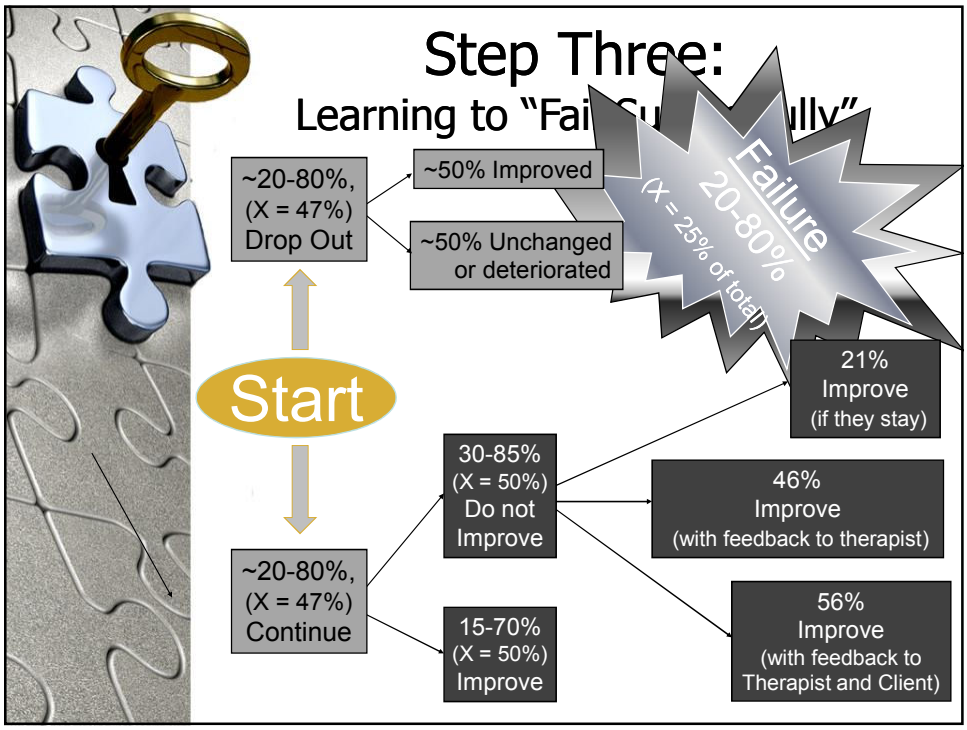
When?

- *At intake;*
- *"Stuck cases" day;*

How?

- *Client and/or Therapist peers observe "live" session;*
- *Each reflects individual understanding of the alliance sought by the client.*
- *Client feedback about reflections used to shape or reshape service delivery plan.*


Step Three:
Becoming FIT
Learning to Fail Successfully


Step Three:
Learning to "Fai
ully"
~20-80%, (X = 47%) Drop Out
~50% Improved
~50% Unchanged or deteriorated
Failure 20-80% (X = 25% of total)
Start
21% Improve (if they stay)
30-85% (X = 50%) Do not Improve
46% Improve (with feedback to therapist)
~20-80%, (X = 47%) Continue
15-70% (X = 50%) Improve
56% Improve (with feedback to Therapist and Client)


That's all folks!
LEON SCHLESINGER
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