Using Client Feedback to Inform Treatment

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Introduction

Feedback Informed Treatment (FIT) is a pantheoretical approach involving the routine and formal administration of empirically validated outcome and alliance measures to monitor client progress and therapeutic alliance in real-time. The benefits of Feedback Informed Treatment are well established. FIT has been linked to increased client retention, reduction of no show rates, increased client engagement in the therapeutic process, reduced length of stay and significant improvement in client outcomes (Miller & Schuckard, 2014). Routine monitoring of outcome and alliance scores offers therapists the opportunity to identify when their work with clients is effective, uncertain or ineffective. When client feedback indicates a lack of progress or problems with the therapeutic alliance, therapists have the opportunity to consider changing their approach to improve the likelihood of helping clients to make the progress that they desire. Understanding client progress based on the feedback obtained through the administration of outcome and alliance measures broadens the clinical utility of Feedback Informed Treatment and maximizes potential for positive therapy outcomes across a variety of treatment modalities and settings.

While obtaining and using client feedback to inform treatment decisions can lead to improved outcomes for individual clients, using summary or aggregate outcome data can inform therapist development strategies by pointing to strengths and areas for improvement. Targeting professional development and monitoring the impact of improvement strategies on clinician effectiveness in a process of "deliberate practice" can help therapists adapt their performance efforts as they reach towards improved clinical outcomes. This chapter will explore both how to

understand an individual client's progress based on outcome and alliance measurement scores and how to use summary outcome data to improve overall clinical outcomes.

Although many empirically validated outcome and alliance measures are available and could be used, two empirically validated measures of outcome and alliance commonly used by therapists who practice Feedback Informed Treatment are the Outcome Rating Scale (ORS) and the Session Rating Scale (SRS). Together the measures are known as the Partners for Change Outcome Management System (PCOMS). The ORS and SRS are brief, with only four visual analog scale questions per measure; both take less than a minute to complete and score. This makes them feasible for administration at each therapy session. Adult, child and young child versions, as well as a version for use in group therapy are available. Several computerized systems have been developed for ease of administration, tracking client scores and provision of summary or aggregated outcome data for individual therapists and also for agencies. In addition, the measures have been translated into over 19 different languages and a script is available for oral administration of the measures when literacy is an issue or clients feel uncomfortable with paper or computer versions. The simplicity and versatility of the PCOMS makes them an ideal option for use in Feedback Informed Treatment. For these reasons, the chapter (like many others in this volume) will focus primarily on the administration and interpretation of the PCOMS in understanding client progress and using summary data in professional development planning.

Understanding client progress: *Generating useful feedback*

Have you ever been asked to complete a survey or provide feedback about a service? If so, have you either not bothered to complete it or minimized negative feedback? A common concern of therapists as they consider adopting Feedback Informed Treatment is whether clients will be forthright in providing honest and useful feedback. Creating an environment, or

"culture", that is conducive to eliciting honest and useful client feedback is the first step towards understanding clients' progress (also see Prescott, this volume). The more accurate picture a therapist has of a client's experience both outside and inside the therapy room, the better chance the therapist has of knowing if the work they are doing with clients is helping. Yet, as Duncan, Miller, and Hubble note in their article "*How being bad can make you better*" (2007) "… the disparity in power between therapist and client, combined with any socioeconomic, ethnic, or racial differences, can make it difficult for our clients to tell us we're on the wrong track." *(p.42).* Think about the last time you told your dentist, doctor or lawyer that he or she was off base. Would you be transparent with your experience or thoughts? If not, why? Likely, a client wouldn't be transparent with their therapist for similar reasons, a true 'culture of feedback' isn't easy to obtain. Therapists need to work at developing a transparent and trusting relationship from their clients' point of view and must be sensitive to, and accommodate for, clients varying levels of comfort in providing feedback. Understanding why you are doing something can make it easier to get on board with it. Providing a rationale to clients about why their honest feedback is important in helping them to achieve their goals opens the door for eliciting honest and useful feedback. Reminding clients that therapy is intended to help them feel better and assuring them that their feedback is the only way to help tailor services accurately to better address and meet their needs if things aren't working, sets the stage for a culture of feedback.

If clients sense that their therapist is uncomfortable with feedback it is likely to impact the amount and type of feedback clients provide and they will not open up about their experience of therapy. By demonstrating comfort with receiving feedback, therapists can open the door for clients to provide honest and useful feedback about their experience of therapy. Therapists must manage countertransference and should be transparent with clients, letting their clients know that no offence will be taken by negative feedback. Demonstrating openness to feedback over time

will contribute to clients feeling safe to share their thoughts and feelings about the therapy. Oftentimes reminding clients that feedback won't be taken personally and that even the smallest things that may seem trivial are important to talk openly about can help to facilitate comfort in providing feedback.

After years of Feedback Informed Treatment implementation, therapists have identified many reasons for discomfort in obtaining feedback. For example, some therapists fear that low alliance scores could threaten their job security while others are afraid of how they will react to receiving negative feedback; some are even afraid that the act of administering outcome and alliance measures could interfere with the therapeutic alliance. These types of worries can get in the way of therapists working diligently to create a culture of feedback and can prevent them from being open to receiving feedback. Therapists who are seeking to create a true culture of feedback should reflect on their own feelings and reactions to feedback, both positive and negative. When natural human responses to feedback emerge, transparency models normalcy and can increase connectedness within the therapeutic relationship. If a person would normally react to the feedback and the therapist doesn't, it could create doubt or mistrust from the client's point of view. The balance in this strategy is to be transparent, while also presenting the response in a manner that clearly demonstrates the initial response is resolvable. Seeking clinical supervision and support can be helpful in this process as well.

As therapists work hard to create a safe environment and work to manage their experiences with eliciting feedback from our clients, they must also focus on obtaining valuable and useful feedback. Asking the right questions is likely to elicit feedback that can be acted on. Task focused questions can reduce the chances of clients providing vague evaluative feedback and help to generate specific feedback that can be acted upon. For example, rather than asking: "how was the session for you today?" (evaluative), the therapist could ask: "Did we talk about

the right topics today?" or "What was the least helpful thing that happened today?" or "Did my questions make sense to you?" (task specific).

Understanding Client Progress: *The Clinical cut-off*

In addition to creating a culture of feedback, monitoring client feedback about their views on progress and the therapeutic alliance using empirically validated measures such as the Outcome Rating Scale (ORS) and the Session Rating Scale (SRS) provides an unbiased means of understanding client progress. Typically, outcome measures assess clients' subjective experience of distress. Measuring client distress at the start of treatment provides a baseline to compare subsequent outcome measurement scores to and allows therapists to see if change is happening as therapy progresses. The clinical cutoff for an outcome measure is the dividing line between the clinical and non-clinical range of client functioning (Miller & Duncan, 2004). Understanding the implications of the clinical cut off can inform therapists about strategies that might be appropriate based on how clients see themselves functioning. The clinical cut-off score for the adult version of the ORS is 25, for adolescents it is 28 and for children it is 32.

While the average intake score on the ORS for mental health outpatient clients is 19 (Bertolino & Miller, 2013; Miller & Duncan, 2004; Miller, Duncan, Brown, Sparks, & Claud, 2003), approximately one quarter to one third of clients have an ORS score that falls above the clinical cut off at initial contact. Studies of change trajectories on the ORS indicate that clients with high initial scores on the ORS tend to have scores that drop over time when they receive therapy treatment. Therefore, caution should be taken in proceeding with treatment in these cases (Miller & Duncan, 2004). Miller and Duncan (2004) suggest that in the case that initial scores are above cut off the first step should be to explore why the client is seeking help. If the client is mandated, it may be appropriate to have the referrer provide a collateral rating or to have the

client complete the measure based on how the client thinks the referrer perceives that the client is doing. If the client is generally not in distress but has one specific problem they want to deal with, taking a problem-solving approach targeting the issue that the client is concerned about would be appropriate (Bertolino & Miller, 2013).

First Session data: ***Intake scores on outcome measures and probable rates of change***

Obtaining an accurate measure of client functioning at the start of therapy can also inform treatment planning. Administering outcome measures at intake provides a baseline score that provides a reference point for comparison to future scores. This helps therapists know if their work with clients is effective. Numerous studies have found that the majority of clients experience change early in therapy, often within the first six visits. (Baldwin, Berkeljon, Atkins, Olsen, & Nielsen, 2009; Howard, Kopta, Krause, & Orlinsky, 1986). Some of these studies have shown that about 15% of clients experience improvement in the time between intake the first appointment (Howard et al., 1986) prompting some agencies to implement a verbal rating script at the time of scheduling an appointment. When clients don't experience early change they tend to either drop out or continue without progress over the course of therapy. (Duncan & Miller, 2008)

Client intake scores provide a measure of the level of distress that clients are experiencing at intake. This, along with clients' explanation for their scores provide valuable information to inform treatment planning.

In 2004, Miller and colleagues developed a set of algorithms using scores obtained from a large, diverse client population. These algorithms are capable of producing expected treatment responses (ETR) based on client intake scores on the ORS. According to these expected treatment responses, if clients indicate they have a high level of distress at the beginning of

therapy (low scores on the ORS), earlier and greater amounts of change can be expected. On the other hand, if client intake scores on the ORS are closer to the clinical cut-off clients tend not to experience as much or as rapid change as clients who have very low initial ORS scores. When initial scores on the ORS fall above the clinical cut-off, the slope of change tends to be flat or downward, indicating that change is very slow or non-existent and clients may even experience getting worse over the course of therapy. The higher the initial ORS score, the more down ward the slope becomes.

Understanding the probable change trajectories based on intake scores can be used to guide initial therapy decisions. For example, to maximize potential benefit of services, clients who are experiencing high levels of distress at intake and are likely to realize rapid change early in treatment could be seen immediately and given intense treatment early on, while clients who indicate that their distress level is lower may be coping with their distress and it may be appropriate to wait list them with the plan to see them over an extended period of time.

Using second session and subsequent outcome measurement scores to guide treatment decisions:

After the initial session, observing the changes on outcome measure scores from session to session offers a guide for therapists to base their treatment decisions on over the course of treatment. For example, when change is moving rapidly upward, increased intensity of treatment may be indicated to support and reinforce positive change. When scores are leveling off after a period of improvement, less intense treatment and spacing of sessions to consolidate change may be the best route. When the slope of change is flat, or downward, in other words no change is apparent, therapists might consider changing the type of treatment, adding some additional services or if that doesn't work to get things moving upward, consider referring to a different

service provider. The question is often asked "If a client reaches the clinical cut off, does that mean I should end treatment with them?" Although on the surface this may seem logical, the clinical cutoff score is only one data point in the therapeutic process to inform the therapist. It does not provide an objective data point to initiate termination. In fact, normative samples show that many clients who start with very low ORS scores may never actually reach the clinical cut off, even if they are ready to end treatment.

Extremely low scores on the ORS (scores indicating very high levels of distress) should alert therapists to potential for self-harm, suicide, harm to others or substance abuse. Although this is something a therapist must always be attuned to, when high levels of distress are indicated by extremely low ORS scores, it is imperative that the therapist seek to understand the client's meaning behind the scores to assess for potential or acute risk factors that may be present and need to be attended to urgently.

Understanding Client Progress: ***The Alliance cut-off at initial contact and over the course of treatment***

The therapeutic alliance consists of agreement on the goals, meaning and purpose of therapy, agreement on means or methods used in therapy and the client's view of the relationship with their therapist. The therapeutic alliance is a robust predictor of outcomes (Norcross, 2009). Clients' ratings of the alliance early in treatment have been found to be "significant predictors of final treatment outcome" (Bachelor & Horvath, 1999). Being alert to and addressing any hint of problems related to the therapeutic alliance increases chances of engaging clients in treatment which ultimately increases opportunities for achieving positive outcomes. The alliance cut off provides a guide for therapists about the strength of the alliance from the perspective of the client. Generally, clients tend to score all alliance measures highly. Indeed, approximately 75% of clients score the SRS above 36. Therefore, the alliance cut-off for the SRS is 36 and any score

of 36 or less on the SRS is a signal for potential concern. Scores falling below 36 or below 9 out of 10 on any one of the 4 scales of the SRS should alert the therapist to check in with their clients to determine the meaning of the low score. Keep in mind that a high rating is a good thing, but it doesn't always reveal issues with the alliance. Even a perfect score on an alliance measure warrants checking in with the client. After the first score is obtained, a drop of even a single point on the SRS is associated with increased risk of drop out and null or negative treatment outcomes (Miller & Duncan, 2004). On the other, hand low initial scores on the SRS that increase over time are associated with a strengthening alliance and positive treatment outcomes. Thus monitoring the alliance in real time is just as important as monitoring progress via outcome measurement.

Understanding Client Progress: *Reliable change and change trajectories*

Indices on outcome measures can also help therapists understand client progress. For example the Reliable Change Index (RCI) on outcome measures indicates if change can be reliably attributed to the work being done in therapy rather than as the result of chance, maturation or statistical error. Determining the RCI for an outcome measure and then comparing client outcome scores to the RCI provides therapists with insight into whether their work is having an impact or not. The RCI for the ORS for example, is 5 points of change (Miller & Duncan, 2004). Therefore, scores that increase by 5 points or more on the ORS indicate that change can be reliably attributed to therapy. Scores which increase by 4 points or less on the ORS may still indicate change, but cannot reliably be attributed to the therapeutic intervention.

Change trajectories

Being familiar with the RCI and routinely administrating and tracking changes on outcome and alliance measures provides insights into the course of change that is taking place

over time. Keeping a watchful eye on trajectories of change and understanding the implications of various change patterns and trajectories can assist clinicians in knowing when it is appropriate to adjust treatment strategies or maintain the approach being used.

Typically, if therapy is going to be successful, change will occur sooner rather than later with the majority of change occurring within the first few sessions. (Baldwin et al., 2009; Howard et al., 1986). Furthermore, the client's subjective experience of change early in the treatment process has been shown to be predictive of treatment outcomes (Howard, Lueger, Maling, & Martinovich, 1993; Mille, Duncan, Brown, Sorrell, & Chalk, 2006). It makes sense that experiencing benefits from treatment early on would increase hope that therapy will be beneficial and in turn would increase commitment and engagement in the therapeutic process and reduce the likelihood of clients leaving therapy prematurely.

Therefore, in general, clinicians should watch for change trajectories that demonstrate a lessening of distress. Therapists who don't pay attention to a lack of change and make adjustments in real time when little or no change is evident or clients are getting worse risk increased client drop outs or continuing service provision with an absence of change (Miller & Duncan, 2004). By reviewing all cases showing deterioration (increased distress) or underperforming (no change in distress levels) in the first 3 to 4 sessions, therapists can catch problems early on in the process. By working with the client, their team and their supervisor they can generate ideas about adjusting the approach to increase treatment adherence and change opportunities. If no change, minimal change, or deterioration is evident by the 6th or 7th session, serious consideration should be given to adjusting the approach. This may include changing the frequency and or intensity of services or the addition of other elements. By weeks 8 to 10, if positive change is still not happening it is advised to then explore a referral to another provider, treatment type, or setting (Bertolino & Miller, 2013). In a famous quote, generally attributed to

Albert Einstein, "doing the same thing over and over and expecting different results is the definition of *insanity*." Clients seek therapy to diminish distress and improve functioning. If this is not occurring and therapists keep implementing the same intervention and expecting different results they may be operating in terms of Einstein's "insanity".

Understanding Client Progress: Tracking change

Tracking ORS and SRS scores on a graph can certainly be done with pen and paper. However, for increased ease and data tracking, there are several computerized systems available to therapists that allow electronic administration of outcome and alliance measures (.www.scottdmiller.com/fit-software-tools/). Some of these systems also automatically score the measures, plot the scores on a graph and compare client scores to an expected treatment response (ETR) established through administration of the measures to large normative sample populations. Not only do such systems simplify the process of outcome and alliance measurement into practice by reducing work for therapists, they also and provide an easy way to compare client progress to the change of the median client in normative samples. In addition, they provide an efficient means for therapists to target cases for supervision and provide concrete, objective information to review and process in supervision. Analysis of data gathered through the administration of the ORS and SRS to thousands of clients reveals several common patterns of change. Being able to identify these patterns can assist therapists in knowing when to change course. What follows is a description of several commonly identified patterns of change and suggested strategies should these emerge.

Understanding Client Progress: *Looking for patterns of change*

Bleeding*:* A typical "bleeding" pattern of change is when outcome scores indicate that distress levels are steadily increasing (scores on the ORS are getting lower) despite therapeutic

intervention (Bertolino & Miller, 2013). When a bleeding pattern of change occurs therapists should monitor change closely. If there is no improvement within a couple of sessions, therapists should consider changes to the approach they are using. Since the alliance is so important to outcome, when the bleeding pattern emerges it is recommended to explore the various aspects of the alliance in more detail with the client to determine if the approach meets with client preferences.

Dipping: Sometimes client scores on outcome measures will increase which indicates that steady progress (*diminishing distress*) is occurring then suddenly there is a rapid drop or dip in the scores suggesting a rapid onset of distress. Typically this type of "dipping" is associated with extra-therapeutic influences that are temporary in nature and will resolve quickly once the event, situation or influence has been resolved. If a rapid increase in distress occurs it is best practice to check in with the client about the change, and then monitor closely to ensure resolution occurs. It may also be worthwhile reminding the client about completing outcome measures based on how they have been doing overall since last session rather than focusing on how they are doing today.

See Sawing or fluctuating scores: See sawing or scores that fluctuate up and down indicating rapid cycling between high and low levels of distress are another pattern of change that warrants attention from therapists. Cycling up and down may be a reflection of a client's sense of instability in their life or it may be because clients are scoring the measures based on how they are feeling at the time they complete the measure rather than as an average of how they have been doing since the last session. Therefore, when this type of up and down pattern of change occurs, therapists should check with their clients about how they are completing the measures ensuring clients understand that the outcome measure is intended to measure how they have been doing since the last session not just how they are feeling today. On the other hand, if

the scores are a representation of a client's sense of instability, then treatment approaches can be tailored to assist clients in regaining a sense of stability. (Bertolino & Miller, 2013).

Plateauing scores: When clients have made progress and functioning has improved, outcome scores will often plateau with very little change occurring session to session. When scores plateau, consolidating and maintenance strategies to maintain change is key as is planning for termination of services. If clients are seen too frequently during this time, see sawing scores can emerge as clients begin to oscillate through the normal ups and downs of life. Spreading out sessions can help with this. (Bertolino & Miller, 2013).

Understanding Client Progress: Alliance trajectories

As mentioned earlier in this chapter, monitoring changes in alliance measures scores can help therapists identify potential issues with the therapeutic alliance. Recall that fewer than 24% of clients provide a score on the SRS that is lower than 36 (Miller & Duncan, 2004). Studies indicate that low alliance scores that improve are predictive of positive treatment outcomes while alliance scores that start high and deteriorate over time are associated with negative outcomes (Miller, Duncan, & Hubble, 2007). Indeed each drop increases the likelihood of a negative outcome. Even minor downward changes in alliance scores increase this risk. Large drops in SRS scores for example, indicate that the therapist has gone off track and is not aligned with the client's preferences for treatment, or the client is not engaged in the process. On the other hand, high SRS scores do not necessarily tell us much because there is always a chance that a client is not being forthcoming with negative feedback. Either way, working at creating a culture of feedback early on and striving to maintain this culture is important to gaining insight into what adjustments, if any, could increase client engagement and improve therapists' alignment with

clients. When scores on the SRS indicate that the therapist has gone off track, taking time to explore each sub-scale on the measure more closely with the client is recommended.

Understanding Client Progress: Correlation of outcome and alliance trajectories:

Tracking both outcome and alliance measures together is important because both the alliance and the client's experience of change influence outcome of treatment. As Miller and colleagues note in their 2007 article, "Clients usually drop out of therapy for two reasons: the therapy isn't helping (thus, the need to monitor outcome) or the alliance, the fit between the therapist and client, is problematic. This isn't rocket science. Clients who don't feel they're making progress or feel turned off by their therapist leave. Accordingly, the most direct way to improve effectiveness is keep people engaged in therapy." (.p.6)

Even if alliance scores are high, if clients are not experiencing change, the risk of drop out or provision of ongoing ineffective treatment is high so it makes sense to adjust the approach. If alliance scores remain low but outcome scores are improving, maintaining the approach being used makes sense. Considering both outcome and alliance scores together also helps to predict problems in progress. For example, often when alliance scores drop, outcome scores will commonly drop at the next session or clients will drop out.

Most likely time for drop outs:

Studies have shown that the modal number of sessions that clients attend is one, indicating that many clients do not return after the first session (Connolly Gibbons et. al., 2011). Dropout rates are nearly 50% in adult therapy and even higher for children and adolescents (Garcia & Weisz, 2002; Kazdin, 1996; Lambert et. al, 2004; Wierzbicki & Pekarik, 1993). In a webinar series on Feedback Informed treatment, Scott Miller says that drop outs after the first

session are commonly the result of alliance issues. This speaks to the imperativeness to solicit feedback regarding the client's experience before they leave at the end of their first session. Miller notes that the third and seventh sessions are also common times for unplanned termination of service by clients. He suggests that when clients leave after the third session may be because: 1. they experience improvements and believe things are resolved; 2. they have not experienced any improvement or have not been totally satisfied with the service despite giving it a second chance. In the first case, therapists should make clients aware of the potential dangers of leaving therapy too soon and adjust the dose and intensity of treatment in relation to the clients experience of diminished distress (i.e. reduce frequency and intensity of service); in the second case, they should explore potential alliance issues carefully and consider adjusting their approach.

Miller says the reasons for clients leaving therapy at the seventh session are similar; that is, their distress has subsided or they may have given up hope that therapy will help after not experiencing change. If there has been positive change, suggesting spreading out sessions a to consolidate change is advisable while if no significant change has been realized by session 7 other treatment options should be presented to the client so they do not give up hope. (Miller & Maeschalck, 2015)

Application of Outcome and alliance measures in specific treatment modalities:

Outcome and alliance measurement is not restricted to one-to-one therapy sessions. Such measurement is equally valuable in a variety of treatment modalities including group work, family and couple work and work with children and youth. Each of these treatment modalities requires some unique applications of Feedback Informed Treatment work. Although perhaps more complex, the benefits of applying outcome and alliance feedback in these modalities have been demonstrated to be worthwhile in terms of improvement of outcomes. It allows the

therapists to structurally elicit the experiences and expectations from each of the applicable clients (Bertolino & Miller, 2013).

Outcome and alliance measurement in groups:

Outcome measures are always used as an individual measure of client progress. Therefore, even in group settings outcome measures need to be completed by each individual in the group based on their own experience of well-being. On the other hand, the therapeutic alliance in group work is more complex because client experience depends not only on the group facilitator but also on their interactions with the other clients in the group. Alliance measures such as the Group Session Rating Scale (GSRS) (Duncan & Miller, 2008) are designed to assess the client's experience in the group. In a large, multisite, international study, researchers Quirk, Miller, Duncan, and Owen (2012) found that the GSRS is reliable and valid as well as capable of predicting early treatment response – an important determinant of engagement and outcome. Rather than asking clients to rate their experience of working with the clinician, the GSRS asks clients to rate their experience of working with both the group facilitator and the group members. The GSRS not only provides information about the alliance between the individual client and group facilitator but also several additional variables associated with effective group treatment: (1) the quality of the relationship among group members; (2) group cohesiveness; and (3) group climate.

Administration of the ORS and GSRS in group presents some challenges to the group facilitator because they are dealing with sometimes 8 or more people all at once. So, how can the group facilitator handle this? Instructions on how to complete and score the measures can be covered during the initial group session or at an intake or screening session. Distributing a clip board with the measures and graph, a pen and a ruler attached (or tablets if using a computerized

system) to each group member so that they can complete, score and plot their own measures during the group session can assist the group facilitator in administering the instruments. As within an individual session, the ORS is completed at the beginning of the group. The group facilitator can ask who's scores have gone up, stayed the same or gone down and generate discussion about what happened to influence change or no change.

Near the end of the group, members can complete, score and plot their GSRS score on a graph. The facilitator can ask who had scores drop since the last group session, who had scores that fell below a total of 36 or had a score of 9 or lower on any domain scale on the GSRS. The facilitator can then encourage discussion about the reasons for the lower scores. Sometimes clients won't feel comfortable discussing their scores in a group setting. If after encouraging discussion during the group, the facilitator senses this, they should follow up by talking to the client privately outside of group. This should be done in a timely manner, preferably right after the group session ends, so that the group facilitator can address any concerns the client may have immediately.

Another challenge of group administration of the measures is when there are multiple services and or providers. In this case there is a danger of over administration of outcome measures. When this happens clients can start to score the measures based on their day to day functioning rather than how they have been doing over time or they can experience "measurement fatigue". For this reason all involved service providers should coordinate about who will administer outcome and alliance measures, how often they will be administered and what the process will be for sharing and acting on client feedback.

Outcome and alliance measurement in couple work:

Use of outcome and alliance measurement in couple work can yield great opportunities to inform and enrich the process of the work. FIT in couple's therapy work involves administering outcome and alliance measures to each partner to elicit information about each partner's progress and experience of couples' therapy. Sometimes outcome and alliance measures will reveal differences between the partners in how they are doing and how they feel that the therapy is meeting their needs. Highlighting discrepancies or disagreements between each partner's perception of how they are doing and how therapy is meeting their needs provides opportunities for the therapist to open up communication by couples so that they can develop a deeper understanding of each other.

In couples work, the ORS is administered to each partner at the start of each session and the SRS is administered to each partner at the end of each session, just as in one to one sessions. Like in other administrations, when introducing the measures to couples, it is just as important to provide a rationale and lay the ground work for developing a culture of feedback. Clients can be taught to score and graph their own measures. Another option, in addition to charting each partner's progress on their own graph, is to plot each partner's scores on a mutual graph. This provides a clear visual comparison of where each partner is in terms of their progress and their perception of how well the therapy is meeting their needs. Each partner's scores can be discussed with them and differences in scores between them can also be addressed. In addition to the benefit identified above where these discrepancies can improve understanding between partners, it can also help the clinician understand the partner's differing positions and perceptions.

One of the biggest challenges in couples work is developing and maintaining a strong alliance with both partners, especially when their individual goals and ideas about how those goals would best be achieved differs. The SRS can be very valuable in informing the clinician

about a potential split alliance, that is, where one partner is experiencing that the therapy is beneficial and meeting their needs while the other partner is not. It can also help alert the therapist to perceived or real impartiality on their part. If this is detected it would indicate to the therapist this is a case to seek supervision.

Outcome and alliance measurement in family work:

Comparable to couples work, implementing FIT in family work offers opportunities for the therapist to develop a better understanding of each family member's perspective and how they are doing compared to the rest of the family.

Since children are involved in family work, it's important to use the appropriate measures for each family member, the adult measures for the adults and the child measures for children. Really young, pre-literate children can be engaged by having them complete the young child measures.

In family work the therapist must make a decision about which family member's ORS score should be used as a comparison point for measuring progress in treatment. Sometimes, when a family seeks help it's because the whole family is in distress. Other times, one family member is identified as having the problem and the rest of the family accompanies that person in the treatment intervention. When the whole family is in distress, each family member should be asked to complete a version of the ORS. For example, adults and adolescents could complete the ORS and children could complete the Child Outcome rating Scale CORS. In the case where one family member has been identified has having the problem that family member can be asked to fill in the outcome measure while other family members can be asked to provide a collateral rating. That is, they complete the outcome measure based on how they think the family member with the problem is doing. In either case, scores can be compared and differences discussed. All

scores can be documented on a comparison chart to give a visual of the difference in progress. Each family member can be asked for their ideas of what would need to happen to have either their own scores or their family members scores improve. At the end of family sessions, the Session Rating Scale (Child Session Rating Scale, Young Child Session Rating Scale) is completed by each family member to elicit feedback about each person's experience of the session. Just as in couples work, these scores and feedback are invaluable to both the family and therapist to develop a deeper understanding of each person's experience as well as identify any potential biases that may be affecting the therapist's objectivity. Again, if biases were detected it would be recommended to seek clinical supervision.

Outcome and alliance measurement with children and adolescents:

The goal of using Feedback Informed Treatment with children and adolescents is similar to use with adult clients: to ensure services are effective and to ensure the therapist is aligned with client preferences and that clients are engaged. Measures such as the Child Outcome Rating Scale and the Child Sessions Rating Scale have been designed for children with a grade 2 reading level or higher. The language is simplified and easier for children to understand. The measures have been validated for children 8-12 and adolescents 13-18 years of age. As mentioned earlier, the clinical cut off on the Outcome Rating Scale is 32 out of 40 for children aged 8-12 and 28 out of 40 for adolescents aged13-18. Perhaps these higher cut off scores reflect that young people have fewer life experiences and a more optimistic perspective than adults. The alliance cut off for children and adolescents on the Session Rating Scale is 36 out of 40, the same as it is for adults. As with adult clients, creating a culture of feedback in relationships with children and adolescents is important to eliciting useful feedback. The challenge for therapists here is overcoming the power differential between adults and young people. Therapists need to be diligent in their efforts to elicit open and honest sharing.

Due to literacy issues, outcome measurement it is not practical with very young children who cannot read how to complete measures such as the ORS/SRS or CORS and CSRS; however, tools have been adapted for this age group and can be used to help develop engagement. For example, the Young Child Outcome Rating Scale and the Young Child Rating Scale are designed so that young children can choose an expression on a "smiley face" or can draw how they feel on a blank face. Then therapists can use this as a springboard to discuss the child's experience of their well-being with them and determine their likes and dislikes about the therapeutic alliance with the goal of engaging them at a deeper level in the process of therapy.

Application of Feedback Informed Treatment in specific settings and populations:

Feedback Informed Treatment is being used by therapists in a variety of treatment settings and with a variety of client populations around the globe, as evidenced by the case study chapters in this volume. FIT is versatile but may require some adaptations depending on the type of setting and client population where FIT is applied. Following is an exploration of the application of FIT in a variety of settings and populations.

Agency Settings (multi-site provider and service settings):

One of the unique applications of Feedback Informed Treatment is in agency settings where there are multiple providers serving clients providing multiple services, sometimes at multiple sites. For example, in some urban centers an agency may have providers working in teams at various locations providing a variety of treatment modalities at each location. Unlike situations where there is a single service provider involved, the challenge in this type of agency is coordination. It must be determined who will administer the outcome and alliance measures and when they will be administered. As mentioned earlier, over administration of measures can lead to "measurement fatigue" or clients reporting day to day changes rather than changes that

occur over time. Then there must be structured communication between providers about the feedback gathered and how any changes will be decided. Timely sharing of information is essential given that a client may see more than one service provider and participate in more than one type of service within in a short time frame, sometimes even within the same day. For example, a client may attend a one-to-one therapy session with their therapist in the morning and then attend a group facilitated by a different therapist that afternoon. Finally, there must be coordination on how to implement any needed changes and a specific strategy to review and assure follow through. Since each agency is likely to have a unique set of circumstances, there is no "one size fits all" solution to this issue. Some agencies may have access to computerized systems for administration of outcome and alliance measures allowing easy access to client scores. Feedback on their progress and therapeutic alliances can be viewed in real time by any member of the care team on or off site. Other agencies may have no such system in place and will need to rely on paper charting and verbal communications. In either case agency administrators should develop and have practice guidelines in place that clearly layout a protocol for therapists to follow from administration of the measures to follow up assurance on implemented changes. For example, in the case where a client is attending one–to-one sessions and group therapy sessions, the practice guideline might direct the provider of one-to-one service to administer outcome and alliance measures once each week in their sessions and document conversations about progress and the alliance within the client's chart. Group facilitators might be directed to check records, have client outcome scores available for discussion during group and administer the Group Session Rating Scale regardless of whether an alliance measure was administered in one-to-one sessions because the alliance measures administered in group would be relevant to the experience of the service including alliance with the group facilitator and the rest of the group.

At a meta-level, unlike individual practitioners in a small or single service provider private practice, agencies have the opportunity to establish agency norms for their client's outcomes. Establishing agency norms provides a benchmark for therapists to compare their outcomes to and create professional development goals. In addition these norms can act as a reference point for evaluating the impact of program changes for quality improvement processes.

Residential and intensive treatment settings*:*

Application of Feedback Informed treatment in residential or intensive treatment settings where clients receive daily services presents similar challenges as the multi-site, multi-service and multi-provider agencies. Generally, clients in residential treatment settings participate in many therapeutic activities each day throughout the week. As in agency applications of FIT, in residential and intensive treatment settings, the issues of over administration of outcome and alliance measures, who will administer and track outcome alliance measurement, communicating feedback, implementation of decided changes and follow through tracking all present challenges. In residential and intensive treatment settings it is recommended to establish a practice of administering an outcome measure at the start of each week and an alliance measures at the end of each week. This reduces the risk of over administration and measurement fatigue (Bertolino & Miller, 2013). Clients can be instructed to rate their experience of the entire week or since the last administration of each measurement. Client feedback on outcome and alliance measures can then be shared and discussed with all of the service providers involved in the client's care. In these settings there may also be a combination of multiple groups and one-to-one services provided. It is important to consider the frequency of the administration of group alliance measures and strategize which group setting it may be most beneficial to collect feedback. For example, if a client participates in 2 skill building or psycho-educational groups and 1 group psychotherapy or processing group, it may be most valuable to administer the ORS and the

GSRS in the psychotherapy group and forego the measure in the skill building or psycho-educational groups.

Application of Feedback Informed Treatment with Substance Abuse and Mental Health populations:

What about using Feedback informed treatment with special populations such as with substance abuse clients and with clients suffering from mental illnesses? Differences in these populations are worthy of consideration when interpreting client progress and the therapeutic alliance. Miller, Duncan, Sorrell, & Brown, (2005) explored the differences between160 substance abuse clients and clients in a general mental health population. Three significant differences were found between the substance abuse clients and clients in the general mental health populations. First, the substance abuse clients tended to have less distress at intake than clients in the general mental health population with an average ORS intake score of 24.5 versus 19.6 for the general mental health population. Second, in general the trajectory of change for the substance abuse clients improved regardless of their intake scores whereas general mental health clients tended to get worse with treatment when their intake score on the ORS was above 25 (the clinical cutoff). Third, longer contact with the substance abuse clients resulted in better outcomes. On the other hand, general mental health clients experienced little or no gain after the first handful of visits**.** The study also found that clients, both voluntary and mandated, completing the substance abuse treatment program, averaged significantly more change than those who dropped out. The last two findings lend support to the importance of monitoring client progress and suggest that therapists who work with substance abuse clients should strive to engage, strengthen the therapeutic alliance, and sustain engagement with these clients for as long as possible to realize the most benefit from treatment. Again, careful monitoring of progress for both substance abuse

and mental health clients is essential to guide practice decisions and act when deterioration in functioning or in the therapeutic alliance is detected.

Application of Feedback Informed Treatment: *Mandated populations*

What about mandated versus voluntary clients? Miller et al. (2005) also looked at difference between (1) voluntary clients who completed the substance abuse treatment program successfully; (2) voluntary clients who ended treatment unsuccessfully; (3) mandated clients who completed the program successfully; and (4) mandated clients who ended unsuccessfully.

Successful cases were defined as those who completed the six-month substance abuse treatment program, maintained employment, and had no positive urine screens. They found that mandated clients who completed the program experienced more positive change in their outcome scores than mandated clients who did not successfully complete the treatment program. Furthermore the authors note that "Interestingly, … only the mandated clients who ended treatment unsuccessfully (e.g., dropout, positive urine screen result, termination from work) scored above the clinical cut-off at intake …This group was also the only one whose change scores did not significantly differ from intake to last recorded session" (p. 8).

You may recall earlier in discussion on administering the ORS that a mandated client may score themselves above the clinical cut off. There are many potential reasons for this. Here are a few possibilities:

- It may be too risky for a client to admit fault or acknowledge a problem area that has been identified by the referring professional due to potential consequence.
- The client may not agree with the reason for the referral or not see the referral reason as problematic.

- The client may not wish to make changes regarding the identified problem in the referral. For example, the client may be referred for an identified substance abuse problem, e.g. alcohol. The client may find benefit in engaging in alcohol consumption and may not be willing to make changes to the expectation of the referring professional, e.g., complete abstinence from consuming alcohol. It could be the client is willing and able to reduce alcohol consumption, but also needs to employ other non-maladaptive coping strategies for stressful situations. Thus, the expectation from the referring professional and the client are different with the client perceiving little or no flexibility. The client is then likely to appear unwilling to engage in the treatment process and less likely to identify low ORS scores.
- The client is distrustful of the system and anyone involved with the system. Therapists complete documentation and provide progress reports to referring professionals. Clients are aware of this and may be hesitant to fully endorse dysfunction within their lives.
- The client may be experiencing shame and it is embarrassing or too overwhelming to acknowledge or talk about problematic behavior.

The therapist should validate and normalize these possible fears. Asking mandated clients to complete the ORS based on how they think the referrer might score them and what changes they think the referrer would need the client to make in order to satisfy their concern can move the client from a defensive position toward problem solving. The problem becomes not what is wrong with the client rather what the client needs to do to alleviate the referrer's concern.

Again, just as discussed earlier, there are strategies to creating a safe culture of feedback for clients. Although there are dynamics that affect any client's perception of safety, the mandated client may have additional or magnified barriers which prevent honest feedback to therapists on

the SRS. As noted in the possible reasons for high ORS scores, many of these likely exist for mandated clients scoring the SRS high. Clients may fear consequences for being honest about a negative experience, they may distrust persons in authority or "the system", they may have a history of feeling unheard or invalidated, they may fear rejection when there is clearly a power differential. Indeed, therapists working with mandated clients may have multiple barriers in developing a safe feedback culture with these clients. It will be important to model transparency and genuineness as noted earlier.

One of the biggest challenges in working with mandated clients may be managing countertransference. Oftentimes clients in mandated treatment situations have made mistakes that make it easy for therapists to judge. For this reason, it will be important for therapists to engage in self-reflection and participate in clinical supervision to assist in managing this. When a therapist is in judgment toward a client, it will affect the therapist's ability to maintain genuineness. Clients will sense this and it will affect their perception of the therapeutic alliance. Utilizing the SRS with mandated clients is extremely beneficial to assure therapists are regularly asking about the client's experience. Earlier it was identified for therapists to ask "task specific" questions in trying to elicit valuable client feedback on the SRS. Therapists of mandated clients may need to be even more specific and ask about particular interactions within the session. For example, rather than asking the client, "Was there anything I said today that didn't sit well with you?" the therapist may say, "I noticed when I said (insert a specific comment here) you sat up straighter, I'm curious what you experienced when I said that?" Practicing these strategies consistently and role modeling will assist the therapist in building a strong therapeutic alliance.

Feedback Informed Treatment and Therapist Development:

Feedback Informed Treatment offers opportunities to improve client outcomes one client at a time by paying attention to client feedback and adjusting accordingly. Indeed, the results of using FIT are well documented in reduction of drop outs and improved outcomes (Miller & Schuckard, 2014). But, what is the impact on therapist development over time? One would think that by implementing FIT, over time therapists would begin to generalize the feedback they have received from clients and the learning that comes from that feedback to improve their outcomes overall. However, this just doesn't seem to be the case. (Shimokawa, Lambert, & Smart, 2010). Analysis of ORS data indicate that with 60 completed cases (minimum number needed to establish a baseline), there is about a 90% confidence rate in predicting future outcomes for a therapist. What this suggests is that once a baseline of therapist outcomes has been established, typically outcomes don't improve beyond this. Further evidence supporting this is studies that indicate that the average clinician's development process plateaus early in their careers (at about 5 years); and studies that indicate that training in "evidence-based," manualized therapies and client diagnosis don't have much impact on therapist outcome (Miller, 2013). Studies that examine the differences in therapists whose outcomes are superior to the average therapist give us clues as to what might be needed for therapists to reach beyond baseline performance.

Baldwin, Wampold, and Imel (2007) looked at the range of therapists with the best outcomes and therapists with the worst outcomes. They concluded that 97% of the difference in outcomes was attributable to variability in alliance while 0% of difference between therapist outcomes was attributable to client variability in the alliance. Implications of Baldwin's study on therapist development points to the importance of finding ways to help therapists connect with more clients by identifying clients they don't connect with and finding ways to improve the connection with these types of clients. Based on this study, therapists should monitor their contribution to the alliance, seek feedback about their alliances and receive training focused on

developing and maintaining strong alliances. Lending weight to the importance of monitoring data to improve outcomes,

ACORN collaborative (2013) looked at improvement in therapists' outcomes over a twelve month period. They found that the frequency in which therapists looked at their outcome data was directly correlated with improved outcomes over time. Therapists who did not review their outcome data or viewed it 50 times or less in a one year period showed deteriorated or no improvement in effects sizes. Therapists who viewed their data between 50 and 200 times over a year showed significant gains in their effect size. Those who viewed their data over 200 times in a year showed the most significant gains at more than double the gains made by therapists viewing their data 50-200 times in a year.

Further supporting this, a recent study conducted by Singaporean Psychologist, Daryl Chow and colleagues looked at how therapists spent their time outside of work (see Chow, this volume). Activities directly related to improving their work and the impact on their outcomes were examined. Chow found that therapists with the best outcomes spent 2.5-4.5 more hours outside of work reflecting on actions, consulting about cases, reading, learning, attending professional development activities, planning and so on outside of therapy sessions than the average therapists. Over an eight-year period outcomes for the top performing therapists grew by one-half of a standard deviation above the mean compared to the average clinician (Chow, D.L, et al, 2015).

Feedback Informed Treatment not only involves monitoring client feedback but using feedback for continuous professional development through a process of deliberate practice. Reaching beyond average therapist development requires a concerted effort on the part of the therapist. Deliberate practice involves monitoring client outcomes and collecting outcome data to

determine a baseline measure of therapist effectiveness. This allows therapists to compare their effectiveness to available norms, standards and benchmarks. By reflecting upon this comparison data, therapist can identify areas for improvement and strategies aimed at improving their outcomes. By executing these strategies and monitoring changes in their effectiveness over time, therapists can continually reach toward excellence in their work. Given the evidence of the importance of strong alliances in determining outcomes, therapist would be wise to focus their deliberate practice efforts on ways to strengthen and maintain alliances with diverse client populations.

Conclusion:

By considering and acting on what clients are reporting about their progress and about their experience of the alliance, therapists can improve the chances of a positive treatment outcome. Understanding how to interpret client feedback generated through the ongoing administration of outcome and alliance measures helps clinicians understand how clients are progressing and creates opportunities to intervene when clients are at risk of treatment failure. Feedback Informed Treatment is a flexible approach to achieving this goal. The ability to apply FIT with a variety of treatment modalities and in a variety of treatment settings means that therapists have the opportunity to improve client outcomes no matter where they work and no matter what population they serve. Feedback Informed Treatment is an important piece not only in improving outcomes but also in therapists' ongoing professional development and their journey towards excellence.

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