Feedback-Informed Treatment in Clinical Practice

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edited by D. S. Prescott, C. L. Maeschalck, and S. D. Miller
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Feedback-Informed Treatment in Clinical Practice

Reaching for Excellence

EDITED BY
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AMERICAN PSYCHOLOGICAL ASSOCIATION • *Washington, DC*

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Feedback-Informed Treatment in Clinical Practice

INTRODUCTION

DAVID S. PRESCOTT, SCOTT D. MILLER,
AND CYNTHIA L. MAESCHALCK

In a scenario with themes familiar to many, Eddie was 17,[1] had an extensive history of trauma, and was tentatively diagnosed on the autism spectrum. He had been removed from his abusive family several years earlier and placed with an aunt who became his guardian. She referred him for treatment because of concerns about explosive and aggressive behavior. These behaviors reflected both his trauma history and his difficulty in interacting with the world around him.

Uncertain about the nuances of relationships, Eddie made it clear that he considered his relationship with his therapist, Bill, to be exclusive and wanted as little information as possible shared with his guardian. Bill had no misconceptions about the tenuous nature of his working alliance with Eddie, and he used measures described throughout this volume to monitor outcomes

[1]In this case example, and in all examples discussed in this book, proper steps were taken to ensure client confidentiality.

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related to overall well-being as well as the alliance. He used these measures routinely on a session-by-session basis and used the feedback he received to work at becoming an even more effective therapist.

One day, Bill made what he considered a "rookie mistake." When Eddie arrived escorted by his guardian, Bill asked to speak with her about a matter related to Eddie's health care insurance, which led to the guardian offering to share a previous psychological evaluation report that Bill had not seen. By the time Bill finished the conversation a few minutes later, Eddie had become quiet, made poor eye contact, and participated minimally in the session. It was easy to assume that Eddie was frustrated because Bill had not respected the exclusivity of their work together. Bill wasn't entirely sure that this was the case because Eddie would not tell him what had happened.

Reflecting on the situation, Bill did as he often did before sessions: He examined the trajectory of scores on Eddie's outcome measure as well as a scale related to the therapeutic alliance. The changes in these numbers told him that treatment seemed to be becoming less helpful, and his alliance with Eddie was indeed in serious trouble. It wasn't just that Eddie was less communicative; the problem was that Bill had unwittingly destroyed the "culture of feedback" he had worked so hard to create with Eddie. Further, Eddie was not improving on certain global outcomes (e.g., his personal sense of well-being; his relationships with others at school and in the community; and his relationships with people close to him, such as his guardian).

Bill was aware that in the past, he might have simply persisted in trying to be helpful to Eddie. He might have even told himself that he had faced similar challenges before and had been able to address them for the most part and that there was nothing to worry about. Now that he had actual measures to review on a session-by-session basis, he became acutely aware that whatever his self-assessment of his abilities might be, Eddie was getting worse when he should have been getting better and that he no longer had a relationship in which Eddie was willing to speak openly about their work together. It was time to return to the basics of the therapeutic alliance with Eddie. Bill needed to work in a deliberate fashion to accept responsibility for his contributions to the situation and make adjustments to their work accordingly.

Bill's experience with Eddie serves as a reminder of therapeutic principles that often go undiscussed in our work. Underneath all of our clinical practices—indeed, all helpful interactions—lies a particular kind of conversation. Our field is replete with examples of how professionals should speak and be with clients. This can be a source of great fascination, from the earliest authors, through Carl Rogers's core conditions, Berg and de Shazer's focus on the seemingly simple search for solutions, and beyond. Wampold and Imel (2015) referred to the conversation as "perhaps the ultimate in low

technology" (p. ix), and Miller and Rollnick (2013) described their work with motivational interviewing as "something done *for* and *with* someone, not *on* and *to* them" (p. 24, italics in original).

Obviously, not all conversations are helpful, even as they are central to all bona fide forms of psychotherapy (Wampold & Imel, 2015). What was central to Bill's assessment of his failure reflects research findings on the therapeutic alliance (Duncan, Miller, Wampold, & Hubble, 2010; Hubble, Duncan, & Miller, 1999). That is, that the most helpful clinical practice takes place when there is agreement, from the client's perspective, on the nature of their relationship, the goals of their work, and the means by which they go about it. This view of the therapeutic alliance dates back decades (Bordin, 1979), although research has also emphasized the importance of delivering treatment in accordance with strong client values and preferences (e.g., Norcross, 2010). Indeed, the importance of the alliance has long been recognized (Orlinsky & Rønnestad, 2005).

Although the therapeutic alliance is central to clinical practice, it is not the only consideration. Without attending to the outcomes (e.g., whether a client's condition is improving, worsening, or staying the same), there is no way to know whether we are helping clients meet their goals.

This book provides insight into how various mental health professionals (individuals and agencies alike) have worked to become more effective. It includes case examples of success, failure, and "failing successfully" (i.e., recognizing when treatment isn't working and negotiating alternatives). The framework guiding this work is feedback-informed treatment (FIT). FIT is a pantheoretical approach for evaluating and improving the quality and effectiveness of behavioral health services. It does not demand that one throw out models and techniques that work with specific clients, although readers may come to view those approaches differently and rethink practices that don't benefit clients. However, it does involve routinely and formally soliciting feedback from consumers regarding the therapeutic alliance and outcome of care using empirically validated measures and using the resulting information to inform and tailor service delivery (Bertolino & Miller, 2013, p. 4).

Bill's use of the Outcome Rating Scale (ORS; Miller & Duncan, 2000) and Session Rating Scale (SRS; Miller, Duncan, & Johnson, 2000), two measures that can be used in FIT, served as an early warning system that alerted him when treatment was not progressing and was in fact unhelpful. Referring to the data that these measures provide helped Bill to see key indicators of the alliance and outcomes of treatment more clearly than he might have under more traditional circumstances. FIT principles (namely, the importance of providing a culture of feedback and embarking on a plan of deliberate practice to improve his outcomes) also guided him into a more

helpful direction, one in which he could more effectively keep his biases about himself and the client in check. Indeed, the combination of these measures and their focus on outcomes and the alliance allowed Bill to be a true partner in change.

The idea of routinely monitoring one's outcomes is not new (Lambert, 2010). However, selecting the right measure can be intimidating. Ogles, Lambert, and Masters (1996) reviewed available tools and found more than 1,400 measures had been used to determine the effectiveness of psychotherapy. Most of these measures were designed for the purpose of research or as part of a comprehensive evaluation. Brown, Dreis, and Nace (1999) observed that measures or combinations of measures that require more than 5 minutes to complete, score, and interpret will typically not be considered feasible by the majority of clinicians. Measures that are user-friendly and provide real-time feedback are therefore all the more important when one considers the often urgent circumstances in which clients and treatment providers exist. This volume considers a variety of outcome and alliance measures (e.g., Chapters 3, 7, and 8).

Even with the right measures, questions remain about meaningful implementation (see Moss & Mousavizadeh, Chapter 5, this volume) and professional improvement (see Chow, Chapter 16). These questions provide much of the impetus for this book. What is the best use of the available measures and methods for outcome monitoring? How can practitioners create an environment where feedback, improved outcomes, and professional growth thrive? What can practitioners learn about themselves and their clientele through FIT? What reliable steps can practitioners take to improve their performance? How do practitioners know when they are getting better? Most practitioners reach for excellence; not all succeed. Research has found few effects of experience or training on improving clinical outcomes (Goldberg et al., 2016; Wampold & Brown, 2005). If there is any lesson from this book, it is that the simple use of routine outcome monitoring alone does not improve practitioners' performance. Going from good to great requires the specific pursuit of *deliberate practice* (see Schuckard, Miller, & Hubble, Chapter 1, and Chow, Chapter 16, this volume).

Deliberate practice is a focused, specific form of hard work. Deliberate practice is far from being inherently and consistently enjoyable, however much the editors of and contributors to this volume might wish it were otherwise. Still, it is vital to bear in mind in an era when new methods for assessment and treatment appear to offer both promise and allure that just as changing one's life in treatment is never easy, neither is becoming an effective agent of change. The obvious payoff of deliberate practice is in performance, although other benefits can appear as a result, such as an improved learning style and, of course, better outcomes.

Part I of this volume examines FIT in theory and general practice. Eeuwe Schuckard, Scott D. Miller, and Mark A. Hubble begin with a chapter on FIT's historical and empirical foundations (Chapter 1). They begin with a well-established but uncomfortable fact: Despite the time, energy, and money expended in many projects aimed at improving psychotherapy, research shows that the majority of such initiatives have failed to improve either the quality or outcome of care. David S. Prescott next presents FIT's basics and core competencies (Chapter 2), reviewing four core areas of competence: research foundations, implementation, the use of relevant measures and reporting, and continual professional development. He also reviews many barriers to collecting feedback that practitioners might encounter. Cynthia L. Maeschalck and Leslie R. Barfknecht explore how to generate and use client feedback to inform treatment (Chapter 3). They review psychometric properties of the ORS and SRS and offer numerous ideas for analyzing the data generated by these measures. Next, Susanne Bargmann discusses the use of FIT in clinical supervision (Chapter 4) and suggests a model for FIT supervision. Randy K. Moss and Vanessa Mousavizadeh conclude this part of the book with a chapter on FIT implementation. They argue that implementing FIT is not simply an event but an ongoing process that moves between distinct stages, often in a nonlinear manner.

Part II explores FIT in specific practice areas. The authors of these chapters offer guidance based on their own experiences implementing FIT in various domains. They present their successes as well as the challenges they faced as lessons for other practitioners who want to integrate FIT into their own work. In Chapter 6, Jason A. Seidel opens this section with a direct, almost unorthodox chapter outlining tips for private practitioners via his personal advice and professional experience. He describes not only the hard work but also the personal and professional rewards of becoming truly feedback-informed. Next, in Chapter 7, Robert L. Gleave and colleagues describe FIT in group treatment settings. They offer explicit advice in using the Outcome Questionnaire—45 and Group Questionnaire and provide findings from their practice and offer implications for practitioners. In Chapter 8, Robbie Babins-Wagner discusses FIT in agency and clinic settings and the painstaking work that her Canadian agency did to improve its outcomes. In Chapter 9, Bob Bertolino summarizes a decade of experience with FIT in an agency serving children, youth, and their families. He describes starting by aligning his agency's mission with the values underlying FIT and eventually producing better lives for many clients. Bill Robinson explores the use of FIT in couples counseling in Chapter 10. A seasoned therapist, Robinson describes how FIT can be used with typical cases in a community-based practice. Julie Seitz and David Mee-Lee discuss FIT in the treatment of substance abuse in Chapter 11, recounting the evolution of their

agency and practice with information about implementation and individual cases. Chapter 12, by Brittney Chesworth and colleagues, explores the importance of FIT with LGBTQ clients. The chapter provides critical information about working with this population that all practitioners should know, along with recommendations for how FIT can improve clients' lives. David S. Prescott discusses FIT with forensic clients in Chapter 13. His chapter focuses on what professionals need to know when practicing in this arena and provides a handful of in-depth examples. In Chapter 14, Ryan Melton and Elinor Taylor explore FIT with early-onset psychotic disorders. They provide actionable knowledge about this population and include the voices of many of their clients as guideposts for professionals working with this vulnerable clientele. Janice Pringle and Jaime Fawcett conclude Part II with a discussion of FIT in the context of medication adherence. They observe that most cases of inappropriate medication use involve whether and how patients take their medications. By facilitating (rather than compelling) patients' behavior change, practitioners can help them take medications as prescribed.

Part III focuses on professional development and the pursuit of excellence. It contains a chapter by Daryl Chow with the self-explanatory title "The Practice and the Practical: Pushing Your Clinical Performance to the Next Level." Chow emphasizes how and why routine outcome monitoring on its own is not enough to improve performance. After describing the characteristics of excellent therapists, he then explores deliberate practice, a central element of FIT. This chapter ties together many of the themes emphasized throughout the preceding ones.

This book is for people who want to become excellent practitioners and are willing to look at and work on themselves along the way. It is aimed primarily at professionals in the mental health fields, such as psychologists, social workers, and others interested in psychotherapy and specialized areas such as substance abuse treatment, medication adherence, and the like. Students who read these chapters will learn that their work can provide benefit every bit as much as more seasoned professionals. It is our hope that this book inspires practitioners and gives researchers ideas for areas of further study. FIT provides a practical means to determine effectiveness, inform our work, and guide us on the path toward excellence.

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1

FEEDBACK-INFORMED TREATMENT: HISTORICAL AND EMPIRICAL FOUNDATIONS

EEUWE SCHUCKARD, SCOTT D. MILLER, AND MARK A. HUBBLE

More than a century has passed since the professionalization of psychotherapy. The discipline is now an integral element of health care, and an extensive body of literature exists demonstrating it to be effective for addressing psychological distress and dysfunction. Nonetheless, practitioners face many challenges. For example, wages are stagnant and have been for more than a decade. Competition is increasing. Bureaucratic procedures have become more time-consuming, and professional autonomy is under siege. In the meantime, use of psychotropic medications has increased fourfold since the early 1990s, while the demand for talk therapies has remained stagnant (G. S. Brown & Minami, 2010).

This chapter begins with a review of efforts to establish psychotherapy as a profession. Despite the time, energy, and money expended, research shows that the majority of such initiatives have failed to improve either the quality or the outcome of care. Feedback-informed treatment (FIT) offers

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an evidence-based alternative for therapists, no matter their therapeutic discipline, to advance the field of psychotherapy in both its legitimacy and effectiveness.

THE EFFECTIVENESS OF PSYCHOTHERAPY

For close to 100 years, the effectiveness of psychotherapy was repeatedly questioned. Ironically, much of the criticism came from within the field (Wampold, 2013). Intense and often acrimonious rivalry between the various theoretical schools complicated efforts to establish overall efficacy (Norcross & Newman, 1992; Rosenzweig, 1936). In 1952, Eysenck reviewed the extant scientific literature, concluding that recovery rates of patients receiving psychoanalytic and eclectic psychotherapies were no better than no treatment at all. Considerable controversy followed, with some advocating that psychologists inform potential clients that psychotherapy was no more effective than a placebo ("Psychotherapy Caveat," 1974).

In time, the empirical support for psychotherapy grew (DeLeon, Kenkel, Garcia-Shelton, & VandenBos, 2011). Largely responsible for this development was the application of two specific research methods: the clinical trial and meta-analysis. Clinical trials, as the name implies, involve assignment of patients to an active treatment condition, a waitlist, or a control group (Wampold, 2013). Hundreds of such studies had been conducted by the early 1970s, documenting the beneficial effects of psychotherapy regardless of the type or approach (Bergin, 1971).

Meta-analysis allows researchers to combine the results of disparate studies to demonstrate the overall efficacy of psychologically informed treatments (Wampold & Imel, 2015). In what became a landmark study, Smith and Glass (1977) subjected 375 research reports to this statistical method, finding that the average individual in psychotherapy was better off than 60% to 82% of those not receiving treatment (Wampold, 2001). Subsequent meta-analyses confirmed these early findings, documenting that the effects of psychotherapy are both robust and equivalent to or better than results obtained in medicine (e.g., chemotherapy for breast cancer, heart bypass surgery; Lipsey & Wilson, 1993; Wampold, 2007).

PSYCHOTHERAPY GROWS

Consistent with historical trends evident in earlier decades, the number of models and related methods continued to proliferate (Miller, Hubble, & Duncan, 1995). In 1975, a task force convened by the National Institute of

Mental Health (NIMH), a U.S. government agency responsible for managing one of the largest psychotherapy research budgets in the world, raised concerns about the large and growing number of therapies, each claiming success with a wide range of problems, in the absence of empirical support (Segal, 1975). At that time, more than 130 different approaches were in play. A challenging economic environment and dramatic changes in health care reimbursement policy only served to intensify such worries.

In an effort to rein in health care costs, the U.S. Congress passed the Health Maintenance Organization Act in 1973 (Ellwood, 1988). Psychotherapists were now subject to external oversight and competed with one another for contracts offered by managed health care organizations (MHCOs). The struggle to earn a living intensified as the numbers of practitioners doubled between 1970 and 1980 (Cummings & O'Donohue, 2008; DeLeon et al., 2011).

NIMH acted, advocating the use of the randomized controlled trial (RCT) to determine which therapies provided the best outcomes and thus were deserving of reimbursement (Segal, 1975). By the 1990s, the RCT had become the primary methodology used in psychotherapy research (Goldfried & Wolfe, 1998). Previously, the method was most often used in medicine and pharmacology. In those fields, the efficacy of a given procedure or medication was thought to be proven by comparing it with a presumably inert or alternative intervention (Thaul, 2012; Wampold & Imel, 2015). Psychotherapy researchers used similar comparisons in their RCTs, but controversy arose about their use. For example, it is simply not possible to blind participants in trials of psychotherapy (O'Leary & Borkovec, 1978; Seligman, 1995; Wampold, 2001). In medicine, the active treatment (e.g., pill) can be made to appear the same as the placebo, even to the point that some placebo substances mimic side effects of experimental substances (Moncrieff, Wessely, & Hardy, 2004). The result is that neither the person administering the drug nor the one receiving it can tell the difference between the real and sham treatment. In sharp contrast, it is nearly impossible to blind therapists to the fact that they are delivering less than the complete therapy (Wampold, Minami, Tierney, Baskin, & Bhati, 2005).

Despite concerns about the use of RCTs in the investigation of psychotherapy, in 1995, a task force within Division 12 (Society of Clinical Psychology) of the American Psychological Association reviewed the evidence obtained in RCTs and then created a list of treatments that, in their estimation, had achieved an acceptable level of scientific support (Task Force on Promotion and Dissemination of Psychological Procedures, 1995, p. 3). Adopting these "empirically validated" or supported methods, the task force argued, would place the field on an equal footing with psychiatry, psychotherapy's major competitor. At that time, the political and social milieu favored a biological view of mental illness (Barlow, 1996). As such, the largest share of funding

for research and training budgets, including contracts with MHCOs, went to psychiatrists (Crits-Christoph, Frank, Chambless, Brody, & Karp, 1995; Goldfried & Wolfe, 1998; Olfson et al., 2002).

In the end, the task force's initiative did little to create an advantage for therapists in the mental health care market. First, psychiatry had two major advantages that allowed it to maintain its dominance. To begin, it had far more influence within the NIMH (Goldfried & Wolfe, 1998). It also had the full financial support and backing of the pharmaceutical industry (Crits-Christoph et al., 1995). Second, within psychology, rather than unifying the profession, the list of treatments created by the task force proved highly divisive (Persons & Silberschatz, 1998). Cognitive and behavioral approaches predominated, leaving out methods used by the majority of practitioners. Furthermore, no evidence existed documenting that the approaches included on the list were actually superior in their effects to any other treatments in use (Wampold et al., 1997). Not surprisingly, the fortunes of psychiatry continued to improve as incomes earned by psychotherapists steadily declined (G. S. Brown & Minami, 2010; Cummings & O'Donohue, 2008; "Psychology Salaries Decline," 2010).

UNANSWERED QUESTIONS

Setting aside the political and economic influences just discussed, a fundamental question remained, one that has dogged the field since its inception and is central to improving outcomes: What makes psychotherapy work? Two major points of view have emerged. The first, and arguably the most popular, holds that psychotherapy is similar to medical treatments (Barlow, 2004). Known as the "specific factors" approach, its proponents believe psychological treatments work like penicillin, containing ingredients remedial to a particular disorder. The second, the "common factors" perspective, maintains that the efficacy of psychotherapy is explained by curative factors shared by all (Hubble, Duncan, & Miller, 1999; Lambert, 1992; Wampold & Imel, 2015).

The two positions offer strikingly different visions for improving effectiveness. If one believes that specific factors account for change, then attention must be directed to selecting the right method for a given diagnosis and ensuring that clinicians deliver the interventions with fidelity (Chambless & Ollendick, 2001; Huppert, Fabbro, & Barlow, 2006; Siev, Huppert, & Chambless, 2009). In contrast, according to the common factors position, success depends on activating, by whatever means possible, the transtheoretical curative elements, including a strong working relationship, believable explanation for

the presenting problem, a healing setting, and credible therapeutic rituals (Frank & Frank, 1993; Lambert, 1992; Miller, Hubble, & Duncan, 1995).

If the success of these factors, be they specific or common, were based on the number of studies and scholarly works published, one would have expected major improvements in the outcome of psychotherapy. Nothing could be further from the truth. Psychotherapy's beneficial effects have remained flat, largely unchanged since the 1970s (Cuijpers, Smit, Bohlmeijer, Hollon, & Andersson, 2010; Lipsey & Wilson, 1993; Smith & Glass, 1977; Wampold et al., 1997). Over time, the reasons neither the specific nor common factors perspective made a difference became clear.

To begin, although common factors most certainly account for why psychotherapy works (Wampold & Imel, 2015), they have proven neither particularly attractive to practitioners nor helpful in improving their effectiveness. Clinicians want and need to know what to say and do to assist their clients. In sharp contrast to the models and techniques that characterize the specific factors approach, the common factors position offers neither (Lambert & Ogles, 2014). Logically, it cannot (Goldfried, 1980). Indeed, as soon as the shared curative elements are translated into specific strategies and techniques, they cease being common (Seidel, Miller, & Chow, 2014). With regard to outcome, available research is devoid of studies showing that common factors can be used proactively or prescriptively to enhance effectiveness (Crits-Christoph, Chambless, & Markell, 2014). It turns out that the empirical foundation for specific factors is equally weak (Laska, Gurman, & Wampold, 2014; Wampold & Imel, 2015). The underlying critical argument is that different therapies are differentially effective, and efficacy is dependent on the reliable delivery of the specific healing ingredient contained in a particular approach. For all that, therapist adherence to and competence in a special method or technique has not been found to improve outcome (Haas, Hill, Lambert, & Morrell, 2002; Webb, Derubeis, & Barber, 2010). In addition, when specific approaches are directly compared, typically no differences are found—results that have been replicated across numerous populations and diagnostic groups (Munder, Brütsch, Leonhart, Gerger, & Barth, 2013). Evidence obtained in what are known as *dismantling studies* is even more damning. In this type of research, the supposed active ingredient in a particular therapy is removed. Contrary to expectations, such modifications have no impact on efficacy (Ahn & Wampold, 2001).

The failure to reach agreement about what makes psychotherapy work was not without consequence. If the two major explanatory paradigms were in dispute and the causal variables defied consensus, how could effectiveness be improved? Fortunately, work on an alternative means of quality improvement had begun during the 1980s.

Patient-focused research, as it was called, involved the monitoring of an individual's progress over the course of treatment. In 1986, researchers Howard, Kopta, Kraus, and Orlinksy demonstrated that change in therapy followed a highly predictable trajectory. Referred to as the *dose–response*, it highlighted the relationship between progress and the amount of time spent in therapy. By examining thousands of sessions and a score of previous studies, the authors found that the lion's share of change occurred earlier rather than later in treatment. Such findings had major implications for improving outcomes. As Howard et al. (1986) suggested at the time, such evidence could be used "to mark a point in treatment at which cases that have not shown any measurable improvement should be subjected to clinical review" (pp. 163–164).

Coincidently, this type of research was developing at the same time MHCOs were increasing their cost-containment efforts, chiefly by limiting the amount and types of treatments reimbursed (J. Brown, Dreis, & Nace, 1999). Such practices proved controversial as consumers were forced to seek care from segments of the medical system that were ill-equipped to work with mental health difficulties (e.g., general practitioners, emergency departments; Castner, Wu, Mehrok, Gadre, & Hewner, 2015; Lechnyr, 1992). Patient-focused research would eventually provide a means for ensuring quality, accountability, and effectiveness within this climate of cost containment (G. S. Brown, Burlingame, Lambert, Jones, & Vaccaro, 2001).

Along with patient-focused research, interest in *continuous quality improvement* (CQI) grew (Johnson & Shaha, 1996). Briefly, CQI involves routinely gathering objective data and using the information for assessing, and then improving, the quality of a product or service (Eckert, 1994). The field of medicine had already implemented such procedures with good results (e.g., Barrable, 1992; Donabedian, 1988). Together, CQI and patient-focused research formed the foundation for the emergence of a new paradigm, termed *practice-based evidence*. Here, emphasis shifted from identifying "best treatments" for particular disorders to determining whether a given course of therapy was working for the individual client (Barkham, Hardy, & Mellor-Clark, 2010; Duncan, Miller, Wampold, & Hubble, 2010; Lambert, 2010).

Researchers who embraced the new paradigm began developing measures that practitioners could use in real time to assess the outcome with each and every client (Miller, Hubble, Chow, & Seidel, 2013). Howard, Brill, Lueger, and O'Mahoney (1992, 1993, 1995) designed the first system, Integra Outpatient Tracking Assessment, later renamed COMPASS (Lueger, 2012). Lambert, Lunnen, Umphress, Hansen, and Burlingame (1994) soon followed with the Outcome Questionnaire—45 (OQ–45). Both were psychometrically sound, sensitive to change, easy to administer and score, and applicable across

a wide range of clients and presenting problems (Lambert, Hansen, & Finch, 2001). Regardless of the measure used, this line of research offered the chance to improve the overall effectiveness of psychotherapy by identifying clients at risk of a poor treatment outcome.

IMPROVING OUTCOME ONE CASE AT A TIME

Once more, Howard and colleagues led the way (Howard, Moras, Brill, Martinovich, & Lutz, 1996). Their work on the dose–response relationship offered an actuarial method for determining when a particular client's course of progress deviated significantly from cases that had achieved a successful outcome. This model for predicting outcomes required the analysis of considerable amounts of data and only became possible with increasing access to powerful computers and the development of sophisticated statistical methods (hierarchical linear regression; Bryk & Raudenbush, 1992). Howard and colleagues (1996) asserted, and Lutz, Martinovich, and Howard (1999) confirmed, that the chance of success dropped from 65% to 46% when clients' scores on their measure (COMPASS) varied a single time from the established norm. With two instances, the probability of success dropped to 36%. At this point, the stage was set for therapists to receive valid and reliable feedback about whether their clients were benefiting, or likely to benefit, from a given course of psychotherapy.

Lambert, Whipple, et al. (2001) were the first to investigate whether providing therapists with ongoing feedback actually improved outcomes. In those therapies most at risk of failure, feedback resulted in better retention, improved outcomes, and reduced rates of deterioration. Clients benefiting from care ended treatment sooner, with no negative impact on the overall result. The following year, Lambert et al. (2002) confirmed these initial findings.

Later research would document the importance of the availability, frequency, and immediacy of feedback. Studies showed, for example, that without access to a formal system for assessing progress, therapists failed to predict or identify deterioration in their clients (Hannan et al., 2005; Hatfield, McCullough, Frantz, & Krieger, 2010). Slade, Lambert, Harmon, Smart, and Bailey (2008) further found that feedback delivered at the time of service had a considerably larger impact on outcomes than feedback delayed by 2 weeks. Sharing outcome data with clients and engaging them in a discussion about their progress further enhanced its impact (Hawkins, Lambert, Vermeersch, Slade, & Tuttle, 2004).

Alerting clinicians to the possibility of treatment failure was a major development. What was missing, however, was practical information for altering the course of treatment. Whipple and colleagues (2003) developed and

tested a package of clinical support tools (CSTs) designed to complement feedback. When a case was deemed “off track,” therapists received information from client-completed questionnaires regarding the strength of the working alliance, existing social support network, and readiness for change. This additional information yielded dramatic effects. Clients of therapists who received the CST data were much more likely to experience a good outcome and far less likely to deteriorate, and they could achieve these benefits in fewer sessions. In fact, nearly 50% more realized these gains relative to clients whose therapists received progress feedback alone.

FROM RESEARCH TO PRACTICE

Despite the clear advantages documented by research, difficulties quickly emerged once efforts turned to implementing feedback shifted from the “laboratory” to real-world practice. In particular, Miller, Duncan, Brown, Sparks, and Claud (2003) observed that the “methodological complexity, length of administration, and cost often rendered . . . [available outcome tools] infeasible for many service providers and settings” (p. 92). In an effort to overcome these obstacles, Miller and Duncan (2000) developed, tested, and disseminated two brief, four-item measures (Duncan et al., 2003; Miller, Duncan, Brown, Sparks, & Claud, 2003). The first, the Outcome Rating Scale (ORS), assesses client progress. The second, the Session Rating Scale (SRS), measures the quality of the therapeutic relationship, a key element of effective therapy (Bachelor & Horvath, 1999; Norcross, 2010).[1] Both scales take less than a minute to complete and score. Owing to their brevity and simplicity, adoption and usage rates among therapists were found to be dramatically higher compared with those of other assessment tools (ORS: 89% vs. 20%–25%; SRS: 96% vs. 29%; Miller, Duncan, Brown, Sorrell, & Chalk, 2006; Miller et al., 2003).

[1]Both the ORS and SRS were developed following the second author’s experience with using longer scales in clinical practice: (a) the OQ–45 and (b) a 10-item measure of the therapeutic alliance. The first was developed by his professor, Michael J. Lambert, the latter, by a mentor and supervisor, Lynn Johnson (Johnson, 1995). At a workshop Miller was conducting on routine outcome measurement, he mentioned the time the measures took to administer as well as the difficulty of completing the tools that many of his clients had reported. Haim Omer, who was in attendance, suggested using a short, visual analogue format to capture the major domains assessed by the tools. Miller’s experience with the Line Bisection Test (Schenkenberg, Bradford, & Ajax, 1980) during his neuropsychology internship and subsequent work on the development of scaling questions at the Brief Family Therapy Center (Berg & Miller, 1992; Miller & Berg, 1995) led him to create measures with four lines, each 10 centimeters in length, representing domains of client functioning assessed by the OQ–45 (Miller, 2010) and the therapeutic alliance as defined by Bordin (1979). Miller, together with his colleague Barry Duncan, measures for adults, children, young children, and groups were developed and tested for reliability, validity, and feasibility.

As had been done with other outcome measures, Miller and colleagues (2006) developed norms for interpreting data derived from the ORS and SRS. Known as PCOMS (Partners for Change Outcome Management System; Miller, Duncan, Sorrell, & Brown, 2005), these norms were programmed into a computerized system (SIGNAL) and used to provide feedback to therapists working in an employee assistance program.[2] As the name implies, the software used a traffic light graphic to provide real-time warnings to therapists when an individual client's ratings of either the alliance or outcome were on track (green), at risk (yellow), or significantly outside of the established norms (red).

During an 18-month study, outcomes of 5,000 clients were monitored (Miller et al., 2006). In the initial phase, lasting 3 months, progress of all clients was measured, but no feedback was provided to therapists. Later, when progress was measured and alliance feedback was provided, outcomes improved markedly (from 34% to 47%), and deterioration rates halved (from 19% to 8%). This study not only confirmed the impact of feedback established in prior studies but also showed that shorter, more user-friendly scales could perform as well as longer, more complex measures. A later meta-analysis comparing a longer system with the ORS and SRS affirmed these results (Lambert & Shimokawa, 2011).

During the same period as efforts were directed toward making feedback more feasible and accessible to practicing clinicians, other studies evaluated its applicability and effects in various treatment settings and populations. Positive results were found in outpatient and inpatient settings, counseling and university training centers, individual and group therapies, and specialized treatment programs (Gondek, Edbrooke-Childs, Fink, Deighton, & Wolpert, 2016). By 2011, four meta-analytic reviews had been conducted underscoring the consistently favorable impact of providing progress feedback to therapists (Knaup, Koesters, Schoefer, Becker, & Puschner, 2009; Lambert & Shimokawa, 2011; Lambert et al., 2003; Shimokawa, Lambert, & Smart, 2010). Two systems (OQ–45 and the ORS and SRS) were vetted and then listed on the Substance Abuse and Mental Health Services Administration's National Registry of Evidence-Based Programs and Practices (https://www.samhsa.gov/nrepp).

[2]The SIGNAL software was used exclusively by the employee assistance program during the period the aforementioned study was conducted. At that time, Miller and colleagues planned to launch a web-based system known as PCOMS "for both monitoring and improving the effectiveness of treatment" (Miller et al., 2005, p. 2). The project did not go forward. Despite that fact, PCOMS remained in use as a shorthand for the ORS and SRS. Miller (2011) continued work on norms and interpretive algorithms that have been since incorporated into several independently owned, web-based systems providing electronic administration, scoring, plotting, data aggregation and interpretation services, including http://www.fit-outcomes.com, http://www.myoutcomes.com, and http://www.acehealth.com.

If obtaining feedback were merely a matter of combining available research support with a feasible methodology, then adoption by practitioners should have been quick and straightforward. After all, whenever asked, a large percentage of practitioners consistently expresses interest in receiving regular reports of client progress (Bickman, 2000; Hatfield & Ogles, 2004). Curiously, although many measures are available, the same body of evidence documents that few actually use measures in their day-to-day work (Gilbody, House, & Sheldon, 2002; Hatfield & Ogles, 2004; Zimmerman & McGlinchey, 2008). Even more troubling, among those who do, research reveals that the impact of feedback varies significantly. Indeed, some use the systems to considerable effect, whereas others experience little improvement in client outcomes whatsoever (de Jong, van Sluis, Nugter, Heiser, & Spinhoven, 2012; Sapyta, Riemer, & Bickman, 2005). Put bluntly, success depends on who uses the feedback.

Although disappointing to those invested in the development and promotion of measurement and feedback, such findings should not have been all that surprising. The impact of the individual therapist on clinical progress has long been known to exceed the effects of whatever intervention is in vogue or under study. In fact, the variance in outcomes attributable to therapists (5%–9%) is larger than the variability among treatments (0%–1%), the therapeutic relationship (5%), and the supposed superiority of an empirically validated or supported treatment over placebo (0%–4%; Duncan et al., 2010; Kim, Wampold, & Bolt, 2006; Lutz, Leon, Martinovich, Lyons, & Stiles, 2007).

In effect, up to and including the development of feedback systems, efforts to improve the efficacy of psychotherapy overlooked the contribution made by the therapist. As early as 1997, Okiishi and Lambert proposed investigating therapist effects using results gathered in real-world settings. Together, patient-focused research studies and MHCOs were generating vast amounts of outcome data that could be used for such analyses. Among the first to compare clinicians directly, Miller et al. (2005) showed just how important the individual therapist was to outcome. Figure 1.1 plots the effectiveness of 30 therapists against the agency average (represented by the solid black line). An individual clinician is statistically above average at the 90% confidence level when the bottom end of his or her range falls above the agency average and below average when the top end falls below. As can be seen, practitioners varied significantly in their effectiveness, with some being consistently more helpful on average than others. Indeed, being seen by one of the most effective therapists improved the chance of success by almost 20%.

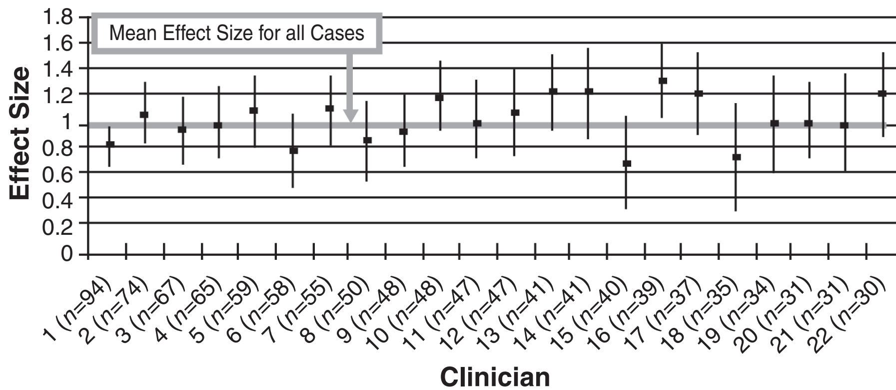

Figure 1.1. Average outcomes of 22 clinicians compared with the agency average ($n = 30$ or more cases). From "The Partners for Change Outcome Management System," by S. D. Miller, B. L. Duncan, R. Sorrell, and G. S. Brown, 2005, *Journal of Clinical Psychology*, *61*, p. 204. Copyright 2005 by Wiley. Reprinted with permission.

Okiishi et al. (2006) confirmed and extended these initial findings in a much larger sample with even more striking results. In their study, clients of the top 10% of practitioners were twice as likely to recover and 50% less likely to deteriorate than clients seen by the least effective therapists. Unfortunately, the size of the difference was surpassed only by its inexplicability. The researchers considered a host of variables traditionally believed essential to the development of an effective therapist. None proved important, including professional discipline (e.g., counseling psychology, clinical psychology, marriage and family therapy, social work), years of training and experience, or the preferred theoretical orientation or approach (e.g., behavioral, cognitive behavioral, humanistic, psychodynamic). Subsequent studies were equally unsuccessful in accounting for the differences in outcome between therapists (Baldwin, Wampold, & Imel, 2007; Kim, Wampold, & Bolt, 2006; Lutz et al., 2007; Wampold & Brown, 2005). As Miller et al. (2005) observed:

> Little is known at present about the cause(s) of the difference. . . . Nor do we know whether anything can be done to close the gap between more and less effective clinicians (e.g., distillation of effective practices by studying the most effective therapists, additional training or supervision). . . . If confirmed [however]. . . perhaps instead of empirically supported *therapies*, consumers should have access to empirically supported *therapists*. (pp. 6–7)

The challenge was first to understand why therapists varied in their effectiveness and then, with that understanding at hand, proceed to improve the outcome of psychotherapy by making better therapists.

TAMING THE WILD CARD

In 1974, psychologist David Ricks coined the term *supershrink* to describe a class of exceptional therapists—practitioners who stood head and shoulders above the rest. In a little-known study, published as a book chapter rather than a peer-reviewed journal article, he examined the long-term outcomes of a cohort of "highly disturbed" adolescents. When the research participants were later examined as adults, he found that a select group treated by one provider fared notably better. In contrast, boys treated by another clinician, termed the *pseudoshrink*, had very poor adjustments later in life.

While Ricks's (1974) report was cited occasionally over the next 3 decades, Okiishi, Lambert, Nielsen, and Ogles (2003) were the first to confirm the existence of exceptional therapists with a large sample and sophisticated statistical procedures. As in other studies, gender identification, level and type of training, and theoretical orientation did not explain the difference in outcome between the most and least effective. As Okiishi et al. (2003) noted, "Unfortunately, what . . . therapists *did* to be 'supershrinks' and 'pseudoshrinks' remains a mystery" (emphasis added, p. 372). At the end of their report, they asserted that "there is an urgent need to take account of the effectiveness of the individual therapist and it is time for clinicians to welcome such research" (p. 372).

Ultimately, understanding the variability in performance of individual clinicians—the "highs" and "lows"—did not come from within the profession. Instead, guidance was found in an extensive scientific literature bearing on the subjects of expertise and expert performance (Colvin, 2008; Ericsson, 2009a; Ericsson, Charness, Feltovich, & Hoffman, 2006). Across a wide variety of endeavors (including sports, chess, music, medicine, mathematics, teaching, computer programming, and more), researchers had identified a *universal set of processes* that both accounted for superior performance and provided direction for cultivating individual development (Ericsson, 2006). In 2007, Miller, Hubble, and Duncan began applying these findings to the study of highly effective clinicians, identifying and describing three essential steps: (1) determining a baseline level of effectiveness; (2) obtaining systematic, ongoing feedback; and (3) engaging in deliberate practice.

With the steps identified and understood, the reason measurement and feedback (Steps 1 and 2) failed to improve outcomes, on their own, became obvious. Together, they operated much like a GPS—the measures alerted therapists when the therapy was off track and at risk for getting lost. Feedback then provided guidance for resuming progress, thereby improving the chance of arriving at the desired destination. Nonetheless, no matter how accurate the information provided, success was completely dependent on the advice's being followed. A later study published in *Psychotherapy Research* confirmed

as much. With a sample of 57 therapists and more than 400 clients, de Jong, van Sluis, Nugter, Heiser, and Spinhoven (2012) showed that one could not count on therapists to ask for feedback or use it productively when provided. Despite measuring progress at every session, half of the practitioners in the study indicated they did not use the feedback in any way. Of those who did, only half showed any benefit from doing so. This state of affairs recalls the stereotypic, comical example of the "guy" who won't ask for directions when lost and then won't follow them once given.

There's more. Research from the field of expertise and expert performance also helped explain another troubling finding that had emerged early on in evaluations of measurement and feedback systems. Namely, even when fully committed to the process, therapists did not learn from the information the systems generated. Lambert observed, for example, that practitioners did not get better at detecting when they were off track with their cases or when their clients were at risk for dropout or deterioration. This happened despite being exposed to "feedback on half their cases for over 3 years" (Michael Lambert, personal communication, July 3, 2003, as cited in Miller et al., 2005, p. 7). To realize the full potential of measurement and feedback, the third step—deliberate practice—was required (Ericsson, 2006, 2009a, 2009b; Ericsson, Krampe, & Tesch-Römer, 1993).

In brief, deliberate practice entails setting aside time for reflecting on one's performance, receiving guidance on how to improve specific aspects of therapeutic practice, considering any feedback received, identifying errors, and developing, rehearsing, executing, and evaluating a plan for improvement. Elite performers across a variety of professions and endeavors had been shown to devote significantly more time to deliberate practice than their more average counterparts (Ericsson, 2006). For example, in a seminal study of violinists, Ericsson, Krampe, and Tesch-Römer (1993) found those rated "best" and "good" spent 3 times longer than the other performers in deliberate practice, averaging 3.5 hours per day for each day of the week, including weekends, compared with 1.3 hours per day for the less highly rated.

In 2015, Chow, Miller, Seidel, Kane, Thornton, and Andrews published the first study on the role of deliberate practice in the development of highly effective therapists. The research examined the relationship between outcome and a variety of practitioner variables, including demographics, work practices, participation in professional development activities, beliefs regarding learning and development, and personal appraisals of therapeutic effectiveness. As in previous studies, gender, qualifications, professional discipline, years of experience, time spent conducting therapy, and clinician self-assessment of effectiveness were not related to effectiveness (Anderson, Ogles, Patterson, Lambert, & Vermeersch, 2009; Malouff, 2012; Walfish, McAlister, O'Donnell, & Lambert, 2012; Wampold & Brown, 2005). Consistent with findings reported

in the expert performance literature, the amount of time therapists spent in activities intended to improve their ability was a significant predictor of outcome. In the first 8 years of their professional work, the top quartile of practitioners spent, on average, nearly 2.8 times more time engaged in deliberate practice than those in the bottom three.

The three steps identified by Miller, Hubble, and Duncan (2007)—establishing one's baseline performance via ongoing measurement, receiving critical feedback on the quality and effectiveness of one's work, and using that information to identify targets for improvement through deliberate practice—are challenging and demanding. Few, if any, practitioners, left to their own devices, can be expected to integrate the steps into their daily work. Experience in the field, and available evidence, indicate that superior performance does not occur in a social vacuum. Taming the wild card depends on creating a "culture of excellence," a community of practice containing an interlocking network of people, places, resources, and circumstances devoted to helping each therapist be the best they can be (Miller & Hubble, 2011). In combination, the steps practiced in a supportive context form the basis of and define FIT.

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2

FEEDBACK-INFORMED TREATMENT: AN OVERVIEW OF THE BASICS AND CORE COMPETENCIES

DAVID S. PRESCOTT

As a start to this chapter, consider a brief thought exercise. First, make a list of what you are hoping to get out of reading this book. What do you hope to accomplish? What do you hope to gain? Then make a list of all of the things you hope to avoid. What do you hope doesn't happen as you read this book? If you're like many participants in trainings by the author, it is easier to produce a list of things you hope to avoid rather than to attain. All too often at the front lines of practice, it is easy to conflate the search for excellence with the search for professional safety. We can improve our confidence more easily than our competence, even as the two are unrelated (Quinsey, Harris, Rice, & Cormier, 2006; see also Chapter 16, this volume). These are not simply academic statements. All too often professional survival requires that we focus more attention on avoiding errors than on becoming more effective. As just one example, the clinician in a multidisciplinary team may have to

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spend more time navigating around the personalities of the other players than building a more helpful alliance with each client.

As another thought exercise, you might ask yourself the following questions.[1] What is the best session you've had with a client in the past 6 months? What did you do that made it so successful? Then ask yourself what gets in your way of doing this work all the time. In answering this last question, did you blame your circumstances or situation more than you examined what you can do better with your clients? There is no question that most readers work in challenging circumstances. The real question is how much we turn our attention to our own contributions to our successes and failures.

Finally, the start of this chapter might be a good time to reflect on what you, as a practitioner, are longing for beyond the momentary challenges of your workplace. What's missing from your practice that (for the moment) is just outside your reach?

It all seems simple at first. Ask your clients for their feedback, track your outcomes, and the next thing you know, you are a more effective clinician. Perhaps you feel that you are getting feedback and tracking outcomes already or that the occasional consumer satisfaction survey at your agency is accomplishing the same goal. Reading an article or going to a workshop can make it seem as though all you need to do is return to your roots as a helping professional and just be a bit more explicit about getting feedback. But then, the deeper you go into feedback, the more you realize that you are only scratching the surface. Getting actionable feedback can be much more difficult than it seems. Indeed, taking deliberate action in response to feedback is likely the hardest part.

Perhaps more disconcertingly, tracking outcomes can lead to questions about what a clinician is actually tracking. Like it or not, professional improvement for many clinicians often means a focus on areas that are tangentially related to client outcomes, such as negotiating insurance companies and other funding sources, time management, timeliness of documentation, and making fewer of the kinds of mistakes that incur the wrath of supervisors and administrators, for example. It can be easier to focus outward on ensuring the comfort and safety of one's immediate work environment than it is to focus inward on the steps one can take to be a more effective clinician tomorrow than today.

This chapter reviews the basics and core competencies of feedback-informed treatment (FIT) practice and practitioners. It borrows heavily on the work of others and represents the work of an entire community of

[1]The author is grateful to Scott D. Miller and Daryl Chow for their development of this exercise.

therapists and administrators who have integrated FIT into their daily work. There are four core areas of competence in FIT:[2]

1. *Research foundations:* These include familiarity with research on the therapeutic alliance, behavioral health care outcomes, and the general research on expert performance and its application to clinical practice. This area of competence also includes familiarity with valid, reliable, and feasible alliance and outcome measures.
2. *Implementation:* This includes integrating consumer-reported outcome and alliance data into clinical work, collaborating and being transparent with consumers about collecting feedback regarding the alliance and outcome, and ensuring that the course and outcome of behavioral health care services are informed by consumer preferences and values.
3. *Measuring and reporting:* This includes documenting the therapeutic alliance and the outcomes of clinical services on an ongoing basis. It also involves providing details in reporting outcomes sufficient to assess the accuracy and generalizability of the results.
4. *Continuous professional improvement:* This includes clinicians' determining their baseline level of performance; comparing their level of performance with the best available norms, standards, or benchmarks; and developing and executing a plan for improving their performance. It also includes developing and executing a plan of deliberate practice for achieving superior performance.

Many of the specifics of these four areas are described directly and indirectly throughout this volume, as well as in manuals and articles (e.g., Bertolino & Miller, 2013; Lambert, 2010) and receive less attention in this chapter. Of vital importance in considering FIT and the competencies it requires is to keep in mind that the therapeutic alliance it relies on is not simply the quality of the relationship between therapist and client, but agreement on the nature of this relationship and on the goals and tasks of treatment in accordance with strong consumer preferences and values.

These areas illustrate that implementing and practicing FIT is about much more than simply gathering feedback. For some, it can mean developing a closer relationship with research, statistics, and measurement than they

[2]These are summarized from an unpublished manuscript by Scott D. Miller, Cynthia L. Maeschalck, and Rob Axsen from 2010.

have had before. For others, it means putting aside pride and making oneself vulnerable. It can even mean embracing one's own biases, as discussed later in the chapter (Hiatt & Hargrave, 1995; Walfish, McAlister, O'Donnell, & Lambert, 2012). Perhaps most difficult for practitioners, FIT can involve thinking about treatment and the role of the treatment provider very differently—including one's own allegiance to the models and techniques one espouses.

WHY USE FIT IN PRACTICE? WHY NOW?

Although small in number, the preceding four areas of competence cover an extraordinary amount of ground. Why should we bother when we know that our efforts are generally effective? Taking into account the evidence presented in Chapter 1 of this volume, elsewhere in this book, and in the literature beyond, several things are clear:

- The variability between therapists working in a given agency, model, or research sample is too often forgotten as a factor in considering treatment outcomes (Wampold & Brown, 2005).
- There are typically more differences between individual practitioners than there are between psychotherapy models (Wampold & Imel, 2015).
- Clinician self-assessment is not a reliable indicator of effectiveness; clinicians typically overestimate their effectiveness (Walfish et al., 2012).
- Clinicians are rarely able to accurately and reliably identify clients who are getting worse while in care (Miller, Duncan, & Hubble, 2004).

Of great relevance to FIT, scientific evidence from studies of both business and health care settings has found that customers and clients who are satisfied with the way *failures* in service provision are managed are generally more satisfied at the end of the process than those who experience no problems along the way (Fleming & Asplund, 2007). One study of the Outcome Rating Scale (ORS) and Session Rating Scale (SRS) involving several thousand at-risk adolescents, for example, found that effectiveness rates at termination were 50% higher in those treatment episodes in which alliances "improved" rather than were rated consistently "good" over time. A take-home message is that the most effective clinicians, it turns out, consistently achieve lower scores on standardized alliance measures at the outset of therapy. This provides an opportunity to discuss and address problems in the working relationship from the outset, a finding that has now received confirmation in a number

of independent samples of real-world clinical samples (Miller, Hubble, & Duncan, 2007).

Ultimately, among the best reasons to immerse one's self in FIT are that, used properly and meaningfully, FIT

- improves outcomes one client at a time;
- identifies areas where clinicians can improve their performance, generally and with specific cases;
- identifies cases at risk for getting worse or dropping out; and
- at the agency level, helps reduce variability in performance between clinicians.

WHAT FACTORS PREVENT CLINICIANS FROM SEEKING FEEDBACK?

Treatment providers experience intense pressures from numerous outside sources. Ever-tighter budgets, difficulties maintaining consistent contact with busy stakeholders and other professionals (e.g., colleagues who share involvement in complicated cases, program administrators), and in some cases (e.g., clients mandated by the legal or child welfare systems) a clientele who wants little to do with treatment may be commonplace realities. Add to this the inherent ethical challenges such as balancing client beneficence and community safety in child welfare and criminal justice settings (see Chapter 13, this volume), and it is not surprising that many professionals can lose their focus on the client's experience of treatment.

In many regions, there can be an implicit belief that participation in treatment is a form of privilege that must take place in accordance with the preferences or timetable of the clinician. The unspoken expectation is that the client must change according to a process set by the therapist. In some cases, such as mandated-treatment settings, this may be apparent in statements such as "Treatment is an opportunity and not a right."

In the author's experience, the belief that collecting feedback is somehow contrary to one's professional discipline can also serve as a barrier. Recent examples of this include one clinician who expressed reluctance to consider many recommendations of an assessment report because they were not in line with the therapist's radical-behaviorist orientation. Others have felt that seeking feedback on whether the client feels heard, understood, and respected and agrees with the therapist's goals and approaches toward treatment would unduly influence the client's transference responses in psychoanalytically based therapy.

Other therapists have expressed the belief that treatment is something that must be subtly (and sometimes explicitly) imposed on a client to prevent

client manipulation of the treatment process. Professionals treating clients who have abused substances or been violent toward their partners have voiced this belief. Under these conditions, it shouldn't come as a surprise that attrition rates are high, and that, in many instances, little effort takes place to prevent adverse terminations. In the author's experience, it is not unusual to hear therapists say that these clients were not ready for meaningful treatment. It is important to point out that there is nothing inherently antifeedback in the professional disciplines just described. Rather, these were professionals who believed that practicing in a feedback-informed manner would be contrary to their beliefs.

Another barrier to collecting feedback is that many clinicians simply believe they already actively do it. In the author's experience, many treatment providers have expressed that they can infer from the client's physical posture or various verbal responses how treatment is progressing. Others believe that because they ask questions such as, "How was this today?" they are soliciting feedback. Unfortunately, such unspecified information-gathering amounts to little more than a polite nicety similar to the easily ignored feedback surveys offered in some restaurants. Clients need to know that someone is genuinely interested in their thoughts, or it is highly likely they will say only what will meet their momentary needs for the situation.

Finally, and perhaps most important, a last barrier to becoming truly feedback-informed is that clinicians who are used to moving speedily into what they believe are the primary components of a treatment model or goals may be concerned that FIT will slow the pace of treatment. There is an inherent dilemma: Treatment can't proceed without a strong alliance, yet therapists often believe that they can make adjustments as they go despite research showing that they are not good at recognizing when treatment isn't working or clients are getting worse. Trying to fix an alliance when it is clearly off track is one thing; careful attention to keeping it on track and improving it is another matter.

ESTABLISHING A CULTURE OF FEEDBACK

As the chapters in this volume show (e.g., Chapter 3), establishing a culture in which clients feel safe in providing honest feedback, like providing therapy itself, is a craft developed over time. It may be worthwhile to pause and reflect on the times when another person was genuinely interested in your feedback and took action accordingly. How often has this happened to you? How was the experience? Would you like more of this in your life?

Beyond developing and actively demonstrating a genuine attitude of openness and receptivity, creating a "culture of feedback" involves taking

time to introduce outcome and alliance measures to clients in a thoughtful and thorough manner. Providing a rationale for using the tools is critical, as is describing how the feedback will be used to guide service delivery (e.g., enabling the therapist to catch and repair alliance breaches, prevent dropout, correct deviations from optimal treatment experiences). Additionally, it is important that the client understands that the therapist is not going to be offended by or become defensive in response to feedback. Instead, therapists must take clients' concerns regarding the treatment process seriously and avoid the temptation to interpret feedback clinically. When introducing outcome and alliance measures (in this case, the ORS and SRS described in the next section) at the beginning of therapy, the therapist might say the following:

> I/We work a little differently at this agency/practice. My/Our first priority is making sure that you get the results you want. For this reason, it is very important that you are involved in monitoring our progress throughout therapy. (I/We) like to do this formally by using a short paper-and-pencil measure called the Outcome Rating Scale. It takes about a minute. Basically, you fill it out at the beginning of each session, and then we talk about the results. A fair amount of research shows that if we are going to be successful in our work together, we should see signs of improvement earlier rather than later. If what we're doing works, then we'll continue. If not, then I'll try to change or modify the treatment. If things still don't improve, then I'll work with you to find someone or someplace else for you to get the help you want. Does this make sense to you? (Miller & Bargmann, 2011; Miller & Duncan, 2004; Prescott & Miller, 2015)

At the end of each session, the therapist administers the SRS, emphasizing the importance of the relationship in successful treatment and encouraging negative feedback:

> I'd like to ask you to fill out one additional form. This is called the Session Rating Scale. Basically, this is a tool that you and I will use at each session to adjust and improve the way we work together. A great deal of research shows that your experience of our work together—did you feel understood, did we focus on what was important to you, did the approach I'm taking make sense and feel right?—is a good predictor of whether we'll be successful. I want to emphasize that I'm not aiming for a perfect score—a 10 out of 10. Life isn't perfect, and neither am I. What I'm aiming for is your feedback about even the smallest things—even if it seems unimportant—so that we can adjust our work and make sure we don't veer off course. Whatever your feedback might be, I promise I won't take it personally. I'm always learning and am curious about what I can learn from getting this feedback from you that will in time help me improve my skills. Does this make sense? (Miller & Bargmann, 2011; Miller & Duncan, 2004; Prescott & Miller, 2015)

HOW DO WE IMPROVE FROM GETTING FEEDBACK?

As effective as feedback has proven to be in improving engagement and outcome (see Chapter 1, this volume), it is not enough for the development of expertise (see Chapter 16). As research into expert performance has repeatedly shown, clinicians do not necessarily learn from feedback provided by clients, as de Jong, van Sluis, Nugter, Heiser, and Spinhoven (2012), for instance, found. In addition, Lambert (2010) reported that practitioners do not get better at detecting when they are off track or their cases are at risk for dropout or deterioration, despite being exposed to "feedback on half their cases for over three years" (Miller et al., 2004, p. 16). Ultimately, many of us are prone to dismissing feedback or not working to become a better therapist as a result of what our clients tell us.

Becoming a more effective professional requires an additional step beyond simply gathering feedback: engaging in deliberate practice (Ericsson, Charness, Feltovich, & Hoffman, 2006; see also Chapter 16, this volume). Deliberate practice, as the term implies, means setting aside time to reflect on feedback received, identifying where one's performance falls short, seeking guidance from recognized experts, and then developing, rehearsing, executing, and evaluating a plan for improvement. Research indicates that elite performers across many different domains devote considerable amounts of time to this process, on average, every day, including weekends. For example, Ericsson and colleagues studied violinists and found that the top performers devoted 2 times as many hours (10,000) to deliberate practice as the next best players and 10 times as many as the average musician. In addition to helping refine and extend specific skills, engaging in prolonged periods of reflection, planning, and practice helps top performers use their knowledge in more efficient, nuanced, and novel ways than their more average counterparts (Ericsson & Staszewski, 1989). It's not just about time spent practicing; it's about the components that come to make one's practice deliberate.

Results from psychotherapy research are in line with findings on the factors that account for the development of expertise elsewhere. For example, Chow et al. (2015) examined the relationship between outcome and practitioner demographic variables, work practices, participation in professional development activities, beliefs regarding learning, and personal appraisals of therapeutic effectiveness. Consistent with previous findings (cf. Anderson, Ogles, Patterson, Lambert, & Vermeersch, 2009; Wampold & Brown, 2005), they found that therapist gender, qualifications, professional discipline, years of experience, and time spent conducting therapy were unrelated to outcome or therapist effectiveness. Furthermore, similar to findings reported by Walfish, McAlister, O'Donnell, and Lambert (2012), therapist self-appraisal was not a reliable measure of effectiveness. Instead, as illustrated in Figure 2.1, the amount of time therapists spent engaged in solitary activities intended to improve their

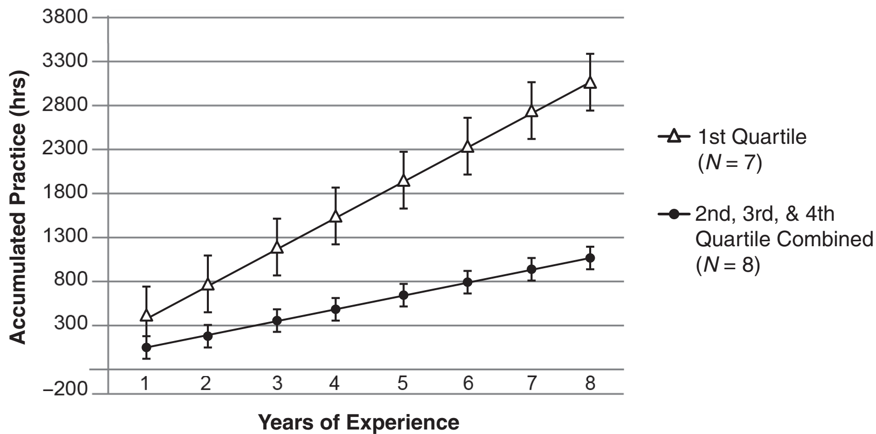

Figure 2.1. Comparing therapists from the top quartile with the others in the lower quartiles on the basis of their adjusted client outcomes as a function of their accumulative time spent on deliberate practice alone in the first 8 years of clinical practice. Error bars represent standard errors of the mean. Reprinted from "The Role of Deliberate Practice in the Development of Highly Effective Psychotherapists," by D. L. Chow, S. D. Miller, J. A. Seidel, R. T. Kane, J. A. Thornton, and W. P. Andrews, 2015, *Psychotherapy*, *52,* p. 342. Copyright 2015 by the American Psychological Association.

skills predicted differences in outcome. Such findings provide important support for the key role deliberate practice plays in the development of expertise.

AVAILABLE MEASURES AND THEIR USE

Many measures can be used in FIT (see Chapters 7 and 8, this volume); readers are strongly encouraged to weigh the pros and cons of each for their own practice. As the saying goes: Your mileage may vary. In the opinion of the editors of this volume, the most important thing is that you are using them.

Two scales that have proven useful for monitoring the status of the relationship and progress in care are the SRS (Miller, Duncan, & Johnson, 2000) and the ORS (Miller & Duncan, 2000). The SRS and ORS measure alliance and outcome, respectively. Both scales are brief, self-report instruments that have been tested in numerous studies and shown to have solid reliability and validity (Schuckard & Miller, 2016). Most important, perhaps, available evidence indicates that routine use of the ORS and SRS is high compared with other, longer measures (99% vs. 25% at 1 year; Miller, Duncan, Brown, Sparks, & Claud, 2003).

Administering and scoring the measures is simple and straightforward. The ORS is administered at the beginning of the session. The scale asks consumers of therapeutic services to think back over the prior week (or since the

last visit) and place a hash mark (or *x*) on four lines, each representing a different area of functioning (i.e., individual, interpersonal, social, and overall well-being). The SRS, by contrast, is completed at the end of each visit. Here again, the consumer places a hash mark on four lines, each corresponding to a different and important quality of the therapeutic alliance (i.e., relationship; goals and tasks; approach and method; and overall). On both measures, the lines are 10 centimeters in length. Scoring is a simple matter of determining the distance in centimeters (to the nearest millimeter) between the left pole and the client's hash mark on each individual item and then adding the four numbers together to obtain the total score (the scales are available in numerous languages at http://scottdmiller.com/performance-metrics).

In addition to hand scoring, a growing number of computer-based applications are available that can simplify and expedite the process of administering, scoring, interpreting, and aggregating data from the ORS and SRS. Such programs are especially useful in large and busy group practices and agencies. They have the added advantage of providing a real-time computation of provider and program outcomes, as well as a normative comparison for judging individual client progress and determining risk. Figure 2.2 illustrates the progress of an individual client over the course of six treatment sessions. The black and gray zones show how unsuccessfully and successfully treated clients respond based on a large normative sample, including 427,744 administrations of the ORS, 95,478 episodes of care delivered by 2,354 providers. As can be seen, the client is not responding like people who end services successfully, enabling providers to make adjustments aimed at improving outcomes in real time. For a complete discussion of scoring, please refer to Chapter 3 of this volume.

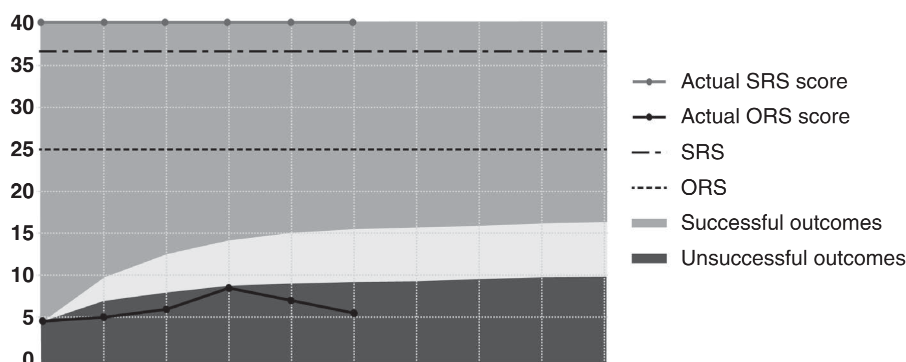

Figure 2.2. A client's progress over the course of six treatment sessions. SRS = Session Rating Scale; ORS = Outcome Rating Scale. The gray area represents successful outcomes; the black area represents unsuccessful outcomes. The solid black line represents the actual ORS score, plotted session by session from left to right.

PUTTING THE PIECES TOGETHER: AN ILLUSTRATION

Heather is a psychologist in private practice. She much prefers therapy to conducting evaluations and has little experience with the latter, even though she resides in an area where providing evaluations often earns more money and commands greater respect. Heather has considerable expertise in working with women who have experienced relationship problems and who are often anxious and depressed. She views herself as incorporating solution-focused therapy and is a great admirer of the work of Carl Rogers. She has used FIT in various ways over the course of many years. Her self-improvement plan has been to better incorporate many of Rogers's approaches into her work.

A new client, Ms. X, came in for a first session. Heather explained that she used FIT and introduced the relevant measures accordingly—in this case the ORS and SRS. Ms. X scored 19 (this number derived by measuring the number of centimeters on each line of the ORS), placing her in the range one would expect for a client seeking services. Ms. X had recently had an anxiety-provoking health scare. After spending the first 15% to 20% of the session engaging Ms. X, Heather started to explore in what ways Ms. X would like her life to be different. Ms. X discussed her health and her relationships, and then discussed the often difficult employment conditions with which she coped. In the end, Ms. X settled on wanting to have only love and serenity in her heart. This was certainly a straightforward answer. Doubtless, many others have wanted to have only love and serenity in their emotional makeup. Heather decided to seek clarification and maybe press the issue a bit along the way.

"I'm not sure I have ever met a person who had only love and serenity in their heart," she said. "Humans are mostly made up of all kinds of attitudes and intentions."

Ms. X said, "Oh, yes. It can be. I am like that when I am deep in my heart and connected with God. God is only love and serenity, and I want to be like that all the time!"

Heather had not anticipated this response, and she did not understand it. She paused to consider this answer and noticed that she had already developed some unhelpful presuppositions about the wish to be more Godlike.

Although many clinicians would find this a response they could work with and explore, Heather suddenly had an extremely strong reaction. "Have you read the Bible?" she asked. Heather would later recount that her tone was confrontational, much to her dismay. In the context of the session, she felt it would have been perfectly acceptable for the client to have left at that moment. Ms. X responded, "Yes, of course." Heather responded back, "Well, then you are aware that God is very definitely not always loving and serene. I mean there is the story of Abraham, and too many others to mention. Surely

it is more accurate to say that humans, like God, have more in their heart than love and serenity." Ms. X looked directly at Heather silently for a few seconds, thanked her, and gathered her things slowly before leaving.

In the days that followed this session, Heather experienced pain, shock, and doubt about the future. She had not only lapsed well out of her solution-focused and Rogerian approaches, she had also behaved far out of her own character. What could possibly have happened? Had this session taken place outside of the context of FIT, it would be easy to assume that the client would not have returned for a second session, confirming research findings showing high rates of clients leaving treatment prematurely (e.g., Wierzbicki & Pekarik, 1993).

Adding insult to injury, Ms. X filled out the SRS, producing a score of 39, seemingly disconfirming obvious problems with the alliance. Knowing that clients often tell therapists what they think they want to hear, Heather redoubled her efforts to build the culture of feedback and said, "You would have every right to say that my approach was not what you needed today." Ms. X said succinctly, "You shouldn't step on people's dreams. My dream is to be more like God—loving and serene."

Heather affirmed Ms. X's feedback, adding that she would be far more careful in the future, adjusting her approach accordingly. Later, at home, she listened to a recorded introductory lecture on solution-focused therapy and decided that she was even less of a therapist than she thought she had been. It was one thing to be challenging; how could she have placed religious beliefs between the client and herself? Or was that even the problem?

Miraculously, Ms. X scheduled another appointment and returned the next week. Her ORS score had gone up considerably and was now above the cutoff for clinical distress, at around 30. Paradoxically, she had seen her doctor, who had scheduled further testing, concerned that she might have cancer. She was aware that whatever may lie in people's hearts, their bodies were certainly another matter, and she was grateful to know where the next challenges in her life might come from.

"You seemed surprised that I came back," Ms. X said. "Maybe you need me more than I need you?" (Given the circumstances of the session and of Ms. X herself, Heather elected not to explore this comment too deeply, instead saying that she was happy to see Ms. X again.) They discussed Ms. X's health status and agreed on working toward goals involving her being able to handle life challenges with grace, poise, love, and serenity.

Ms. X again produced a 39 on the SRS and volunteered, "The reason I came back is that you seemed so determined to change your approach to suit me." Heather nonetheless pressed for more feedback, having learned that a voluntary affirmation is not necessarily the end of feedback. Ms. X said,

> Last time you disagreed with me about God, and although you did not have the right to step on my beliefs, I understand that I need to be able

> to defend my points of view. I need you to be a little more argumentative with me. Even argue with me. That will give me a chance to practice supporting my perspective in a conversation. And you're the expert. Sometimes I want you to tell me what is the problem, to give me a diagnostic and to tell me what to do!

With this, Heather later said, she received her own mini-lesson in love and serenity.

In a later conversation with the author, Heather said, "I assumed that my arguing over religion—including the entire Bible—had been the worst of my mistakes. I was wrong. She had actually been clear about the problem and I missed it. Don't step on people's dreams. She was right." Heather was better prepared for other implications from this feedback. "So much of my deliberate practice has focused on living up to my solution-focused and Rogerian ideals. This woman taught me that there is more to therapy."

Although this statement might seem heretical to some adherents of this model or that technique, it proves that our clients often have other plans for us if we are willing to explore. "I am so very grateful that I made the mistakes that I did," Heather concluded.

> It was awful in the moment (while most feedback is actually easy to accept). Now it is one of my favorite examples of how I could become a better therapist. I am not just keeping safe in a specific approach. Maybe I was the more orthodox of the two of us after all that. What I learned from this is that it doesn't matter what you infer, interpret, or think you know. Human interaction is so complicated. What saved the experience is what every business owner already knows: If you make a mistake and you take responsibility for it and make things better, you have a more committed customer. The measures are not just another form to fill out; they are a way to understand at a deeper level.

Clearly, Heather's success came from her being more faithful to her client than to any one model or clinical orthodoxy. As Heather would explain it,

> I was confident going into that session. I thought I was competent. This situation raised questions for me. What exactly is competence? When you say you are competent, what are you competent in, exactly? The approaches I was competent in were meaningless to this client in these two sessions, although I have no doubt they will be important later in our work together. What I thought would be helpful wasn't helpful at all. It was actually the mind-set underlying my attempts to be helpful that were actually the most helpful part of the session.
>
> Without careful attention to the alliance, my competence would have been better off elsewhere. I know the research about people quitting treatment and how therapists don't often recognize when their clients are actually getting worse. Confidence is misleading.

CONCLUSION

Mastering the four areas of core competency with FIT can mean a lifetime of work. As illustrated in this and other chapters, the models and techniques that every therapist adheres to can, when considered at the individual level, be both a blessing and a curse depending on how they serve the needs of a client and the deep, domain-specific knowledge of the therapist. Deep, domain-specific knowledge refers to the depth and breadth of practitioners' knowledge in their specific area of practice. For example, it is one thing to learn an approach such as motivational interviewing, and quite another to learn to use it effectively with a specific clientele. Examples of deep, domain-specific knowledge in this volume include being able to build an effective alliance with young people with early-onset psychotic features, preventing problems in establishing trust with clients in the criminal justice system, and anticipating the often unspoken concerns that patients have about their medications, for example. Clinicians therefore find themselves on the horns of a dilemma: On the one hand, the alliance is often necessary but not sufficient for sustainable change in behavioral health services. On the other hand, it can be easy to overestimate the importance of the models and techniques that move clients closer to meaningful change.

An analogy might be to become lost in the woods. It is easy to assume that the direction one is taking (e.g., model, technique) will work out. Often it will, and at other times the consequences are potentially life altering. On the other hand, attention to the basics of the alliance can be like the compass that confirms whether the apparent direction was correct in the first place. By all means, if your direction (i.e., model) is correct, then go forward. If there are questions, and if you need to orient to "true north," then assessing your outcomes and alliance is—research and practice agree—the most effective way to retask.

The research is clear on what makes the most effective therapists beyond the approach taken in specific cases. These features include warmth, empathy, genuineness, among others. Although it can be easy to learn approaches that help one develop these qualities, the same approaches are often, in reality, practiced without them, despite the self-assessment of practitioners. In the end, central steps that practitioners can take to begin developing the core competencies and FIT proficiency include the following:

1. *Cultivating transparency*. Studying one's own outcomes, to say nothing of opening them up to others, can be a harrowing experience. It often seems that every professional believes their clientele is a uniquely challenging population.
2. *Cultivating openness*. Ask yourself how open you really are to your clients' feedback and how you know this. Then ask your-

self how confident you are that you can or can't learn something from what they have to say.

3. *Cultivating surprise*. Always remember that the most effective feedback is the feedback you didn't see coming. Always remember that an "Oh wow!" response leads to a better outcome than an "Oh no, not again" response.

Of course, no one ever said going from very good to excellent would be easy. The authors and editors of this volume wish you the very best of both outcomes and self-compassion along the way.

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3

USING CLIENT FEEDBACK TO INFORM TREATMENT

CYNTHIA L. MAESCHALCK AND LESLIE R. BARFKNECHT

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 the therapeutic alliance in real time. The benefits of FIT are well established. It 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

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utility of FIT and maximizes the potential for positive therapy outcomes across a variety of treatment modalities and settings.

Obtaining and using client feedback to inform treatment decisions can lead to improved outcomes for individual clients, and 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 toward improved clinical outcomes. This chapter explores 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 that are commonly used by therapists who practice FIT are the Outcome Rating Scale (ORS; Miller & Duncan, 2000) and the Session Rating Scale (SRS; Miller, Duncan, & Johnson, 2000). 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 more than 19 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 FIT. For these reasons, this chapter (like others in this volume) focuses 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 FIT 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 toward understanding clients' progress (see Chapter 2, this volume). The more accurate picture therapists have of a client's experience both outside and inside the therapy room, the better chance they have of knowing whether the work they are doing with clients is helping. Yet as Duncan, Miller, and Hubble (2007) noted in their article "How Being Bad Can Make You Better," "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 his or her 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 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. One can set the stage for a culture of feedback by 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 meet their needs if things aren't working.

If clients sense that their therapist is uncomfortable with feedback, it is likely to affect 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 them know that no offence will be taken from negative feedback. Demonstrating openness to feedback over time will contribute to clients feeling safe to share their thoughts and feelings about the therapy. Often, 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 FIT 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, and 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 presenting the response in a manner that clearly demonstrates that 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 that clients will provide vague evaluative feedback and help to generate specific feedback that can be acted on. 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).

The Clinical Cutoff

In addition to creating a culture of feedback, monitoring clients' feedback about their views on progress and the therapeutic alliance using empirically validated measures such as the ORS and 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 against which to compare subsequent outcome measurement scores and allows therapists to see whether change is happening as therapy progresses. The clinical cutoff for an outcome measure is the dividing line between the clinical and nonclinical range of client functioning (Miller & Duncan, 2004). Understanding the implications of the clinical cutoff can inform therapists about strategies that might be appropriate based on how clients see themselves functioning. The clinical cutoff score for the adult version of the ORS is 25, for adolescents it is 28, and for children it is 32.

Although 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 cutoff 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) suggested that if initial scores are above cutoff, 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 he or she wants to deal with, taking a problem-solving approach to target the issue 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 whether 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 and the first appointment (Howard et al., 1986), prompting some agencies to implement a verbal rating script at the time an appointment is scheduled. 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' explanations for their scores, provides 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 (ETRs) based on client intake scores on the ORS. According to these ETRs, 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 cutoff, 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 cutoff, the slope of change tends to be flat or downward, indicating that change is slow or nonexistent, and clients may even experience worsening over the course of therapy. The higher the initial ORS score, the more downward the slope becomes.

An understanding of the probable change trajectories based on intake scores can be used to guide initial therapy decisions. For example, to maximize the 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 be given intense treatment early on, whereas clients who indicate that their distress level is lower may be coping with their distress, and it may be appropriate to waitlist 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 can guide therapists in their treatment decisions. 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 (i.e., no change is apparent), therapists might consider changing the type of treatment or adding services. If those options do not work to get things moving upward, they might consider referral to a different service provider. Therapists often ask, “If a client reaches the clinical cutoff, does that mean I should end treatment?” 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. ETRs based on algorithms established by Scott D. Miller (2011) show that very low ORS scores may never actually reach the clinical cutoff even if clients are ready to end treatment.[1]

Extremely low scores on the ORS (scores indicating very high levels of distress) should alert therapists to the potential for self-harm, suicide, harm to others, or substance abuse. Although therapists must always be attuned to these possibilities, when high levels of distress are indicated by extremely low ORS scores, it is imperative that the therapist seek to understand the client’s

[1]Such ETRs can be observed in the My Outcomes database, which incorporates these algorithms (http://www.myoutcomes.com). This database is available on a subscription basis only.

meaning behind the scores to assess for potential or acute risk factors that may be present and need to be attended to urgently.

The Alliance Cutoff at Initial Contact and Over the Course of Treatment

The therapeutic alliance consists of agreement on the goals, meaning and purpose of therapy, means or methods used, and the client's view of the relationship with the therapist. The therapeutic alliance is a robust predictor of outcomes (Norcross, 2010). 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 the chance of engaging clients in treatment, which ultimately increases opportunities for achieving positive outcomes. The alliance cutoff 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 high. Indeed, approximately 75% of clients score the SRS above 36. Therefore, the alliance cutoff 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 four scales of the SRS should alert the therapist to check in with the client 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 dropout and null or negative treatment outcomes (Miller & Duncan, 2004). In contrast, 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.

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 whether change can be reliably attributed to the work being done in therapy rather than to 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. 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 that increase by 4 points or less on the ORS may still indicate change but cannot reliably be attributed to the therapeutic intervention.

Being familiar with the RCI and routinely administering 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; Miller, Duncan, Brown, Sorrell, & Chalk, 2006). It makes sense that experiencing benefits from treatment early on would increase the hope that therapy will be beneficial and in turn would increase commitment to and engagement in the therapeutic process and reduce the likelihood that clients will leave 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 increasing client dropouts 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 three to four sessions, therapists can catch problems early in the process. By working with the client, their team, and their supervisor, therapists 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 sixth or seventh 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 advisable 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 definition of insanity.

TRACKING CHANGE

Tracking ORS and SRS scores on a graph can certainly be done with pen and paper. However, there are several computerized systems available that allow electronic administration of outcome and alliance measures (see http://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 with an 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 by reducing work for therapists, they also provide an easy way to compare client progress with 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.

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, they should consider changes to the approach they are using. Because the alliance is so important to outcome, when the bleeding pattern emerges, it is recommended that therapists explore the various aspects of the alliance in more detail with clients to determine if the approach is meeting 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 extratherapeutic 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 to remind clients to complete outcome measures based on how they have been doing overall since the last session rather than focusing on how they are doing today.

Seesawing or Fluctuating Scores

Seesawing 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 clients' sense of instability in their life, or it may indicate that 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 scale 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 the client 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 little change occurring from 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, seesawing scores can emerge as clients begin to oscillate through the normal ups and downs of life. Spreading sessions out can help with this (Bertolino & Miller, 2013).

Alliance Trajectories

As mentioned earlier in this chapter, monitoring changes in alliance measure 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, whereas 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 that 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 are important steps in 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 subscale on the measure more closely with the client is recommended.

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 noted (2007),

> 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 dropout 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 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 Dropouts

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., 2003; Wierzbicki & Pekarik, 1993). In a webinar series on feedback-informed treatment, Scott D. Miller noted that dropouts after the first session are commonly the result of alliance issues (Miller & Maeschalck, 2015). This speaks to the high importance of soliciting feedback regarding clients' experience before they leave at the end of their first session. Miller noted that the third and seventh sessions are also common

times for unplanned termination of service by clients. He suggested that clients may leave after the third session because they experience improvements and believe things are resolved or because 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 client's experience of diminished distress (i.e., reduce the 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 sessions out to consolidate change is advisable; if no significant change has been realized by Session 7, other treatment options should be presented to the client so he or she does 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 FIT work. Although the process may be 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 therapist to structurally elicit the experiences and expectations from each of the applicable clients (Bertolino & Miller, 2013).

Group Settings

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 his or her own experience of well-being. In contrast, 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, Quirk, Miller, Duncan, and Owen (2013) 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 provides information about not only the alliance between the individual client and group facilitator but also several additional variables associated with effective group treatment: (a) the quality of the relationship among group members, (b) group cohesiveness, and (c) group climate.

Administration of the ORS and GSRS in group presents some challenges to group facilitators because they may be dealing with eight or more people 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 clipboard 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 in an individual session, the ORS is completed at the beginning of the group. The group facilitator can ask whose 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, 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 facilitators sense this, they should follow up by talking with 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 immediately address any concerns the client may have.

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 overadministration 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 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.

Couples Work

Use of outcome and alliance measurement can yield great opportunities to inform and enrich the process of couples work. FIT in couples 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 these discrepancies or disagreements provides opportunities for the therapist to open up a couple's communication 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 individual sessions. As in other administrations, when introducing the measures to couples, it is important to provide a rationale and lay the groundwork 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 progress and their perception of how well the therapy is meeting their needs. Each partner's scores can be discussed with them, and differences between their scores can also be addressed. Just as discussing these discrepancies can improve understanding between partners, it can also help the clinician understand the partners' 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 valuable in informing the clinician about a potential *split alliance*—that is, when one partner is experiencing therapy as beneficial and meeting his or her needs while the other partner is not. It can also help alert therapists to perceived or real impartiality on their part. If this is detected, it indicates to the therapist that this is a case in which to seek supervision.

Family Work

As does 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 with the rest of the family.

Because children are involved in family work, it's important to use the appropriate measures for each family member, that is, the adult measures for

the adults and the child measures for children. Young, preliterate 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 cases when one family member has been identified as 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. Family members can be asked individually for their ideas about what would need to happen to have either their own scores or their family members' scores improve. At the end of family sessions, the SRS (Child Session Rating Scale [CSRS], 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 the therapist to develop a deeper understanding of each person's experience and identify any potential biases that may be affecting the therapist's objectivity. Again, if biases are detected, seeking clinical supervision is recommended.

With Children and Adolescents

The goals of using FIT with children and adolescents are similar to its goals with adult clients: to ensure that services are effective, that the therapist is aligned with client preferences, and that the client is engaged. Measures such as the CORS and the CSRS 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 to 12 and adolescents 13 to 18 years of age. As mentioned earlier, the clinical cutoff on the ORS is 32 of 40 for children aged 8 to 12 and 28 of 40 for adolescents aged 13 to 18. Perhaps these higher cutoff scores reflect that young people have fewer life experiences and a more optimistic perspective than adults. The alliance cutoff for children and adolescents on the SRS is 36 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/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 children's experience of their well-being 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 FIT IN SPECIFIC SETTINGS AND WITH SPECIFIC POPULATIONS

FIT 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 in which FIT is applied. The following is an exploration of the application of FIT in a variety of settings and populations.

Agency Settings (Multisite Provider and Service Settings)

One of the unique applications of FIT 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 in which 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, overadministration 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 a short time frame,

sometimes even within the same day. For example, a client may attend a one-to-one therapy session with her 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 ensure follow-through. Because each agency is likely to have a unique set of circumstances, there is no one-size-fits-all solution to this issue. In some agencies, computerized systems for administration of outcome and alliance measures allow easy access to client scores. Feedback on a client's progress and therapeutic alliances can be viewed in real time by any member of the care team on- or offsite. 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 lay out a protocol for therapists to follow from administration of the measures to follow-up assurance on implemented changes. For example, in a 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 his 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 clients' outcomes. Establishing agency norms provides a benchmark for therapists to compare their outcomes with and create professional development goals. In addition, these norms can serve as a reference point for evaluating the impact of program changes for quality improvement processes.

Residential and Intensive Treatment Settings

Application of FIT in residential or intensive treatment settings where clients receive daily services presents similar challenges as the multisite, multiservice, and multiprovider 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 overadministration 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 measure at the end of each week. This reduces the risk of overadministration 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 for which group setting it may be most beneficial to collect feedback. For example, if a client participates in two skill-building or psychoeducational groups and one group psychotherapy or processing group, it may be most valuable to administer the ORS and the Group SRS in the psychotherapy group and forego the measure in the skill-building or psychoeducational groups.

Substance Abuse and Mental Health Populations

What about using FIT with special populations, such as clients with mental illness or substance abuse? Differences in these populations are worthy of consideration when interpreting client progress and the therapeutic alliance. Miller, Duncan, Sorrell, and Brown (2005) explored the differences between 160 clients with substance abuse and clients in a general mental health population. They found three significant differences between the groups. First, the clients with substance abuse 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 clients with substance abuse 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 greater than 25 (the clinical cutoff). Third, longer contact with clients with substance abuse resulted in better outcomes. In contrast, 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, who completed 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 them, strengthen the therapeutic alliance, and sustain engagement for as long as possible to realize the most benefit from treatment. Again,

careful monitoring of progress for clients with both substance abuse and mental health concerns is essential to guide practice decisions and action when deterioration in functioning or in the therapeutic alliance is detected.

Mandated Populations

What about mandated versus voluntary clients? Miller et al. (2005) also looked at differences among (a) voluntary clients who completed the substance abuse treatment program successfully, (b) voluntary clients who ended treatment unsuccessfully, (c) mandated clients who completed the program successfully, and (d) mandated clients who ended unsuccessfully.

Successful cases were defined as those who completed the 6-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 noted 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. (Miller et al., 2005, p. 8)

You may recall from the earlier discussion on administering the ORS that mandated clients may score themselves above the clinical cutoff. 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 consequences.
- 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 that the client is willing and able to reduce alcohol consumption but also needs to use other nonmaladaptive coping strategies for stressful situations. Thus, the expectation from the referring professional and the client are different, with the latter 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 it. 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 them to make 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 but rather what the client needs to do to alleviate the referrer's concern.

Again, there are strategies for creating a safe culture of feedback. Although there are dynamics that affect any client's perception of safety, the mandated client may have additional or magnified barriers that 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, or they may fear rejection when there is clearly a power differential. Indeed, therapists working with mandated clients may have multiple barriers to developing a safe culture of feedback. It is thus important to model transparency and genuineness.

One of the biggest challenges in working with mandated clients may be managing countertransference. Often clients in mandated treatment situations have made mistakes that make it easy for therapists to judge them. For this reason, it is important for therapists in these situations to engage in self-reflection and participate in clinical supervision. When a therapist feels judgmental toward a client, it will affect the former's ability to maintain genuineness. Clients will sense this, and it will affect their perception of the therapeutic alliance. Using the SRS with mandated clients is extremely beneficial to ensure that therapists are regularly asking about the client's experience. Earlier it was recommended that therapists 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.

FIT AND THERAPIST DEVELOPMENT

FIT offers opportunities to improve client outcomes one client at a time by paying attention to client feedback and adjusting one’s practice accordingly. Indeed, the results of using FIT are well documented in reduction of dropouts and improved outcomes (Miller & Schuckard, 2014). But what is the impact on therapist development over time? One would think that by implementing FIT, therapists would over time 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 doesn’t seem to be the case (Shimokawa, Lambert, & Smart, 2010). Analysis of ORS data indicates that with 60 completed cases (the minimum number needed to establish a baseline), there is about a 90% confidence rate in predicting future outcomes for a therapist (Miller & Maeschalck, 2015). What this suggests is that once a baseline of therapist outcomes has been established, outcomes typically do not improve beyond this. Further evidence supporting this is found in studies indicating that the average clinician’s development process plateaus early in their career (at about five years) and that training in “evidence-based” manualized therapies and client diagnosis does not have much impact on therapist outcome (Miller, 2013). Studies that examine the differences in therapists whose outcomes are superior to those of 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 ranges of therapists with the best outcomes and the worst. They concluded that 97% of the difference in outcomes was attributable to variability in alliance, whereas 0% of the difference between therapist outcomes was attributable to client variability in the alliance. Baldwin et al.’s study on therapist development points to the importance of finding ways to help therapists connect with more clients by identifying clients with whom they don’t connect and then finding ways to enable that connection. On the basis of 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.

The ACORN (2013) collaborative outcomes resource network looked at improvement in therapists’ outcomes over a 12-month period. They found that the frequency with 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 fewer in a 1-year period showed deteriorated or no improvement in effect sizes. Therapists who viewed their data between 50 and 200 times over a year showed significant gains in effect sizes. Those who viewed their data more than 200 times in a year showed the most significant gains at more than double those made by therapists viewing their data 50 to 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 Chapter 16, this volume). Activities directly related to improving their work and their outcomes were examined. Chow found that therapists with the best outcomes spent 2.5 to 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 8-year period, outcomes for the top-performing therapists grew by one half a standard deviation above the mean compared with the average clinician (Chow et al., 2015).

FIT involves not only monitoring client feedback but also 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 with available norms, standards, and benchmarks. By reflecting on these comparison data, therapists 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, therapists 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. FIT 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. FIT is an important piece not only in improving outcomes but also in therapists' ongoing professional development and their journey toward excellence.

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4

ACHIEVING EXCELLENCE THROUGH FEEDBACK-INFORMED SUPERVISION

SUSANNE BARGMANN

Therapist development can be a highly sensitive endeavor. This chapter focuses on using feedback-informed treatment (FIT) in supervision, including possible traps and tips for the most effective and ethical use of feedback in professional development. It offers a model for supervision focused on improving client outcomes.

SUPERVISION DEFINED

There are several definitions of *supervision* in psychotherapy. This chapter uses the following definitions, which are taken directly from FIT manuals published by the International Center for Clinical Excellence (ICCE; Bertolino & Miller, 2012):

- A relationship between a supervisor and supervisee that promotes the professional development of the supervisee through

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interpersonal processes, including mutual problem-solving, instruction, evaluation, mentoring, and role modeling (Hill & Knox, 2013).

- *Competency-based supervision* represents a "metatheoretical approach that explicitly identifies the knowledge, skills and attitudes that comprise clinical competencies, informs learning strategies and evaluation procedures, and meets criterion-referenced competence standards consistent with evidence-based practices (regulations), and the local/cultural clinical setting (adapted from Falender & Shafranske, 2004). Competency-based supervision is one approach to supervision; it is metatheoretical and does not preclude other models of supervision" (American Psychological Association, 2014).
- FIT supervision differs from traditional supervision, which is usually guided by a particular treatment model or theoretical orientation. FIT supervision is instead guided by outcome and alliance feedback provided by clients. Because of this broad approach to supervision, FIT supervision may be applied across therapeutic modalities, disciplines, and service settings.
- From a feedback-informed perspective, the purpose of supervision twofold: (a) to ensure that services delivered to clients are having a positive impact on their outcomes and (b) to improve a clinician's effectiveness. FIT supervision is provided from a metatheoretical perspective, in line with the approach of FIT.

Most research on clinical supervision concerns more traditionally oriented types of supervision. The following section offers current evidence for clinical supervision practice, as well as existing research on FIT-driven supervision.

RESEARCH ON CLINICAL SUPERVISION

There is ample evidence of the effects of supervision on professional development. Effective supervision is associated with increased supervisee self-efficacy (Gibson, Grey, & Hastings, 2009), decreased supervisee anxiety (Inman et al., 2014), skill acquisition (Lambert & Arnold, 1987), increased supervisee openness (Ladany, Mori, & Mehr, 2013), and reduced confusion about professional roles (Ladany & Friedlander, 1995). Numerous studies have also documented the negative effects of inadequate or harmful supervision. For example, these have found increased supervisee anxiety, decreased supervisee self-disclosure, and even cases of supervisees dropping out of

the field entirely (e.g., Ellis, 2001; Gray, Ladany, Walker, & Ancis, 2001; Ladany & Inman, 2012; Mehr, Ladany, & Caskie, 2010). In other words the research shows that supervision can have both positive and negative effects on supervisees.

The impact of supervision on enhancing and protecting the well-being of the client is less clear. As of today, there is only one experimental study (Bambling, King, Raue, Schweitzer, & Lambert, 2006) in the literature documenting a small positive effect of supervision on client outcomes. The study has a number of limitations, making its conclusions uncertain. This methodological uncertainty is found in most of the research done on clinical supervision. In a review of the existing research on supervision that did not use an experimental design, Watkins (2011) noted that most studies exploring the impact of supervision on client psychotherapy outcome relied on supervisors' or supervisees' perceptions, rather than client self-reports and psychometrically sound measures. Regarding the supervisor-to-client treatment outcome connection, Watkins concluded, "After a century of psychotherapy supervision and over half a century of supervision research, we still cannot empirically answer that question" (p. 252).

In recent years, research has focused on the impact of supervision on client outcomes when using formalized client feedback to guide supervision. Reese et al. (2009) conducted a controlled study of 19 psychotherapists working with 115 cases over a year. In the study, they compared the effect of supervision using regular outcome feedback to the effect of supervision without regular outcome feedback. The therapists in the feedback group had significantly better outcomes than the therapists in the nonfeedback group. These outcomes imply that the effect of supervision is increased by including the ongoing outcome feedback from clients in the supervision.

FIT SUPERVISION

Basic Principles

The idea behind FIT supervision is to approach supervision in a more specific and deliberate way than traditional supervision by focusing on the outcome and alliance feedback gathered from clients via the administration of empirically validated outcome and alliance measures. The aim is to address cases in which the feedback indicates cause for concern and develop ideas for working with the client in a more helpful way. By using the data from the outcome and alliance feedback from clients, the supervision can be used to identify specific areas for improvement for a particular clinician or agency and develop a plan for deliberate practice.

The following principles of FIT supervision are based on outcome research and research on supervision:

- The client's experience of the alliance and outcome are the best predictors of retention and progress in treatment.
- Because of the low correlation between client and clinician ratings of outcome and alliance, therapists must routinely seek client feedback via valid and reliable measures of the alliance and outcome.
- No one model, method, or clinician is sufficient for treating all problems.
- Feedback is crucial to help services address the diverse problems and people in care.
- By monitoring client outcomes, supervisors can determine their effectiveness when the goal of supervision is to improve client outcomes by reducing dropout and ineffective long-term treatment. (Bertolino & Miller, 2012, ICCE Manual 3, p. 5)

Administrative and Clinical Supervision

To create an environment conducive to learning and developing new ideas and strategies, it is important to create a culture that is "error-centric," meaning that errors are valued as opportunities for learning and dealt with in a nonblaming atmosphere where focus is on learning and providing better care for clients. This will also make clinicians more likely to bring nonprogressing cases forward in supervision. As part of creating this culture, it is important to have an open and transparent dialogue about difficulties or struggles, as well as successes. The supervisor encourages clinicians to bring up nonprogressing cases in supervision and focuses on making sure the feedback is being used actively when discussing and planning the treatment of a client. The supervisor also focuses on using the aggregate data to identify areas for improvement for the organization or the clinician (Bertolino & Miller, 2012, ICCE Manual 3).

In FIT supervision, the supervisor is balancing two "roles," or perspectives, at the same time: an administrative and a clinical perspective. These perspectives require different actions from the supervisor.

From an *administrative perspective*, the focus is on how and to what extent formal client feedback on progress and the therapeutic alliance is being gathered and used, that is, are therapists administering outcome and alliance measures and documenting the scores in their paperwork? Another important focus is to what extent the clinician adheres to the FIT approach, that is, how are the data being used in the treatment planning? The administrative perspective relies on the surrounding structure of implementation: Without

a clear and effective implementation strategy, the FIT administrative supervision becomes difficult. In some practice settings, these structures may be clear, for example, if the supervisee works alone or in a small private practice. In larger practice settings, a close collaboration with management and clear management support is crucial for the supervisor to be able to ensure that the clinicians use FIT as intended.

In agency settings, the supervisor may need to work with management to create structures supporting the use of FIT to ensure that the tools are being used correctly, that any barriers to implementation of formalized feedback tools are identified and solved, and that FIT practice is consistent with the principles of the organization.

In the second, the *clinical perspective*, the focus is on consulting with clinicians on specific clinical cases and on developing ideas and suggestions as to how the supervisee can move forward with a particular client. Part of the clinical supervision may include working on how to create a culture of feedback with clients, that is, how feedback measures are introduced to clients and how the feedback is used in the session with the client. The main focus is on using and integrating client feedback in the clinical work. It is important that the supervision centers on working with "at-risk cases" (i.e., clients at risk for dropout, deterioration, or ineffective treatment). As mentioned earlier, the supervisor must work to create a culture in supervision where the clinicians feel safe bringing up difficulties, challenges, or mistakes. This is achieved by welcoming questions, acknowledging the clinician's concerns about FIT, and asking for ongoing feedback from supervisees on the supervision process, for example, by using the Leeds Alliance in Supervision Scale to evaluate the supervision alliance (Wainwright, 2010).

A crucial part of creating a useful supervision climate is setting guidelines for the communication in the supervision session. Communication needs to be clear, respectful, and acknowledging. The supervisor can act as a role model by sharing and learning from his or her own mistakes, demonstrating how to use FIT in practice, or offering to do a "live interview" with a client to demonstrate how to work with FIT in practice. To provide the necessary support, it is important that supervisors use FIT in their own clinical work and are well versed in the research and principles supporting FIT (Bertolino & Miller, 2012, ICCE Manual 3).

FIT SUPERVISION IN PRACTICE: A MODEL FOR SUPERVISION

FIT supervision can be applied in either individual or group supervision formats. Group supervision can provide rich learning opportunities, enabling clinicians to learn and share ideas with peers about how to introduce, integrate, and use the feedback tools in practice. Group supervision can also be helpful

in addressing skepticism or reluctance that some clinicians may display in the implementation process of FIT. It can be helpful to hear about colleagues' experiences of benefits of using formal feedback with clients (Bertolino & Miller, 2012, ICCE Manual 3, p. 10).

The FIT supervision process consists of three steps in both individual and group formats:

1. basic presentation of the client–consumer using the case presentation format (see Exhibit 4.1),
2. exploring the feedback graphs focusing on the therapeutic alliance (see Figure 4.1), and
3. reflections (either by supervisor or by the group).

1. Basic Presentation

The core focus of FIT supervision is the feedback from clients, and especially bringing up cases for supervision where feedback indicates that the case is not progressing as could be expected—in other words, bringing up cases where the clinicians' ideas about working with a particular client have not been helpful in achieving the desired changes. Therefore, it is important that the presentation of background information about the client is kept brief, simply describing basic factual information and taking no more than a few minutes (Mee-Lee, 2009). This will prevent the clinician from sharing too many of his or her ideas about the case with the supervisor and the team, allowing for a more free reflection and ideally bringing new perspectives about the case. The case presentation format in Exhibit 4.1 describes the basic information that the clinician is asked to give about the client.

This way of presenting a case for supervision can feel new, different, and perhaps challenging to many clinicians. They can feel like "something

EXHIBIT 4.1
Case Presentation

- Name
- Age
- Sex
- Relationship status/family
- Work/education
- Concerns of the client/significant others
- Treatment start
- Current treatment (including drugs)
- Previous treatment
- Abuse
- Reason for seeking treatment

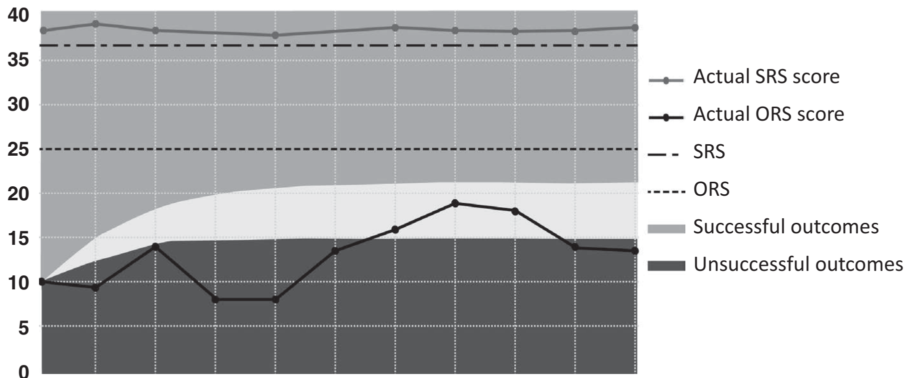

Figure 4.1. Feedback graph from the Outcome Rating Scale (ORS) and Session Rating Scale (SRS). In the feedback graph, the solid black line represents the score on the ORS, illustrating the client's experience of progress. The black dotted line at the number 25 represents the clinical cutoff where scores falling below 25 are in the clinical range. The solid gray line at the top of the figure represents the client's feedback on SRS, illustrating the client's experience of the therapeutic alliance. The dashed line near the top represents the cutoff for the SRS, where scores below 36 indicate a lower alliance score and possible problems in the alliance. The gray and black zones represent predictive trajectories for successful and unsuccessful treatment, where the gray zone is the "zone for successful treatment" and the black zone is the "zone for unsuccessful treatment." The lightest gray zone is the area where there is no clear prediction of the outcome of treatment.

is missing" when they don't get a chance to describe all the work they have done with a particular client. When FIT supervision is new to a group or a clinician, it can be useful for the supervisor to ask permission from the group or the clinician to try out a completely different format in supervision and ask them to observe what happens: What is different when supervision is structured in this way? This can prevent the group from reacting negatively toward this new model of supervision.

2. Reviewing the Feedback Graph

Before the review begins, studying a client's feedback graph, such as the one presented in Figure 4.1, can be useful in terms of practicing how to understand and interpret feedback data. Ask the clinician or the group to simply review the graph and take a vote: Is the client getting better? No difference? Worse? Is there cause for concern? This can allow the supervisor to teach the skill of reading the graph by focusing on the following questions regarding the data (and demonstrating what to look for on the graphs):

- Does the outcome score indicate progress, no progress, deterioration?

- Does the alliance score indicate a positive working alliance or problems in the working alliance?

After the voting, the supervisor turns to the supervisee and starts a review focused on understanding what the client wants in terms of the therapeutic alliance (Norcross, 2010; see Figure 4.2).

Using the therapeutic alliance as the center of the supervision reflects the concept that the therapeutic alliance is central to the outcome of therapy. When treatment is not progressing, the first place to make adjustments is the collaboration between the therapist and the client, exploring and trying to better understand what the client wants in terms of the therapeutic alliance. This can be done by talking specifically about the areas of the alliance in Figure 4.2, by exploring the movements of the feedback graphs, and by investigating the client's explanations and feedback from the sessions. It can be useful to draw the alliance stool on a flip chart or whiteboard and write down the words from the client on the different items. This gives all the participants in the supervision an overview of what the clinician currently knows and understands and also what information might be missing.

In the case review, the following questions can be helpful when exploring the client's wishes for the therapeutic alliance:

- If no progress is evident on the outcome measure or the alliance measure indicates possible concerns, is the clinician addressing this with the client? What is the plan to address lack of progress or alliance issues?

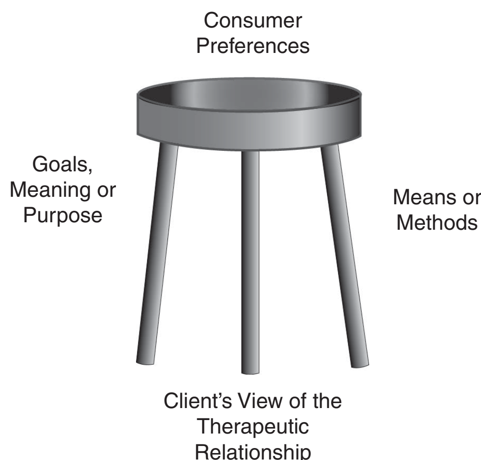

Figure 4.2. The therapeutic alliance.

- Has the clinician explored what the client wants from treatment? Does the client have a stated goal for treatment? (This is often an important question to explore because the lack of a clear agreement on the goals of the treatment is one of the primary reasons for difficulties in the alliance.)
- Has the clinician asked the client about his or her ideas about how change happens? (This is part of the "preferences.") What does the client believe needs to happen to solve the problems or to achieve the goals that are important to him or her?
- Has the clinician asked the client about his or her preferences regarding the therapy relationship (e.g., gender preferences, cultural awareness, specialized approaches). The client may also express "identity preferences" that relate to how the client wishes to be seen and understood by the clinician (e.g., as a competent person, as an intelligent person, as a considerate or caring person).
- Has the clinician asked the client about his or her expectations regarding the clinician's role in the treatment? How does the client want the clinician to be in the relationship to be most helpful (e.g., supportive, challenging, a mentor, a mother figure).
- Is the clinician talking with the client about his or her outcome and alliance scores and the meaning the client puts to those scores?

Often the supervision session, in itself, will be helpful to the clinician because it helps focus on the client's feedback and the alliance. It will typically become clear which part of the alliance has not been properly clarified with the client, providing the clinician with new ideas about what he or she needs to explore further. After the review, the supervisor can ask the clinician if there are specific areas or themes (in relation to the alliance) that he or she would like the team to reflect on. Then the supervisor asks the clinician to listen to the reflections from the team without responding to what is said.

3. Reflections

In individual supervision, the reflection will be done by the supervisor sharing his or her thoughts and ideas about the case. The reflections are focused specifically on the feedback graph and the therapeutic alliance. The aim is to provide as many ideas and reflections as possible, giving the clinician the chance to get new ideas and help to change the way he or she is working with the client.

The reflections from the supervisor about "what needs to happen now" are also influenced by the treatment length. Supervision in a group setting

provides an opportunity for the supervisor to build a culture around handling nonprogressing cases and how quickly something needs to change. This can be done by teaching the group about the meaning of the predictive trajectories (the green and the red zone on the graph) that give a prediction of how much change is necessary to consider the treatment to be on track. The supervisor can also reference research on how quickly change happens in successful treatment (Brown, Dreis, & Nace, 1999; Lambert, 2010), showing that if change hasn't happened within the first eight sessions or weeks, then the risk of an unsuccessful outcome is 90%. On the basis of this research, the recommendation for dealing with nonprogressing cases in supervision are as follows:

- After one to three sessions or weeks: Consider smaller changes or adjustments to the alliance (e.g., the goals, the means or methods, or the relationship).
- After six or seven sessions or weeks: Consider larger changes, such as adding elements to the treatment (e.g., more intensive treatment, group treatment, seeing a psychiatrist or dietician).
- After nine or 10 sessions or weeks: Consider changing the treatment or the clinician.

In group supervision, the assembled team should create as many reflections about the case as possible, focusing on the feedback graph and the therapeutic alliance. The idea of the reflecting team is inspired by the work of Tom Andersen (1987). Its aim is to create a group dialogue that can generate a multiverse of hypotheses and ideas to give the clinician new perspectives and ideas about ways to work with his or her clients. If there is a reflective team, the supervisor may not necessarily participate as actively in the reflections but will focus on guiding the process and keeping the reflections on track. It is important that the supervisor is clear about what types of reflections are useful in this type of supervision: The team must provide reflections on the alliance based on what they have heard in the review and what they pick up from the feedback graph. The reflections must be made in an open, hypothesizing, and acknowledging way, making it as safe as possible for the therapist to listen to the reflections. The team speaks to each other and talks about the therapist in third person, making it easier for the therapist to listen without feeling the need to respond. The reflections can focus on questions such as the following: Are there parts of the alliance that are unclear in terms of what the client wants? What possible disagreements do they hear between the client, the clinician, or other people involved in the treatment? The goal is to help the clinician become aware of elements of the alliance that they may not fully understand (i.e., the client's preferences or purpose for seeking treatment) or to become more clear about what questions they need to ask the client to fully understand what he or she wants from the alliance. By exploring and

adjusting the alliance, the hope is to increase the client's engagement in the treatment, leading to a better outcome.

It is important to prevent the team from getting into a discussion about "who is right" in the reflections. The goal is to gain a variety of reflections, and all are explored and offered as possibilities for the clinician. If the team starts discussing which reflections are right, the supervisor may need to intervene and restate the purpose of the reflections. It is important for the supervisor to ensure that the clinician doesn't feel criticized by the reflections or feel the need to dismiss or discuss reflections with the team. This can be done by making sure that the reflections focus specifically on the feedback data and the alliance; that they are made in an open, hypothesizing, and acknowledging way; and that the clinician knows he or she can take the ideas that are helpful and disregard the others.

During the reflections, the supervisor must keep the process on track. The reflections can easily drift into more "traditional" reflections that are more technical, theoretical, or diagnostic. These reflections are not congruent with a FIT perspective, which is metatheoretical and focuses on understanding the alliance rather than specific theoretical understandings. If these reflections are brought up, the supervisor must help the team by restating the focus of FIT supervision and redirecting the attention back to the alliance stool (Figure 4.2). To create and maintain a safe environment in the group that will encourage open sharing of nonprogressing cases, the supervisor must pay careful attention to reflections that can seem criticizing or judgmental and intervene by asking questions to help redirect the reflections back to the metatheoretical perspective focusing on the client feedback. In starting a FIT supervision culture, the supervisor may need to actively create a safe, acknowledging, and helpful supervision context.

CASE EXAMPLE

The following case describes supervision for Maria, a therapist working in a small group practice with eight other therapists. All of the therapists in the agency work with the Outcome Rating Scale (ORS; Miller & Duncan, 2000) and Session Rating Scale (SRS; Miller, Duncan, & Johnson, 2000) and use the software system FIT-Outcomes to calculate data. The FIT supervision is done with all eight therapists in a group format.

Case Presentation

Name: Linda
Age: 51
Sex: Female
Relationship/family: Married, two children (15 and 20 years old)

Work/education: Works part time as a receptionist for a large law firm

Concerns of client/significant others: Linda is worried about her youngest son, who has developed a substance abuse problem over the past 2 years. The client finds it hard to deal with her life, and her husband and colleagues are concerned about her.

Treatment start: Started treatment 3 months ago

Current treatment: Individual sessions once a week. No medication.

Previous treatment: Linda was recently given a diagnosis of depression by a psychiatrist she has been seeing for 2 months to cope with feelings of sadness. The consultations with the psychiatrist haven't been helpful, and when he suggested medication, she decided to find a therapist instead.

Abuse: None

Reason for seeking treatment: Linda wants a place to talk about her worries about her son and wants help dealing with having a son with a substance abuse problem.

As previously mentioned, one way to ensure a focus on the alliance in supervision is to draw the alliance tool on a flip chart or a whiteboard and add the descriptions and words from the client and the reflecting team. In the supervision of Maria, who is working with Linda, the supervisor starts by talking to the team members about the graph and what ideas might be helpful. Linda has come for 11 sessions, and the scores are in the red zone, indicating that the risk of an unsuccessful outcome is high, so the supervisor invites the team members to reflect on what changes could make therapy more helpful to Linda.

Team Member: It sounds like family is important to Linda, and I was wondering if it would be a good idea to offer a treatment that includes the whole family. I am not sure where this should be offered, perhaps in one of the family treatment centers?

Supervisor writes "family treatment" under *Means/method* on the whiteboard.

Team Member: I get the impression that Linda really wants to be viewed as and acknowledged for being a competent woman capable of dealing with many things by herself. I am wondering how to combine this preference with asking for therapeutic help? Maybe she needs to find things she can do herself to feel that she is actively dealing with these things herself.

Supervisor writes under *Preferences*: "be viewed as competent, dealing with things herself" and writes under *Means/method*: "finding things she can actively do to deal with her problems."

Team Member: I am wondering how Linda feels about being the mother of a son with a substance abuse problem. I could imagine she might feel guilt or shame, and maybe she feels she needs to talk to a professional because she feels she can't talk to other people about it out of fear of being judged. Would it be worthwhile to refer her to a group treatment where she can talk with other parents of children with substance abuse problems? I know there is such a group at one of the agencies that work with substance abuse treatment.

Supervisor writes under *means/method*: "being in a group with other parents of children with substance abuse problems."

Team Member: I notice that the alliance score is consistently high, and I'm thinking Linda really appreciates talking with Maria, and she might also be scared of being pushed out of treatment given how low her ORS score is. I am thinking Maria may need to be careful when talking to Linda about a referral, making sure Linda doesn't feel pushed out, because she might react by trying to hold on to Maria even tighter. I've had this experience with a client myself, and I had to be very careful in the way I worded this—letting her know that I was committed to helping her and supporting her until she found a new therapist or treatment.

Supervisor writes under *relationship*: "feels dependent on Maria to help, may be afraid of being pushed out."

In writing the statements down, the supervisor tries to be as close as possible to what is being said, both during the interview with the clinician and during the reflections. This can give the clinician a helpful overview after the reflections have been given and may help them make a decision about how to move forward. The clinician can revisit the reflections again later by taking a picture of the whiteboard or flip chart.

Rounding Off With the Therapist

After the reflections, the supervisor returns to the clinician to give him or her the opportunity to comment on some of the ideas that came up. There is an important balance between giving the clinician the chance to comment on the reflections without going into a longer discussion about the ideas that

the team came up with. The supervisor can help the clinician by asking, "Were there certain reflections that stood out to you as particularly interesting or useful?" or "Are there ideas that you want to pursue in your work with this client?" The supervisor needs to make sure that the clinician commits to doing something differently in the work with the client. Depending on how long the clinician has been working with the client, how much the supervisor needs to insist on getting a clear commitment may vary, but typically the supervisor should seek to make a specific plan to move forward with the case and also set a specific time frame for when the case will be brought up in supervision again if the new ideas are not helping the client. Often this can be done by simply asking the clinician how many sessions he or she will need to work on the new ideas and determine whether they are helping. Most of the time, the clinician and supervisor can then agree to follow up after two or three sessions. If the clinician wants to wait a longer time (e.g., eight sessions) before bringing up the case again, then the supervisor may need to push a little to get the clinician to commit to bringing up the case again sooner. This can sometimes be done by restating the goal of the supervision: to help the clinician change if treatment isn't helping and thus be helpful to the client. By waiting too long, the chances of success drop, and the window of opportunity for change closes.

Ideally, supervision of a case using the FIT supervision model takes about 15 to 20 minutes. The key is to spend only a short time on descriptions of how the clinician has worked with the client and instead focus directly on the outcome and alliance feedback from the client and on unfolding the therapeutic alliance.

FIT SUPERVISION AND CONTINUOUS PROFESSIONAL DEVELOPMENT

A supervisor can work with the FIT approach to achieve continuous professional development. The process of professional development work must be focused and deliberate, specifying target areas of improvement while simultaneously tracking the impact of practice on the outcome of the clinician or the agency. The process of *deliberate practice* is described in the works of Anders Ericsson (Ericsson & Charness, 1994; Ericsson, Charness, Feltovich, & Hoffman, 2006; Ericsson, Krampe, & Tesch-Romer, 1993) as an effortful activity designed to improve target areas of performance. The ideal process of deliberate practice follows these steps:

1. identifying your current level of performance,
2. developing a specific plan for improving target performance,

3. practicing in a deliberate and focused way, and
4. ongoing feedback and evaluation.

Deliberate practice can be applied when working on elements of an individual clinician's performance and when working with aggregate data for an agency. The clinician can use the process to look at specific parts of his or her work; for example, "How do I balance the alliance when working with couples?" or "How do I solicit detailed feedback at the end of my sessions to detect when a client is at risk for dropout?" The goal is to help the clinician improve target areas of performance that might negatively affect the effectiveness of treatment. These areas might be discovered by reviewing individual cases, noticing consistent patterns in the clinicians work, or reviewing the aggregate data of the clinician.

At an agency level, the supervisor focuses on the ongoing professional development of the agency by looking at its aggregate data. This can help the supervisor identify agency trends, areas of the treatment that are falling below the norms, and programs or treatments within the agency that are less effective. Tracking the aggregate data allows the agency to test the impact on outcome of the changes that are made to try to increase effectiveness.

Working With Aggregate Data in FIT Supervision

Aggregate data from the outcome and alliance measures can give the clinician or the agency a statistical description of their effectiveness. This can be valuable in planning professional development initiatives for the clinician or the agency. Computerized systems can facilitate comparisons to standardized norms for the effect of treatment, making it possible for a clinician or agency to identify areas for improvement.

Analyzing and interpreting aggregate data can be a sensitive endeavor for the individual clinician and for the agency. Most clinicians and agencies will discover that they are average in terms of their effectiveness, but many will also find areas of their practice that fall below the norms. The supervisor plays an important role in creating a safe atmosphere when looking at data: It's not about evaluating who is "good" and who is "bad." The aim is to be more specific and deliberate when planning professional development initiatives. As is true with the supervision of client cases, it is important to create a culture where "errors" (or results falling below the norm) are viewed as opportunities to get better rather than as something to be ashamed of or as something deserving of punishment. The supervisor must strive to be as specific and precise as possible when identifying areas for improvement. The atmosphere must be nonjudgmental and constructive, providing a clear signal that improvement is possible by working in a concrete, goal-directed fashion.

Figure 4.3 shows an example of aggregate data from the data system FIT-Outcomes, which aggregates data from the ORS and SRS. Aggregate data from FIT-Outcomes illustrates the process of working with aggregate data in supervision.

The data reported in the data system FIT-Outcomes is divided into active and inactive clients, making it possible to compare the effectiveness of the ongoing (active) cases to the cases that have been closed (inactive).

The first section of data gives a statistical summary of how many clients, treatment episodes, and therapy sessions the clinician or agency has. It also calculates average treatment length and dropout rate.

The second data set calculates statistical indices related to the effectiveness of the clinician or the agency. *Percentage reaching target* quantifies the percentage of clients in the green zone (above the predictive trajectory of successful cases). *Effect size* calculates the effect of treatment compared with no treatment. *Relative effect size* compares the effect size of the clinician or agency with the *grand mean effect size* in the system. The grand mean effect size is a norm generated from 250,000 cases, representing the mean outcome of treatment. If the relative effect size is positive, it means the clinician or agency delivers a treatment that is more effective than the norm. If the relative effect size is negative, it means the clinician or agency delivers a

	Active	Inactive
Clients	524	1045
Collateral Raters	5	19
Episodes	561	1189
Sessions	3614	8935
Average Sessions	6.44	7.51
Average Treatment Length (months)	16.16	4.65
Dropout Rate	–	29.5%
Clients		
Average Intake ORS	23.26	22.53
Adults	23.68	21.68
Adolescents (13–18)	26.61	26.76
Children (0–12)	26.14	26.61
Average Intake SRS	35.69	35.28
Average Raw Change	5.39	6.75
Percentage Reaching Target	68.30	70.50
Effect Size	0.51	0.73
Relative Effect Size	-0.25	-0.03

Figure 4.3. Aggregate data from the Outcome Rating Scale (ORS) and Session Rating Scale (SRS).

treatment that is less effective than the norm. A relative effect size of zero means the clinician or agency delivers a treatment that is average compared with the norm.

Working with the clinician or agency, the supervisor can explore relationships between the various statistical indices—that is, differences between active and inactive clients that may point to areas for improvement. This helps the clinician or agency identify focus areas for professional development initiatives.

CASE EXAMPLE: INDIVIDUAL THERAPIST

A clinician working with the ORS and SRS wants to look at her aggregate data in the supervision session to identify areas for professional development. The effectiveness of the clinician is average (relative effect size = 0), but a large percentage of clients drop out without improvement (dropout rate = 33%). At the same time, the average intake SRS score is high (39.4 out of a possible 40).

This makes the supervisor curious about the relationship between clients' not being critical on the SRS but then choosing to drop out after the session. The supervisor proposes a hypothesis that clients lose engagement in the session but choose not to come back rather than telling the clinician about their feelings. In other words, they give up on treatment instead of giving the clinician a chance to adjust what may not have worked for them. The clinician recognizes this picture and says this has been her feeling about the dropouts as well. So the two agree that they need to focus on developing strategies that allow the clinician to talk more with clients about what they didn't find helpful in the session before they go out the door.

The supervisor first suggests that they do a role-play in which the clinician introduces the SRS to the supervisor in the way she would normally introduce it in the session with clients. Then they switch roles, and the supervisor introduces the SRS to the clinician in the way she would normally introduce it to clients. Afterward, they talk about similarities and differences in the two introductions, and they talk about how the clinician can adjust her introduction to increase the likelihood that she will get critical feedback from clients who are not satisfied with the session. After the exercise, the clinician spontaneously says that she has probably been afraid of getting negative feedback from clients, which has been apparent in the way she has introduced the scale, making the clients withhold negative feedback.

After this, the supervisor and the clinician start working on specific sentences and words the clinician can use the next time she introduces the SRS. They also talk about timing, tempo, and tone of voice when introducing the

SRS. The clinician is enthusiastic and relates her experience in other situations where she felt nervous but found that being well prepared helped her overcome the overt nervousness.

Next, the supervisor suggests that the clinician record her introduction of the SRS in the next couple of session so that they can review and focus on what she does in the introduction that enables the client to give her more negative feedback. They agree to use the data to see whether the strategies lead to a lower intake SRS score and fewer dropouts. After 2 months, they can see a clear change in the data. The average intake SRS for new clients has dropped to 35.4 of a possible 40, and the dropout rate is also lower (around 15%).

Case Example: Agency Level

An agency with 20 therapists has been working to implement FIT. After a year and a half, they are curious to see what their current effectiveness is, and they ask the FIT supervisor to help them analyze and interpret their data. The first thing that stands out is that the effect of the treatment falls below the norm (relative effect size = –0.29). They are both surprised and frustrated with the data because this is a workplace known for its professional skills and knowledgeable therapists. They start working with the supervisor to explore the reasons for the lower level of effectiveness to understand what they need to work on to improve their outcomes.

It becomes clear that a particular treatment program is pulling down the average by not helping the clients improve. This program offers youths a place to drop in and talk to peers about their lives. The clinicians working in this program recognize the feeling of not really helping the youth. They feel that the service they offer is insufficient in terms of helping youth deal with the serious problems they face (e.g., cutting, suicide attempts, alcoholic parents). The clinicians share ideas about offering a more intensive service with more resources that actually help the youth with their problems. After the data analysis, management decides to allocate more resources to the program to see whether this makes the treatment more helpful to the youth.

After a year, the agency decides to look at its aggregate data again with the supervisor. This time, the relative effect size for the entire agency has improved significantly (relative effect size = –0.17). However, the clinicians are now talking about how they know they can still improve the outcome by looking more specifically at the data. In the analysis of the data, it becomes clear that there are still differences in the outcomes of the various programs. The program dealing with the “long-term” or “chronic” problems is less effective than the rest of the programs. It is clear that they spend significantly more time and more resources without being as helpful as the rest of the agency. The clinicians recognize this pattern and describe feeling burned out and frustrated. They describe how it is

often difficult to end ineffective treatment because there is nowhere else to refer the clients. The supervisor talks with the management and the clinician about the importance of having a continuum of care—knowing where to refer clients if the treatment is not helping. They also talk about the importance of creating a clear structure for talking about the nonprogressing cases quickly to prevent clients from coming to treatment for a long time without being helped. The goal is to make sure all clinicians in the agency spend most of their time working with the clients they are helping instead of having a full caseload with cases that are not progressing.

After the analysis, management and staff meet with the network of services around them to develop a clear referral strategy. They also decide to implement regular FIT meetings where they review the nonprogressing cases on a regular basis so they can change the treatment or refer the client to another service more quickly, if the current treatment is not helping the client.

The following year, they ask the supervisor to help them look at their data again. The relative effect size for the entire agency is now above the norm (0.12), and they no longer have programs falling below average.

When Things Are Not Getting Better

The supervisor should always assume that positive change is possible. In most instances, change will start to happen when clinicians or agencies start working more deliberately on improving their outcomes. In the rare cases where there is no progress and an ongoing issue of outcomes falling below the norm despite attempts at engaging in deliberate practice, coaching, and training, the supervisor faces a new challenge. For individual clinicians in private practice, the supervisor can engage the clinician directly in discussing how to deal with the lack of improvement.

In an agency setting, the supervisor must rely on a close collaboration with the agency manager. The question here might be more about leadership, and the agency manager will need to take over the process with the non-progressing clinician or program. The separation of leadership and supervision can be crucial to ensure that the supervisor can continue to have a role as a coach and mentor for the clinicians and continue to create an open and creative atmosphere in the supervision setting.

CONCLUSION

Current research shows that the impact of supervision is unclear. Supervision can help clinicians learn new approaches and improve their sense of efficacy. Yet supervision does not appear to affect clients' treatment

outcomes. A supervision model focused on using formalized client feedback can improve the effect of treatment for clients, one client at a time. Formalized client feedback also allows the clinician or the agency to gather aggregate data that help to identify specific areas for improvement that can be developed through deliberate practice. In FIT, the role of the supervisor is significantly different from that of a "traditional" supervisor in that it includes not only clinical supervision but also teaching, coaching, analyzing data, and consulting with management. Ideally, this will inspire the reader to view the helpful supervisor in a different way.

A supervision model that is more specific and deliberate than traditional supervision can shape professional development in specific areas that will increase the efficacy of a particular clinician or agency. This model holds promise for creating improvement that can benefit both clinicians and, more importantly, the clients seeking their help.

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5

IMPLEMENTING FEEDBACK-INFORMED TREATMENT: CHALLENGES AND SOLUTIONS

RANDY K. MOSS AND VANESSA MOUSAVIZADEH

Feedback-informed treatment (FIT) is a disruptive innovation (Christensen, 2014). FIT unsettles one's current practice with a new, proven avenue to improve services. Implementing FIT can aid in the pursuit of clinical excellence within a culture of feedback. The intent of this chapter is to inspire hope and patience in those interested in implementing FIT while providing practical guidance and vision.

FIT implementation is not a discreet event, but an ongoing process that moves between distinct stages in a nonlinear manner. As with any change, various stages may need to be revisited as part of the process. There is no single recipe for system change and implementing new processes or technologies. General stages and rules tend to be consistent across implementation projects, but implementation is not a one-size-fits-all activity.

There is an ample supply of scientific inquiry into organizational change and best practice integration. Translational medicine (Woolf, 2008), technology

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transfer (Addiction Technology Transfer Center, 2010), and implementation science (Backer, David, & Saucy, 1995; Eccles & Mittman, 2006; Fixsen, Naoom, Blase, Friendman, & Wallace, 2005; Gagliardi, Alhabib, & Guidelines International Network Implementation Working Group, 2015; Madon, Hofman, Kupfer, & Glass, 2007; Powell et al., 2012; Proctor et al., 2015) are all efforts to delineate the science of implementing best practices and executing mature change within organizations. These authors share many similar procedures and structures while differing in language and timing. What is consistent is that implementation is not easy, quick, or smooth, which poses significant opportunities for iterative planning, adjusting, experimenting, and disseminating.

Although every agency is unique, in most cases adoption before adaptation is a starting principle of FIT implementation. Thus, adoption of the approach, the measures, and the clinical role using FIT precedes adaptation of the process to unique aspects of the individual organization or practice. Although every agency is unique, in most cases, adoption should be considered before adaptation as a starting principle of FIT implementation. Adhering to *core intervention components* while accommodating *local adaptations*, complemented by strong leadership, is a formula for implementation success (Fixsen et al., 2005; Kotter, 1996). FIT implementation demands complex thinking, collective effort, feedback exchange, patience, strong leadership commitment, and ongoing adjustments and maintenance. Without a plan, leadership commitment, adequate resources, and patience, FIT implementation is likely to be fragmented and ultimately fall short.

Fixsen, Blase, Horner, and Sugai (2013) outlined a stage-based developmental model of implementation based on thorough review of the literature and science. Large-scale change typically involves five stages: exploration, installation, initial implementation, full implementation, and sustainment. Within each of these stages numerous tasks, processes, and adjustments drive the change, from exploration through sustainment. It is not uncommon to revisit a stage. Or an agency could skip a stage, but this may increase project risk. The checklist in Exhibit 5.1 offers insight into milestones and estimated timelines for each stage of FIT implementation.

- *Exploration* is the "why?" stage. During this time, leadership must determine a reasonable need for a change as well as secure a commitment to the process and resourcing.
- *Installation* is the "how?" stage: planning, mapping, assigning, messaging, and generally building the foundation for implementation.
- *Initial implementation* is the experiment stage. Here, the pilot team leads the startup program, gathering data and reporting to an oversight committee (Transition Oversight Group [TOG]).

EXHIBIT 5.1
Feedback-Informed Treatment (FIT) Implementation Checklist

Stage 1: Exploration

Timeline: 1–4 months
Responsible parties: leadership, stakeholder, initial implementation team (IIT)

- Communicate to all levels of hierarchy the motivation and urgency to change.
- Articulate FIT vision and connect to agency values and mission.
- Define roles and responsibilities and shift expectations to accommodate learning.
- Clarify and secure budget requirements.

Stage 2: Installation

Timeline: 2–6 months
Responsible parties: leadership, transition oversight group (TOG), consultant

- Establish TOG and group charter.
- Initiate planning foundations: high-level work plan, communication plan, training plan, and stakeholder analysis.
- Contract with a FIT consultant.
- Select FIT data management solution.
- Assess agency readiness.
- Address process improvement opportunities.

Stage 3: Initial Implementation

Timeline: 3–9 months
Responsible parties: TOG, champions, consultant

- Train pilot team.
- Establish clear goals, measures of success, and timeline for pilot phase.
- Establish pilot team and gain team agreement.
- Initiate FIT case review process with pilot team.
- Create feedback loop process between pilot team and TOG.
- Test-run aggregate reports to familiarize staff with using the data.

Stage 4: Full Implementation

Timeline: 6–12 months
Responsible parties: TOG, champions, consultant

- Orient staff to FIT.
- Introduce new policies and procedures plus expectations regarding FIT adoption.
- Train staff on computer-based data management program (if applicable).

Stage 5: Sustainment

Timeline: ongoing
Responsible parties: FIT oversight group

- Conduct ongoing oversight and troubleshooting.
- Ensure fidelity to FIT policies and procedures.
- Data reporting and analysis.

The intent is to identify and troubleshoot obstacles, gain experience with the FIT measures, train champions, and develop staff trainings, policies, and procedures for the next stage.

- *Full implementation* is the launch stage, featuring an agency-wide rollout. It represents application of the lessons learned and the policies and procedures in the initial implementation stage with the planning and supports of all the previous stages.
- *Sustainment* is the maintenance stage in which FIT is sufficiently embedded within the culture and structures are in place to support FIT within the agency over the long term. Meanwhile, policies, procedures, and business practices reflect feedback-informed, deliberate practice to aid positive clinical outcomes.

Committing to a long timeline is critical for large-scale change. Mature implementation may take 5 to 7 years (Fixsen et al., 2005) or longer. This allows the stages of implementation to be executed, the principles and philosophy embraced, new policy and procedures created, and a FIT approach reflected in the organization culture.

PREPARING LEADERSHIP AND ADMINISTRATION TO SUPPORT FIT

Innovation begins when an agency is ready to tailor the FIT approach to specialized programs and populations (Bertolino, Axsen, Maeschalck, & Miller, 2012). New staff members or unique community circumstances might challenge the standards (Fixsen et al., 2005). However, innovation is not a FIT stage, but more a facet of a commitment to continuous quality improvement that shares the end goal of positive clinical outcomes. In the installation stage, leadership and clinicians solicit and respond to client feedback about agency processes such as scheduling ease, availability of the provider sought, and access to other critical health and social services. Client feedback informs decision-makers about how the agency can better meet client needs, which in turn become process improvement opportunities. Leadership that encourages a commitment to continuous quality improvement informed by client voice and the desire to monitor and facilitate positive client outcomes will naturally innovate.

Leadership is responsible for understanding and managing the expectations of auditors, funders, and oversight agencies with regard to clinical outcomes. Approximately 70% to 90% of failed implementation efforts happen when leadership is not fully committed to the process (Fixsen et al., 2005).

Without enduring leadership support, many efforts to bring about evidence-based transformation are likely to fail (Gallon et al., 2010). Administrators are key stakeholders who, if not actively engaged, may pose a high risk to the project. At the same time, administrators rightly expect to see some return on investment throughout most stages. Even when administrators are told that FIT implementation is a 5- to 7-year project or longer, they may push to see some evidence of value for money between 6 and 12 months. This expectation poses a challenge to mature implementation.

A few proactive steps may help leadership manage administration expectations. First, leadership should communicate consistently that FIT will ultimately provide evidence of positive outcomes, without which services could be at risk in the long term. Second, leadership should seek opportunities to show how the process of FIT implementation will address the administration's current priorities, such as dropout rates or hospitalization rates. In addition, leadership may wish to publicly recognize and validate current good work and connect FIT to the agency's vision for staff. Third, administrators are more likely to support FIT in the long term when they also feel engaged by the vision, stages, goals, and timeline. Finally, administrators should see samples of early aggregate data with caveats about its reliability while team and individual data remain in the hands of clinical staff.

A common misstep when implementing large-impact projects is not emphasizing the urgency of the change (Kotter, 1996). Leadership should maintain a sense of urgency that extends both upstream to administrators to secure resources and downstream to clinicians to support engagement and patience. If FIT ultimately is perceived to be a passing fad, effort will wane, and resistance will increase. Here is the greatest risk for old habits to creep back; the project may stall and eventually deteriorate. Leadership may leverage local and national health care transformation efforts reported in the news to emphasize the urgency of implementing a FIT approach to achieving measurable clinical outcomes.

As leadership emphasizes urgency, recognizing recent achievements provides a platform on which to build on current good work. This is a potent way to engage clinicians' desire to feel competence as they pursue professional excellence. Leadership might explore ways to connect FIT utilization to existing agency expectations or personal professional goals related to clinical or process outcomes. For example, leadership might discuss how improving client outcomes will lower emergency room admissions or other results that administrators already prioritize.

Developing and sharing a clear vision is vital to the long-term success of any high-impact change project (Kotter, 1996). Once the FIT vision is integrated into an agency's mission, it is helpful to create forums to report progress and field questions. The vision shaped around FIT and data must

be clear, responsive to shared goals and concerns, sufficiently detailed, and measurable.

A key element of project management is the development of a communication strategy. Leadership is responsible for executing a planned and resourced timeline. Reporting progress throughout the effort reinforces any improvement, so developing an effective communication strategy is essential. Communication about project progress must be balanced, always tracking phase and timeline, so people know where they stand. Some agencies report on progress at all staff meetings. Some create a newsletter segment. Others rely on enthusiastic and competent practitioners known as *champions*—respected staff who have adopted and practice FIT—to communicate progress informally. Some use combinations of these. Communication needs to fit the culture of the agency, vary enough to be accessible to all stakeholders, and remain consistent in honestly reporting and articulating the shared vision.

A computerized scoring system can facilitate aggregate reporting capability at the touch of a button. Such systems can help isolate clinical concerns and facilitate responses to outside funding and accountability pressures. Convenience and real-time access to usable data for leadership and clinical staff usually justify the cost of computer-based data management systems. During implementation, aggregate data involving a relatively small number of completed clients can be useful but not necessarily reliable. As such, during initial stages aggregate outcome data reports should not drive decisions, but rather should show how to interpret the data and engage administrators and clinical staff with the data. Basic trend analysis—such as number of sessions needed to bring about reliable change, types of alliance misses across the agency, and entry level of distress, among others—is important feedback for implementation.

When an agency has accrued a sufficient number of completed cases, it can consider reporting reliable aggregate trends. Aggregate data may be considered generalizable to the agency when policies and procedures are enforced that result in the following: (a) all clinicians are consistently using FIT tools with 90% of clients; (b) regular fidelity checks are in place, such as in peer observation or recorded sessions; and (c) signs of cultural adoption pervade all levels of the organization. These signs of adoption include clinicians and leadership using FIT language in reference to client progress, FIT data informing treatment options, and clinical supervision privileging FIT data over narrative. A crucial sign of adoption is the observation of exchanges of clinical experiences happening openly and honestly with little regard to position and title. Meanwhile, administrative support is secured with regular progress reporting, improved key clinical processes, and data-indicated client–clinician engagement.

The Role of a FIT Consultant in Implementation Efforts

Hiring a consultant can be enormously helpful to FIT implementation efforts. Consultants offer FIT implementation and practice experience, guidance, and a neutral voice. They keep leadership engaged in discussion about the appropriateness of FIT for the agency and may be asked to present the theory, research, and application of FIT to professionals in the trenches. Consultants often guide the TOG in the appropriate use of the FIT outcome and alliance measures. They offer advice about adopting a computer-based scoring system, help to address staff resistance, and aid in managing staff critical questions. Consultants may offer advice about how to channel the enthusiasm of the earliest adopters while inspiring the doubtful and jaded. Furthermore, they can adeptly maneuver between noticing and publicly recognizing progress and mitigating disappointments. In other words, the consultant has a role in every stage and can be a critical support to the TOG, leadership, and line staff. However, an agency may choose to move forward without a consultant, relying on published materials and online forums, such as the International Center for Clinical Excellence (https://www.centerforclinicalexcellence.com).

In the example that follows, agency administrators were invited to FIT workshops and trainings. This gave administrators insight into clinic engagement in the project. In addition, leadership reported to administrators at regular intervals about FIT implementation progress. At the transition point of the installation stage, one funder asked for aggregate data. Leadership provided a sample of aggregate data in person, explaining what it did and did not show. Administrators received the aggregate data enthusiastically and voiced their support of implementation and the shared vision.

IMPLEMENTING FIT: A CASE STUDY

The following description illustrates the stages of a mental health agency's implementation of FIT, as well as key roles and responsibilities. This agency comprises 60 mental health specialists, psychiatric nurse practitioners, and psychiatrists. The example is intended to be instructive rather than representative. What can apply more broadly is this: Expect to plan for implementation at three levels simultaneously—data driven clinical outcomes, client-directed care, and a culture of feedback.

Exploration

The exploration stage is the time to ask: Why do this? Why this change? Why now? What or who is driving the change? In our example, the agency

administration had been conveying to leadership that forthcoming funding would be outcome based. Hence leadership was tasked with figuring out how to get ahead of a payment structure based on outcomes rather than visits. The health plan was prepared to fund any best practice behavioral health outcome measure that the agency was willing to adopt. A stakeholder from within the agency proposed exploring FIT and the use of the Outcome Rating Scale (ORS; Miller & Duncan, 2000) and Session Rating Scale (SRS; Miller, Duncan, & Johnson, 2000) as a potential solution. This had been tried in the past but had been poorly implemented. This time, because the solution was proposed from within the agency, clinicians were more inclined to consider it. Leadership agreed to explore this option. Indeed, throughout implementation of FIT the leadership remained receptive to grassroots solutions.

Members of the leadership exhibited consistent willingness to discuss concerns, and their appropriate resourcing of the project, including formal trainings, also contributed to motivating many clinicians. The leadership team and the FIT consultant were tasked with creating and maintaining a sense of urgency around the change project (Kotter, 1996). Therefore, the vision-based message was simple: (a) FIT implementation is consistent with the agency's long-term goals; (b) FIT is a best practice that complements good work already in progress; and (c) pursuing FIT outcomes will be challenging but worthwhile. Leadership managed administration expectations by structuring productive goals and time frames, tempering funder expectations for immediate clinical outcomes, and communicating progress to external stakeholders. Leadership allowed time for staff members to learn, practice, and mature in their use of FIT.

Members of the leadership team quickly moved to emphasize the role of clinical supervision in supporting FIT implementation. They carved out time for supervisors and key clinicians whom they had selected to use the FIT measures, the ORS, and the SRS, with small client caseloads to inform how to help others integrate FIT into their practice. Clinical supervisors led the change effort, troubleshooting the adoption and integration of FIT during sessions, case conferences, and documentation. They practiced using the ORS and SRS tools with clients to gain experience and clinical credibility in their role as the first FIT champions. Early on, the clinical supervisors learned to administer, score, plot the ORS and SRS data, and analyze the graphs, so they were prepared to demonstrate the clinical use of FIT. Every supervision and team meeting soon became a data-centered case review. Clinical supervisors modeled error-centricity, feedback exchange, and the pursuit of deliberate practice. Furthermore, the flattening of the hierarchy paved the way for an error-centric culture of feedback—one in which supervisors modeled a willingness to be vulnerable while navigating the new tools. As permitted, this flattening occurs as FIT principles of feedback exchange redefine

colleague interactions. As a result, clinical supervisors gained respect as FIT champions alongside clinician champions, which sent a message to clinicians that the change was not a passing fad and would be adopted throughout the agency, not just on the front lines.

Leadership secured a 3-year budget to fund the effort. Notably, the budget included funding for a project manager/change facilitator and for FIT consultation. It also included resources to cover the cost of training materials, a computerized scoring system, and adjusted productivity during the first year. Performance appraisals were not to reference FIT clinical data.

Leadership and administration commitment to implementing FIT marked the end of the exploration stage. At this point, clinic leadership articulated a vision that incorporated staff concerns, cultivated the sense of urgency, and clarified the reasons for change. Clinical leadership then felt prepared to engage staff in the installation stage.

Installation

The installation stage (timeline: 2–6 months) was characterized by an initial implementation team (IIT) made up of members of the leadership. Leadership communicated the need to change and asked clinicians to challenge their thinking with regard to knowing what's best for a client without considering client voice and systematically collecting data. They introduced the ORS and the SRS, and presented FIT as a viable solution to address the required movement to data-driven, outcome-based payment.

The IIT contracted with an external FIT consultant, who provided an orientation workshop for management and agency staff on FIT research, principles, and the ORS and SRS tools. The IIT also identified key stakeholders in the agency to form a FIT TOG. The role of the TOG was to establish a pilot consisting of a few staff using FIT and to oversee the entire FIT implementation process.

The TOG consisted of a collection of stakeholders, including a couple of clinician resisters. The program manager and all clinical supervisors were required members to ensure execution on the timeline and appropriate resourcing. Clinical staff made up the bulk of the membership to build buy-in across agency programs and ensure that the path to implementation and adoption was grounded in the reality of those who deliver services most regularly. Including clinicians in planning empowered them and increased the likelihood of FIT adoption (Fixsen, Blase, Naoom, & Duda, 2013). The project manager was not a voting member on the TOG but organized all meetings, tracked decisions, and tracked all deliverables to timelines. The TOG steered and tracked all dimensions of project progress and provided a feedback loop among leadership, staff, consultant, and partner agencies.

Under most circumstances, standard project management might call for a pilot phase to test assumptions. A change adopted in a pilot setting would be a contained test that provides data that will inevitably result in new realizations about what implementation means to an agency. A pilot team would experiment with FIT in the context of an agency's unique characteristics. Of course, a pilot team experience at one agency cannot be applied in total to another unless the agency processes and culture are alike.

At the agency in our example, pilot team clinicians became project champions alongside clinical supervisors. The FIT consultant recommended that pilot team members should be chosen carefully, looking for early enthusiasts who would embrace learning and change, who would make time for deliberate practice, and who had the respect of their fellow clinicians. Pilot team members at the agency were respected practitioners, clear communicators, and self-reflective participants (Fixsen, Blase, Naoom, & Duda, 2013). These pilot team members became FIT champions who shared their experience and data informally during conversation and later shared them formally during trainings. They fielded questions and concerns while being open about not having all the answers. They agreed to lead ongoing trainings. All clinician champions were volunteers and agreed to the roles and responsibilities. All clinical supervisors were required to be pilot champions as well. Clinical supervisors set aside extra time for the pilot champions and provided a safe space to share concerns, struggles, and ideas about how to address issues.

A subgroup of clinicians from the pilot group compared two FIT scoring systems. They engaged in a cost–benefit analysis and tested each product for 2 weeks. When fully implemented, clinicians would be using the scoring system daily, so the system needed to be user-friendly and intuitive. Once a decision was made about which system would be used and it was purchased, the pilot team was trained to use the system and began delivering the ORS and the SRS to all new clients. At this point, the pilot team reported that the FIT measures generated valuable feedback and data about their client interactions. Leadership expected pilot clinicians to administer FIT consistently while sharing their experiences with each other and with the TOG. Whereas the TOG managed implementation planning, troubleshooting, and communications, the pilot team practiced using FIT tools and provided feedback to the TOG about barriers, concerns, and what worked for them and their clients. Regular FIT meetings naturally involved a combination of troubleshooting and data discussion, which created deeper trust among pilot team members and inspired new ways of approaching the work.

After collecting sufficient data, pilot team members gained expertise in interpretation and analysis with the aid of an external consultant via webinar. For example, the pilot team provided feedback that integrating ORS and SRS delivery into the child program would take longer than with

the adult program. This was because children were accompanied by families, and it took a while for clinicians to figure out who best to solicit for feedback and how to store and graph multiple surveys from the same session. Another concern was how to organize their sessions so that administering FIT did not encroach on therapeutic flow. From the adult program, clinicians reported the need to troubleshoot solutions for clients who experienced anxiety using a mouse or iPad or who were confused by the instructions for the adult survey.

The TOG acted as a communication hub and a decision-making body. They developed an implementation work plan; formulated guidelines, policies, and procedures; and ensured adequate clinician training. The group coordinated all FIT progress and failure reports, grounded expectations, and tracked process and clinical outcomes. Leadership provided regular updates during all staff meetings, via email, and via the internal newsletter. They also provided monthly updates to funders during their regular meetings. Clinical supervisors all had an open-door policy when it came to inquiries about FIT. Once the pilot was launched, champions fielded questions and troubleshot with new clinicians.

During the installation stage, the supervisors used an agency readiness assessment tool and drafted project milestones. A plan to train and support agency staff in FIT was also developed.

Initial Implementation

A work plan in hand, the initial implementation stage (timeline: 3–9 months) promptly followed. A team of champion clinicians and supervisors prepared and committed to train and mentor peers.

In this case, the pilot team led an interactive training open house for all clinical staff, which included an introductory speech by the program manager. The program manager reminded everyone what the ORS and SRS were, what was being asked of those in attendance, why the tools were important, why clinicians should care. Four training stations were set up around the room. Each station gave staff a chance to engage with FIT, including (a) developing a narrative about why FIT should matter to the client, (b) role-playing ORS delivery, (c) role-playing SRS delivery, and (d) interpreting graphs.

The TOG set expectations, rolled out initial policies and procedures, and developed internal continuing education FIT learning opportunities. Once all staff members were trained on the computerized scoring system, leadership shared the expectation of 100% use with new clients, discretionary use with current clients, and mandatory use of FIT data to lead case discussion during group or one-on-one case reviews. Policy incorporated consistent documentation that included ORS and SRS data. When the FIT approach had been shared, analyzed, and assigned, those clinicians who were

initially resistant were held accountable for using FIT. The clinical supervisors deployed the clinician champions to advocate, share success stories, and converse daily about how FIT would aid the achievement of clinical outcomes. Clinician champions validated concerns but also shared success stories. They normalized the expectation of using the ORS and SRS consistently and spoke openly about mistakes they made to encourage error-centricity.

Full Implementation (Timeline: 6–12 Months)

At the full implementation stage, all clinicians were using the ORS and SRS and following the principles and practices of FIT. The full implementation stage showed maturity when client data consistently drove case reviews. At that point, FIT data became part of everyday case review and discussion.

At the same time, the project prompted increased questioning from administrators who were anxiously awaiting clinical outcomes as a return on investment. Consistent dialogue that shared progress milestones and demonstrated process improvement partially lessened administrators' fears that the return on investment may not be realized. Reassurance and early data sharing with trend analysis helped bolster their patience and commitment. The centerpiece of this stage was a solidly emerging culture of feedback within the agency. Leadership recognized clinicians privately during supervision and publicly during staff meetings for their engagement and patience with changing their session practices. Clinical rather than administrative supervision was protected and elevated in importance, which clinicians had been requesting for years. Eliciting feedback about session experience became more common. Fear of errors and uncertainty were greeted with more dialogue and openness.

Sustainment

The agency achieved full implementation; its challenge going forward will be to sustain FIT implementation over the long haul. Developing a maintenance plan that outlines the checks and balances to ensure the fidelity and utility of FIT thinking and practice is the key task in the sustainment stage. Sustainment can be threatened by external and internal factors, such funding cuts to the agency or changes in management when the new management is not adequately oriented to its role in supporting FIT.

Establishing a FIT oversight group (FOG) that will continue to troubleshoot, ensure that FIT policies and procedures are maintained, and ensure that client feedback and outcome data are used to inform agency practice decisions is a key task in the sustainment stage of FIT Implementation. The FOG will

also ensure that FIT training is integrated into new staff orientation/training and that outcome data remain visible and reported appropriately to key stakeholders. The group will check the fidelity of data gathering, analysis, and reporting; monitor feedback mechanisms to identify concerns or areas for improvement; and check to ensure that case review continues to be delivered in team settings that facilitate meaningful feedback exchange. The goal of sustainment is to ensure that the change endures and that whatever adaptation experiments are tested, the fundamental principles of FIT are uncompromised. This phase is about the long-term survival and continued reliability of FIT tools and practice (Fixsen et al., 2005).

THE IMPORTANCE OF A COMPUTER-BASED SCORING SYSTEM IN FIT IMPLEMENTATION

In the authors' experience, using the ORS and SRS on paper may complicate implementation. Paper introduces several logistical variables, such as increasing clinicians' paperwork burden and thus resistance. Filing, organizing, coding, and retrieving surveys for different clients adds an administrative layer when delivering FIT to more than a small number of clients across many practitioners. The survey lines may change size with every run through a photocopier, requiring the clinician to recalibrate each time. Clinicians may also be tempted to skip graphing the results during sessions, undermining the main application of the tools. Longer term, identifying irregularities across client data sets, reporting on individual and organization trends, and visibility of the data are more difficult without a computer. Yet, some agencies and private practitioners have successfully used paper for years. It is simply about convenience and logistics based on agency preferences.

Although the costs of purchasing a computer-based system present concerns for agency administrators, ultimately these costs will be recouped through the efficiencies that these systems provide. In addition, investing early in a computer-based data management system can strengthen FIT implementation overall. There are several computer-based management systems available that allow electronic administration of the ORS and SRS and then score, plot, and aggregate the data gathered. Such systems are user-friendly and save time and reduce paperwork. They also provide immediate access to client progress charts, facilitating prompt responses to client feedback. These systems provide immediate alerts to clinicians and their supervisors when clients are not making progress. Further, leadership and administrators will appreciate the electronic option with its ability to produce instantaneous aggregate outcome data reports at the clinician, supervisor, program and agency levels.

LESSONS LEARNED: RESISTANCE, CHALLENGES, AND WINNABLE BATTLES

Rogers (2003) found a variety of staff reactions and engagement levels during innovation and change. Agency professionals generally fall within three categories: early adopters, fence-sitters, and resisters. Although he described more categories, the basics of innovation or change adoption can be contained within these three. Rogers discovered that some staff embrace the innovation quite readily. He saw a large cohort that was ambivalent about the change. Finally, Rogers found that some are quite opposed to any innovation or change. Adoption of change, according to Rogers, requires recognition of and strategies to address each response category.

Early adopters (Rogers, 2003) strain at the slow pace of implementation and are anxious to engage in relationship-based therapy, having been motivated by research and foundational trainings. They eagerly volunteer for champion slots and offer peer testimony that can appeal to the next wave of change adopters. They possess a level of excitement that needs to be guided toward shared experimentation so their experiences may be leveraged on a larger scale. The challenge with this allied group is showing them the value of making time for necessary practice and planning, which may slow their individual progress. Their enthusiasm can lead to premature adoption and execution, which may result in project drift and fragmentation. Early adopters usually comprise about 15% to 20% of professionals (Rogers, 2003). They are easy to identify with their vocal approval of FIT, matched with impatience due to the lengthy time to full implementation.

Fence-sitters wait for proof of leadership commitment, direct commands, and basic incentives to embrace FIT. Moderately interested and obligatorily attentive, this majority group—usually about 60% (Rogers, 2003)—waits for their peers, the consultant, and the TOG to persuade them. The challenge is to engage them in reflective auditing of their relationship with clients and their outcomes. Often the best approach is to plant seeds of questioning and doubt in their ability to know a client's perspective without asking, leading to the consideration of formal feedback and solicitation of that perspective. Many will claim they already provide client-directed care through casual questioning and gut feelings, but in the same breath they will diminish or outright reject the need for a systematic process to gather, analyze, and respond on progress and the therapeutic alliance. On the other hand, fence-sitters provide an opportunity to present research on gathering feedback, clinician versus client perceptions, and how relationship or specific best practice approaches are not diminished through FIT's formal process. Their disproportionate influence demands focused attention from any transformation team. Their influence tends to pull the agency back into habit rather than toward

innovation. As the pilot team begins to generate local data, they can offer fence-sitters a more targeted comparison.

Resisters are clearly opposed to any change. Whether devoted to a specific model or steeped in their ways despite data, members of this group present the most direct and interesting challenge. Many times the resisters wield both overt and subtle power against change. Their engagement in debates and suspicion of the process and philosophy are clues. Their defining trait is a contentious disbelief in the intended and cited research outcomes. In support of the status quo, they may list excessive documentation requirements, an insurmountable lack of resources, and couched mistrust of administration and experts who may be unknown to them. They also tend to highlight selected positive clinical examples as evidence against the need for change. The challenge for leadership is to, without judgmental confrontation, acknowledge fears associated with increasing visibility and accountability in daily work. Reasonable responses might include conveying the urgency for more agency accountability to outcomes along with the eventuality of the tipping point of agency expectation. It may be tempting to threaten or dismiss resisters publicly, but this reaction can put project credibility at risk. That said, a resister who is willing to share fears can be a valuable contributor to change adoption by providing alternate viewpoints.

Within the resister group is a subclass that might publicly present as early adopters. However, they exercise backroom destructive strategies to undermine implementation efforts. This particularly toxic minority is hard to identify but must be uncovered. One agency's experience was that a very vocal middle-level manager who presented as an early adopter and champion was discovered to be dismissive of the practice outside the formal trainings, going as far as to discount the research and encourage passive acceptance awaiting administrative capitulation. This opposition dressed in vocal acceptance pushed back the implementation by 6 months. Identifying and addressing these resisters is a task for the TOG and administration. Strong clues are excuses as to why their ORS and SRS are not being delivered, reports from colleagues and supervisees, ongoing questioning of the need despite general agency acceptance, and hesitancy to share their experiences with tool delivery, especially when they have publicly endorsed FIT. Addressing members of this resister subgroup may involve understanding the root of their fears and responding to their concerns, or it may involve supporting them to find alternative employment or functions. Dealing with covert resisters requires savvy leadership and artful communication. In the preceding example, the middle manager was ultimately let go because the covert resistance, when discovered and addressed, uncovered other performance issues, which is not uncommon.

It is vital to support staff through any change. To prevent or address resistance, the initial and long-term resourcing of the project must include

some workload relief during novice use of FIT (e.g., fewer deliverables, more supervision, simple documentation). Agency-learned helplessness poses a challenge. At the same time, agency change fatigue is a reality. Increases in productivity quotients; increased accountabilities, including more documentation; increasingly complex and resource-intensive, nonprogressing clients; and underresourced agency supervision and materials are common. These are often accompanied by low pay, secondary trauma, and professional burnout. Without concerted effort and visible evidence of staff accommodations, the resistance can fester in suspicion of a lack of substantive administrative commitment.

FIT establishes a new prime target of therapy by focusing on outcome alliance data and deliberate practice, which is counter to the specific ingredient theory of therapy. Clinicians may fear that FIT will further drain time during sessions appointed to treatment procedures. One way of calming these fears is to elevate the importance of theoretical allegiance—the necessary belief that what you do works. Another is to highlight the value of FIT as an engagement tool, a way for clients to feel heard, not just a tracking or evaluative tool. As leadership makes time to recognize the value and skills clinicians bring every day, clinicians may be further encouraged to pursue excellence and deliberate practice.

In our experience, clinicians sometimes use the severity of client disorders as a reason not to introduce FIT tools. Other times clinicians may suggest that, due to their credentials or role, they ought to be excluded from FIT. Some just say they do FIT. Take care not to diminish clinical judgment and observation skills while elevating trust in hard data and the ongoing voice of the client; all are central to improving treatment interactions. Lived examples in which client behavior contradicted clinician intuition (e.g., no-show, recovery, continuous showing with no improvement) stimulate reflection and interest in FIT as a tool. FIT processes compensate for the shortcomings of guessing, simple observational cues, or informal inquiry. FIT overlays and builds on existing expertise and experience while demonstrating the need for something more formal and reliable.

Another challenge for leadership is to guide the movement away from a solely diagnosis-driven approach to one that prioritizes the evaluation of service effectiveness, leading to positive outcomes for clients. Regularly evaluating the therapeutic alliance provides clinicians with feedback as to whether their goals are aligned with clients' and whether both parties share an understanding of respective roles. The feedback provides opportunity to make responsive adjustments from session to session to better align with client preferences, leading to positive outcomes.

Training, both experiential and theoretical, poses a similar challenge. Experiential learning during FIT introductory trainings is essential to the

implementation process. First, the TOG is responsible for organizing FIT trainings for all staff. Planning for training may take different forms. For example, from the beginning one agency assigned a champion to cotraining, that is, recruiting a trainer inside the agency to work alongside the consultant. This individual can interpret theoretical learning into the language of the agency. One agency asked the consultant to teach all the basics. Then a champion who emerged with enough skills was assigned to work with all new practitioners. Using scenarios familiar to the setting and elicited from the audience goes a long way to contextualize FIT usefulness and encourage integration into current practices. After a demonstration (either via training video or role-playing) of how to administer the measures, it can help to provide different scenarios for clinicians so that they can script their own responses to client resistance, unfamiliarity, and surprise. Acting out scenarios, soliciting audience questions to direct training examples, and providing didactic teaching have proven successful (see Clark, 2010). One particularly useful technique is an adapted process of the teach-back method (Wikipedia, n.d.), during which a prepared champion demonstrates and explains an assigned principle or practice using the language of FIT. They then reflect on what went well in real examples and what could have gone better. Such training modalities move FIT from theory to practice and can contribute to developing a culture of feedback. Regardless of the training structure, it is important to reiterate the basics of FIT.

Turnover is a common problem for agencies. Because implementation takes considerable time, some champions, TOG members, and significant staff will inevitably leave. Others, those without the foundation of FIT or any history to justify the change in practice, may take their places. The TOG and leadership must anticipate this actuality and have trainings and policies, including hiring criteria, that support the agency vision and FIT principles. Early champion losses can be particularly disruptive. It may become necessary to have multiple leaders and champions to broaden the foundation and influence. Turnover in leadership can be particularly hard. The loss of a CEO or administrator often scuttles any project. For mature adoption, the administrative group should be committed to the larger vision. This offers the best chance for continuation of FIT. In one agency, after almost 2 years of training and nearing full implementation, the agency executive director and team was replaced. Chaos and deterioration in FIT ensued. Luckily, a champion was finally appointed as new executive director. FIT change was postponed by almost a year, and a return to earlier stages was necessary. Turnover is something that needs to be planned for with immediate responses.

Practice and learning through trial and error generally includes a prescribed grace period while practitioners familiarize themselves with FIT. Safety and opportunities to try, to be awkward, and to hone the skills of eliciting

client feedback using the measures are fundamental and must be guaranteed by the leadership. An insufficient no-fault period produces a lack of fidelity due to inadequate training. An overlong period can cause the implementation process to sputter due to training fatigue. Spending 6 months in the initial installation stage developing champions is consistent with the authors' experiences and with implementation research.

One last pitfall to watch for is practitioners' perception that a culture of feedback applies only to those in the trenches. Early on, clinicians may fear that SRS and ORS scores and discussions about FIT overall may become part of performance appraisals. It is not uncommon for FIT learners to voice concerns regarding open dialogue about clinical errors and uncertainty, especially with clinical supervisors. ORS and SRS scores are not designed to be used as a heavy management tool, so scores should not become part of performance evaluation for any clinician. Consistency when communicating on this topic is important.

Clinical leadership must lead by example in eliciting direct and meaningful feedback. Ideally, clinical leadership would take on a small caseload to experience, learn from, and model feedback exchange in and out of sessions. Using the SRS as the determinant of a specific session's interventions can be unsettling and disorienting for practitioners. Over the course of implementation and while using the measures, clinical supervisors and pilot team members should support each other in accommodating this practice transformation.

Maintaining safe space for honest feedback exchange about clinical progress means putting client outcomes first. This is a topic for the TOG and consultant to tackle. Reactive power structures and unidirectional feedback inhibit FIT culture transformation. Instituting a culture of feedback broadly accompanies a successful implementation of FIT because making adjustments to the therapeutic alliance is reinforced by honest feedback between client and clinician and between clinician and clinical supervisor.

A reduction in no-shows and dropouts, better direct participation in therapy, clearer feedback, and increased ORS scores follow when clinicians use the FIT principles and measures in deliberate practice while finding themselves embedded in a culture of feedback. In daily practice, a FIT clinician works hard to elicit brutally honest feedback, receives that feedback as a gift without taking it personally, reflects on the feedback alone and/or with peer clinicians in data-driven group case review or one-on-one, and makes a plan to be responsive to client needs in total. This is deliberate practice at work. Leadership paves the way for honest feedback exchange, and it is those delivering care day in and day out who are responsible for fostering a culture of feedback that is safe and open. Modeling this culture during training and leveraging the enthusiasm of the TOG and clinician champions as trailblazers during feedback exchanges all work together to build confidence in the FIT approach.

CONCLUSION

Implementing FIT is a major undertaking, following researched stages and timelines. This does not mean that a one-size implementation fits all agencies or situations. Implementing FIT is not a single event but an iterative process. Clear intentions and planning are crucial. Without a commitment to addressing the urgency to improve, FIT may be easily dismissed as a fad or a repackaging of current practice. Emphasis on data-driven decision making, deliberate practice, and client voice are central aspects of FIT implementation. Any organization seeking improvement in both process and clinical outcomes can find application for routine and systematic gathering and analysis of real-time, person-centered data.

Sharing experiences in group training and with FIT supervision can help develop a culture guided by FIT practice and principles. As an agency matures, the introduction of the measures and their analysis can guide each clinical conversation about a client. Using interpretation of ORS and SRS data to discuss client progress eventually becomes second nature, underpinning chart interpretation, consultations about failing cases, and shared stories of struggle or success in clinical settings. At all levels of training and practice, a successful FIT implementation repeatedly demonstrates and integrates responding to the client's voice in the data, the deliberate practice of professional improvement driven by client feedback, and the privileging of the client's perspective. The professional is accountable for fostering honest interest in soliciting meaningful feedback from the client.

FIT transformation requires vigilance, appropriate resourcing, and long-term leadership commitment. The promised clinical outcomes will follow fidelity to the FIT approach. To ensure routine and uniform application of FIT principles and the measures, the first logical step is a work plan, based on visioning, with outlined phases, a timeline, and expectations. Challenges and barriers to change can be ongoing. Some will be obvious, and others may arise during the application of FIT. Flexibility, commitment, and urgency empower leadership to respond to challenges and adapt to context and setting. Yet mature implementation requires the development of foundational skills well before situational changes are allowed. Adaptation and innovations are inevitable components of successful implementation. Implementation science (Fixsen, Blase, Metz, & Van Dyke, 2015)—and the authors' experiences—point to the importance of timely execution and enforced accountability. Implementation that drags on puts the project at risk, yet moving too quickly—without giving staff time to integrate the ORS and SRS into daily sessions, to learn how to interpret the data, or to practice deliberately—can also put the project at risk.

The shift from FIT in the power relationship between professional and client is often daunting and uncomfortable. Adept leadership, emphasizing

clinical supervision, and presenting facts and research all reduce discomfort. Constant, patient encouragement is needed regarding trials, errors, and frustrations. Outside consultants can provide a fresh perspective and researched facts for the real change agents: the leadership team, the TOG, and the pilot team champions. Meanwhile, successful leaders are likely to protect clinicians during the learning process, recognize misunderstandings or errors as learning opportunities, model error-centricity, and support all who demonstrate error-centricity, engendering a culture of feedback.

FIT implementation is not easy, smooth, or without barriers, but it is promising. The active ingredient is not the tools, not the planning, not the science, but the solicitation of and responsiveness to meaningful feedback both within the client relationship and among colleagues. First and foremost, feedback-informed care requires asking for and responding to meaningful feedback—feedback within the clinician's offices, among administrators and staff, or among partners in health. Successful FIT implementation relies on real-time, routine, and honest feedback in sessions and in the workplace. The clinical and working relationships that follow create a data-driven culture of openness, which in turn promotes deliberate practice and clinical effectiveness. This parallels the principle application of FIT tools in therapy: Asking for meaningful feedback is an essential skill to develop, while using feedback appropriately to both grow professionally and better monitor client progress toward positive outcomes becomes a professional obligation.

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6

FEEDBACK-INFORMED TREATMENT IN A PRIVATE PRACTICE SETTING: PERSONAL ADVICE AND PROFESSIONAL EXPERIENCE

JASON A. SEIDEL

Although most psychologists and other mental health professionals may be motivated to excel at their work, it is my experience that solo practitioners and those working in small agencies often have difficulty finding enough time for collegial consultation. Worse, the self-assessment bias noted elsewhere in this volume (see also Walfish, McAlister, O'Donnell, & Lambert, 2012) can often lead the solo practitioner into a state of complacency: Why improve if you have already assessed your abilities, and your clients mostly return week after week? Client satisfaction surveys may make us feel good, but they are not the best measure of service excellence. The value of outcome measures—those that assess general well-being, and those that identify specific behaviors or targets of change—is enormous.

Case consultation and supervision are one thing. Making the journey toward becoming a better therapist by using your clients as your toughest supervisors is a different matter. Thus, this chapter takes the form of advice to colleagues from one therapist who incorporated FIT into practice.

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By seventh grade, coping with my family had become impossible, and I begged my parents to send me to a therapist. This was 1979, in the golden age of indemnity health insurance, so they took me to one of the "best" child psychiatrists in the Washington, DC, area. I was motivated: I took the subway for 30 minutes and walked more than a mile to go to the appointments. I sat there week after week, my anger and depression deepening. These feelings were worsened by a growing resentment toward the therapist's impenetrable smugness and detachment (which, in all candor, probably matched my own). I kept going for 2 years, but I found myself punishing him by lying to him in increasingly creative ways. Naturally, fooling him so easily made me feel even more hopeless. At the end of treatment, I was 13 years old on a lonely and dangerous road toward adulthood—and more unhappy and desperate than when I began. By the time I finished treatment with him, I knew that I wanted to be a therapist. I was outraged that I could not get the help I needed, but I was sure it was possible.

Tip 1: Feedback Is There for the Asking, but Not Always Freely Given

One day, you will encounter a client like my 13-year-old self in your caseload, hiding in plain sight. You will only get feedback that you are wildly out of touch with this client if you ask, but some clients will also require more—a kind of secret password—before they give it to you. That password may be an alliance instrument or, as I address later, gaining feedback may also require focused and dogged persistence that finally pays off.

By the time I finished graduate school in the late 1990s, I had already spent 9 years in therapy spanning a range of helpfulness: from heartbreakingly useless to profoundly life changing. I wanted to be the kind of therapist I had experienced in the best moments. When I walked into a conference in 1998 and started hearing Scott D. Miller, Barry Duncan, and Mark Hubble talk about client-directed, outcome-informed therapy (the predecessor of feedback-informed treatment [FIT]), I felt a kinship with these psychologists related to quality, accountability, and an effective form of skepticism about therapy that I wanted to learn more about. My own skepticism about their approach led to 6 years of due diligence about the methods, premises, results, and philosophy before I was willing to try it out with my clients. As has happened with many of the people I have trained over the years, the process showed its value in the first week or two, once I was willing to expose myself to my clients' feedback through this strange new system. One client said that if I would push him to emote more and to connect with deeper feelings, it might improve the alliance ratings. Another client said that she liked the idea of outcome and

alliance ratings because it "took some of the burden off" of her for the session. She then gave a low score on an alliance item, saying she needed to leave the session with more of a sense of what to do next rather than "disturbing an anthill" of emotions and not knowing how to contain them. My use of the alliance scale and earnest desire for bad feedback allowed us to address this concern right then and there, before she left the office. It turned out that this was a general failing of mine at that point in my career: I often was not sensitive enough to the postsession burden on my clients after prying off an emotional lid in the session. My clients were giving me some good supervision right from the start.

Tip 2: At First, Feedback Can Be Surprising and Intimidating

It is scary and strange for most clinicians to start collecting feedback. Getting your first surprising insight from this kind of feedback does not take long and often appears as a hilariously simple confirmation of its value—the feedback quickly becomes its own reward.

Like many therapists, I just had not believed that people would mark on a piece of paper something that was so different from what they revealed (verbally or nonverbally) about how they felt in their life or in the session. I also doubted their willingness to mark down something that was not socially desirable to report. I wondered if the feedback would be deep enough or useful enough. I thought I already knew how things were going, and that if I didn't, there was no other, simple way that I could know. Once I bothered to ask my clients in such a formal and regular way, I was quickly proved wrong on both counts, and it was incredibly satisfying—it took some of the burden off of me, too! I realized that, as seldom as I might get these little surprises or contradictions, each of these moments allowed me not to be the kind of therapist I abhorred. This is a core premise of FIT, even if it is not often explicitly talked about: Successful implementation requires an openness, need, and desire to have our mistakes shown to us so we will have the opportunity to self-correct and make amends. It requires us to be nondefensive and openhearted. This kind of passion and attitude cannot be taught in a 2-day workshop, nor will most practice managers and supervisors have the resources to develop their therapists to this degree (for further discussion, see Chapters 4 and 5, this volume). More important, I do not believe that practice managers or other administrators can develop this in therapists who do not already have their own motives for doing outstanding work. But therapists who already feel this way can be found. Then the manager can do a lot to support the therapist, provide resources, and not impede their progress through micromanagement. As in other industries, the hiring process is critical. And for the hiring process to succeed in attracting this kind of therapist, the culture of the practice has

to effectively express and support this premise of needing raw, honest feedback among the staff and administration (see Chapter 2).

Tip 3: It's About Humility, not Humiliation

As in most relationships, possessing a core of humility (approaching each client as an equal partner in change) will save you, but fearing humiliation can destroy your alliance and result in adverse termination of therapy. Being warmly open to negative feedback about how you are handling the therapy (and even eager to have your shortcomings brought to light) requires a profound degree of self-acceptance—beyond shame, narcissism, and the mask of competence. As someone who juggles all three of these impediments, I would offer that learning to juggle them lightly makes the difference between obtaining accurate feedback that opens the dialogue about a better process and being protected from it by those who do not want to hurt your feelings.

One of the appeals of private practice is being one's own boss—or at least not having to deal with the office politics, bureaucracy, and paperwork found in larger agencies and organizations. In our group practice of about six clinicians, we try to nurture a feeling of autonomy, creativity, and freedom, while providing the moral support, excellence orientation, and camaraderie that are often missing when therapists practice on their own. There are many ways to position a private practice in the community, but few therapists base their practice on the evidence of superior outcomes and accountability to clients and referrers. As a prospective patient, I would love a choice of therapists who all engage in this kind of rigorous patient-focused, quality-centered way of doing things. Anyone would. Yet as a practice owner, the lack of competition works great for us. Our reputation is crystal clear: We provide effective therapists—and have the data to show it; and we have patients who are willing to drive 50 to 100 miles for sessions with us. Some people are tired of mediocre therapy and taking chances when they are searching for one therapist among thousands. Some people are willing to pay more when they have solid reasons to be more confident about the outcome.

Tip 4: Not Everyone Will Buy the Quality That You Are Selling

Know your clientele and focus on that without excessive explanation. Accountable therapy is better than unaccountable therapy, and not all therapists are equally effective. These ideas are worth sharing, but do not expect everyone to care. Those clients and referrers who are oriented toward quality will quickly get it. However, there is no need to convince people who are not focused on this as a priority.

A solid reputation is something that each therapist must be able to provide to establish himself or herself among other therapists. Although we may compete for billable hours, therapists can be our greatest allies, partners, and referral sources—and we want to be the same for them. We all know that outstanding fellow therapists are not easy to find and should be cherished (or hired if possible!). Yet we each still have to establish our niche among other therapists as well as nontherapy approaches to achieving well-being: yoga, books, body work, drugs, meditation, exotic teas, martial arts, support groups, and social clubs. For the fees we charge, how can our potential clients justify risking so much money, time, and energy, when there are so many easy alternatives for improving their well-being that are cheaper, closer to home, and can be ordered from their phone? And how do potential clients justify driving long distances each way when they could just go around the corner? We have to make a compelling case, and even then we are not going to appeal to everyone. We look to serve clients who expect a more thorough, personalized, and intensive process than other approaches or therapists might offer. These people will commit to treatment if they have enough reassurance that they will receive a high-quality outcome. Remember that 13-year-old boy who *wanted* to ride the subway for 30 minutes and walk a mile each week for therapy—even when he found it "useless"?

Tip 5: Actions Speak Louder Than Words When You Respond to Feedback

If you want people to come to you for help, make it clear that doing so is worth their time and expense. In addition to offering your accountability and data as assurances, make it possible for clients to use their smartphones to book or change an appointment; be on time; have a well-soundproofed office. Use the feedback you get from clients, referral sources, and associates to make your whole practice better from top to bottom if you want to stay ahead of the competition. Certainly, someone will complain that you don't serve cappuccino or have Saturday sessions, but you will also get actionable intelligence that you can put into practice quickly and easily. What follows are two nonclinical, but highly applicable, vignettes that speak to how feedback can work to improve human experience.

Recently, I called a credit card processing company to get some information about my account. The person I spoke with was friendly and tried to help. At the end of the call, she said that I would receive an e-mail survey from her company. It would be great, she said, if I could give her a positive rating. I felt a familiar irritation come over me. This is an increasingly common experience with satisfaction surveys: tracking customer satisfaction as if to improve service for the *customer* but with employees emphasizing to the

customer that the employee (or company) needs outstanding marks. One recent postcard from a car dealership used the words "begging you" when asking for positive feedback. Car dealerships in particular seem to live and die by these ratings, and many customers feel pressured by salespeople to give them high satisfaction ratings. This distorted feedback process is inevitable when feedback-based outcomes are tied directly to rewards and as companies focus on improvement in service to profit. As a customer, this sort of manipulation is beyond irritating, making any outcomes geek practically apoplectic. Most businesses are far from realizing the level of service for which we aim. The good news is that in private practice, we get to make our own choices and create our own culture about service and outcomes, and we have enormous opportunity to do things right if we so choose.

In contrast to my experience with the credit card company, one morning about a week later, I ran over a glass bottle and punctured my tire. After mounting the spare, I had a feeling that the store where I bought the tires might repair the flat for free. I called their tire center and the person assured me that yes, they would do the repair for free; but if the tire were too badly damaged, they would replace it under the road hazard warranty. He said I should bring it in that evening before they closed. I got there at a little before 6:00 p.m. He said that although they closed at 7:00, and had customers before me, they would have it finished by 7:30, and I could get it then. He called me at 7:42 to tell me it was ready. Would they leave the keys under the mat and lock the car so I could pick it up later? Yes, no problem. When I arrived, not only had they repaired and remounted the tire and rebalanced all the wheels for free, but they had stored the spare back under the vehicle, put the jack and tools I had left in the rear of the vehicle back into their pouches and straps, and fastened them into their proper positions. No one asked me to give them high marks on a survey. Instead, I *felt* like I wanted to tell people about how great the service was, and I did.

Tip 6: A Focus on Service Quality Keeps "Client Experience" Front and Center

Word-of-mouth recommendations are powerful and happen more when you care deeply about your clients' actual experiences, not about doing a particular kind of therapy the right way. We improve from clearer access to the bad news from clients, rather than focusing on what *should* work and trying to get good news. As seldom as people want to tell all their friends about their therapist (regional differences abound in this regard), you will not get high marks simply by focusing on how to get positive reviews. On the other hand, you will improve outcomes and thus enhance your reputation when you focus on how to be more effective and client-centric.

How do we get this right in therapy? Perhaps it means being ready for sessions on time and not running late while our clients are waiting. Perhaps it is giving clients a free session when we make a scheduling error (given that we charge our clients for no-showing and late cancelling, we hold ourselves to the same standard). Perhaps it comes as we are vigilant for how we might be mishandling or missing something in the process that we can then reflect on, talk with a colleague about, or launch into an intensive training, supervision, or personal retreat to overcome. Perhaps simply returning calls promptly is a way to stand out. It is astonishing how uncommon this last behavior appears to be among some practitioners (not that we can be perfect in this respect). None of these things are especially difficult or entail clinical genius, but they do lead to better service and may promote higher levels of trust along with a creating sense of being cared about and feeling secure in the treatment relationship, which may indeed contribute to better clinical effects. I have a colleague who is usually at least 5 minutes late to sessions and will even interrupt the session to get himself a cup of coffee. As a client, this would be appalling to me; and as a colleague I make similarly scathing judgments about it. But with FIT, this therapist would know from the alliance feedback whether these behaviors were getting in the way of retaining this particular client (and possibly others); and the therapist would know from comparing outcome data with other therapists in similar settings whether such practices were associated with worse clinical outcomes. Rather than relying on the quirks of my judgment or the other therapist's judgment about such things, we can make it easier to hear it from the source—where it really matters.

The motivation for reaching high degrees of service or performance varies among professionals, but we all know from experience that few people have this kind of burning need to work so hard, learn so much, and challenge themselves emotionally to achieve these levels—in any industry. Ultimately, professional success (either financial or in terms of fame and reputation) does not require us to achieve great outcomes.

Tip 7: Reaching for Clinical Excellence Is Both Unnecessary and Insufficient for Financial Success and a Great Reputation

Reaching for clinical excellence is both unnecessary and insufficient for financial success and a great reputation. If you want fame and fortune, you likely chose the wrong profession anyway. Success and reputation come from other methods that require extraordinary social skills. Being effective certainly helps, but salesmanship, social connection, and confidence are much better tools for building a practice. Although constantly striving toward better quality may have an intrinsic beauty, it is too loosely tied to extrinsic reward to be useful for that purpose.

Recently, I received a call from a prospective client who seemed to be in a big hurry. The main thing he wanted to get across to me was that he had a particular kind of insurance, but he said nothing about why he wanted therapy. (We do not contract with major insurance carriers.) From the rushed way he was speaking, he likely did not have much time to consider whom he worked with, the conversational feel, or any of the factors that therapists know are important to establish a better working alliance at the outset. I called him back offering to discuss his concerns further, but I was not intent on selling him, given our lack of a contract with his insurer.

Tip 8: Save Your Breath, but Be a Helpful Resource

This is the corollary to Tip 4, which is about focusing on your target audience when you are going out in the world to express who you are. When calls come in, accept the individuals who are your target clients, and also accept those who are not your target. In other words, accept that the latter are OK as they are and do not need you to save them from their agenda or argue the merits of your case. They provide an opportunity for you to meet them where they are and, if possible, to connect them with your trusted colleagues who may be a better fit. Want better alliances? Want better outcomes? Do not try to force a fit between you and a prospective client. Instead, develop ways to triage more effectively.

Consider the previous example of the credit card company. The emailed survey said, "Your survey participation will help us improve your experience with us. Please take a few minutes to share your candid feedback." Yet the company failed before they emailed the survey by not creating a true "culture of feedback" among their employees. If they had, then the customer service representative would never have asked me for high marks. She would have asked me to complete the survey and focus on what she could have done better. As a customer, I am not going to bother to give them feedback. I already assume that the company is not oriented to improving my experience as a customer because they are not soliciting accurate feedback. Why would I waste my energy being honest? Most companies that send surveys have employees who are motivated to get high marks, to hear how great they are doing so they can receive bonuses or avoid being fired. Each of these companies is also likely to have a few employees who intrinsically want to be outstanding at what they do, driven by their own deep need to do outstanding work, not by cash. Like these workers, a FIT-based practice focuses on figuring out how it has failed in major or minor ways at each session. High alliance (satisfaction) marks are experienced as boring or concerning, not reassuring (how can I improve the process if I do not get feedback that helps me fine-tune it?). High outcome marks provide the reassurance.

As another practical example, Marcus Lemonis, an entrepreneur and reality TV personality who invests in and fixes struggling businesses on a program called *The Profit*, seeks a lot of customer feedback on the street, in focus groups, or from corporate buyers when he is trying to help his new partners change direction and improve service or product quality. While giving free samples of pie on a sidewalk, the question he asks tasters is not "What do you think?" or "What feedback do you have for us?" He asks, "What would you do different?" He pushes the tasters toward complaining. In five words, he seeks out what is *wrong*. This is the improvement orientation: asking relentlessly (but also sensitively, caringly, politely) for feedback about what is failing and needs to change rather than asking for reassurance using a yes/no question ("Is everything to your satisfaction?" "Did you find everything that you were looking for?"). A client of mine that had given me perfect alliance score after perfect alliance score for dozens of sessions had resisted all of my attempts to extract some kind of nuance in how she was experiencing the session somewhere below total perfection. I felt challenged in how to keep asking in a way that would break through but also not feel like I was "badgering the witness." It finally worked in a session when I cajoled for the umpteenth time and tried to express not frustration but honest desire to understand what might be happening with all of these perfect scores. The client cried and acknowledged that her own perfectionism and near-constant fear of criticism from a father-figure caused her to use the perfect alliance scores as a shield, hoping on some level that I would need to reciprocate the kindness with kindness of my own. Like many of these poignant moments, it gave me an opportunity not just to achieve a deeper connection and empathy for this particular client but also to reflect on personal relational patterns I may have as a therapist with many clients: In what ways can I be too harsh or blunt? In what ways do I intimidate clients with my intense facial expressions? How many of these high alliance scores are influenced more by fear than gratitude?

Clients generally want to be nice, and they need to be actively supported and guided if we want them to give us the gift of their brutal honesty so that we can be more effective. In other words, we have to convince them that this kind of feedback *is* nice, both appreciated and welcome. We can only convince them of this if we actually feel that it is true, and that is why so much of our attention as a practice is focused on hiring new therapists with this intrinsic motivation. When meeting a new client for the first time, we have a few minutes and only a first impression to show that this is what we stand for, to set the tone for the feedback we get. Even with this intention, many clients will struggle to give negative feedback. To get truly useful feedback (rather than reassurance), we must truly desire it when we ask for it.

Tip 9: Go Wrong or Go Home

There is no point in collecting feedback to improve your service quality unless you specifically focus on the mistakes and are willing to apply the resources to correct them. In our practice group, we use the approach that if we focus relentlessly on these negatives (without fear of judgment or humiliation), then our numbers will take care of themselves.

One of the revolutionary features of psychotherapy outcomes (and most importantly, having practical methods for measuring them) is the capacity for private practitioners to ground their practice in quality, rather than just aspiring to it. The difference between satisfaction surveys and outcome measures is enormous. Even with all the statistical noise and conceptual malleability in subjective reports of clinical change, being able to know and report on the amount of improvement in the week-to-week lives of virtually all the clients you work with is pure gold for a practitioner who wants nothing more than to be the most effective clinician around. Obtaining your own outcome data is also dramatically different from using empirically supported treatments that others (i.e., researchers) have used successfully and calling your use of these methods "evidence-based practice." From what we know about the high variance in outcomes between practitioners versus the low variance in outcomes between methods, this comes dangerously close to falsely advertising someone else's results as indicators of our own.

Tip 10: If You Collect no Evidence, You Are Basking in Reflected Glory, Not Doing "Evidence-Based Practice"

On the other hand, false advertising cuts both ways: If you are not careful with how you present your data or how your results are calculated and benchmarked, you may wind up falsely promoting your position.

We can know the ways we are failing, under what conditions, and where we may need to develop more as therapists only when we have a tremendous capacity to see ourselves as flawed, and instead of feeling ashamed are inspired to work even harder. Outcome data are analytical nirvana for someone like this. Group consultation and supervision become different processes in which, instead of telling stories and receiving our colleagues' attention, sympathy, or confirmation, we dig into the struggle of what we are missing and how we are being at least slightly blind, obstinate, or theory bound. In private practice, consultation often takes the form of telling stories to those who mostly see things the way we do and can offer some support and an idea or two. We should also (or instead) seek out those who challenge, argue, and offer alternative ways of seeing and interacting with clients. If we operate without the shame, narcissism, and need for social confirmation, our work will get even better.

Tip 11: Seek Out Smart and Insightful but Highly Divergent Colleagues

If you surround yourself with fellow Adlerians, cognitive behavioral therapists, or primal-scream adherents, how much of a different perspective are you likely to get? How much will you be radically challenged about your narrow way of doing the work from which your client is not shifting into a better way of life? From whom will the novel approaches come? Who will boldly suggest that you consider other interventions that favor the client's well-being over your own sense of competence? Negative feedback can also instruct and develop us when it comes from colleagues. Once you are in private practice, you will have to invite this on purpose, beyond the typical support of your friends and colleagues.

A wise and artistic client who had returned to school after many years marveled in a recent session about a highly anxious and obsessive classmate who was bent on getting the highest grade possible in her classes. The client laughed that while he could imagine being that way, "I wouldn't want *her* life!" Frankly, the relentless striving for excellence is not the most balanced or healthy pursuit one can have. Think for a moment about the absurdity of trying to be the *most* balanced person possible, or practicing the *most* moderation of anyone you know. We all have different priorities at different times in our lives. Not only is an excellence orientation difficult, requiring a persistent focus on mistakes and failures, it also requires a level of hard work that is simply not a relaxing way to live. As E. L. Kersten (founder of http://www.despair.com) put it, "Hard work often pays off after time, but laziness always pays off now." Yet for those who somehow need to live this way, it can provide a level of satisfaction that we are involved in a meaningful and valuable activity in our daily lives: Not only do we intend to help and think that we help, but our patients report through the changes in their lives that we (mostly) *are* helping. Perhaps even more important, when we are *not* helping, there are ways to discover and perhaps fix it.

On occasion, I have been asked about the practical side of FIT: How have we been able to continually implement FIT in our practice with 100% participation of our therapists and with extremely little data loss (fewer than 5% of sessions or clients lacking outcome and alliance data). Without a doubt, the successful implementation of FIT requires total commitment and investment from the top. In private practice, this is simple. In building a FIT-oriented group practice, we recruit new therapists by making sure they understand that FIT is the centerpiece of what we do. When therapists come to work with us, they clearly see how much the feedback-informed philosophy pervades everything we do: meetings, supervision, paperwork, and policies. The whole practice is oriented to continual improvement through feedback

among the therapists, with management, from clients, referrers, colleagues, and even vendors. Emotional safety and integrity are the key ingredients to making all of this work, to creating the culture of feedback. People have to feel safe and supported in giving negative feedback and have to believe that conflicts and bad feelings are possible to work through to get to a better place together. *Integrity* means that we follow through in a genuine way with our stated mission. We do what we say, and we act toward our aspirations (conveniently, the FIT philosophy also encourages people to call out the system or its leadership when we are not acting toward our aspirations, and it licenses all the participants in the system to do so with gusto). In other words, FIT is not simply about using forms or analyzing data; it's about a way of practicing and living that is driven from an inner need and longing to be better, to do better, and to achieve better results even through the conflicts and tensions that are necessary to face our mistakes. That "inner need" is not enough to make us better, though. We still need outcome data to determine how much our philosophy is actually translating into effective treatment for our clients.

Tip 12: We Sink or Swim Together

In a multiperson practice, FIT must be practiced from the top down and infused in the whole culture, or efforts to implement it will fail. Moreover, the integrity of FIT will drift constantly and threaten to veer off course—we are dealing with flawed humans with limited energy and attention spans. People will fall asleep at the wheel, so everyone in the car needs to have at least one eye open to what the whole system is really doing and be willing to cry out when we are going off the road. When everyone feels responsible for doing that, course corrections come faster and from a broader base of creativity and insight. We might even extend this to psychotherapy as a general industry: Either we come to grips with how we are failing to promote the value of psychotherapy, and we answer the call to serve our clients more effectively (rather than being defensive about the great work we are doing), or we are likely to perish as a discipline while scrappier, more aggressive, cheaper, or more quality-focused approaches to mental health survive.

A one-person private practice is easy enough to manage for the successful training and implementation of FIT. For me, the challenge came when I started The Colorado Center, a group practice, which now employs six therapists. Integrating the FIT philosophy throughout the practice, hiring only FIT-friendly practitioners from the very beginning, and having regular meetings that included discussions about alliance and outcome helped keep FIT and rigorous measurement at the forefront. There were a couple of other things we did to support the uptake of FIT: We did not set up any rewards or punishments based on data collection or actual outcomes. We simply *required*

data collection (naturally, because it is the basis of our practice) with every client and every session unless a client expressly refused to do it. To be honest, we first had contemplated a retention-bonus system for high-achieving clinicians, but our research revealed so much variation in the way outcomes could be measured and analyzed that we instead began a research program focused on reducing grade inflation and decided that it was premature and unwise to try any kind of retention-bonus or pay-for-performance system. In retrospect, this was a good decision regardless of how much faith we could have in our statistics. In our practice, a pay-for-performance program would miss the point. Although our clients pay for our performance and we will not retain therapists with below-average outcomes, our clinicians are motivated intrinsically to be more effective. We track whether they are more effective, and these high performers will stay as long as our practice supports them in a good way and provides a more nourishing and happy environment than they can get elsewhere. Everyone wants to be compensated fairly for their work, but we feel that performance bonuses based on client outcomes (especially when the metrics are continuing to evolve) are a distraction from the main agendas of the personal need for excellence and wanting a highly supportive work environment that provides an honest day's pay for an honest day's work. Our therapists agree that this works better to create a collaborative and supportive environment.

Tip 13: Use Extreme Caution Before Considering or Even Talking About a Pay-for-Performance Plan

If you attempt a pay-for-performance plan, you are likely to make a huge mess and not know what you are doing. Will the outcome instruments and benchmarks you use today be what you use in 5 years? Will such a plan actually help you retain the best therapists, or will it have unintended, unnecessary, and destructive consequences such as stimulating more envy or fear among colleagues? Some insurance plans have tried to implement outcomes-tracking programs by providing incentives for participating and submitting data rather than for achieving certain outcome benchmarks. At this time in the development of patient-reported outcomes, this is a more prudent idea: Motivate therapists to capture the data rather than to cash in on the data.

Another method we used to ensure almost perfect implementation was to integrate our billing process (the submitting of session fee information for the purposes of compensation) into the footer of our outcome forms. When therapists start at The Colorado Center, they get immediate training in how to integrate FIT into their clinical work and are shown how to make a copy of each client's completed outcome form, write in the billing information for that session, and turn in these sheets at the end of the week. When there is

a billed session without scores (e.g., with a no-show), the clinician turns in a blank, unscored version of the outcome form with the billing information at the bottom. Our therapists know that someone else will see their outcome data, but they do not have fear about how an administrator will judge those scores—trusting that we all know that the outcomes will likely take care of themselves as long as the training, skill, and intention are present (and that if not, poor outcomes will be addressed in a supportive, nonpunitive, and nonshaming way). We believe that this sense of a supportive observer can help each therapist have more awareness of the measurement process.

So how is our attention to poor outcomes nonpunitive if we will not retain therapists with below-average results? Our clinicians know that our first response as a practice is to try to improve the results to address what may be going wrong in a way that is oriented toward development and change. If these efforts do not succeed, we think it is only natural that the therapist and the practice would want to separate: Why would the therapist want to stay in such a frustrating environment if efforts to address ongoing problems have been unsuccessful, and why would the practice want to encourage the therapist to stay? This is a close parallel to what happens with individual clients who experience persistently low states during treatment with no real signs of change. Are the data pointing to unproductive therapy? In such cases, why would the therapist want to encourage continuing on that course without a radical change? On the other hand, we do not want our clients to fear that we will dismiss them if they do not show quick or consistent improvement any more than we would want our employees to fear it. We want to focus on development, improvement, and growth up to the point that therapy just does not seem to be working. At that point, we want to have the courage to separate and encourage a better fit.

Tip 14: Make Outcome Tracking an Easy, Automatic, and Expected Part of Daily Work

Integrate outcomes clinically and through procedures or routines that your practice already does. High implementation rates (e.g., more than 90% of sessions) and the frequent examination of data lead to greater awareness of problematic trends that can be addressed effectively, providing a higher quality experience for clients and greater work satisfaction for practitioners.

By discussing interesting and surprising events in the use of outcomes and alliance monitoring, our clinicians continue to learn from each other and develop more nuanced ways of using the data with our clients—and we keep taking it seriously without feeling as if we are being forced to take it seriously or as if the feedback should drive the process rather than being an

appropriate advisor to the process. Few therapists are statistics fans or want to get deep into the research about methodology, validity, and such. Somehow, I have not been able to get my colleagues terribly excited about new and complicated research protocols. Yet when we start a new protocol (which can last for a year or more of data collection), I do my best to explain clearly the rationale for how it fits our mission of greater quality, greater integrity, greater transparency, or greater service. I also try to offset any increase in workload with reductions elsewhere, to reduce the strain on our therapists. Given the interest that everyone has in getting an accurate sense of how their clients are actually faring and in how they themselves are performing (wanting the truth more than a flattering portrait), these conversations tend not only to improve the morale and buy-in of our therapists but also to generate frank and critical discussions about how best to implement the research or make improvements to the methodology. The bottom line is that we make it clear that there is a real point to all of this research and measurement, and it leads to better care and better-informed therapists who can focus on what they may need to change and improve. The more clearly we can draw the connection between a given research protocol and how it will lead to better data or a simpler way to measure, the more a clinician will understand the importance of digging in and being a part of the process.

Tip 15: Reduce Sources of Friction With Clear Communication

Communicate with your colleagues about the purpose of outcome monitoring and any changes you make to it. Seek collaboration and feedback (of course) about how best to implement FIT with your colleagues.

Being a full-time therapist in this group allows me to test each of the protocols with my own patients to make sure the process is clear and the steps are laid out in a way that can be followed and repeated. I also take responsibility for putting together clearly organized and labeled packets of forms, instructions, and diagrams for how to implement the research. Not only is it important to lead by example with my own patients, but I also want to serve my colleagues and show them that I am willing to put in my overtime, my sweat, and a ton of thought before asking them to take on the burden of data collection. Why do I do all that when their job description already says that they will be collecting these data? Each change and each added task can feel like a massive burden until it becomes established as habit. By showing them that I want to make things as easy on them as possible, I hope to get them to be willing to stretch as well. It seems to work because they have demonstrated a willingness to engage in this process and adapt as each new protocol comes along—as long as I follow the guidelines and do not saddle them with too much additional work.

Tip 16: Act as the Guinea Pig

Beyond simply implementing or administering FIT, be the test case. Model how you want this done, and work out the kinks with your own clients before you ask colleagues and employees to do FIT. Your greater empathy and understanding of the process will pay off in better implementation with those who understandably fear taking on something so new and different.

In the 6 years that The Colorado Center has been operating, I have noticed that the group culture that has emerged so far is, in a word, neurotic. I mean that in the best way. It has seemed to me that those who choose this path when it is still so far from the norm are a bit more concerned with being good enough than are typical professionals. We are appropriately nervous about making major therapeutic mistakes, and we tend toward perfectionism and a lot of reflection about how we are doing and what we can be doing differently or better. Like most therapists, we are not particularly extraverted, which can make person-to-person networking a challenge. Putting our outcomes clearly on our website (and being circumspect about how to calculate and interpret our results) is one way we let our effectiveness speak for us; and these results do make an impression on some clients (on the other hand, it is likely that such an unusual and quantified discussion of therapy outcomes also discourages some clients).

CONCLUSION

Naturally, we have made our rigor in tracking and measuring outcomes a centerpiece of our public relations at the Colorado Center. It is the cornerstone of who we are as a practice. For some clients, knowing in advance that a particular therapist is more likely to help them reduces their concern with the typical out-of-pocket cost of therapy. Although we cannot provide anything close to certainty, we hope to improve the odds for our clients. I live in dread of a 13-year-old boy sitting through 2 years of useless, depressing therapy in our offices. We cannot guarantee that it will never happen, but we strive every day to be a sanctuary from the ordinary or mediocre care that many people endure, and to create the greatest possible value for our clients.

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7

FEEDBACK-INFORMED GROUP TREATMENT: APPLICATION OF THE OQ–45 AND GROUP QUESTIONNAIRE

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Group psychotherapy is complex and requires attention to multiple individuals, alliances, goals, structures, dynamics, processes, and possibilities. The literature on group therapy has struggled to find construct clarity for its varied concepts. For instance, how is cohesion the same or different from therapeutic alliance in group treatment? Further complexity is added when we measure these constructs taking into consideration the interactional effects of the dynamic processes that occur in groups. For example, there are at least three relationship structures in groups that are in constant interaction: member-to-leader, member-to-member, and member-to-group. Advances of the past decade have some added clarity, yet clinicians remain unable to accurately predict member status on important client variables in real time. Scientific, logistical, procedural, and technological challenges have stood in the way of implementing a viable feedback mechanism to provide reliable information that is clinically significant, comprehensive, quickly accessible,

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and clinician-friendly. Feedback-informed group treatment (FIGT) provides clinicians with information about clients, member interactions, and whole group dynamics quickly and concisely.

This chapter details how one clinical setting implemented FIGT. We specifically describe three implementation challenges and their solutions, including details and visual examples of the feedback used to inform group treatment, and the science behind the instruments. In addition, we offer textual examples in the form of clinical vignettes to illustrate several ways clinicians can use FIGT.

CONTEXTUAL FACTORS OF THE CLINICAL SETTING

Two contextual factors associated with our clinical setting are central to understanding the problems we address in this feedback-informed treatment (FIT) case study: the type of clinical setting we work in and the contribution our center has made to the FIT literature. Our setting is a large university-based counseling center that employs 30 clinical faculty members who are predominantly clinical and counseling psychologists. We are also a practicum and internship training site for 20 doctoral psychology students. These 50 clinical faculty and students serve a university community of 30,000 full-time students and their families by providing therapy, assessment, and training related to psychological and academic concerns. Our therapists report a range of theoretical orientations (cognitive behavioral, interpersonal/humanistic, existential, and psychodynamic) and most clients are treated in individual therapy. However, 25 groups ranging from general process groups to more structured groups composed of members with common diagnoses or treatment foci (e.g., anxiety, eating disorders, sexual abuse, pain management) or treatment modality (e.g., dialectical behavior therapy, meditation, acceptance and commitment therapy) are run each academic term.

Our center has played a fundamental role in FIT literature over the past 25 years. We hosted the first series of randomized clinical trials in the 1990s conducted by Lambert and colleagues (Shimokawa, Lambert, & Smart, 2010) that tested the effect of providing clinicians with progress feedback using the Outcome Questionnaire—45 (OQ–45), a 45-item instrument designed to assess symptom distress, relationship concerns, and difficulties with social roles. The OQ–45 provides a way to track whether clients are improving, deteriorating, or staying the same in terms of symptom distress. It has a clinical cutoff score of 63 and a reliable change index (RCI) of 14 points. This 14-point RCI provides a way to differentiate statistically significant change on the measure from daily mood fluctuations.

Later trials in our clinic also tested the effect of giving therapists feedback on known moderators of treatment success (therapeutic relationship, social

support, motivation and critical life events) using clinical support tools. These studies involved clients receiving individual treatment and consistently showed that FIT led to a reduction in the rate of treatment failure and improved outcomes (Shimokawa et al., 2010). Our center became a leader in FIT research and practice with our clinicians ranging from enthusiastic supporters through neutral to a few skeptics. So what was the problem we faced? Applying FIT to our groups.

CHALLENGES TO IMPLEMENTING FIGT

As a busy research-driven university counseling center, we experienced several logistical challenges in adopting FIGT in daily practice. The first was administering the OQ–45 to six to 12 group members who show up at the same time before a group session. The second was providing progress feedback on all group members before a group session in a timely manner that respected the fast pace of clinical practice. A third challenge was selecting a measure of the group therapeutic relationship that engaged clients and informed clinicians. In the following subsections we address each of these challenges with their solutions followed by examples of how leaders used FIGT in daily practice.

Administering

Our center's initial FIT practice focused on individual-therapy clients who checked in with the receptionist and completed an OQ–45 on a computer tablet. The OQ–45 was then scored, the receptionist notified the therapist, and treatment began. Due to a limited number of tablets, we invited group clients to bypass the receptionist and go directly to their group rooms. The OQ–45 was not administered, and we inadvertently created a center norm that FIT was not relevant for groups. There were, however, a few clinicians who used the OQ–45 in their group work and by the late 1990s we had sufficient data to indicate that group clients' progress on the OQ–45 followed the same trajectory as individual clients (Burlingame et al., 2016; Burlingame, MacKenzie, & Strauss, 2004; Burlingame, Strauss, & Joyce, 2013). This led to a decision in 2005 to have all group clients complete the OQ–45. However, our center norm was difficult to change. Very few group clients completed the OQ–45, making FIGT nearly impossible. To overcome this norm we purchased more computer tablets and posted signs on group room doors reminding clients to complete the OQ–45 *before* entering the group. However, the critical success factor in FIGT was getting our group leaders on board. Clinician buy-in posed our second challenge: providing FIGT reports that depicted data for all group members.

Providing Feedback

OQ Measures, which disseminates the OQ–45, has implemented FIT systems all over the world, and a critical success factor is providing immediate progress feedback *before* a clinician sees a client. The provision of immediate feedback was the fundamental reason for the creation of the OQ—Analyst (OQ–A), an Internet-based FIT system containing over 30 outcome and relationship assessment tools including the OQ–45. Our center began using the OQ–A in the early 2000s, but the client-centric database was a significant limitation of the OQ–A in supporting FIGT. In short, OQ–A feedback reports are produced for individual clients, not groups of clients, making reviewing six to 12 feedback reports prior to each group session prohibitively labor intensive for the therapists.

Figure 7.1 shows an example OQ–45 report for an individual client. Higher scores indicate greater distress. Clinicians also see five critical items and are given an alert status that provides information about whether a client is on track to have a positive therapeutic outcome (white or green) or is at risk for treatment failure or deterioration (yellow or red).

Selecting a Measure

In the late 1990s, we began training group leaders in FIT at the annual meetings of the American Group Psychotherapy Association (MacKenzie, Burlingame, & Fuhriman, 1999) by exposing them to outcome and relationship measures that had a solid empirical foundation in the group literature (Burlingame et al., 2006). In the early 2000s, we selected two of these measures, a group climate measure (i.e., Group Climate Questionnaire; MacKenzie, 1983) and a therapeutic factor measure (i.e., Fuhriman, Drescher, Hanson, Henrie, & Rybicki, 1986), and conducted an FIGT study where group leaders received feedback about the therapeutic relationship. We were interested in replicating findings from the individual therapy literature using group clinical support tools. The study failed to show an effect (Davies, Burlingame, Johnson, Gleave, & Barlow, 2008), and our primary conclusion was that we had provided feedback on a construct—therapeutic factors—that was neither easily understood nor valued by group clients. The measures we used were shorter (12 items) than the OQ or clinical support tools used in individual therapy, so feasibility was not the issue. Rather, clients failed to see the value of the measures to their treatment, and some clients refused to complete them at all. This feedback regarding therapeutic factors was also difficult to translate into actionable information to assist group leader interventions, so clinicians struggled to apply the findings to their practices in any pragmatic way.

In previous studies, we had shown that the group therapeutic relationship was a reliable predictor of treatment success (Burlingame, Fuhriman, & Johnson,

Name:	C-OQ45. Alan, G	**ID:**	MRN0112
Session Date:	10/30/2015	**Session:**	8
Clinician:	Supervisor, Tom	**Clinic:**	SLC Clinic
Diagnosis:	Unknown Diagnosis		
Algorithm:	Empirical		
Instrument:	OQ®-45.2 English		
Questionnaire Status:	Valid		

Alert Status:	Green
Most Recent Score:	79
Intake Score:	89
Change from Initial:	No Reliable Change
Current Distress Level:	Moderate
Graph type:	Total

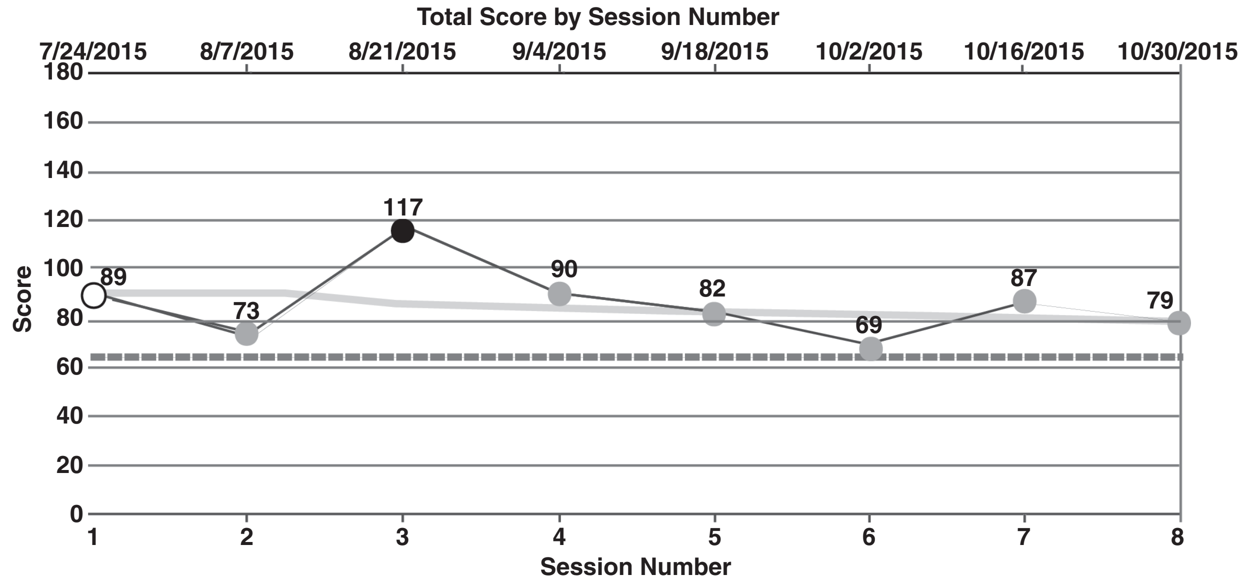
Most Recent Critical Item Status:

Item	Status
8. **Suicide – I have thoughts of ending my Life**	Rarely
11. **Substance Abuse –** After heavy drinking, I need a drink the next morning to get going	Never
26. **Substance Abuse –** I feel annoyed by people who criticize my drinking	**Sometimes**
32. **Substance Abuse –** I have trouble at work/school because of drinking or drug use	Rarely
44. **Work Violence –** I feel angry enough at work/school to do something I might regret	Rarely

Subscales	Current	Outpat. Norm	Comm. Norm
Symptom Distress	37	49	25
Interpersonal Relations	21	20	10
Social Role	21	14	10
Total:	79	83	45

Figure 7.1. Example OQ–A report.

(continues)



Graph Label Legend:

- **Red: High chance of negative outcome**
- **Yellow: Some chance of negative outcome**
- **Green: Making expected progress**
- **White: Functioning in normal range**

Feedback Message:

Although the patient has not yet recovered, his/her progress appears to be on track. Progress is judged to be within the range of expected response. Further progress is expected.

REMINDER: THE USER IS SOLELY RESPONSIBLE FOR ANY AND ALL DECISIONS AFFECTING PATIENT CARE. THE OQ®-A IS NOT A DIAGNOSTIC TOOL AND SHOULD NOT BE USED AS SUCH. IT IS NOT A SUBSTITUTE FOR A MEDICAL OR PROFESSIONAL EVALUATION. RELIANCE ON THE OQ®-A IS AT USER'S SOLE RISK AND RESPONSIBILITY. (SEE LICENSE FOR FULL STATEMENT OF RIGHTS, RESPONSIBILITIES AND DISCLAIMERS.)

Figure 7.1. (Continued)

2002; Burlingame, McClendon, & Alonso, 2011), so we knew we were on the right track. However, we also noted that there were numerous constructs and measures used to assess the group therapeutic relationship (i.e., group climate, cohesion, working alliance, and empathy) and that variability in findings existed between constructs and measures. We selected the four most frequently used measures of group climate, cohesion, working alliance, and empathy and had nearly 700 members attending more than 100 groups complete each using their group as a reference (Johnson, Burlingame, Olsen, Davies, & Gleave, 2005). The resulting identification of three latent factors—positive bond, positive work and negative relationship—explained much of the measurement variance when one also models the three structural facets of relationships in group treatment: member-to-member, member-to-leader, and member-to-group. The three latent factors crossed with the three structural dimensions created the empirical underpinnings of the Group Questionnaire (GQ; see Table 7.1). Using data from this study, we discarded items with low factor loadings or that were highly correlated with one another resulting in a 30-item questionnaire.

Figure 7.2 is an example GQ report. The GQ positive bond subscale captures the positive affective items associated with other members, the leader, and group as a whole (higher scores indicate greater levels of cohesion and alliance within the group), and the negative relationship subscale captures the opposite of positive bond (higher scores indicating greater empathic failure, alliance rupture, and conflict). Only two relationship dimensions come into play with the positive work subscale (i.e., member-to-member and member-to-leader) where higher scores indicate greater sense that an individual is meeting his or her goals in the group. Subsequent GQ research (Bakali, Baldwin, & Lorentzen, 2009; Bormann, Burlingame, & Strauss, 2011; Bormann & Strauss, 2007; Krogel et al., 2013; Thayer & Burlingame, 2014) has shown that these three factors explain a group member's perception of the therapeutic relationship in groups. More specifically, the factor structure has been studied and supported in therapy groups conducted in four countries (United States, Germany, Switzerland, and Norway) across four clinical settings (counseling center, European inpatient, severely mentally ill inpatient, and nonclinical). As with the therapeutic relationship research in individual therapy, group therapists are unable to accurately predict member status on the positive bond and work subscales until the ninth session, and

TABLE 7.1
Constructs Assessed by the Group Questionnaire (GQ)

GQ subscales	Member–member	Member–leader	Member–group
Positive bond	Cohesion	Alliance	Climate
Positive work	Task/goals	Task/goals	None
Negative relationship	Empathic failure	Alliance rupture	Conflict

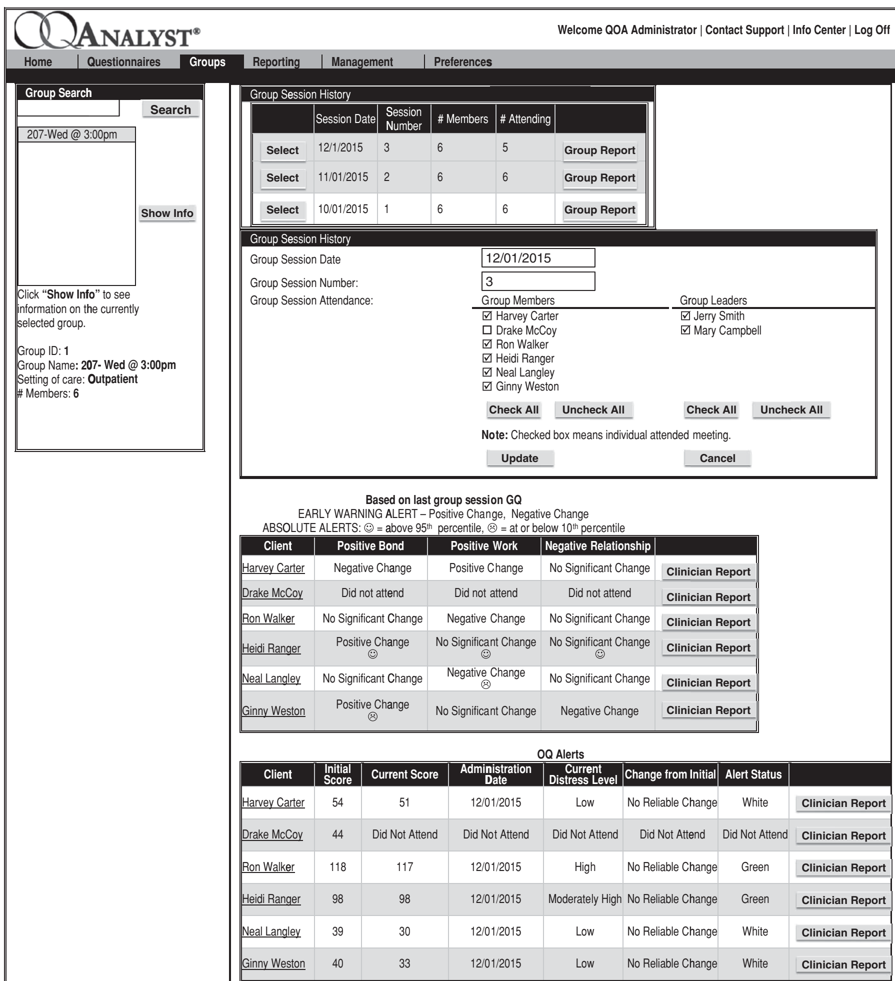


Figure 7.2. Example GQ report using fictional group member names.

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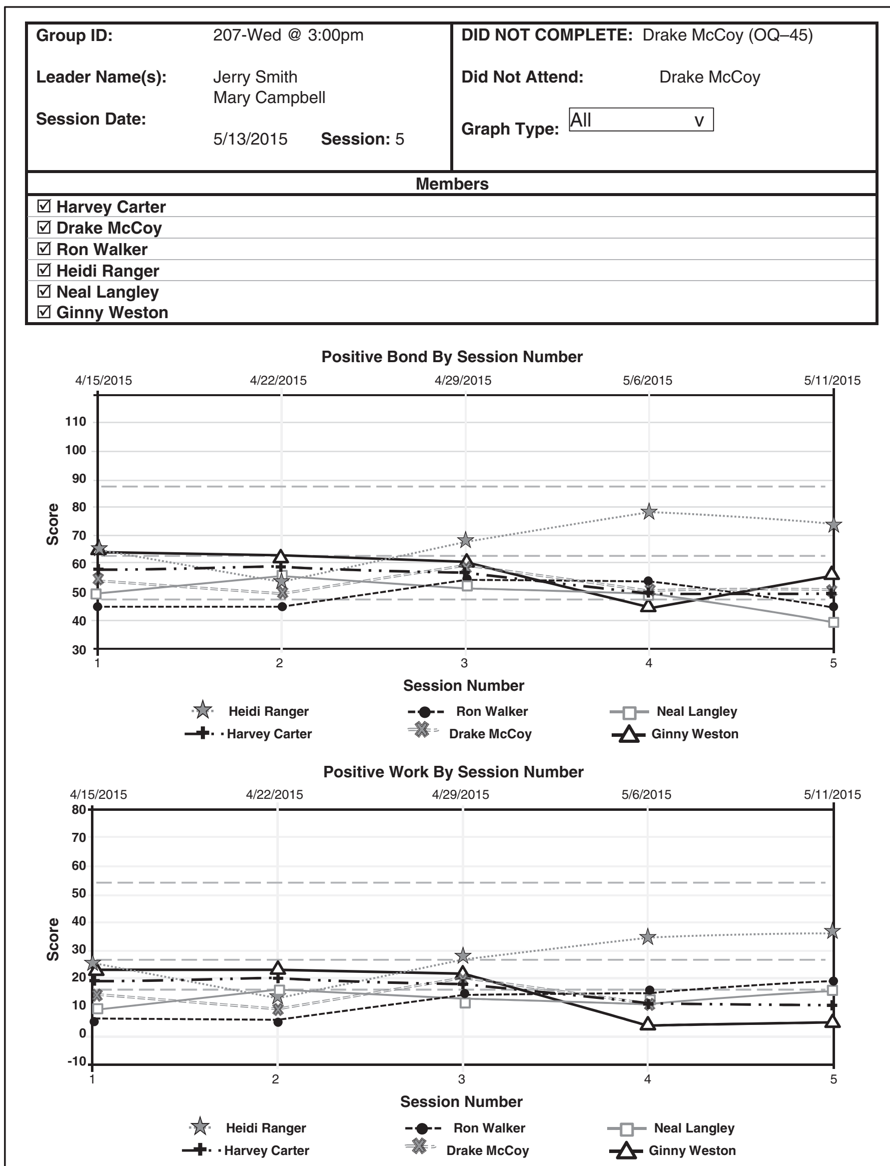

Figure 7.2. (Continued)

they never succeed in predicting member status on the negative relationship subscale (Chapman et al., 2012).

While the OQ and GQ provide valuable information about individual and group functioning, group leaders charged with examining six to 12 OQ–45 reports as well as six to 12 GQ reports for each group session felt overwhelmed. Sometimes such analysis was not even possible, considering that group members were completing the OQ–45 a few minutes before the group began. Even so, the compelling results from the trials of FIT in individual therapy provided sufficient motivation for us to continue to look for solutions to make FIGT practical in daily clinical practice.

Both clinical and technological solutions were required to produce a viable FIGT program in our center. Our clinical task was to create a single-page FIGT report that captured salient OQ–45 and GQ information for all members of the group. We wanted a report on which our group leaders could spend less than a minute to assess group climate and to assist in identifying who might be in trouble in their group before they walked into a session. A technological task was to create the capability to drill down into individual client data to provide greater detail if the therapist wanted it. This was made possible when the FIGT group report became accessible online as each client's GQ and OQ–45 reports were hotlinked to the FIGT report, enabling a leader to quickly retrieve and review more detail about an individual client if needed.

Creating this FIGT report addressed the three challenges that our clinicians faced. Group members are now consistently completing the OQ online before group sessions, group leaders are motivated to use the feedback given its usefulness and convenience, and group leaders now have access to reliable group-as-a-whole data. This version of the FIGT report has now been used with more than 70 groups and 18 group leaders. The middle portion of this report provides GQ information, whereas the bottom summarizes key OQ–45 information. The GQ portion of the FIGT report parallels RCI change information from the OQ–45. Early warning GQ alerts are issued when a subscale drops (deteriorates) or rises (improves) by one RCI since the previous session. Red (negative) and green (positive) fonts provide unambiguous feedback on the direction of change. Members who did not attend the previous group session are indicated near the top right corner. Absolute GQ alerts identify scores that are below the 10th percentile of a norm group (off-track) and above the 95th percentile using frowning and smiling icons. Our past research suggests that early warning alerts precede off-track status (Woodland, Whitcomb, & Burlingame, 2014), thus we encourage leaders to focus on early warning as well as absolute alerts. In the OQ section of this report, each member of a group is represented by a row with columns capturing information from the OQ–45 including alert status, initial score, change from initial (RCI), and current score.

CLINICAL EXAMPLES

Armed with the information in Figure 7.2, group leaders have successfully implemented FIGT across a variety of groups ranging from process to manual-guided groups. The high-level summary can be reviewed in under a minute, and the links to individual reports provide immediate access to greater detail if a leader wants to review specific data on an individual client. Two pages of graphs provide additional chronological and visual information to guide group leaders. The combination of clinical and technological solutions has breathed life into our FIGT program, and we believe that an integrated solution is the only viable alternative when conducting multiperson therapy.

What follows is a series of case examples from several clinicians using FIGT illustrating some ways group treatment is informed by the OQ–45 and GQ. Please note that each of these case examples was possible only after solutions were found to the logistical and technological problems. Clinicians would not have had time to sift through and aggregate all of the considerable data provided by the measures without an integrated report that was quickly available. With the automated report, however, valuable information on a multitude of factors and dimensions could be scanned quickly, and the clinicians could use their skills to construct a composite clinical picture. The following clinical vignettes show a progression from using measures to support conceptualization of a single case, to understanding member interactions, to providing information on the group as a whole.

The first vignette illustrates the use of the OQ and the GQ to track a single case. The second vignette illustrates use of FIGT to integrate a single member's feedback into the dynamics of a group. The third demonstrates a way to use feedback to inform clinicians regarding interactions between two members and a possible way to bring FIGT feedback directly into a group meeting. Such interactional effects can be very informative yet are not easily determined without FIGT. The fourth vignette describes using FIGT information to understand the functioning of the whole group, the exchanges between two particular members, and the treatment planning and interventions that follow. Possible uses of FIGT for supervision and training are also included.

When the Therapist Is Wrong

Brad had been a group member in two of my previous groups. This fall semester, the group moved quite rapidly, creating cohesion and a good working relationship. During the last 15 minutes of a session about 6 weeks into the group, Brad began to be challenged about his part in the breakup of his previous marriage. I felt that the interaction in the group was similar to other feedback that had been shared and was typical of this group's process. Brad

had previously responded well to this kind of personal challenge and interaction, and I expected that he would continue to do so in this session.

When I received the OQ and GQ feedback, I was surprised to find that all of Brad's scores indicated significant distress (see OQ and GQ Scores, Session 6 in Figure 7.3). This group had requested that we not talk about OQ or GQ scores in the group meetings. Instead, the group members preferred that I use the information gained from the scores in leading and guiding the group processes but avoid specifically referring to the scores during our sessions.

During the next session, Brad waited for about half an hour for the group to invite him to speak. When the group did invite him, he said that he

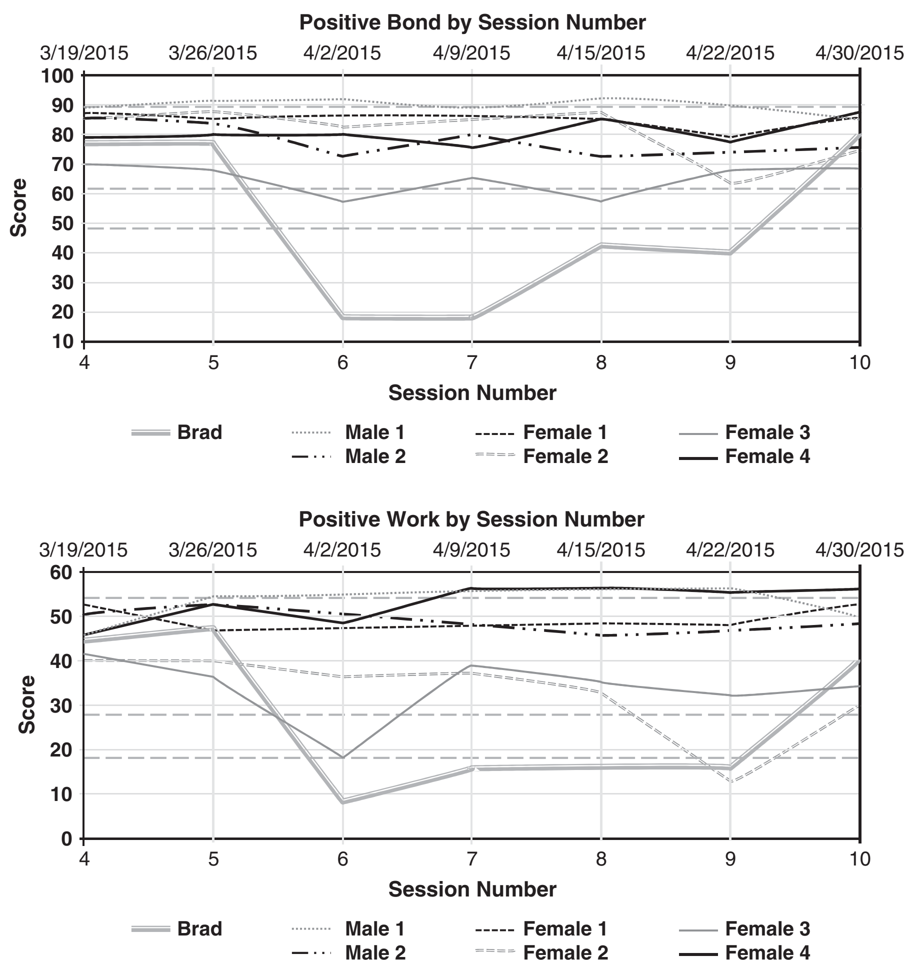

Figure 7.3. Positive bond report.

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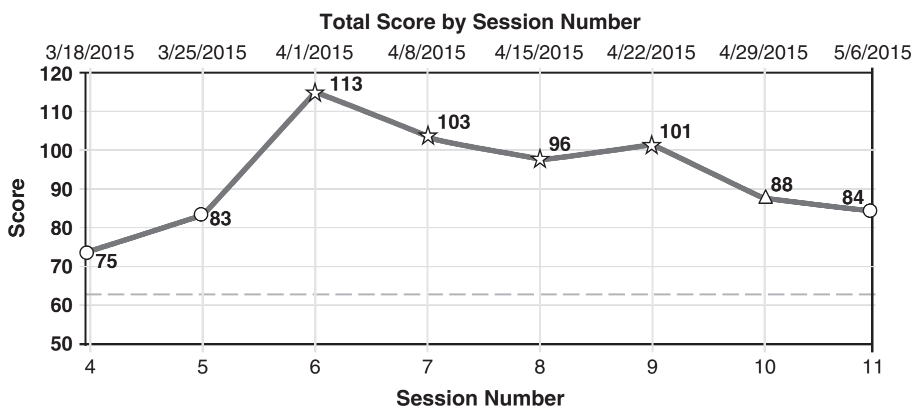


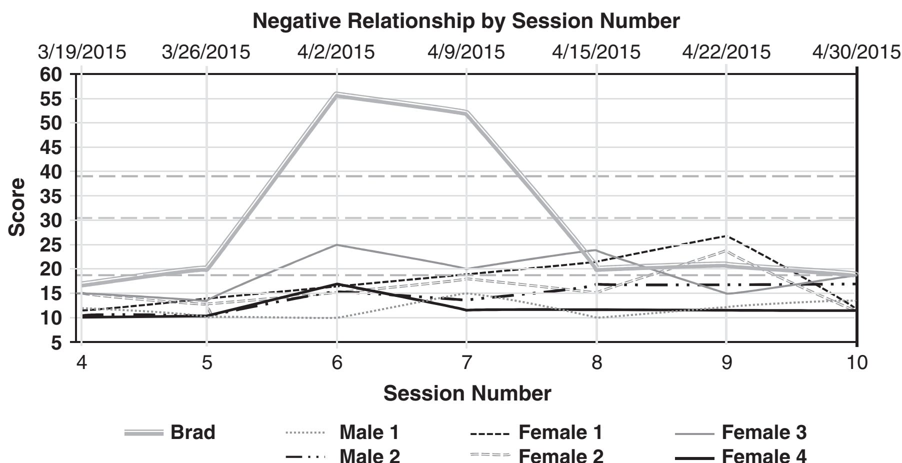


Figure 7.3. (Continued)

was bothered by the interactions from the previous week. However, he had difficulty being clear with the group about what the problem had been. He revisited the content, and the group pressed for his emotions. He expressed anger about feeling betrayed and abandoned by another group member who had expressed compassion for Brad's ex-wife. The group offered significant support for his pain, and he expressed feeling better.

I again felt very good about the work the group did in this session. The dialogue was very interactive, group members expressed important emotions, and clients appeared to understand both the content and process of the group. In short, the group seemed to be progressing as they had previously. I expected

that what I perceived as progress would result in a return to improved OQ and GQ scores for Brad. However, I was again surprised that his scores were not significantly changed and continued to indicate distress and distance from the group (see OQ and GQ Scores, Session 7 in Figure 7.3).

In the following session, Brad came into group energized and angry, stating that he again felt betrayed and abandoned. I encouraged additional interaction and revisited the themes from the previous session, which, again, in form and content, seemed similar to previous interactions that had been helpful for Brad and for the rest of the group. The group spent significant time supporting him and still showing compassion for his ex-wife. The group addressed with more clarity how Brad's patterns may have contributed to his divorce and also highlighted the improvements they had seen in him. Throughout the session, the group held both significant support for his pain and continued compassion for his ex-wife. Brad appeared to understand and accept that both he and his ex-wife had difficulties that precipitated the divorce, and he seemed calm as the session ended. I expected that the apparent working through of this issue would result in a return to previous levels on the instruments. Although there was some improvement, I was surprised that they didn't improve more than they did (see OQ and GQ Scores, Session 8 in Figure 7.3).

In the next session, Brad appeared contemplative for much of the session as others worked to hold multiple positions and ideas together. There was not as much focus on Brad's particular situation, but the idea of holding multiple positions in the same space occupied the majority of group time. Brad seemed to be processing these complexities and to be coming to terms with his own situation as the group used other content to wrestle with similar situations. He participated in the group by helping another member hold multiple positions in her situation. I was pleased that he appeared to be integrating concepts and resolving his divorce situation.

As the session ended, my first thought was that he had made a shift and that his OQ and GQ scores would improve. I then recognized that these were the thoughts of the past weeks, and I was curious to see (and not confident about) the next set of data. This has become my preferred way to anticipate the data. I approach each review with curiosity about what I will learn about my group and my clients. When I saw that the scores were still modest (similar to the previous week), I was no longer surprised—I was informed (see OQ and GQ Scores, Session 9 in Figure 7.3). I remained confident that I understood the nature of Brad's problem but was aware that I couldn't read how well he was internalizing the interventions of the group, especially because his overt behaviors remained typical. It would have been easy to move on too quickly and miss the repetition it was taking to help him.

The next session Brad again started with a bid for the group to side with him against his ex-wife. The group refused and again held both his pain and

his possible contributions to the divorce, and compassion for his ex-wife as well as her errors that may have contributed to the divorce. Once again, he appeared to be touched by the caring he received and to be making internal adjustments to see and feel the situation in new ways. This session, he was more willing to openly engage the group's confrontations and to actively seek and work with the group's feedback. He asked for additional feedback about how he presents in the group and worked out some differences with other members. I was informed by Brad's next set of scores that he had returned to previous levels, which continued until he finished treatment. (See OQ and GQ Scores, Session 10 in Figure 7.3.)

I find outcome and process measures extremely helpful as I lead my groups. Although I believe in and trust my intuition and feel fairly confident in interpreting the interactions and processes in my groups, it is clear to me that I cannot capture everything each person is thinking or feeling through my observations. I find clients' voices, provided through the measures, to be another way for them to let me know about their experience. The group was an ideal place for Brad to address and resolve the conflict around his divorce. Although I was aware that it was difficult for him to give up blaming only her and embrace his contributions to the divorce, I was missing that it was more difficult to be genuinely vulnerable and open about this shame in the here-and-now interactions of the group. His willingness to be vulnerable and open about other difficult issues obscured his difficulty with this one. Because he wasn't able to speak it out loud in the group, his only opportunity to express his distress was through the measures (he himself may not have been clear about the dynamics behind the distress). Without the objective feedback venue for his voice he found through the instruments, we may have moved on too quickly, and the opportunity might easily have been missed. We have found that for some group members, the GQ is an intervention they use to communicate things to the leader that are difficult for them to discuss in the group. After sharing on the GQ, it often feels like they have permission to discuss issues more openly with the group.

"You Think You Know Me"

In the first semester of the year, I co-led a group in which there was a member who presented as bold, harsh, blunt, and seemingly unaffected by others' responses to him. He reported that he liked it when there was conflict and that these times felt more like "work" to him than times when everyone was getting along and amicable. He often said harsh things that were quite hurtful to others and seemed to like it when they pushed back or reported feeling offended. His scores on the GQ indicated that he actually relished the conflict and felt best about group when there was some tension. As coleaders, we appreciated his boldness and willingness to say what others would not, and

we were able to help him soften his comments somewhat so that he was still bold but not so harsh that he drove people away.

That group ended in the summer of that year, and I began another group a few months later with all new members. Among the members was a man who seemed to be quite similar in his presentation to the bold member of the previous term. Almost from the start of the group, he made blunt comments to other group members that seemed quite harsh and unfeeling. When group members pushed back and expressed feeling hurt by his comments, he seemed rather unaffected, simply folding his arms and becoming quiet without trying to rectify the rupture. I assumed that, similar to the man in my previous group, he liked this approach and felt like we were really working when group members were interacting this way. I felt that the affected group members were working through their hurt well with him, so I figured he was making progress. I did not see any reason to do anything differently with this member from what I was already doing.

After the session, I looked at his GQ results and was surprised to find scores that were quite different from what I had expected. I found that his positive bond was rock bottom, his Positive Work was low, and his Negative Relationship was extremely high (see GQ Scores, Session 1 in Figure 7.4). All of this suggested that he was far from okay with what had happened in that session. Instead, it indicated that he was struggling significantly in the group and was a serious risk for premature termination. In addition, before the next session, I noticed that his OQ score (see OQ Scores, Session 2 in Figure 7.4)

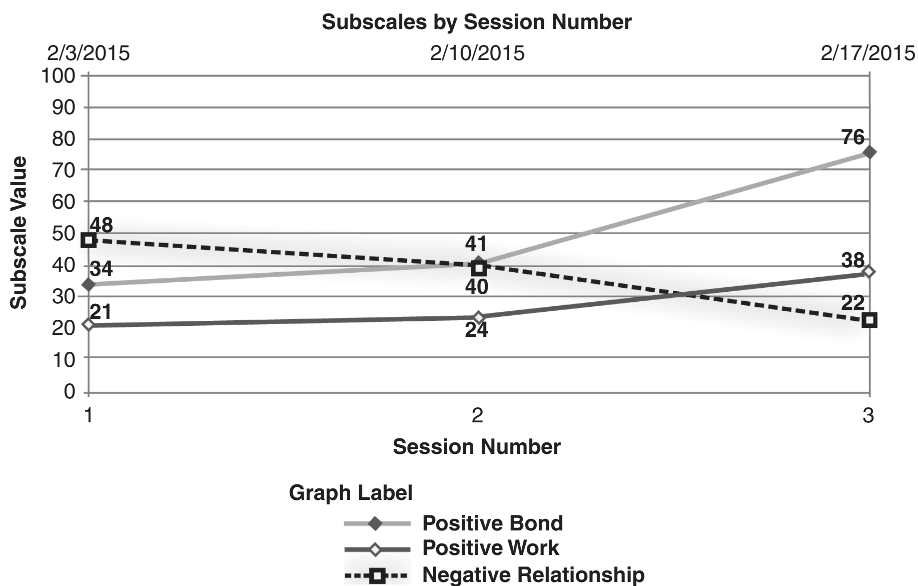


Figure 7.4. Subscales by session number.

had risen slightly from its already "Moderately High" position, suggesting that he was feeling significant distress. Although we shared individual GQ and OQ reports with each group member at the beginning of each session in the form of an OQ—Analyst printout, we did not discuss the results with the group.

At the beginning of Session 2, the client appeared quite distant, with his arms folded and expressions on his face that seemed to indicate lack of interest. Equipped with the information gleaned from the OQ and GQ, my coleader and I challenged this member to share. He initially indicated that he did not feel connected to the group and that he did not want to share. With a little more support and challenge, he began to open up about his fears in the group. This seemed to help him feel more comfortable and helped other members soften toward him. His scores following this session (see GQ Scores, Session 2 in Figure 7.4) showed that he was feeling significantly better about what was happening in the group. His OQ score for the next session (see OQ Scores, Session 3 in Figure 7.4) showed his distress level dropping into the moderate range. During Session 3, he opened up even more about the issues that brought him to group, and he seemed to really join the group for the first time (see GQ Scores, Session 3 in Figure 7.4).

I do not think my coleader and I would have pushed this client as much as we did in that second session if we had not had the OQ and GQ data. I would have assumed he was just fine and would have underplayed the significant distress he was experiencing (Figure 7.5).

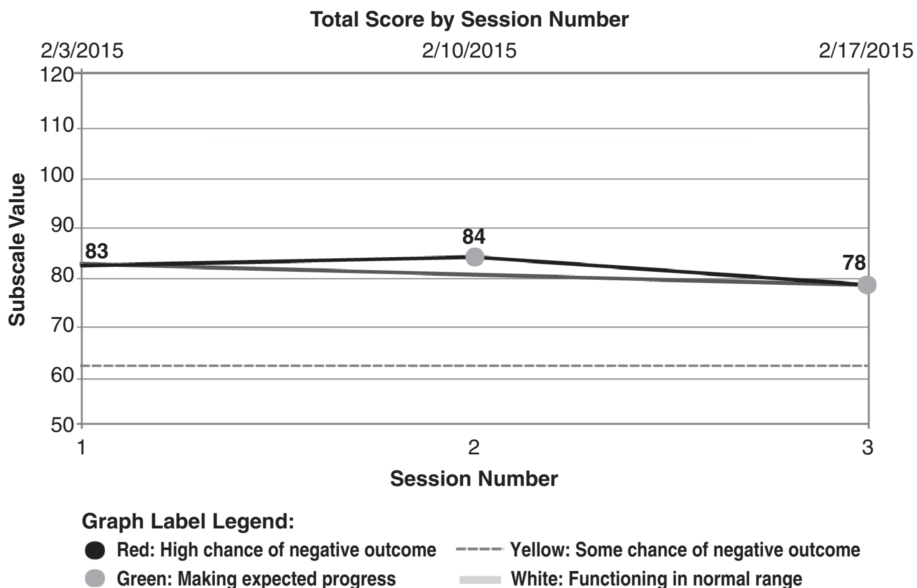


Figure 7.5. Total score by session number.

What's in a Name?

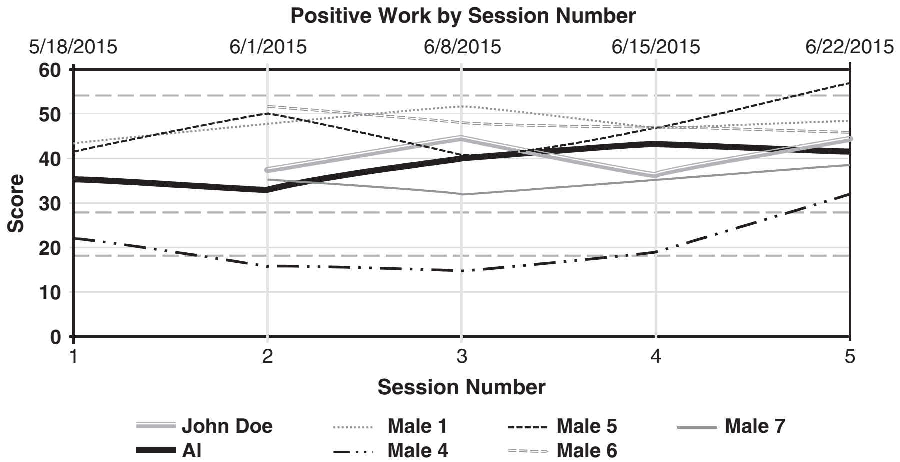
Al was a 23-year-old, single, White, heterosexual male who had attended four groups before this one, was quite analytical, and had determined that "group is where you are open and share stuff." John was a 29-year-old, single, Latino (second-generation American), heterosexual male who considered himself a "very private person." He was not comfortable revealing his real name, so "John Doe" was a pseudonym he used during sessions. He was attending his second group. Al and John were referred to this group to help them connect with others and to connect with and accept emotions that they typically tried to avoid. For the purposes of this vignette, the interactions between these two clients from a seven-member acceptance and commitment–based men's issues group are highlighted.

Fifteen minutes into our second group session, "Analytic Al" challenged John: "You're seriously not going to tell us your real name? Really? That's not how group works. We all say our real names." In a tensely controlled staccato voice, "John Doe" responded, "I don't think it's really all that important that you know my name. You know why I'm here and that's enough."

Both John and Al had subclinical initial OQ scores of 27. Such low scores in the presence of ongoing therapeutic issues are sometimes indicative of low self-awareness or emotional avoidance. This was a hypothesis I was interested in exploring as the group progressed. During the first session, I spoke with the group about ways the OQ and GQ data could be used in our group. The group ultimately decided that they would like for me to bring these data directly into our group sessions.

When I handed out the OQ and GQ scores during our third session, John's OQ score was 52, and Al's score increased slightly (31). Their GQ data were similar to one another; however, Al had slightly lower scores on positive bond and positive work, suggesting that he was less satisfied with the previous session (see OQ and GQ Scores, Session 3 in Figure 7.6). When I asked for thoughts and reactions regarding the data, Al expressed surprise that John's GQ scores were similar to his, while their OQ scores were markedly different. Al proceeded to provide his interpretation that John was "hiding from the group" and that this was unfair both to John and to the rest of the group. John responded that he did not feel a need to bring himself into the group and became increasingly withdrawn and quiet.

During Session 4, both John's and Al's OQ scores increased. Typically, lower OQ scores are interpreted as an indication that clients are experiencing less distress and are potentially progressing therapeutically. However, in this case, I viewed these group members' increased OQ scores as evidence that these two men were more in touch with their inner subjective worlds and were actually experiencing what they typically avoided. Again, John



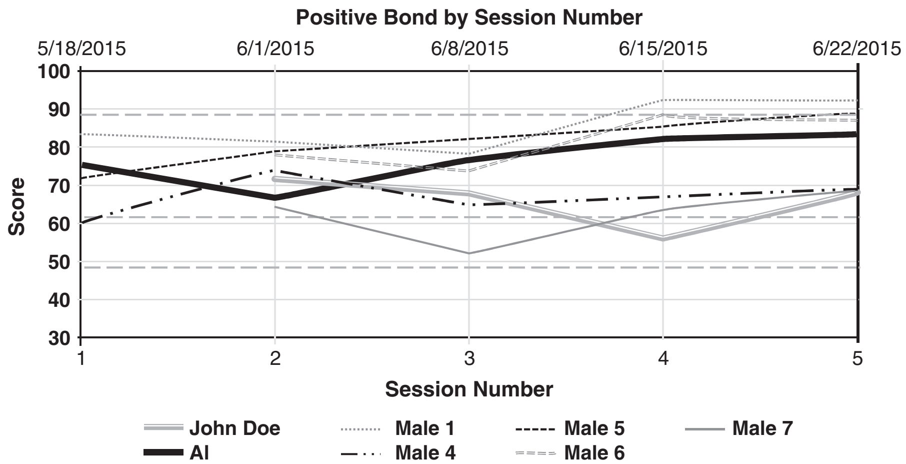


Figure 7.6. Positive work by session number.

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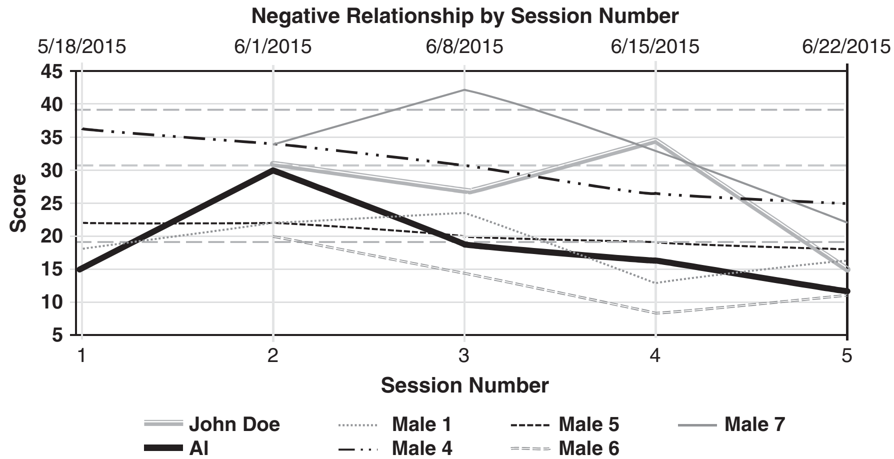


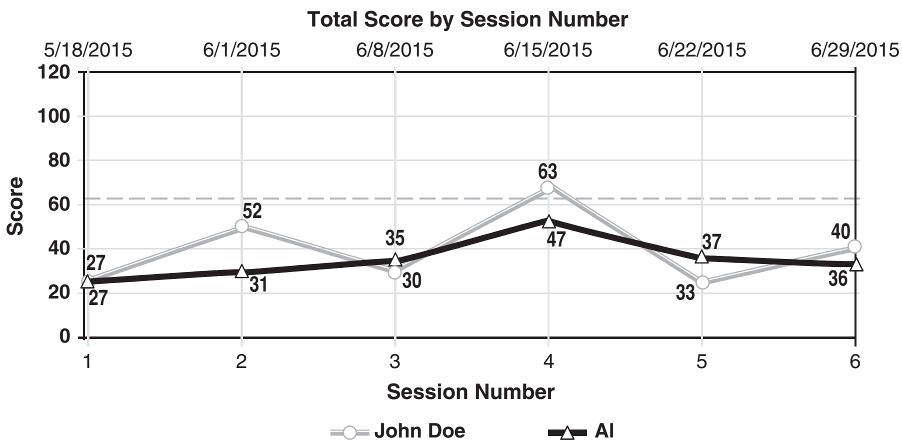


Figure 7.6. (Continued)

and Al examined the OQ and GQ data and discussed their findings. While both men's Negative Relationship scores decreased and Positive Work scores increased slightly from the previous session, John's Positive Bond score decreased and Al's increased (see OQ and GQ Scores, Session 4). Other group members wondered why John's scores reflected less connection to the group and pressed him to join them. In response to Al and other group members wanting to know more about him, John angrily expressed, "You don't know anything about me and then you judge me for not sharing! You want to know me?! Fine!" John then revealed his real name and went on to talk about several struggles that he faced in life and how he had to face them alone. He shared his pain associated with feeling weak for wanting or needing help. The group attempted to provide support in response to this disclosure.

In Session 5, John and Al both had a marked decrease in their OQ scores. This was somewhat surprising to me given that John's GQ showed a significant decrease in Positive Bond and Positive Work, and an increase in Negative Relationship. I had expected John to be upset and potentially more withdrawn. John was actually much more open from the very beginning of this session and explained that he felt angry and disconnected when filling out the GQ immediately after group the previous week. He stated that his feelings changed during the week as he reflected on the support he received from others. John tearfully thanked the group members for their willingness to "stay with me." Following Session 5, the GQ data showed that John and Al had a significant decrease in Negative Relationship and a significant increase in Positive Bond (see OQ and GQ Scores, Session 5 in Figure 7.6). I was pleased to see that both of their OQ scores remained higher than their initial scores but lower than they were at the height of conflict.

I found that allowing clients to see and use their own data in group was incredibly helpful. In this case, I was able to use the data to have John and Al track their own experience as well as graphically observe the way others perceived the group. While I certainly do not believe that the OQ and GQ are substitutes for clinical judgment and skill, they were extremely helpful in promoting discussion, disagreement, and connection within this group.

Catching the Little Things

One semester I cofacilitated with a doctoral student clinician a mixed-gender general process group with seven members. We met at a university counseling center for a total of 10 sessions. Each of our group members completed the OQ–45 before each group psychotherapy session and the GQ after each session. When my coleader and I discussed with the group members how they would like their data to be used, they requested that we, as facilitators, review the feedback they provided and use it to guide our interventions and that we avoid discussing specific group member scores during group sessions. A recent study (Woodland et al., 2014) indicated that this "hands-off" but informed group leader approach seems to be normative.

In the first several sessions, the group moved from discussing the acceptability of and willingness for conflict from a philosophical, hypothetical perspective to actual experience. During Session 5, two quieter group members (Carrie and Steven) were challenged to experiment with conflict. Carrie had OQ–45 scores within the recovery range and was participating in the group to address some patterns of interpersonal relationships with which she had grown dissatisfied over time. Carrie described herself as conflict avoidant and expressed a desire to be more assertive in her interactions with others. When encouraged, Carrie gently pressed another group member, Steven, on his

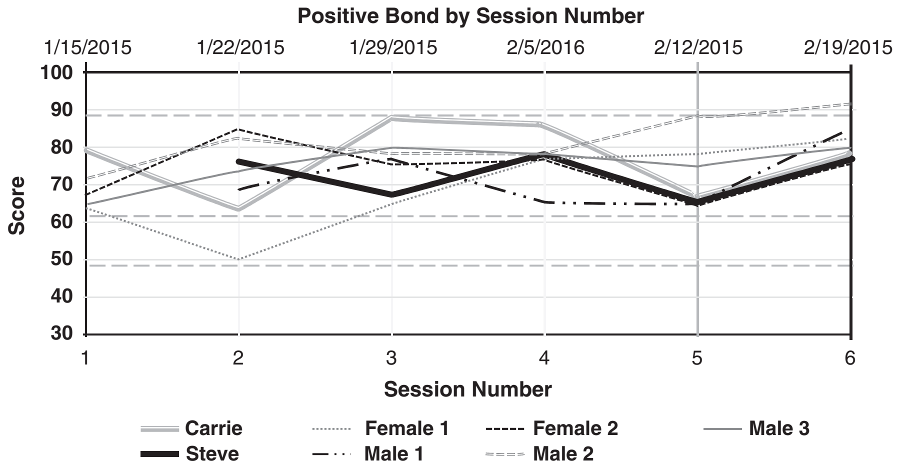
vagueness and lack of engagement with the group. This dyad and the group processed this challenge and moved on to other content and process. At the session's ending, I discussed with my coleader how well this mild confrontation went and observed that the group members appeared to handle it in ways that showed growth and connection.

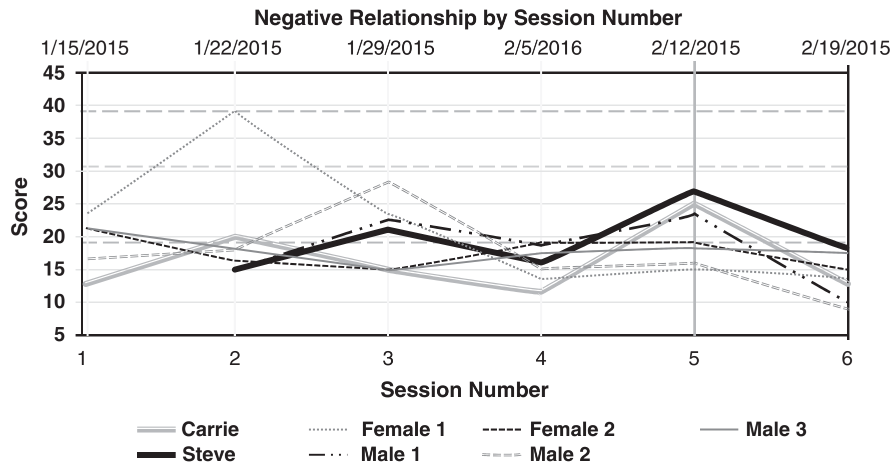
When my cofacilitator and I reviewed the GQ data for this group gathered immediately after Session 5, however, we were surprised to find that scores for Carrie and Steven differed from most of the other group members and showed decreased positive bond, decreased positive work, and increased negative relationship (see GQ Scores, Session 5 in Figure 7.7). These scores were surprising because both group members shared connecting feelings and received feedback during the session regarding the meaningful effects Carrie asserting herself had on the two involved in the conflict, on the other individual group members, and on the group as a whole. The GQ data signaled to us that the group may benefit from additional processing of what we had originally believed to be quite mild conflict that was resolved positively in Session 5.

In Session 6, I encouraged group members to check in with Carrie. When pressed, Carrie revealed her continued concern about challenging Steven in the previous session. She expressed guilt, embarrassment, and concern that Steven and the other group members were angry with her. Steven and the group reacted energetically to Carrie's self-blame. Contrary to what she had projected onto the group, Carrie learned that her willingness to do something different and experiment with assertiveness implicitly granted permission for several other group members to try their own new behaviors both within group and in their outside relationships. Both Carrie's and Steven's GQ scores following Session 6 reflected increased positive bond, increased positive work, and decreased negative relationship.

In this situation, data generated by the GQ were helpful to me and to my cofacilitator. Because the scores of several of the other group members indicated that their positive bonds were likely high enough to withstand the challenges made and their negative relationship scores remained relatively stable from Session 4 to Session 5, we felt confident in revisiting this issue with Carrie knowing that her reaction was related to her own aversion to conflict, which she was trying to address in group, rather than to the true reactions of the group. The GQ data enabled us to encourage follow-up process that emphasized important learning, resulting in Carrie's changed behavior and increased engagement and authenticity with her peers thereafter.

While multiple group factors contributed to our intervention decision-making, data collected using the GQ also provided training material for the doctoral student clinician under supervision. Throughout this study, we met each week before the group session to discuss the GQ data collected from the





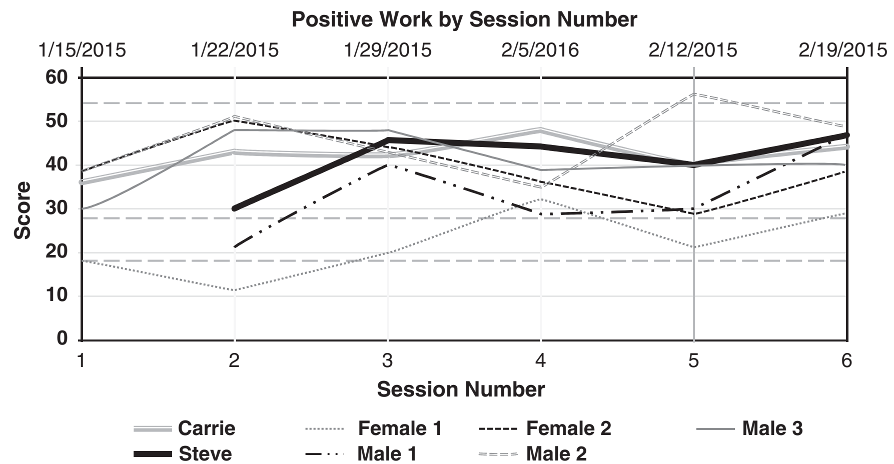


Figure 7.7. Positive bond, negative relationship, and positive work by session number.

group from the previous session. Between Sessions 5 and 6, for example, we discussed the data, hypothesized about what group content and process might have contributed to the scores received, and talked about interventions that could be used to test our hypotheses or to follow up on unfinished business indicated by the GQ scores.

DISCUSSION

The majority of writing about FIT and other forms of practice-based evidence[1] (PBE; an accepted evidence-based treatment; Lambert, 2010) discusses its application in individual treatment. It is clear that adapting FIT to group work requires significant adjustment and a comprehensive delivery system. There are multiple clients and many more variables that require attention to adequately capture the richness and complexity of group work, so both outcome and relationship measures and feedback are required to capture the complexity of FIGT.

This chapter highlighted how one system worked through challenges to implementing FIGT. We noted contextual factors that influenced the developmental process of our system. We described three problems and how we have worked through these problems over time: (a) administering the measures; (b) providing timely feedback; and (c) selecting a measure that engages clients and provides valid, reliable, and clinician-friendly information. Any one of these issues left unresolved is sufficient to make a system untenable. We described the rich clinical information (including cut scores, alert thresholds, and norms) available in each of the measures and the science behind the scales. We offered visual examples of the integrative reports and provided case studies (clinical vignettes) to illustrate some ways FIGT can be implemented.

We have demonstrated that FIGT is an important and compelling clinical tool. We have shown that logistical and procedural issues are the "make-or-break" elements of implementing any FIGT system. We have also made clear that reducing the available clinical information to the smallest useful unit is only one way to address the logistical and procedural requirements necessary to implement a viable system that is useful to clinicians in fast-paced practice settings. We are firm believers in using measures such as FIGT to give an additional voice to clients, to ground clinical decision-making in science, and to enhance clinical judgment.

[1]"Practice-based evidence consists of real-time patient outcomes being delivered to clinicians immediately before treatment sessions so that they can make decisions about effective interventions based on current patient status. The burning question guiding this EBP model is as follows: 'Is this treatment working for this client?'" (Burlingame & Beecher, 2008, p. 1200).

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8

FEEDBACK-INFORMED TREATMENT IN AGENCY AND CLINIC SETTINGS

ROBBIE BABINS-WAGNER

Calgary Counselling Centre's implementation of feedback-informed treatment (FIT) may serve as a model for other agencies and clinics. Our experience occurred in phases and stages and was by no means linear or straightforward; agency directors and clinicians who have implemented outcome measurement programs in other jurisdictions will agree that the process seldom is. We made the decision to implement FIT because we thought it would be the right thing to do for our agency and, most critically, because the research evidence was so compelling. We began the process long before funding bodies opened the discussion about accountability and results.

This chapter describes our experience, and I expect that future implementation at sites across the globe will each be different, reflecting the context of the agency, community, setting, culture of treatment, payment systems, and more. FIT implementation, although not for the faint of heart, is one of the most rewarding undertakings I have pursued in the course of my

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career, and I would not go back to working in any context if measures and a culture of feedback were not available to me and my team.

BACKGROUND

As a practicing clinical social worker and educator, I worked for most of the 1980s in health care, where I was initially introduced to outcome measures. When I moved to the nonprofit sector in the early 1990s, many of my peers did not see the potential benefit of measuring outcomes and were mistrustful of pressure from funders to introduce these in community agencies. I had the privilege of cochairing the outcome measurement initiative for the family violence sector in our community, which set the platform for the full implementation of outcome measurement in the nonprofit sector.

Little published counseling research has taken place in practice settings because of the nature of traditional research, the confidentiality of the counseling relationship, and the relative autonomy of the professionals who practice counseling. One of the important questions is whether routine counseling, as a part of everyday practice, is effective.

As the CEO of the Calgary Counselling Centre, I found that the challenge of measuring outcomes in a growing counseling agency was significant. The Centre needed to decide whether to develop a protocol for each component of the counseling programs, and we were struck by how large and complex such a task might be. In early 2000, I was introduced to the work of Scott D. Miller. His work introduced new possibilities for outcome measurement in counseling and, potentially, for a large counseling agency. My subsequent work with Scott and others across the globe introduced me to the work of Michael Lambert, Gary Burlingame, Bruce Wampold, Michael Barkham, Wolfgang Lutz, K. Anders Ericsson, and many others who have influenced me and the work we do at Calgary Counselling Centre.

CALGARY COUNSELLING CENTRE

A charitable organization founded in 1962, Calgary Counselling Centre offers a full range of individual, couple, and family counseling services to the community at large. Client referrals come from a variety of sources. Most clients are self-referred, but referrals also come from physicians, school counselors, the provincial court (for domestic violence), and child protective services. In addition, the Centre has contracts with external organizations to provide services to domestic violence offenders (both male and female) mandated by the Provincial Court of Alberta for treatment, and offers employee

and family assistance services to a variety of organizations. Services at Calgary Counselling Centre are offered on a sliding fee scale.

The mission of Calgary Counselling Centre is as follows: Improving the well-being of individuals and families and strengthening communities by delivering best practices in counseling, training, and research. The Centre is located in Calgary, Alberta, Canada's fourth-largest city, with a population nearing 1.2 million people. In 2015, the Centre received a record 8,778 new requests for service and provided 29,031 counseling sessions 40,000 counseling visits (a number that includes the total number of people who visited, including couples and groups, thereby making this a greater number than the total of sessions) through 27,464 hours of counseling. All Calgary Counselling Centre clients complete outcome measures on a routine basis at every session with the understanding that they will be used to improve the clinical services they receive.

THE COUNSELING TEAM

The counseling team comprises three groups: one staff group and two student groups. The first group represents our staff counselors who are all licensed professionals primarily with master's degrees or doctorates in social work, psychology, marriage and family therapy, and pastoral counseling. This group provides counseling services and also supervises students in our training programs. We have two groups of students. The first group includes provisional psychologists and social workers who have completed their master's degree programs and are completing their required year of supervised practice to register in our province. The other group is made up of master's level practicum students who are with the Centre for 8 months while completing their master's degrees.

THE COLLECTION OF GROUP OUTCOME DATA

In 1994, we began collecting pre- and postoutcome data in our family violence group program as a way of understanding why 60% of clients registering for the group program and attending an initial assessment session did not attend a first or subsequent group session. Through extensive formative and summative evaluations, we learned that the 40% of clients who attended the group program achieved statistically improved results, but we needed to understand why so many clients elected to withdraw from service after the assessment.

A single interaction changed our focus for the client assessment. During an assessment for the group program, a counsellor was completing the formal assessment interview, which, at that time, was a 14-page questionnaire

focused on all the abuse activities and behaviors an abusive man could perpetrate against his female partner. This counselor, an experienced social worker, arrived in my office for a consultation midsession. While completing the 2-hour assessment, the client disclosed that he had been a victim of child sexual abuse. The counselor asked if she should focus on the disclosure of child sexual abuse or if she had to complete the "form." We agreed that she should focus on the disclosure, and I stated that I would take responsibility for any consequences of her not completing the questionnaire.

This single, albeit simple, interaction, changed the way we viewed assessment in not only the family violence program but across all group programs. What we realized was that we were processing clients into a program and had completely disregarded the needs and lens of the client in the process. We had not attended to the alliance with the client. Within weeks of this interaction, I changed the protocol for group assessments—not only for this one program but for all the group programs in operation at the time. As we made the change, we slowly and consistently saw the numbers of clients moving into group increase into the 80% range, where it remains to this day.

The experience in the family violence program resulted in our developing a philosophy that the client and client experience needs to be in the center of all decision making. We developed a chart that represented this concept and brought it to all meetings to have it visible. The client's experience became a focus for most, if not all, conversations about programs and process.

With our experience in the family violence group program, we reviewed all of the Centre's group program processes and ensured that we focused on alliance with the client in the assessment stage. All questionnaires were completed during the first night of group, with a final set of questionnaires completed the last night of group.

When we first began considering the collection of outcome data in the counseling program for individual, couple, and family sessions, we had already been collecting data in all our group programs for 5 years. The idea of collecting data was not new to the counseling staff.

PRE-PILOT PHASE (2000–2004)

The Centre first became interested in developing a pilot project for the use of outcome measures in early 2000. When initially proposed by funding bodies in the late 1990s, the notion of measuring outcomes was not embraced by the nonprofit sector in North America (Plantz, Greenway, & Hendricks, 1997). The initial conversation about outcome measurement brought with it fear of potential funding cuts, limitations of service to clients, and concerns that outcomes of interest to funding bodies would not be the same as those

of interest to practitioners. Some of this remains true today. Although there is increased knowledge about outcome measurement and more agencies are collecting some data, outcome measurement has, for the most part, not been included in the operational DNA of most organizations.

From the onset, Calgary Counselling Centre's and my interest in collecting outcomes was driven internally, not by funder request or requirement. At an agency level, we were interested in learning more about how our services could improve clients' well-being. We already had experience collecting program data, so collecting outcome data was not a huge stretch.

In 2000, the Centre commissioned some initial research to see which measures were being used in other agencies in Canada and the United States and tried to understand the process of implementation. As part of this research, we assembled a task team that guided our pre-pilot and pilot project until implementation began in September 2004. Our counselors were consulted at each stage of the project. Our pilot project began in early 2002. The first task was to select the outcome and alliance measures to use. In reading *The Heroic Client* (Duncan, Miller, & Sparks, 2004), which significantly influenced our thinking and decisions, the authors described the use of an outcome measure—the 45-item Outcome Questionnaire (OQ–45; Lambert et al., 2003). We purchased a license and piloted the use of the measure along with the Session Rating Scale, Version 2.1 (Johnson, 2000). Counselors were also provided the Outcome Rating Scale (ORS; Miller, Duncan, Brown, Sparks, & Claud, 2003) and the short-form Session Rating Scale, Version 3.0 (Duncan et al., 2003; Johnson, Miller, & Duncan, 2000). The OQ–45 and the SRS 2.1 were long-form traditional Likert scales. The ORS and the SRS 3.0 were four-item visual analogue measures. The counseling team at Calgary Counselling Centre piloted both sets of measures. We collected data for 2 years and compared the measures to determine whether the data were collectable and usable. Each of the measures had strengths and weaknesses. We put the choice to a vote by the team, and the OQ–45 and SRS 2.1 were selected for use at Calgary Counselling Centre.

In September 2004, we began routine collection of Outcome Questionnaire 45, version 2 (OQ–45) and Session Rating Scale 2.1 (SRS). When we first started collecting data in 2004, we could not have envisioned the journey we would traverse over a 10-year period.

IMPLEMENTATION—PHASE 1 (2004–2008)

Between September 2004 and September 2008, we simply asked counselors to collect OQ data before every session and SRS data toward the end of the session. Data were entered into an Excel spreadsheet and converted

using SPSS (Statistical Package for the Social Sciences) to produce statistical reports once per year at the end of December to aggregate our client outcomes. We shared these reports with the counselors and sought their feedback on an ongoing basis at counseling team meetings and when data were reviewed at year end. At this stage, all reports were aggregate agency-level data with no individual reports for counselors. The aggregate reports provided high-level data about outcomes and an opportunity for engagement and feedback. The counselors seemed interested in the data and continually questioned the validity of the reports despite demonstrated improvement in outcomes year after year. Walfish, McAlister, O'Donnell, and Lambert (2012) referred to this phenomenon as the "Lake Wobegon Effect" in their article that explored the self-assessment bias of mental health professionals. The implication of this study is that therapists, as a result of self-assessment bias, will generally overestimate their positive client outcomes. Lambert (2012) suggested that most therapists who are considering feedback about their effects on client outcome will be unhappy with the findings and will "look for reasons that the data are flawed and discount the data, rather than seek to change routine practice patterns" (p. 89).

It is important to remember that these reports were for our own purposes; there was no external driver or funding body asking these this data. From the outset, we made a commitment to our staff that counselor outcomes, based on the use of the measures, would not be used for performance management and would not appear on any yearly performance plan or report.

Overall, we were pleased with the results; they revealed that client outcomes were at least as good as reported by Hansen, Lambert, and Forman (2002), and at times our data indicated that we averaged greater percentages of clients improving or recovering. A segment of the counseling team that adopted the use of the measures was curious about their personal outcomes. A larger segment of the team did not adopt the measures, and the leadership team was confused by their lack of uptake.

In fall 2008, we did an analysis of client outcomes over a 12-month period. We learned, to our surprise, that we had data for only 40% of our clients. Counselors were not offering the questionnaire to more than 60% of the clients. Determined to do something different and transformative to increase the percentage of clients who completed the measures, we began some internal discussion about the low usage rates. We naively believed that simply bringing the research results to the counselors would increase utilization. We were wrong. The counselors provided many reasons as to why they could not use the measures—how the use of the measures interfered with their counseling sessions and affected their work with clients. One counselor stated that she thought the use of measures was "an aspirational goal" not a real one—one without timelines. After a year of discussion with our staff,

there was no improvement in the percentage of clients who used the measures, and it became clear that something needed to change.

IMPLEMENTATION—PHASE 2 (2008–2011)

In the last quarter of 2008, we developed a new policy (see Appendix 8.1) supporting the use of measures. The new policy stated explicitly that all counselors were expected to provide the measures to all clients. Counselors did not have the prerogative of opting out of the use of measures with the clients. We added a policy in which counselors' use of measures would be tracked, and individual counselors would be held accountable to the requirement that clients complete the measures. To support counselors, we developed an automated report that provided them with monthly data on their clients who did not complete an outcome measure during their course of treatment. Although we began tracking the percentage of clients who completed the measures at each counseling session, we remained committed to not using counselor outcomes for performance measurement.

Within 4 months of implementing the policy that required use of measures in all cases, almost 40% of the licensed professionals on staff resigned to either move into private practice or to work for provincial health services with the explicit intention of not collecting outcomes as part of their work. Although we were not surprised by the resignations, we wondered if we could recruit licensed professionals to join our team. A new strategy for staff recruitment was developed with the intention of selecting practitioners who were interested in collecting and using outcomes in routine practice. We also attempted to identify the characteristics of clinicians who appreciated using measures. The characteristics included curiosity and flexibility. Ideal candidates could identify a preferred practice model, were interested in learning, and did not see themselves as experts, even though they may have had expertise in one or more areas of practice. Successful staff members were interested in contributing to an environment where we shared our work, especially cases that were not progressing, publicly and in consultation sessions within supervision and with the external consultant. Within 4 months, we were fully staffed.

From the time the measures were first introduced, clients had the choice as to whether they wanted to complete the measures. Few clients declined the invitation to complete the measures, and most appreciated seeing the graphs of their scores because it provided them with an objective visual representation of their progress—or lack thereof. Although this was a choice for clients, it was not a choice that was available to the counselors. To work or train at our Centre, one had to complete and use the outcome data in practice.

At the time of the policy change, we also added monthly clinical consultations with an external consultant to discuss cases and build a culture of feedback. For consultation purposes, the counseling team was divided into two groups, a staff team and a student team. Consultations lasted 2 hours and took place via online video chat. Counselors were each asked to provide a graph for a case for discussion. For the first 8 months or so, the live consultation reviewed graphs for cases that appeared to be going well. We used the graphs as provided because they created a context in which we could begin to discuss cases with the full group and start the process of building trust and support. We were aware that to build a culture of feedback, counselors needed to bring cases that were not progressing and that counselors had to become comfortable talking about what wasn't working with their peers. We called these *error-centric consultations*.

At the 8-month point, we became aware that there were few cases being presented that were not progressing. At that point, we initiated a new policy that required counselors to present cases that, on the basis of the data and graphs, were not going well. The consultant was well-versed in the OQ and asked specific questions about the progress or lack thereof in each specific case. Over time, the case consultations became more and more focused on what was not working well in the therapy or in the relationship between the clinician and client. As counselors took risks and implemented suggestions discussed in the consultations, client scores began to improve. These positive changes affected the use of measures in other cases and across counselors from both teams. This was a slow and deliberate process.

With the implementation of these changes, we once again had staff members leave with the intention of moving into private practice or joining an organization that did not collect outcome data. However, this time, only four staff members left, less than half the number of the previous group. It's interesting to note that while we were going through these changes, we were seeing data that suggested the overall agency outcomes were improving. We had the opportunity to further refine our recruitment strategy and were pleased to discover that the number of qualified applicants for vacancies exceeded available spaces.

IMPLEMENTATION—PHASE 3 (2011–2015)

As we began to see small changes in both our counseling and our student teams, we became more deliberate in the structure of the consultations and started developing themes for consultations. We asked that counselors bring cases not improving with a focus on depression, relationship distress, anxiety, poor alliance, and more. As the conversations in the consultations

became more focused, counselors became increasingly engaged. Engagement also improved when counselors started using the feedback they received in consultations. As the feedback helped them produce results, they slowly became more open to applying the specific skills they had learned to other client situations.

During this phase, we became increasingly deliberate about all our activities aimed at outcomes. We began redeveloping our internal software systems to help the staff manage caseloads with a focus on client outcomes. Staff teams' input was incorporated in the development of software tools, signals, and dashboards, which allowed them to focus on metrics they understood.

LESSONS LEARNED

One of the early lessons was that senior leadership must choose a measure that meets the varying needs of their organization. Although staff feedback can and should be invited in early stages, this decision is ultimately up to the leadership. Although the staff recommendation was not problematic for the Centre, the senior leadership has to see the "big picture" in the context of the agency, which is sometimes beyond the vision of individual counselors.

Over the past 10 years, we have learned the importance of developing and supporting a culture at our agency that focuses on curiosity, inquiry, and being deliberate about understanding ways we can improve client outcomes. This has meant focusing on metrics that would allow us to track and review outcomes to improve them. When we started on this journey, we were not sure of the steps in front of us. We developed internal systems and processes to support the work. We produced reports that would be meaningful to the staff members, summarizing the number of cases they had with one session or more than one session. Although we had many reports that provided information and data, the reports we produced did not have any counselor names or identifiers. This allowed us the opportunity to speak freely about what we were learning. The conversations were global and not attributable to individual staff members or students. We started attaching names to reports at the request of the counseling team members, when they were ready to see the reports of their work with their clients. We further refined our own software system to support our work and developed reports for the staff members as they started asking for them. One such tool, the counselor dashboard (see Appendix 8.2), is in the process of conversion to an electronic tool. When this is done, it will provide real-time data to the counselors.

Creating a culture of feedback was an important part of our journey. We needed to create a milieu of trust with the counseling team, and we also knew this would take time. We experienced increased trust and improved

morale as the counseling team began to trust the process of using outcomes and feedback. It helped that they recognized consistency between the internal messages from supervisors, program leaders, and the external consultant. Firsthand feedback that their own individual outcomes were improving also contributed to improved morale and trust in the process. Success with clients and using consultation advice bred more success. This process took almost 6 years. The challenge for the future is to continue to build the culture of feedback and ensure that the needed support is available to counselors.

The Centre's goals are clear: We are interested in ensuring that we meet the needs of clients who seek our services and that we have the capacity to work with cases that may not be progressing as expected. To this end, we identified the following objectives (see also Appendix 8.1):

1. to assist counselors to build and monitor their alliance with their clients based on client feedback;
2. to help counselors reduce their no-show and cancellation rates;
3. to remove some of the guesswork about client progress and include the client's perspective through the OQ and SRS;
4. to improve client outcomes;
5. to improve counselor success with clients;
6. to help counselors identify when clients are at risk of dropping out of counseling, getting worse (i.e., deterioration), or flat lining (i.e., no change); and
7. to help supervisors develop FIT competencies with counselors.

In working toward these objectives, we established monthly clinical consultations, which provide an opportunity to nurture an error-centric culture of feedback. In these sessions, which are guided by the director of counseling or the consultant, counselors present graphs of cases to a team of peers and receive feedback from the group. This process has built confidence in our counselors, in our students, and for the clinical supervisors.

With respect to implementation, the writing of this chapter has reminded us that 10 years into the process of collecting outcome data, we have an oral tradition of policies and practice in outcome measurement. One of our current outcome goals is to develop a Calgary Counselling Centre policy/practice manual for our outcome measurement program.

IMPROVING OUTCOMES

Some of the data compiled at Calgary Counselling Centre illustrate how our outcomes are improving and what we are learning (see Table 8.1). Through part of our long-term collection of outcome data, we saw our

TABLE 8.1
Calgary Counselling Centre Outcomes

	Deteriorated	Stable	Improved	Recovered	Total improved and recovered
Benchmark[a] *n* = 6,072	8.2%	56%	20.9%	14.1%	35%
2007	9.9%	52%	20.3%	17.9%	38.2%
2014	7%	46.4%	24.1%	22.6%	46.7%

[a]Hansen, Lambert, and Forman (2002).

overall outcomes improve 21.7% since 2007, from 38.2% of clients improving or recovering to 46.5% in 2014. Our results are also exceeding published benchmarks (35% improved or recovered; Hansen, Lambert, & Forman, 2002) by 32.8%.

Our 2014 data reveal a dose–response relationship (see Table 8.2). Although, predictably, there is individual variability, on average, clients with higher levels of symptom severity at the start of counseling stay in therapy longer. When they begin therapy, single-session clients have a lower mean OQ compared with those who have more sessions. Two sessions are helpful but are not enough to bring the mean OQ to below the clinical cutoff of 63. For clients with higher initial OQ scores, a course of seven to nine sessions seems optimal. Most clients with the highest severity benefit from over 15 sessions even if they do not reach the cutoff of 63.

TABLE 8.2
Change in Mean OQ Score by Number of Sessions for 2014

Total sessions	Mean OQ score of first counseling session (*SD*)	Mean OQ score of last counseling session (*SD*)	Change (*SD*)
1	68.7 (26.3)	—	—
2	69.7 (24.6)	63.1 (25.3)	–6.6 (14.6)
3	72.8 (24.5)	61.6 (26.9)	–11.2 (18.6)
4	74.8 (24.6)	61.7 (25.5)	–13.2 (19.9)
5–6	73.2 (23.5)	56.5 (25.8)	–16.6 (19.8)
7–9	78.2 (26.0)	57.9 (28.1)	–20.3 (21.2)
10–14	79.9 (24.7)	61.0 (27.4)	–19.0 (23.9)
15 or more	87.8 (25.6)	65.3 (26.3)	–22.6 (25.6)
Total	74.1 (25.0)	60.9 (26.4)	–13.2 (19.8)

Note. *N* = 4,651; OQ = Outcome Questionnaire.

DROPOUT RATES

Calgary Counselling Centre continues to focus on helping clients improve their mental health outcomes and well-being. The issue of dropout rates is complex in that there are many definitions of *dropout*, and we have yet to identify one that will best capture our results. One definition is the number of clients who attend a single session. Early research by Sue, McKinney, and Allen (1976) suggested that the single-session rate was 40.8%. A more recent research study found that between 18% and 19% of adults who begin psychotherapy do not return for a second session (Hamilton, Moore, Crane, & Payne, 2011). A meta-analysis by Swift and Greenberg (2012) found that in duration-based studies, which is where one would find data on single session attenders, there was an overall dropout rate of 18.3%. An analysis of Calgary Counselling Centre's data between January 1, 2009, and March 31, 2014, found that 23.8% attended one session. The average OQ score for the single session attenders was 69.42, well below our average OQ first session score of 71.2 suggesting that, on average, clients who attended a single session were less distressed and that a single session of counseling may in fact have met their needs.

Those who attended more than one counseling sessions (n = 13,223, 76.2%) had an average OQ score of 73.31 at the first session. The average scores were significantly higher for clients who had more than one session ($t_{17,352} = 3.981$, $p < .001$), suggesting that single session attenders may not have needed more than one session given their lower level of distress.

SESSION LIMITS: ROLE OF SUPERVISORS AND CONSULTANTS

Clinical supervision is widely regarded as an essential component of psychotherapy training (Bernard & Goodyear, 2014). There are two primary goals of supervision: enabling the professional development of clinicians and ensuring the well-being clients (Falender & Shafranske, 2004). Supervisors at Calgary Counselling Centre work toward both of these objectives. Group supervision to discuss cases and achieve case monitoring occurs both in live clinical consultation sessions and administrative meetings. Individual supervision to address specific clinical issues occurs on a less frequent basis.

Supervisors currently have access to manual dashboards, which are used to track client activity, outcomes, client volumes, and more (Appendix 8.2). Both counselors and supervisors review cases that are failing or at risk. The Centre is implementing electronic dashboards to help identify at-risk cases, which will then become a deliberate focus of supervision and consultation. Counselors are expected to follow up and use supervisor and/or consultant

feedback on failing cases, but as yet we have no way of monitoring these activities other than conversations with counselors or video review. Electronic dashboards can facilitate follow-up.

DELIBERATE PRACTICE

Ericsson and Lehmann (1996) defined *deliberate practice* as "individualized training activities especially designed to . . . improve specific aspects of an individual's performance through repetitive and successive refinement" (pp. 278–279). At Calgary Counselling Centre, we have been using methods of deliberate practice in our training with practicum and postgraduate students by converting their weekly training session to experiential sessions where they practice skills that will be needed for effective therapy. These could include discussing a problem with a client, providing feedback to a client whose OQ scores suggest that he or she is not benefiting from counseling, and discussion about termination. As we have been more deliberate with our trainees, they seem to be more accepting of the process and are developing increased confidence in their work with clients. We have just begun discussions about how we might use similar strategies with the staff counselors.

IMPLEMENTATION IN AGENCIES AND CLINICS

The journey our agency has taken to implement FIT is unique to us and cannot fully represent every such attempt in all settings. Many issues influence implementation, including agency leadership, the community context, the funding context, regulation, the people involved, and more. Many readers will live and work in a setting where the practice of therapy is regulated by provincial or state licensing bodies, including professional associations. These bodies have an impact on who can do therapy and how therapy is funded. Additionally, those who fund therapy—government bodies, insurance companies, and private corporations—increasingly expect therapists or agencies to provide outcome reports to assure that there is benefit to the consumer of service.

Calgary Counselling Centre functions in a context where there is regulation of practitioners, but not to the point where we have lost the opportunity to do what is required. As a province, we have not been affected as others have, particularly in the United States, by the requirement that all programing be evidence-based practices. We have the latitude to develop and change our programs as necessary and to use the data we collect to modify and structure programs to increase the likelihood that client outcomes can further

improve. Although we have some funders who require program outcome data, not all do, and those who require data are working with us to explore how best to affect client outcomes and increase likelihood of client benefit.

Agency or clinic leadership is critical because it provides the blueprint for the development of the culture for FIT and for the ways that it will be implemented across the agency or clinic. As CEO Calgary Counselling Centre, the idea to develop an outcome measurement program was initially mine and was influenced by work I had done at other settings and my own efforts to integrate practice with measurement and research. Agencies need to be clear about why they are choosing to embark on this journey, even if it is a funding requirement rather than a clear choice. First steps include the development of a strategy for implementation, goals for the program, consideration of both positive and negative outcomes, and backup plans for any eventualities. The use of a pilot project will give an organization the opportunity to test strategies, learn what is or is not working, and modify and test new strategies before fully implementing outcome measurements.

THE NEXT PHASE

The use of outcomes at our agency is no longer a challenge; it has been well integrated into agency culture and experience. We have developed systems to train and orient new staff and, most critically for us, to teach the 90 students who join our team each year. In 2015, for the first time, we recruited and screened students with some of the same criteria we used for staff and have discovered little opposition to the collection and use of measures with the group that started in September of that year. The journey is far from over, but we continue to learn, grow, and change as individuals and as an organization as we focus on ensuring that clients receive the results they are seeking from counseling.

APPENDIX 8.1
Calgary Counselling Centre
Procedure for Clinical Consultation—
Feedback Informed Treatment

The following is an outline of the process of feedback-informed treatment (FIT) consultations. This is the exciting work we do to provide clients with the best counseling experience possible.

OBJECTIVES OF FIT CONSULTATIONS

1. To assist counselors to build and monitor their alliance with their clients based on client feedback.
2. To help counselors reduce their no-show and cancellation rates.
3. To remove some of the guesswork about client progress and include the client's perspective through the OQ and SRS.
4. To improve client outcomes.
5. To improve counselor success with clients.
6. To help counselors identify when clients are at risk of dropping out of counseling or getting worse (deterioration) or flat lining (no change).
7. To help supervisors develop effective FIT supervision competencies.

HOW DO I DECIDE WHICH FIT GRAPH TO SUBMIT?

First priority, if a counselor sees a client for three or four sessions with no improvement or deterioration, they must consult with their supervisor. Your supervisor will assist you with feedback and will also help you prepare the case if he or she thinks it is a good case for the consultation.

Your supervisor may also assist in the following ways:

- Notice a graph during file review of green sheets and ask you to submit this graph for the consultation.
- In preparation for the monthly consultation with the external consultant, interns and residents select a graph for use in the consultation. They review the graph with their clinical supervisor, develop the question for the consultation, and write it directly onto a copy of the client graph.
- Remember, counselors should never consult about a clinical case with their supervisor without the client file and FIT graph.

- There are also different types of graphs that are useful for the consultations. You can submit graphs that demonstrate different patterns, outline work that has gone well, bring up questions about alliance or leave you curious about a process you want reviewed, or graphs that demonstrate SRS issues (dependency), for example.

HOW TO SUBMIT YOUR GRAPH

- You need to submit an FIT graph when you have a client with three or more sessions.
- You need to make sure there is no client name on the graph.
- You need to make sure that your printing is legible, both letters and numbers.
- You need to make sure that both your full name (not initials) and your supervisor's name are on the graph.
- You need to write the consultation question on the graph.
- You need to submit the graph to your supervisor by the declared date. Your supervisor will forward the graph to me to input the data and prepare it for the session.
- You need to bring the client file on the day of the consultation and be prepared to share your work.
- If you are submitting a complicated couple or family graph, make sure that each individual is indicated in a separate color on the photocopy with the OQ score and the SRS score. Make sure that if a client is being seen individually that this is clearly indicated on the graph by color. It is important that individuals in the sessions are identified and couple or individual sessions are also identified on the graph by OQ and SRS.

APPENDIX 8.2
Calgary Counselling Centre
Outcome Summary
Closed Cases
January 1, 2015–August 31, 2015

Counsellor: Female Provisional Clinician

Average no. of sessions* (single sessions included)				Average no. of sessions (excluding single sessions)		
No. of cases	Average no. of sessions	CCC average residents 2015		No. of cases	Average no. of sessions	CCC average residents 2015
86	5.37	5.26		69	6.45	6.41

*Average number of sessions based on clients with First and Last OQ data

Average change score

	Your scores for 2015	CCC average for residents 2015
Average first session OQ	73.81	74.76
Average last session OQ	57.26	60.61
Average change score	–16.55	–14.16

Effect size

		CCC average effect size (agency)
Your effect size for 2015	0.58	0.55
Severity adjusted effect size	0.60	0.50

Reminders:
*In instances when there are less than 30 cases, the effect size calculation is not valid.
Reliable Change Score (RCI) for the OQ is 14.
Effect size is simply a way of quantifying the size of the difference between groups. It is particularly valuable for quantifying the effectiveness of a particular intervention, relative to some comparison. Effect size is an important tool in reporting and interpreting effectiveness.

Relative Size of Effect Size
Negligible effect (–0.15 or less and <. 15)
Small effect (≥ .15 and < .40)
Medium effect (≥ .40 and < .75)
Large effect (≥ .75 and < 1.10)

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9

FEEDBACK-INFORMED TREATMENT IN AN AGENCY SERVING CHILDREN, YOUTH, AND FAMILIES

BOB BERTOLINO

The year was 2009, and Youth In Need (YIN), a community-based nonprofit organization in eastern Missouri, faced a conundrum. We were preparing a funding proposal that would substantially expand counseling services to children, youth, and families (CYF) in our largest catchment area, St. Louis County. As a 35-year-old organization with a continuum of services and an annual budget approaching $20 million, we'd written many such proposals. But this proposal was different. A new funder, the St. Louis County Children's Service Fund (CSF), had been created to oversee a recently passed tax initiative that would fund programs for CYF. As an agency, we had lobbied and participated in efforts to educate the public about the initiative so we understood *what* services would be part of the request for proposal (RFP). But it wasn't until the CSF actually released the RFP that we were clear on *how* services would have to be delivered.

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As it turned out, a primary requirement in the RFP for counseling services was either to choose from a list of evidence-based practices (EBPs) or to propose a reliable and valid alternative EBP. Choosing the latter was risky. If the CSF board did not understand or agree with the proposed program, it would be rejected. However, choosing one of the tried-and-true models listed, such as cognitive behavior therapy or dialectical behavior therapy, would perhaps increase the likelihood of being funded but also effectively tie the hands of clinicians, who would be required to strictly adhere to the model selected. The competition for funding would be stiff, and the number of proposals would be in the hundreds. There was little margin for error.

As senior clinical advisor with 19 years of service to YIN, I was concerned about maintaining our therapists' ability to work collaboratively with clients to determine which methods of therapy provided the best fit. We developed a *strengths-based philosophy*, which was founded on empirical evidence around "what works in therapy" (Bertolino, 2010, 2015; Duncan, Miller, Wampold, & Hubble, 2010). We also trained therapists in multiple modalities to ensure therapeutic flexibility. At the core of our clinical philosophy was the use of routine and ongoing client feedback to monitor the effects of therapy and guide decisions. The Outcome Rating Scale (ORS) and the Session Rating Scale (SRS), first known to us as the Partners for Changes Outcome Management System (PCOMS; Miller, Duncan, Sorrell, & Brown, 2005), had been part of our culture since 2004 and were integral to our therapeutic approach. We were confident in our clinical approach, and yet the PCOMS was not an option offered by CSF, making it a risky proposition. It was well understood at YIN that our decision could affect programs and services for years to come. I was reminded of the words spoken by the Grail Knight to Indiana Jones in the film *Indiana Jones and the Last Crusade* (Watts & Spielberg, 1989), "You must choose. But choose wisely, for as the true Grail will bring you life, the false Grail will take it from you."

A CRITICAL DECISION

The time between the release of the RFP and the due date for proposals was only 3 weeks. Program startup would then be just 30 days after awards were made. The total time from RFP to live programming was 90 days. With pressure mounting, eyes were on me since I was in charge of the clinical position of the agency. But to be clear, if we did not succeed, it would be our president and CEO who would have to explain to our board and staff why we rolled the dice and lost. I wondered, shouldn't we just take the path of least resistance and pick a model to ensure being funded? Doing so did not preclude us from using the ORS and SRS measures. It would, however, limit what we could do

therapeutically and go against what we stood for as an agency. We had always encouraged therapists to work collaboratively with clients to determine the course of action in therapy. I couldn't find it within myself to agree with the idea of writing a proposal that contradicted what we believed and had worked very hard to achieve clinically. Fortunately, I didn't have to.

With little trepidation, both our president/CEO and chief operating officer stood behind the idea that we should stick with what we believed, had taught, and invested in at YIN. Inspired by their support, we crafted what I believed to be a strong counseling proposal on the PCOMS (and subsequent submissions on feedback-informed treatment [FIT]). In addition, we also developed proposals for emergency shelter and transitional living, which included FIT as a key practice.

A short time later we learned that all our programs had been fully funded. The CSF had recognized the value of FIT. It was a proud moment for the agency. At a time of great pressure, we remained on the right path as an agency and for our clients. Now, over a decade into our experience with FIT, we've learned about how to create a culture based on routine and ongoing real-time feedback. For the remainder of this chapter, I describe five of the ideas that we have found both promising and useful.

IDEA 1: ALIGN FIT WITH AGENCY MISSION AND PHILOSOPHY

Every second Tuesday of each month, we hold training for new employees titled Strengths-Based 101 (SB 101; Bertolino, 2011). In this full-day training, we talk in great detail about the importance of research and personal philosophy or worldview. Experience has taught me that one doesn't work without the other in behavioral health. There is a "YIN-Yang," as we refer to it, in our organization. Skills can be taught, but without heart, our clients don't get the best of us. At YIN, FIT is part of who we are and what we stand by as an organization. We are, after all, people helping other people, and we put our best foot forward when we combine research and the humanity.

The CSF expansion meant an even larger scale adoption of feedback-informed processes. To ensure that FIT would "fit" with our strengths-based philosophy, we even modified our operational definition:

> A strengths-based perspective emphasizes the abilities and resources people have within themselves and their support systems to more effectively cope with life challenges. When combined with new experiences, understandings and skills, these abilities and resources contribute to improved well-being, which is comprised of three areas of functioning: individual, interpersonal relationships, and social role. Strengths-based practitioners value relationships and convey this through respectful,

> culturally-sensitive, collaborative, practices that support, encourage and empower. Routine and ongoing real-time feedback is used to maintain a responsive, consumer-driven climate to ensure the greatest benefit of services. (Bertolino, 2014, p. 18)

There are four parts of the definition that reference FIT. The first is the mention of the individual, interpersonal, and social domains on the ORS. Second, reference is made to the value YIN places on the therapeutic relationship. Third is the importance of culture, which is part of the American Psychological Association, Presidential Task Force on Evidence-Based Practice's (2006) definition: "The integration of the best available research with clinical expertise in the context of *patient characteristics, culture, and preferences*" (emphasis added; p. 273). Because of the diversity represented in our clientele and programs, a variety of treatment approaches are practiced.

It is the fourth part, detailed in the final sentence of the definition, that spells out the role of FIT at YIN. What binds our staff together is the value of routine and ongoing feedback as a means of monitoring the effectiveness of all forms of prevention and intervention. To this end, our experience has been that staff members are far more interested and excited about adding new practices when they understand how those practices enhance and strengthen the culture, which in turn benefits clients, staff, and the community.

The presence of FIT filled another void. In community-based nonprofits like YIN, there exists a long history of reliance on standard indicators of program effectiveness—the number of children and youth served, therapy sessions completed, days of care in residential programming, client satisfaction, and the like. Such data were pleasing to funders, and clients seemed satisfied as evidenced by their touching stories of how YIN had changed their lives. But the numbers didn't reveal the overall impact of services, and the staff knew it. It didn't sit well with the staff members of YIN to not really know whether services were making the kind of difference they hoped. The available data were without meaning. Knowing how many children and youth were served did not reveal anything about the quality of those young persons' lives, particularly at the end of services. The implementation of FIT gave us a reliable and valid way to measure the benefit of services to CYF.

IDEA 2: DEVELOP AN AGENCY-WIDE UNDERSTANDING OF FIT

To increase the likelihood of agency-wide acceptance of FIT, we involved staff with different degrees of experience and responsibility. Clinically, we sought champions who would lead others in the use of FIT day by day, session by session, shift by shift, and interaction by interaction. Similarly, we invited supervisors and administrators to champion FIT through activities such as

leading trainings and mentoring, working on software, grant writing, communicating with funders and board members, and raising funds to support the use of FIT. The inclusion of staff in different roles and experience began with planning and extended through implementation and oversight.

Our approach was in contrast to a directive, in which management simply instructs staff members to implement new practices; instead, our management consulted with staff members to accomplish our goals. Under a directive, the staff is required to make changes because an administrator or someone of authority has learned of the latest and greatest practice that is espoused to revolutionize care. Lacking in such decisions is discussion of how the adoption of a new practice will enhance current programs. We understood that a top-down approach might lead to FIT being used, but the likelihood that real-time feedback would be seen as valuable and anything more than "another thing we have to do" would be diminished. By involving staff at all levels, we generated interest, curiosity, creativity, and expertise, which enhanced the "stickiness" of FIT—that is, the likelihood that the ideas would remain with staff over time.

A further benefit of multilevel staff involvement is that no one person "holds the keys to the kingdom." Although our clinical staff turnover rates are low, if we relied on one or two persons as the in-house experts, FIT would be vulnerable to extinction. All it would take is for the person or persons with the knowledge and leadership to leave for the foundation to become unstable. At minimum, we would have to regroup and retrain, which would be costly, especially for nonprofits like YIN that already operate within thin financial margins. At worst, FIT would disappear as a cornerstone practice of our agency.

Because CYF-oriented agencies are subject to sudden, often large-scale changes to programming, we learned that stability can come from having multiple persons with knowledge of and competency in FIT. Doing so increases the likelihood that the foundation will remain solid not if, but when, the agency undergoes change. What follows are examples of how YIN developed an agency-wide understanding of FIT in different roles. Other examples are provided as the chapter progresses.

Example 1: Clinical Staff and the SONAR SSFC

Clinical staff members receive in-depth training in FIT, including the research and psychometrics behind the measures, application, how to elicit feedback, patterns of client response, and so on. In addition, training delves into use of YIN's cloud-based software ("Imagine") and performance-driven activities involving deliberate practice. Because clinicians work in a variety of programs, it is particularly important that the differences between settings (e.g., office-based, residential, school) are discussed.

Another way that direct services staff remained attuned to the use of routine and ongoing feedback can be found on laminated images with the word “SONAR.” These images are on the walls of offices where CYF are seen at YIN. SONAR is the short form of the SONAR Session Feedback Checklist (SSFC; Bertolino, 2013).

The term SONAR stands for

Setup

- (Intake/Initial Session) Introduce and discuss the role of real-time feedback.
- (Subsequent Sessions) Reorient to the role of real-time feedback.

Outcome

- Complete outcome measure(s).
- Score measure(s) and plot the results.
- Identify high and low scores and variations from previous scores (in subsequent sessions).

Now

- Discuss outcome feedback.
- Collaborate and proceed.
- Continuously monitor.

Alliance

- Complete alliance measure(s).
- Score measure(s) and plot results.
- Identify low scores.

Respond

- Discuss alliance feedback.
- Determine next steps.

Although no single tool will change the culture of an organization, the SONAR helps to keep feedback at the forefront of conversations and services. One indicator that staff has embraced the value of feedback is in ORS completion rates. From 2011 to 2015, the time frame in which the agency developed and began using its own proprietary software, the client completion rate for the ORS was 98.2%. Consistency is particularly important in the face of evidence suggesting that periodic (e.g., every third session, once a month) outcome measurement is insufficient in tracking client progress (Warren, Nelson, Mondragon, Baldwin, & Burlingame, 2010).

Example 2: Supervisory Oversight

A second example of how YIN has incorporated an agency-wide understanding of FIT can be found in supervision. All supervisors are trained in

using FIT as a method of oversight. Monthly trainings serve as follow-up. Supervision is discussed in detail under Idea 4. Additionally, there are six to eight supervisors who are able to train staff in FIT and another team of six to eight members that tests the agency's software functionality and updates. A third team of three to five staff members reviews and analyzes data to identify trends and patterns. Each year new staff is invited to join one or more of the teams.

Example 3: Administration

As YIN's use of FIT expanded from program to program, the role of administration has become more and more pivotal. To illustrate, the vice president of development has a firm understanding of FIT and the importance of the real-time feedback and can clearly articulate its value to the community. In fact, he played a crucial role in exploring donor and foundation funding options as YIN developed two web-based software systems. Similarly, the chief financial officer has championed the software development, describing it as a "necessary part of YIN's current and future success."

For FIT to become a cornerstone of services at any organization, top administration must be on board. During my tenure at YIN, there have been two president/CEOs, each instrumental in supporting FIT within and outside of the agency. Examples of this support include communicating the benefits of FIT to the community, working with the agency's board of directors, and approving funds for training and software development.

Example 4: Frontline Staff

In residential programs, teams are at the epicenter of services. Multiple service providers form a supportive network for children and youth. At the heart of YIN treatment teams is frontline staff, which include frontline support staff, including resident counselors, youth counselors, psychiatric technicians (psych techs), caseworkers, case managers, and house parents or managers. I'll use the term *youth care workers* (YCWs) because the moniker is common to programs that serve children and youth (Bertolino, 2014, 2015).

YCWs are the go-to persons, preserving the safety and well-being of youth while juggling multiple on-shift tasks. YCWs not only have numerous responsibilities, they carry out those responsibilities in environments that are fast-paced and require conscientious, on-the-spot decision making. Despite their responsibilities, YCWs often report that they do not feel valued as contributors to the treatment of the children and youth with whom they work every day. This is in part because of an artificial division that can occur between clinical and frontline staff. Counselors, therapists, social workers,

and psychologists are seen as the ones who do the "real" work, whereas frontline staff members are seen as supportive yet not directly involved in treatment. This is, of course, a false perception. YCWs are central to residential services. When it comes to FIT, YIN has taken the position that routine and ongoing monitoring of services is everyone's business.

YCWs at YIN use the oral version of the ORS as a prescreening tool (see Idea 3) for phone contacts. Frontline staff also complete about half of the intake assessments in residential programs, which involves administering and discussing the measures with individual children and youth, caregivers, and other family members who may be part of the support system. Beyond administration of the measures, frontline staff have access to the results of the measures during the time a child or youth is in the program. Client progress is also discussed in staff meetings (see Idea 4), which YCWs participate in.

IDEA 3: USE FIT TO DETERMINE THE TYPE AND INTENSITY OF SERVICES

Collecting data is one thing. Using data in a meaningful way is another. A necessary step for YIN was to be more deliberate in the use of data to inform decisions around the level and intensity of services. Over time, data became increasingly influential in the areas of prescreens and waitlists, risk and program responsiveness, and scaling down services.

Prescreens and Waitlists

We use prescreening in most services at YIN. An example can be found in Outclient, (office-based) counseling. First, an oral ORS is taken over the phone to gain a sense of the level of distress that the child, youth, or young adult is experiencing. Consistent with the paper and computer versions of the ORS, oral ORS involves a series of four questions aimed at understanding the client's current level of stress. Questions asked of clients or their caregivers include the following:

- How have you been doing personally?
- How have things been going in your relationships?
- How have things been going for you socially?
- Given your answers on these specific areas of your life, how would you rate how things are in your life overall?

During phone screens, staff provide more direction as needed. For example, with the third question, a staff member might offer clarification by saying,

"How has your life been outside the home or in your community (or work, school, church, etc.)?"

On the basis of the information gathered during the call, the staff member completes a second measure referred to as a Risk Rating (RR; i.e., provider rating). RRs are scores ranging from 1 to 10 that reflect any safety concerns that may arise during the contact. Scores of 1 to 3 indicate high risk and are highlighted in red. For example, if a youth has had suicidal ideation or been hospitalized in the past 30 days, a 1 to 3 rating may been assigned. Medium risk, or yellow, is given to scores between 4 and 7, and scores of 8 to 10 are highlighted in green, indicating low risk. Most children, youth, and young adults who are screened fall into the 1-to-7 range given that, more often than not, there are some existing safety concerns to bear in mind.

Similar to the RR, ORS rankings are based on numerical ranges and are assigned color codes depending on the range they fall within. Scores of 0 to 15 receive a red indicator, a yellow indicator is assigned to scores within a range of 16 to 27, and a green indicator is given to scores of 28 to 40. All information is displayed on the client Waitlist. The Waitlist can be sorted according to ORS score, RR, date of contact, name, and so on.

The method described creates a way of keeping track of client distress and determining an appropriate, timely response. For example, clients with ORS scores of 0 to 15 are typically seen within 24 hours for crisis sessions or further assessment. These clients may also be referred to other programs such as YIN's crisis shelter for 10- to 19-year-olds, to other local programs, or to the emergency room. In other cases, phone check-ins may be completed each day until counseling can begin.

Risk and Program Responsiveness

Another way that we use the ORS to inform decisions about services is in our emergency shelter program. Using the ORS numerical ranges discussed earlier, during intake assessments, a cutoff score of 15 or below requires staff to do further risk assessment, even if no other clear indicators of risk are present. When the intake is completed by a YCW or other frontline staff member, risk assessment is completed by reviewing the individual ORS (or Child ORS [CORS]) domains with the child or youth and/or others who may be present. Follow-up assessment is done to further evaluate risk. A supervisor is then consulted to review the intake and ensure an appropriate plan is in place for the child or youth. Should the type of risk indicate that a more intensive form of services is needed and those services are outside of the scope of what is provided at the emergency shelter or in other YIN programs, the child or youth is referred to other providers to secure an appropriate level of care.

In terms of risk responsiveness, we have periodically found older youth or caregivers hesitant to fully verbalize their concerns out of fear that they may be seen as "too severe" and not qualify for services. Homeless youth often worry that revealing too much may jeopardize their chances to secure a place in a transitional or independent living program. Alternatively, some caregivers want to reveal "just enough" to gain access to services but not too much, believing that doing so may lead to denial of services (i.e., a program may view a youth's behavior as something they are not equipped to handle). These types of client responses may be seen as atypical, and perhaps examples of score inflation (see Idea 5) because they do not necessarily reflect the degree of distress of the client and his or her situation. Our approach at YIN is to create an environment in which the role of feedback is openly discussed with clients as a way to better understand how clients see their lives. We convey empathy and positive regard, remaining transparent about how feedback is going to be used. Doing so helps to neutralize fears CYF have that are grounded in their experiences with child protective services or other service providers. The following exchange between a therapist and Francisco, a male 17-year-old Latino, illustrates this point.

Therapist: Thank you for completing the ORS, Francisco. Is it okay with you if we discuss how you scored?

Francisco: Yeah.

Therapist: I noticed that all of your scores are above 8.0 and your total score is 37.4 out of 40. That tells me that things are going pretty well for you. Does that sound right to you?

Francisco: [*pause*] I just need a place to stay for a while. There's nothing wrong with me. I'm not bad or anything.

Therapist: Francisco, you're not bad. I'm sorry if I somehow gave the impression that there was something wrong with you. Thanks for helping me to me to understand where you're coming from. I think I may have made a mistake when I explained the ORS. Could I clarify things a bit? This will help me to get better at it.

Francisco: Okay.

Therapist: The ORS doesn't tell me who you are as a person. And that's something I want to know. What the ORS does do is give me, and our whole team, an idea of how you think things are going in your life so we can all work together to figure out how to help. The ORS will help us all get on the same page. And no matter how you score, we are going to help. How does that sound?

Francisco: That's cool.

Therapist: Thanks again for giving me another chance to talk about the purpose of the ORS.

Another way we neutralize the fears youth may have about rating how they are doing is by talking about the ORS as a way of understanding how things are now so staff can help youth to have the future they want. Staff members also talk about the ORS as a way of taking the youth's "temperature." Here is an example of how a YCW might talk with a youth:

> Completing this scale is a bit like taking your temperature. In a minute or less, we can get an idea about how you think things are with you and your life. Just as your temperature tells us something about how much distress your body is in, so do the scores on the scale. And like your temperature, this scale will let us know how things have been with you during the past week up through today—not tomorrow or in a month. Right now we are trying to understand how we can help you, which is more difficult if we don't have a good idea of how you are doing to begin with. Can you help us out?

YIN does not rely on any single method of assessment. Instead, the ORS is part of a decision-making process to determine which programs provide the best fit for a child or adolescent at that moment in time. We also avoid the use of formal score cutoffs for programs (e.g., ORS scores of 20 or below trigger referral to more intensive services) because CYF score differently for various reasons. However, our results indicate that aggregate, initial, and, in some cases, final ORS scores, typically reflect the intensity of services provided. For example, our internal outcome data from 2012 through 2014 indicate that youth in emergency shelter care began services in more distress (initial/final ORS = 22.8/28.8) compared with youth in outpatient counseling (initial/final ORS = 24.8/30.8), transitional living (initial/final ORS = 25.2/29.8), and school-based counseling (initial/final ORS = 27.8/33.6). These findings are as expected given that youth in the shelter usually come from relatively higher crisis situations in which there is current or very recent abuse or neglect.

In contrast, youth in both outpatient counseling and transitional living also frequently have histories of abuse and neglect but tend to have lower levels of immediate crisis. Additionally, children and youth in outpatient services are more often than not brought to services by a concerned adult and are living in safer environments than youth serviced in emergency care. Youth in transitional living tend to seek services on their own volition and report less up-front distress, with the majority seeking a safe environment and a future that involves education and employment. Finally, those seen in school-based counseling are typically referred by a concerned person in their school (with the consent of the caregiver). Although these children and youth often live in high-stress, high-risk areas and experience distress,

unlike outpatient counseling, it is unlikely that their caregivers would seek counseling. Therefore, initial ORS scores tend to higher.

Scaling Down Services

A final way we used data to inform decisions about service intensity and dosage involves using the ORS as a determinant to scale down services or transition youth out of services altogether. The slope of change can vary from youth to youth, and yet program trends often emerge out of initial ORS scores. For example, in YIN's emergency shelter care, the aim is to reduce the immediate crisis. Because distress ratings are higher (i.e., lower ORS scores), the slope of change is typically more pronounced, as illustrated in Figures 9.1 and 9.2. To this end, children and youth usually remain in services for a briefer period of time ($\bar{x} = 9.2$ days), have fewer sessions ($\bar{x} = 4.1$), demonstrate sharper improvement ($\bar{x} = 6.0$ points on the ORS), and yet transition out of services with lower ORS scores than in other programs ($\bar{x} = 28.8$). Despite lower ORS scores at disposition, most children and youth are considered out of immediate crisis, which is the goal. And in many cases, children and youth transition from the shelter into outpatient counseling or into our transitional living program.

By comparison, in other programs, such as transitional living, there is often a flattening or leveling off of scores, which can contribute to discussions about transition from the program or a revision in goals. Figure 9.3 provides an example of a youth whose scores have flattened out while in transitional living. In this case, the youth had achieved his goals for the program in 7 months (27 sessions) and was transitioned into an independent living program (i.e., a scattered site apartment). In contrast, Figure 9.4 shows

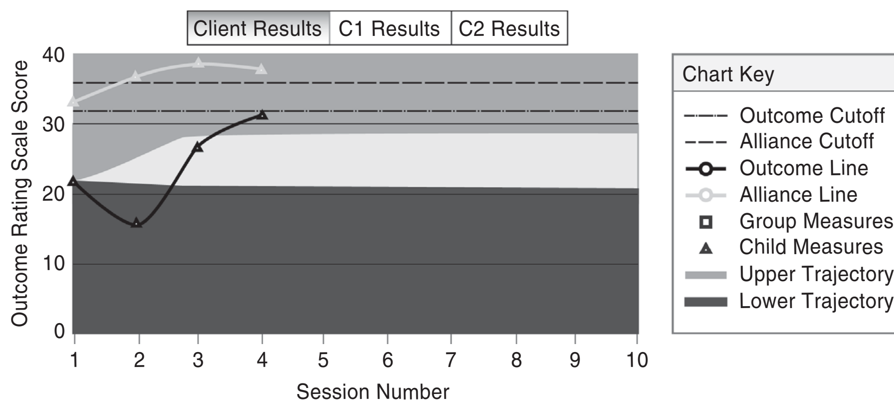

Figure 9.1. Example 1: slope of change in emergency shelter setting.

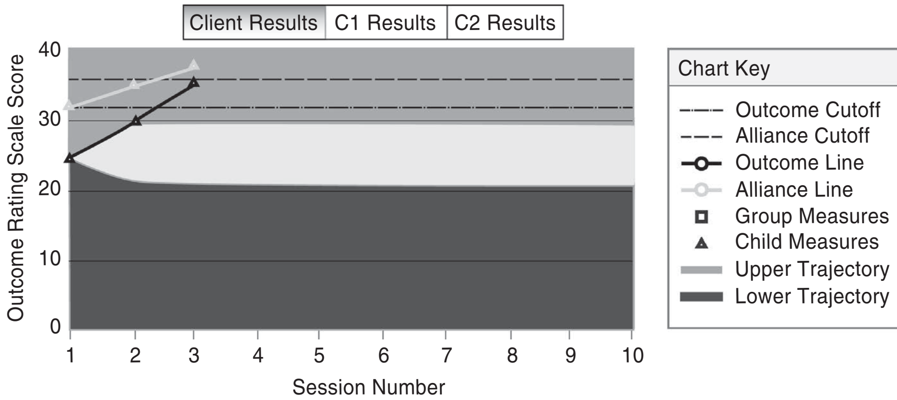

Figure 9.2. Example 2: slope of change in emergency shelter setting.

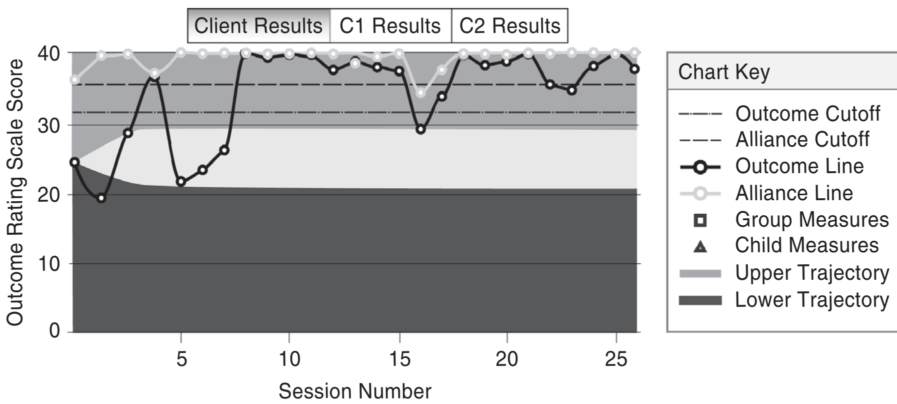

Figure 9.3. Example 1: trajectory of change in transitional living setting.

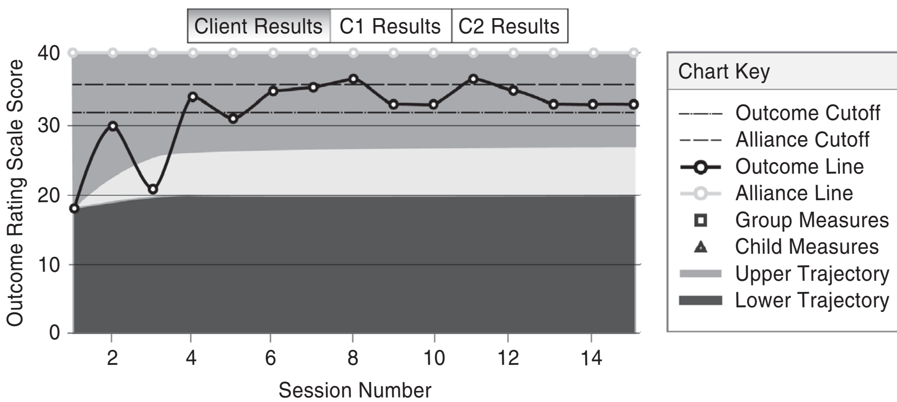

Figure 9.4. Example 2: trajectory of change in transitional living setting.

a youth who has made progress over the course of 3 months and 15 sessions. This youth had achieved his goals, and yet he was not quite ready to be transitioned. Therefore, program staff worked with him to revise his goals.

IDEA 4: MONITOR SUPERVISION OF FIT IMPLEMENTATION AND STAFF MEETINGS

Unwilling to hinge the success of FIT on hope, randomness, or luck, we took our time planning, training, and implementing methods of oversight. At the center of our planning were clinical supervision and staff meetings, which we considered critical to monitoring the effectiveness of services. We also kept in mind that our strategies of supervision had to be revisited. Too often supervisors would rely on ineffective and impractical methods of oversight passed along during training or on the job and continued without any questioning of whether they actually proved beneficial. Following an evaluation of supervision practices, YIN made three overarching changes.

Five-Minute Model

There is only so much that can be discussed in an hour of face-to-face supervision per week, which is the standard of practice in most settings. Even with periodic staff meetings, it is difficult to sufficiently cover one's caseload. To address this issue, we implemented a 5-minute supervision model to include discussion of ORS scores, therapist RRs (to identify areas that may indicate risk of harm to self or others and act as hurdles to children or youth achieving their preferred futures), and a plan of action.

Although there are exceptions, for example, with safety planning, as a rule, longer discussions about youth do not typically translate to better ideas and better outcomes. Time limits help to keep conversations moving, discussions focused, ensure that all children and youth are discussed, and keep staff engaged. It is further recommended that a listing of children, youth, and their levels of distress be available to ensure those at highest risk are discussed.

Knowing a child or youth's level of distress helps to determine the type and intensity of services, with matching services, and, most important, whether services are working. We ask not whether youth need services but rather, are youth benefiting from our services? When the best available type of service is determined and provided in a timely and efficient manner and routine and ongoing outcome management is incorporated, we create a responsive climate and can reduce the suffering of children and youth and help them to achieve greater well-being.

The 80:20 Concept

FIT offered YIN supervisors a new way to structure supervision so that multiple clients, in particular, those most at risk, could be discussed in a short period of time (i.e., usually in an hour a week meeting; Bertolino, 2014). The new supervision structure was largely based on the "80:20 rule" or the Pareto principle, named after Italian economist Vilfredo Pareto (see Juran & De Feo, 2010). The idea is that 80% of the results or value comes from 20% of the source or focus. In clinical practice, pages and pages of information are gathered, and yet as much as 80% of that information has no bearing on services. Supervision requires determining what information is most relevant to making decisions and doing so as thoughtfully and efficiently as possible. The 20% of clinical information that we have determined to be most viable originates from routine and ongoing feedback. Accordingly, in supervision, therapists are asked to focus on three things: (a) the ORS score, (b) the RR (provider rating), and (c) the Plan of Action. In other words, therapists were asked, What is your client saying about their struggles and degree of distress? What is your view of the client's current state and level of risk? and, What is your plan to address both your client's perspective and yours? Although there remains room to broaden discussions as needed, the supervisor maintains a close eye on the three aforementioned areas, which keeps supervision focused, efficient, and productive.

An Outcome Focus

A third change was to shift from a focus that was almost exclusively on the achievement of goals, which provides an incomplete picture of the benefit of services. This is because youth can meet goals without necessarily having an improved outcome. For example, a youth may report that she is meeting goals such as getting to school on time, completing her homework, and getting better grades. However, that same youth may remain depressed or anxious or continue to have trouble in relationships with peers, indicating an unimproved outcome. In supervision, attention is still given to goals (e.g., it is important for youth to live in a safe environment, get an education, etc.), but more emphasis is placed on outcome—the impact of services on the major life areas reflected in the ORS/CORS measures. Our belief is that a youth who self-reports in the nonclinical range (as evidenced by ORS scores above the clinical cutoff) at the end of services is likely to fare better than a youth, for example, who has passing grades but whose ORS scores are in the distressed range at the end of services.

IDEA 5: USE FEEDBACK TO FURTHER KNOWLEDGE AND IMPROVE SERVICES IN THE LONG TERM

A decade of using feedback as a central clinical practice has helped us to learn more about the clients and community we serve at YIN. Although some of what we have gleaned reinforces previous findings and understandings, we have also found some specific areas in which the use of feedback can also improve clinical practice. Each of these areas is discussed in the sections that follow.

Thoughts on Score Inflation

It is not uncommon for children and youth to score high (i.e., above the clinical cutoff) on the ORS/CORS, with or without collateral ratings from their guardians or other stakeholders. As previously discussed, at YIN we've found numerous youth who are concerned that reporting too much distress could jeopardize placement. For homeless youth who seek a safe place or long-term setting, revealing the extent of their current concerns or histories (i.e., at-risk behavior) could have staff questioning whether the youth is "appropriate" for the program. It is a legitimate concern for youth.

A more frequent type of score inflation we've experienced occurs when a child or youth enters services involuntarily. In the majority of these situations, children and youth report less distress, represented by higher scores on the ORS (and SRS) in an apparent attempt to end or avoid being in services. It is important to accept the scores youth give. An example is if a youth scores 40 on an ORS when he was referred to therapy for being suspended from school for bullying another student. It is not difficult to understand why a practitioner would question the youth's ratings. But to do so is to blame the youth. The integrity of ORS and SRS scores exists not in the child, youth, or other (e.g., a parent who does not believe there is a problem) but in the relationship between the child, youth, or other and the practitioner administering the measures. It is therefore crucial that practitioners accept the feedback of CYF while simultaneously joining such persons in exploring the nuances of their situations and scores. The following dialogue between a therapist and Shane, a 14-year-old Caucasian boy, illustrates one way of accepting a youth's scores and wading further into the conversation to flesh things out a little more:

Therapist: If I understand you correctly, based on your overall score of 40 on the measure, things are going very well for you. Is that correct?

Shane: Yep.

Therapist: Okay, well, even when things are going really well, there's always something that can be a little better, you know?

Shane: I guess.

Therapist: I heard you like baseball. Is that right?

Shane: Yeah.

Therapist: Who's your favorite team?

Shane: The Cardinals.

Therapist: Me too. If you were at a baseball game, and the Cardinals were winning big, by a score of 10–0, what's one thing that might make the game just a little better?

Shane: If Matt Carpenter hit a home run.

Therapist: Very cool. Okay, so you're at a 40 on the scale you just completed. That's like being up 10–0. What is one thing that might be like a Matt Carpenter home run for you—something that would get things from a 40 to a 41? Just a little better than things are now.

Shane: I guess if I could get back in school.

Therapist: I'd really like to hear more about that.

Shane: It's boring at home, and I can't see my friends or do anything.

Therapist: That does sound boring. So things are pretty good for you but not as good as you'd really like them to be, right?

Shane: Yeah.

Therapist: Could I ask you to redo the scale based on what you just said about school, not being able to see your friends, and being bored?

Shane: Okay. *(Rescores the ORS, marking the "Individual" and "Social" scales lower)*

Therapist: Thanks, Shane. That really helps me to get a better idea of what things are like for you.

We don't push youth to revise their scores. Doing so would likely close things down even further. Instead, we try to join with CYF and invite them to help us better understand their perceptions. If our invitation is accepted, they will either retake the ORS or perhaps score the measure based on the person who is responsible for services being initiated. The following interaction between a therapist and a 14-year-old Caucasian girl named Jana illustrates this idea.

Therapist: Thanks for completing the ORS, Jana. It didn't take you but a couple seconds on each domain. Your score of 39 says things are going pretty well for you . . .

Jana: I don't need to be here.

Therapist: Thanks for letting me know. I'm glad you decided to come even though, if I understand it, your teacher, Ms. Elliott, wanted you to see me. Is that right?

Jana: My mom, too. I don't know what's up with them.

Therapist: Your mom and Ms. Elliott both thought it was a good idea for you to come here, but in your eyes things are okay.

Jana: Uh-huh.

Therapist: Have they told you why they thought it would be good for you to come see me?

Jana: Yep. They think I'm depressed.

Therapist: Both your mom and Ms. Elliott think that?

Jana: It's more my mom, but she convinced Ms. Elliott I should see a counselor.

Therapist: Ah, I think I get it. Would you be willing to help me better understand how you and your mom might see things differently?

Jana: Okay.

Therapist: I'd like to ask that you complete the ORS once more, but this time fill it out as your mom rating how she thinks you are doing. Is that okay?

Jana: I guess. (*Completes the ORS*)

We've learned at YIN to invite further feedback by expanding our conversations. And one of the best ways to do this with children and youth is by asking for them to provide ratings of the person or persons—"stakeholders"—who requested services and/or also have the ability to end services.

Because the majority of children and youth served at YIN fall between the ages of 7 and 17, we strive to get at least one actual collateral rater. With very young children, typically below the age of 7, the caregiver or referrer will often serve as the primary rater and the child will be the collateral. We make a decision up-front about whose rating will be used to determine progress. We've found it important that the primary rater be able to provide consistent

feedback. With YIN's school-based counseling program, teachers often provide ratings, but they are not used as primary raters unless the child is under age 7 and the teacher is able to complete an ORS within 24 hours before an upcoming session. This is to create some proximity between the child's and teacher's scores.

When collaterals are present in sessions, there are more opportunities to compare scores and perceptions. In such cases, we have a youth and a caregiver each complete a measure. Because youth often rate their situations differently from adults, administering the ORS two or more times provides valuable points of comparison. In such an instance, a therapist might say, "Leah, I noticed that you have rated things currently at about a 31. Your mom rated things as a solid 18. Can you tell me about the differences between how you and your mom scored?" Discussion about any differences can then be explored, along with clarification about how the presenting issue(s) is seen by both or all the involved parties.

We have found that other reasons for high initial ORS scores include the following: (a) youth may have difficulties reading and writing; (b) youth have not understood the meaning or purpose of the measure; and (c) high-functioning youth may want services for growth, self-actualization, and optimizing performance. When children or youth have reading or learning disabilities, we read the measures out loud and discuss in supervision and meetings different ways of introducing them. The same follows when youth struggle with comprehension of the measures. It may also be necessary to change the type of ORS and SRS measures used. For example, there will be 11- and 12-year-olds who are more comfortable with the adult versions, and there will 13- and 14-year-olds who prefer the child versions. Scoring for all of the measures is the same so that they can be switched easily. Along these lines, we want to be sure youth understand the language we use to describe the measures. For high-functioning youth, a strengths-based, coaching-type approach focused on achieving specific, targeted, and measurable goals is likely to be most helpful while minimizing risks of deterioration.

There is one other form of score inflation we have seen among children who complete the CORS. Younger children sometimes gravitate toward the smiley faces on the CORS even if they are feeling more down. They lean toward how they want to feel instead of how they are feeling in the present. Because in our experience children are typically more optimistic than adolescents and adults, they often see things in a future-oriented way. In some cases, to accommodate a child, we ask them to complete two CORSs (one of how they feel right now and another of how they wish to feel), obtain an ORS from a collateral rater, or both.

IN THE MARGINS: FURTHER CONSIDERATIONS WITH CYF

If we are patient and pay close attention, there is much to learn from client responses and trends. The balance of this chapter offers a few additional nuances we have uncovered over time.

No-Cost Services

We have noticed differences in expectations between clients who use insurance, which may involve copays; clients who pay out of pocket; and clients who receive services at no cost. At one time, YIN had programs that operated on a variety of fee schedules, including sliding scale, Medicaid, and block funding. Today all services to CYF are covered through local, state, and federal funding. Clients do not pay for any form of services. To this end, feedback from clinicians reveals a tendency for clients to express caution about services coming to an end. This is the case even when there is agreement that presenting concerns have been resolved and ORS scores have remained above the clinical cutoff for several sessions or an extended period of time.

When we've asked clients about their apprehensions, we've received two types of responses. First, clients express concern that if services end and there is a setback, they may not be able to get back in right away. Clients understandably do not want to be waitlisted, which happens more often when services are provided at no cost. A second form of apprehension is commonly expressed by clients who have inadequate support systems and feel isolated or alienated. In effect, these clients, often caregivers, do not want to lose the connections they have with service providers. As a result, some clients will identify new concerns as others are resolved, which can contribute to dependency.

There appears to be a difference in client expectations when third-party payment is being used or clients pay for services compared with no-cost services. We have found FIT to provide an excellent response to client concerns and provider challenges. From the outset of services, clients are told that the aim of services, which varies slightly from program to program, is to help them improve their situations as quickly as is possible so they can get on with their lives. FIT helps clients and providers to work together to determine when things are at a point at which services can be tapered and transition can occur. In addition, clients know YIN uses an "open-door" approach, meaning that they can return to services at any point in time and do not have to return to the waitlist. Efforts are also made to strengthen the support systems of CYF to reduce the possibility of dependency so that when services do end clients maintain support through the agency and their community.

Program-Specific Trends

The average number of sessions in YIN's outclient services is 7.4 over 5.1 months. YIN clinicians work with clients to lower the dosage form of services once the improvement has occurred. Clients may be seen once a month or every 6 weeks to ensure progress is being maintained.

Program-specific trends can be found in more structured settings, as is the case with YIN's school-based counseling program. For example, an expectation is that the school counselor will work with a child or youth for the entirety of the academic year. YIN supervisors and school counselors have engaged school officials in 17 school districts to discuss the role of counseling and FIT as an approach to monitoring the benefit of services. In doing so, teachers and support staff (including a couple of principals in alternative schools) have embraced their role as collateral raters. The data suggest that this approach has been effective. The average number of sessions is 9.0, and length of service is 6.0 months, which are only slightly higher compared with YIN's office-based, outclient counseling program.

A glimpse into residential programing also affords an opportunity to understand more about influences and trends with CYF. As discussed earlier, the slope of change in YIN's emergency shelter differs from that of both longer term transitional living programs and traditional office-based outclient counseling. In addition, dramatic drops in score are not unusual in the emergency shelter as youth get closer to transition. This may be because many homeless youth realize they will be going to another facility (sadly referred to as the "Shelter Shuffle" by youth). To remedy this, YIN staff—and in particular, YCWs—talk with youth about maintaining their gains and positioning themselves for longer term, transitional, or independent living programs.

By contrast, a pattern in longer term programs is for ORS scores to become flat then bleed—to gradually slope downward and drop off. In response, youth are talked with about the meaning of scores so that adjustments can be made, whether it is reenvisioning of goals or preparation for transition from services. A key decision in residential programs is how often to administer FIT measures. It is recommended that the measures be used at least weekly. At YIN, the measures are used in each therapy session, which take place two to three times per week in the emergency shelter and one time per week in transitional and independent living programs. No matter the frequency of administration in a setting, we have found that it is essential that professionals not view FIT as the "bookends" of services. FIT is an approach that is reliant on continuous feedback. Every effort should be made to ensure staff are checking in with children and youth and learning about their experiences with services and responding to that feedback (Bertolino, 2011, 2014, 2015; Bertolino, Axsen, Maeschalck, Miller, & Babins-Wagner, 2012).

Two final observations associated with FIT may enhance services for working with CYF. First, through our multiprogram implementation of FIT, we have noticed some differences in the experiences of users with paper and electronic measurements. YIN practitioners have used both forms, and feedback from children and youth has consistently revealed their preference for using the electronic versions (i.e., computers, tablets, and smartphones). When asked, these young people will say, “I like the computer” and “It’s more fun this way!” Although lacking scientific corroboration, there may be preferences among children and youth around the interactive nature of electronic measurement.

Finally, it is clear that client dropout is an enormous problem in behavioral health, with rates ranging between 20% and 47% (Swift, Greenberg, Whipple, & Kominiak, 2012). Rates are even higher with children and adolescents (Garcia & Weisz, 2002). By comparison, YIN’s program dropout rates are as follows (programs with at least $n = 100$): Outclient Counseling 6.7%, School-Based Counseling 2.1%, Teen Parent 8.1%, Transitional Living 3.2%, and Emergency Shelter 1.4%. The agency’s collective dropout rate is 4.8%. For YIN, the responsive consumer-driven climate created by FIT substantially reduces potential influences on client dropout including but not limited to lack of client progress, poor alliances, and an inadequate match between CYF and services.

CONCLUSION

Since initial CSF funding in 2009, our counseling program has grown from eight therapists to more than 40. Agency-wide, we now have 60 therapists and case managers. With an annual budget of $24 million, the use of routine and ongoing feedback is standard across the organization’s philosophy and practices. FIT has been implemented in YIN programs including emergency residential shelter care, independent and transitional living, office- and school-based counseling, teen parent, therapeutic supervised visitation, and street outreach. This chapter has explored five ideas and associated strategies for changing the culture and practices of services with CYF. It is hoped that these ideas will encourage further conversations that will result in a new continuum of effective services.

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10

FEEDBACK-INFORMED TREATMENT WITH COUPLES

BILL ROBINSON

In recent years, research has shown how mistaken counselors can be in estimating their own effectiveness and noticing when the treatment they offer is failing their clients (Hannan et al., 2005; Walfish, McAlister, O'Donnell, & Lambert, 2012). Treatment can drift on without achieving anything significant, or clients can quietly drop out. In some situations, we have the uncomfortable feeling that progress might be slow, but the clients seem happy enough and they keep turning up, until one day they don't, and we don't hear from them again. We perhaps wonder if clients were as satisfied as we thought with the service they were given or if our alliance with them was as solid as we assumed it was. An end-of-service evaluation questionnaire might answer one or both of those questions, but by then it is too late for this information to salvage the work with this person or couple. I experienced this with the following couple—not from an evaluation form but from a client who, having dropped out of treatment, contacted me again months later.

http://dx.doi.org/10.1037/0000039-011
Feedback-Informed Treatment in Clinical Practice: Reaching for Excellence, D. S. Prescott, C. L. Maeschalck, and S. D. Miller (Eds.)
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I had seen Mike and Alice for five sessions of couples counseling. The sessions were becoming frustrating for me and, as I was later to discover, frustrating for them as well. They postponed their sixth appointment and did not rebook as a couple. About three months later, Mike called to schedule an individual session and informed me that he and Alice had separated shortly after the last couple meeting. He told me that, throughout the time they had been meeting with me, both had been having extramarital affairs. He added that he strongly suspected Alice at the time but feared that if he raised the subject, his own infidelity might come to light. He had booked this session to clarify his feelings about his new relationship and to reassure me, because he felt they had not been fair to me by not being honest, when I had clearly been doing my very best to help them.

Far from feeling reassured, Mike's disclosure left me feeling incompetent, that I had let them down. I had not even considered infidelity as a factor in this case. Why had I not picked up the signs that not just one but both partners had already taken this step outside the relationship? Embarrassingly, I could not recall ever asking them if either was having an affair. My faith in my clinical judgment was seriously challenged.

This all took place some years ago. I had just attended a workshop with Scott D. Miller, where I had been introduced to the principles of FIT, and to the Outcome and Session Rating Scales (ORS and SRS), which I had tentatively begun to use with some of my clients, but not Mike and Alice. Had I done so, the Outcome Rating Scale (ORS) would likely have illustrated the lack of progress that both clients were experiencing. Subsequent discussions could have led to the secret that both were hesitant to explore and was stifling progress. I resolved to seek formal feedback from every client, every session, from this point on in my career.

Acceptance of couples counseling as a professional discipline—and, by implication, as an effective intervention—has been hard earned over the 60 to 70 years it has been practiced. In 1963, for instance, Jay Haley claimed that couples therapy had not developed a theoretical basis and models of practice but had borrowed from individual and family therapy. This may have been true then, but in the intervening period many theories and models have been developed specifically for the practice of couples counseling. Two of them, emotion-focused therapy and integrative couples behavior therapy, are recognized as evidence-based practice (Christensen et al., 2004; S. Johnson, Hunsley, Greenberg, & Schindler, 1999).

As a new practitioner in the field, I needed to know that couples counseling, as a discipline, was worthwhile in improving the lives and relationships of people who trusted themselves to it. As I gained in experience, however, I realized that there was a more important question to ask. Was I, as an individual practitioner, being as effective as I possibly could? Mike and Alice had

taught me that, to be able to say yes to this, I needed to get much better at asking for, and listening to, client feedback.

In this chapter, I address the particular opportunities and challenges arising in feedback-informed practice in the context of couples therapy. I illustrate this with examples from my own practice and from the practice of colleagues.

EFFECTIVENESS OF COUPLES THERAPY

When considering the effectiveness of couples therapy, we need to be clear about what we mean when we refer to a successful outcome in this clinical setting. A popular assumption is that a successful outcome means the couple stays together, in which case we would measure our outcomes by the percentage of client couples whose relationship remains intact. The problem with a global measure of this nature is that there are a number of other factors, outside the sphere of influence of the therapist or therapy, that can influence this. In addition, most couples counselors would question the automatic ascription of failure to a situation in which one or both of the partners decide, after much discussion and soul searching, that the best way forward is to separate amicably and respectfully with a focus on the best interests of their children and to make a fresh start in their personal lives.

A further problem here is that couples counseling agencies, such as the organization for which I work, offer and promote the benefits of post-separation or divorce counseling to encourage cooperative parenting and address any potential mental health issues for either or both of the clients. Also, as I explain later, we can only reliably measure the individual's sense of well-being, and, with couples counseling, the improvement or deterioration of individual well-being may or may not correlate with the couple staying together or separating.

For couples desiring to maintain and strengthen their relationship, we can measure the effectiveness of our intervention by using a marital satisfaction survey, which we may give to the couple before the start of therapy to establish the baseline, to be repeated again at the conclusion of therapy to see what difference, if any, has been made. This survey can be conducted again at a 6-month follow-up to see if the improvement has been maintained. There are a number of relationship satisfaction surveys available. The best known would be the Dyadic Adjustment Scale (Spanier, 1976) and the Marital Adjustment Test (Locke & Wallace, 1959). More recently, the precision of these measures and a number of others was critiqued by Funk and Rogge (2007), who produced, out of their research, the Couple Satisfaction Index.

These measures may be useful in assessing the outcome of a course of counseling when applied pre- and posttreatment and at a 6- or 12-month follow-up. They are, however, too long and time-consuming and are not designed to be given every session. Thus, they do not enable us to monitor closely the course of counseling and whether it is on target for success or failure.

This is where feedback-informed treatment (FIT) can be used by the couples counselor as both an evaluative and a clinical tool. To be feedback informed, the counselor will need to use an outcome measure to monitor the progress being made and a process measure to monitor the strength of the therapeutic alliance. Because of its brevity and simplicity, my colleagues and I use the ORS. This scale can be administered at every session, enabling the counselor to monitor progress as treatment is happening. It may not have the exactness of a marital satisfaction measure, but the combination of the individual, interpersonal, and overall lines on the ORS will give a good snapshot of the current level of satisfaction that a client is experiencing in their most important relationship.

Compared with individual counseling, being feedback informed in couples counseling presents new challenges but can also open up new opportunities. It may be argued that the ORS and the alliance measure that is used with it, the Session Rating Scale (SRS), are measures of individual well-being and satisfaction with the service received, when the real client of couples therapy is the relationship. The relationship, however, does not have thoughts and feelings. These belong to the two people who have chosen to be in a relationship with one another, and their individual sense of personal well-being and their perception of the health of their relationship is the surest measure we can have.

CASE EXAMPLE 1: WHEN ONE PARTNER "ISN'T THE CLIENT"

The challenges of couples therapy will be evident to any clinician with experience in this field. Having two clients in the room means that there are two alliances to establish, monitor, and maintain. Also, the question of whether the couple is achieving their goals may be difficult because partners may differ in what they want to achieve. To complicate the situation further, some of the people who attend couples counseling may not see themselves as clients. This may be because a partner has been diagnosed with a mental health disorder, may be affected by a disability, or may have an alcohol or substance abuse problem. Thus, they may see themselves as attending to support the partner and assist the counselor in helping them deal with their individual problem.

Therapists skilled in using formal client feedback will find measures such as the ORS and SRS particularly helpful in these varied scenarios. An ORS graph showing that one partner is improving while the other is deteriorating can alert the therapist to the possibility that they may have underestimated the degree to which the partners' desired outcomes differ. When a couple presents at a first session, and one scores the ORS in the clinical range while the other scores well above the clinical cutoff, it will alert the therapist that one person may not see himself or herself as a client and may not believe that he or she has a problem that needs a counselor's help to resolve. In this situation, therapists will recognize that although the therapy may be focused on helping one partner get better, they need to guard against the danger of the other partner being harmed by the process and feeling worse at the conclusion of therapy than he or she did at the beginning.

Sara and Jim came to couples counseling to look at how Sara could best help Jim in dealing with his depression. Sara had fought her own battle with this problem a few years earlier, was very clear that she had navigated her way through it, and did not at first see the relevance of doing the ORS for herself when her reason for being there was to support Jim. The counselor acknowledged her position and affirmed her achievement in successfully addressing her own mental health challenges, but she suggested that the relationship line on the ORS would be helpful because it could give an idea of how Sara felt Jim's depression was affecting them as a couple. She also pointed out to Sara that listening to Jim talking about his depression could be challenging and could trigger depressive thoughts and feelings in her. If she were to do the ORS each session, we would be alerted if this started to happen.

A number of alternative responses would have been possible here. Some therapists would have seen Sara's insistence that depression was not a problem for her as a denial in need of confrontation. A systemically oriented therapist might have tried to reframe the problem as a depression carried by the couple and alternatively manifesting in one or the other. Both of these approaches could have been valid but would have risked undermining Sara and putting the therapy at risk of premature termination. By accepting Sara and Jim's view of the situation, the counselor set the foundations of a strong alliance, at the same time ensuring that they could monitor the effect of the counseling on both partners.

Sara completed the ORS every session, and her scores remained stable, above the clinical cutoff. In a discussion after the administration of the SRS at a later session, Sara expressed her appreciation that the counselor had accepted her view of herself as a depression survivor rather than a depression sufferer. Jim, whose ORS scores steadily improved during the course of counseling, later said that seeing Sara in this light was freeing for him as he saw her as a strong person with whom he could be open and honest in talking about

his depression. He also felt that the feedback they had given the therapist and the conversations this had initiated had aided them in achieving better and more constructive communication as a couple.

CASE EXAMPLE 2: WHEN COUPLES' PERSPECTIVES OF THEIR RELATIONSHIP DIFFER

Another situation that can challenge the couples counselor is when one partner considers that the couple has a relationship problem, while the other is happy with the way things are and does not perceive a problem or the need for a therapist. The danger here is that the therapist can rush into validating the problem-aware client and inadvertently join with them against the other client, thus, in systemic terms, becoming part of the couple system and severely compromising their ability to affect the situation. As in the previous case, the feedback-informed therapist is likely to be confronted with different treatment recommendations when a client's differing views are reflected on his or her ORS scores. The more problem-aware client is likely to score the measure in the clinical range, communicating to the therapist a desire for change. By contrast, the partner is likely to score well above the clinical cutoff, and the FIT therapist will be aware that this client's sense of well-being could deteriorate as a result of therapy, especially if the therapy pushes the client into areas he or she does not wish to disturb. The FIT therapist is alerted to this dynamic by the first administration of the ORS when there is a significant discrepancy between the scores of the two clients. The therapist's response should be to address this difference openly with the clients, to discuss with them how their differing views can be validated and to make the work helpful for both of them.

Paul and Jeff contacted a counselor when they had been together for about two years. Paul liked to check in with Jeff and talk about their relationship and their goals and dreams for a long-term future together. Jeff was more comfortable living for the moment, acting spontaneously, and not analyzing things too much. In the weeks leading up to the first appointment, Paul had been feeling more and more lonely and distant from Jeff and was beginning to question the viability of their relationship.

At the first session, Paul scored the individual, relationship, and overall lines on the ORS at around 5, whereas Jeff had all four lines at around 8, signifying that he was happy with the way his personal life and his relationship with Paul were going. The therapist resisted the temptation to turn Jeff into a more willing client. Instead, he started by noting and respecting the view of both clients, first tracking carefully with Paul the factors feeding his unhappiness, and his perception of the problem. The therapist then did the

same with Jeff, going over his ORS score, identifying the factors feeding his satisfaction with the situation and exploring with him how he thought this could be maintained or improved still further. The therapist then explored with Jeff the possible reasons for his higher level of satisfaction with the situation. Were there good things about their relationship that Paul was not seeing, or was it that the way they lived their relationship at this time fitted his needs more than it did Paul's?

Couples counselors will recognize the pattern here as the counselor reflects back the views and perceptions of the clients to help them move into a more reflective and empathic attitude toward themselves and their partner. This is not new. It describes the typical process of couples counseling. The use of the ORS as a measure of each partner's level of well-being and the discussion of differing perceptions can introduce this process early without the need to confront either client or to try and push them into a discussion they don't see the point of having. Continued monitoring of ORS scores can be valuable in tracking where each client is as the therapy process unfolds. For Paul and Jeff, it is probable that Jeff's ORS scores will go down. I say this for two reasons. First, changes are likely to sit a bit uncomfortably with him because he was happy with things as they were. Second, analysis of ORS data shows that scores for clients who score above the clinical cutoff at the intake session are likely to go down (Miller, Duncan, Brown, Sorrell, & Chalk, 2006). If Jeff's ORS scores do go down, the crucial question is, by how much? If the graph goes down slightly but remains on track, or is just below the statistically expected path for a successful intervention, the counselor can reasonably surmise that, although perhaps uncomfortable, the process is tolerable for him. If it shows a serious drop, the counselor will be alerted to the probability that this client may drop out of counseling altogether and end up feeling much worse for the experience. Feedback-informed counselors have a crucial advantage here because they will be made aware at the beginning of a session when a client is feeling far worse than he was at the start of counseling. In this case, the counselor will have the opportunity to address changing scores with Jeff and Paul. They can look together at how the counseling approach could be changed to make it more helpful to Jeff while ensuring that it continues to fit Paul's needs.

If this happened, there would be a number of possibilities to explore. Perhaps the therapy process had triggered something painful or uncomfortable for Jeff, or perhaps the alliance between the therapist and Jeff had broken down. Maybe coming to therapy had made it clear to Jeff, Paul, or both that the differences between them were too great and they were heading toward a separation. If the practice of seeking and responding to client feedback has been established and maintained, these possibilities can be quickly assessed and the cause of Jeff's deterioration identified and prevented from bringing the therapy to a premature end.

It is certainly possible that a competent couples counselor might identify this without the use of formal measurement and respond accordingly, but this will not always happen. As stated earlier, we should bear in mind the research showing that counselors are not always good at identifying cases at risk of deterioration and/or dropout (Hannan et al., 2005). We can still exercise our clinical judgment, but we should allow it to be regularly informed by input from the client.

CASE EXAMPLE 3: ESTABLISHING AND MAINTAINING A GOOD ALLIANCE WITH BOTH PARTNERS

Overwhelming evidence suggests that the most important change factor the counselor has power to influence is the therapeutic alliance (Norcross, 2011; Wampold, 2001). Over the past few years, a number of studies in the field of couples counseling have looked at the challenge of maintaining a good alliance with both partners (Friedlander, Escaduro, & Heatherington, 2006; Sprenkle, Davis, & Lebow, 2009; Symonds & Horvath, 2004). There is no doubt that balancing two alliances is more complicated than managing one. The possibility exists that if the counselor connects too well with one partner, say, a wife, this could create a problem for the husband, who may feel that the counselor's understanding and acceptance of his wife's position precludes the counselor from understanding his own.

An alliance measure, such as the SRS, can be invaluable to the couples therapist in keeping this balance. It is particularly important for the couples therapist to make time at the end of a session to discuss the SRS. This is especially important if one partner is scoring it much higher than the other, and the therapist may be facing a split alliance (Sprenkle et al., 2009; Symonds & Horvath, 2004). Discussion of the SRS can enable the therapist to mend the alliance with the unhappy partner and rebalance the therapeutic process for future sessions, and thus ensure that there will be future sessions.

When they came to couples counseling, Julia and David were both in their mid-40s and had been married just over 20 years. David had successfully established his own business to the point that he could delegate more and work fewer hours. He had become aware that he and Julia had drifted apart over the previous 15 years as he worked long hours and she assumed almost sole responsibility for raising the children. David's vision was to take 6 months off so that the two of them could do a leisurely tour of the country and recover the spark in their marriage. Julia, on the other hand, having put her career on hold to raise the family, had undertaken further study during this time and was now keen to get back into the workforce and pursue some professional goals of her own.

At their first session, the counselor connected strongly with David and affirmed the way he had been able to reflect on his marriage, realize how important it was to him, and initiate a plan to renew it. The counselor also acknowledged Julia's vision of the future and her desire to pursue personal goals now that the family situation allowed it. He felt that he had understood and affirmed the importance of the views of both clients. He was surprised, therefore, when he administered the SRS and discovered that Julia's perception was different. The relationship line and the overall line on Julia's SRS were both between five and six out of 10, and this clearly needed to be addressed before the couple left the office. In the ensuing discussion, Julia expressed her view that the counselor seemed to embrace David's dreams and plans with more enthusiasm and understanding than he did hers. The counselor listened to Julia's concerns, acknowledged their validity, expressed regret that he had not fully understood what she had been trying to communicate, and thanked her for pointing this out. He promised to reflect on what she had said and address it again at the next session. Julia accepted this and confirmed that she was happy for them to book another session.

This discussion is unlikely to happen if the counselor is not using a formal alliance measure, such as the SRS. Had it not happened here, there was a strong possibility that Julia would not have wanted to return for another session. Julia's subsequent SRS scores were all higher than the initial one and were maintained above the SRS cutoff, suggesting that the counselor, in demonstrating his willingness to accept feedback and respond positively to it, strengthened the therapeutic alliance over the course of treatment.

CASE EXAMPLE 4: MENDING A BROKEN ALLIANCE

The discussion between counselor and client after administration of the SRS is particularly important in couples therapy. One feature of couples who present for therapy is that their attempts to resolve problems alone tend to stall and end up with people saying things to each other that damage the alliance between them. John Gottmann (1999, 2011) has written extensively about the importance of relationship repair when this happens. If the SRS score suggests there is a breach in the alliance between the counselor and one of the clients, the feedback-informed counselor will address it immediately. This can achieve two things. First, it can ensure that this person stays committed and involved in the counseling process. Second, doing this in the presence of both partners gives the counselor the opportunity to demonstrate how to repair a breakdown in communication with the unhappy client and reestablish a working alliance.

Martin and Pippa came to couples counseling reporting that their communication was breaking down. Pippa had recently completed a course of individual counseling to deal with abandonment issues from her childhood and a consequent difficult relationship with her family. Martin had also experienced difficulty with a critical father. Pippa would frequently offer the opinion that it was this that lay behind his perfectionist drive, which, in turn, caused him to suffer from stress-related problems. Martin's view was that all this was in the past and he had always found it more beneficial to focus on the present and future.

At the end of the second session, Martin marked the goals and topics line and the overall line on the SRS considerably lower than at the first session. When the counselor commented on this, Martin's response was that he could not see the relevance of his early family experience and had been somewhat irritated by the counselor's asking him questions about it. He commented further that this approach had led him to expect that the counselor would be supporting his wife in the lectures she kept giving him on this subject. The counselor acknowledged Martin's view that the past was the past and that looking forward had worked for him. She stated clearly that she would continue to respect this and would not be giving him lectures that might suggest to Martin that she knew better than he did when it came to dealing with his family. At the following session, the counselor pointed out to Martin and Pippa that they had different ways of dealing with personal issues and making sense of their life experience. She suggested that instead of trying to convert the other to his or her way of thinking, it could help them both to look at how the space could be created for each of them to meet their personal life challenges in the way that they chose. She said that if they were successful in doing this, they could experience less tension and enjoy better communication. Finally, the counselor got Martin to agree that if this happened and his level of tension and general unhappiness did not change, then he would be willing to reconsider the impact of his current relationship with his father and mother and how this was affected by past experiences.

As it turned out, Martin, acting independently of the counseling process, addressed some long-standing problems with his parents. Pippa saw this and allowed it to change her view of Martin. She started to trust his judgment, especially in dealing with his own family. Because of this, she no longer felt compelled to convert him to the self-growth path that was working for her. Thereafter, tracking of ORS feedback and discussion of it with Martin and Pippa reflected the improvement that both were experiencing around the issues that had brought them to counseling. At a later session, Pippa referred back to the discussion at the second session, saying that she had feared that the counselor was caving in to Martin, colluding with his denial, and undermining her efforts to help him and their relationship. Looking back, she now

realized that the counselor had shown her a more constructive and effective way of dealing with disagreements with Martin and repairing the damage if those disagreements threatened to damage the relationship.

CASE EXAMPLE 5: MANAGING THE INITIAL SESSION

Introducing the outcome and process measures we are using at our first meeting with the client(s) is of central importance to the FIT counselor. Finding the time to do this can be difficult, however, because there are other important things that must be addressed at the initial session. In most parts of the world, there are legal and ethical requirements with which practitioners must comply, such as Standard 4 of the American Psychological Association's (2017) *Ethical Principles of Psychologists and Code of Conduct* and Standard A.5 of the Australian Psychological Society's (2007) *Code of Ethics*. This means, for example, that we have to spend time explaining to clients the rules on confidentiality that govern us, making sure they are fully aware of any circumstances in which their confidentiality could be breached or their counselor's notes subpoenaed by a court. As we move into asking the couple about the problems that have brought them to us, we have to be mindful of safety concerns and spend time carefully assessing for domestic violence, suicidality, risk to children, or abuse of elders.

Most couples counselors will inquire about any other counseling that either partner has undertaken currently or in the past. They will also want to be aware of any medical conditions affecting either client, any prescribed medication they are taking, and any recreational substances they are using.

All this can make the traditional 50- or 60-minute session go very quickly. If we are going to spend the time necessary to introduce clients to the process and outcome measures, this can add extra time pressure. First sessions often extend to 70 or 75 minutes, and scheduling 90 minutes might be more realistic. My experience, over years of using written feedback measures and discussing feedback with clients, points to the importance of introducing clients to this process and explaining it carefully at the first meeting. First, I need to be sure they are clear about the measures and what they are being asked to consider when they complete them at the beginning and end of each session. Second, and probably more important, I need to take some time assuring them that I will value and respond to their feedback. I have found that establishing this foundation has led to more accurate and honest feedback, which in turn has led to better outcomes and fewer premature terminations.

If we are using the ORS, we will want to be sure that fluctuations in clients' scores reflect their perception of progress in addressing the problems that brought them to therapy. In this context, the second line on the ORS, on

family and close relationships, assumes particular importance for the couples counselor. We need to be careful, however, in assuming that the clients are telling us about their relationship with each other in their responses to this.

Tom and Amelia attended counseling largely at Amelia's instigation, and it quickly became apparent to the counselor that she was seriously considering leaving the marriage. Thus, the counselor was somewhat puzzled that Amelia marked the family and close relationships line at between eight and nine out of 10. When the counselor raised this with Amelia, she stated that she had excellent relationships with her adult children and was receiving a lot of support from them. She felt that these relationships were vital in sustaining her through the difficulties she was experiencing in her marriage. On hearing this, the counselor realized that they had not been adequately clear when introducing the measures. He asked Amelia to fill out the ORS again, and mark this line according to how she felt the relationship between her and Tom was going because it was this relationship that had led them to seek counseling. This time, the score went down to between 2 and 3 out of 10. This is important because if counseling is to be feedback informed, then the issues that are causing distress and brought clients to counseling need to be reflected in the outcome data.

CASE EXAMPLE 6: ADMINISTERING THE SRS

There can also be a pitfall for the couples counselor when administering the SRS. The first question on the SRS under the heading "Relationship" asks clients whether they felt heard, understood, and respected. It is important to stress that this refers to the therapeutic alliance. What is being asked here is whether each of the clients felt heard, understood, and respected by the counselor rather than by each other. This can be a bit confusing for clients because the session they have just participated in might well have focused on the degree to which they felt heard, understood, and respected by each other, and this may still be dominating their thinking. From a strategic point of view, it is important that the counselor makes this very clear before asking the clients to complete the SRS.

Tim and Sally came to the end of the first session, and the counselor gave them the SRS to complete. The counselor was rather disconcerted when Sally's response made it clear that she had not felt heard, understood, and respected. When he inquired about this, Sally said that she had responded with Tim in mind rather than the counselor. She then accepted the invitation to do the measure again with the counselor rather than her partner in mind, and this time, it showed a high degree of satisfaction in all domains. The problem was exacerbated, however, when she added that at least some

men were able to respect and understand women, which, she added, showed how incompetent Tim was at doing this. Although the counselor may have experienced this as a compliment, it was not the ideal note on which to finish a counseling session, especially a first session, because it led to Sally expressing a criticism of Tim that he could not respond to, and the counselor could not address, in the time available. This could have been avoided had the counselor taken the time to ensure that Tim and Sally were clear about the questions that were being asked.

Discussion after the administration of the SRS can be highly informative for the counselor and have a significant effect on the eventual outcome of therapy. This can be one of the most challenging parts of being feedback informed. If, for example, a highly conflicted couple have different responses to the postsession discussion, this can lead to them blaming and criticizing each other—effectively getting back into the session they have just completed rather than standing outside the process, reviewing it, and allowing the counselor to assume some accountability for what has or has not happened. We need to tread a fine line here in being responsive to the feedback of each client. Discussion of the second (goals and topics) line of the SRS can easily push the couple back into conflict because it is likely that they will disagree about what needs to be addressed to make the situation better. Trying to redirect the therapy toward areas that one partner feels are central to their problem may steer it away from issues that are fundamental to the other. Any given approach may be a good fit for one partner but not quite right for the other. One may want to stay in the present, while the other believes strongly in the influence of the past. One may operate more comfortably from a cognitive standpoint and be uncomfortable with emotion, while the other may be more at ease with emotional expression.

It is important that in these postsession discussions, the counselor is able to keep everyone focused on the bigger picture and the overall goal(s) that brought them to couples counseling in the first place. There will certainly be some situations in which the desired outcomes of the partners will be so different that at least one will be disappointed. If we use the Outcome Rating Scale, we need to remember that it is a measure of well-being, and the task of the couples counselor in this context is to support the client who is not happy with the outcome and whose perception of well-being has gone down. If this happens, we must enable them to self-soothe and make any necessary readjustments in their lives to deal with the situation. The extent to which they are successful in doing this should be reflected in the client's ongoing ORS scores. As practitioners of couples counseling will be aware, sometimes our job is to assist clients who did not obtain their desired outcome in couples therapy to deal with negative emotions and recover their sense of well-being. This situation can arise for the couples counselor when counseling has been

instrumental in a relationship ending, especially if this has been the unilateral decision of one person. The partner who did not want this result is likely to experience a decline in psychological well-being. The counselor will need to review this client's feedback and have an open discussion about his or her experience of counseling and current psychological needs. In doing so, decisions can be made about the additional counseling and, if desired and needed by the client, whether the same counselor is the best person to provide it.

The experience of the client in couples therapy is different from that of a client in individual therapy. The client in the individual setting can largely control the personal information they bring to the counseling and when they bring it. The presence of their partner in a couples counseling session significantly reduces this control.

In one-on-one counseling, clients can feel comfort in the knowledge that if their counselor is competent and professional, they will be responded to with understanding and empathy. If their partner is in the room with them, they may not always feel confident about this. It is possible that their partner will respond to their contributions to the conversation with criticism and opposition, rather than empathy and understanding. Their partner is also likely to raise confrontational and unwelcome things that they might not want to talk about, but they will be expected to listen and respond. With regard to the alliance, couples counselors can find themselves in a challenging position. If they lean too far toward supporting one client's right to say what she feels or raise any subject he thinks is relevant, the other client can feel attacked, exposed, and outnumbered. If, on the other hand, the counselor tries to tone down or reframe the confronting expressions of one client, then that person can feel gagged and inhibited. This, again, is a situation that will be well known to practitioners of couples counseling, who will probably say that this dilemma will become part of the agenda of the counseling. That discussion can be difficult to initiate, however, because it may be hard for the client to express feelings of being overwhelmed or silenced. An alliance measure, such as the SRS, and the discussion after its administration can be the opportunity to do this. As always, this will depend on the degree to which the counselor has managed to persuade the clients that he or she values and will respect their feedback at all times.

CASE EXAMPLE 7: DOMESTIC VIOLENCE

In the past couple of decades, dealing with domestic and family violence has become increasingly important to the practice of couples counseling. There is now a strong awareness among practitioners of couples counseling that they must ensure that it is safe for both partners to express themselves freely without the threat of violence or intimidation. Regulatory and

advisory bodies in the domestic violence field normally do not recommend couples counseling when violence is present in the relationship. These include the U.S. National Domestic Violence Hotline (National Domestic Violence Hotline, 2014) and the *Best Practice Model* by the Government of Western Australia, Department for Child Protection, Family and Domestic Violence Unit (2000, Essential Principle 7.5, p. 25). Readers are encouraged to read guidelines relevant to the jurisdiction in which they are practicing.

In his analysis of the typology of domestic violence, Michael P. Johnson (2008) divided intimate partner violence into four subtypes. First, there is intimate terrorism, where one partner is violent and controlling, and the other is neither. Second is violent resistance, where one partner is violent and controlling, and the other resists with violence but is not controlling. Third, is situational violence, where one or both partners may be violent, but neither is controlling. Finally, Johnson says, there is mutual violent resistance, where both partners are violent and controlling.

With frameworks such as this in mind, feedback-informed therapists will be as wary with classifications as they are with any other type of client labeling. They will remind themselves that every client and every client couple is unique and that every situation needs to be addressed accordingly, with the client's expressed views being given precedence.

The normal practice when violence has been disclosed is to work with each partner individually until such time as the counselor is confident that the situation is safe enough to offer couples counseling with both partners in the room. In the case of extreme and entrenched controlling violence, that may take a long time or may not happen in this round of treatment, so the counselor's main role may be to make successful referrals to a behavior change program for the perpetrator and a support program for the victim. To do this, it is important that the counselor has, through the use of process and outcome measurement, established a culture of feedback with both clients and is able to consult in good faith with them in deciding the best way forward individually and as a couple.

The measures can be just as important in situations when the counselor is working with each client individually toward a point where all three are confident that couples counseling can proceed safely. If the violence has been more of the controlling type, the victim's ORS scores are likely to rise if he or she feels safer and less controlled. The perpetrator who is committed to behavior change is also likely to show improvement if he or she feels more confident about being able to maintain change in actions and reactions. The discussions that follow administration of both the ORS and the SRS are vital to ensure that such decisions are made jointly and not left up to the counselor's clinical judgment alone.

It can be argued that if both partners are adamant that they want couples counseling to go ahead, but the counselor is not convinced that it is safe

enough to be appropriate, then the counselor faces a difficult ethical dilemma. It is important to note that giving preeminence to the client's voice does not mean always accepting the client's direction. In discussions evoked by the ORS and SRS, the counselor listens to the clients' views and participates in the discussion by responding and, if appropriate, voicing an alternative view. If the culture of feedback has been established and maintained, these discussions can be more honest and open. A further point here concerns accountability. Practitioners, regulatory bodies, funders, and researchers in the domestic violence field stress the importance of perpetrator accountability (Government of Western Australia, 2000; Illinois Coalition Against Domestic Violence, 2005; Male Family Violence Prevention Association, 2015). By constantly eliciting and responding constructively to their feedback, the counselor is modeling to both clients what it means to be accountable for their words and actions.

Ernie and Veronica were a highly distressed couple. Both were survivors of childhood abuse, found it enormously difficult to trust another human being, and would at times have extreme outbursts of rage. Ernie had hit Veronica on more than one occasion. He said sometimes he hit her in self-defense, but on other occasions he was the primary aggressor. Veronica had hit, kicked, and thrown hard objects at Ernie. In addition, both Ernie and Veronica tended to self-medicate with alcohol, which at times made the situation extremely dangerous. The level of conflict had escalated to the extent that Veronica's contact with her children from a previous relationship had been suspended. To add to the pressure, both were also dealing with individual issues: Veronica with her critical parents who now had day-to-day care of her children, and Ernie with the recent death of his mother, with whom he had experienced a difficult relationship.

Veronica and Ernie were in a quandary about their relationship. They maintained that for periods of time, it was warm and loving but acknowledged that at other times, it was highly destructive. They considered that the best immediate way forward was to live separately for a time and give each other the space to focus on the troubling personal issues that were affecting the way they thought and acted, and to learn alternative ways of dealing with differences. This plan could not, for financial reasons, be put into practice for another 6 weeks, so they needed to put short-term strategies in place during this time to ensure mutual safety. At this time, Ernie had just started participating in a men's behavior change group, and Veronica was waiting for the start of a women's support group. The counselor, having referred them to these programs, assumed that couples counseling would be put on hold for the time being. The couple disagreed, saying they needed ongoing couples counseling, especially through the time that they would still be living together.

The counselor was doubtful about this and concerned that couples counseling at this time could evoke feelings and emotions that both would find

difficult to contain. He was also concerned that Ernie, although considerably less intimidating, was still occasionally exhibiting controlling behavior toward Veronica, which could make it difficult and potentially dangerous for her to express herself openly in a couples counseling session. The therapist met separately with Ernie and Veronica, paying careful attention to their ORS and SRS scores. The ORS was improving for both at this point. They were both of the opinion that this was because they now had a plan to move forward and help in sticking to the plan. Their SRS scores were mostly high, and discussion of them confirmed that they had trust and confidence in the counselor. Veronica, however, marked the overall line on the SRS at 7 out of 10, having marked all the others at 10, suggesting that there was something missing from the session. In discussing this, she asserted that it was Ernie who was missing. She acknowledged that they were not ready to explore the complex and highly emotive issues that characterized their relationship but that during the short time they were going to be living together, she wanted to arrange a couples session every 2 weeks to focus on day-to-day safety until they could put their longer term plan into action.

The counselor checked this out with Ernie and was satisfied that this would be helpful and not expose Veronica to increased risk. On this basis, three sessions of couples counseling took place before being put on hold while they each pursued their individual paths. With the couple's permission, the counselor blocked discussions that would have led into deeper, more potentially volatile areas and focused only on their day-to-day lives and their safety. As an additional safety measure, the counselor made extra time available to discuss the SRS score separately with each person to ensure that there was nothing being felt or thought but not said in the session that could be a trigger for a dangerous situation outside the counseling room.

SUMMARY

FIT can be immensely valuable in couples counseling and can certainly improve therapeutic effectiveness if the counselor is comfortable and practiced at receiving and responding to client feedback. The case examples in this chapter do not necessarily fit specific patterns, although experienced couples counselors might have recognized familiar scenarios. They should not be taken as literal instructions on how to work with outcome and alliance measures with couples but rather as illustrations of how using them respectfully and sensitively can contribute to successful outcomes. In couples counseling, as in individual and family counseling, it is the attitude with which counselors approach their clients and the extent to which they invite, hear, understand, and respond to their feedback that is the vital factor.

This is not the development of another model of couples therapy. There are plenty of helpful models to guide couples counselors, and FIT can be woven into the practice of any therapeutic approach or model. Ideally, counselors are able to practice in more than one modality. For couples counseling, this sometimes means following the process according to one model with one partner and using techniques of a different model with the other. For the feedback-informed couples counselor, the choice of which model or approach to use emerges from careful consultation with the clients. The formal outcome and process measures provide the ideal opportunity for consultation to occur.

Couples counseling offers unique challenges. In recent years, the field has become more professional with better training available to newer counselors than it was for earlier pioneers in the field. Couples counseling is no longer the poor relation of individual and family counseling, borrowing its models and techniques from them; it is now a professional discipline in its own right, with practitioners in the field doing their own research and developing their own practices. It will be interesting to see whether the maturation of couples counseling is reflected in improved outcomes for partners seeking help. Although common sense would tell us that it should, we need to bear in mind that outcome research does not suggest that higher academic qualifications necessarily lead to greater effectiveness. Furthermore, there is little evidence that the choice of any particular model affects outcome rates (Wampold, 2001).

The factor most connected to outcome is the therapeutic alliance (Norcross, 2011; Wampold, 2001). In couples counseling, as in all other therapeutic settings, it is critical. For outcomes to improve, couples counselors must develop the skill to form successful alliances with a wide range of clients. The availability of honest feedback from the client(s) enhances this process (Anker, Duncan, & Sparks, 2009; Lambert et al., 2003; Reese, Toland, Slone, & Norsworthy, 2010).

Couples counselors are passionate in our desire to be as helpful as possible to as many people as possible. Although a successful outcome is important to us, we should always remember that it is even more important to our clients. For couples in counseling, their family, their primary relationship, and even their lives could be in the balance. It is essential for the counselor to hear and respond to their voices in planning and delivering their treatment.

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11

FEEDBACK-INFORMED TREATMENT IN AN ADDICTION TREATMENT AGENCY

JULIE SEITZ AND DAVID MEE-LEE

HOW WE GOT HERE

Founded in 1961 as the Center for Problem Drinking, the Center for Alcohol and Drug Treatment (CADT) in Duluth, Minnesota, has always been progressive, pragmatic, and innovative. As a treatment provider where the Minnesota model reigned, introducing a client-centered and feedback-driven approach came with hesitation and doubt. The Minnesota model blended professionals and nonprofessionals in recovery based on the Twelve Steps of Alcoholics Anonymous (AA). It was a deeply embedded treatment model in centers—not only in Minnesota but nationwide. It was modeled primarily on the fixed-length inpatient rehabilitation programs initially established by the Hazelden Foundation and the Johnson Institute (Sullivan & Fleming, 1997, p. 55).

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In 1999, the shift from standard abstinence-based treatment to a multidimensional, collaborative care model began at CADT with the introduction of a transtheoretical understanding of stages of change (Prochaska, DiClemente, & Norcross, 1992), the American Society of Addiction Medicine (ASAM; 1996) Patient Placement Criteria, and what was then client-directed, outcome-informed treatment using the Outcome Rating Scale (ORS) and Session Rating Scale (SRS) tools (Duncan et al., 2003; Duncan, Miller, & Sparks, 2004; Miller, Duncan, Brown, Sparks, & Claud, 2003). We knew treatment worked for some of the people some of the time. The Twelve Step philosophy worked for some of the clients, but it did not meet the clinical needs of others. Cognitive behavior therapies worked for some but were less helpful with others.

This shift in our treatment approach, welcomed by clients who received direct services, required definition for referring agencies. CADT is one of the primary community-based substance use disorder treatment centers in Duluth, collaborating with mental health, criminal justice, and medical agencies in the community. Data indicate that the percentage of clients mandated to seek our services by probation or parole averages 30% (Minnesota Department of Human Services, 2014). Counselors began using the data provided by the outcome tools to aid in their treatment planning and recommendations, including to the community referring agencies. When referencing objective data, we were able to articulate the client's preferences, needs and plan in a meaningful way. This is discussed further later in the chapter (see Engaging Staff, Referral Sources, and the Community).

Our statewide normative data indicated that our dropout or noncompletion rates were higher than the state averages. This raised a fundamental question: How do we identify completion? Was it by the number of hours clients completed? Was it based on the amount of time they remained abstinent? Was it when they completed a specific step in the Twelve Steps of AA? Our completion questions began to change, inspired by a series of workshops with Scott D. Miller, when he introduced what is now known as feedback-informed treatment (FIT; Miller & Bargmann, 2011). We began asking questions such as the following: What did a given client identify as goals? How would the client know they had met their goals? What if their goals did not align with the clinical expectations? How would we align with our clients to optimize the effectiveness of treatment, increase completion rates, and comply with the state and regulatory components?

Before we began FIT, staff meetings consisted of counselors describing client successes with pride in the counselor's work, while client struggles were blamed on the client. This is not to diminish the hard and dedicated work of the counselors but to emphasize the belief that success rested within the therapist and failure with client. Treatment planning was program-driven. If

the client did not engage, relapsed, or was unable to follow the rules, it often resulted in discharge.

I (JS) remember one of my first outpatient group sessions as a counselor. A man with a history of alcohol abuse reported in group therapy that he had a lapse to alcohol use over the weekend. At the time, I had a senior consulting counselor who stated that the client needed to be discharged because he did not remain abstinent despite programming. I remember thinking, If he is struggling with his alcohol use, do we not have the perfect place to come and talk about that? Furthermore, if he was able to stop using alcohol with ease, he would not be here. The client wanted to continue in treatment, yet program protocol and counselor beliefs dictated that he would be discharged and referred to a more intensive level of care. He did not have a voice in his treatment or change in his plan. We learned that when given a choice, clients often choose the appropriate level of care. When given a voice, clients become the change agent in their own treatment plan.

WHERE WE ARE NOW

Implemented throughout our center, the ORS, SRS, and Group SRS (GSRS; Quirk, Miller, Duncan, & Owen, 2013) are used in assessment as well as individual and group substance use disorder treatment sessions. They are blended with the existing treatment planning, lessons, therapy, and education sessions. As primary tools for engagement, they aid in treatment planning, group discussions, and coordination of services. In individual therapy, the ORS is administered at the beginning of sessions, and sessions end with the administration of the SRS. Group therapy sessions vary from two to five times per week, depending on the type and intensity of the group sessions. Therefore, the ORS is given the first day of the week at the beginning of the session, and the GSRS is given on the last day of group therapy for the week, nearing the end of a 3-hour session. As much time as needed is allotted for the ORS process because it relates to the significant life areas of the client, aiding in determining treatment planning, along with the intensity and length of services. For new clients, clinicians make sure that the purpose of seeking feedback and instructions for marking the tools are explained at each point of service delivery.

One lesson learned along the way is that clinicians can quickly become familiar with the tools, leading to complacency about providing optimal instruction to new clients. Without an explanation at the point of service, clients have often become confused and unsure how to mark the tool, leading them to develop their own inaccurate explanations and undermining

attempts to build a meaningful culture of feedback. To resolve this, we now have staff use a script to explain the purpose and provide direction to clients on how to use tools to assist in building the culture of feedback.

Approximately 30 minutes are allotted for the GSRS process in group therapy sessions on the last day of service for the week. As mentioned, we have found that using scripts helps define the purpose of the GSRS and emphasizes the process of creating a culture of feedback. Clients complete the GSRS and share their scores with the group. They are offered an opportunity to share any concerns or feedback. Clients who score below the clinical cutoff and do not wish to share in a group setting are given the opportunity to meet individually with their counselor.

The counselor makes every effort to address potential problems with the alliance and group process when indicated by GSRS scores and client feedback. Clients share what they liked about the session and what they believe would make the session a better fit. Examples of feedback from GSRS scores below the clinical cutoff vary but often involve problems with peers and content. This feedback is used to adjust and make changes to the sessions. Clients quickly learn that feedback is embedded in the treatment culture at CADT.

ENGAGING STAFF, REFERRAL SOURCES, AND THE COMMUNITY

Our center was one of the first agencies to implement FIT. Not all clinical staff working at the agency believed in FIT. Counseling staff members found it difficult to change their existing structures and processes and did not trust that the feedback tools would provide valuable or useful information. Many clinicians were initially skeptical, but they eventually learned to trust the data. Building opportunities for staff members to question their experiences with the data was critical in weekly clinical meetings with supervisors.

Our primary obstacle seemed to be what we later identified as *storytelling*. Counselors trained to understand the fundamentals of how to implement, use, and interpret the ORS and SRS would often fail to listen to the client and in turn make up their own story of why the client scored as he or she did, or they would even challenge the client's score. Clinical staff meetings often consisted of counselors talking about "problem" clients, using language such as *resistant*, *in denial*, *uncooperative*, and *manipulative*. A focus of clinical supervision was to help the clinicians understand that the client's perception of the problem and the therapeutic alliance is critical to meaningful and lasting change. Clinicians had to learn that it is possible for a client to be incarcerated and score a 36 out of a possible 40 on the ORS (indicating they were not experiencing much distress). They came to realize that despite our personal beliefs that incarceration

and all it entails may sound terrible, the client might not perceive his or her situation as untenable, as we might.

For clients in the criminal justice system—whether they are incarcerated or are required to attend treatment—scores above the clinical cutoff offer an opportunity to engage community agents and collateral sources. When a client shares with us that she or he does not perceive distress, we explore collateral ORS scores. For example, using a client's probation officer (with appropriate release of information in place), we are able to not only gain an alternative perception as to the concerns but also to use this as an opportunity to share our philosophy and clinical practice using the ORS and SRS/GSRS tools with the referring agencies. Often the collateral source will provide additional insight for the client. Clinical updates provided to referring parties include the client's score, collateral scores, and clinical interpretation. It is often an opportunity to advocate for the client's strengths and progress. The data also aid in the determination of discharge or transfer to a different level of care.

We also engaged the community with FIT through the local social service conference. We provided several workshops using the research, data, and practice of FIT. Sharing with other social workers, community mental health providers, corrections agents, and treatment providers created an opportunity to involve the community in the shift in clinical practice at CADT. Initial comments from community agencies and referral sources included: "You are just giving them what they want. They [clients] do not know what they want. They will just tell you what you want to hear." This emphasized the belief that clients were not their own change agent. It was important to make clear that FIT was not like a fast-food restaurant drive-through window where the cashier asks, "Do you want fries with that?" We had to explain that understanding the client's perceptions of problems and the alliance does not mean that clients are not challenged to explore the discrepancies between their behavior and their goals. FIT aligns with the goals and practices of motivational interviewing, a "collaborative conversation style for strengthening a person's own motivation and commitment to change" and "eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion" (Miller & Rollnick, 2013, pp. 12, 29); ASAM Criteria (Mee-Lee, Shulman, Fishman, Gastfriend, & Miller, 2013), individualized treatment, cognitive behavior therapies, and other models. It encourages the perspective that giving the client a voice in his or her change plan results in better outcomes.

External stakeholders include family members, social workers, physicians, the criminal justice system, and others who may refer clients to the agency. Efforts to engage family and others at the onset of a treatment episode include obtaining the appropriate releases as well as discussing our clinical model and a culture of feedback. Although some family members can be difficult to engage for a multitude of reasons, efforts are nonetheless made. When

a family member does participate, with the client's permission, we describe our practice and tools. We use the same approach as with clients to engage collateral raters and stakeholders.

Collateral rating scores are sought when working with mandated clients when their ORS scores are at or above the clinical cutoff. Having the two scores, often differing, provides an opportunity to identify discrepancies with the client between how they view their situation versus others' perspectives, such as family or probation officers. The client may articulate that he or she does not experience distress regarding the areas measured. However, when the counselor is able to explore why a collateral rater may have scored differently, it opens a dialogue. This dialogue becomes a catalyst for enhancing change talk in the client (Miller & Rollnick, 2013, p. 159).

CREATING A CULTURE OF FEEDBACK

Fundamental to getting started with FIT is engendering buy-in from management, clinical supervisors, therapists, and line staff. At CADT, we instituted supervisory practices, including weekly staff meetings and individual supervision sessions, where it is a priority that the clinical focus uses the data provided by the ORS and SRS tools. We learned over the years of trial and transition not to assume that other provider staff can or will train the new staff. This was an assumption that came with negative consequences, including decrease in effect sizes and increase in client dropout rates.

As the center grew, so did our training needs. Hiring counselors from other agencies, backgrounds, or life and career histories often began a lot like a first session with a client. We needed to establish swiftly and certainly that counselors not only understood FIT but were also able to put it into practice. For us, this meant starting an interview much like we would a therapy session:

> We do things very differently here. We believe feedback from the client is fundamental to establishing good outcomes. You will find we are exactly what we say we are when we say we are client and outcome driven, rather than program driven. To achieve our client- and outcome-driven goals, we use tools called the Outcome Rating Scale and the Session Rating Scales.

Clinical supervisors must not only have fundamental knowledge of FIT, they must be able to translate the data into clinical supervision sessions. If supervision does not use the data to guide clinical supervision sessions, fidelity to the tools and clinical practice will falter. A recent and ongoing example involves differences in clinical opinion about the level of care needed for a client. We had a woman drop out of one of the residential treatment programs. She immediately sought reassessment and placement in an outpatient

level of care. Counselors had wanted the client to stay in residential services. When supervisors requested the clinical reasons for the recommendation of the more intensive residential level of care, they received only anecdotal information and historical behaviors exhibited by the client. A review of the outcome data, however, showed that the client had been consistently scoring in the successful zone and began to indicate problems with the therapeutic alliance through lower GSRS scores.

With the objective data and ASAM placement criteria (Mee-Lee, Shulman, Fishman, Gastfriend, & Miller, 2013), we are able to make informed clinical decisions. Clinical supervisors have access to a data management system at a level that allows them to review the clinicians' individual effect sizes as well as agency averages and norms. These data are not used for performance or disciplinary purposes but to identify clients at risk for dropout to be discussed in clinical supervision sessions. The data allow for the supervisor to discuss client progress, lack of progress, or alliance issues in an objective manner. Counselors often describe their supervision sessions as helpful, aiding in treatment planning and in redirecting the focus back to the client's stated treatment goals.

From the start of implementing a data management system to gather ORS and SRS data, we have been able to use the data in clinical supervision sessions, both individually and in staff meetings and trainings. The supervisor reviews the most current data of both the therapist and the agency before the weekly staff meeting and has access to the data during the meeting. We are able to identify clients who are at risk for dropout or stuck, and this helps in continued treatment planning. We learned it was important to discuss three client trends: "Red clients" refer to the data management systems we have used that alert us when clients are at risk for dropping out or disengaging. Second, the data management system tells the clinician who is in the successful zone or on track. Finally, it identifies those whose trajectory may be uncertain because there has been less change than expected. Discussions happen in both group meeting sessions and individual supervision sessions.

SUCCESSES

Thinking back to where we were with our attitudes and practices at CADT in the 1990s and the journey and process of change, it started when we were required to sit through training with Scott D. Miller, who captured our attention immediately. He began sharing the research findings of the effectiveness of the varied therapies, pointing out that no one theory or model is best. He introduced the concept of *listening to your clients* to a room full of skeptical addiction treatment counselors: "Our clients lie." "Our clients

manipulate." "They only want to keep using." These attitudes highlighted that the counselors saw themselves as the experts regarding their clients' lives and that clients did not deserve a voice in their change plan. They further exemplified the perspective of the treatment field in general: "We know best; our clients are broken."

What captured CADT clinical staff was how Miller shared his own struggles and videos. The particular story that resonated with our clinicians back then was a case he was called to consult on. It was a woman who had been a firefighter and suffered a brain injury. She had been in therapy for quite some time with less-than-predicted success using the outcome measures. The client shared repeatedly with her therapist that she wanted to get back to firefighting, and the therapist would reply that this was not likely an option given her injury. Miller came in to consult and was able to identify her goal, support it, and help her make a change plan. Where previous therapists were focused on trying to redirect her career goals and encourage her to look for work outside of the fire hall, Miller explored other capacities in which she could return to the fire hall. This allowed the client to share insight into her abilities and identify potential options for future employment. Ultimately, the woman went back to the fire hall to work, in a new position that was both meaningful and purposeful to her. This story demonstrates how someone listening changed a life forever, not for what was wrong with the client but for what was right with her.

To illustrate how we have evolved at our agency, we had a young woman in the extended-care residential program with a history of amphetamine use disorder. She had been convicted for possession and a felony in Minnesota, and she was on probation. Before her arrest, she had been in college and employed. During her 3 months in treatment, she had seen a mental health therapist and was diagnosed with bipolar disorder. Her treatment plan included medications and therapy. Throughout the course of her treatment, her ORS scores remained in the successful zone, while her SRS and GSRS scores were indicative of problems with the therapeutic alliance.

The client was reporting that she believed things were going well in her life. She identified one goal of wanting to become a social worker and go into substance use disorder counseling. At the time, she was told that she would never be able to pursue the career because of her felony. Enter discussion on the alliance and a fresh perspective. During clinical supervision sessions, it was suggested that the counselors encourage the client to explore her career goals, mainly to determine what she would need to do. Allowing her the autonomy to explore this career path strengthened the therapeutic alliance and increased her outcome measures. After treatment, she was able to return to school. Fast-forward 4 years, and she is a graduate of the social work program and a professional in the community, living a life

of recovery and wellness. This example illustrates how we are able to integrate a feedback-directed approach when working with clients in any of our programs—building on their strengths and what they already have versus a focus on problems, barriers, and disorders.

Feedback from clients confirms that our approach is different from anything else they may have experienced in previous treatment programs. We have a formalized, long-established satisfaction survey. A CADT outpatient program client in 2015 offered one comment that typifies the spirit and content of feedback we now receive: "I feel like part of the solution now, not the main part of the problem." Traditional addiction treatment has focused on problems. State regulations and stakeholders indicate we need to identify problems with our clients to treat them. At CADT, we are a long way from those initial attitudes and practices of the 1990s. Now we focus on what is right with our clients, what they already have, rather than what is wrong with them, while maintaining fidelity to both regulatory practices and our core care model.

HAVE WE BECOME MORE EFFECTIVE?

Implementing an outcome-driven, feedback-informed process and maintaining fidelity to state and federal regulations is not only possible but encouraged. At CADT, we have been able to use the data and demonstrate with both state regulatory and third-party payers that FIT planning results in improved outcomes, decreased dropout rates, and cost savings.

During site visits with managed care auditors, state regulators, and external stakeholders, an introduction to our model and tools is included. Not only are they interested in the regulatory process, they are often impressed that we have a formalized, up-to-date feedback system that streamlines and improves outcomes for both clients and interested parties. Stakeholders have been affected and now ask for the data. We include current ORS and SRS scores with continued authorization for services with managed care companies interested in measurable outcomes.

Addiction treatment is traditionally a field where outcomes have not been well measured. Recorded outcomes have not consistently recognized addiction as an ongoing disease process. McLellan, McKay, Forman, Cacciola, and Kemp (2005) argued for a shift away from conventional methods of retrospective follow-up and posttreatment outcome evaluation to what they called *concurrent recovery monitoring*. In keeping with that shift, incorporating the ORS and SRS has provided us with a validated and reliable tool to aid in treatment planning and outcomes evaluation in real time. Using the feedback, we are able to advocate effectively with stakeholders for a client's

treatment plan. It was important for external agencies to understand this process and that a client-driven model of care is more effective, improves outcomes, and is more likely to produce lasting results; with this understanding, we were able to obtain buy-in from these external stakeholders. It also helps referral sources understand that program deadlines and imposed compliance do not equal real change.

The addiction treatment field has traditionally conformed to a fixed, explicit length of stay in treatment, with schedules and language designed for the convenience of the program. For example, it is common to see 28-day residential programs, 90-day extended care, 7-day detoxification, and 48-hour outpatient programming. Although our center has not entirely divorced itself from these structures (we are still required to request authorization for billable time from payers), we strive to recognize when a client appears to have reached maximum therapeutic benefit, is at risk for dropout, or is likely to get worse with treatment. Additionally, we have helped probation and parole officers, social workers, and other external stakeholders move away from a fixed mindset regarding length of stay. We now have a community culture that does not expect a certain amount of time from CADT. Rather, they have come to expect transparency and positive outcomes.

A FIT culture requires ongoing maintenance because it can be easy to fall back into time- and program-driven treatment planning. Recently, I (JS) was consulted regarding a client in a medium-intensity program where the counselor was discussing the client's treatment plan in terms of length of stay rather than trajectory and motivation for change. It is a simple redirect that includes a reminder that we are not a time-driven program and asking where the client is scoring within the trajectory (successful, unsuccessful, or unknown). Upon redirect, I learned that the client was not scoring within the predicted trajectory and that the alliance scores indicated problems. The client's treatment plan was focused on program-driven tasks, rather than the client's own goals. A discussion with the client to review the scoring trajectory and adjust the treatment plan and tasks resulted in improved outcome and alliance data. Additionally, the counselor was able to use the data to help determine when this level of treatment could be completed, rather than focusing on how many days the client had been in the program.

IMPLEMENTING AN OUTCOME MANAGEMENT SYSTEM: FIT-OUTCOMES

At initial implementation, CADT relied on the client's paper-and-pen graphs to alert us to failing cases. Used in group and individual sessions, the scores would inform us of client progress or lack thereof. The counselor and

clinical team would determine whether the client was within the predicted trajectory of change. Although this was a much more informed way of practice and aided in the clinical buy-in, it was difficult to track the aggregated data used in measuring the effect sizes. Counselors did not track the data and therefore did not have a way to compare their own effectiveness with others in the agency.

We began with a computerized, software system called ASIST (a precursor to web-based systems in operation today) for which CADT was chosen as a beta testing site (Miller, Duncan, Sorrell, & Brown, 2005). Using the system to determine the effectiveness of the counselors individually and overall as an agency, we began with a clinical assistant assigned to data entry. The ASIST program was on one workstation. Counselors would send in the client's weekly graph, the data would be entered manually, and the results printed and returned to the counselor for informed feedback. This process took about a week and provided objective data of clients at risk for dropout, those who were below the predicted trajectory, and those whose alliance scores may have indicated problems. Clinical supervision sessions were able to take a directed, data-informed path.

Our initial agency data indicated that we increased our retention rates and had the highest completion rates in the state (at the time, state completion rates ranged from 76% to 78%, whereas CADT's maintained steady at about 86%). It was clear that FIT and a data measurement tool proved invaluable. As the feedback on counselor effectiveness and alliance became available, we were able to adjust our approach, frequency, and length in treatment with client and clinical need prioritized.

I (JS) often share my example of the importance of objective data. From the start of FIT and the introduction of the ORS and SRS into CADT practice, FIT aligned with my own beliefs about therapy and treatment. Meeting clients "where they were at" regarding their stage of change and listening to their ideas and goals were inherent in my practice. This is in sharp contrast to my early training and to my colleagues who required a client to be discharged for relapsing. When we began data entry, I was excited to see the effect sizes of our staff, including my own. Given my use of the tools in my practice, treatment plans, and group discussions, I was certain my effect size would be one of the highest. To my shock, it was the opposite! I actually had one of the lowest effect sizes. Without the data in front of me, I am not sure I would have been able to recognize this objectively. Once I had weekly and ongoing data, I was able to identify client completions, successes, and risk for dropout sooner. By making the necessary treatment plan adjustments, I was ultimately able to increase my effect size. I share this story frequently when providing trainings to new clinicians at our clinic, particularly those with little to no background in feedback and

outcome-driven practice. It emphasizes that our beliefs and perceptions can be and often are inaccurate.

IMPROVING THE OUTCOME MANAGEMENT SYSTEM

ASIST was able to gather thousands of data points for us. Using the latest algorithms and program updates, we continued with a data-entry staff processing the results. However, once the printout was returned to the clinician, the data were already a week old. Although having the data changed the trajectory for our agency, it was time-consuming and costly with data entry, faxing, and delivering to the multiple clinic sites. At a FIT conference in St. Louis, Missouri, I learned about new web-based systems used to administer, score, and interpret the ORS and SRS tools. Upon analysis and review of our existing procedures, including cost of staff time, we were able to determine that the implementation of a web-based system was both necessary and cost-effective.

This review also afforded the opportunity to present our core care model and FIT to the CADT Board. As nonprofit entity, the financial commitment required board approval. The board was impressed not only with the immediate data we would have access to, but also with our clinical practice of using feedback to improve the treatment planning. We now have board members who are able to advocate for and champion the work we do, using FIT language.

Although there are several options now available, CADT selected FIT-Outcomes.com. The primary change was that clinicians would now enter their own weekly data and receive immediate feedback. CADT continues to provide paper-and-pen ORS, SRS, and GSRS tools for clients to fill out. After discussion in sessions, clinicians transcribe the paper results into the web-based program. The paper forms are then filed in client medical records. Clinicians now have ready access to information to address predicted scores, trajectories, and alliance feedback with clients—no more waiting for a week. Most systems have notification and warning systems for counselors. The notifications alert the counselor and supervisors if the client is within the predicted trajectory of change and in the successful zones or is outside the predicted trajectory in the unsuccessful or uncertain zones.

To assess the time requirements for counselors to complete yet another task on top of an already burdensome workload, we included a trial period. We concluded that it takes approximately 10 minutes to log in and enter the data of an average group caseload of 10 to 12 clients. Although the web-based program allows for real-time administration, CADT does not yet have the necessary technology and equipment at all sites. However, when entering the data for an individual client after pen-and-paper administration, it

only takes a few minutes. FIT-Outcomes is user-friendly and includes a help section. Regardless of the program, in my (JS) experience, the systems have all been user-friendly and invaluable to the immediate feedback to the agency. Invest in a computerized data management system. Although most systems come with a yearly financial commitment, it will prove beneficial to long-term outcomes and retention rates. With clinicians and supervisors monitoring real-time outcomes, clients receive expedited treatment planning with relevant individualized changes in the plan, rather than receiving one-size-fits-all standardized program services.

CLINICAL APPLICATION OF THE DATA

Our current data (3,100 clients in the database since 2013) indicate that 84% to 88% of our clients reach their targeted trajectory, the dropout rate is 18%, and our average effect size for active clients is 1.04. Our average intake ORS is 26.6. The average intake score for a client entering an outpatient community mental health center is 19 (Miller, Duncan, Brown, Sorrell, & Chalk, 2006). We are able to conclude from our data that we have a high percentage of mandated clients who, on intake, do not acknowledge significant concerns personally, interpersonally, or socially.

Our strategy when working with clients who score above the clinical cutoff is simple. We explore why the client decided to enter treatment. We do not tear them down to build them back up. During an early training, Scott D. Miller referred to it as "scab picking." Scabs are a sign of healing; left alone, they often leave less of a scar; pick them and the wound is reopened and takes longer to heal. As tempting as it may be to do exploratory work with a client scoring above the clinical cutoff, the data show that this approach will likely make them worse. Instead, we become solution focused and aim to understand where the distress is and obtain collateral scores when possible.

Similar to client data informing engagement and treatment planning, using feedback data allows for informed decision-making to modify program services and improve outcomes. A good example of this was Mental Health and Recovery, an outpatient program designed for persons with co-occurring disorders. Clients who enter this program have both a mental health diagnosis and a substance use disorder. Historically, this program's effect size had been negative. Yes, negative. The data were telling us that clients were actually getting worse in the program. With state regulatory and program requirements directing the treatment planning, nothing was getting better. This went on for years and prompted a decision to make programmatic changes, including the materials used. Rather than beginning each session with a symptom checklist, clients began their sessions with ORS and ended sessions

with an SRS and GSRS. The feedback from clients began to drive treatment planning. Clients began to have more control over their treatment plan and goals. The central core of treatment was no longer symptom management but a more deliberate focus on clients' goals. The current data for the program indicate an effect size of a much improved .95.

Our documentation includes and interprets clients' ORS, SRS, and GSRS scores using both clinical interpretation of the scores (distress levels) and client feedback. We document both client statements about their scores and how they perceive the measured areas to be improving or not over the past week, including the current day. We also document the clinical interpretation of the data, including any warnings flagged by the data management system. Examples of alerts include problems with the therapeutic alliance, prompting the counselor to discuss this further with the client; client's scores below the predicted trajectory; and those who scores indicate that they may be ready for transfer to continuing care. The data management system allows a counselor to have a visual, objective aid in the treatment planning and continuity of care process.

It is important that clinicians understand how to interpret the data. We encourage role-plays in staff meetings where the counselors introduce the tool to a mock client. It is important to practice the language and create consistency.

NEW STAFF TRAINING

Creating a culture of feedback and informed practice is easy when you bring in a trainer, have years of ongoing training and consultation, and maintain the same approach after the counselors have been adequately trained. Unfortunately, it is rarely that easy—but often for good reason! Over the years, our agency and service menu have grown significantly. We went from nine counseling staff to 33 in less than 10 years. Much of that is attributed to the way we do treatment. Creating a culture of feedback also created a larger referral base. Now we are known within the community and at a state level for being an agency where we listen, advocate, and evoke change, and this has resulted in growth. With growth came new employees who were not familiar with this approach or the tools. It became clear that counselors would need more than a new staff orientation training session to become competent and effective in FIT. After all, what took us years to understand, much less implement and practice, should involve a more comprehensive training agenda for staff who are newly introduced to FIT.

We implemented what we call the Core Care Model. It is a 90-minute orientation training that we require all CADT staff to attend upon hiring. We offer it once a month, ensuring that all new staff becomes familiar with

the model of treatment and the tools we use. Second, in addition to weekly clinical supervision sessions, each treatment site within the CADT system has a monthly staff meeting where general housekeeping issues are addressed and clinical cases are brought for consultation using the FIT data.

Third, we began an annual FIT Training, where the latest research and findings are presented to both experienced and new clinicians. This serves as an opportunity to discuss the fundamentals of FIT, as well as specific cases. Clinicians are encouraged to bring in difficult or stuck cases for review. This has a twofold purpose: Not only is there additional consultation, it serves as a training opportunity for the new staff. They see that counselors are eager to share stuck cases, where traditionally they may not have been. They see that the tools provide guidance and insight for supervision sessions, yet they are not used in a punitive manner.

SUPERVISION

If alliance measures are indeed the best predictors of outcomes, it would appear useful to consider focus on the supervisor–supervisee alliance during supervision sessions. This is a concept we are exploring at CADT because it is important to us to retain counselors.

Although we have not used a formal supervision measurement process, we often ask if the supervisee feels heard, understood, and respected and if we addressed what the counselor wanted to address in the supervision session. We take this approach with our management team as well. Although some decisions are made independently, when making decisions, we often use the feedback and alliance process.

Approximately 4 years ago we performed a 360-degree feedback measure, where employees were able to give anonymous feedback. The results were mixed, emphasizing the polarity of opinions. It also revealed the need for obtaining objective feedback in real time within the supervision session. Supervision, as a result, became more of a collaborative process, recognizing the individual styles and preferences of the employee while maintaining fidelity to the model and procedures of CADT.

A CONFESSION: WITH GROWTH AND CHANGE COMES DISTRACTION

Two years ago, it was evident with an increase in dropout rates and deflating agency effect sizes that fidelity to the Core Care Model was compromised. Priorities to open additional programs, changing of supervision, and

consistent staff growth prompted some regression. Although the tools have always been used or completed with a client, it became apparent that they were not being integrated into treatment planning and clinical supervision sessions as effectively as they had been. Treatment plans became rote and reverted to program- and time-driven considerations, which could be subjective and arbitrary. Alignment was not with the client.

The good news is that a strong commitment to return to the inspirational principles of FIT made it possible to get back on track. Additionally, we found it helpful to use resources and training opportunities outside of the agency from time to time. We participated in webinars offered by the International Center for Clinical Excellence that focused on FIT and in webinars offered by the ASAM. These activities were informational and rejuvenating.

EXPANDING SERVICES AND MAINTAINING FIT

The only thing constant is change. We continue to grow and expand our services. In 2015, we opened ClearPath Clinic at CADT to provide maintenance medication for people with opioid use disorder. We will implement the ORS, SRS, and GSRS tools, and we believe that these will provide more actionable, real-time data than what is already required by state and federal regulations. We know from our already expansive body of data that these tools will guide us in informed practice, aid in retention rates, and provide important outcome measures needed to obtain and sustain licensure and accreditation. Our future depends on outcomes. Patients, payers, external community stakeholders, family members, third-party payers, and managed care agencies want to know if the treatment we provide is effective and efficient.

The development of the clinic was a 4-year process of community education, meetings, collaboration, planning, and significant financial expense. Because of our established outcomes with our treatment modality and approach, we received substantial backing from two of our contracted managed care companies. We will be providing them with our outcome data, including effect sizes, dropout rates, average treatment lengths, and percentage of clients reaching their targeted trajectory.

Using the ORS, SRS, and GSRS data, along with other state and federally regulated tools, we are able to not only demonstrate our effectiveness and completion rates but also to indicate sooner when a client is at risk for dropout and make necessary treatment plan adjustments. In contrast, the current statewide standard procedure in Minnesota is to complete data upon admission and discharge of clients, and the information is often subject to interpretation and inaccurate. It also does not account for variable lengths of stay related to the service provided. For example, clients may appropriately

require maintenance medication and services indefinitely and therefore are not fully discharged. This skews the interpretation of the state-required data collected on treatment completions and discharges that do not fit medication maintenance treatments. Additionally, statewide data are usually 1 or 2 years old before they are available to the public and do not provide actionable information that can improve care in real time.

CONCLUSION

FIT fundamentally changed the way clients receive treatment at CADT. It is at the core of what we do and will continue to do. This approach adopted into substance use disorder treatment has brought us recognition from all over the world. CADT has been asked to consult at international, national, and local levels. We have shared our philosophy and approach, which has been embraced in parts of Finland and Russia, as well as the United States. Although other models and approaches are deemed the best for substance use disorder populations, FIT truly encourages an individualized service approach that is person centered and outcome driven. Clients present themselves to us at different points in their lives. Understanding what is important to them and listening to them improves outcomes. Improved outcomes are exactly what clients, their family, their referent, their community, and their payers are expecting out of treatment services.

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12

FEEDBACK-INFORMED TREATMENT WITH LGBTQ CLIENTS: SOCIAL JUSTICE AND EVIDENCE-BASED PRACTICE

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Despite years of studies documenting the benefits for those participating in mental health treatment compared with those who remain untreated (Lambert & Ogles, 2004; Wampold, 2001), some clients are still at risk of experiencing treatment failure (Lambert & Ogles, 2004). Research indicates that dropout rates average 47% (Wierzbicki & Pekarik, 1993). In addition, mental health professionals frequently fail to identify cases that aren't making progress. In response to concerns about treatment failure among clients, researchers have put great effort into identifying the factors that contribute to therapy outcome. Specifically, many studies have found that engaging in deliberate practices to improve the therapeutic alliance is a powerful contributing factor to treatment success (Baldwin, Wampold, & Imel, 2007; Friedlander, Escudero, Heatherington, & Diamond, 2011; Miller, 2011; Norcross, 2011). What's more, the client's view of the alliance has been found to be a much more accurate predictor of success than the therapist's perspective (Duncan & Miller, 2000).

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Although many studies have validated the effectiveness of using feedback-informed treatment (FIT) to evaluate the therapeutic alliance and outcomes, none to date has tested it specifically with lesbian, gay, bisexual, transgender, and queer (LGBTQ) clients. This gap in the literature is particularly striking because people who identify as LGBTQ are at higher risk for poor mental health outcomes compared with their heterosexual and/or cisgender[1] ("straight") peers, including depression, anxiety, substance abuse, suicide attempts, suicide completions, and other types of self-harm (Clements-Nolle, Marx, Guzman, & Katz, 2001; Jessup & Dibble, 2012; Lawrence, 2007; Marshal et al., 2011; Mereish, O'Cleirigh, & Bradford, 2013; Talley, Hughes, Aranda, Birkett, & Marshal, 2013). What's more, members of the LGBTQ community are more likely to report unmet mental health needs (Jessup & Dibble, 2012; Steele et al., 2016) and are at higher risk for null or negative therapy outcomes due to oppressive experiences in the mental health system, such as being discriminated against or pathologized for their sexual orientation or gender identity (Mikalson, Pardo, & Green, 2012; Steele et al., 2016).

FIT is well suited for marginalized communities with a history of being disempowered in the mental health system. It has been suggested that the gap in practitioners' knowledge, skills, and competence regarding the treatment needs of LGBTQ individuals can be addressed by implementing a collaborative approach that elicits clients' input about their treatment goals (Singh & dickey, 2017). The practices of FIT are based on this very approach, promoting a collaborative relationship between client and therapist that empowers clients to play an active role in the treatment process.

This chapter features a mixed method single study at a nonprofit agency serving the LGBTQ community, the Gender Health Center, to evaluate the usefulness of FIT with clients who identify as gay, lesbian, or transgender. We begin with a discussion of why the ethics and practices of FIT are congruent with the social justice values of working LGBTQ communities. The next section depicts quantitative data collected at the Gender Health Center (GHC; 303 LGBTQ clients) through FIT-Outcomes computer-based outcome management system. After the quantitative data section, the chapter examines qualitative interviews with 10 GHC clients who self-identified as transgender and/or queer regarding their experiences of the Outcome Rating Scale (ORS) and the Session Rating Scale (SRS). The chapter concludes with a summary of the results and a discussion on how to ensure FIT is used in a social justice, culturally responsive manner, especially with LGBTQ clients.

The GHC is a community-based organization in Sacramento, California. GHC's mission "is to provide education, advocacy, mental health and other health services to underserved and marginalized populations as an act of social

[1]The term *cisgender* describes people who are not transgender; that is, people whose gender identity as "man" or "woman" matches the sex they were assigned at birth: "male" or "female."

justice with a specialization in gender and sexual identities" (http://www.thegenderhealthcenter.org/about.htm). GHC was founded in 2010 by community members who saw a critical need for culturally responsive mental health services for marginalized and underserved populations, specifically transgender individuals. To support the LGBTQ community, and transgender clients in particular, counselors at GHC receive antioppressive clinical training in narrative therapy and queer theory so that they are able to see how systemic power operations such as heteronormativity and antitransgender values and assumptions show up in everyday counseling practices. *Heteronormativity* is a dominant cultural system of values and beliefs that assumes that LGBTQ clients have the same beliefs, wants, and desires in their lifestyle, relationships, and family practices as cisgender ("straight") people do. For example, heteronormativity assumes that "family" is synonymous with family of origin, whereas for many LGBTQ people, "tribes" or "chosen family" is often synonymous with family and is distinct from the biological family or family of origin. Antitransgender beliefs and practices include ignorance of issues related to the gender binary, gender dysphoria, and the impact that antitransgender violence and microaggressions have on the lives of transgender clients. For example, counselors might not use language (e.g., pronouns, names) that support their clients' transgender identities, nor understand the significance that using proper language plays in affirming transgender identities.

At GHC, counselors are encouraged to engage in ongoing practices of self-reflection in supervision so that they recognize when heteronormativity and antitransgender assumptions show up in their professional work. They are supported in naming and engaging in practices that take counteract these limiting discourses, thus providing culturally relevant counseling to LGBTQ clients. Given the commitment of the GHC to provide culturally responsive counseling to LGBTQ clients, the implementation and evaluation of FIT as a key component of the therapeutic process has been ongoing since the GHC opened its doors. In providing FIT, GHC uses the ORS and SRS to monitor treatment processes.

WORKING WITH LGBTQ CLIENTS

Persons who seek counseling are asked to trust in the knowledge and guidance of their therapist. As a result, clients are potentially susceptible to harm through a misuse of power and influence by the therapist. This power differential may be particularly the case with LGBTQ clients due to deeply embedded heteronormative assumptions in the therapy process. LGBTQ clients' lived experiences frequently fall beyond the culturally produced categorizations of what is considered normal by the heteronormative mental health

system. Heteronormativity can be understood as the assumption that heterosexuality is right and natural, thereby making relationships and lifestyles that do not reflect dominant cultural norms at best "alternative," at worst, abnormal and pathological. In therapy, heteronormativity shows up as antiqueer attitudes and behaviors. Because heteronormativity is rooted in the belief that gender is binary and the assumption that the sex one is assigned at birth "naturally" is in alignment with one's gender identity and expressions, heteronormativity has far-reaching consequences for transgender individuals as well. There is extensive literature documenting LGBTQ clients' experiences of antiqueer attitudes and behaviors in therapy (Mikalson et al., 2012; Shelton & Delgado-Romero, 2011). Most literature focuses on the experiences of gay and lesbian individuals. There needs to be more research focusing on how to improve therapy for transgender individuals (Mikalson et al., 2012).

Transgender clients are particularly marginalized in mental health settings (Benson, 2013). Although homosexuality was removed from the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) in 1973, gender dysphoria continues to be classified in the *DSM* as a mental disorder (Nylund & Temple, in press). As a result, mental health providers continue to play the crucial role of gatekeepers for transgender individuals seeking transition-related health services such as hormone therapy and gender affirmation surgeries. For many transgender clients, counseling may be a necessary part of their gender journey. The World Professional Association for Transgender Health recommends a thorough assessment with a mental health professional for all transgender individuals seeking transition-related surgeries (Coleman et al., 2012). However, for many transgender clients, finding a culturally responsive therapist can be challenging. Systemic transphobia permeates every aspect of daily living. Compared with the general population, transgender individuals experience disproportionate rates of violence and suicide, as well as stigma and discrimination in employment, housing, and health care settings (Lombardi, 2001). Antitransgender attitudes and behaviors also show up in mental health care settings (Lombardi, 2001); unfortunately, culturally responsive training for working with transgender individuals is rarely offered as part of mental health professional programs (Nylund & Temple, in press). These factors reflect a lack of understanding of transgender issues within the medical and mental health systems, thus adding additional layers of complexity to the power differential within the therapeutic alliance.

Treatment at the GHC offers a sympathetic context for clients who may have experienced treatment settings where they have had little control or have experienced a history of traumatic therapy experiences. For instance, some people have had experiences with their gender identity or sexual orientation being pathologized, resulting in experiences of being judged, shamed and ridiculed, or feeling generally unsafe. Others have been institutionalized

against their will, with some being forced into gender-segregated spaces that don't correspond with their gender identity. Many clients feel misunderstood and have been forced to spend valuable therapy time educating therapists on basic LGBTQ definitions or topics.

How does the practice of FIT support effective practices with LGBTQ clients? First, FIT leverages what research suggests works in therapy, challenging practitioners to be accountable to clients by ensuring that their services are properly focused. At the most basic level, therapeutic practices may border on unethical if they are not adequately prepared to address the clients' needs. Further, seeking and responding to client feedback is a measure of accountability. Therapy itself is an institution fraught with problematic power relations, not the least of which is the expert authority imbued with the professional. Seeking and responding to client feedback serves to balance power and develop trust in the conversation, elevating clients' voices, and situating their perspectives in collaboration with therapists. Explicit acknowledgment and integration of client knowledge helps counter the common assumption that the therapist is always the expert. As such, it functions to facilitate a reworking of the traditional power structures implicit within the institution of psychotherapy. FIT operationalizes the practice of doing *with* rather than doing *to*, a relational stance central to ethical practice.

Therapy with LGBTQ people presents particular concerns around the potential for perpetuation (even if unwittingly) of heteronormative discourses of identity, kinship structures, and sexual practices. Conventional psychotherapy practices are informed by psychological and developmental theories that are not accountable to—because they do not account for—LGBTQ identities (Tilsen, 2013). Soliciting client feedback is a practice of inviting more of the client's world into therapy, and putting less therapy (i.e., theory-centric ideas) into their world. This serves to shape the therapist and the therapy process as much as it shapes the client. This mutual influence further contributes to the restructuring of traditional power relations by amplifying the authority of the client's voice.

For marginalized people such as LGBTQ individuals, this amplification helps mitigate the effects of being made invisible and devalued by Western social norms and traditional psychological theories. Integrating client feedback into treatment generates experience-near descriptions—that is, descriptions based on local or personal accounts and understandings, rather than the experience-distant descriptions generated by experts or universalized accounts (White & Epston, 1990). This places clients' preferences and perspectives as valuable and necessary resources for a successful therapeutic engagement. This is especially important for people who live nonnormative lives that are often erased or pathologized within mainstream accounts of acceptable identities and relationship structures.

METHOD

This study used a mixed-method approach comprising quantitative and qualitative strategies. The qualitative component of the research was in-depth interviews of GHC client's experience of FIT. The results of the qualitative research are reviewed later in the chapter. The quantitative aspect was ORS and SRS outcome data of GHC clients collected by a computer-based outcome management system, FIT-Outcomes, from February 2012 through February 2015.

FIT-Outcomes calculates the most important outcome data, giving access to the numbers and graphic results. This makes it feasible for single providers or agencies to document the effect of services delivered. The aggregate data collected by FIT-Outcomes is divided into active and inactive clients. The first section of the data provides agencies (both individual and agency-wide data) with the following: (a) total number of clients, (b) total number of treatment episodes, (c) total number of sessions, (d) average number of sessions per episode, (e) average treatment length in months, and (f) dropout rate. The section provides data on the (a) average intake ORS score, (b) average intake SRS score, (c) average raw change, (d) percentage of client reaching target, and (e) effect size.

QUANTITATIVE METHODOLOGY

Clients

The quantitative data collected from FIT-Outcomes were from 303 GHC clients who have terminated treatment either voluntarily by finishing therapy or dropped out of treatment. The data were collected from February 2012 through January 2015. Approximately 28% of the subjects in the FIT-Outcomes database were straight, cisgender clients, 40% were transgender, and 32% of clients identified as gay cisgender men or lesbian cisgender women. The FIT-Outcomes data reflect the overall demographic data of the GHC's clientele (the qualitative interviews focus exclusively on the LGBTQ persons with an emphasis on transgender clients). Given the focus of the study, quantitative results from clients who identified as lesbian women, gay men, and transgender persons and have two or more ORS and SRS assessments are reported ($N = 177$). Specifically, 82 clients self-identified as lesbian cisgender women, 47 clients self-identified as gay cisgender men, and 48 clients self-identified as transgender persons.

The average number of sessions was 7.35 with the average treatment length of 8.3 months and a dropout rate of 18.4%. The average overall intake

ORS score was 22.93. These average ORS scores hover right around the clinical cutoff of 25, which is congruent with data collected at other agencies using FIT-Outcomes. The average intake SRS score was 36.84, right around the alliance cutoff of 36. This number suggests that GHC clients were experiencing a good alliance with their therapists. In this study, the internal consistency of the ORS was α = .89, .85, .94, and .89 for all 177 clients, 82 lesbian women, 47 gay men, and 48 transgender persons, respectively. The internal consistency for this study with the SRS was α = .89, .89, .85, and .94. In the current study, the internal consistency of the SRS was α = .89, .89, .85, and .94 for all 177 clients, 82 lesbian women, 47 gay men, and 48 transgender persons, correspondingly.

QUANTITATIVE RESULTS

Clinically Significant Change

A key statistic is the percentage of clients reaching target or what is referred to as *clinically significant change*. This figure refers to the number of clients whose scores improve by the end of treatment at least to a score that is expected given their ORS score at intake. Overall, 70.7% of clients reached target or "clinically significant change." Average raw change, the average number of points change for all clients on the ORS from first to last session, was 6.77. These figures suggest that the majority of GHC clients experienced clinically significant change during the course of treatment.

Effect Size

The effect size used for this study was Cohen's *d*. Table 12.1 summarizes the descriptive statistics for the ORS and SRS as well as the pre–post

TABLE 12.1
Descriptive Statistics and Effect Sizes

	ORS				SRS
	n	First session *M* (*SD*)	Last session *M* (*SD*)	*d*	Last session *M* (*SD*)
Lesbian cisgender women	82	20.23 (9.20)	26.56 (10.24)	0.67	36.35 (5.77)
Gay cisgender men	47	22.40 (10.50)	29.38 (9.01)	0.65	36.48 (4.69)
Transgender persons	48	21.65 (9.91)	31.22 (10.16)	0.95	37.89 (3.01)
All	177	21.18 (9.73)	28.56 (10.06)	0.75	36.78 (4.90)

Note. ORS = Outcome Rating Scale; SRS = Session Rating Scale.

effect size. The overall effect size $d = 0.75$ for all clients indicate that 77% of the clients who had two or more sessions improved compared with the average client before treatment. The largest effect size $d = 0.95$ was observed among transgender clients, indicating that 83% of the transgender clients who had two or more sessions improved compared with the average client before treatment.

Limitations

Software data collection methods in the quantitative section of the study treated sexual orientation and gender identity as mutually exclusive categories. The authors recognize that this is not the case; in fact, the opposite is true. Additionally, the data collection did not account for nonbinary sexual identities such as bisexuality, queer, pansexuality, and nonbinary gender identities such as genderqueer and agender. Further, many LGBTQ individuals experience their gender and sexuality as fluid and nuanced identities that are not readily categorized, or which evolve over time. Further research ought to reflect a more nuanced understanding of the constructive nature of both gender and sexuality to more accurately capture the experiences of and distinctions between people of diverse genders and sexualities using FIT in counseling. In addition, FIT-Outcomes does not collect data on racial identities—another limitation of this study.

QUALITATIVE METHODOLOGY

A total of 10 present and former GHC counseling clients participated in the qualitative component of our study through a variety of recruitment methods, including posted bulletins at GHC, an electronic newsletter, social media advertising, and referrals from GHC counseling interns. To qualify, research participants were required to self-identify as transgender and/or queer. Because only 10 GHC clients who volunteered met the criteria, the qualitative research also has limitations: The small sample size might not be representative of a larger group of subjects. Yet the interviews did bring forth a great deal of rich, illuminating data on LGBTQ clients' experience of the ORS and SRS.

The researchers conducting the interviews are affiliated with GHC but not in a counseling capacity. Clients who chose to participate were assured anonymity from their past and/or current counselors and staff. Our participants comprised the following demographic categories: 60% are transgender (30% cisgender, 10% not specified), 50% are White (20% Chicana, 30% mixed ethnicity), 40% pansexual (30% queer, 20% bisexual, 10% lesbian). Participants' ages ranged from 24 through 54, with four respondents being in

the 40- to 49-year age range. Because we gathered open-ended responses from each participant, responses were collapsed into the aforementioned categories for summary purposes only. The descriptions of the participants that follow in the qualitative results section are true to participants' self-identification.

Given that we were interested in learning how clients experienced FIT, including their perspective of the ORS and the SRS, a qualitative interview design was implemented. The GHC researchers developed a series of 27 semi-structured interview questions exploring clients' overall experiences of both the GHC counseling program and FIT, in addition to clients' specific experiences with the ORS and SRS. Interviews were conducted one-on-one, lasting anywhere between 30 and 90 minutes. Interviews were digitally recorded live, and later transcribed verbatim by the researchers. Clients received a $10 coffee card for their participation.

Researchers used two types of coding to analyze the data. First, an open coding process (Corbin & Strauss, 2007) was used in which each of the two researchers reviewed the transcribed documents line by line to find patterns in the data. Thereafter, researchers individually used an axial coding (Corbin & Strauss, 2007) process based on the patterns found during open coding to develop a range of categories. After the first level of analysis, researchers then implemented a second level of analysis by evaluating the individual results from open and axial coding, and collaboratively agreeing on a broad set of categories.

In the analysis of the data, themes were classified under two main categories: client experiences with the ORS and client experiences with the SRS. Under the main theme, client experiences with the ORS, two subthemes emerged: (a) the ORS as an effective tool for identifying and clarifying feelings at the beginning of sessions and (b) the ORS facilitates a collaborative therapy process. Under the main theme, client experiences with the SRS, two subthemes emerged: (a) the SRS as an effective tool used to monitor and drive the sessions and (b) client discomfort in giving honest feedback on the SRS when feedback is not positive. Details of the findings are discussed further under each subtheme.

QUALITATIVE RESULTS: CLIENTS' EXPERIENCES USING THE ORS

Effective Tool for Identifying and Clarifying Feelings at the Beginning of Session

The ORS empowers GHC clients by creating a routine structure for them to contemplate, identify, and clarify their experiences and feelings. Many clients expressed an appreciation that the ORS grounded them at the

beginning of sessions. The tool was a way for them to check in with themselves by pausing and deliberately taking time to contemplate their feelings. As one respondent, a 24-year-old, White, bisexual person stated:

> It was generally helpful to be able to sort of stop and assess where I was at, and to put it somewhere. Because I have anxiety and so to be able to stop and think about where on this [ORS] do I lie, and it was a good way to sort of self-check and start things.

Other clients reported similar experiences, saying that they specifically enjoyed clarifying their feelings with their therapist in the discussions that followed completion of the ORS. For instance, a client completes the measure, and afterward, the therapist points out the categories in which the client rated particularly high or low and facilitates a discussion about this. This then provides the client with an opportunity to confirm or redirect (modify) the therapist's translation of the ORS score and provide detailed information on the topic. A transgender woman, age 47, explained:

> It really helped me feel like I was directing the conversation with this thing . . . I wouldn't even mind filling it out more so that I could direct it even more.

Moreover, clients also appreciated when therapists habitually addressed how the client's scores have changed over time and used this as a starting point to explore potential causes for this change. In the words of one participant, a 25-year-old pansexual Chicana:

> The therapist would say, "I've noticed things have changed . . . do you feel that that's accurate?"

In this example, the therapist responds with positive concern and frames the changes in the client's rating of the scales as an observation. This provides an entry point to initiate a discussion that recenters the client's experiences of their well-being rather than the therapist's interpretation of the client's well-being over the course of the therapeutic episode. The therapist uses the ORS as a tool to aid the direction of therapy, but it does not replace the client's insider knowledge. By using the ORS as an interactive tool for eliciting clients' view of their experience, therapists create an environment where clients' voices are heard and honored, which is especially important with LGBTQ clients, who have historically been marginalized in therapy.

Facilitates a Collaborative Therapy Process

FIT provides an opportunity to create a new, empowered experience in therapy for clients who have previously faced many types of oppression. Clients repeatedly expressed that the ORS allowed them to direct the sessions

and have a strong voice in the therapy process. For instance, some clients said the ORS allowed them to rate the areas in their life where they were struggling at that time, and it often served as the foundation on which to build the rest of the session. Consequently, clients reported that they enjoyed being able to spend sessions focusing on the topics they deemed most important, as thoroughly illustrated by the words of a 25-year-old pansexual Chicana client:

> I like that if today I want to talk about my "mommy issues," then I throw the X down low on the family section (laughing) or if I really wanna focus on how school or work isn't going well, I know which Xs to make the priority. Like, I'm having a bad day at work or I'm having a bad day with my family. But, I really wanna talk about this, and not this so much.

This client reports that having agency over the direction of the therapy process supported a positive therapeutic alliance. She continues:

> It makes me kind of center myself before session, and be present, and then be able to have a more focused session. Which then, in turn, has a positive effect on the SRS, because then we are focusing on the things that really bother me because we addressed it at the beginning of the session and talked about what was really bothering me.

Finally, it's important to note that some clients challenged the idea of being compared with the norm when their ORS scores are being evaluated. Psychotherapy has a historic and contemporary practice of using measurement and evaluation as tools of comparison with baselines and norms (Tilsen, Maeschalck, Seidel, Robinson, & Miller, 2012, p. 20). Tools of measurement designed by mainstream psychology effectively impose a heteronormative dichotomy of normal–abnormal on LGBTQ clients. Given this specific historical significance, it is crucial that therapists recognize LGBTQ clients' feedback about using measures in therapy as a meaningful insight into their cultural experience. For example, LGBTQ people have developed different definitions of *family* and *friends*, in many cases due to being estranged or cut off from family who fail to accept them for who they are. As a result of these cultural differences, some clients experienced confusion or alienation when completing the ORS because the category options did not reflect their own worldview. For instance, work, school, and friendships are in the *social* category, whereas family and close relationships are under the *interpersonal* category. In the words of one client, a transgender woman in her mid-40s:

> I often struggle to answer the . . . questions . . . about my interpersonal and my social because they are so overlapping. They want to know about my family and my close relationships at the same time, and that is confusing to me because I have a family of origin that is on the other side of the country, and I have different relationships with each of them. And then I have my ex-partner who I live with, and my close friends, and maybe

> a partner that I'm seeing, maybe, so I'm not sure how to answer that. I try to picture some combination of all that but each one is in a different place. It sounds like there are some assumptions about how family is defined . . . yeah, I think it could be upgraded to differentiate between family of origin, street family, and the different types of close relationships that people have, which, especially for those that are not married are not necessarily considered family.

Rather than applying the ORS in a one-size-fits-all manner, creating a culture of feedback with LGBTQ persons requires that therapists hear the challenges that clients experience with the categories of the ORS as cultural experiences that are different from their own. "Feedback-informed clinicians know that therapy will not be as engaging or effective when limited to their own knowledge, experiences, and cultural understandings" (Tilsen et al., 2012, p. 19). Therapists, therefore, must be responsive to the cultural differences and practices that exist in queer and transgender communities.

Other clients felt that the ORS's attempt to quantify their well-being was impossible or ineffective. For this two-spirit[2] client in her 30s, capturing a weekly average of her well-being failed to encapsulate a realistic and authentic picture of how she was actually doing:

> It wasn't an accurate reflection of how I was because my moods and situations changed far more rapidly than my therapy, so my score on any given day was just a snapshot of a day. If we really wanted meaningful information on the ORS, I would basically have to have an ORS app on my phone . . . and give 10, 20, 30 scores a day. Then we would be able to get some meaningful data.

This client does not object to having her well-being quantified, but she does challenge the assumption of how frequencies and averages of measurement are constructed as normal. In this case, that a one-time rating on the ORS fails to capture an accurate picture of her well-being moment to moment from one therapy session to the next. In contrast, another client, a 53-year-old, White transgender man, did object to his experience being quantified:

> I didn't feel like it was worth [the time and effort], and because of my own philosophical beliefs, it's hard to do an objective ORS on something as subjective as therapy and what is happening in my outside life.

Rather than trying to persuade, explain, or justify the application and categorization of the ORS, the preceding examples demonstrate that client criticism about the measurement is an opportunity for the client and therapist to have a meaningful discussion about the client's unique worldview.

[2]*Two-spirit* refers to a person who has both a masculine and a feminine spirit and is used by some First Nations and Native American people to describe their sexual, gender, and/or spiritual identities.

The ORS becomes and entry point for the therapist to take a learner's stance regarding their clients' experiences with the application of the measurement that may not have happened otherwise.

An Effective Tool Used to Monitor and Drive the Sessions

Therapy is a relational process. The interviews demonstrated that clients are acutely aware of this fact, as well as the power differential that exists within the therapeutic alliance. When used effectively and in the way it is intended, the SRS can be an effective tool to drive therapy sessions with LGBTQ clients. However, the onus is on therapists to create enough safety for clients to trust that they can provide meaningful feedback without fear of retribution. If therapists do not take responsibility for their contributions to the therapeutic alliance, the SRS will not be a reliable indicator of the strength of the therapeutic alliance with these clients. Clients observe that when therapists incorporate feedback into their approach in future sessions that this process has a positive outcome on the clients' experience in therapy. In the words of one participant, a 54-year-old, White transgender woman:

> I'm glad that she was able to adjust and you know, had we not had the rating thing [SRS] I may have just said, "Oh, yeah, everything is OK."

Although some clients reported that their therapist inquired as to whether they understood or had further questions, other clients reported that their therapist gave a brief introduction and then simply handed the measure to them to complete. Clients who reported that their therapist provided little or no explanation seemed to be less connected to the overall goal of using the measures to enhance their experience in therapy. In the absence of a thorough explanation, research participants concluded that FIT was either a tool to evaluate GHC's counseling program in general or, more specifically, an evaluation of their therapist for the purposes of their internship.

Client Discomfort in Giving Meaningful Feedback With the SRS When Feedback Was Not Positive

Providing meaningful feedback can potentially put clients in an uncomfortable position, depending on how the therapist guides the implementation of the SRS. LGBTQ clients may be particularly uncomfortable in giving feedback because of past experiences of feeling unsafe and marginalized in therapy. It is important that therapists are critically aware of the hierarchical power differential that exists in the therapeutic alliance and of ensuring LGBTQ clients' comfort. Our study found that failure to do so resulted in clients rating the SRS higher than their actual experiences of the therapy.

In fact, half of respondents who felt comfortable providing feedback on the SRS indicated that it was because their feedback was always positive. For these clients, in the event that they had constructive feedback to provide, they would not have felt equally comfortable. Therapists therefore need to be intentional about cultivating safety for the client to provide feedback by anticipating and alleviating some common client fears and ensuring clients that feedback would be used exclusively to improve their experience in therapy. In the words of another client, a bisexual cisgender woman in her 20s whose therapist attended to client fears about providing negative feedback:

> But she made it really clear to me, probably because I was so nervous, that I didn't have to worry about her feelings or anything and that if at some point I wanted somebody else, that she wouldn't take it personally or anything because it's about me.

It is through a culture of feedback that the therapist can learn what works and what doesn't work for the client in sessions. In effect, what may seem negative is in fact meaningful feedback. Using verbiage that has proven effective, therapists are able to stress the point that "no one is perfect, and neither am I." In the words of one queer person who did not disclose their gender identity:

> The therapist would say, "[the SRS is to] rate how it went between [us] to make sure that we were a good fit for one another because the overall purpose is to grow."

In this example, the study participant articulates the importance of a strong therapeutic alliance. There is an assumption that the therapeutic alliance—and the corresponding ratings on the SRS—should improve over time as the therapist comes to know the client's preferences in therapy.

Interview participants are overwhelmingly grateful that they are able to access affordable therapy that is culturally responsive to the LGBTQ community. In the interview sessions, many clients were transparent about their investment in rating their therapists highly, regardless of their experience of counseling. It is critical that therapists are aware of the larger structural and historical forces that shape how LGBTQ clients may respond to providing feedback about the therapeutic alliance. Therapists should be transparent about their awareness of these power relations and be genuinely invested in fostering a culture of feedback. With regard to the SRS, this includes spending time with every client to explain each measure, including explaining the purpose of FIT and the benefits that it can provide to the client in therapy. Therapists should demonstrate their willingness to tailor therapy to meet the LGBTQ client's needs. If LGBTQ clients do not see the ORS and SRS as having a significant purpose, they will

be less inclined to put effort into completing the measures thoughtfully and honestly.

CONCLUSION

People in the LGBTQ community have a disconcerting history of being marginalized, shamed, and pathologized in traditional mental health systems, which too often has resulted in treatment failure. FIT has shown promise in improving treatment effectiveness among the majority population but has not yet been studied among the LGBTQ community. This study attempted to explore its use in identifying the impact of deliberate practice among LGBTQ clients. More specifically, this study focused on identifying the effect of FIT as captured in statistical data and qualitative narratives. Use of the ORS and SRS instruments in the therapy sessions reveal that FIT is an effective approach for LGBTQ clients (Cohen's effect value of $d = 0.73$ suggests a moderate to high practical significance).

Qualitative data added to the statistical findings gave further voice and visibility to the participants' experiences. For example, primary measures emerged of the ORS as an effective tool for identifying and clarifying feelings at the beginning of sessions, of the ORS's ability to facilitate a collaborative therapy process, of the SRS as an effective tool used to monitor and drive the sessions, and of client discomfort in giving honest feedback on the SRS if feedback was not positive; these findings supported the significance of a culture of feedback in the therapeutic encounter. As one 54-year-old, White, transgender woman so aptly stated, "Had we not had the rating thing [SRS], I may have just said, 'Oh, yeah, everything is OK.'"

It is important to note that while the FIT instruments are actualizations of client-informed treatment, they can still fall victim to heteronormative narratives and thus may be alienating to LGBTQ clients and others. ORS and SRS results highlight disenfranchisement and can inform further refinement of FIT instruments. How do we prevent the tools of FIT from becoming harmful to queer and transgender clients? Cultivating a culturally responsive practice is vital to creating a culture of feedback, the hallmark of FIT. Being culturally responsive requires, in part, that therapists engage in reflexive consideration of their own social locations and assumptions about the world and clinical practice. The best feedback-informed clinicians know that a therapeutic encounter that is limited to the therapist's worldview and cultural understandings will fail to engage and to be effective. Clients' ways of being in the world and finding meaning are stifled in such narrowly informed encounters. Thus, the potential of FIT is lost and the risk of doing harm increases. Ultimately, FIT is about client engagement, which makes it vital that the client's voice is heard and understood—a key ethic of social justice.

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13

FEEDBACK-INFORMED TREATMENT WITH CLIENTS IN THE CRIMINAL JUSTICE SYSTEM: THE TIME IS NOW

DAVID S. PRESCOTT

In a 1974 essay, criminologist Robert Martinson famously asked, “Does nothing work?” His preliminary analyses of data had found that rehabilitation efforts in prisons weren’t working and prompted widespread defunding and elimination of services in the criminal justice world. His essay, which became the basis of the “nothing works” philosophy, was premature. Indeed, the following year, Martinson was part of a group of researchers whose findings were more encouraging (Lipton, Martinson, & Wilks, 1975). Martinson (1979) would subsequently reconsider his earlier statements, but by then the damage was done, followed by decades of belief that criminals don’t change and that treatment doesn’t work. It would be roughly 15 years before improved statistical procedures revived rehabilitative efforts in the criminal justice field (e.g., Gendreau & Ross, 1987). Martinson’s story offers a vital reminder: Political agendas and charismatic personalities are not the same thing as facts or findings.

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Fast-forward 30 years to 2014, and psychologists Therese Gannon and Tony Ward wrote an article provocatively titled "Where Has All the Psychology Gone?" In it, they observe that treatment in the criminal justice system in the past several years has often had an overly narrow focus is specific areas and does not adequately consider the therapeutic alliance (Gannon & Ward, 2014).

Some of the clearest examples of how treatment in the criminal justice system can go wrong are found in the treatment of substance abuse and sexual offending. White and Miller (2007) wrote about inherent problems in adopting harsh and confrontational approaches. Many, but not nearly all, efforts to treat people who had sexually abused were overtly confrontational in nature (e.g., Salter, 1988). In many ways, this presented professionals with dilemmas. Confrontational professionals often maintained seemingly straightforward relationships with their clients, even as Jenkins (1990) noted that many clients who have been violent can interact in subtly provocative ways that appear to "invite" their therapists to interact with them in a violent way. On the other hand, although many professionals working in the 1980s and early 1990s received explicit instruction on harsh confrontation that would have been considered completely unacceptable in more traditional mental health settings, they did not learn how to develop a relationship, much less agreement on the goals and tasks of the treatment experience itself.

This chapter illustrates how, contrary to historical wisdom, actively engaging criminal justice clients in treatment is critical to successful outcomes. Psychoeducation, such as that provided to domestic violence perpetrators or drunk drivers, may be necessary but is far from sufficient to making interventions meaningful. Ultimately, decades of research have shown that imposing a crime-free lifestyle onto a person does not make him or her safer. Indeed, a large meta-analysis (Parhar, Wormith, Derkzen, & Beauregard, 2008) found coercive, mandated treatment methods to be generally ineffective. A central problem in current methods of treatment provision is that professionals can make highly inaccurate assumptions about their clients' experience of treatment (Beech & Fordham, 1997).

A rich body of research has found that programs adhering to effective correctional principles (i.e., those of risk, need, and responsivity) have the greatest effect on criminal reoffense. These principles, championed by Andrews and Bonta (2010), have explained the success and failure of numerous criminological interventions. Simply put, the *risk principle* holds that the majority of treatment resources should be allocated toward those who pose the highest risk. The *need principle* holds that interventions should focus on treatment goals demonstrated to be related to criminal reoffense. The *responsivity principle* holds that interventions should be tailored to the individual characteristics of each client. This last principle—responsivity—can be the

most confusing and challenging for professionals to accomplish. At its most basic level, the responsivity principle includes matching treatment to specific client features, such as intelligence and learning style. At a more challenging level, responsivity involves a deep understanding of, and respect for, each client's motivation to change and the barriers the might hinder meaningful engagement in treatment (see Chapter 14, this volume).

People convicted for sex crimes frequently present with barriers to immediate treatment engagement (Mann, 2009). In some cases, these barriers include responsivity issues such as learning disabilities or concerns about acknowledging one's actions. The very nature of the material covered in these programs increases the likelihood of attrition, especially among those who would benefit from treatment the most. However, those who are able to establish meaningful and relevant treatment goals are more likely to complete treatment programs and reduce their risk for reoffense. Ultimately, the challenge for treatment providers is to create an environment in which change is possible, where treatment is tailored to each client's abilities, and where there is agreement on the nature of the relationship, the goals and tasks of treatment, and accommodation of strong client preferences (Bordin, 1979; Duncan, Miller, Wampold, & Hubble, 2010; Norcross, 2011).

CONSIDERATIONS IN THE CRIMINAL JUSTICE SYSTEM

Professionals are rightly concerned that attempting to build therapeutic alliances in the wrong way can lead to colluding with procriminal attitudes and beliefs (e.g., the therapist who says, "I agree with you that the rules here are nonsense, but what are you going to do? They're the authorities."). In some cases, an improper alliance may compromise the professional's effectiveness and even his or her career (e.g., sharing highly personal information). Not surprisingly, many criminal justice treatment programs emphasize one-size-fits-all policies for treatment providers (e.g., no physical contact of any sort between therapist and client, which in my experience can include shaking hands). Although the American Psychological Association's (APA; 2017) *Ethical Principles of Psychologists and Code of Conduct* offers helpful guidance (e.g., Standard 3 on Human Relations), ethical dilemmas can sometimes seem to come from out of the blue. Likewise, issues around confidentiality can sometimes be problematic without a clear understanding between therapist and client at the outset of treatment (cf. APA, 2017, Standard 4 on Privacy and Confidentiality).

Therapists treating people in the criminal justice system require expertise not just in negotiating the system itself but also in understanding their clientele. They also need global knowledge of how to establish empirically

supported treatment goals. These professionals must also have expertise in providing treatment and helping clients navigate change processes. Where the daily challenge lies, however, is in developing expertise at building responsivity in each client. One helpful approach is for therapists to recognize that although they possess expertise in the subject area, the clients are the experts on their own lives.

This approach may seem to contrast sharply with traditional ways of viewing clients. Where Salter (1988) advocated the use of statements such as, "No, I don't trust you and you would be pretty foolish to trust yourself" (p. 93), it may be more useful—in the presence of newer scientific knowledge—to think of interactions between clinician and client as a kind of choreography. The clinician's role is to elicit what is meaningful and relevant to the client in accordance with his or her values, at the same time ensuring that interventions target necessary goals that are directly related to reducing risk of reoffense. Where accurate risk and need assessment is essential, feedback-informed treatment (FIT) can

- ensure the best tailoring of services to each client,
- serve as an early-warning system in cases where treatment is not going well,
- reduce the likelihood of grievances and other complaints,
- identify cases at risk for exiting treatment prematurely, and
- identify cases that are simply going through the motions to fulfill legal obligations.

Each of these features has a clear advantage in professional development, cost reduction, and public safety. They enable the best allocation of resources and ensure that clients and professionals alike have options if treatment proves unsuccessful.

The following sections offer illustrations of how I have used FIT in treatment, including lessons learned and tips for newer therapists working in criminal justice. These cases occurred in my practice, which includes both inpatient and outpatient settings and clients of all ages.

DANNY

Danny was referred to my outpatient program by his probation officer for treatment to reduce his risk for sexual reoffense. At 58 years old, Danny had been convicted of molesting the younger of his two daughters many years earlier. Just before these allegations came to light, he was arrested for drunk driving. Danny was a decorated public servant, having worked for the fire department of his small city for 35 years. He had saved his share of lives and

ran with a group of friends whom he described as "rough and tumble." He had two children, now grown, with his ex-wife. His older daughter was doing well and lived with her own young family in a small town a half hour away, visiting with Danny every 2 weeks or so. His younger daughter had followed in his footsteps and worked for the fire department in another city about 4 hours away.

His situation was unusual in many subtle respects: His younger daughter had been seriously mentally ill and had made many allegations of sexual abuse by him—and on one occasion against her stepfather (who had married Danny's wife after their divorce) throughout her adolescence and early adulthood. Subsequently, she recanted the allegations each time until she and Danny got into an argument over otherwise trivial arrangements for a party. It was then that she called the police, with whom Danny had worked professionally and who took him to the county jail. While in jail, Danny contacted a lawyer and told him to get him out in any way possible. Danny's attorney arranged for a plea deal involving 20 counts of simple assault for which he would serve 1 year of probation concurrently for each. Danny was out of jail but would be on probation into his mid-70s.

In most treatment programs in North America, the treatment of people who have sexually abused can be perfectly straightforward. The client discusses what he did; explores the thoughts, feelings, situations, and behaviors that led up to the offense(s); and develops plans for preventing such behavior from happening again. Depending on the model and techniques used, treatment might also involve active attempts to build on the client's capacities so that the client may develop a lifestyle in which sexual abuse is unnecessary and undesirable (Yates & Prescott, 2011; Yates, Prescott, & Ward, 2010). Because of the nature of harm that can result from sexual abuse and the fact that treatment takes place at the intersection of mental health and the criminal justice system, professionals often rely on polygraph examinations to verify client accounts of past offending and current behaviors (English, 1998). This practice is understandably controversial in many quarters (Rosky, 2013). In practice, I use it exceedingly rarely.

Danny opened our first session succinctly: "You know that I'm mandated into treatment. You should also know that I don't want to be here. I didn't molest my daughter and would never do such a thing. There was one time when I was 20 that I got drunk at a family gathering. I grabbed at a young woman's butt who was there, but the idea that I would sexually abuse my own daughter is disgusting." Although such categorical denial by clients in the criminal justice system is an everyday occurrence for clients starting in treatment, Danny's argument went against self-interest, essentially admitting to a different sex crime even as he was trying to claim his complete innocence in the current situation.

In this moment, the Outcome Rating Scale (ORS; Miller & Duncan, 2000) was a perfect means for slowing the tempo of this session and diffusing the tension of his having to be someplace he did not want to be. His initial ORS score was 29 (above the cutoff for adults), causing some immediate concerns that he was at risk for dropping out of treatment or participating in treatment only to the extent necessary to prevent violating the conditions of his probation, a kind of psychological dropout. One option would have been to ask how he believed his probation officer would have scored the ORS. However, in Danny's case, discussing his scores provided a framework for discussing other areas of his life and an opportunity to learn as much as possible about him. Danny shared much of his life's story, including the many efforts he had put into his daughter's well-being as she grew up. A critical dilemma for therapists under these circumstances is that, on the one hand, the client may be lying outright and attempting to place himself in the most favorable light; on the other hand, he may be telling a strange but common truth: that he was an otherwise good father at the times when he was not abusive.

After listening to Danny's story, I invited him to reexamine the ORS to make sure that he was still comfortable with his scoring. This would enable him to reconsider his current situation in light of our beginning attempts to understand each other. Danny reiterated that his scores were accurate and went on to explain that, despite his legal circumstances, his life was actually now more satisfying than ever. After years of stressful work and family circumstances, he was finally able to enjoy semiretirement. For the rest of our time together, his ORS score would remain in the upper 20s, slowly ascending to 35 and staying there for some time until termination of treatment.

Knowing that the most important thing for now was to establish agreement on the goals and tasks of our work together and to allow Danny to leave feeling heard, understood, and respected, I proposed that our work focus for now on preventing even the possibility of further allegations of abuse (i.e., allegations of abuse that might happen in the future, not the prevention of others coming forward based on past experiences). After all, with his recent conviction, he was now highly vulnerable should anyone make subsequent allegations. I knew that if he had in fact abused his daughter, appropriate safety planning to prevent new allegations would also result in reduced risk (Serran & O'Brien, 2009).

The combination of the goal of preventing new allegations and simply listening with interest to Danny's story, which stemmed from the initial structure of the ORS, resulted in a Session Rating Scale (SRS; Miller, Duncan, & Johnson, 2000) score of 39 out of 40 (1 point off on the item involving goals). Danny's feedback was that although we had a good plan for now, he was still interested in clearing his good name and finding out more about how his daughter could have come to make these sorts of allegations in the first place.

To this point in our treatment, I still had no idea whether Danny had committed these crimes or not, even as I was certain that he had taken a plea agreement to get out of jail. This presented a number of dilemmas for moving forward. Preventing further allegations was a legitimate goal in these circumstances, and we could always revisit this later. It was necessary to be careful about how we discussed his daughter until Danny had ample opportunity to work himself into a level of comfort where he would be able to discuss his abusive behaviors if they had indeed happened. Disclosure of abusive behavior is best thought of as a process that one can foster over time and not an event that one can compel.

Building a therapeutic alliance in Danny's case was a challenge. Criminal justice clients can be sensitive to any misuse of authority (Prescott & Wilson, 2012), even as they appear to elicit brusque, confrontational responses from their therapists (Jenkins, 1990). Learning how best to strike the balance between being directive, guiding, and remaining sensitive to the relational needs of a man who did not display a high level of sensitivities could easily take more time than I had without a measure such as the SRS. Danny's interpersonal style was what one might expect from someone who had spent his days putting out fires in apartment buildings and his nights drinking beer with other firefighters; his approach to conversations was straightforward and blunt. At the same time, Danny also came from a conservative regional culture, being descended from early French-Canadian settlers in northern New England and truly found discussing sexual matters objectionable. Danny was at risk for dropping out, and without an explicit method for ensuring that treatment was working for him on a session-by-session basis, he very well might have. Were that the case, and if he had indeed abused his daughter, this treatment noncompliance would actually have increased his risk (Hanson & Bussière, 1998).

Danny's progress over time was exceptional. Using the ORS and SRS, we developed a solid therapeutic alliance and identified areas of Danny's life where he could benefit from making effortful changes, which he did (e.g., skills for self-care when anxious or angry). Also important, we reviewed how he had made changes to his life since the time his daughter had claimed he had abused her. These involved his self-regulation skills with respect to managing emotions and situations in which he had managed the collapse of his interpersonal support systems. Although not directly related to reducing risk, Danny used some sessions to describe the lengths he had gone to be a good father, using as examples his daughter's artwork and treatment progress documents he had saved. He had come to accept my stance that I was supportive of him even as I would never entirely know whether he had abused her.

It would have been easy to continue to see Danny in perpetuity, and his probation officer had made clear her desire that Danny stay in treatment as

long as possible. However, his high score on the ORS caused concern that treatment might not be helpful in the long run, and potentially unnecessary (indeed, the use of outcome and alliance measures can provide additional support to treatment decisions such as termination in situations where supervising agents would prefer that treatment last for the duration of each client's term of probation). Danny was managing his life in accordance with a safety plan we had developed, even as he continued to maintain his complete innocence. Grounded in the desire to be an agent of change and not simply a rent-a-friend, I took the unusual step of encouraging Danny to take a polygraph examination to clarify his account that he had not abused his daughter. It might provide additional information that could benefit all involved in his case.

Danny passed this examination in such a way that the examiner called to ask why he hadn't been provided the same opportunity during the legal proceedings. He apparently shared this same concern with Danny, who then called his attorney with the same question, only to find out that the lawyer had lost his license to practice. These events led to reduced supervision and probationary obligations and to a termination of treatment.

Setting aside the more lively aspects of this case, using FIT made possible several critical accomplishments with Danny:

- It identified him from the start as being at risk for dropping out of treatment, whether literally or psychologically. It would have been easy for another professional to write him off as an unmotivated offender in denial, possibly leading to a violation of his probation.
- It enabled a careful, balanced tailoring of treatment to meet his interpersonal style (in accordance with the responsivity principle, mentioned earlier). With Danny, I could be more straightforward and direct than I might have been with a different client. At the same time, I had to work to consistently demonstrate respect for Danny's sense of privacy and cultural values.
- Using the ORS provided confidence that Danny was making reliable change in areas that were personally meaningful to him. This occurred simultaneously with my efforts to ensure that we were working on goals that are scientifically related to reoffense processes (in accordance with the need principle, mentioned earlier).
- It kept me, as the therapist, focused in key therapeutic process areas that could be easily missed under other circumstances.

In the end, simply establishing and maintaining a culture of feedback was critical to Danny's success. Despite his rough external appearance, he also

had a strong value about keeping private matters private. Careful attention to the alliance (e.g., his blunt interpersonal style combined with a cultural value of privacy) via the SRS enabled him to discuss sensitive issues more openly. Danny's was a challenging case, especially when one recalls that treatment in the criminal justice system requires a careful balance of individual client beneficence and public safety.

ERIC

I met with Eric for only five sessions. He was referred by his probation officer after severely assaulting another student at school when he was 14. Before this, he had been physically aggressive to family members as well and had displayed a wide variety of odd and eccentric behaviors. At the time we met, Eric was highly reluctant to discuss emotionally charged subjects of any kind and not only blamed outside circumstances for his behavior but also consistently scanned the world around him for threats. Having been severely beaten by his maternal grandfather from a very early age, Eric viewed the world, and men in particular, as unpredictable and dangerously out of control.

In apparent contrast to his circumstances, Eric initially scored the ORS at 35, saying only that things would be better "if people would stop giving me such a hard time." After all, "I may need to teach them all a lesson someday." His mother was deeply concerned about his well-being and future, while his stepfather (who had recently married Eric's mother) had little hope that he would fit into the world in any meaningful way. Eric consistently scored the SRS at a 40; he stated with little emotion that everything was fine and that our relationship would be better if I took him out for fast food.

I quickly had to face some facts. Eric was unwilling to discuss anything of relevance except for his descriptions of situations at school that unfailingly contained the attainment of glory through macho displays of dominance. I was unable to get any feedback from him whatsoever. In my experience, this is a point where many clinicians in and around criminal justice make a critical mistake by believing that if they just keep working with their clients long enough, things will change. Some therapists believe their clients may need to get worse before they can get better, despite there being no research evidence for this. Worse, this determination to keep going in the absence of any success and without making feedback-informed changes to one's approach, while seemingly praiseworthy on the surface, can mask a more problematic truth: The therapist is acting on his or her own behalf as much or more than the client's. Often, holding on to clients despite failure is couched in otherwise noble beliefs: "I'm not the kind of therapist who gives up. I always go the extra mile," for example. In the criminal justice world, this kind of attitude in

the absence of evidence can be dangerous. After all, the client can be getting worse (a potential hazard for the client and community alike) at the very time the therapist is thinking that they are almost successful.

At the fifth session, Eric's ORS score had dropped to 20, and he began to make serious and credible threats toward his 5-year-old sister. It seemed that she had made fun of him and he was strongly convinced he needed to teach her a lesson through brutality. Eric was clearly at imminent risk for violence against a defenseless and easily accessed victim. Following the principle of "duty to warn," I immediately contacted Eric's parents and stated that it was not safe for him to return home that evening. The parents agreed, and contacted various authorities to have Eric assessed on an emergency basis. Perhaps not surprisingly, the crisis team evaluators suggested that Eric might be dissuaded with further therapy and wondered aloud if I wasn't trying to terminate him too early in treatment. Through the use of the measures, however, it was clear that any therapeutic alliance with me and possibly anyone else would be illusory at this point and that his current life situation was deteriorating. The crisis team might not have seen this, but the numbers were disturbing indicators.

Eric was admitted to the hospital and spent the next 2 years in residential treatment. After months of agonizing over how I could have worked more effectively with Eric, I concluded that a primary element of FIT in criminal justice and elsewhere is that it allows professionals to be excellent clinicians even when they aren't the right therapist for the job. I may not have helped Eric achieve his goals, but I was able to spot things getting worse when other professionals couldn't, and the family had grown used to not knowing when he would become violent.

By way of an epilogue, I am happy to report that Eric's treatment team contacted me 3 years later, requesting a risk assessment. I explained that I was not the best person for the job and why, but apparently there was no alternative. Determined to give it a chance, I met with Eric, who was clear that I had made the right call and that he was still at high risk for violence under the wrong conditions (such as returning to live with his parents). In the end, I am grateful to research showing that clinicians are not often adept at recognizing when their clients are getting worse (Lambert, 2010). In the criminal justice world, this can mean very high stakes.

GORDO

Gordo was 17.5 years old and had come to the attention of the legal system for physical violence against his mother. He received a deferred disposition from the court in a state where he could stay under legal supervision until

age 21. This meant that if he could complete treatment, his charges would be dropped. Adopted at age 10, Gordo had previously received treatment for concerns related to trauma and attachment. Although he had received a familiar suite of diagnoses from previous providers (oppositional defiant disorder, attention-deficit/hyperactivity disorder, and reactive attachment disorder), his problems revolved around balancing his needs for independence and connection in the wake of serious childhood adversity. Now, as a young man, he also wished to make his mark on the world, attain a sense of meaning and purpose in his life, and have some fun along the way.

Treatment took place in an outpatient setting. Gordo's mother had sought me out due to concerns that when Gordo wasn't physically aggressive, he sometimes hugged his mother to an inappropriate extent (e.g., very frequently, often while he had an erection). Furthermore, his mother was concerned that he seemed particularly fixated on some girls in his school and that he needed help before getting himself into further trouble with them. Our first session was easy enough, and Gordo took the ORS seriously, a pattern that would persist across the course of his treatment. His initial ORS score was 22, well below the cutoff of 28 for adolescents. As his therapist, I used motivational interviewing to explore the difference between Gordo's current and desired future states.

At the end of the first session, Gordo thought carefully about the SRS and returned a score of 37, nearly perfect except for a score of 7 out of 10 on the item related to the therapist's approach. Suspecting that this is part of a typical pattern of responding on the SRS in which clients provide high scores and the challenge for therapists is to elicit negative feedback, I asked for his thoughts on my approach. Gordo stated bluntly, "You're too nice. You're going to have to be really hard on me, or else I'm just going to lie to you."

This comment was particularly striking, as I had been particularly proud of my use of motivational interviewing that day. Were Gordo any other client, my work with him might have been considered a truly expert performance by my peers. Indeed, I am very involved in the community of motivational interviewing and generally confident in my abilities. One might say that I self-identify as a motivational interviewing specialist.

Of course, self-identification such as "I use cognitive therapy" or "I'm a radical behaviorist" risks speaking more to one's limitations than capacities. In other words, self-identifying as a provider of treatment X or Y may come at the cost of actual helpfulness with clients like Gordo who don't like those particular approaches. After all, speaking to empty chairs or going into hypnosis is not to everyone's taste. This was especially true in light of Gordo's statement to the effect that motivational interviewing was useless to him; he wanted someone who would challenge him overtly. This point is not merely academic; it is crucial when one considers that clients in the criminal justice system

rarely have any say over who their therapist is. Under these circumstances, overidentification with a model or technique comes at the cost of producing better outcomes. I have come to believe that the pursuit of excellence in one way of working is worthwhile only as long as therapists also ask themselves how they can move beyond their current limitations with each client.

Of course, although Gordo may have been the expert on what would work for him, I still possessed some expertise about adolescents in criminal justice. It was clear that if all I did was turn up the volume of my voice and confrontation, I would not only lose our alliance but also provide Gordo with further opportunities for opposition and defiance. Besides, the entire rest of the world had been harsh with Gordo, and the outcome was that he was in my office.

Developing a different style with Gordo required consistent checking in to ensure that it was working. Indeed, Gordo responded well to a combination of very direct statements mixed with affirmations. As soon as he began to offer excuses or externalize blame for his actions, I would say something like:

> Look, you're a great kid, but you're not delivering the goods. We can talk all you want about how others are responsible for your behavior, but if that kind of excuse-making continues, what is going to happen? You know I'm the president of your fan club, but your mom is still in a world of hurt. I know you're going to make this better someday—that's clear—but what I don't know is how.

My rate of speech and timing turned out to be critical. Because I had confused him slightly with questions alongside affirmations and blunt, sudden feedback, Gordo ended up confronting himself more than I did.

Gordo's SRS scores went up and generally hovered between 38 and 39; he stated that no one was perfect and that he would therefore not provide a perfect score. This was welcome to me, as he still provided excellent feedback about what did and didn't work with him. For example, after our third session, I commented that he had specifically stated I needed to be hard on him and asked how that was going. His response was, "It's great, but you know, I've noticed you say some things, but you don't ask many questions. You could ask more questions." Over time, as the depth of our work increased, I specifically aimed to decrease the amount I spoke by becoming less directive and simply asking more open-ended questions.

Gordo's ORS scores gradually increased. Where he had been quick to blame others, he displayed a curious trend on his ORS scores: He typically scored the "overall" item lower than the others (in my experience, other clients often seem simply to average out the other scores). When asked about this, he stated,

> If you ask me, I really am doing well individually, with my family, and with the people at my school. I'm getting better at being who I really am, and I want people to get off my back. I score that one (the "overall" item) because all week I know there are things I still need to work on.

Ultimately, Gordo's ORS scores rose to 32 and stayed there, despite moderate friction with his mother over the timing of completing domestic chores and the like. His outbursts and inappropriate behaviors with sexual overtones had stopped altogether. Statistically, his ORS scores indicated a reliable level of change. At a point when we considered terminating treatment, Gordo described his birth mother at length. In a manner uncharacteristic of him, he described how much he loved her:

> She was my whole world. She was like my bodyguard; I always felt safe when I was with her, even though my dad was no good. There was never anything better than surprising her with a great big hug. I would sneak up behind her and just hug her. She loved it every time. I don't think I ever felt better than in those moments. My life was hell the rest of the time. I wish it could be like that with my [adoptive] mom now.

With this statement, the origin of his inappropriate behavior with his adoptive mother became eminently clear. What had begun as behavior that was as heartwarming as it was normal had become inappropriate, upsetting, and potentially abusive over time. When I commented that this was perhaps where his recent behavior had originated, Gordo stated he didn't really care about that; he was more invested in improving his relationships with all women, including his mother. Had I been too attached to a psychoanalytic mind-set, I might have found this response disturbing. By this time, however, I had grown accustomed to changing my approach to make the greatest gains with Gordo.

In the end, Gordo was able to make significant changes to his life on his own terms and not because of his therapist's pet approaches. Being Gordo's therapist meant reaching beyond my current limitations to what would work for him in the long and short terms. What I learned from Gordo (and what other colleagues have observed informally) is that the concept of confrontation is best considered to be a goal that the client can accomplish; in the long run, it is not an effective technique on its own.

CONCLUSION

Pilots, doctors, and others engaged in high-stakes work all use checklists to ensure that their work goes safely and that they can respond to sudden changes in status quickly and successfully. Indeed, no one would undergo

surgery or get onto a plane with people who state that they are already experts at their job and don't need such unnecessary measures. In the criminal justice world, structured session-by-session feedback is the clinician's checklist to improve services, reduce risk, eliminate unnecessary treatment and, ultimately, identify when services aren't working.

The following are some key lessons from nearly a decade of practice using structured feedback in various forms:

- *Trust your measures*. It is easy to assume that clients lie or that measures such as the ORS and SRS don't apply in a certain case or program. Instead, consider that you need to work to understand the meaning of each score for each client and then examine changes for better or worse.
- *When all else fails, look in the mirror*. A common complaint in my experience is that clients simply draw a line down the SRS thoughtlessly. These clinicians believe that their clients are not interested in providing feedback and are therefore different from clients in the available research. In my experience, it is much more likely that these clients are making a statement worthy of exploration. It may be that they don't believe their therapist can handle the feedback or perhaps the therapist hasn't introduced the measures well.
- *Remember that the most effective clinicians identify imminent risk and that client worsening in treatment is a primary indicator*. In the criminal justice world, this is manifestly essential.
- *Risk and need assessment are vital, but only client feedback can confirm that your efforts are making a difference*. FIT can help professionals document that what they do matters.

Ultimately, a review of the feedback-informed literature poses the ultimate question: Do we want our clients to reoffend? Assuming that the answer is no, what steps can we take to ensure that our work is successful? The answer, without a doubt, is to check in with our clients to make sure that we are all on track and building better futures one client at a time.

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14

FEEDBACK-INFORMED TREATMENT FOR ADOLESCENTS AND YOUNG ADULTS WITH EARLY-ONSET PSYCHOTIC DISORDERS: DEVELOPMENTALLY APPROPRIATE MENTAL HEALTH SERVICES AND THE NEED FOR RELEVANT OUTCOME MEASURES

RYAN MELTON AND ELINOR TAYLOR

Based in Oregon, the Early Assessment and Support Alliance (EASA) offers early intervention for adolescents and young adults, aged 15 to 25 years, with schizophrenia and schizophrenia-related disorders, who are experiencing symptoms of this condition either for the first time or within the past year. This chapter describes implementing feedback-informed treatment (FIT) in this setting with young individuals experiencing the onset of psychotic disorders. It provides several case examples of how FIT has improved engagement and outcomes of clients attending EASA programs.

EASA has been operating in Oregon for 15 years. As the program has grown, the need to track outcomes, and pressure from funders to do so, has increased. EASA has historically tracked individual program outcomes for each of its sites in Oregon. This has included psychiatric hospital admissions, employment, and diagnosis, among other factors. Although the outcomes have been good at a state level, with as high as 70% of participants working

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or in school and psychiatric hospital readmissions less than 10%, the data indicated that only half of the participants were completing the 2-year program. Some of the reasons for this included moving out of the state or finding more appropriate treatment. Other reasons included disengagement and unknown reasons. It was the latter two reasons EASA leadership wanted to understand in more detail to increase the number of individuals completing the 2-year program. The answers to this were not in the program data nor in symptom data collected by individual practitioners. Despite including several evidence-based practices for working with individuals with early psychosis, there was no change in the number of individuals completing the program. EASA was also faced with the challenge that the EASA teams are located within community mental health agencies and in some cases had additional non-EASA caseloads. In addition to high caseloads, the practitioners were burdened with a large amount of paperwork due to federal and state requirements. To the EASA leadership, this indicated that any assessment implemented had to be simple to use and meaningful to the practitioners using it. Approximately 5 years ago, the clinical director attended a preconference workshop at a national mental health conference on outcome-based treatment. In that workshop, he was introduced to FIT and the use of the Outcome Rating Scale (ORS) and Session Rating Scale (SRS). Given the findings that the presenter of the workshop demonstrated on dropout and the individualized nature of the instrument, the clinical director felt that the use of the ORS and SRS had the potential to address the questions EASA had as a program. Over the next 5 years, FIT was introduced to the EASA steering council and is now present in EASA fidelity. EASA practitioners using FIT report that it takes little time to implement in practice, and the clinical utility of the practice supersedes any time burden.

FIT as a model, in addition to offering the EASA practitioners a way to measure and facilitate outcomes and alliance, has inspired EASA as a whole to take on the challenge of creating a culture of feedback at all levels. The EASA practice guidelines now include a section on program leaders seeking feedback from stakeholders on how the program is designed and on future directions. The culture of feedback currently exists in EASA from the individual sessions with clients to leadership at the state level from the practitioners.

To explore FIT with this population more deeply, consider the following interactions with clients. The following question was asked of the members of the Young Adult Leadership Council, an advocacy group consisting of current EASA participants and graduates of the program: Was there anything you found helpful about the mental health services you've received? Here are some of the replies:

- "It was important," one replied, "for me to be listened to. Not to be told what to do, but for me to have a voice."

- "Being able to tell my practitioner what's working and what's not. Having a real conversation where I'm respected and heard."
- "People that stayed with me and focused on my goals—even if I wasn't always sure what they were."
- "Instead of being *worked on*, I was *worked with*."
- "We want to pursue our occupational dreams and goals and contribute our talents to society. We just need a little more help."

These answers reflect the importance of developmentally appropriate mental health services to adolescents (roughly ages 13–18) and young adults (roughly 18–30) for whom maturation is as challenging as it is complex. This is the time of life when they establish autonomy and identity amid rapid change (e.g., new social situations and interactions, school, searching for employment). Recent developmental research identified several key tasks for members of this age group: deciding who they are and what they want from life, seeking independence, and forging a sense of self through experimentation and decision-making (Arnett, 2000, pp. 472–474; Benson & Elder, 2011, p. 11). Experiencing a mental health disorder can affect a young person's ability to navigate these central tasks (Davis, Sabella, Smith, & Costa, 2011). Services for these youth must be consistent with and respectful of their development.

WHERE WE ARE AND WHERE CAN WE GO? BACKGROUND, RATIONALE, AND DISCUSSION

EASA has found that developmentally appropriate treatment for adolescents and young adults respects and encourages their autonomy. Young people who have the power to make their own decisions in treatment and who are valued as equal collaborators by mental health practitioners consistently make better progress than those who don't. FIT therefore presents many opportunities for improving outcomes with these young people.

For example, a practitioner using FIT may recognize that a client is psychotic and say, "I would like to help you with the anxiety associated with your auditory hallucinations." The client would be asked if that goal makes sense to him or her, to which the client may state, "No, I really would like to focus on spending time with my friends." The practitioner would honor and take the client's preferences into consideration. In this case, for example, exploring how the client could spend more time with friends is likely a better way to engage this individual in the treatment process.

By tracking clinical outcomes using FIT, the practitioner and the client can talk about how the goal of spending time with friends is working out. This collaborative approach to goals can be effective regardless of specific clinical interventions (although it works well in conjunction with many models). Although this may seem contraindicated at first, EASA practitioners have found through FIT that the client later reported that auditory hallucinations did not bother him as much when he spent more time with friends. Anecdotally, EASA therapists have also found that a by-product of using FIT in this way is that psychotic symptoms (the symptoms the young person is least likely to want to focus on) actually improve.

Similarly, it is not uncommon for young people suffering from psychosis to get in trouble with the law. This is often due to acting on their symptoms or engaging in substance abuse. EASA practitioners have found the use of FIT especially helpful with these clients: Because a basic function of FIT is to focus on the outcome more than the process, EASA practitioners can start with the end goal. From the client's perspective, this often manifests in goals such as, "I want to get my probation officer off my back" or "I would like to not see you [the practitioner] anymore."

Using FIT, EASA practitioners let the client guide the interventions on how those goals are achieved. The outcomes are subsequently tracked to allow for an honest dialogue of how those interventions are working. If the client is moving toward the clinical cutoff on the ORS, and the SRS (or Child ORS/SRS depending on age) scores are above the cutoff—especially on the goals and approach scale—the practitioner can continue, even if the intervention would not be a traditional mental health intervention for working with mandated clients.

One challenge noted with FIT is encouraging truly open dialogue, especially with those adolescent and young adult clients who believe they are being forced into treatment. One avenue for dialogue that EASA practitioners have noted as being especially helpful is asking the client to rate how his or her parole officer or any outside entity (e.g., family, employer) who is "forcing" them to be there would think they are doing. This often leads to agreement on the common goal of getting the "forcing party" off their back. One way that EASA clinicians regularly explain the ORS and SRS to mandated clients is this:

> It seems you are mandated to see me. In some ways, we are in the same boat, as I am mandated to see you. Of course, our circumstances are very different because you have fewer options than I do. I am hoping we can have the mutual goal of not being forced to see each other anymore. I have these tools that can help us both gauge how we are doing on achieving that goal.

MONITORING PROGRESS AND SHIFTING TREATMENT USING FIT

The following vignette illustrates how progress can be monitored, then corrected when there is a lack of progress with a client suffering from psychosis.

Randy, a 23-year-old college student who was recently hospitalized for psychotic depression, was referred to therapy to address depression and psychosis with a practitioner who had extensive experience using cognitive behavior therapy (CBT). The client was also prescribed an antidepressant. After approximately 2 to 3 months of treatment, the CBT and the medication seemed not to be affecting his depression as indicated by a depression outcome measure, nor did his ORS demonstrate a clinically significant change from his baseline score. However, this client never missed an appointment and did report to the practitioner that he enjoyed their meetings.

Practitioner: In reviewing your outcomes, Randy, it looks like you view our relationship as being strong; however, your clinical outcomes remain lower than expected. Given your view of the relationship, I am wondering what else I could be doing differently?

Randy: You are doing great; I enjoy meeting with you. I don't even mind doing those "stinkin' thinking" homework assignments you have me do. It at least gives me something to do.

Practitioner: I am happy you enjoy the assignments, yet based on your reports on outcomes, they don't seem to be making a difference.

Randy: Oh, yeah, right, they help with boredom, but don't help with other things.

Practitioner: Is there anything I could do to help with the "other things"?

Randy: There is nothing you can do about those, unless you can get me a new refrigerator. [*Randy laughs.*]

Practitioner: A refrigerator?

Randy: Yeah my refrigerator broke a few months ago, and I can't afford a new one, so I have to buy food that goes bad fast daily from the Quick Stop in smaller sizes, which costs a lot!

Practitioner: Thanks so much for telling me that. Would it work if we changed the focus of our meeting time to focus on resources to get you a new refrigerator?

Randy: Hell, yeah, if we figure that out, that would help a ton!

The practitioner problem solved with Randy to use his Facebook and Twitter accounts to ask all of his contacts if they had a refrigerator available. The practitioner did the same with his contacts. Shortly after this intervention, several contacts offered a refrigerator if someone would take it from their garage. The practitioner used a future appointment time to go pick up the refrigerator, and take it back to Randy's apartment. Randy's clinical outcomes improved immediately and maintained over the next several weeks.

The focus of treatment shifted from CBT techniques to obtaining resources and skill development (e.g., how to shop cheaply, budgeting). If clinical progress and alliance were not measured in this case, it could easily have been the case that the client continued to do the homework, the practitioner might have assumed Randy was doing fine, and the impact of treatment would take time. Ultimately, it is likely that Randy would have dropped out of therapy, perhaps because the CBT was not meeting his need to obtain resources, his material needs were distracting him from making progress, or for another unknown reason. When clients drop out, it is often the case that the practitioner is left guessing why they left. Such guesses often blame the client: "Randy was just not ready to do the work to get better." Randy, however, feels that therapy was not helpful and chooses to not see a therapist again.

EASA has found that FIT honors the client's voice by eliciting his or her feedback and taking it into consideration when making treatment decisions. Recovery is defined on an individual basis. A young adult, for instance, may define recovery as getting a steady job despite experiencing persistent symptoms. A practitioner using FIT would support the client in obtaining her objective rather than imposing his own. This is particularly important for young people for reasons noted earlier in this chapter, but also for individuals with psychosis because they do not always acknowledge their psychotic symptoms. Imposing interventions focused on psychotic symptoms on a client who does not acknowledge the symptoms can and will produce resistance, dropout, and lack of trust for the mental health system as a whole. The following vignette illustrates this practice.

> A young adult man, Chris, who was enrolled in EASA, believed others could read his mind. He was not interested in being told he was wrong—he just wanted to work. He and his therapist collaborated in identifying strategies to manage his symptoms and still function. A strategy they developed was wearing a piece of tinfoil under his hat to every day to keep coworkers from detecting his thoughts. He has been steadily employed for years. This outcome was a direct result of his therapist's use of FIT. By administering outcome and alliance measures with Chris, his therapist learned that the approach of explaining Chris's symptoms from a medical model was not helpful. Following is a description

of how monitoring Chris's progress and the alliance—in this case, by administering the ORS and the SRS, enabled Chris's therapist to adjust her approach and consequently help Chris achieve the change he was seeking.

Practitioner: Do you mind if we review the results of your SRS for a few minutes before you leave today?

Chris: Sure.

Practitioner: I noticed that you did not feel the approach I used today was helpful. You rated me a 7 out of 10.

Chris: I was angry early in the session when you told me my coworkers' reading my mind was due to a chemical imbalance. Is has nothing to do with my brain. People can read my mind, and you telling me it has to do with something wrong with my brain is bullshit. I have tried pills to rebalance, and that did nothing.

Practitioner: I am sorry about my approach, but I am thankful you felt comfortable enough to tell me your thoughts. Is there another way I could be helpful in therapy?

Chris: [*laughing*] Make people stop reading my mind.

Practitioner: I really wish I could . . . anything else?

Chris: I could use some advice on what to do at work when everyone is reading my mind. It does make it difficult to focus on my job, and I can only take so many breaks before my supervisor gets on my case about it.

Practitioner: It sounds like taking breaks has been helpful, but I am also hearing you can't do that all the time.

Chris: Exactly.

Practitioner: I'm wondering if anything has helped in the past . . . anything at all.

Chris: At home when the neighbors start reading my mind, I will put some tinfoil over my head. That seems to help, but I can't do that at work. They will think I am crazy.

Practitioner: What if we came up with strategies in which you can do that at work or something similar. Are you allowed to wear hats at work?

Chris: Yes.

Practitioner: Do you think putting a piece of tinfoil under your hat would work for you?

Chris: I could try. My supervisor likes the Cubs, and I have a Cubs cap. I can try to get it under there.

Practitioner: Great, give that a try and let me know if that approach helps. And again I really appreciate you being honest with my about my approach. I want to be helpful in our sessions.

In this vignette, like the other in this chapter, had the practitioner not asked for feedback, she would not have known what specific intervention was helpful for Chris and may have defaulted to use unhelpful interventions, perhaps based on a medical model approach.

Practitioners using FIT do not assert primary control and refrain from the use of coercion. Furthermore, the goals of the family and community are not prioritized over the client's. This is especially important with individuals experiencing psychosis and when insight into their symptoms is lost or minimal, as it was in Chris's situation. Although the medical model may be helpful to some in understanding symptoms, it will not be helpful for everyone.

Using FIT can help the practitioner identify what the client finds helpful and support his or her explanatory model. EASA clinicians have found FIT helpful regardless of ongoing psychosis. As long as the client is able to have a conversation, even if the content is unusual or bizarre to the practitioner, the measures can be implemented. Doing so indicates to clients that the practitioner is interested in what they have to say regardless of content, because content is part of process and not always predictive of outcomes. EASA clients have reported that often EASA clinicians who use FIT were the first to listen and take seriously what they were saying and were willing to continue to see them. They have noted that other clinicians often told them (in the form of well-intended psychoeducation) that their "mental illness" was taking over their thoughts and, consequently, they felt unheard and decided to discontinue service. Researchers have speculated that as many as 50% of individuals diagnosed with psychotic conditions do not see themselves as having a mental illness (Amador, 2007). Given this finding, providing psychoeducation on a person's diagnosis may not be helpful and perhaps may even be harmful to the relationship. Even when clients lack insight into their symptoms, FIT can be helpful. Seeking clients' feedback on their subjective experience via the use of outcome and alliance measurement can be implemented in almost all settings with almost all clients.

EASA clinicians have reported that it can be challenging and awkward to administer the ORS and SRS to clients in cases when they pose an immediate danger to themselves or others, when clients are experiencing an immediate crisis, or when clients are so disorganized that communication at any level is difficult. In the cases of immediate danger to self or others, the practitioner must adhere to their specific discipline's code of ethics (e.g., American Counseling

Association's [2014] *Code of Ethics for Counselors*; American Psychological Association's [2017] *Ethical Principles of Psychologists and Code of Conduct*) and applicable state laws regarding these circumstances. Despite these challenges, EASA clinicians will often try to administer the scales orally to seek feedback, as in the cases described earlier. It is always possible to look for openings and have the mind-set of maintaining an attitude of openness and seeking client input. Building a culture of feedback is important no matter the circumstances.

THE CLIENT–PRACTITIONER ALLIANCE

One of the most important predictors of outcomes is the quality of the alliance between client and practitioner (Duncan, Miller, & Sparks, 2007; Duncan et al., 2003; Joosten et al., 2008). Working alliance data on young people in treatment indicate that therapy is most effective when "clients [youth and parents] experience the relationship positively, perceive therapy to be relevant to their concerns and goals, and are active participants" (Duncan, Miller, & Sparks, 2007, p. 39). Studies have also found that client-based outcome feedback dramatically increases effectiveness (decreased likelihood of deterioration, duration of productive engagement, achieving clinically significant change) and efficiency (reduced cancellations, no-shows, dropouts) for this population (Duncan, Sparks, Miller, Bohanske, & Claud, 2006, p. 73). Young people experiencing psychosis are no exception. In qualitative explorations of the empowerment indicators in treatment for teenagers experiencing psychosis, young people placed highest importance on being listened to, being understood, taking control, and receiving sufficient information (e.g., psychoeducation) to make decisions for themselves (Grealish, Tai, Hunter, & Morrison, 2013; Welsh & Tiffin, 2014). These are all components consistent with principles of FIT. By seeking feedback and adjusting treatment on the basis of the feedback received, therapists provide youth with the opportunity to actively participate in therapy and practice independence and self-determination.

Movement toward collaboration between practitioners and clients can represent a significant shift, particularly for young adults and adolescents experiencing severe and persistent mental illnesses, such as chronic psychosis. Often, mental health treatment for young adults and adolescents emphasizes a unidirectional hierarchy that places the provider in a position of power and control. Psychologist Patricia Deegan, a leading researcher on recovery and empowerment of people with mental illness, described this as a model based on adherence and coercion. "The compliance vs. noncompliance dichotomy," she noted, "can serve to reinforce the power of the physician and silence people with psychiatric disabilities" (Substance Abuse and Mental Health Services Administration, 2010, p. 2). The generally poor engagement rates

(some figures estimate 40%–60%) for young adults can be attributed in part to this compliance-based approach (Duncan et al., 2006, p. 72). If a primary goal of young people is to establish independence and make decisions, then being rendered without voice is a developmental misfit. FIT, on the other hand, encourages young people to exercise their voice via honest and direct feedback to their helpers.

The treatment of psychosis, too, has historically been shaped by a one-way hierarchical structure and limited focus in outcomes. German psychiatrist Emil Kraepelin, arguably the first to etiologically categorize psychosis as belonging to either manic depression or "dementia praecox" (later called schizophrenia; Burns, 2007, p. s1), based recovery largely on symptom reduction or elimination. Consequently, he developed a bleak prognosis for schizophrenia, calling recovery next to impossible. The modern relevance of Kraepelin's views cannot be overstated (Burns, 2007).

These diagnostic categorization theories served as the foundation for the *Diagnostic and Statistical Manual of Mental Disorders* and the *International Classification of Diseases*. As a result, Kraepelin's pessimistic views on recovery from psychosis were integrated, and the focus on symptom reduction inspired the resultant outcome measures. These included the Brief Psychiatric Rating Scale (BPRS; Overall & Gorham, 1962), the Positive and Negative Syndrome Scale (Kay, Fiszbein, & Opler, 1987), and the Clinical Global Impression (American Psychiatric Association, 1994). These assessments focus only on symptoms and do not measure overall functioning (e.g., employment, quality of life, psychosocial connections). They are practitioner rated, ignore subjectivity of response, and place no emphasis on the client–therapist alliance. When used on their own, these assessments can enable a constrictive view of recovery that reinforces a unidirectional compliance-based approach. This can be profoundly disempowering to clients. For example, in working with young adults experiencing psychosis, a practitioner may emphasize "correcting" delusional thinking (e.g., convincing someone the FBI is not monitoring them) and thereby creating insight. When clients do not wish to change their beliefs and disengage, they are considered "resistant" and their outcomes are consequently rated poorly.

Research indicates that symptom reduction and elimination have little to no impact on outcomes, especially compared with other factors, such as employment (Bond, Drake, & Campbell, 2016; Drake, Xie, Bond, McHugo, & Caton, 2013). Indeed, in early psychosis intervention, steady employment has been identified as one of the most common goals of young people and one of the most important predictors of less drug dependence, fewer negative symptoms, and better psychosocial functioning (Drake et al., 2013). This is not to say that reducing or eliminating symptoms should not be considered an important outcome alongside factors like employment, particularly if clients

define it as part of their recovery. Rather, it should be one component in a multifaceted clinical approach.

The following example demonstrates the use of FIT in combination with a symptoms measure in a case consultation with a psychiatrist.

Psychiatrist: I would like to talk about Vince. He has been taking his antipsychotic on a regular basis, but his BPRS score indicates that he is experiencing moderate to severe hallucinatory symptoms. I think I am doing all I can with meds. Are there any other suggestions on how we can support him? I know he is working; perhaps we should talk to him about cutting back on his hours. The job may be too stressful for him.

Therapist: In looking at his ORS scores, he has been in the high 20s and low 30s over the past 6 weeks, and note on the week after he started work, his scores spiked over 33. He marked the "socially" scale on the ORS. That particular scale on the ORS includes a measure of perceived work functioning and satisfaction. It makes me wonder if he is doing well despite having symptoms.

Psychiatrist: I am glad we reviewed this. I will ask him next time if he thinks his symptoms are getting in the way. I guess I am just accustomed to seeing psychotic patients not functioning well.

Therapist: When I started working with Vince, he gave me feedback that the goal he wanted to focus on in therapy was keeping his job. He really does not talk about his symptoms much in our sessions, other than that he manages them on his own and he thinks the meds are helpful.

Psychiatrist: Perhaps the meds are helping enough to keep the floor from falling out from under him by reducing his hallucinations somewhat and thus helping him to work, but they are not reducing his overall psychotic symptoms. I will focus more on how Vince perceives he is doing, especially when it comes to work and less on the BPRS scores.

This example highlights how the therapist and the psychiatrist were able to use Vince's feedback to adjust to his specific preferences on outcomes. After this interaction, the psychiatrist in his sessions focused more on asking how Vince was doing at work and how the medications were helpful in maintaining his job. After several weeks, the therapist checked in with Vince on how his meetings with his psychiatrist were going. Vince reported, "All is going well. The meds he is prescribing are helping me stay focused at work, and when he asked me if I was having any side effects, I told him yes, I am not hearing those voices as much."

To the present, there has been a lack of outcome measures that focus on indicators of improved functioning outside of symptom reduction. FIT is highly applicable to young people and helps maintain a flexible and developmentally appropriate definition of recovery for each client. Relevant instruments and protocols are currently undergoing testing (Ishii et al., 2014), including the online decision aid programs developed by Patricia Deegan and colleagues (Drake et al., 2010). However, availability for many of these is limited, and EASA is aware of none that incorporate an awareness of adolescents and young adult development and recovery from psychosis.

At EASA, we have found that FIT lends itself well to a team approach, especially when each team member understands the how and why of its implementation. Implementation can be individualized to the culture of the specific team (e.g., Chapter 5, this volume). EASA multidisciplinary teams implementing FIT meet weekly. The rule is that the last team member to see the client over the week completes the ORS and SRS and asks questions based on the team approach to treatment and not the individual practitioner's approach. EASA multidisciplinary teams have also found it useful to present graphed ORS and SRS scores in team meeting case reviews. It is common for case reviews to focus on the diagnosis of the client, with subsequent treatment recommendations from team members being related to that diagnosis. This is often a frustration to the practitioner presenting the case because it is likely that they have already tried the recommended approach without success, which is why they are presenting the client to the team. EASA's FIT approach focuses on the client's goals and reported outcomes. Suggested treatment interventions are based on those individual outcomes and goals.

People experiencing psychosis often have impairments in cognition and memory. Furthermore, clinical transparency can be hindered when clients are unable to understand the instruments and their purpose. The straightforward visual layouts of the ORS and SRS accommodate a wide range of clients and can reduce the stress and confusion of the impairments associated with early psychosis. An EASA client where the team was using FIT commented:

> It was so nice that they checked in with me all the time and in a way that was focused on my goals and not the goals of the so-called medical model world. I also liked that they wanted to hear what I had to say, even when what I said was not always positive. When I did tell them I did not like what was happening, they always made changes. This really keeps me coming back to EASA.

This accessibility makes FIT developmentally appropriate for youth. FIT is also open-ended in how it defines outcomes, categorizing them into

the broad domains ("Individually," "Interpersonally," "Socially," "Overall"). Clients can interpret these categories in a way that fits their goals and experiences (e.g., "How am I doing socially? I think I'm good. I've lost friends on Facebook, but made more on Instagram"). As discussed before, adolescents and young adults mature in a complex and multifaceted way. Thus, subjective outcome definition is developmentally appropriate. The ORS facilitates a broader definition of functioning. Progress is defined as improvement in broad domains, as opposed to focusing solely on symptom reduction and elimination as the standard of recovery. The combination of these features can make the ORS especially effective for use with adolescents and young adults experiencing psychosis. The ORS can also help practitioners determine whether their intervention of choice is effective with the client sitting across from them, as opposed to what should be effective according to the research. Evidence-based research is based on generalized models, rather than individual needs. So although several studies (e.g., Wykes, 2014) have suggested that CBT is effective with clients (from large clinical research samples) who have early psychosis, it may not be effective for the specific client with early psychosis who has been referred to you. There is also a belief that other therapy techniques, such as psychodynamic therapies, are not effective for clients with psychosis (Wykes, 2014). However, such a therapy may be effective for the individual client who has asked for your help in understanding how their past relationship patterns relate to the meaning of his psychotic symptoms. The point is that FIT helps practitioners to measure outcomes of the specific approach as they implement it with each client.

CONCLUSION

Given the findings and feedback from clients requesting a clear process to provide feedback, the EASA program has decided to implement FIT across its programs in Oregon. To help support the implementation, the EASA practice guidelines (Melton et al., 2013) include FIT as one of its treatment elements. EASA also has made a commitment in its practice to create a culture of feedback. Agency leaders agreed on this culture before implementing FIT. Adding FIT was an easy sell, given the commitment to create and maintain such a culture. Every 2 years, the agency conducts a fidelity review of the practice guidelines to ensure EASA practice guidelines are being followed, including the use of FIT. The EASA fidelity reviewers also model the culture of feedback by consistently asking for feedback on how they can be more supportive of individual programs and have made modifications to the support based on that feedback. The majority of the practitioners in the program are using FIT in individual sessions either via paper scales or a FIT mobile app.

Practitioners report that it is easy to use and that the majority of clients find the process helpful. The challenges reported are similar to those of many FIT users, with the primary reasons being forgetting to use the tool and not having the mind-set around using feedback as a part of practice. Some EASA sites are considering the use of a computerized system for administering the ORS and SRS and are working to integrate that software with their electronic medical records.

Through incorporation of SRS and ORS into their practice, mental health practitioners have a practical step toward integration of FIT. In turn, FIT offers a starting point for the implementation of developmentally appropriate mental health services for adolescents and young adults. Research thus far supports the efficacy of the ORS and SRS. According to the State of Oregon's Addictions and Mental Health Division (Sands, 2015), engagement rates of young adults with mental health services are critically low. If practitioners want to help young people grow and thrive, then they must start by creating a culture of feedback that values and respects personal preferences with regard to treatment and relationships with mental health practitioners.

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15

FACILITATING THE THERAPEUTIC ALLIANCE BETWEEN PHARMACISTS AND PATIENTS TO IMPROVE MEDICATION ADHERENCE

JANICE PRINGLE AND JAIME FAWCETT

Unsafe and inappropriate medication use has been counted as one of the most significant factors leading to unnecessary health care costs and poor patient outcomes (Balkrishnan, 2005; Sokol, McGuigan, Verbrugge, & Epstein, 2005; Vik et al., 2006). Most cases of inappropriate medication use involve whether and how patients take their medications. By facilitating patients' behavior change, practitioners can help their patients take medications as prescribed. Often frontline responders when it comes to patient medication use, pharmacists can facilitate appropriate medication use through patient communication approaches, thus developing a therapeutic alliance (Berger, 1993). As this chapter illustrates, extending feedback-informed treatment (FIT) into pharmacist–patient interactions has the potential to significantly improve patient medication adherence and thus improve health outcomes and reduce mortality.

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This chapter presents two case studies on the use of FIT centered on building a pharmacist–patient therapeutic alliance in community pharmacy settings. In each of these case studies, pharmacists used the Outcomes Rating Scale (ORS; Miller & Duncan, 2000) and Session Rating Scale (SRS; Miller, Duncan, & Johnson, 2000) in conjunction with communication-based intervention strategies to initiate a dialogue with their patients on medication use and behaviors (Pringle, Boyer, Conklin, McCullough, & Aldridge, 2014; Pringle, Melczak, Aldridge, Snyder, & Smith, 2011). These case studies detail the successes and challenges of implementing the FIT approach and associated instrumentation in a community pharmacy setting. They also provide some insight into an intervention that involves counseling patients of various health and behavioral risks to improve appropriate medication use. Of great importance to note is that the use of FIT in this area remains in its infancy; the work presented in this chapter involves primarily the use of feedback measures in building the alliance between pharmacists and patients. It focuses less on some elements of FIT described elsewhere in this volume, such as the nuances of outcome monitoring systems and deliberate practice.

THE MANY FACES OF INAPPROPRIATE MEDICATION USE

There are five types of inappropriate medication use.

- *Underuse* (nonadherence) occurs when patients take their medication at a lower frequency or dose than prescribed (Piette, Heisler, & Wagner, 2004).
- *Overuse* occurs when patients, without understanding the risks, take more medication than prescribed.
- *Misuse* occurs when patients intentionally take their medications differently (often at higher amounts) than prescribed for the purpose of achieving a secondary gain (usually either mood alteration or another psychoactive effect).
- *Unsafe use* occurs when patients take medications as prescribed but the medications have deleterious side effects when used alone, are clinically contraindicated with other prescribed medications, or both.
- *Misapplied medication* occurs when a patient is prescribed a medication that does not effectively address the targeted medical issue, and the patient's condition continues to worsen.

Medication nonadherence is a serious problem, with patients typically taking less than half of their prescribed doses (Ho, Bryson, & Rumsfeld, 2009;

Osterberg & Blaschke, 2005; Yeaw, Benner, Walt, Sian, & Smith, 2009). In a number of studies, this nonadherence has been associated with poor health outcomes (Choudhry et al., 2014; Kuntz et al., 2014), increased mortality (Rasmussen, Chong, & Alter, 2007), and increased downstream health care costs, largely reflected via increased hospitalizations and emergency department visits (Egede et al., 2012; Roebuck, Liberman, Gemmill-Toyama, & Brennan, 2011; Sokol et al., 2005). When medication nonadherence is prevalent among patients with common chronic illnesses, as it is with diabetes, cardiovascular disease, chronic obstructive pulmonary disease, and psychiatric illnesses, its impact can lead to significant monetary and resource waste. In the United States, Medication nonadherence has been associated with an estimated $300 billion in avoidable health care costs per year (Martin, Williams, Haskard, & DiMatteo, 2005).

Medication Overuse

In a 2012 *Clinical Toxicology* report, researchers found that the most common type of patient-mediated medication therapy error was patients double-dosing, with 28.7% of poison control calls being made as a result of this error (Mowry, Spyker, Cantilena, Bailey, & Ford, 2013). As with medication nonadherence (underuse), medication overuse is also associated with poor health outcomes, including clinical changes that can both exacerbate chronic diseases and create new acute health problems that can pose serious risks, including death (von Mach, Meyer, Omogbehin, Kann, & Weilemann, 2004). Taking more insulin than prescribed because of dietary lapses, taking multiple doses of medications to complete the regimen sooner or because planned doses were skipped (double-dosing), and increasing the use of pain medications beyond what is prescribed for the purpose of treating breakout pain are common examples of medication overuse. Although there are no figures on the health care costs associated with medication overuse alone, medication (and other therapy) overuse is associated with at least 30% of total health care spending (Korenstein, Falk, Howell, Bishop, & Keyhani, 2012).

Medication Misuse

Patients deliberately taking a higher or different level of medication than prescribed to achieve a secondary effect, such as feeling high, characterizes medication misuse. Common examples of medication misuse involve opiates and benzodiazepines (separately or in combination). The misuse of these medications has resulted in an unprecedented rise in overdose deaths nationwide (Beletsky, Rich, & Walley, 2012; Centers for Disease Control and Prevention, 2013, 2015). Patient misuse can also result in substance use

disorders (SUDs), poor health outcomes as a result of the SUD, accidents, criminality, domestic violence, poor work performance, child abuse and neglect, among other concerns (Swartz et al., 1998). In the United States, medication misuse is associated conservatively with an estimated $50 billion to $55 billion in health care and indirect societal costs per year (Hansen, Oster, Edelsberg, Woody, & Sullivan, 2011; White et al., 2005).

Unsafe Medication Use

Unsafe medication use involves prescribing a medication that increases the risk for deleterious outcomes either because the medication causes adverse side effects or is contraindicated with other medications the patient is using. Providers may prescribe medications with serious side effects because they do not know about the side effects or because the side effects are rare and unexpected. Commonly, patients who experience side effects fail to report them to their physician (Gerlach & Larsen, 1999). This is especially common if the physician fails to follow up with the patient to ask about possible side effects or fails to educate the patient about potential side effects and when to report them to a physician. When patients experience side effects, they commonly either continue to take the medication and prolong the side effects or discontinue taking the medication and do not seek an alternative. The preferred alternative would be discontinuing the medication and seeking an alternative medication from the prescriber. Practitioners typically prescribe drugs that are contraindicated in combination with others because they are unaware of all the medications the patient is taking. Although the cost of unsafe medication use within the community is not known, unsafe medication use with hospitalized patients is associated with an estimated $8.5 million in health care costs per hospital per year in the United States (Bates et al., 1997).

Misapplied Medications

Misapplied medications may be prescribed to a patient for a given condition; however, the patient may not respond because the condition has been either misdiagnosed or diagnosed correctly and the incorrect medication prescribed. When the condition is minor and unlikely to progress to something more serious, then the medication misapplication may only result in frustration for the patient and a small amount of health care resource waste. However, if the condition is likely to progress and worsen if not effectively treated, then the misapplication could increase morbidity and mortality. This can also increase avoidable downstream health care costs associated with the worsening health conditions (e.g., hospitalization).

THE PHARMACIST'S ROLE IN MEDICATION USE BEHAVIOR CHANGE

Inappropriate medication use is largely a problem of behavior because patients fail to take medications as prescribed, fail to notify their provider when the medications are causing adverse side effects and health outcomes, or fail to notify their provider when medications are not effectively treating their symptoms. There are an estimated 290,780 licensed and practicing pharmacists in the United States (Bureau of Labor Statistics, 2014). Despite training, however, most of these pharmacists do not provide direct patient care services that could significantly decrease inappropriate medication use, making them a largely untapped resource for improving population health. Moreover, pharmacists are consistently viewed as one of the most trusted health care professionals (Riffkin, 2015). Thus, the foundation for a strong therapeutic alliance is already present. Pharmacists present an essential conduit for improving patient medication use, patient health outcomes, and the prudent use of health care resources.

A plethora of internationally published studies point to the effectiveness of pharmacist-led interventions on inappropriate medication use for patients in a variety of community and health care settings (Pringle et al., 2014; Taitel, Jiang, Rudkin, Ewing, & Duncan, 2012; Van Boven, Stuurman-Bieze, Hiddink, Postma, & Vegter, 2014). Most of these studies focus on medication nonadherence and indicate that pharmacist-led interventions have a significant impact on improving patient medication adherence using various strategies and settings. Some of these interventions include the provision of devices or mechanisms designed to guide appropriate medication use (Hayes, Hunt, Adami, & Kaye, 2006; Pop-Eleches et al., 2011; van Eijken, Tsang, Wensing, de Smet, & Grol, 2003). These devices can include pillboxes, automated reminder systems, literacy aids, smartphone apps, and interactive websites, for example. Pharmacist interventions may also include working collaboratively with health care providers and caregivers to clarify and improve medication safety and effectiveness (Hanlon et al., 1996; Schnipper et al., 2006). Successful pharmacist interventions can be provided within any health care or community setting (Kaboli, Hoth, McClimon, & Schnipper, 2006; Rupp, DeYoung, & Schondelmeyer, 1992; Schnipper et al., 2006; Smith, Giuliano, & Starkowski, 2011).

Despite the variety of tools, personnel, and settings involved in pharmacist-led medication-focused interventions, they all depend on pharmacist–patient communication strategies and styles. These communications can occur face-to-face, over the phone, via electronic messaging, or by any mechanism that facilitates communication between health care practitioners and patients. To achieve the highest impact on patient health, it is important

that pharmacist–patient communication use strategies that are effective, permit pharmacists to be efficiently and reliably trained, and that can be consistently implemented with fidelity within the relevant practice setting.

The following two case studies detail pharmacist–patient communication-based interventions using FIT. Specifically, the researchers were interested in using these interventions to improve medication nonadherence. However, the interventions allowed the pharmacists to help the patients or their prescribers address medication overuse, unsafe medication use, and misapplied medications.

In the first case study, community-based pharmacists used medication therapy management (MTM) to improve medication adherence for Medicare Part D patients (patients 65 years or older in the United States) with a diagnosis of diabetes. The FIT approach was used to explore the hypothesis that the ORS and SRS instruments, which are key to providing FIT, could enhance the effectiveness of the MTM session (Pringle et al., 2011). In the second case study, pharmacists applied a combined screening and brief intervention (SBI) that included motivational interviewing (MI) principles with FIT. Pharmacists also used the ORS and SRS instruments to identify patient risk for adherence problems and to establish a therapeutic alliance as a base for conversations regarding how the patient could improve his or her adherence. These case studies illustrate some successes and challenges of using FIT to improve appropriate medication use in pharmacy practice and suggest ways that FIT can be applied to pharmacy services.

CASE STUDY 1: FIT IN A NORTH CAROLINA PHARMACY

Although they may not fit the traditional definition of behavioral health practitioners, pharmacists can still play a therapeutic role to guide patient behavior regarding medication use or encourage patients to seek behavioral therapy when medication misuse may be problematic. Berger (1993) emphasized the importance of therapeutic alliance in pharmacy practice, writing that "pharmaceutical care requires a much more intimate and intensive relationship between the pharmacist and patient than simple pharmaceutical dispensing" (p. 2399). Most important, he noted that patients who worry that they will be judged or scolded for nonadherence or for taking their medications inappropriately are less likely to discuss medication problems with their pharmacist (Berger, 1993). Thus, for pharmacists to become the significant driver of appropriate patient medication use, it is important for them to understand the potential breadth of their relationship with their patients with regard to appropriate medication use.

Routinely, pharmacists are providing MTM services to patients at risk for adherence problems or for deleterious health outcomes should adherence worsen. MTM services typically involve brief sessions in which pharmacists identify and discuss medication-related problems in depth with the patient. To develop and facilitate adherence to optimal medication regimens, MTM services assess patients' medications and how they are (or are not) using them as prescribed.

This first study examined whether patients who received MTM services in conjunction with the FIT process (MTM + FIT) would have better medication adherence than patients who received MTM services alone (MTM Only). The FIT process involved (a) using the ORS to assess a patient's potential adherence risk by determining in which of the domains (individually or collectively assessed by the instrument) the patient may not be functioning in a desired way, (b) using the SRS to collect feedback from the patient regarding how well the MTM session met criteria associated with a stronger or weaker therapeutic alliance between the pharmacist and patient, and (c) applying the results of the SRS to future communications for the purpose of improving the therapeutic alliance.

Case Presentation

Beginning in November 2008, pharmacists in Kerr Drug, a small chain drugstore in North Carolina, began inviting patients to participate in the study. Patients were provided with an informational script detailing rights as a participant. Patients provided verbal consent for participation. Participating patients were 65 years or older, diagnosed with diabetes, receiving Medicare Part D services involving MTM services funded and managed by a pharmacy benefit management company (i.e., OutcomesMTM), and taking at least one medication to treat their diabetes. Patients could participate in up to three MTM sessions before the end of the study. OutcomesMTM paid Kerr Drug via a traditional claims process for the patients who received the MTM services in either experimental group. Patients were randomly distributed into two test groups: the direct intervention group (MTM + FIT) and a comparison group (MTM Only).

Six pharmacists at the organization volunteered to participate in the study. They completed a 1-hour training on the administration and interpretation of the ORS and SRS with Scott D. Miller (the instruments' developer). The pharmacists were given only general guidance during the trainings on how to apply FIT into their MTM sessions. The pharmacy clinical manager at Kerr Drugs, who oversaw the study, developed and shared additional strategies for applying the instrument results to the MTM sessions and patient communications.

Patients and pharmacists met in a private office located in the central reception area of the community pharmacy. They began with the patient completing the ORS. The pharmacist then reviewed the ORS results and used them as appropriate as the consultation session began. Because there was no formal protocol for how the pharmacist should use the ORS results within the MTM session, the training suggested that the pharmacist begin the session by asking broad, general questions such as: "So, I see from your response you are having problems with overall well-being. Could you tell more about how that may be affecting how you are taking your medication?" Or just asking, "What can I do to help you today?" The pharmacists then continued by asking patients about their medication use, how they felt physically and psychologically (using the ORS results to probe), and how the patients followed recommended lifestyle behaviors (e.g., diet and exercise) At the end of the session, the pharmacists asked the patients to complete the SRS instrument.

Study findings suggested that using FIT in conjunction with MTM services produced a significant improvement in patient medication adherence for the targeted diabetes medications compared with the patients who participated in standalone MTM sessions. Medication adherence was measured as the Proportion of Days Covered (PDC) and PDC80, where adherence is defined as a PDC of 80% or greater within a given time interval (Hess, Raebel, Conner, & Malone, 2006; Nau, 2012). The effects of the MTM + FIT intervention were measured using double robust propensity score matching between the study groups. The study revealed that the MTM + FIT intervention led to a PDC80 rate that was 4.6 percentage points higher than MTM alone. This effect was statistically significant at $p = .020$. This result was consistent with the improvement seen for the PDC metric that revealed PDC increased by 3.1 percentage points from 93.9 to 97.0 ($p < .01$).

SUCCESSES AND CHALLENGES USING FIT IN A PHARMACY SETTING

As part of the study, the researchers interviewed pharmacists about their experiences incorporating the FIT instruments and process into the MTM counseling sessions. Overall, pharmacists had positive remarks regarding how the inclusion of the FIT methods improved patient medication adherence and the pharmacist–patient relationship. For example, one pharmacist noted,

> I found that using these instruments helped me focus on what the patient needs instead of a medication list or what I think they need. It has caused me to think "out of the box" in ways that I did not realize I could.

The pharmacist here underscores a common problem in pharmacy practice: pharmacists assuming they know why the patient isn't properly adhering to a medication or taking a medication appropriately. For example, pharmacists believe that the major cause of patient nonadherence is patient forgetfulness. However, in reality, in addition to forgetfulness, patients fail to take their medications because they are concerned about side effects, cannot afford the medications, do not think they need them (they are in denial about their condition), have psychosocial issues (e.g., depression, protracted grief, stress, anxiety, alcohol use problems) that impede their ability to prioritize self-care, or cannot logistically get to the pharmacy to pick up their medications on a regular basis (among other reasons; Bautista, Vera-Cala, Colombo, & Smith, 2012; García-Pérez, Álvarez, Dilla, Gil-Guillén, & Orozco-Beltrán, 2013; Vermeire, Hearnshaw, Van Royen, & Denekens, 2001). In addition, pharmacists receive little training regarding why patients misuse their medications and can often make inaccurate judgments about patients who have become addicted to prescription medications, thus removing the opportunity to intervene appropriately with patients and connect them to needed behavioral health services (Dole & Tommasello, 2002; Lafferty, Hunter, & Marsh, 2006). Essentially, inaccurate assumptions as to why patients are not taking their medications appropriately can be detrimental to the therapeutic alliance process and hinder patients from seeking or receiving help for their medication use problems. The FIT approach expanded pharmacists' understanding of these issues.

The ORS administered at the beginning of the MTM session allowed patients to voice their concerns and pharmacists to look for the root of patients' medication use problems. Because the FIT practices allowed patients to feel more comfortable discussing problems and concerns, the pharmacists were able to uncover medication use problems beyond the typical failure to take a medicine or fill a prescription. As a result, the pharmacists could fix the medication use problem and improve the patients' adherence and health outcomes. One pharmacist provided the following anecdote:

> One patient told me she was very tired. I found this out when I questioned her from the ORS . . . it turns out she is taking four sedatives throughout the day prescribed by three different physicians . . . much more than she should be . . . I spoke with her PCP [primary care physician], and we changed her regimen.

It is clear that pharmacists can use the ORS to address patient functioning as it may relate to medication use and self-care, and then use the SRS to ensure that they are interacting in a manner that the patient finds beneficial and collaborative. Pharmacists reported that overall, patients were willing and comfortable to provide feedback on the MTM session using the SRS. Most participating pharmacists also reported that they found the feedback

from the SRS helpful. Rather than dreading it, they began to look forward to the SRS results so that they could learn how to improve their collaboration with patients. These effects could be reinforced by the pharmacists actively telling patients to be comfortable and honest in providing feedback.

There were some challenges in using FIT in a pharmacy setting. Although all the pharmacists at the site were trained to use FIT and the ORS and SRS instruments, some pharmacists did not want to do the extra work associated with the MTM and FIT processes and had to be tightly managed by the lead pharmacist. Because this was the first study to use FIT in pharmacy practice, there were no established guidelines for integrating FIT with the sessions. The integration was mostly developed ad hoc by the participating pharmacists. The lead pharmacist reported reinforcing and managing these integration strategies via regular group and individual supervision sessions but was not sure that these were the most effective or appropriate methods.

The researchers also observed that some pharmacists were initially concerned about the SRS results and resistant to receiving patient feedback. This largely dissipated as pharmacists began receiving regular feedback and learned to react constructively. It seemed that patients were initially giving pharmacists more positive scores on the SRS instrument than they did throughout the trial. The pharmacists felt patients were providing positive scores out of politeness. However, as the study progressed and patients became more comfortable providing constructive feedback, the SRS scores became more variable, with pharmacists sometimes receiving lower scores. Although most of the pharmacists felt comfortable with the constructive feedback and willingly asked their patients how they could improve, a few grew more resistant to the SRS and felt threatened by the worsening scores.

Another interesting effect of implementing FIT was the patients' new reliance on pharmacists as important partners in managing their health care. Although, overall, this can overall be seen as a success to the process, some patients started calling the pharmacists between visits to discuss issues outside of the scope of the pharmacists' care and services (i.e., questions better suited for primary care physicians). This caused some workload issues, and when the pharmacists would ask the patients why they didn't call their physician, the patients would frequently respond, "Because he doesn't listen to me like you do."

Overall, Kerr Drugs and OutcomesMTM felt this study demonstrated promise for the application of FIT with MTM counseling to improve medication adherence among the targeted patient population. The clinical lead pharmacist left Kerr Drugs near the end of the study and expressed a strong desire to apply the FIT process to Medicaid patients she would be managing in her next position. Unfortunately, neither Kerr nor OutcomesMTM continued the application of FIT in their MTM service models beyond the study.

CASE STUDY 2: FIT IN PENNSYLVANIA COMMUNITY PHARMACIES

The second study arose from the pilot phase of a previous study designed to use a web-based platform for pharmacists to report quality metrics associated with medication adherence and safety. In the first phase of the study, pharmacists reported that although the data were useful, they wished they had had intervention methods to improve medication adherence when the metrics indicated patients showed poor adherence for specific medication classes.

In the second pilot phase, Pringle, as principal investigator, developed an intervention combining the principles found in SBI, including MI and FIT. SBI commonly uses a developed screening tool for evaluating patients with hazardous alcohol use problems and providing a brief intervention (BI, typically a 3- to 5-minute conversation). The BIs in this study used MI principles to understand the patients' substance abuse behaviors and help them take a proactive role in changing their behaviors (Aristeiguieta, 2000; Babor & Kadden, 2005). Pringle hypothesized that SBI could be transferred easily to the pharmacy setting with pharmacists screening for poor adherence risk and providing a BI to facilitate patients' medication adherence. Pringle also felt that applying BI sessions with FIT would enhance the results of the previous study, where the MTM counseling sessions were not specifically based on a communication strategy that had been demonstrated to facilitate patient behavior change.

This study based the BIs on MI principles originally developed by Miller and Rollnick (2002). MI is a patient-centered, evidence-based communication style that aims to collaboratively motivate patients to change their behaviors (Miller, 1996; Miller & Rollnick, 2013). MI coincides with therapeutic alliance goals because the key role of the pharmacist in this practice is to act as a nonjudgmental guide for the patient, rather than someone forcing or urging the patient to change. To help the pharmacists apply the targeted MI principles, the principal investigator developed the POLAR*S (pronounced Polaris) schema and acronym:

- *permission*—asking patients' permission to talk about their medication adherence;
- *open-ended questions*—asking open-ended questions to learn more about patients' problems with adherence;
- *listen reflectively*—using verbal and body language that shows patients you hear and understand their concerns;
- *affirmation*—signaling to patients through words or body language that you understand their motivations, thought processes, and choices about their medication use;

- *rolling with ambivalence*—signaling to patients that you understand why they are ambivalent about changing their behaviors, but not giving up on them; and
- *summary*—reviewing with patients what you have talked about and your plan of action.

This schema uses MI principles in a sequence typical for a community pharmacy interaction.

As part of the intervention, pharmacists used the Adherence Estimator (McHorney, 2009) and ORS instruments to screen patients for adherence problems and then followed the BI (POLAR*S) session with the SRS instrument to gather patient feedback on the intervention so pharmacists could use this information to improve their alliance with subsequent patients. The main advantages of this SBI + FIT intervention are (a) its ability to quickly determine patient adherence risk, rather than applying interventions to the entire patient population whether it is warranted or not; (b) its use of both an evidence-based communication strategy that facilitates patients' behavior change and FIT to facilitate therapeutic alliance; and (c) its scalability for large numbers of pharmacists and pharmacies.

This study was designed to evaluate the impact of the pharmacy intervention on patient adherence to five chronic medications (e.g., beta-blockers, calcium channel blockers, statins, renin angiotensin system antagonists, and oral antidiabetes medications) and on downstream health care costs. This study compared medication adherence and health care use (via claims data) among patients who had received two or more refills at the intervention pharmacies (and received BIs and FIT), with patients who had received two or more refills at pharmacies that provided standard pharmacy services with no intervention (no BIs and no FIT).

Case Presentation

The study took place across 218 Rite Aid pharmacies located in Pennsylvania. Across the pharmacies, 283 pharmacists went through a 4-hour training that included a didactic portion on how adults change behavior; the application of the SBI, MI principles, and FIT; and the associated screening and feedback instruments, such as the Adherence Estimator (McHorney, 2009), ORS, and SRS. The training also included an experiential component in which the pharmacists practiced applying the instruments and the BIs in mock sessions with colleagues playing patient and pharmacist roles in standardized cases. After a period of practice, the pharmacists were assessed for proficiency in providing the BIs using one randomly assigned role-play scenario and a checklist based on the relevant MI principles. Pharmacists were

required to meet at least beginning proficiency on the role-play as determined by the trainer and the proficiency checklist. Upon completion of training, pharmacists were given a laminated card that outlined the POLAR*S principles to use as a guide during their interventions with patients.

Three Rite Aid clinical managers and one manager of the participating insurance company also received an 8-hour training by the research team that provided a more in-depth review of the same curriculum presented to the pharmacists. This training also reviewed the principles for FIT, the results of the Kerr Drug study, as well as potential strategies that the pharmacists could use to incorporate the ORS and SRS instruments into their BIs. The managers receiving this training were expected to provide logistical and clinical support to the pharmacists applying the SBI + FIT approach. This support took the form of site visits, phone calls, and review of performance reports (e.g., the SRS scores).

Pharmacists at 107 of the pharmacies applied the SBI + FIT intervention to patients, while pharmacists at 111 control pharmacies simply administered standard care. A total of 29,042 patients were identified across the intervention sites, and a total of 30,454 patients were identified across the control sites. The study patients had to be at least 18 years of age and taking a prescription in one of five medication classes: (a) beta-blockers, (b) calcium channel blockers, (c) oral antidiabetes medications, (d) renin angiotensin system antagonists, and (e) statins.

For patients with new prescriptions in the intervention pharmacies, screening and intervention included the Adherence Estimator to identify patients with possible low adherence. This short 6-point Likert-scale questionnaire asks patients about their agreement with three statements regarding their new prescriptions: “I worry that my prescription medication will do more harm than good,” “I am convinced of the importance of my prescription medication,” and “I feel financially burdened by my out-of-pocket expenses for my prescription medication.”

The ORS was administered to patients obtaining refills for existing prescriptions to identify those at risk for adherence problems and to guide the pharmacist during the course of the BI. Patients completed the SRS instrument at the end of the intervention session. Because it was not feasible for pharmacists to stop and review each individual SRS immediately after the BI, the pharmacists faxed completed SRS instruments daily to the research team. In turn, the team aggregated the data to compare patient SRS responses within and across pharmacies and provided a report to the pharmacy weekly with these results. The research team also flagged SRS responses that were particularly poor, indicating that a particular patient was very unhappy with his or her session, indicating a poor therapeutic alliance with the involved pharmacist, and brought these to the attention of the pharmacists within the

participating pharmacy and the clinical managers who were overseeing the study in as close to real time as possible.

The PDC and PDC80 metrics described earlier measured medication adherence. A propensity score approach using mean adherence measures compared differences in adherence between the intervention and comparison groups. For all medication classes, the intervention had a positive effect on adherence, and all findings were statistically significant. In both the intervention and control groups, low-risk patients with a PDC greater than 80% before the intervention were very likely to remain at this level at follow-up. In the control group, the number of patients who had a baseline PDC of 80% or greater (PDC80 status) but then fell below 80% during the study was roughly equivalent to the number of patients who achieved PDC80 following a non-PDC80 baseline status. Approximately 75% of net improvement in PDC80 among the intervention group was attributable to high-risk patients who reached PDC80.

Analyses on health care claims data also revealed promising results for the intervention to reduce downstream health care costs. For intervention patients using oral diabetes medications, annual costs during the intervention period were lower by $341. The intervention group patients who used statins also saw a $241 decrease in annual costs. The remaining three medication-class samples did not demonstrate significant health care cost reductions compared with the control group patients largely because of the number of patients taking only these medications was likely too small to demonstrate an effect on downstream health care costs.

SUCCESSES AND CHALLENGES OF IMPLEMENTING FIT

Overall, the pharmacists conveyed positive experiences with the FIT approach and instruments. Most pharmacists said they enjoyed the entire intervention process—SBI + FIT. Some pharmacists commented that this form of patient care is what they felt they had gone to school to provide, "not just to count pills." The pharmacists mentioned that the majority of their patients also seemed to appreciate the conversations and interventions. A majority of the pharmacists said that they wished they could continuously learn how to use the interventions even more effectively and wished their job primarily involved applying this kind of patient care.

Integration of the SBI + FIT model was a relatively seamless process. Pharmacists reported that the interventions did not conflict with their other duties, such as administering immunizations and reaching personal and pharmacy target rates for these activities. These findings suggest that the SBI + FIT intervention would likely be scalable.

Researchers' interviews with some of the patients who received care within the intervention pharmacies indicated that they "loved their pharmacist." Some patients even mentioned that they passed other pharmacies closer to their residence to come to the intervention pharmacy because they knew their pharmacists cared and would answer their questions. In fact, the intervention pharmacies realized an increase in script volume of 900 pills per 1,000 patients.

One pharmacy stands out as an example of the positive effect of ORS instruments. Located in a distressed and underserved area with a disproportionate number of patients who were dual eligible (i.e., receiving both Medicaid and Medicare benefits) and had a serious or persistent mental illness, one might expect this unit to have difficulty, but the opposite proved true. Pharmacy staff learned how to adapt and administer the ORS to this specific patient population, and patients took to it well. This location had high rates of applied BIs compared with other pharmacies and demonstrated better adherence metrics during the study (demonstrated via the online platform) despite their obvious challenges.

Most challenges with implementing the SBI + FIT intervention involved convincing pharmacists to embrace the process. Some pharmacists reported having trouble using the ORS at first and didn't see how it was relevant to pharmacy practice. The clinical managers assured these pharmacists that the ORS had been used in pharmacies previously and was successful in improving medication adherence (i.e., the Kerr Drug study). Initially it was difficult to motivate the pharmacists to have patients complete the SRS following the BIs. Clinical managers added the number of completed SRSs to performance metrics, and pharmacies with low completion rates received individual guidance to increase their SRS completion rates.

There are also some practical challenges to implementing FIT interventions in community pharmacies. The first is time spent per patient. Fortunately, this intervention only takes 2 to 10 minutes with longer interventions occurring mostly for patients who score as having a higher risk for medication nonadherence. A second is ensuring patient privacy. At this point, most pharmacies have some space set aside to conduct patient consultations, and it is expected that these spaces will continue to become more common over time.

The results of this study were published in *Health Affairs* (Pringle et al., 2014), resulting in numerous national conference speaking invitations for both the research team and pharmacy managers. Rite Aid reports that all of its pharmacists nationwide are now prepared to apply the SBI portion of the intervention once it has negotiated new financial models with relevant payers and pharmacy benefit managers. Other pharmacies are now interested in using the intervention, and researchers offer online training in the application of these FIT tools.

THE ROLE OF THE PHARMACIST ACROSS HEALTH CARE SETTINGS AND WITH MENTAL HEALTH PROVIDERS

The application of FIT in pharmacies could have wide implications across the spectrum of health care settings, with each setting offering a different opportunity to enhance patient care services with the SBI + FIT or MTM + FIT. In community settings, pharmacists can integrate the SBI + FIT processes into their workflow without significantly affecting their ability to dispense medications or provide immunizations.

Poor medication management upon hospital discharge can increase unnecessary hospital readmissions (Sokol et al., 2005). Pharmacists in hospital settings might do well to initiate interventions (BI or MTM) via FIT and other medication management processes with patients upon hospital discharge. Pharmacists within primary care practices can be regular staff or contracted within the community. Staff pharmacists can provide ongoing care including the full continuum of cognitive services described (MTM + FIT and SBI + FIT) to all patients within the practice or act as a liaison between patient and physician as needed.

Pharmacists within long-term care facilities typically manage patient medications and provide clinical consultations to prescribers. Because pharmacists sometimes provide cognitive services to patients and their caregivers as patients are discharged, FIT interventions (MTM or BI) may be especially helpful here.

Furthermore, it will be increasingly important for pharmacists to understand their role in screening and intervening with patients who have mental health problems. First, patients with mental and behavioral health disorders are less likely to comply with medical treatments and medications, both those that treat mental health disorders and other chronic diseases (DiMatteo, Lepper, & Croghan, 2000; Higashi et al., 2013). Pharmacists conducting FIT interventions have the opportunity to coordinate not only with prescribers within general medicine settings (i.e., primary care physicians) but also with specialty prescribers (i.e., psychiatrists) who are prescribing mental health medications, and psychologists, who are often not prescribers but who can act as another touchpoint for addressing behavioral modifications to improve adherence.

Additionally, pharmacists can also act as an additional professional to provide primary screening to patients for behavioral health disorders alone or as part of collaborative care teams (Rubio-Valera, Chen, & O'Reilly, 2014). In the community pharmacy setting, mental health screening questions can be easily appended to the nonadherence screening instruments described in this chapter. Pharmacists can then serve to identify patients at risk for behavioral health problems (i.e., opioid use disorders), providing the patient with appropriate interventions and referrals to additional services that could ultimately reduce the patient's risk for outcomes such as overdose death. Pharmacists will also have a

potent incentive that will support their need to learn how to identify and address behavioral health issues among their patients as future Medicare Star ratings associated with adherence will become harder to achieve. This planned raising of the Medicare Star ratings bar will force pharmacists to address factors such as the role of depression or alcohol use on the patient's medication use behavior.

FUTURE WORK

Further research and quality improvement efforts applied to the MTM and BI via FIT interventions portrayed in this chapter can help these processes become even more effective in supporting patient behavioral change toward optimal medication use and improved health care outcomes. Some additional areas of research might include (a) exploring additional screening tools that may be useful in identifying risk factors associated with medication underuse (e.g., evidence of depression, alcohol use, self-efficacy status, values or beliefs concerning how active the patient should be in managing their health), (b) understanding how to develop and implement interventional approaches via FIT that would optimize patient care and outcomes within any pharmacy practice setting, (c) developing information technology applications to support serial MTM + FIT and/or SBI + FIT sessions with patients; and (d) creating effective training programs for pharmacists to implement evidence-based interventions via FIT.

CONCLUSION

Pharmacists are an untapped resource in assisting our health care system to significantly improve appropriate medication use among patient populations. MTM and BIs using MI and FIT have demonstrated significant promise in optimizing the therapeutic alliance between patients and pharmacists and improving medication underuse (adherence) among diverse patient populations, which can reduce downstream health care costs. As the U.S. health care system undergoes dramatic changes, the need to engage pharmacists in improving appropriate medication use will become increasingly important, and interventions via FIT will be a vital strategy to facilitate engagement.

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16

THE PRACTICE AND THE PRACTICAL: PUSHING YOUR CLINICAL PERFORMANCE TO THE NEXT LEVEL

DARYL CHOW

"If your mind is empty, it is always ready for anything; it is open to everything. In the beginner's mind there are many possibilities, in the expert's mind there are few" (Suzuki, 1970, p. 1). Renowned Zen monk and teacher Suzuki-Roshi's words have much to say to psychotherapists. Ours is a field that values professional development, and there's always room for improvement. The issue is not about will but about finding a way. We need to get better at getting better. With the aid of routine outcome monitoring (ROM), an executable plan for deliberate practice can take competent practitioners beyond their current edge of ability.

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WHY ROUTINE OUTCOME MONITORING IS NOT ENOUGH TO GET YOU BETTER

"In times of change, learners inherit the Earth, while the learned find themselves beautifully equipped to deal with a world that no longer exists" (Hoffer, 1973, p. 22). Across various disciplines of psychotherapy and mental health services, integrating ROM into clinical practice makes perfect sense. Meta-analysis has clearly demonstrated that ROM helps reduce deterioration rates (Lambert & Shimokawa, 2011). The reality is that a small proportion of clients do get worse during the course of treatment, and unfortunately, clinicians are not only highly optimistic (we really have to be to keep functioning, don't we?) but are also poor judges of which clients might deteriorate.

Self-Assessment Bias

In a year-long treatment study (Hannan et al., 2005), researchers asked a group of 48 clinicians to identify which of their 550 clients had deteriorated at the end of treatment. To help the practitioners, they were given the average based rate of deterioration among clients (i.e., 8%). In other words, approximately eight of every 100 clients are likely to experience this decline. However, as sanguine as therapists usually are, they collectively predicted three of 550 cases (that's 0.5% against a norm of 8%), correctly identifying the failure in only one of their three chosen cases. Not only were therapists optimistically biased, they performed worse than the basic predictive analytics, which came in at 7.3%, that is, 40 of the 550 clients actually deteriorated by the end of treatment. Hannan's team couldn't have made this point clearer: "Therapists tend to overpredict improvement and fail to recognize clients who worsen during therapy" (Hannan et al., 2005, p. 161).

We are poor evaluators of our own performance. Without the aid of ROM, we are poor forecasters of our client outcomes (Tetlock & Gardner, 2015). Like other professionals, therapists are not immune to the phenomenon of self-assessment bias (Dunning, Heath, & Suls, 2004; Kahneman, 2011). The least effective therapists rate themselves as the most effective cohort (Brown, Dreis, & Nace, 1999; Hiatt & Hargrave, 1995). Similar to Hannan et al.'s (2005) study, Walfish, McAlister, O'Donnell, and Lambert (2012) found that therapists overestimate their rates of client improvement and underestimate their deterioration rates. Specifically, therapists rated their current effectiveness levels around the 80th percentile, and none rated themselves below average. It seems we managed to defy the bell curve! We initially thought that this was due to a lack of systematic monitoring of outcomes in this cohort, but in our attempt to reexamine this in one of our studies, we found similar results despite the fact that the therapists we investigated in a

practice research network (PRN) setting were using ROM in their clinical practice (Chow, 2014). These practitioners rated their current effectiveness level above the 70th percentile. As in Walfish and colleagues' study, none of them rated below average. Curiously, self-assessment of effectiveness did not predict outcomes consistently. Two things could be happening. First, perhaps therapists were not keeping an eye on their performance relative to their peers in the PRN. Second, despite the results, the poorer performers might discount the results and persist based on biased reasoning. Taken together, we fall prey not only to self-assessment bias but also to self-optimism bias.

Limitations of ROM

Although continuous use of outcome measures guards against self-assessment and self-optimism biases, it does not necessarily help a therapist get better in the long run. In a wide range of scientific disciplines, a common phenomenon called the *decline effect* occurs. That is, promising findings from initial studies with stronger effects tend to taper off in further replication studies. In some cases, they even contradict past findings (Ioannidis, 2005a). This is largely a product of publication bias, in which null or negative findings are often left unpublished and highly cited initial trials are left unchallenged (Ioannidis, 2005b).

ROM and feedback studies are not immune to the decline effect (Miller, Hubble, Chow, & Seidel, 2015). Earlier studies have demonstrated therapeutic benefits of using feedback measures, but more recent studies have showed contradictory results. Four recent studies seem to point toward this trend. First, in an emergency outpatient psychiatric setting in Holland, van Oenen and colleagues (2016) compared the outcomes of 370 randomized patients grouped into a feedback (Partners for Change Outcomes Management System [PCOMS]) or no-feedback condition (treatment as usual). No differences were found between the two groups, both on the primary outcome measure (Outcome Rating Scale [ORS]), as well two other independent outcome metrics (the Brief Symptom Inventory and the Outcome Questionnaire—45). Second, in a naturalistic multisite randomized clinical trial (RCT) conducted in six psychiatric clinics in southern Norway ($N = 259$; Amble, Gude, Stubdal, Andersen, & Wampold, 2015), researchers found the main effect to be nearly half the size ($d = .32$) of what was previously reported in a meta-analysis by Lambert and Shimokawa (2011; $d = .69$). Third, another RCT study in Holland (de Jong et al., 2014) found that although feedback reduced the deterioration rates (but did not result in positive change) and had an impact on the speed of change in therapy, the use of feedback did not have an impact on the final outcome. Finally, in a naturalistic setting, my colleague and I conducted a feedback study within an Asian outpatient psychiatric setting

(clients: $n = 178$; therapists: $n = 4$). We found the impact of using PCOMS to be more modest than previously established. In addition, not all therapists benefited from the use of feedback (Chow & Lu, 2015).

If feedback mechanisms help therapists not only obtain good outcomes but also learn, then we would expect to see therapists improve across time. Yet a recent study concluded otherwise. In a sobering piece, Goldberg et al. (2016) examined 170 therapists' outcomes across a longitudinal data set of an average of 5 years' worth of clients' results ($N = 6{,}591$) and found that therapists not only did not improve across time but grew worse. This could not be explained by clients' initial severity, length of treatment, rates of early termination, size of caseloads, or a variety of other therapist factors (e.g., therapists' age; years of experience, excluding trainees who had less than 1 year of experience).

So what's going on? For starters, we can conclude that focusing entirely on performance does not necessarily mean that we are learning (see Figure 16.1). Bjork and Bjork (2011) stated that emphasizing on short-term performance may not necessarily translate to an increase in long-term learning. Likewise, a focus on learning may not necessarily improve performance in the short term. However, promoting learning may improve performance in the long term. For example, researchers found that in a complex business simulation situation, giving employees specific learning goals led to better performance, compared with those who were given performance goals (Seijts, Latham, Tasa, & Latham, 2004). Using current performance as a measure of learning is susceptible to misassessing whether learning has or has not occurred (Bjork & Bjork, 2011). Like self-assessment bias, we are typically poor judges of what is deemed relevant in enhancing our own learning (Kornell & Bjork, 2008).

At this stage of scientific enquiry, we can only speculate that feedback mechanisms promote performance—or, more specifically, prevent deterioration. However, feedback tools do not address helping clinicians learn and

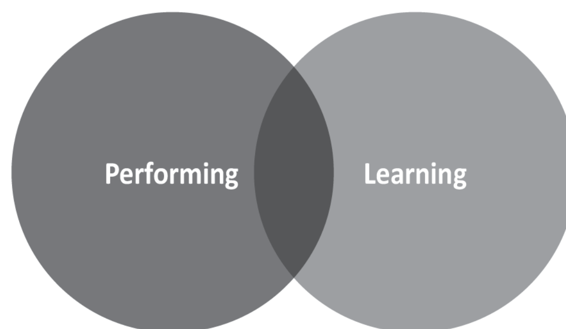

Figure 16.1. Differentiation between performance and learning.

push the plateau of individual therapist performance, nor should we expect them to do so.

The combination of real-time clinical data and clinical intuition can aid in making better clinical decisions. ROM measures our performance. It helps us keep score. Especially when used session-by-session in a collaborative manner with your client, it helps to keep both clinicians' and clients' eyes on the road. ROM is a platform for the performance, not the performance itself. It wouldn't make sense to expect the scoreboard to help an athlete improve his or her game. You can't expect a stopwatch to improve a runner's speed (Birgit Villa, personal communication, August 9, 2015). Any clinical tool is only as good as the person who uses it. Although ROM provides an indicator of *outcome*, what is currently lacking is a systematic professional learning framework to guide therapists in the *process* of getting better at their craft.

Therapist Effects

In my professional career, it has been a painful process for me to come to the realization that the next new psychotherapeutic approach isn't necessarily going to take me to the next level. It is less about the tools of psychotherapy than it is about effectively using the tools at our disposal.

Like therapy models and techniques, there is no magical feedback measure out there. As already noted, it is the user of the tool, not the tool itself, that influences client outcome (Miller et al., 2015). This is an important point to stress, given the groundswell of research hailing the use of this or that measure in monitoring psychotherapy outcomes.

Given the sobering findings from recent feedback studies, as well as observing the declining effects across time, it is crucial to examine other factors within our influence that influence outcomes. Although the impact of the therapeutic alliance (Horvath, Del Re, Fluckiger, & Symonds, 2011) has entered common parlance in our field, a lesser known but equally if not more important finding that has stood the test of time in empirical studies concerns the role of the therapist (Miller, Hubble, Chow, & Seidel, 2013).

It was more than 50 years ago that Hans Strupp (1963) shined the light on the importance of the therapist's role in psychotherapy. About a decade later, Ricks's (1974) influential study came along. He examined the long-term outcomes of "highly disturbed" adolescents who were treated by two therapists. When the participants were later reviewed as adults, the results dramatically differed between the two groups of clients. A significant number of the adults who had seen the first therapist were more socially well-adjusted, compared with those who saw the second therapist. This variance appeared despite the fact that, at the start of therapy, both therapists' caseloads were equal in most variables, including level of disturbance, gender, IQ level, socioeconomic status,

age, ethnicity, period seen, and frequency of psychotic disturbances found in the parents. Among the results, 27% of the first therapist's cases received the diagnosis of schizophrenia as adults, whereas 84% of the second therapist's cases met diagnostic criteria for that diagnosis. In fact, it was the youth seen in the child guidance clinic who called the exceptional therapist the "supershrink."

To date, few clinical trials (see exceptions: Anker, Duncan, & Sparks, 2009; Owen, Leach, Wampold, & Rodolfa, 2011; Wampold & Brown, 2005) have factored in therapist effects in the primary analyses (Wampold & Bhati, 2004), which Sol Garfield (1997) called the "neglected" factor in psychotherapy research. More crucially, when researchers ignored therapist effects in their analyses, it falsely inflated the impact of treatment model effects (Wampold & Serlin, 2000).

The variability in outcomes attributable to the therapist has been documented to be within 4% to 9% (Crits-Christoph et al., 1991; Wampold & Brown, 2005; Wampold & Imel, 2015), with one naturalistic design study indicating variability as high as 8% to 17% in an outpatient psychotherapy clinic (Lutz, Leon, Martinovich, Lyons, & Stiles, 2007). A recent meta-analysis by Baldwin and Imel (2013) found that in naturalistic/effectiveness studies, therapist effects accounted for 7% of the variance in outcome, whereas in efficacy studies (i.e., clinical trials), this was 5%. It is likely that therapist effects were lower in the efficacy studies due to the higher amounts of training, supervision, and structure, leading to increased homogeneity. Nevertheless, across the 45 studies examined, Baldwin and Imel estimated that therapist effects accounted for approximately 5% of outcome.

CHARACTERISTICS OF HIGHLY EFFECTIVE PSYCHOTHERAPISTS

Previous studies have emphasized the importance of studying characteristics of "master" therapists (Jennings, Hanson, Skovholt, & Grier, 2005; Levitt & Williams, 2010). To this effect, there are inherent limitations when the criteria are based on peer nomination, as determined by the chosen therapist's reputation. This methodological approach dilutes the theoretical interest of how someone develops actual superior performance (Orlinsky, 1999). If resorting to detailed elaboration of peer-nominated or popular therapists isn't an adequate way to learn from the best in our field, we need to refocus on examining highly effective psychotherapists—that is, those who not only systematically collect client outcome on a routine basis but also on those who consistently outshine the rest of us.

Although examining differences between only two therapists (i.e., a supershrink and a pseudoshrink), Ricks (1974) found that, compared with

the pseudoshrink, the supershrink allotted extra effort to help the more disturbed adolescents he saw instead of those who were easier to treat. He also tapped into resources external to therapy and was more competent in supporting the youths' development of autonomy, while helping parents to recognize the importance of their adolescents' individuation. Furthermore, the supershrink was firmer and more direct with the families and used fewer intrapsychic interventions. This therapist tended to be more skilled than the pseudoshrink in developing a deeper and more lasting therapeutic relationship. Finally, it was also apparent that the supershrink was keen to elicit patients' feedback for each session. Ricks foreshadowed the importance of outcome measurement:

> If a major clinic were to set up an "outcomes board" to look over the long-term outcomes of therapy conducted by staff psychotherapists, it would be possible to determine, within a few years, whether particular therapists were unusually harmful or helpful. (p. 292)

Some two decades later, Blatt, Sanislow, Zuroff, and Pilkonis (1996) found that the more effective therapists were more psychologically minded, as opposed to having a biological orientation (i.e., medication, electroconvulsive therapy), and they also expected more outpatient therapy sessions than did moderately and less effective therapists. These differences were independent of the four types of treatment provided (cognitive behavior therapy, interpersonal therapy, imipramine [medication] plus clinical management, and pill placebo plus clinical management) or the research site. The difference in effectiveness was also not related to the therapists' level of clinical experience; this concurred with an extensive review by Beutler et al. (2004), which found no persuasive indicators that therapist characteristics (e.g., years of experience, age, gender, professional qualification, personality traits), or therapist involvement in personal therapy, predicted better client outcomes in therapy.

Various hypotheses question what contributes to alliance formation. Four sources of contention exist: (a) the client, (b) the therapist, (c) the interaction between client and therapist, and (d) alliance as a consequence of outcome. In an elegant study, Baldwin, Wampold, and Imel (2007) were able to disentangle the alliance–outcome correlation, and found that the alliance formation was not due to the client, the interaction of client and therapist, nor the consequence of early improvements. Rather, the researchers found that it was largely due to the contribution of the therapist in the alliance. Said in another way, therapists who, on average, are able to establish agreement on goals, tasks, and level of bond with the client (Bordin, 1979) performed better than therapists who did not form as strong a therapeutic engagement with their clients. In fact, 97% of the variability between therapists was due

to their ability to form good alliance. In the field of social sciences, it is a rarity to see a single factor explain such a large proportion of the variance.

Other therapist qualities stand out between the best and the rest. In light of the vital contribution of therapists' ability to form a good alliance, it was found that skill in handling challenging interpersonal encounters predicted therapist success in terms of outcomes (Anderson, Ogles, Patterson, Lambert, & Vermeersch, 2009). In other words, it is likely that these supershrinks possess well-honed relational skills specific to the psychotherapeutic endeavor. As recent studies would suggest, progressive increase of positive working alliance is predictive of good outcomes, as seen in youth (Owen, Miller, Seidel, & Chow, 2016) and couples therapy (Anker, Owen, Duncan, & Sparks, 2010). It also appears that highly effective therapists were more likely to obtain lower initial alliance ratings, followed by gradual improvement across sessions, because they seemed to be more receptive and able to elicit negative feedback at an early stage of the treatment process (Miller, Hubble, & Duncan, 2007). What's more, therapists who were more active and overt in checking in about the alliance with their clients predicted better outcomes (Slone & Owen, 2015).

The more effective therapists seemed to be a self-critical bunch. In the Vanderbilt psychotherapy research study, Najavits and Strupp (1994) found that effective therapists were more self-critical and reported making more mistakes than less effective therapists. In a later study, therapist-reported professional self-doubt (PSD) was found to have a positive effect on client ratings of working alliance, with higher levels of PSD suggesting an open attitude toward admitting their own shortcomings (Nissen-Lie, Monsen, & Rønnestad, 2010).

For what appears to be a self-castigating group of therapists, these findings say more about their approach to dealing with feedback than about their personalities. In a randomized clinical trial by de Jong, van Sluis, Nugter, Heiser, and Spinhoven (2012), the effects of feedback were moderated by therapists' commitment and attitude of openness toward the use of outcome measures. As a result, not all therapists benefited from the use of feedback. Most recently, we found that highly effective psychotherapists reported being "surprised by client feedback" more times in a typical workweek than their less effective counterparts, indicative of both an awareness of and receptivity toward feedback (Chow, 2014). As the results suggest, it wasn't that the feedback confirmed what therapists already knew; rather, it appears that the supershrinks in our study felt more disconfirmed—therefore surprised—by the feedback they received from their clients about the sessions. At this stage, it is unclear whether the surprising feedback resulted from their ability to elicit more nuanced feedback or from their responsive and tentative posture, conveying a sense of openness and newness toward their clients' emerging narratives. Another possibility is

that the less effective folks, who are less "surprised by clients' feedback" might have been conveying an "I knew it all along" disposition to their clients—what cognitive scientists call *hindsight bias* (Roese & Vohs, 2012). It is possible that seeking to confirm what the therapist might already know can have a negative consequential effect on the developing interaction between therapist and client because the therapist might be less receptive, and, in turn, the client becomes less interested and more disengaged.

Perhaps true experts think like novices, while true novices think they are experts.

GOING BEYOND MEASURES

> The dedication to mastery needs the mastery of practice.
> —(Barron, Montuori, & Barron, 1997, p. 172)

What Is Deliberate Practice?

How do highly effective psychotherapists—the supershrinks—become good at what they do? The notion of deliberate practice, championed by K. Anders Ericsson, has been elaborated in an impressive number of popular books, although somewhat misrepresented by Malcolm Gladwell's (2008) engaging book *Outliers*, in which he stated that to achieve top performance, one must clock the mythical "10,000 hours" of practice. Previous studies have indicated that this may be only a very rough estimate, rather than a rule (e.g., Ericsson, 2006). On the basis of Ericsson and his colleagues' extensive body of research studies on this topic in a variety of fields (Ericsson, 2006; Ericsson, Krampe, & Tesch-Romer, 1993), the gradual incremental development of extended deliberate practice, rather than the presence of innate talent (Ericsson, Roring, & Nandagopal, 2007), was found to mediate performance in broad-ranging areas of expertise, from music to medicine (e.g., Ericsson et al., 1993; Norman, Eva, Brooks, & Hamstra, 2006). Nevertheless, deliberate practice in a given domain does not magically improve less skilled learners; rather, it helps to define the necessary prerequisite cognitive skills and knowledge requirements for effective learning to take place.

Although it has been found that some experts reach a plateau and disengage from deliberate practice, evidence suggests that superior performers counteract automaticity by developing increasingly complex mental representations to acquire higher levels of control of their performance (Ericsson, 2009). Superior performance is also domain specific and limited to the scope of expertise, with limited transferability of high-level proficiency from a similar domain to another. Finally, superior performers engage in the metacognitive

activity of self-reflecting about their existing knowledge, while synergistically adopting the mass of knowledge and skill set to perform a particular task more efficiently and effectively (Feltovich, Prietula, & Ericsson, 2006).

Deliberate practice is defined as

> Individualized training activities especially designed by a coach or teacher to improve specific aspects of an individual's performance through repetition and successive refinement. To receive maximal benefit from feedback, individuals have to monitor their training with full concentration, which is effortful and limits the duration of daily training. (Ericsson & Lehmann, 1996, pp. 278–279)

Taken together, the key attributes of deliberate practice are to "seek out challenges that go beyond their current level of reliable achievement—ideally in a safe and optimal learning context that allows immediate feedback and gradual refinement by repetition" (Ericsson, 2009, p. 425). It is important to note that deliberate practice is vital not only for the acquisition of superior performance but also for skills maintenance (e.g., Krampe & Ericsson, 1996).

In the following subsections, I highlight the four key components of deliberate practice (see Figure 16.2).

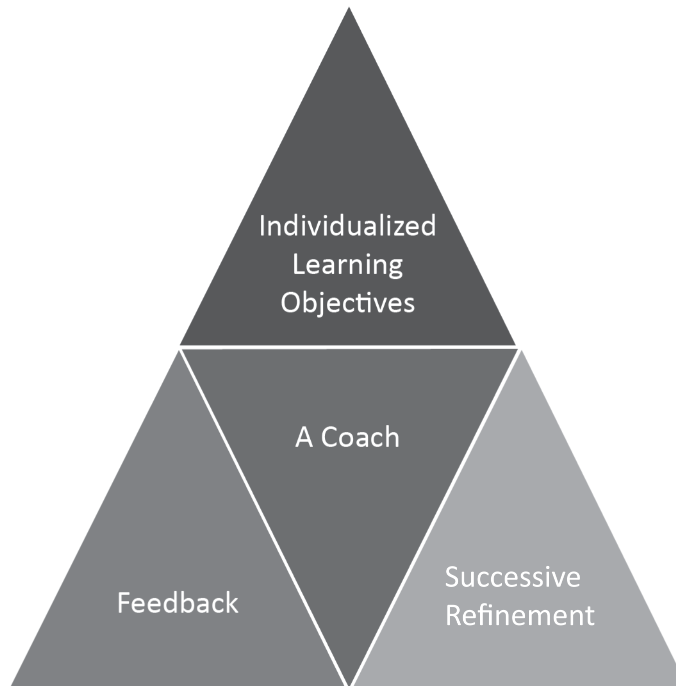

Figure 16.2. Four primary components of deliberate practice.

1. Individualized Learning Objectives

This may be one of the most vital and sorely lacking element in a practitioner's professional development. Too often, we engage in clinical supervision on a case-by-case basis, with no coherent thread explicitly weaving in the therapist's learning needs and clinical case concerns. It is vital to help therapists go beyond their zone of proximal development (Vygotsky, 1978), but to do so, one's current realm of ability and limitations needs to be well-defined. Once this is done, we need to help therapists stretch out of their *comfort zone* and move into a sweet spot called the *learning zone*, while making sure that they do not get too overwhelmed and tip over to the *panic zone* (see Figure 16.3).

Even when this is done, there is often a lack of systematic tracking of the supervisee's development over time. As useful as client feedback is to clinical practice—spotting anything glaring or missing and pointing out if the session is on track or not—this does not necessarily help therapists improve on their therapeutic skill, based on their current professional developmental phase. As mentioned previously, focusing solely on performance goals impedes learning, whereas learning goals can affect performance in the long term (Bjork & Bjork, 2011). Consider another example: A top musical performer does not benefit from the feedback of the crowd (e.g., the decibels of the audience's applause, the verbal comments about the performance) as much as from the nuanced and specific feedback she might receive from her maestro or producer.

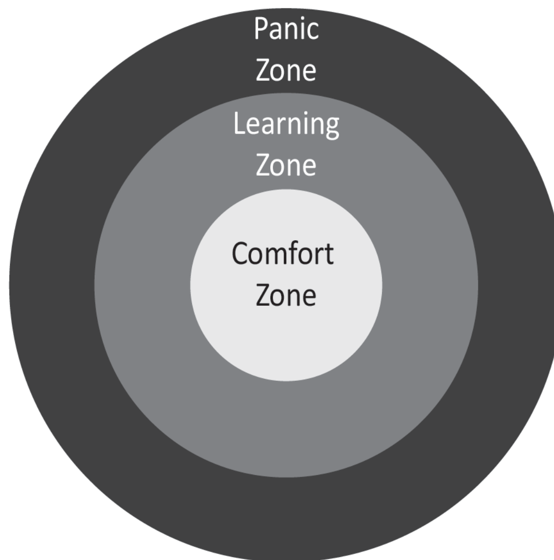

Figure 16.3. Zones of learning and development.

2. A Coach

Ideally, a coach should help create a plan for instruction to improve on a specific area of a performance for a well-defined task. The role of devoted teachers and coaches is evident in top performers' development (Hunt, 2006). Top performers in a variety of fields were mentored by devoted coaches, and they also benefited from ongoing encouragement from their families through years of development.

It may seem odd to be using the term *coach* in psychotherapy as opposed to the traditionally defined role of a clinical supervisor, which has been the signature pedagogy in psychotherapy (Watkins, 2011b). Our field will do well to apply useful aspects of coaching and teaching to the domain of clinical supervision. This would include establishing an ongoing learning and development plan in a clinical supervision context and optimizing the use of feedback. This applies not only to beginning therapists but also to seasoned practitioners, who would do well to have a coach help them counteract automaticity through consistent emphasis on reviewing and redefining their learning objectives and integrating the feedback provided by their coach.

3. Immediate Feedback

Performance Feedback

The mere anticipation of more immediate feedback, as opposed to delayed results, improves performance in students' grades (Kettle & Häubl, 2010). When chess players engage in solitary examination of past chess games by masters, they are able to compare their own moves with those of the masters, thus receiving immediate and specific feedback on the quality of their moves. Athletes get virtually immediate feedback by the observable outcome itself, feedback from coaches, as well as delayed viewing of video recordings of their games. Such feedback looping provides rich and contextual information about the performance, which in turn helps to develop actionable steps toward improvement. To this effect, it is vital for psychotherapists not only to receive ongoing client feedback but also to have the audio/video means to record their sessions, so that supervisors can provide specific feedback about their performance.

Learning Feedback

Coaches and supervisors should provide feedback not only regarding performance, but also detailed feedback about how the practitioner is learning. This can provide a more measured guide for acquiring and mastering clinical skills. Learning feedback focuses on the learning task at hand, not on criticizing the learner (Shute, 2008). Therefore, the delivery of nuanced

feedback relies on the coach or supervisor to impart descriptive and elaborated feedback in manageable chunks that encourage clinicians to reach beyond their comfort zone and into their learning zone (see Figure 16.3).

4. Successive Refinement

Repetition should not be confused with experience. The mere accumulation of experience does not equate to expertise. Educator Dylan William quipped, "People make claims about having 20 years' experience, but they really just have one year's experience repeated 20 times" (Leslie, 2015). We already know that clinical experience is not a significant predictor in client outcomes (Beutler et al., 2004; Chow et al., 2015; Wampold & Brown, 2005).

Repetition can provide opportunities for gradual refinement with formative feedback, while correction of errors can occur on well-defined tasks (Ericsson, 2006). A study on ice-skaters found that they devoted a considerable amount of time to practicing jump combinations they had already mastered, rather than working on newer combinations where there was more room for improvement (Deakin & Cobley, 2003).

In psychotherapy, once the therapist and the coach or supervisor map out a clear and unambiguous path for deliberate practice, they can adopt a broader and deeper vision (isn't that where the word *supervision* came from?) to monitor the level of performance (i.e., outcome) and how the therapist is implementing and refining what he or she is learning (see Figure 16.1). For example, both parties in the supervisory relationship can revisit cases that were discussed previously, examine what was implemented on the basis of the clinical supervision, and identify the barriers encountered along the way. Consequently, the supervisor can refine the feedback based on targeting the client's treatment needs, as well as the supervisee's learning needs.

THE DIFFERENCE BETWEEN CLINICAL PRACTICE AND DELIBERATE PRACTICE

Why Practice?

> "To practice isn't to declare that I am bad. To practice is to declare that I can be better."
>
> —(Dan Heath, as cited in Lemov, Woolway, & Yezzi, 2012)

Mental health professionals, counselors, psychologists, psychiatrists, nurses, social workers, and marriage and family therapists alike spend

hundreds of hours clocking in practicum and internship to be accredited or licensed to practice. Thereafter, we spend hundreds, if not thousands, of hours seasoning ourselves in clinical practice. Not to be confused, the word *practice* here essentially means *work*: the delivery of mental health services to someone in distress who is in need of help. It is not practice in the sense of a musician spending hours playing the same tunes over and over in the hopes of landing a paying gig. It means actually doing the work: applying knowledge or ideas to achieve a desired outcome. We end up falsely believing that because we have spent all that time in training during our educational and apprentice years, with ongoing professional development activities, and seeing clients, we are well rehearsed. We call that *clinical experience*.

Psychotherapy is one of the few professions in which *practice* doesn't not mean a rehearsal but the real thing. It is important not to conflate clinical practice with deliberate practice (see Figure 16.4). Although actual clinical practice is necessary, it is not sufficient to develop and refine the skills of the craft. Clinical practice is not practice in a learning sense. It's the culmination of all our efforts to be helpful. It's the output part of the equation. It's the performance of all that effort that we put in, so that we can be helpful to a wide variety of clients. However, deliberate practice is aimed at improving skills in a well-defined manner. The returns are often not immediate; it's rarely monetarily rewarding but is designed to improve the quality of your clinical practice.

With few exceptions (Miller & Hubble, 2011; Miller et al., 2013; Tracey, Wampold, Lichtenberg, & Goodyear, 2014), the field has hardly examined the development of superior performance in psychotherapy. My mentor and collaborator, Scott D. Miller, was one of the pioneers to glean concepts from other expert domains, as studied by Ericsson and his colleagues (Miller et al., 2007). Modeling from other fields, in 2010, we decided to investigate the impact of deliberate practice on performance.

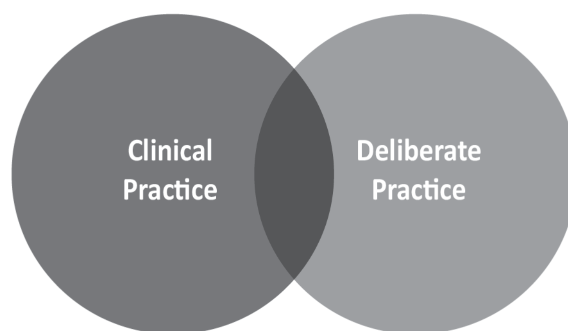

Figure 16.4. Differentiation between clinical practice and deliberate practice.

Specifically, with a cohort of psychotherapists in a PRN in the United Kingdom that had amassed approximately four years worth of outcome data, we examined the details of their practice activities related to their professional development (Chow, 2014). Consistent with past findings, the multilevel model analyses in our study of 69 therapists who treated 4,580 clients revealed that therapist effects accounted for approximately 5.1% of the variance in treatment effectiveness, after adjusting for treatment severity (Chow et al., 2015). Clearly, the role of the therapist overshadows the contribution of treatment models and techniques (0%–1%; Wampold & Imel, 2015). Concurring with past studies (Anderson, Ogles, Patterson, Lambert, & Vermeersch, 2009; Walfish et al., 2012; Wampold & Brown, 2005), therapist factors such as gender, age, qualifications, professional discipline, years of experience, degree of theoretical integration, caseload, and self-assessment of effectiveness were found to be unrelated to outcome. However, what emerged from the subsample of the cohort who took part in our further investigations was that the amount of time therapists reported being engaged in solitary activities intended to improve their skills was a significant predictor of outcomes. Using a similar methodology as previous deliberate practice studies (Charness, Tuffiash, Krampe, Reingold, & Vasyukova, 2005; Ericsson et al., 1993), the amount of time spent in deliberate practice was based on self-report in a typical workweek. This figure, in turn, was first multiplied by 52 (weeks per year) and then by years of experience to obtain an estimate the amount of accumulative practice. Because the average amount of experience for the subsample was approximately eight years, only these years of professional experience were included (see Figure 16.2).

Specifically, the highly effective psychotherapists spent, on average, about 2.8 times more hours per week engaged in deliberate practice activities aimed at improving their effectiveness than did the other therapists. The estimated cumulative impact of deliberate practice on clinician effectiveness can be seen in Figure 16.5. The first eight years of experience was used to exemplify the impact of deliberate practice because this was the average of the cohort.

Although these are crude estimates, the trajectories seen in Figure 16.5 are similar to the trends observed in studies in other domains, such as music, chess, and figure skating (e.g., Charness, Tuffiash, Krampe, Reingold, & Vasyukova, 2005; Ericsson et al., 1993; Starkes, Deakin, Allard, Hodges, & Hayes, 1996). Although there were no specific deliberate practice activities that reliably led to better outcomes, examples that the cohort rated as highly relevant from the taxonomy of therapist activities included (a) reviewing difficult cases alone, (b) mentally running through and reflecting on past sessions, and (c) mentally running through and reflecting on what to do in future sessions.

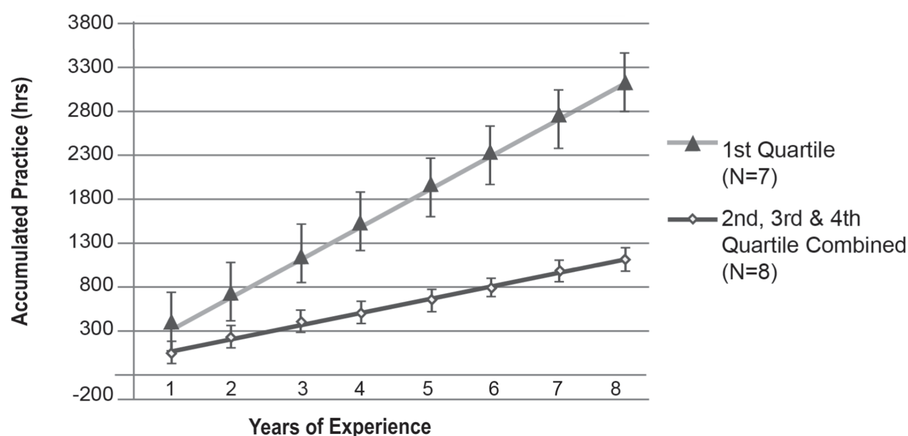

Figure 16.5. Comparing therapists from the top quartile with the others in the lower quartiles on the basis of their adjusted client outcomes as a function of their accumulative time spent on deliberate practice alone in the first 8 years of clinical practice. Error bars represent standard errors of the mean. Reprinted from "The Role of Deliberate Practice in the Development of Highly Effective Psychotherapists," by D. L. Chow, S. D. Miller, J. A. Seidel, R. T. Kane, J. A. Thornton, and W. P. Andrews, 2015, *Psychotherapy*, *52*, p. 342. Copyright 2015 by the American Psychological Association.

Current Professional Training Activities

> You win by becoming a better player of the game at large, not by adapting your technique to every new team you face. Your opponent will always be changing; it's a losing race. But if you master the game, you will have skills and knowledge you need to defeat whoever you are facing.
>
> —(Renowned basketball coach John Wooden, as cited in Wooden & Yaeger, 2009, p. 41)

We now know that devoting time to targeted forms of solitary deliberate practice activities is vital and predictive of more effective therapists. Although significant emphasis is placed on continuing professional development (CPD) and continuing education (CE) programs, this is rarely based on the core tenets of deliberate practice. Although self-reports of satisfaction ratings have also provided encouraging findings about the impact of such formal professional training (Neimeyer, Taylor, & Wear, 2009), there has been a lack of evidence in the correlations of demonstrable outcomes and therapists' satisfaction ratings of CPD and CE activities, such as therapist effectiveness in their practice settings. Clinicians might really enjoy continuing education, but it doesn't always make them better at their jobs.

Aside from CPD and CE activities, clinical supervision has been the mainstay for most practitioners. In a meta-analysis conducted by Watkins

(2011a), based on the past 30 years of research, only 18 empirical studies specifically examined the impact of supervision and client outcomes. Clinicians ranging from trainees to experienced psychotherapists rated clinical supervision and supervising others as highly integral to their professional development (Orlinsky, Botermans, & Rønnestad, 2001). However, further inspection showed that seven of the 18 studies were not actually related to client outcomes. Critically, Watkins wrote, "the collective data appeared to shed little new light on the matter: We do not seem to be any more able to say now (as opposed to 30 years ago) that psychotherapy supervision contributes to patient outcome" (p. 235). More recently, Rousmaniere, Swift, Babins-Wagner, Whipple, and Berzins (2016) conducted a hierarchical linear modeling (clients nested within therapists, and therapists nested within supervisor) on 5-year data set consisting of 23 supervisors involved in a naturalistic setting, and supervision was not found to be a significant contributor to client outcome. To make things worse, the supervisors' experience level, profession (social work vs. psychology), and qualifications did not predict differences between supervisors in client outcomes either.

To date, there has been limited empirical evidence to suggest clinical supervision is more effective than other types of training (for an exception, see Bambling, King, Raue, Schweitzer, & Lambert, 2006). Most training and learning activities fail to meet the four components of deliberate practice (see Figure 16.2).[1] The following five strategies can help strengthen the impact of clinical supervision.

Analyzing Your Game

Often the encounter in clinical supervision revolves around case discussion, theoretical formulation, case conceptualization, and even gossip. Traditional clinical supervision is often constrained by a certain prescribed model of therapy, and much of the time spent is based on a theoretical construction of the case—that is, the supervisor's theoretical biases. It is important to have a sound content knowledge of the client's presenting concerns (e.g., depression, obsessive-compulsive disorder, schizophrenia). However, the most critical forms of guidance in supervision are more in the domains of *process* knowledge (i.e., the moment-by-moment interaction between client and therapist) and *conditional* knowledge (i.e., how you would work with someone who is depressed is different if she has a context of bereavement, compared with someone else who has a history of domestic violence). (See

[1]In a critique of Ericsson et al.'s (1993) notion of deliberate practice, Macnamara, Hambrick, and Oswald (2014) conducted a meta-analysis that attempted to disprove Ericsson's deliberate practice hypothesis. However, upon further scrutiny of the studies included in their meta-analysis, several did not meet the criteria of a bona fide deliberate practice structure.

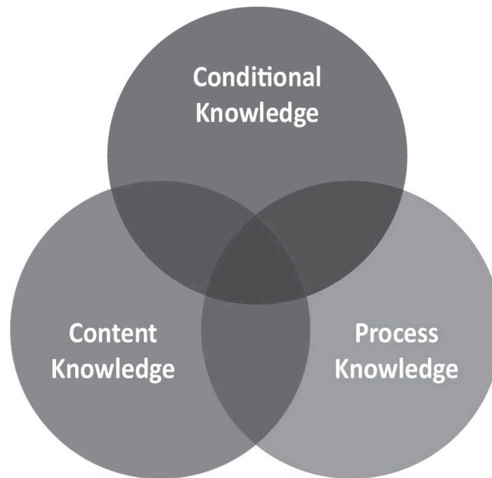

Figure 16.6. Different forms of knowledge in the practice of psychotherapy.

Figure 16.6; Note: For *content* knowledge, a supervisor can adopt a didactic stance of imparting the information, as well as providing reading materials on the particular clinical area, especially for beginning practitioners.) Even for intermediate and advanced therapists, it is important to return continuously to the fundamentals, such as aspects of the working alliance, including goal consensus, emotional bond and safety, or agreement on the task at hand. To work at the fundamentals, it is not enough to talk about the session. Although less effective coaches get lost in complexity, good coaches tend to return to basics (Nater & Gallimore, 2010). It is more effective to study segments of the therapy hour via audio or video recordings. Much like other fields (music, sports), it is important to record sessions to receive feedback about actual performance, rather than feedback about a *perceived* performance. Feedback is useful when it is based on well-defined objectives, observables, and specifics.

Carl Rogers (1939) couldn't have articulated this point more clearly: "A full knowledge of psychiatric and psychological information, with a brilliant intellect capable of applying this knowledge, is of itself no guarantee of therapeutic skill" (p. 284).

Corrective, Not Critical

We all know this experience: A good-hearted supervisor, providing you the best form of support and encouragement in the face of a difficult case at hand, comforts you with well-meaning words such as, "Well, you did your best . . . at least your client came back, right?" or "It's a difficult case, the client is simply resistant/not ready for change." Such statements may actually

contain words of truth, but neither provides guidance or direction on how to better approach the case. Although a friendly consolation and peer venting is inevitable at times and might make you feel better in the moment, we know it isn't going to help improve the case, nor improve your craft. Even when there is a will, we still need a way of getting there.

Rather, a good supervisor is likely to help a therapist stretch beyond the comfort zone. He or she is likely to be more corrective and less critical by pointing out errors and suggesting specific alternatives, without making the learner feel personally attacked or deficient. In other words, tell the learner what to do, not what's wrong with him or her.

Monitor Client Progress

Although the benefits are obvious, there are few supervisors who use client outcome monitoring as a tool for supervision (Swift et al., 2015). For starters, to monitor the impact of supervision on therapy outcome, supervisees would need to use the feedback scales themselves. Second, they would need guidance on administering the measures meaningfully, addressing glaring or missing issues concerning the outcome data, eliciting nuanced feedback, making better clinical decisions by integrating clinical intuition with clinical objective data, and detecting patterns in the supervisee's professional development. Working without information about a supervisee's clients' progress is like a football team playing without knowledge of the scoreboard.

To date, only one preliminary study has looked at the impact of feedback-informed supervision influencing client outcome (Reese et al., 2009). Although the study did not delineate whether outcomes were the result of differences in therapists' use of ROM or were due to the feedback-informed supervision, clients whose feedback was included in the supervision achieved statistically significant benefits compared with those whose feedback was not included. Worthen and Lambert (2007) suggested that to maximize improvement in those clients who are not responding to treatment as expected, progress needs to be monitored not only at the therapist level but also at the supervisory level.

Monitor Engagement Level of Supervision

A culture of feedback be experientially developed under the auspices of supervision, but in addition, monitoring the impact of supervision also helps to provide ongoing systematic information about the engagement process between supervisor and supervisee. With the feedback-informed treatment (FIT) approach, Wainwright (2010) developed a brief sessional measure of the supervisory alliance called the Leeds Alliance in Supervision Scale, which can be used at the end of each supervision session. Supervisees can

observe as well as experience the parallel process of this feedback loop: what it's like to elicit, give, receive, and reflect on the feedback.

Developmentally Appropriate Learning Objectives

Developing a systematic focus in supervision helps to address developmentally appropriate learning needs of the supervisee. When we are in case consultation mode, we risk losing out on purposeful and directed learning and may get trapped in "firefighting mode." In the long run, a lack of clear learning objectives, even with the benefits of ROM, will not lead to professional development and improvement in performance (Goldberg et al., 2016). Instead, a combined focus on outcomes and the therapist's learning objectives provides a dual lens with which to view professional development that may lead to improved performance.

To help in this process, we created the Taxonomy of Deliberate Practice Activities worksheets (Chow & Miller, 2015) to guide practitioners and supervisors in identifying and monitoring areas for further development.[2] Using the worksheets, clinicians and their supervisors rate key aspects of their work on a routine basis, and both parties identify the top three areas to focus on in their clinical supervision.

An effective supervisor will incorporate the preceding five strategies to develop a better version of the supervisee, not a mere clone of the supervisor. Rogers (1957) echoed this point:

> I believe that the goal of training in the therapeutic process is that the student should develop his own orientation to psychotherapy out of his own experience. In my estimation, every effective therapist has built his own orientation within himself and out of his own experience with his clients or patients. (p. 87)

Contention surrounds various models containing specific healing ingredients (e.g., Ehlers et al., 2010). Given the lack of preeminence of any given approach, even among bona fide psychotherapies (e.g., Wampold, Minami, Baskin, & Callen Tierney, 2002; Wampold et al., 1997), supervisors should strive to nurture supervisees' unique voicing in therapy while grounding them in working at the fundamentals, as opposed to mimicking the approach of others. Perhaps that is what Carl Rogers meant when he said he is not a Rogerian or when Virginia Satir replied to an interviewer asking her what she thought about neurolinguistic programming (NLP), which was modeled after her approach to therapy, "I would not want to learn NLP, if you want to know the truth. I am not sure I could learn it" (Simon, 1985). There is no manual for this; each individual's therapeutic style is an uncharted terrain.

[2]To request a copy of the taxonomy, contact daryl@darylchow.com.

Deprivatization of the Practice of Psychotherapy

Let's face it: Our work is lonely endeavor. Even though psychotherapy is an ongoing ebb and flow of emotionally charged interaction between the therapist and client (Frank & Frank, 1993), most practitioners, especially private practitioners, feel the absence of connection with other clinicians. How often do we get to share our real struggles? To this effect, because psychotherapy can be such a private affair, we often lack the context to work collaboratively at improving our craft. Most of the time, instead of seeking feedback from others about our work and the interaction process in therapy, we spend our time talking about cases and not "analyzing our game" (for an exception, see, e.g., Rousmaniere & Frederickson, 2013). Ericsson (2009) articulated this concern:

> Most professionals—such as doctors, nurses, stockbrokers, and accountants—do not receive the constant pressure from performing in front of an audience of paying ticket holders, like actors, musicians, and athletes. The lack of scrutiny and perhaps feedback may be an important difference that explains why many doctors do not spontaneously adopt the best practice methods for treating their patients, and spend a rather modest amount of time engaged in deliberate practice and effortful training to improve and maintain their skills. . . . The greatest obstacle for deliberate practice during work is the lack of immediate objective feedback. (p. 422)

Clearly, as Ericsson stated, the lack of scrutiny from the eyes of another and the lack of objective feedback hinder the possibility of benefiting from another mind pushing us to the next level in our clinical performance.

Scenius Versus Genius

While solitary deliberate practice is necessary, it isn't sufficient. If the voluminous amount of self-help books published each year is a reflection of our appetite, we are certainly persuaded that we've got to "make it on our own." Yet the pursuit of excellence is not a solo endeavor. Similar to the development of expertise in sports (Starkes et al., 1996), professional development activities in psychotherapy are necessary supports to build better therapeutic skills. These activities will vary based on the therapist's current level of professional competency. For example, beginning therapists would need more exposure to client-contact hours, whereas more experienced senior therapists would likely need more specific forms of ongoing skills development (e.g., Binder, 1999). What's more, as previously mentioned, a coach/supervisor is needed to help design a learning objective.

Musician and producer Brian Eno (2009) coined the term *scenius*, explaining that "genius is individual, scenius is communal." Eno's point was that we should look beyond ourselves as standalones to see ourselves as

individuals who can facilitate creativity and growth within a community. Take another example, the ever-popular notion self-attribution theory of ability (i.e., fixed and growth mind-sets; Dweck, 2006). A person who endorses a growth mind-set believes that his abilities can be cultivated and developed through effort. On the flip side, a person who has a fixed mind-set views his abilities as innate and stable across time, an attitude that presumes you either have it or you don't. The development of mind-sets must be seen within a systemic lens, not solely as an individual construct. Going beyond the constrained dichotomy, we must acknowledge that the development of mind-sets is determined by the relational context. It is the task of the teacher/coach/supervisor to foster a safe environment that recognizes errors as part of the learning process and distinguishes failing from failure ("Here's something I didn't do well." vs. "I'm no good."), rather than an overemphasis on performance. For example, a supervisee might feel worried and anxious about sharing an at-risk case with his supervisor if he feels that he might feel questioned about his competence. In contrast, the same supervisee can feel safe and supported receiving emotional support and specific guidance on how to handle the case better, without being patronized with a pat-on-the-back approach. There should be no reason to shift blame onto a client for a poor outcome. This balance is vital in managing the impact on the supervisee's self-esteem. Interestingly, Niiya, Brook, and Crocker (2010) found that even people with a growth mind-set who feel that their self-worth is contingent on their performance might self-handicap (i.e., avoid practicing) their work to protect against bruising their ego.

Once we learn to look beyond facing criticism about our own work and embrace our imperfections and vulnerabilities, we can share our craft and thus create a democratic learning environment. While remaining respectful of our clients who entrust us with their privilege of confidentiality, we can seek to be part of an ecology of talent—a *scenius* community that fosters excellence. No therapist is an island.

Deliberate Practice Plan

In the words of journalist David Brooks (2014), great creative minds "think like artists but work like accountants." Three essential activities that give rise to superior performance (e.g., Miller et al., 2013) are (a) determining your baseline performance; (b) obtaining systematic, ongoing feedback; and (c) engaging in deliberate practice. Miller and colleagues (2007) detailed a three-step process for deliberate practice: (a) think, (b) act, and (c) reflect (TAR).

Expanding further, if you are ready to take your clinical practice to the next level, you need a frame to hold it together. Frank Zappa (1997) said, "The most important thing in art is the frame . . . you have to put a 'box'

around it because otherwise, what is that shit on the wall?" (p. 196). In our case, a frame is necessary because sustaining efforts in deliberate practice can be demoralizing. Like most important things in life, it's for the long haul and requires a well-defined structure to sustain motivation. The suggestions in Table 16.1 can help pull together the ideas about deliberate practice that we have addressed in this chapter so far. I'd use the acronym ARPS—which stands for Automated structure, Reference point, Playful experimentations, and Support—to outline a plan for deliberate practice.

TABLE 16.1
ARPS Deliberate Practice Framework

Prescription	Description
Automated structure	1. We are busy people. Block out 1 hour a week during your workweek. Avoid being in a work environment where other things distract your attention (e.g., colleagues, emails). 2. Design a structure on how you would spend your time (e.g., reflection, reviewing segments of a recording), instead of trying to squeeze in time. 3. Set up automated reminders in your digital devices for deliberate practice.
Reference point	1. Keep one eye on the outcome data (individual cases and aggregate) and another on systematically monitoring your learning objectives (Figure 16.1). 2. At the end of each workweek, use a system to note down your weekly learnings briefly (e.g., notebook, note-taking apps such as simplenote.com or evernote.com). 3. As you record your sessions, pick one that stands out as representative of you at your best. Analyze the session and tease out your specific strengths. Get your supervisor to watch it, too.
Playful experimentation	1. Watch 5- to 10-minute segments of your recordings. Pause and consider how you might carry on the session more constructively. 2. Seek to be disconfirmed by your clients' feedback rather than confirmed. Without looking at their scores first, fill out the alliance scale as your client does. Compare and contrast. 3. Learn to step out of your comfort zone (see Figure 16.3) in one area of your usual habit of conducting therapy (e.g., the way you start your session). Monitor the impact.
Support	1. Seek out a coach/supervisor based on the five strategies in clinical supervision (listed previously in the section Going Beyond Measures). 2. Evaluate whether your supervisor helps you to reach into your learning zone, rather than tipping you into the panic zone (see Figure 16.3). 3. Form a community with a few practitioners who are equally dedicated (see the section Scenius Versus Genius).

Note. ARPS = automated structure, reference point, playful experimentations, and support.

Table 16.1 combines the four tenets of deliberate practice—(a) individualized learning objectives, (b) guidance from a coach, (c) immediate feedback, and (d) repetition (see Figure 16.2)—into something that you can implement into your typical workweek. The ARPS framework provides dual lenses: It focuses on both automation and deliberation, outcome and process, structure and playfulness, as well as solitary and communal efforts in providing a vehicle for advancing your performance to the next level.

CLOSING

Upon completing the ceiling of the Sistine Chapel, Michelangelo is said to have opined, "If people knew how hard I worked to get my mastery, it wouldn't seem so wonderful after all" (as cited in Brown, Roediger, & McDaniel, 2014, p. 184). Much promise looms in the area of deliberate practice in psychotherapy. Colleagues and I recently completed the first in our series of studies called "Difficult Conversations in Therapy" (DCT). The objective was to investigate whether therapists can improve their therapeutic relational skills with deliberate practice. We used simulated client videos depicting challenging interaction patterns in therapy (i.e., a client displaying anger toward the therapist; Chow, Lu, Owen, & Miller, 2017). After reviewing a brief description and clinical background of the client in the video, participants were asked to respond to the video as if the client were seated in front of them. Two raters scored each participant's responses based on subscales of the Facilitative Interpersonal Skills (Anderson, Patterson, & Weis, 2007) scale. The results suggest that when presented with a well-defined area to work on, combined with immediate individualized feedback and successive refinement, most therapists in our sample were able to improve their therapeutic responses. Furthermore, compared with participants who improved the least (low gainers), it turned out that the participants who improved the most (high gainers) not only rated feedback as having higher utility and value but were also less preoccupied with impression management (i.e., trying to appear a certain way in the eyes of others) and how others perceive them.

Given the growing interest, new research is likely to examine factors that account for differences in therapists' performance. We are laying the groundwork for studying the effects of ongoing deliberate practice on client outcomes based on a group of committed practitioners who already use feedback measures in their routine practice. Further studies in DCT are currently underway, as we examine how a structured deliberate practice format can help therapists go beyond their current ability.

One of the greatest misunderstandings about development of expertise in our field was articulated by a friend who asked, "Isn't focusing on the therapist too much of an indulgence? Aren't we not the experts, but our clients are? If so, shouldn't we focus on the client instead?" The deliberate practice of any craft, in this case, psychotherapy, should not be about focusing on our own indulgent needs in sharpening our navel-gazing ability or getting more mindful, nor is it about outshining others. The purpose of investing in our development is to help our existing clients reap more benefits and to reach a wider range of people. As we get better, so do our clients. In relation to feedback, anyone seeking to be a better parent cannot simply rely solely on their child's feedback. To do better, we need to listen and tune into the child's world, and we also need the help of others in our circle.

Indeed, the pursuit of excellence is not so much about self-indulgence, nor is it about thinking less about yourself. Rather, it is thinking about yourself less. This keeps us focused on getting better at serving the ones who come to us in times of hurt. There is something sacred about this secular enterprise because it's the coming together of people to serve the needs of the one who is suffering. It's not an individual endeavor. It calls for community, humility, and vulnerability to heal and to be healed. We seek out gifts of wisdom, so that we can bring gifts. It calls upon us to reach beyond ourselves.

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