Feedback Informed Treatment

Making Services FIT Consumers

David Nylund, LCSW, PhD
Alex Filippelli, BSW
www.centerforclinicalexcellence.com
Worldwide Trends in Behavioral Health

“Do More with Less”

Increasing caseloads, regulation, and documentation;

Funding challenges;

Demand for accountability.
The Evidence:  
Three “Stubborn” Facts

- Drop out rates average 47%;
- Mental health professionals frequently fail to identify failing cases;
- 1 out of 10 consumers accounts for 60-70% of expenditures.
FEEDBACK-INFORMED TREATMENT (FIT)

• Feedback-Informed Treatment (FIT) is a pan-theoretical approach for evaluating and improving the quality and effectiveness of behavioral health services.
• FIT involves routinely and formally soliciting feedback from clients regarding the therapeutic alliance and outcome of care and using the resulting information to inform and tailor service delivery.
Evidence-Based Practice

• ‘The integration of the best available research...and monitoring of patient progress may suggest the need to adjust the treatment...(e.g., problems in the therapeutic relationship or in the implementation of the goals of the treatment)' (American Psychologist, May 2006,).’

• FIT is not only consistent with but operationalizes the American Psychological Association's (APA) definition of evidence-based practice
FIT: The Evidence

- Currently, 13 RCT’s involving 12,374 clinically, culturally, and economically diverse consumers:
  - Routine outcome monitoring and feedback as much as doubles the “effect size” (reliable and clinically significant change);
  - Decreases drop-out rates by as much as half;
  - Decreases deterioration by 33%;
  - Reduces hospitalizations and shortened length of stay by 66%;
  - Significantly reduced cost of care (non-feedback groups increased).
The Wheel of Change: Factors Accounting for Successful Outcome

The Therapeutic Alliance

Client’s Theory of Change

Client’s View of the Therapeutic Relationship

Goals, Meaning or Purpose

Means or Methods
The Outcome Rating Scale

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<th>Overall:</th>
<th>(General sense of well-being)</th>
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<th>Individually:</th>
<th>(Personal well-being)</th>
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<th>Interpersonally:</th>
<th>(Family, close relationships)</th>
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<th>Socially:</th>
<th>(Work, School, Friendships)</th>
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- **Client places a mark on the line.**
- **Each line 10 cm in length.**
- **Add the four scales together for the total score.**
- **Give at the beginning of each session or “point of service.”**

Looking back over the last week, including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels.
Child Outcome Rating Scale (CORS)

Name ____________________ Age (Yrs): __
Sex: M / F __________
Session # ___ Date: __________________
Who is filling out this form? Please check one: Child______ Caretaker______
If caretaker, what is your relationship to this child? __________________

How are you doing? How are things going in your life? Please make a mark on the scale to let us know. The closer to the smiley face, the better things are. The closer to the frowny face, things are not so good. If you are a caretaker filling out this form, please fill it out according to how you think the child is doing.

Me
(How am I doing?)

1-_________________________1

Family
(How are things in my family?)

1-_________________________1

School
(How am I doing at school?)

1-_________________________1

Everything
(How is everything going?)

1-_________________________1
The Session Rating Scale

• Client places a mark on the line.
• Each line 10 cm length.
• Add the four scales together for the total score.

• Give at the end of each session or “point of service.”
• Before the client leaves, discuss their responses any time the total score falls at 36 or below.
Child Session Rating Scale (CSRS)

Name ___________________________ Age (Yrs): ____
Sex: M / F
Session # ____ Date: ____________________

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

Listening

I did not always listen to me.

I listened to me.

How Important

What we did and talked about was not really that important to me.

What we did and talked about were important to me.

What We Did

I did not like what we did today.

I liked what we did today.

Overall

I wish we could do something different.

I hope we do the same kind of things next time.
Three Steps for becoming FIT:

1. Create a “culture of feedback”
2. Integrate alliance and outcome feedback into clinical care
3. Learn to “fail successfully”
Step One:
Creating a “Culture of Feedback”

Involves more than simply administering ORS/SRS:

• Spending time to introduce measures thoroughly
• Encourage honesty and emphasize that client not worry about offending or hurting therapist’s feelings
• Emphasize that the client’s view of the treatment is critical in informing therapy process for effective services
• Clarify that the purpose is not diagnostic or bureaucratic
Some examples:

When scheduling a first appointment, provide a rationale for seeking client feedback regarding outcome:

• “I work a little differently”
• “I’m very interested in your feedback”
• “If we are going to be helpful should see signs sooner rather than later”

• If our work helps, can continue as long as you like;
• If our work is not helpful, we’ll seek consultation (at week 3 or 4), and consider a referral
ORS: An Example

- What can we glean *clinically* from the client’s scores in addition to being above the clinical cut off?

- How could we use this information to begin or focus the session
“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 we can adjust our work and make sure we don’t steer off course. Whatever it 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?”
SRS Example: Interpretation?

• Because *most* people score high on such measures:

  - You can’t interpret high ratings (trying to please, etc.)

• Thank the person for completing the measure and maintain an openness to feedback.

• Most useful if negative!

### Example SRS Scores:

| Relationship: | 9.5 |
| Goals and Topics: | 9.7 |
| Approach or Method: | 10.0 |
| Overall: | 9.8 |

Total = 39
Interpreting the SRS

• Did we talk about the right topics today?
• What was the least helpful thing that happened today?
• Did my questions make sense to you?
• Did I fail to ask you about something you consider important or wanted to talk about but didn’t?”
• Was the session too (short/long/just right) for you?”
• Did my response to your story make you feel like I understood what you were telling me, or do you need me to respond differently?”
• Is there anything that happened (or did not happen) today that would cause you not to return next time?
Interpreting the SRS

IF THE SCORE IS BELOW 36:
“Thanks for the time and care you took in filling out the SRS. Your experience here is important to me. Filling out the SRS gives me a chance to check in, one last time, before we end today to make sure we are on the same page – that this is working for you. Most of the time, about 75% actually, people score 37 or higher. And today, your score falls at (a number 36 or lower), which can mean we need to consider making some changes in the way we are working together. What thoughts do you have about this?”
Step Two: Integrating Feedback into Care

- The dividing line between a clinical and “non-clinical” population (25).

- Basic Facts:
  - As many as 1/3 of clients score in the “non-clinical” range.
  - Clients scoring in the non-clinical range tend to get worse with treatment.
  - The slope of change decreases as clients approach the cutoff.
The Clinical Cutoff

I’ve plotted your score on the ORS on this graph, and as you can see there is a dotted line on 25. What we know is that generally people who score below the dotted line are more like people who seek treatment. They are more like people who are saying, “There are things in my life I would like to change; things that are bothering me”; and generally people who score above the dotted line are more like a broad range of people who have not chosen to be in treatment. So your score is here, on 16.5, so you are below the dotted line, does that make sense to you? (client nods) So it seems that coming here to see me ... that you’re feeling pretty bad, pretty distressed. A 16.5 on a scale of 0 to 40. Does that sound right? Does that match how you’re feeling?”
Using the “Clinical Cut-off” to Inform Care

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

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

- What does the person want?
- Why now?
- How will the person get there?
- Where will the person do this?
- When will this happen?
Step Three: Failing Successfully

Per national averages, 50% of the clients you work with will not have a reliable improvement. Thus, failing successfully is being aware of this and planning accordingly:

• Monitoring every step of the way and having these vital conversations with client at each step
• Assessing WITH client whether to continue treatment or explore other options (new therapist, change course or frequency of treatment, etc.)
Research on Most Effective Therapists

1. Give Yourself the Benefit of the Doubt
2. Connect for Success
3. Deliberate Practice
Benefit of the Doubt

- Professional self-doubt
- Less certain about how they work and their results
- Research: Most overestimate how effective they really are...
  - ...on average, by 65%!
- Augmenting clinical judgement with reliable and valid feedback
Connect for Success

• 97% of the difference in outcome between therapists can be accounted for by therapist variability in the therapeutic relationship

• Ability to connect with a broader, more complex, and diverse group of clients
Deliberate Practice

• Top performing clinicians approach the subject of improving their outcomes….
• …the same way investors prepare for retirement: a little bit every day over a long period of time…
• …slow but steady.
• Compared to average therapists, top performers spend 2.5 to 4.5 more hours per week outside of work in activities specifically designed to improve the effectiveness of their work:
  • Workshops
  • Reading
  • Supervision
Gender Health Center: North American Pilot for FIT

• GHC is the first to test FIT efficacy with LGBTQ clients
• GHC has used FIT with all clients consistently since 2010
• Goal: use client feedback to modify treatment plans according to their needs
• Mixed methods study on FIT efficacy with GHC clients
The Purpose of our Mixed Methods Study

• Add to the current body of research by disseminating results of FIT efficacy with LGBTQ folks

• Evaluate FIT service provision at GHC: to ensure that FIT is being effectively implemented for best possible client outcome

• For GHC program evaluation services in general: assess what has been effective and address areas that need improvement
Research Findings

- Among our 391 active clients currently using FIT, the average intake SRS score reflects a good baseline alliance with therapists and our overall treatment outcomes are well above the national average
- Among the 681 inactive clients, we have found the dropout rate to be half that of the national average age
Research Findings

• 91% of our participants emphasized the GHC as providing a safe and comfortable community space:

“I felt like it was the only safe place in the world...at the time, even in my own apartment, my roommate was not supportive, they were not antagonistic or anything, like openly, but they were very phobic, and so I had to deal with the tension of that in my own household. So I often felt safer and more comfortable going to my counseling sessions than I did my own home.”
Research Findings

• 100% of our participants described an appreciation that GHC service providers don’t impose judgment and are educated or trained on issues surrounding sex and gender, as compared to outside mental health services:

“It is important to know that somebody somewhere gets it. You don’t have to explain, to go into details, to answer silly questions. This is an important place to be able to come, to be able to speak freely. It wouldn’t get better otherwise. It’s an invaluable resource really.”
86% of the participants described FIT as facilitating a client-centered therapeutic process:

“I was very pleased with FIT. Because in other circumstances when I’ve dealt with mental health care professionals, it’s always been very authoritarian. It’s always been, ‘Oh well, you know, don’t get excited. Don’t talk too much to us about your narrative, I’m basically examining you and your immediate personality and then I’ll decide on a course of treatment.’ I’ve always felt that was the case. Whereas, when I was with the GHC, the fact that they even asked me at all what I thought about the entire process and then made that the focal point about what we are doing... I felt it was amazing. For the first time in my life, I actually trusted a mental healthcare professional there.”
Contact:

Alex Filippelli: alex@ghcmail.org

David Nylund: dknylund@csus.edu

2020 29th Street, #201
Sacramento, CA 95817
Phone: 916-455-2391
www.thegenderhealthcenter.org