Feedback Informed Treatment:

Making Services FIT Consumers

Scott D. Miller, Ph.D.

http://twitter.com/scott_dm
http://www.linkedin.com/in/scottdmphd
Worldwide Trends in Behavioral Health

“Do More with Less”

• Increasing caseloads, regulation, and documentation;
• Funding challenges;
• Demand for accountability.

The Evidence

• In most studies of treatment conducted over the last 40 years, the average treated person is better off than 80% of the untreated sample.

• The outcome of behavioral health services equals and, in most cases, exceeds medical treatments.

• On average, mental health professionals achieve outcomes on par with success rates obtained in randomized clinical trials (with and without co-morbidity).


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.


The Evidence:

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


The Impossible Profession
Research on the power of the relationship reflected in over 1100 research findings.


Clinical implications include:

1. therapists monitoring their contribution to the alliance;
2. providing feedback to therapists about their alliances; and
3. therapists receiving training to develop and maintain strong alliances.


Seeing More:
What to “Watch”

The Course of Progress in Successful Care

Seeing More: Another approach

The O.R.S  The S.R.S

Feedback Informed Treatment
The Evidence

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

Feedback Informed Treatment

The Evidence

- FIT is being used with broad and diverse group of adults, youth, and children in agencies and treatment settings around the world including:
  - Inpatient
  - Outpatient
  - Residential
  - Prison-based (mandated care)
  - Case management

What Works in Therapy

<table>
<thead>
<tr>
<th>Consumers:</th>
<th>Clinicians:</th>
<th>Payers:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individualized care</td>
<td>Professional autonomy</td>
<td>Accountability</td>
</tr>
<tr>
<td>Needs met in the most effective and</td>
<td>Ability to tailor treatment to the</td>
<td>Efficient use of resources</td>
</tr>
<tr>
<td>efficient manner possible</td>
<td>individual client(s) and local norms</td>
<td></td>
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<tr>
<td>(value-based purchasing)</td>
<td></td>
<td></td>
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<tr>
<td>Ability to make an informed choice</td>
<td>Elimination of invasive</td>
<td>Better relationships with providers and</td>
</tr>
<tr>
<td>regarding treatment providers</td>
<td>authorization and oversight procedures</td>
<td>decreased management costs</td>
</tr>
<tr>
<td>A continuum of possibilities for</td>
<td>Paperwork and standards that facilitate</td>
<td>Documented return on investment</td>
</tr>
<tr>
<td>meeting care needs</td>
<td>rather than impede clinical work</td>
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• Clinical expertise also entails the monitoring of patient progress (and of changes in the patient's circumstances—e.g., job loss, major illness) that may suggest the need to adjust the treatment (Lambert, Bergin, & Garfield, 2004a). If progress is not proceeding adequately, the psychologist alters or addresses problematic aspects of the treatment (e.g., problems in the therapeutic relationship or in the implementation of the goals of the treatment) as appropriate.

FIT Fits

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


Feedback Informed Treatment

“The devil is in the details…”
Three Steps for becoming FIT:

1. Create a “Culture of feedback”;

2. Integrate alliance and outcome feedback into clinical care;

3. Learn to “fail successfully.”

Step One:
Creating a “Culture of Feedback”

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

• Work a little differently;
• If we are going to be helpful should see signs sooner rather than later;
• If our work helps, can continue as long as you like;
• If our work is not helpful, we’ll seek consultation (at week 3 or 4), and consider a referral (within no later than 8 to 10 weeks).
The Outcome Rating Scale (ORS): Seeking Feedback about Progress

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

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

The Outcome Rating Scale (ORS):

Child Outcome Rating Scale (CORS)

<table>
<thead>
<tr>
<th>Name</th>
<th>Age (Yrs):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex: M / F</td>
<td>Date:</td>
</tr>
<tr>
<td>Session #</td>
<td></td>
</tr>
</tbody>
</table>

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

Me
(How am I doing?)

Family
(How are things in my family?)

School
(How am I doing at school?)

Everything
(How is everything going?)

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The Outcome Rating Scale (ORS):
Seeking Feedback about Progress
Step One:
Creating a “Culture of Feedback”

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

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- If our work helps, can continue as long as you like;
- If our work is not helpful, we’ll seek consultation (session 3 or 4), and consider a referral (within no later than 8 to 10 visits).

Step One:
Creating a “Culture of Feedback”

When scheduling a first appointment, provide a rationale for seeking client feedback regarding the alliance.

- Work a little differently;
- Want to make sure that you are getting what you need;
- Take the “temperature” at the end of each visit;
- Feedback is critical to success.

Restate the rationale at the beginning of the first session and prior to administering the scale.
Seeking Feedback about the “working relationship”

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

Child Session Rating Scale (CSRS)

<table>
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<tr>
<th>Name</th>
<th>Age (Yrs): __</th>
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<tr>
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<td></td>
</tr>
<tr>
<td>Session #: ___ Date:</td>
<td></td>
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</table>

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

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.
Supercharging the “Culture of Feedback”

Severity Adjusted Effect Size

9000 cases

First/last alliance

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Step Two: Becoming FIT

Integrating Feedback into Care

- The dividing line between a clinical and “non-clinical” population (25; Adol. 28; kids 30).
- Basic Facts:
  - Between 25-33% of clients score in the “non-clinical” range.
  - Clients scoring in the non-clinical range tend to get worse with treatment.
- The slope of change decreases as clients approach the cutoff.
Step Two: Using the “Clinical Cut-off” to Inform Care

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

Step Two: Becoming FIT

Integrating Feedback into Ongoing Care
Step Two: Integrating Feedback into Care

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

Step Two: Integrating Feedback into Care

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

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

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

In 1906, 85 year old British Scientist Sir Francis Galton attends a nearby county fair; happens on a weight judging competition:

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

Step Two: Integrating Feedback into Care

Directions for change when you need to change directions:

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

Outcome of treatment varies depending on:

- The unique qualities of the client;
- The unique qualities of the therapist;
- The unique qualities of the context in which the service is offered.
1. **What does the person want?**
2. **Why now?**
3. **How will the person get there?**
4. **Where will the person do this?**
5. **When will this happen?**

**Goals, Meaning or Purpose**

**Client’s View of the Relationship**

**Means or Methods**

**Client Preferences**

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**Collaborative Teaming & Feedback**

**When?**

- At intake;
- "Stuck cases" day;

**How?**

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

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Step Three: Becoming FIT

Learning to Fail Successfully

~50% Improved
~50% Unchanged or deteriorated

~20-80%, (X = 47%) Drop Out
~20-80%, (X = 47%) Continue

30-85%, (X = 50%) Do not Improve
15-70%, (X = 50%) Improve

21% Improve (if they stay)
46% Improve (with feedback to therapist)
56% Improve (with feedback to Therapist and Client)
That’s all folks!