FEEDBACK-INFORMED TREATMENT

2018
David S. Prescott, LICSW
Welcome!

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- *Healthy lives, Safe communities*

AGENDA

1. Opening Comments
2. Background: Responsivity Defined
3. Feedback Informed Treatment
4. Measuring Outcome and Alliance
5. Deliberate Practice

THREE CRITICAL SKILLS

- Measuring Outcomes
  - Global as well as risk, need, etc.
- Measuring the Alliance
  - Goals, tasks, relationship, strong client values
- Deliberate Practice
  - Solitary, often mundane activities aimed at professional development

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SHOULDERS OF GIANTS

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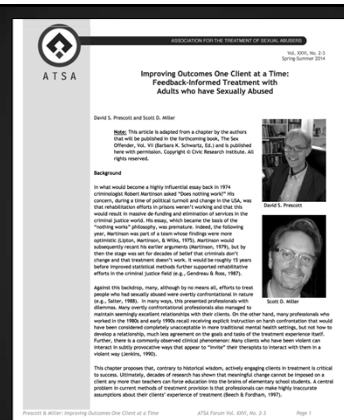

ATSA

ASSOCIATION FOR THE TREATMENT OF SEXUAL ABUSERS

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Improving Outcomes One Client at a Time: Feedback-Informed Treatment with Adults who have Sexually Abused

David S. Prescott and Scott D. Miller

Note: This article is adapted from a chapter by the authors that will be published in the forthcoming book, The Sex Offender, Vol. VII (Barbara K. Schwartz, Ed.) and is published here with permission. Copyright © Civic Research Institute. All rights reserved.

David S. Prescott

Scott D. Miller

Background

In what would become a highly influential essay back in 1974 criminologist Robert Martinson asked "Does nothing work?" His concern, during a time of political turmoil and change in the USA, was that rehabilitation efforts in prisons weren't working and that this would result in massive de-funding 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 team whose findings were more optimistic (Lipton, Martinson, & Wilks, 1975). Martinson would subsequently recant his earlier arguments (Martinson, 1979), but by then the stage was set for decades of belief that criminals don't change and that treatment doesn't work. It would be roughly 15 years before improved statistical methods further supported rehabilitative efforts in the criminal justice field (e.g., Gendreau & Ross, 1987).

Against this backdrop, many, although by no means 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. Many overtly confrontational professionals also managed to maintain seemingly excellent relationships with their clients. On the other hand, many professionals who worked in the 1980s and early 1990s recall receiving explicit instruction on harsh confrontation that would have been considered completely unacceptable in more traditional mental health settings, but not how to develop a relationship, much less agreement on the goals and tasks of the treatment experience itself. Further, there is a commonly observed clinical phenomenon: 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 (Jenkins, 1990).

This chapter proposes that, contrary to historical wisdom, actively engaging clients in treatment is critical to success. Ultimately, decades of research has shown that meaningful change cannot be imposed on a client any more than teachers can force education into the brains of elementary school students. 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).

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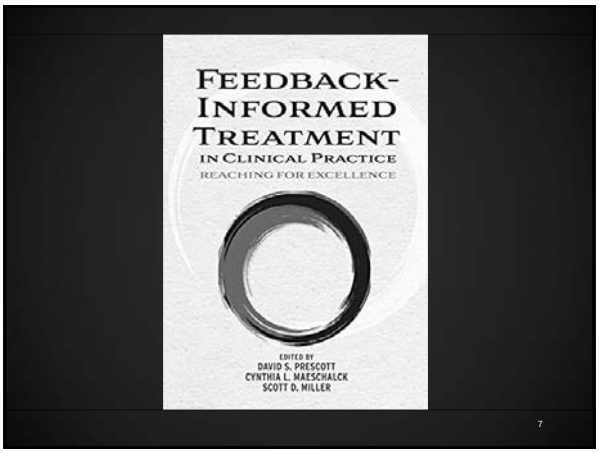
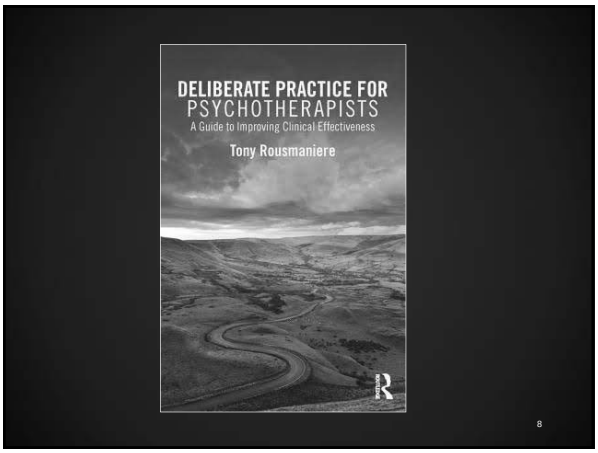


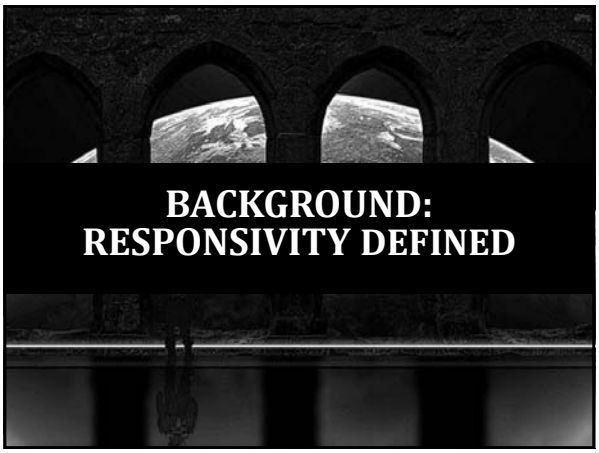


BAD NEWS

- Lots of information
- Will take time to absorb
- Might involve thinking about assessing and treating people who have abused very differently

FOCUS

- Describe Feedback-Informed Treatment (FIT)
  - FIT's place in current context of evidence-based practice
  - Discuss importance of knowing one's baseline
  - Describe two measures for measuring the therapeutic alliance and outcomes
  - Describe the "deliberate practice" of FIT
- Case Examples along the way



BACKGROUND: RESPONSIVITY DEFINED

DEFINED

Responsivity definition, the quality or state of being responsive (dictionary.com)

BONTA (2007)

"3) the *responsivity principle* describes how the treatment should be provided. …

"***Responsivity principle*:** Maximize the offender's ability to learn from a rehabilitative intervention by providing cognitive behavioural treatment and tailoring the intervention to the learning style, motivation, abilities and strengths of the offender."

https://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/rsk-nd-rspnsvty/index-en.aspx

BONTA (2007)

"There are two parts to the responsivity principle: general and specific responsivity. General responsivity calls for the use of cognitive social learning methods to influence behaviour. Cognitive social learning strategies are the most effective regardless of the type of offender (i.e., female offender, Aboriginal offender, psychopath, sex offender). Core correctional practices such as prosocial modeling, the appropriate use of reinforcement and disapproval, and problem solving (Dowden & Andrews, 2004) spell out the specific skills represented in a cognitive social learning approach.

Specific responsivity is a "fine tuning" of the cognitive behavioural intervention. It takes into account strengths, learning style, personality, motivation, and bio-social (e.g., gender, race) characteristics of the individual.

https://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/rsk-nd-rspnsvty/index-en.aspx

CORRECTIONS CANADA

http://www.csc-scc.gc.ca/research/forum/e073/073k_e.pdf

Client Responsivity Factors	
General Population	**Factors more common in offenders**
Anxiety	Poor social skills
Self-esteem	Inadequate problem-solving skills
Depression	Concrete-oriented thinking
Mental illness	Poor verbal skills
Age	
Gender	
Race/ethnicity	

NAT' L INSTITUTE FOR JUSTICE

- …the general responsivity principle, which states that programs should use theoretically relevant models for individual change, specifically cognitive-behavioral and cognitive-social learning models (Andrews & Bonta, 2010).
  - Taylor, 2015, NCJRS

https://www.ncjrs.gov/pdffiles1/nij/grants/248590.pdf

NIJ, continued

"The following techniques are consistent with these models: "role-playing, modeling, repeated practice of alternative behaviors, cognitive restructuring to modify thoughts/emotions, skills building, or reinforcement" (Andrews & Bonta, 2010, p. 50)."

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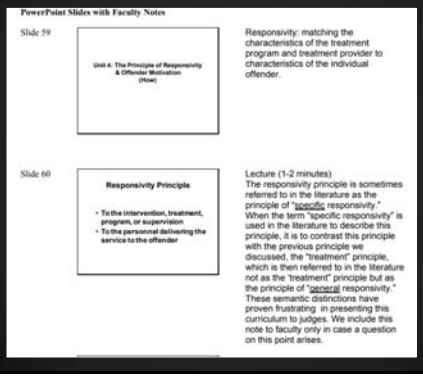

PowerPoint Slides with Faculty Notes

Slide 59

Unit 4: The Principle of Responsivity & Offender Motivation (How)

Responsivity: matching the characteristics of the treatment program and treatment provider to characteristics of the individual offender.

Slide 60

Responsivity Principle

- To the intervention, treatment, program, or supervision
- To the personnel delivering the service to the offender

Lecture (1-2 minutes)
The responsivity principle is sometimes referred to in the literature as the principle of "specific responsivity." When the term "specific responsivity" is used in the literature to describe this principle, it is to contrast this principle with the previous principle we discussed, the "treatment" principle, which is then referred to in the literature not as the 'treatment" principle but as the principle of "general responsivity." These semantic distinctions have proven frustrating in presenting this curriculum to judges. We include this note to faculty only in case a question on this point arises.

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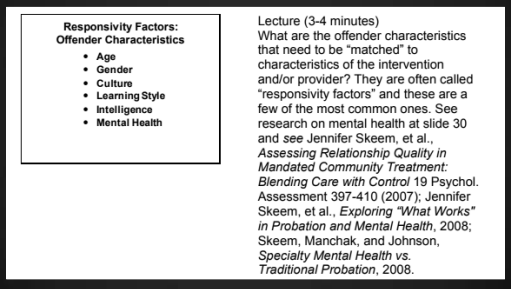

Responsivity Factors:
Offender Characteristics

- Age
- Gender
- Culture
- Learning Style
- Intelligence
- Mental Health

Lecture (3-4 minutes)
What are the offender characteristics that need to be "matched" to characteristics of the intervention and/or provider? They are often called "responsivity factors" and these are a few of the most common ones. See research on mental health at slide 30 and *see* Jennifer Skeem, et al., *Assessing Relationship Quality in Mandated Community Treatment: Blending Care with Control* 19 Psychol. Assessment 397-410 (2007); Jennifer Skeem, et al., *Exploring "What Works" in Probation and Mental Health*, 2008; Skeem, Manchak, and Johnson, *Specialty Mental Health vs. Traditional Probation*, 2008.

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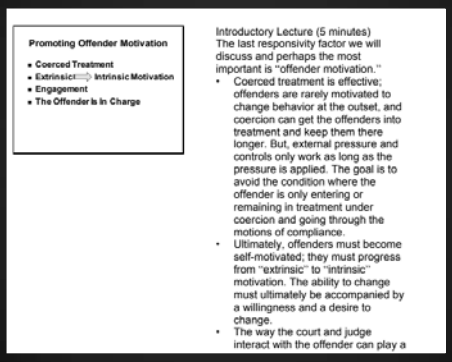

Promoting Offender Motivation

- Coerced Treatment
- Extrinsic ⇨ Intrinsic Motivation
- Engagement
- The Offender is in Charge

Introductory Lecture (5 minutes)
The last responsivity factor we will discuss and perhaps the most important is "offender motivation."

- Coerced treatment is effective; offenders are rarely motivated to change behavior at the outset, and coercion can get the offenders into treatment and keep them there longer. But, external pressure and controls only work as long as the pressure is applied. The goal is to avoid the condition where the offender is only entering or remaining in treatment under coercion and going through the motions of compliance.
- Ultimately, offenders must become self-motivated; they must progress from "extrinsic" to "intrinsic" motivation. The ability to change must ultimately be accompanied by a willingness and a desire to change.
- The way the court and judge interact with the offender can play a

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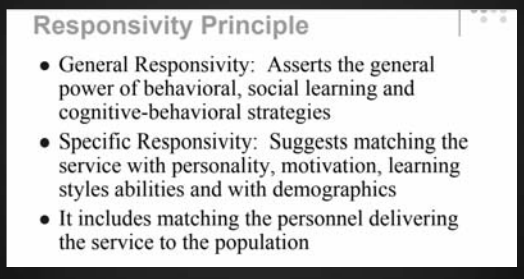
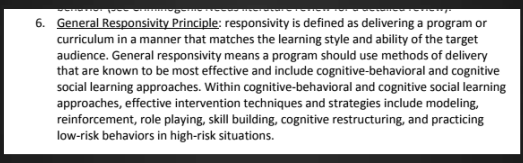


Responsivity Principle

- General Responsivity: Asserts the general power of behavioral, social learning and cognitive-behavioral strategies
- Specific Responsivity: Suggests matching the service with personality, motivation, learning styles abilities and with demographics
- It includes matching the personnel delivering the service to the population

UTAH CJ CENTER



6. General Responsivity Principle: responsivity is defined as delivering a program or curriculum in a manner that matches the learning style and ability of the target audience. General responsivity means a program should use methods of delivery that are known to be most effective and include cognitive-behavioral and cognitive social learning approaches. Within cognitive-behavioral and cognitive social learning approaches, effective intervention techniques and strategies include modeling, reinforcement, role playing, skill building, cognitive restructuring, and practicing low-risk behaviors in high-risk situations.

WHAT'S MISSING?

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HOW DID WE GET HERE?

- Quick look backwards
- Retrospective bias
- Great respect for all involved
- Intent: Tough on issues, tender on people
  - *People are not now as smart as they think; people used to be smarter than we now think they were* (Quinsey, Harris, Rice, & Cormier, 2006)

MY CONCERN

During the past 30 years, the majority of our progress has been technological

MARTINSON, 1974

...probable duration of this ...
...t know.

Does nothing work?

...o all of these studies lead us irrevocably to the conc...
...g works, that we haven't the faintest clue abo...
...ders and reduce recidivism? And ...

PAUL GENDREAU

- "Something works"
- "What works!"

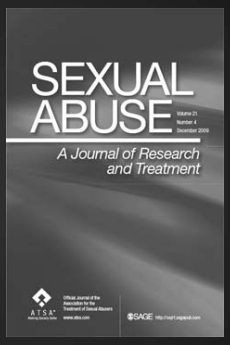
1979: EDWARD S. BORDIN

- Therapeutic alliance:
  - Agreement on relationship
  - Agreement on goals
  - Agreement on tasks
  - (Norcross, 2002, would add client prefere...
  - Over 1,000 studies have emphasized the importance of the alliance in psychotherapy since (Miller, 2011)

HOPE THEORY, 1999

- C.R. "Rick" Snyder:
- Agency Thinking
  - Awareness that a goal is attainable
- Pathways Thinking
  - Awareness of how to do it
- ***"Therapists who are burned out or otherwise fail to convey hopefulness model low agency and pathways thinking."*** (in Hubble, Duncan, & Miller, 1999)

Marshall, 2005



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MARSHALL, 2005

- Warm
- Empathic
- Rewarding
- Directive

Problem:
Many people think they have these qualities, but don't

PARHAR, WORMITH, ET AL., 2008

- Meta-analysis of 129 studies
- *In general, mandated treatment was found to be ineffective … particularly when the treatment was located in custodial settings, whereas voluntary treatment produced significant treatment effect sizes regardless of setting.*

Walfish et al., 2012

- No differences in how clinicians rated their overall skill level and effectiveness levels between disciplines.
- On average, clinicians rated themselves at the 80th percentile
- Less than 4% considered themselves average
- No one rated themselves below average
- Only 8% rated themselves lower than the 75th percentile
- 25% rated their performance at the 90th% or higher compared to their peers

WHAT *ELSE* WORKS?

- **'Common factors' of effective psychotherapy**
  (e.g., Marshall, 2005; Marshall et al., 2002)
- **Comprehensive re-entry planning**
  (e.g., Willis & Grace, 2008, 2009)
- **'Cognitive transformations', achieving informal social control**
  (e.g., Sampson & Laub, 1993; Maruna, 2001)

WHAT WORKS?

***Who* works?**

TAKE-HOME SKILL

- Let's all get humble about our abilities
  - If there hasn't yet been consensus about the definition of responsivity…
  - There are many people who speak with authority about RNR, and yet…
  - Maybe it's time to get back to the basics about how treatment works.

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Feedback-Informed Treatment

DIRTY LITTLE SECRETS

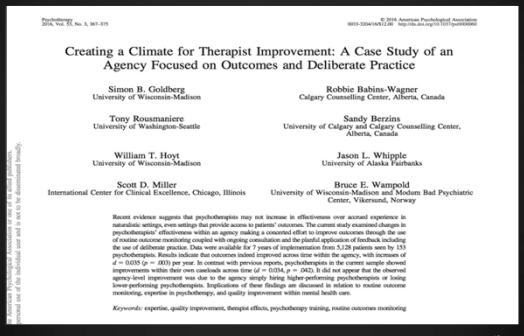
- … from outcome studies
  - More difference between the best and the worst therapists **within** any treatment method, than there is **between** treatment methods
  - Some therapists are better than others
  - Hiatt & Hargrave (1995) asked therapists to estimate their effectiveness in a treatment study
    - The LEAST effective therapists rated themselves as being among the most helpful

ARE YOU EFFECTIVE?

Wampold & Brown (2005)

- 581 therapists
- 6,146 real world clients
- Average sessions = 10
- 46% depression, 30% adjustment disorder, 11% anxiety, plus other diagnoses
- Who got the best outcomes?
  - Training makes no difference
  - Profession makes no difference
  - EXPERIENCE makes no difference
  - Diagnosis makes no difference

ARE YOU EXPERIENCED?



Creating a Climate for Therapist Improvement: A Case Study of an Agency Focused on Outcomes and Deliberate Practice

Simon B. Goldberg, University of Wisconsin-Madison
Robbie Babins-Wagner, Calgary Counselling Center, Alberta, Canada
Tony Rousmaniere, University of Washington-Seattle
Sandy Berzins, University of Calgary and Calgary Counselling Center, Alberta, Canada
William T. Hoyt, University of Wisconsin-Madison
Jason L. Whipple, University of Alaska Fairbanks
Scott D. Miller, International Center for Clinical Excellence, Chicago, Illinois
Bruce E. Wampold, University of Wisconsin-Madison and Modum Bad Psychiatric Center, Vikersund, Norway

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PROFICIENCY VERSUS EXCELLENCE

- Proficiency in most fields can be obtained within 6 months
- The same goes for therapy
  - Most people are at their most effective 1 year after licensing/registration
  - Confidence improves throughout career
  - Competence does not

FIT IN CONTEXT

Defining "evidence-based"

EVIDENCE-BASED PRACTICE

- "Evidence-based practice in psychology is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences."
- *American Psychologist*, May 2006.

FIT DEFINED

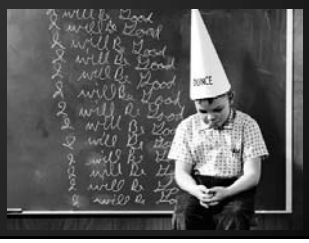
- Pantheoretical approach for evaluating and improving the quality and effectiveness of behavioral health services
- Involves routinely and formally soliciting feedback from consumers regarding the therapeutic alliance and outcome
- Uses the resulting information to inform and tailor service delivery
- Consistent with and operationalizes the American Psychological Association's (APA) definition of evidence-based practice…

FIT DEFINED

- FIT involves "the integration of the best available research…and 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…(e.g., problems in the therapeutic relationship or in the implementation of the goals of the treatment)"

PROBLEM

- Even when we ask clients for their feedback, we often still don't learn!



THE GOAL

- Culture of feedback
- Integrating alliance and outcome data into clinical care
- Failing successfully

THE RESULTS

1. Reduced therapist variability
2. Improved Outcomes
3. Improved detection of at-risk cases

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IMPORTANT

1. It's not just about being open to feedback
2. It's about getting data and using it effectively, with a goal of getting better.

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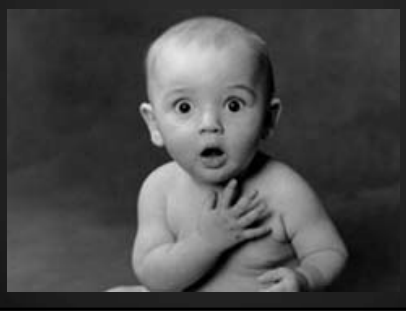
CULTURE OF FEEDBACK

- Superior therapists elicit more negative feedback
- Atmosphere in which clients are free to rate their experiences
  - Without retribution
  - With a hope of having an impact
- Beyond displaying openness, this involves introducing the measures thoughtfully and thoroughly
- It is not just another form to fill out!

OPENNESS AND SURPRISE



EXAMPLE

- Anker, Duncan, & Sparks (2009) in JCCP
- Couples therapy (n = 410)
- Feedback condition
  - nearly 4 times the rate of clinically significant change
  - maintained a significant advantage at 6-month follow-up while attaining a significantly lower rate of separation or divorce.

MILLER, DUNCAN, ET AL. 2006

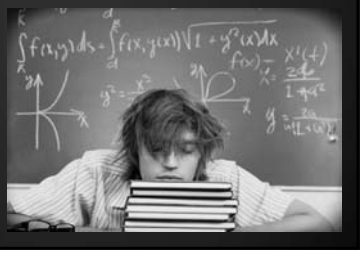
- 75 therapists and 6,424 clients over two years
- Formal, ongoing feedback about the alliance and progress in treatment resulted in significant improvements
  - client retention and outcome
- Clients of therapists who did not seek feedback regarding the alliance were three times less likely to return for a second session and had significantly poorer outcomes

FIT

- Knowing our base rates
- The importance of feedback
- Deliberate practice
  - Think
  - Act
  - Reflect

DELIBERATE PRACTICE

- The specifics:
- Think
- Act
- Reflect
- TAR



One step further…

- **Think** Identify a problem; write out four possible responses you might give to a client; anticipate responses the client might give you; compare and select best apparent choice
- **Act** Try it out
- **Reflect** Actively review session. What went well? What did you skip? How can that inform your work?
  - Honor thy mistake as a hidden intention
  - Repeat these steps

EXAMPLE: ME

- Ensuring safety and connection at start of sessions
- Identifying ambivalence earlier in session
- Improving the balance of ORS score exploration and respecting client narrative

ONE CONCRETE STEP

- If you were to establish a deliberate-practice plan to become a better therapist, what would be the first step you would take?

WHAT PREDICTS CHANGE?

- Early change in therapy
  - Clients who do not see gains quickly tend to drop out
  - Around 20% just stay in therapy indefinitely
- Therapeutic Alliance
  - Feeling heard, respected, and understood
  - Agreed-upon goals
  - Agreed-upon methods
  - Client preferences

WHY DO WE MEASURE PROGRESS?

- Studies where therapists have had accurate information as to client progress have consistently shown outcomes improve for clients
- Effectiveness increases and negative outcomes reduce significantly
- Having a formal system of monitoring client progress improves outcomes by 30%

HOW DO WE MEASURE PROGRESS?

- Objective measures
  - Clients who are not improving and likely to drop out
  - Clients who have made gains quickly and are likely to drop out or have trouble progressing
  - Clients who are getting worse
- Asking how have things been is not the same thing

OUTCOME RATING SCALE

Overall:
(General sense of well-being)

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

Individually:
(Personal well-being)

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

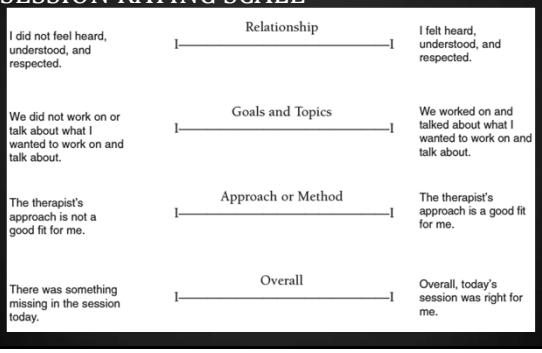
Interpersonally:
(Family, close relationships)

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

Socially:
(Work, School, Friendships)

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

SESSION RATING SCALE



INTRODUCING THE ORS

- We work a little differently at this agency. Our first priority is making sure that you get the results that you want. For this reason it is very important that you are involved in monitoring our progress throughout therapy. 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'll fill it out at the beginning of each sessions and then we'll talk about the results…

Continued…

- A fair amount of research shows that if we are going to be successful in our work together, we should see signs of improvement sooner rather than later. If what we're doing work, then we'll continue. If not, however, 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 that make sense to you?

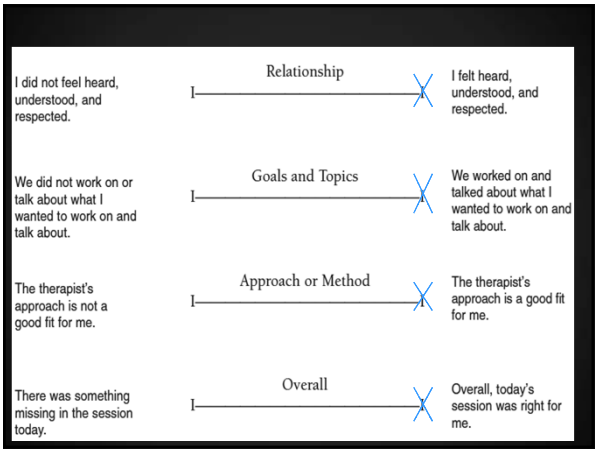
INTRODUCING THE SRS

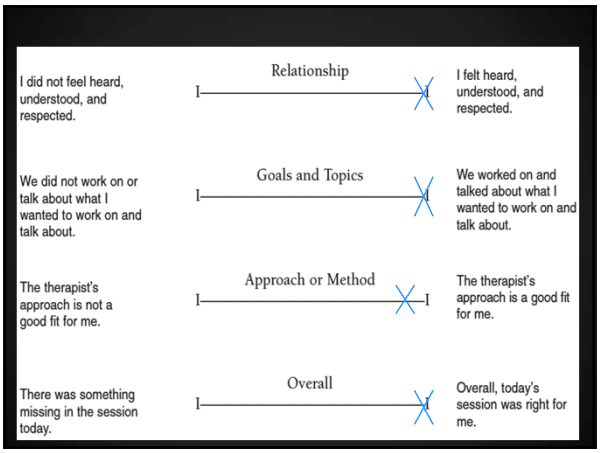
- At the end of each session, you can fill out one additional form, the Session Rating Scale. Again, it's very short, taking about a minute or less to complete and score. This scale helps me to know how the session went. It takes the "temperature" of the visit, so to speak. I ask you to fill this out because the research shows your experience of our work together during the visit is a good predictor of whether we're successful. I'll explain more about this at the end of the session. Does this make sense?

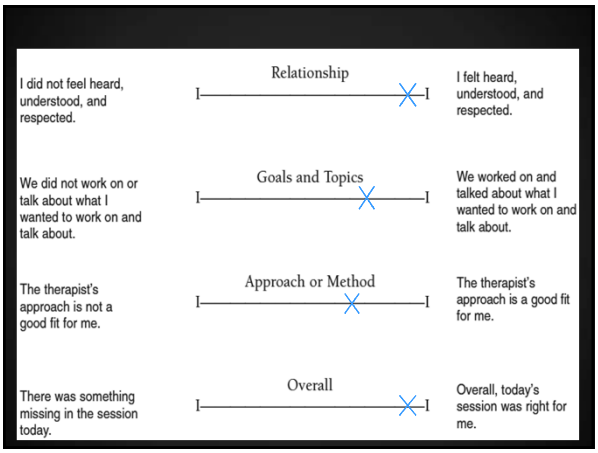
LEARNING TO ADMINISTER THE SRS

Self-examination

- Individually
  - Write a brief introduction to the SRS that YOU would use with a client (no longer than 50 words)
- Small Groups
  - Read your introduction to a colleague
- Feedback
  - Write down anything in this introduction that you would like to do better
  - Ask your partner for feedback




I did not feel heard, understood, and respected.
Relationship
I felt heard, understood, and respected.
We did not work on or talk about what I wanted to work on and talk about.
Goals and Topics
We worked on and talked about what I wanted to work on and talk about.
The therapist's approach is not a good fit for me.
Approach or Method
The therapist's approach is a good fit for me.
There was something missing in the session today.
Overall
Overall, today's session was right for me.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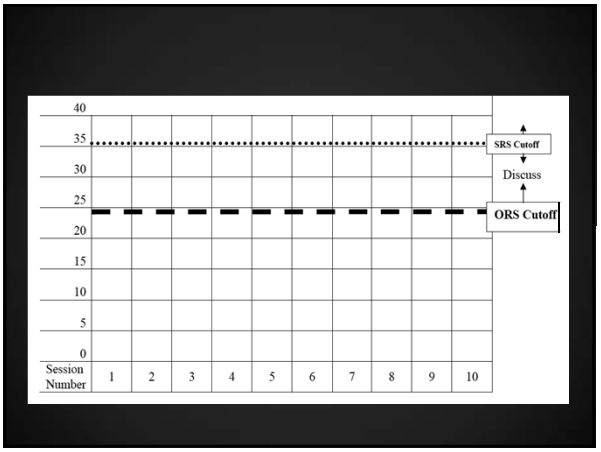
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SRS Cutoff
Discuss
ORS Cutoff
Session Number
1
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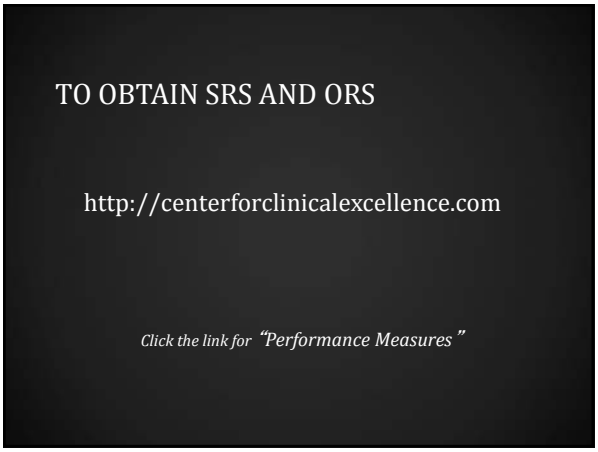
TO OBTAIN SRS AND ORS
http://centerforclinicalexcellence.com
Click the link for "Performance Measures"