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

PLEASE BE PATIENT WITH ME
• We live in troubled times
• I am going to be very provocative
• I am going to be highly irreverent
• This is a training for professionals only
• I come in peace and believe in human dignity
• I mean no harm
• Please take everything I say in the spirit in which it is intended

TAKE HOME MESSAGES
• What you do matters
• What you do works
• Follow the research
• Be data driven
• Beware of false advertising
• Always keep the big picture in mind

I GET BY WITH A LITTLE HELP FROM MY FRIENDS
TAKE-HOME SKILL #1

- Express kindness and gratitude to your colleagues
- Mind your manners
- Use greetings in emails
- Emojis in low doses

Remember that they are suffering as much or more than you.

WHAT’S OUR GOAL?

- Stopping the behavior?
- Justice for the victim?
- Preventing re-offense?
- Better lives for all?

WHAT WORKS?

- Do we want them to re-offend or not?
- What can we do?
- Who should we be?
- Is that enough?

ASK YOURSELF

- What’s the best session you’ve done in the past year?
- What made it so effective?
- What gets in the way of your doing that all the time?

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
Feedback Informed Treatment

Welcome to My Hell

- 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

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

BONTA (2007)

“3) the responsibility principle describes how the treatment should be provided. ...”

“Responsibility principle: Maximize the offender’s ability to learn from a rehabilitative intervention by providing cognitive behavioral treatment and tailoring the intervention to the learning style, motivation, abilities and strengths of the offender.”


CORRECTIONS CANADA

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

<table>
<thead>
<tr>
<th>Client Responsibility Factors</th>
<th>General Population Factors more common in offenders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>Poor social skills</td>
</tr>
<tr>
<td>Self-esteem</td>
<td>Inadequate problem-solving skills</td>
</tr>
<tr>
<td>Depression</td>
<td>Concrete-oriented thinking</td>
</tr>
<tr>
<td>Mental illness</td>
<td>Poor verbal skills</td>
</tr>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Race/ethnicity</td>
<td></td>
</tr>
</tbody>
</table>
Informed Treatment 9/20/2018

David S. Prescott, LICSW

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
  

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):
**WHAT’S MISSING?**

**THE BEST QUESTION**

Am I the professional that this client can respond to?

**MY CONCERN**

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

**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)

**IN THE BEGINNING...**
MARTINSON, 1974

Does nothing work?

Do all of these studies lead us irrevocably to the conclusion that nothing works, that we haven't the faintest clue about what to do here and reduce recidivism? And it was 1974.

1979: EDWARD S. BORDIN

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

PAUL GENDREAU

• “Something works”
• “What works!”

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
- Warm
- Empathic
- Rewarding
- Directive

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

Challenging our cognitive distortions...
- Being warm and empathic ≠ being naïve
- Being rewarding and affirming ≠ being a “thug hugger” or “defender of deviants”
- Being kind and generous ≠ being gullible or foolish
- These are frequently confused
- You can be foolish, gullible, and naïve without having these qualities, too. 😊

Telling “The Hard Truth”
- Feedback Sandwich
  - Affirm => Feedback => Affirm
- Elicit => Provide => Elicit
  - Ask permission to give feedback, give the feedback, then elicit the client’s thoughts about your feedback
- Motivational approaches are not necessarily warm and fuzzy

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?

IMPORTANT STUDY
  - Blasko & Taxman (2018)
  - Offenders who believe their supervising agent is:
    - Fair
    - Respects them
    - Listens to them
  - Have lower rates of violations and returns to prison
  - The working relationship matters!

SEQUENCE FOR STUCK CASES
1. What are this client’s goals?
   - Do you have agreement on them?
2. What is the nature of your relationship with this client?
   - Do you have agreement on this?
3. What approach works best with this client?
   - Do you have agreement on this?
4. What are this client’s strong personal values?
   - How can you work within them?
TAKE-HOME SKILL

- Let’s all get humble about our abilities
  - If there hasn’t yet been consensus about the definition of responsibility...
  - 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.

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?

- 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?

- 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

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.

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?
MEASURING OUTCOME AND THE ALLIANCE

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

<table>
<thead>
<tr>
<th>Overall</th>
<th>Relationship</th>
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<tbody>
<tr>
<td>(General sense of well-being)</td>
<td>(Feel heard, understood, and respected)</td>
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<table>
<thead>
<tr>
<th>Individually</th>
<th>Goals and Topics</th>
</tr>
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<tbody>
<tr>
<td>(How well you feel)</td>
<td>(What we talked about)</td>
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<tr>
<th>Interpersonally</th>
<th>Approach or Method</th>
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<tbody>
<tr>
<td>(Family, close relationships)</td>
<td>(How the therapist worked)</td>
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<table>
<thead>
<tr>
<th>Socially</th>
<th>Overall</th>
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<tbody>
<tr>
<td>(Work, school, friendships)</td>
<td>(Overall of today's session)</td>
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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

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ARTURO, 17
- Sexual abuse of two children three years previous. Assessment showed him to be low risk.
- Others’ goals = no more victims
- My goal was building a better life
- His goal was getting others off his back
- As Jay Haley observed: The problem is being in therapy

Arturo’s initial ORS
- Scored at 31; cause for concern
- Discussed situational factors throughout first session and arrived at 21
- SRS was 35. Discussed how he was mostly angry about having to be in treatment at all
- Arrived at goal of showing others he was not who he had been three years earlier.
- ORS and SRS both improved

ARTURO AND DELIBERATE PRACTICE
- I had to review the goal before each session and intersperse it throughout in order to keep it alive and ensure it wasn’t just a token goal
- Arturo was able to discuss what happened because as far as he was concerned he had a new identity. He had a plan for preventing sexual aggression and for preventing allegations
ERIC, 12
- Trauma and physical aggression, at home and school; had assaulted children at church
  - Explained limits on confidentiality
- Initial ORS score of 38 (at risk)
- SRS was 38. Said I would do better if I took him out to McDonald's
- Wouldn’t discuss his scores:
  - Would describe situations at home, school, community; massive disparity with scores

ERIC: TEACHING POINT
- By using the scales as a tool for clinical dialog, I was able to pick up on risk for dropout and trouble earlier than I might have.
  - After all, I was enthusiastic to provide treatment
  - Others were too, despite lack of success
- We continued for several sessions, still no dialog on the feedback measures.

ERIC: TAR
- Mistake: Talked to father. Inferred violation of trust
- Action plan of emphasizing I’m Eric’s therapist and not his father’s; Emphasized a calm and soothing approach.
- It worked, but only to the point where he described homicidal intent and no safety plan
- Out of concern for younger people, I called for a team meeting. Beyond my inability to reach Eric, the safety concerns were over-arching.

THE MORAL
- Local ethical codes left me with no choice
- I might have been the wrong therapist, but I accurately predicted that things might get worse.
- I might have been the wrong therapist, but thanks in part to the ORS & SRS I was the right clinician!
- The others who were waiting patiently for him to become safer would have waited a long time at great expense.

TO OBTAIN SRS AND ORS
http://centerforclinicalexcellence.com

Click the link for “Performance Measures”
Let’s Make a Plan for Becoming a Better Therapist

Courtesty of Daryl Chow and Scott Miller

HOW DO PROFESSIONALS CHANGE?

• Carl Rogers (1939):

  “… 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.”

IMPOSTER ANXIETY

LEARNING

Supervisor Mistakes

(With thanks to Daryl Chow)

• Too much theory talk
• Pats on the back
  - (“you did your best, the client came back, it's a tough client, hang in there, things will improve”)
• Lack of monitoring progress
• Supervisor doesn't monitor engagement of supervisee
• Not analyzing the processes
  - (Talking about sports is not playing the game)
• Lack of learning objectives

QUALITIES OF A GOOD COACH

• Continuously returns to teaching fundamentals
• Willing to analyze your game
• More corrective than critical
• Focuses more on process than techniques
• An authority, but not authoritarian
• Keeps an eye on your outcomes and learning needs
• Focuses on developing you, not a version of the coach
“Scenius” versus “Genius”

"Genius is individual, scenius is communal".
-- Brian Eno

BERG-SMITH

MI is also a style for training.
Model, model, model motivational interviewing from the beginning to the end of training.
Keep it simple. Less is more.
Decrease content, increase involvement.
The trainer is the most powerful visual aid, not the slides.
The wisdom is in the room.
Make it multi-modal.
Expect and respect the unexpected.

ARPS

• Automated Structure
• Reference Point
• Playful Experimentation
• Support

AUTOMATED STRUCTURE

• 1. Block out one hour a week during your work week. Avoid distractions (e.g., colleagues, emails).
• 2. Create a structure on how you will 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.

REFERENCE POINT

• 1. Keep one eye on the outcome data (individual cases & aggregate), and another on systematically monitoring your learning objectives.
• 2. At the end of each work week, employ a system to note down your weekly learnings briefly (e.g., notebook, note-taking apps).
• 3. Pick out sessions that are representative of your best work. Analyze the session and identify out your specific strengths. Involve your supervisor in this process.
PLAYFUL EXPERIMENTATION
1. Watch 5-10 minute segments of your recordings. Pause and consider how you might carry on the session more constructively.
2. Actively 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. Practice stepping out of your comfort zone (see Figure 1) in one area of your usual habit of conducting therapy (e.g., the way you convey hope). Monitor the impact.

SUPPORT
1. Seek out a coach, consultant, or supervisor.
2. Evaluate if your supervisor helps you to reach into your learning zone, and not tipping you into the panic zone (see Figure 1).
3. Form a community with a few practitioners equally dedicated as you (Review “Scenius vs. Genius”).

Clinical Practice Deliberate Practice

![Deliberate Practice Diagram](image)