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Moving from Evidence Based Practice to Practice Based in Evidence

Nancy Olson-Engebreth
St. Catherine University, njoengebreth@gmail.com

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by

Nancy J. Olson-Engebreth, MA

MSW Clinical Research Paper

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Committee Members
Michael Chovanec, Ph.D. (chair)
Daniel Frigo, Ph.D., LICSW
Gay Rosenthal, M.A.

The Clinical Research Project is a graduation requirement for MSW students at St. Catherine University/University of St. Thomas School of Social Work in St. Paul, Minnesota and is conducted within a nine-month time frame to demonstrated facility with basic social research methods. Students must independently conceptualize a research problem, formulate a research design that is approved by a research committee and the university Institutional Review Board, implement the project, and publicly present the findings of the study. This project is neither a Master's thesis nor a dissertation.

Abstract

This study addresses the issue of the lack of research in the use of client feedback tools, specifically the Outcome Ratings Scale (ORS) and Session Ratings Scale (SRS), from the perspective of the clinician. The study uses a mixed method design with Likert-scale questions as well as open-ended questions which are qualitatively analyzed. The surveys were administered through Qualtrics and an online list serve through the International Center for Clinical Excellence (ICCE). The findings echoed research in regards to their use supporting the growth of therapeutic rapport between clinician and therapist. The implication for social work practice is to use these tools as a way to offer better routine services to clients.

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Introduction

Research suggests many clinicians are completely unaware if they are effective. According to Newham and Page (2010), clinicians are often poor judges of client progress. Additionally, clinicians often think that they are doing better than they actually are (Sapyta, Riemer, Bickman, 2005). In a research study by Halford, et al, (2012) they shared that 10 to 15% of psychotherapy patients deteriorate during outpatient therapy and that another 25 to 30% show no improvement due to therapy. This means that almost half of those attending therapy either do worse in life or show no improvement. They further shared not only do clinicians not know when clients are doing well, they also do not recognize when clients are doing poorly. Sapyta, Riemer, and Bickman (2005) shared, most professionals who choose clinical practice in the mental health field believe that they are, in fact, helping people.

To begin understanding the client/therapist relationship a focus is placed on the importance of establishing therapeutic rapport and alliance as factors that assist individuals to remain in therapy. Shaw and Murray (2014) shared that therapeutic alliance: "...is an agreement between counselor and client on goals, treatment tasks or methods, and the relational bond" (p.43). They further mentioned that the client's view of the alliance is a better predictor of client outcomes than what the therapist sees for the client (Shaw and Murray, 2014). Related to this, Miller, Duncan, Sorrell, and Brown (2005) reasoned that by looking at the alliance from the client's perspective the clinician can then gauge the appropriateness of the treatment. Their article looked at a research study with 160 clients in a substance abuse program. Participants were asked for their feedback in the first session regarding the therapeutic alliance. By asking for this feedback, researchers found an overall increase in positive treatment outcomes (Miller et. al, 2005). This shows by assessing from the client's perspective how the therapy is impacting them, rather than how the clinician believes the therapy is impacting the client, there will more likely be a positive impact for the client.

In order for this to be achieved, clinicians must efficiently and effectively assess the client's perspective of the therapeutic relationship. By using client feedback tools, clinicians can readily gather this information from their clients. A variety of tools currently are on the market and it is up to clinician discretion in terms of which tool they choose to implement into their practice. For the purpose of this paper, the tools which have been previously developed and assessed will be referred to as Client Feedback Tools (CFTs). There are two main tools found in the research; the OQ-45 to the Session Rating Scale (SRS)/Outcome Rating Scale (ORS). These tools will be further discussed with an emphasis placed on the SRS and ORS for direct research.

Between clinical research and clinical practice there is a discrepancy between CFTs being used for research purposes and clinicians utilizing the tools in practice. This is evidenced not by the lack of research, but by the lack of research from the perspective of clinicians who are utilizing the tools in clinical practice. Hence, a study will be completed addressing what clinician's experiences have been in using client feedback tools. Specifically, the research will address the challenges, limitations and strengths of utilizing the tools in a clinical setting. Therefore, the research will use a mixed method design using online surveys with those who are currently using these tools. In order to access professionals who use CFTs the researcher will post a notice asking clinicians who use the tools to complete an anonymous survey on the International Center for Clinical Excellence (ICCE) professional website.

Literature Review

As clients are entering into therapy both client and clinician are uncertain about what is to come. Herein lies the importance of rapport building and therapeutic alliance. When this is not achieved, there is a greater instance of client's dropping out of therapy with little warning for the clinician. The use of Client Feedback Tools (CFTs) supports clinicians in terms of having better relationships with their clients as well as achieving better outcomes. Because clinicians are often unaware of fissures in the relationship, these tools assist clinicians in seeing what areas of the relationship they can improve on with their clients. For the purpose of the literature review, the Outcomes Rating Scale and the Session Rating Scale will be compared with the Outcome Questionnaire-45.

Therapeutic Alliance and Rapport

Given that the therapeutic relationship is an important predictor in treatment outcomes (Harmon et al., 2007) and that Meta-analytic research shows alliance factors are major contributors to successful client outcomes (Shaw & Murray, 2014), clinicians should and need to be doing more to ensure quality relationships with their clients. Therapeutic alliance is often defined by Bodin: "It is an agreement between counselor and client on goals, treatment tasks or methods, and the relational bond." (Shaw & Murray, p. 43, 2014) These three areas: goals, tasks, and relational bond are what make up therapeutic alliance and have been found to be the most important factors in whether or not clients will do well in treatment (Swift & Greenberg, 2015). In terms of the counselor specifically, Novotney (2013) states: "Effective therapists have a sophisticated set of interpersonal skills, including verbal fluency, warmth, acceptance, empathy and an ability to identify how a patient is feeling. Successful therapists can also form strong therapeutic alliances with a range of patients and are able to induce them to accept the

treatment and work with them" (p. 2). The use of CFTs are the best way to measure the relationship from the client's perspective.

Clinicians also need to keep in mind that a client's view of the alliance is a better predictor of positive outcomes, as well as client-perceived empathy is a better predictor of outcomes than that of therapist-perceived empathy (Shaw & Murray, 2014). Therefore if clinicians truly are in the business of assisting clients to make positive change, then influencing the alliance is the most impact clinicians can have on clients' positive outcomes (Duncan, Miller, Sparks, Claus, Reynolds, Brown, Johnson, 2003). Challenging the validity of evidence-based practice in light of the importance of therapeutic alliance, Newnham & Page (2010) argued that the alliance is more important than the theory base or practice of the clinician. The tools are effective on a wide therapeutic style scale as they are atheoretical.

Importance of Client Monitoring

As discussed, the therapeutic bond has been found in research to be one of the most important predictors to the outcome of therapy; however, without a tool to discover the relationship from the client's perspective, therapists are lost in their own beliefs and they are often incorrect. In fact, those who fail to improve in the first few sessions are more likely to continue doing poorly or to drop out early (Halford et al. 2012). According to Newnham and Page (2010) clinicians often attribute client failure to the client. Yet the therapist may be doing very little to monitor for how the client perceives treatment is working. They pointed out that because clinicians attribute failure to the client, the use of a tool to assess how the client is proceeding in treatment from a neutral base would be helpful for both client and clinician (Newnham & Page, 2010). This is echoed in

additional studies in that clinicians are poor judges of how clients are doing in treatment. In a study with 48 clinicians using the OQ-45, 40 clients were seen as deteriorating in treatment and only one was correctly identified by clinicians (Shaw & Murray, 2014). This stems from what Newnham and Page (2010) have also found in that clinicians tend to be overly positive when it comes to the progress of clients towards their goals and therefore clinicians are not seeing that their clients, in fact, are not doing well. To reduce rates of client failure clinicians should monitor progress or lack thereof through a systematic process (Halford et al., 2012). Newnham and Page (2010) shared clinicians often steer the session based on what they believe is occurring rather than assessing from the client's perspective. They also found that sessions often ebb and flow with the mood of the clinician, not with the needs of the client. Based from this and the significant variables at play in the therapeutic relationship, the use of CFTs is imperative to quality treatment.

Client Feedback Tools

Development: The development of client feedback tools (CFTs) largely came out of the idea that clinicians were unaware of their effectiveness with clients and a desire to improve client outcomes. Newnham and Page (2010) state: "There is substantial literature outlining low reliability of clinical judgment when assessing patient outcomes" (p. 130).

This may be due to what Sapyta, Riemer, and Bickman (2005) share in that clinicians are not trained with an objective source but only by themselves and a supervisor. They go on to share that clinicians often think they are doing better than they actually are. In a survey they conducted with 143 counselors asking them to grade themselves, 66% graded themselves with an "A" or better and no one felt they were

below average. However, with research showing that clients "fail" at a rate of roughly 50% it does not seem logical that most clinicians are above average.

Another issue is that clinicians' effectiveness does not seem to improve over time. The use of CFTs serve as a way to help clinicians know they are being effective with their clients (Sapyta, Riemer, Bickman, 2005). Swift and Greenberg (2015) share that through the use of CFTs therapists can more easily see what patients see as their symptoms, distress, and impairment and can then administer therapy geared toward what the clients truly need, rather than what a therapist perceives that the client needs. By providing this feedback in real time it is more beneficial for both the clinician and the client (Newnham, Hooke, & Page, 2010; Miller et al, 2005). Therapy and the outcomes are not about the end of the therapy, but finding out during the treatment what is or is not working well for the client and adjusting as the therapy is in progress (Howard, Moras, Brill, Martinovich, Lutz, 1996; Halford et al., 2012). Sapyta, Riemer, Bickman (2005) found that more immediate feedback also indicates to client and clinician if more should be spent on those cases that are not going well.

Two tools which have been developed as a result are the OQ-45 and the ORS/SRS. One of the first tools developed was the Outcome Questionnaire-45 (OQ-45). The OQ-45 is a 45-item self-report feedback tool and identifies clients as either being "off-track" or "on-track". The SRS and ORS are more commonly thought to be used for clinical purposes rather than for research purposes (Swift & Greenberg, 2015). They were first developed in the 1990's as a shorter alternative to the longer already existing scales and to obtain feedback on a regular basis in counseling sessions (Duncan et al., 2003; Shaw and Murray, 2014). The SRS/ORS are also recognized as an evidence-based

practice and are part of the National Registry of Evidence-based Practices (NREP) (Shaw & Murray, 2014).

What The Tools Do: The tools prove to have some similar and yet different functions in obtaining client feedback. The OQ-45 specifically monitors clients along three dimensions of subjective discomfort (eg: anxiety and depression), interpersonal relationships (eg: "I feel lonely"), and social role performance (eg: "I have too many disagreements at work/school"). The OQ-45 is more of a research tool as researchers wanted to try and find a way to assess a client's expected course of treatment response (Howard, Moras, Brill, Martinovich, Lutz, 1996). In contrast to this, the ORS/SRS are used by clinicians to assess perspectives from the clients attending therapy on a session by session basis. This information is obtained by ORS measures of individual functioning, interpersonal relationships, and social role performance. The SRS measures the hallmark qualities of the therapeutic alliance by asking clients about the quality of the relational bond, the agreement between client and therapist on the goals, methods, and overall approach to therapy (Miller et al., 2005). It also allows clients greater permission to speak negatively about the therapist or how the therapy is working (Duncan et al., 2003) which differentiates it from the OQ-45. The SRS/ORS are also recognized to be reliable and valid tools with higher compliance by clients due to their shorter length (Shaw & Murray, 2014; Halford, et al., 2012).

Application in Practice: The OQ-45 and the ORS/SRS are administered in similar fashion, although the time of administration and the information extrapolated from the tools are used in different manners. The OQ-45 is administered at the beginning of a therapy session. Because they are labor intensive, the feedback is occasionally

unavailable for the current session and is gone over in the following session. In a study done by Harmon, et al. (2007) they found that it was more successful to have both the therapist and the client receive the feedback for session-by-session progress. The client's progress is plotted against expected treatment trajectory to help assist clinicians in interceding when clients are not doing well (Newnham & Page, 2010). Scale scores range between 0 to 180 with higher scores reflecting a greater feeling of distress for the client. (Harmon et al., 2007).

The ORS is administered at the start of the therapy session to provide some level of conversation as to how life is faring for the client (Shaw & Murray, 2014). This differs from the OQ-45 as the information may not be received until the following session. The SRS is completed at the end of the session. It contains four scales: relationships, goals/topics, approach/method, and overall - each one is then measured. a score of 9 or lower on each individual scale or a score under 36 overall is a cause for concern (Duncan et al., 2003; Miller et al, 2005). The scales are broken down into two different four-question Likert-scale measures to accommodate the differences between client functioning and the therapeutic alliance. Studies note how easily administered clients believe the ORS/SRS to be (Miller et al, 2005) in addition to their ability to be used with any psychological theory or method (Overington, Ionita, 2012).

Both the OQ-45 and the ORS/SRS offer web-based scoring systems for clients and clinicians. The OQ-45 has a web-based scoring system that assists clinicians identifying where clients are at with their trajectories as well as next steps for the client. The OQ-45 also has indicators for ending treatment and suggestions for when clinician should change direction with a client (Overington & Ionita, 2012). The ORS/SRS has an

online tool for scoring: FIT-Outcomes and MyOutcomes which help generate an initial dosage curve for clients. When future scores deviate from the projection, the system shares ideas for activities to do with the client to help them come back with their projected curve (Overington & Ionita, 2012).

Importance in Clinical Practice: The importance for using CFTs in clinical practice are twofold: first, clients are becoming better informed consumers when it comes to mental health care. Second, from the clinician's perspective, the use of CFTs should be considered part of ethical practice.

The use of CFTs provides better results and more efficient treatment for clients. Consumers of mental health services are demanding proof of results (Miller, Duncan, Sorrell, & Brown, 2005; Overington & Ionita, 2012). The use of CFTs provides this proof for not only the client, but assists the clinician in knowing the effectiveness of treatment and next steps to take with the client. The use of CFT assists in this by alerting both parties how close they are to the goal being accomplished (Sapyta, Riemer, Bickman, 2005). Because most change for clients occurs in the first half of treatment it is therefore important for early detection of client failure for the clinician to intervene (Halford et al., 2012). Additionally, research has found that the use of CFTs improve outcomes for those that are at risk to leave treatment or those that have deteriorated (Harmon et al., 2007). Clients struggling in treatment had better success with CFTs than those that were doing well in treatment as it signified to the clinician that something in the therapy needed to change (Sapyta, Riemer, Bickman, 2005). Moreover, clinicians also need to know that the work they are doing is helpful and the use of these tools may prove to be the piece missing from this assessment (Howard et al., 1996). "The broad philosophy underlying

the scientist-practitioner model proposes that clinicians should be active consumers of research findings, participate in the ongoing evaluation of their own practice, use these data to produce new research, and report these findings to the professional and scientific communities" (Newnham & Page, p. 136, 2010)

An ethical thing to do in clinical practice it to utilize CFTs. Through using these tools, it shows the client that their perspective is valued (Newnham & Page, 2010; Shaw & Murray, 2014). Looking into the continuation of therapy, clinicians and clients are better off with on-going use of CFTs as clinicians do not improve in their ability to foresee client issues without the use of the CFT. Therefore it is vital that clinicians are consistently using these tools (Miller et al, 2005). As social work is moving toward more of a science based field with not only evidence based theory, but evidence based tools, "Researchers and clinicians alike have expressed concern regarding the 'gap' between science and practice that the claim is evident in clinical psychology" (Newnham & Page, 2010). They also stated that with the use of clinical support tools, clinicians now have an ability to diminish the gap. This is seen in a marked effort in bridging the gap between evidence-based practice and practice-based evidence (Newnham & Page, 2010). Shaw and Murray (2014) shared that use of these tools adds to ethical practice in that it elevates the client's voice in the direction of where he/she would like the treatment to go; thus corresponding with the ethics of self-efficacy and client determination in social work practice and values.

Gap in Literature

The gap in the literature is seen by research showing the positive outcomes for clients with the use of CFT's, but a lack of research from the clinician's perspective. This

is echoed by Newnham, Hooke & Page (2010) as they found a highlighted gap in the research around feedback tools having been shown to be of great benefit, but are underutilized in practice. This is further evidenced in searches through databases on the use of client feedback tools. In consultation with social work research librarians, there were no studies looking at the use of client feedback tools from the perspective of the clinician. These tools have the ability to provide clinicians with the best and most optimal care for their clients and yet there are no studies reflecting the actual use of the tools based on feedback from clinicians.

Summary

Literature shows the importance of therapeutic alliance and that the use of CFTs can assist not only with recognizing this alliance, but create more positive outcomes for clients. This, too, has been studied in regards to CFTs showing that clients report better outcomes with the use of these tools. What seems to be missing is research demonstrating use of the tools from a clinician's perspective. This may be one factor as to why the tools are not being utilized more fully across the mental health field.

Conceptual Framework

The conceptual framework used for formulating survey questions for the research is based on the ecological model and on the social work concepts of micro, mezzo, and macro level interventions. According to social work definitions, micro level work is found to be that which is done on an individual or family basis. This work forms the survey questions for deciphering the application of the ORS and SRS on an individual basis. This fits with the micro level of intervention and therefore questions are asked regarding this level of interventions. The mezzo level of intervention is found from an agency level. This is applicable to the research and survey in asking about the positive and negative aspects of the survey from an agency perspective. The macro level is addressed in the research by gaining information regarding the support or lack thereof from larger organization such as the National Association of Social Work or the American Psychological Association. Questions are asked on the survey addressing how the field, on a larger scope, supports the use of these tools.

Methods

RESEARCH QUESTION:

What are clinicians' experiences and purposes in using client feedback tools in a mental health clinical setting?

RESEARCH DESIGN:

This was a mixed method design focused on describing and analyzing the quantitative and qualitative responses. The study utilized a group of individuals who are networked via the use of client feedback tools, specifically the Outcome Rating Scale and the Session Rating Scale. The rationale in choosing a mixed method design was that it was the most effective way to ask those who use the tool for their opinions and observations in the utilization of the tool. The components of the survey were both Likert-style and open-ended question format. The survey was administered through an online survey mechanism, Qualtrics.

RESEARCH SETTING:

The setting for this research was through an agency network, the International Center for Clinical Excellence (ICCE). It is a network of mental health clinicians who utilize client feedback tools, specifically the Outcome Rating Scale and Session Rating Scale.

SAMPLE:

The sample was self-selecting mental health providers who made the decision as to whether or not they chose to reply to the request which was posted on a message board within the ICCE website. They were recruited through a message board on the ICCE website by being asked to complete a short survey around their experience in the use of CFT. The individuals for the survey must be mental health clinicians in any setting who

are connected to the ICCE network. They all had one year of experience in using the specific CFT of ORS/SRS.

PROTECTION OF HUMAN SUBJECTS:

Anonymity was assured for the participants by a statement on the survey stating that the individual was consenting by completing the survey. Additionally, because the surveys were administered electronically, the researcher was the only individual with access to the survey responses. The data came into a secured Qualtrics account on a password protected computer. Data will be destroyed by May 16, 2016.

INSTRUMENT:

The instrument was a set of approximately 5-7 open ended questions geared toward the clinician's experience in the use of the ORS/SRS/GRS. Demographic questions compiled information as to the specific tools each responder uses, how long they have used the tools, how long they have been in practice, their credentials, and the agency setting in which they administer the tools. These questions were reviewed by the researcher's committee members.

DATA COLLECTION:

The data collection was done using the following steps:

1. A letter was posted on the ICCE list serve requesting members to participate in the survey.
2. A consent form was included on the ICCE list serve in conjunction with the letter clarifying anonymity of the survey.
3. An on-line survey was completed by those who respond to the online posting on the message board of the ICCE website.

4. A follow up message was posted after one week of the original posting.
5. Data was returned to the researcher and analyzed for themes consistent with current literature.

DATA ANALYSIS:

The data collected was analyzed for themes consistent with current literature. It was also analyzed for problem solving regarding the tools not being utilized by more clinicians. Analysis also consisted of strengths and limitations of the tools as well as clinicians feelings regarding the building of the therapeutic alliance with the use of these tools.

BIAS:

The bias of the researcher is that CFTs are a useful resource in building better outcomes for clients. However, there seems to be a gap between the known benefits of their use and implementation by clinicians. These tools have not been directly utilized by the researcher. To address bias by the researcher a committee reviewed the survey questions. The anticipated findings were that clinicians have found improvement for their clients by using the tools.

Results

Sample: The survey was distributed electronically through the website Qualtrics. Qualtrics offers a free service for individuals to design and then distribute surveys. The survey was then posted for two weeks on the International Center for Clinical Excellence (ICCE) website with a letter explaining the purpose of the survey along with a consent from. ICCE was chosen as they are supporters of the ORS and SRS client feedback tools. It is unclear as to how many individuals are a part of the ICCE list serve.

There were 36 survey respondents. A slight majority of the respondents had 11-15 years of experience in a mental health related field.

Table 1: The Number of Years Practicing in a Mental Health Field

#	Answer		Response	%
1	1-5		7	19%
2	6-10		7	19%
3	11-15		6	17%
4	16-20		4	11%
5	21-25		2	6%
6	25 - +		10	28%
	Total		36	100%

Of these 36 respondents, four have a bachelor's degree, 26 hold a master's degree, and 6 have a doctorate. All participants positively responded to using both the ORS and SRS tools; the period of use of the ORS and SRS was largely 1-5 years. This shows that the individuals who took the survey have been in the field for a number of years, but have had less time using the client feedback tools. Where they learned about the use of the tools came mostly from either attending a workshop related to the tools or personal research about CFTs.

Table 2: Where Respondents Learned About the Tools

#	Answer		Response	%
1	Personal research in client feedback tools		15	42%
2	Through another colleague		4	11%
3	By attending a workshop on FIT (Feedback Informed Therapy)		18	50%
4	From an agency I have worked for		7	19%
5	At my current agency		9	25%

Utilization of Tools:

The respondents were asked about the use of tools building therapeutic rapport and the extent to which the tools assisted in this from “very little” to “very much.” Survey respondents answered favorably with the average score of 3.92 on a scale from 1-5 with a Standard Deviation of 0.97. This shows belief from the respondents that these tools do assist in building rapport with clients.

Respondents were then asked the level to which they believed the use of the tools supported treatment planning. Out of 33 responses, the average score on a scale from 1-5 was 3.76 with a Standard Deviation of 0.94. By engaging with clients it may be easier and more helpful to both client and clinician to formulate treatment planning ideas for the client to pursue.

As rapport building is noted in the literature as being a positive factor in clients remaining in treatment, an additional question was asked about the use of these tools improving retention for clients in therapy. Of the 32 responses on the same Likert Scale of 1-5, the average score was 3.75 and the Standard Deviation was 0.88. As it can be important for a clinician to retain a full caseload, the use of these tools may prove to assist in the ability for one to fulfill agency expectations as well as assisting clients to a healthier wellbeing.

When asked if fellow clinicians also utilize these specific tools in clinical practice the results were an average of 3.04 with a Standard Deviation of 1.54. The results of this question had only 26 responses as compared to the 36 individuals who participated in the survey. The purpose of the survey was to hear from the voice of clinicians in their use of the tool. It is disappointing to see that fewer answered this question as well as do not believe that others are using these tools in their practice.

Factors Impacting Use of Client Feedback Tools

Participants were also asked to answer six qualitative questions. Themes for the responses were determined by the number of times a similar phrase or idea was mentioned by respondents within each answer. Themes of the qualitative responses coincide with social work ideology as they focused on micro, mezzo, and macro levels of practice. Within these questions specifics were asked about the positive and negative factors of using the ORS and SRS in mental health clinical practice.

On the micro level the strongest theme was the tools' ability to assist with the development of therapeutic rapport. From one respondent regarding rapport building, "I

believe it definitely improves rapport as we have open conversations about our relationship and work together, and how to make it better."

For the mezzo level of looking at the use of these tools from an agency standpoint, the theme was that of agencies expecting their clinicians to use these tools in their practice. From the place of feeling the tools were helpful a respondent shared, "We wrote into our mental health program that we will use these tools at every session and use them in our program evaluation. The fact that they are written into our overarching program and outcome measures makes us consistent with using them." There were also respondents who shared they are "mandated" to use the tools by their current agencies.

From the macro level of trying to identify the support of using these tools from larger entities such as the National Association of Social Workers, the American Psychological Association, or SAMHSA (Substance Abuse and Mental Health Services Administration) there seemed to be no theme. One person shared being connected with ICCE, the organization's list serve utilized for the purpose of the survey. One person mentioned contact with Scott Miller who is one of the developers of the ORS and SRS. There was a lack of consistency regarding support from a larger entity.

The themes of which aspects hinder the micro level of administering the ORS and SRS are clinicians stating there is not enough time in the session as well as client's being apprehensive to participate in filling out the tool. From the micro level, the clinician is in charge of the time of the session and therefore it may be more about the clinician not finding the tool a priority to make time for the tool. Also, if there is apprehension from the client to fill out the tool it may also be from the clinician not stressing the importance of the use of the tool in the overall relationship and therapy with the client.

From the hindrance at the agency level there were three of the 30 respondents who made reference to concerns related to their performance. One shared worries that the tools would be used for their performance review. Another also shared concern of being measured by their clients. One respondent further shared, "Providers will also acknowledge (in contexts in which they feel safe enough) that getting regular, direct feedback about the alliance is anxiety provoking."

Regarding the hindrance of these tools from a more global professional perspective, there was not a solid theme which appeared. There was an individual who shared others in the profession being unaware of the research supporting the use of these tools. Another shared the importance of the NASW or APA putting support behind the use of the tools. Yet another shared a statement related to the overarching theme of this survey by stating, "I think a big problem is that behavioral health is still too focused on evidence based treatments."

Discussion

Sample:

The sample was found through the researcher's knowledge of the International Center for Clinical Excellence website. Within the site there is an ability to post questions and requests to the entire list serve. The researcher had noticed other students had posted on this page and decided this would be an excellent way to post a survey and obtain results. The population is one of convenience as the individuals on the site most likely use the ORS and SRS as that is a main focus on the ICCE. It is difficult to know how many clinicians are members of this site, but the researcher was surprised with the response rate being 36 as it was assumed there would be many clinicians interested in this survey. The researcher's assumption came from the lack of literature found based on the clinician's perspective of the ORS and SRS in professional practice and therefore thought respondents would also be interested in knowing more about this perspective. The researcher speculates that respondents did not respond based on time constraints. This speculation is based on responses from other individuals stating they feel strapped for time during sessions to complete the ORS and SRS. If they feel this way about administering these tools, it is possible that others did not feel they had enough time to devote to the survey. The majority of those who answered the survey were master's level therapists with 26 of the 36 respondents reporting having such a degree. There were 10 individuals who responded to having over 25 years of experience in behavioral health. However, the results also showed that individuals have only been using the ORS and SRS for roughly 1-5 years which shows that this is a tool that people have only recently been utilizing. This may be due to clinicians only now hearing about these tools or the lack of research from clinicians supporting the use of these tools.

Utilization of Tools

Most individuals reported that the ORS and SRS are beneficial in building therapeutic rapport with clients. They reported this at a rate of 3.92 on a scale from 1-5 with 1 = very little and 5 = very much. This is supported in research as stated by Novotney (2013) “Successful therapists can also form strong therapeutic alliances with a range of patients and are able to induce them to accept the treatment and work with them”.

Regarding the benefit of using these tools in treatment planning, respondent’s average score was a 3.76. Using these tools can be helpful in treatment planning to gain knowledge from the client about what they would like to be working on. This was echoed by therapists in the open-ended question section by a respondent: “Under the FIT model (which Integrated SRS and ORS), conceptualization in "failing cases" becomes more focused on what the client needs/wants and what I can do about it than other supervision/consultation models I have used.”

Regarding client retention in therapy, respondents shared an average of 3.75 in believing that these tools do assist in keeping clients engaged in therapy. This is also supported in literature as Shaw & Murray (2014) reported that clinicians are often poor judges of client’s progress in treatment. By using the ORS and SRS, clinicians are better able to gauge client’s investment in treatment.

The lowest average for clinicians was when asked the extent to which fellow clinicians use the ORS and/or SRS in practice. The average score was 3.06. Although this score does not appear much lower, it is the lowest of all the Likert-Scale questions. The reason for the response being lower may be what the survey and research are attempting

to point out; there is good research that support these tools, but clinicians are not using them.

Positive Implications in Utilization of the ORS and SRS

Micro

The responses regarding the ORS and SRS being helpful in building therapeutic rapport in both the quantitative and qualitative responses were supported by the literature. One of the main arguments of using the ORS and SRS is because they help engage clients and assist in establishing therapeutic rapport. From the survey, this is what respondents had to say, “I believe it definitely improves rapport as we have open conversations about our relationship and work together, and how to make it better.” Respondents also agreed that using the tools at the micro level increases therapist effectiveness. Knowing one is effective is important as it keeps therapy going in a positive direction rather than the client and therapist losing motivation for therapy.

Mezzo

In terms of the mezzo or agency level regarding the use of the ORS and SRS, respondents shared the theme of agencies needing to be supportive of the use of the tools. This was noted in respondents stating that things worked well due to agency support. There were others who shared they are “mandated” to use the tools which may mean clinicians feel forced to use the tools. If there are poor feelings about the use of the tools one could speculate that clinicians do not have good attitudes about the implementation of these tools with their clients which may impact the feedback they receive from their clients.

Macro

It seemed that there was also a commonality that those who found the tools to be helpful were networked with support from the ICCE and sought support from others who are also using the ORS and SRS. One respondent shared, "Support from other ORS and SRS practitioners mostly" were the clinicians they sought out.

Challenging Implications in the Utilization of the ORS and SRS

Micro

On the other side, individuals commented that the tools take time away from the session and that they can cause performance anxiety for the clinician. This is one of the arguments made in the literature in that clinicians often believe they are performing better than what they are from the client's standpoint. To reduce rates of client failure clinicians should monitor progress or lack thereof through a systematic process (Halford et al., 2012). One respondent shared, "Providers will also acknowledge (in contexts in which they feel safe enough) that getting regular, direct feedback about the alliance is anxiety provoking." Another concern brought forward was the dishonesty from the client in filling out the tools based on a variety of things such as wanting the clinician to believe they are doing better in life than they actually are. This was not indicated in the literature reviewed for this project, yet was something mentioned by two respondents. However, one could also use this as a therapeutic talking point with the client to ask questions and discover where the client is coming from with this mentality.

Mezzo

Based on the responses from the agency perspective, it was mentioned that there are struggles with the use of the tools due to agencies not being supportive. This shows

the importance of agencies needing to understand what the literature shows as better outcomes for clients. Additionally, agencies can benefit from having greater client retention and therefore better financial incomes as well as overall client outcomes. This is based off a decrease in client drop-out rates, which creates an increase in client revenue for the agency.

Macro

From the macro-level stand point, most respondents wrote "N/A" or "none" as their response. This may be due to clinicians not operating within a larger body. Perhaps many were independent clinicians. Within what context clinicians practiced were not asked in the survey and therefore it is difficult to know if this may have been a factor. This then makes the response rate appear at a larger rate than the actual data collected. From those that did respond, the theme was a need to have a large body, such as the APA or NASW, support the use of these tools.

Limitations/Recommendations for Future Research:

A limitation to this study was that there was not a large sample size. This may have been due to time constraints by those the notice was sent to. Additionally there was no incentive to complete the survey which may have caused individuals to choose to not complete the survey. What may have helped in having a larger response base would have been to also send the survey to those associated with PCOMS (Partners for Change Outcome Management Systems) which is an organization which also utilizes the ORS and SRS.

A limitation to the method was no opportunity for follow-up questions as it was a structured survey administered electronically. This was most noticed in the open-ended

questions asked at the macro-level of social work by respondents typing in “none” or “N/A” for their responses. Of the 28 respondents of this final question, 12 responded with phrases like “none” or “N/A”. Because of this, the response rate is high; however, there is little actual data to report from this section. Perhaps they responded in this manner due to no affiliation with a larger entity. Additionally, respondents may have not felt comfortable answering these questions as they were asking for more specific answers than a number like on the Likert Scale questions.

Also, if respondents received the email and survey attachment on their work computer they may have had some concerns about answering questions on a computer that may be monitored by their employer. There were comments made by respondents that they did not feel comfortable using their computers to enter in the scores of the ORS and SRS due to others having access to their computer. This then may also be a reason to not complete a survey of the nature within a work environment.

Responses and feedback from clinicians is the level where research seems to be lacking and it was therefore disappointing for the researcher to not hear more from the voices of the clinicians who are using these tools in practice. Therefore, continued research from the perspective and voice of the therapist is needed. Also, research support from larger entities like APA, NASW, and SAMHSA may be important to have a larger voice to clinicians about the importance of the use of these tools in mental health practice.

Implications for Social Work

The key findings come from seeing that those who use the tools in their mental health practice report that they assist in therapeutic rapport. Research supports that the

most important thing in having a positive impact in therapy is the relationship between the client and therapist. The average rating from the survey regarding therapeutic rapport building was 3.92. This was the highest rating of any of the Likert Scale questions. This was also seen in the themes reported in open-ended questions regarding use of the tools on a micro-level in therapy. Mentioned one respondent, "I believe it definitely improves rapport as we have open conversations about our relationship and work together, and how to make it better." The use of the tools can substantiate client rapport building as well as retention in therapy. As retention is the way one can assist clients in making positive changes it is certainly an implication for practice.

Conclusion

In conclusion, the findings of support of the use of these tools and the knowledge from the respondents who acknowledge their use is justification to continue the use and research of these tools. By being in a helping profession and wanting what is best for clients, this research shows including feedback from the client is helpful in maintaining good relationships. By having open relationships with clients we have a better chance of assisting them in making the changes they desire to live better lives.

As clinicians, by using these tools, we become better at our craft and our profession. As one respondent shared, "I am convinced from reading the literature and from personal experience that feedback informed treatment/practice based evidence improves effectiveness." This truly articulates the idea of moving from evidence based practice to practice based in evidence.

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Appendix A: Information and Consent Form

MOVING FROM EVIDENCE BASED PRACTICE TO PRACTICE BASED EVIDENCE INFORMATION AND CONSENT FORM

Introduction:
You are invited to participate in a research study investigating Outcome Rating Scales and Session Rating Scales. This study is being conducted by Nancy Olson-Engebreth, a graduate student at St. Catherine University under the supervision of Michael Chovanec, a faculty member in the Department of Social Work. You were selected as a possible participant in this research because you belong to the International Center for Clinical Excellence. Please read this form and ask questions before you agree to be in the study.

Background Information:
The purpose of this study is to discover, from clinician's experience the benefits and barriers to using Outcome Rating Scales and/or Session Rating Scales. Approximately 60 people are expected to participate in this research.

Procedures:
If you decide to participate, you will be asked to click on the survey link provided and then answer the survey questions. The survey will take approximately 10-15 minutes over 1 session.

Risks and Benefits of being in the study:
The study has minimal risks. Potential risk for the participants may be sharing negative information about their work setting. By providing anonymity in the survey the participants are protected from potential negative reactions from agency administration.

The benefits to participation of this research to clinicians is a greater awareness of the benefits and barriers of the use of client feedback tools. There are no direct benefits for your participation in this research.

Confidentiality:
Your participation in this survey is anonymous. There is no connection between your person and the answers you provide.

I will keep the research results in a password protected computer file in my home and only I and my advisor will have access to the records while I work on this project. I will finish analyzing the data by May 16, 2016. It will be destroyed at that time.

Voluntary nature of the study:
Participation in this research study is voluntary. Your decision whether or not to participate will not affect your future relations with St. Catherine University in any way. If you decide to participate, you are free to stop at any time without affecting these relationships.

Contacts and questions:
If you have any questions, please feel free to contact me, Nancy Olson-Engebreth, at olso1868@stthomas.edu. You may ask questions now, or if you have any additional questions later, the faculty advisor, Michael Chovanec, will be happy to answer them. He can be reached at (651) 690-8722. If you have other questions or concerns regarding the study and would like to

talk to someone other than the researcher, you may also contact Dr. John Schmitt, Chair of the St. Catherine University Institutional Review Board, at (651) 690-7739 or jsschmitt@stkate.edu.

You may keep a copy of this form for your records.

Statement of Consent:
You are making a decision whether or not to participate. By clicking on the link provided, you are consenting to participate in this anonymous survey. Clicking on the link indicates you have read this information and your questions have been answered.

Appendix B: Survey Questions

The purpose of this survey is to find out more from professionals who are currently using the SRS/ORS in behavioral health practice.

Please complete the following questions to the best of your ability. The survey should take approximately 10 - 15 minutes.

DEMOGRAPHICS:
Current professional licensure:
Bachelor's level provider
Master's level provider
Doctoral level provider

I have been practicing in the behavioral health field for the following range of years:
1-5 6-10 11-15 16-20 21-25 25 - +

I use the following tools in my practice (check all that apply):
ORS _____ SRS_____

I have used the above mentioned tools for the following number of years:
1-5 6-10 11-15

I learned about the use of these tools from:
Personal research in client feedback tools
By attending a workshop on FIT (Feedback Informed Therapy)
Through another colleague
From an agency I have worked for
At my current agency

LIKERT QUESTIONS:
The extent to which the tools build therapeutic rapport:

1	2	3	4	5
Very little				Very much

The extent to which the tools support treatment planning:

1	2	3	4	5
Very little				Very much

The extent that the use of these tools improve retention of clients in therapy:

1	2	3	4	5
Very little				Very much

The extent to which the tools improve client outcome:

1	2	3	4	5
Very little				Very much

The extent to which fellow clinicians use these tools in clinical practice:

1	2	3	4	5
Very little				Very much

OPEN-ENDED QUESTIONS:
What factors support the use of these tools on an individual basis (ex: rapport building)?
What factors support the use of these tools on an agency basis (ex: supervisor support)?
What factors support the use of these tools on a professional basis (ex: support by a professional organization)?

What factors hinder the use of these tools on an individual basis (ex: rapport building)?
What factors hinder the use of these tools on an agency basis (ex: supervisor support) ?
What factors hinder the use of these tools on a professional basis (ex: support by a professional organization)?