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

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**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).

The most recent sexual offender treatment outcome meta-analysis (Hanson, Bourgon, Helmus, & Hodgins, 2009) found that programs adhering to the effective correctional principles (i.e., those of risk, need, and responsivity) have the greatest effect on sexual re-offense rates. Also known as the risk-need-responsivity model, these principles, summarized by Andrews & Bonta (2010), have explained the success and failure of numerous criminological interventions. Simply put, the *risk principle* holds that the majority of treatment resources should be allocated towards those who pose the highest risk. The *need principle* holds that interventions should focus on treatment goals demonstrated to be related to criminal re-offense. The *responsivity principle* holds that interventions should be tailored to the individual characteristics of each client. This last principle can sometimes be the most confusing and challenging for programs to achieve. At its most basic level, the responsivity principle includes efforts to ensure that the client is capable of responding to an intervention (e.g., matching treatment to cognitive abilities). At a more challenging level, responsivity involves efforts at understanding motivation to change and what problems may constitute barriers to meaningful engagement in treatment.

People convicted for sex crimes very frequently present with barriers to immediate treatment engagement (Mann, 2009). In some cases, these barriers include responsivity issues such as learning disabilities or concerns about acknowledging one's actions. The very nature of the material covered in these programs increases the likelihood of attrition, especially among those who would benefit from treatment the most. However, those who are able to establish meaningful and relevant treatment goals are more likely to complete treatment programs and reduce their risk for re-offense. Ultimately, the challenge for treatment providers is to create an environment in which change is possible; where treatment is tailored to each client's abilities; and where there is agreement on the nature of the relationship, the goals and tasks of treatment, and accommodation of strong client preferences (Bordin, 1979; Duncan, Miller, Wampold, & Hubble, 2010; Norcross, 2011).

Professionals treating people who have sexually abused need expertise at understanding their clientele, as well as global knowledge of how to establish empirically supported treatment goals. These professionals also need expertise in providing treatment and helping clients navigate change processes. Where the daily challenge lies, however, is in developing expertise at building responsivity in each of their clients.

An emerging body of research indicates that incorporating formal feedback regarding progress and engagement into treatment services builds responsivity while simultaneously improving outcome and retention (Lambert, 2010). Briefly, Feedback-Informed Treatment (FIT) has been successfully integrated into both mental health and substance abuse services, serving both voluntary and mandated clients, in agencies and systems of care around the world (Bertolino & Miller, 2012). Multiple, randomized clinical trials demonstrate that adding FIT to existing treatment services as much as doubles the effectiveness of the care provided, and reduces attrition and deterioration rates by 50% and 33%, respectively (Miller, Hubble, Chow, & Seidel (2013).

In practice, FIT involves administering two scales over the course of treatment; one measuring the quality of the therapeutic relationship, the other assessing progress or outcome. Over 1,100 studies have made clear the importance of the therapeutic relationship to treatment outcome (Duncan, Miller, Wampold, & Hubble, 2010). Indeed, in an era that emphasizes evidence-based practice, the therapeutic relationship is the most evidence-based concept in psychotherapy research (Miller & Bargmann, 2011). Understanding changes in the relationship can help ensure that clients are meaningfully engaged in change efforts, assist treatment providers in adjusting their strategies to meet each client's needs (thereby adhering to the responsivity principle), and act as an early warning system for treatment deterioration and failure. At the same time, research has demonstrated that changes in a person's individual, relational, and social functioning are strong predictors of successful therapeutic work (Miller & Bargmann, 2011; Miller, Duncan, & Hubble, 2004).

To date, research shows that access to real time feedback regarding progress and engagement provides clinicians with an opportunity to adjust services in a way that enhances individual client responsivity and achievement of treatment goals (e.g., decreased reoffending). The same body of evidence documents that FIT promotes professional development, resulting in measureable improvements in individual provider responsivity and effectiveness (Miller, Hubble, Chow, & Seidel, 2013). In 2013, FIT was deemed an evidence-based practice by the Substance Abuse and Mental Health Service Administration (SAMHSA) and

listed on the National Registry of Evidence Based Practices and Programs (see http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=249).

**What are the Barriers to Seeking Feedback?**

Treatment providers are under enormous pressure to produce results under difficult circumstances (e.g., Oaks, 2008). Shrinking budgets, difficulties maintaining contact with other over-burdened professionals and outside stakeholders (e.g., program administrators, supervising agents, victims' advocates), and a clientele that would frequently prefer to be anyplace else are the everyday realities of the sexual offender treatment provider. Add to this the inherent ethical challenges (such as balancing client beneficence and community safety), and it is not surprising that many professionals can lose their focus on the client's experience of treatment. In many regions, there can be an implicit belief that participation in treatment is a privilege and must take place to the complete satisfaction of the provider and/or supervising agent. The unspoken expectation is that the client must change according to a process and timetable set by the treatment provider or supervising agent. Under these conditions, it shouldn't come as a surprise that attrition rates are high, and that – in many instances – little effort takes place to prevent it.

Another barrier to collecting feedback is that many treatment providers believe they already do it. In these authors' experience, many treatment providers have expressed that they can tell by the client's expressions and mannerisms how treatment is progressing. Others have felt that because they ask questions such as "how was group today?" that they are therefore soliciting feedback. Unfortunately, such vague information-gathering amounts to little more than a polite nicety similar to the easily ignored feedback surveys offered in some restaurants. Clients need to know that someone is genuinely interested in their thoughts or it is highly likely they will say only what will meet their momentary needs for the situation.

**What Kinds of Feedback Systems Exist?**

Within the field of treating sexual aggression, the available measures for assessing treatment progress examine change in dynamic risk factors, but do not examine factors related to engagement or predictive of treatment response (e.g., the therapeutic relationship, client functioning). Finding the right measure can be a daunting process. In 1996, Ogles, Lambert, and Masters reviewed available tools and found over 1,400 measures had been used to measure the effectiveness of psychotherapy. For the most part, the vast majority of these measures have been designed for the purpose of research or as part of a comprehensive evaluation.

A key consideration in selecting a method for gathering feedback is for it to be user-friendly and to provide real-time results. Until recently, many of the available measures have involved over 40 questions and required specialized software and outside consultation. The client and/or their family would take time during a clinical session to fill this out, and the results would not come back to the treatment provider for several days to weeks. Consider this case example from the first author's experience.

Jackie is a clinician providing in-home services for adolescents who have sexually abused. The Department of Human Services (DHS) for her state has taken the research on measuring clinical outcomes very seriously and has mandated that all therapists providing in-home services use a standardized measure for tracking clinical outcomes. The position of the DHS administration is praiseworthy. As one senior administrator put it, "We have an awesome obligation to the taxpayers and public at large. It is essential that we make sure that the services we provide are working and that if they are not that the providers have some idea of what they can do to reach our state's most vulnerable citizens." At a meeting of DHS administrators and their treatment providers, however, the mood was not so optimistic. Many treatment providers whispered amongst themselves that the information gleaned from this measure would be used against them by a governmental agency that is more adept at creating attractive spreadsheets than at understanding the complex needs of the families it serves. "My clients have real problems. They often complain that things are getting worse just before they're actually getting better," one treatment provider said. "Now the state wants information for a spreadsheet that they can put before the governor. Well, I'm not 'spreadsheet guy.'"

Attempting to mandate a feedback structure such as this without gaining meaningful buy-in placed every professional, including the DHS administration, their stakeholders, and clientele, in a difficult position. It was Jackie, however, who observed how this approach played out at the front lines of treatment:

*What I think the state administration forgets is what an honor it is to actually work with these clients. I really become a part of their lives. I have to do a special kind of dance with them in order to keep them engaged. Now I have to bring a laptop and have them fill this thing out so that their data – their lives – go to another state for analysis. At the end of the day, no matter that they might have brought things on themselves, these people are in pain and one of the greatest things I can do is listen. And on the days when we fill out this measure, that can't happen. So this is one more meaningless thing we do to get to the real issues. By the time I get to the feedback and the consult calls, everything's changed.*

This example highlights many of the ways in which the best-intentioned attempts of large groups of people to improve services can fail. Brown, Dreis, and Nace (1999) report that "any measure or combination of measures that [take] more than five minutes to complete, score, and interpret [are] not considered feasible by the majority of clinicians". Measures that are user-friendly and provide real-time feedback are therefore all the more important when one considers the often urgent circumstances in which clients and treatment providers exist.

Although any measures may be used in FIT, two scales that have proven useful for monitoring the status of the relationship and progress in care are the Session Rating Scale (SRS [Miller, Duncan, & Johnson, 2000]), and the Outcome Rating Scale (ORS, [Miller, & Duncan, 2000]). The SRS and ORS measure alliance and outcome, respectively. Both scales are brief, self-report instruments that have been tested in numerous studies and shown to have solid reliability and validity (Miller & Schuckard, 2013). Most importantly, perhaps, available evidence indicates that routine use of the ORS and SRS is high compared to other, longer measures (99% versus 25% at one year [Miller, Duncan, Brown, Sparks, & Claud, 2003]).

Administering and scoring the measures is simple and straightforward. The ORS is administered at the beginning of the session. The scale asks consumers of therapeutic services to think back over the prior week (or since the last visit) and place a hash mark (or "x") on four different lines, each representing a different area of functioning (e.g., individual, interpersonal, social, and overall well being). The SRS, by contrast, is completed at the end of each visit. Here again, the consumer places a hash mark on four different lines, each corresponding to a different and important quality of the therapeutic alliance (e.g., relationship, goals and tasks, approach and method, and overall). On both measures, the lines are ten centimeters in length. Scoring is a simple matter of determining the distance in centimeters (to the nearest millimeter) between the left pole and the client's hash mark on each individual item and then adding the four numbers together to obtain the total score (the scales are available in numerous languages at: http://scottdmiller.com/performance-metrics/).

In addition to hand scoring, a growing number of computer-based applications are available which can simplify and expedite the process of administering, scoring, interpreting, and aggregating data from the ORS and SRS. Such programs are especially useful in large and busy group practices and agencies. They have the added advantage of providing a real time computation of provider and program outcomes as well as a normative comparison for judging individual client progress and determining risk Figure 1 illustrates the progress of an individual client over the course of six treatment sessions. The red and green zones show how unsuccessful and successfully treated clients respond based on a large normative sample, including 427,744 administrations of the ORS, 95,478 episodes of care delivered by 2,354 providers. As can be seen, the client is not responding like people who end services successfully, enabling providers to make adjustments aimed at improving outcomes in real time.

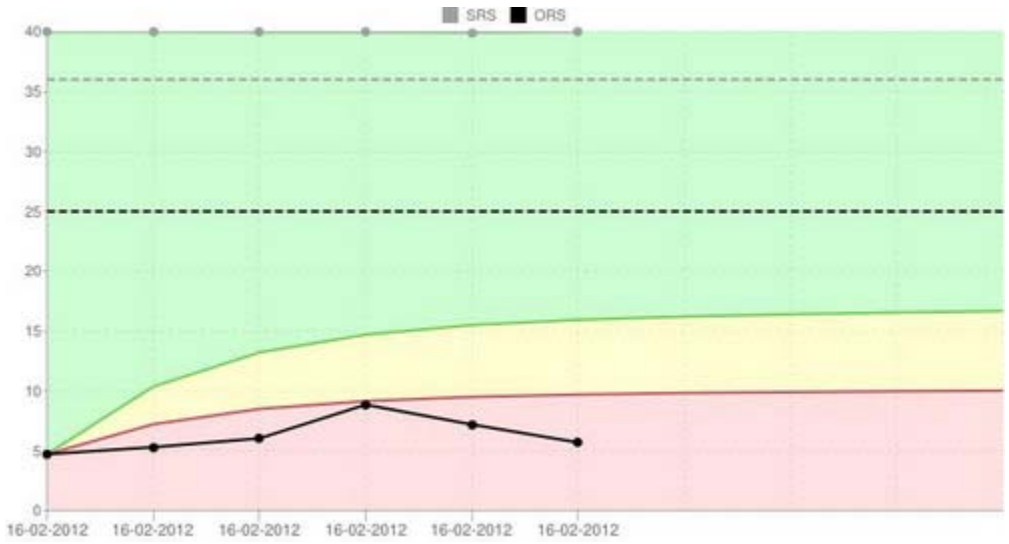


**Figure 1:** The green area represents successful outcomes; the red area represents unsuccessful outcomes. The solid black line represents the actual ORS score, plotted session by session from left to right (Screen shot courtesy of fit-outcomes.com)

Detailed descriptions of these applications can be found online at: http://scottdmiller.com/performance-metrics/.

Of course, soliciting clinically meaningful feedback from consumers of therapeutic services requires more than administering two scales. Clinicians must work at creating an atmosphere where clients feel free to rate their experience of the process and outcome of services: (1) without fear of retribution; and (2) with a hope of having an impact on the nature and quality of services delivered.

Interestingly, empirical evidence from both business and healthcare demonstrates that consumers who are happy with the way *failures* in service delivery are handled are generally *more* satisfied at the end of the process than those who experience no problems along the way (Fleming & Asplund, 2007). In one study of the ORS and SRS involving several thousand "at risk" adolescents, for example, effectiveness rates at termination were 50 percent higher in treatments where alliances "improved" rather than were rated consistently "good" over time. The most effective clinicians, it turns out, consistently achieve *lower* scores on standardized alliance measures at the outset of therapy thereby providing an opportunity to discuss and address problems in the working relationship—a finding that has now been confirmed in a number of independent samples of real world clinical samples (Miller, Hubble, & Duncan, 2007).

Beyond displaying an attitude of openness and receptivity, creating a "culture of feedback" involves taking time to introduce the measures in a thoughtful and thorough manner. Providing a rationale for using the tools is critical, as is including a description of how the feedback will be used to guide service delivery (e.g., enabling the therapist to catch and repair alliance breaches, prevent dropout, correct deviations from optimal treatment experiences, etc.). Additionally, it is important that the client understands that the therapist is not going to be offended or become defensive in response to feedback given. Instead, therapists must take client's concerns regarding the treatment process seriously and avoid the temptation to interpret feedback clinically. When introducing the measures at the beginning of a therapy, the therapist might say:

*(I/We) work a little differently at this (agency/practice). (My/Our) first priority is making sure that you get the results you want. For this reason, it is very important that you are involved in monitoring our progress throughout therapy. (I/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 fill it out at the beginning of each session and then we talk about the results. A fair amount of research shows that if we are going to be successful in our work together, we should see signs of improvement earlier rather than later. If what*

*we're doing works, 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 this make sense to you?* (Miller & Duncan, 2004; Miller & Bargmann, 2011).

At the end of each session, the therapist administers the SRS, emphasizing the importance of the relationship in successful treatment *and* encouraging negative feedback:

*I'd like to ask you to fill out one additional form. This is called the Session Rating Scale. Basically, this is a tool that you and I will use at each session to adjust and improve the way we work together. A great deal of research shows that your experience of our work together—did you feel understood, did we focus on what was important to you, did the approach I'm taking make sense and feel right—is a good predictor of whether we'll be successful. I want to emphasize that I'm not aiming for a perfect score—a 10 out of 10. Life isn't perfect and neither am I. What I'm aiming for is your feedback about even the smallest things—even if it seems unimportant—so we can adjust our work and make sure we don't steer off course. Whatever it might be, I promise I won't take it personally. I'm always learning, and am curious about what I can learn from getting this feedback from you that will in time help me improve my skills. Does this make sense?* (Miller & Bargmann, 2011).

**Case Example**

Eric was 19 when he came into treatment. He had accepted a plea agreement of numerous fourth-degree charges for Simple Assault following allegations that he had molested an 11-year-old girl, the daughter of some family friends. Eric did not acknowledge culpability during the assessment process.

Eric entered his first session understandably guarded. His initial ORS score was 30 of a possible 40. However, with attempts by the therapist to understand his situation at a deeper level, Eric's score went down to 15, well within the range of people who are distressed enough to seek therapy. Over time in the session, Eric and his therapist discussed his situation further.

At the end of the session, the therapist introduced the SRS with the template used above. Eric provided scores that totaled to 39. This is above the cutoff and suggestive of a positive alliance, although the lowest score was on the item related to goals. This led to considerable discussions about what would be meaningful to Eric given the results of an earlier evaluation.

Eric's ORS scores rose over 12 weeks to 30. At 12 weeks, he discussed the crime for which he'd entered treatment at a much deeper level. He worked with his therapist and entered group treatment with others. This group also used the ORS and the Group SRS.

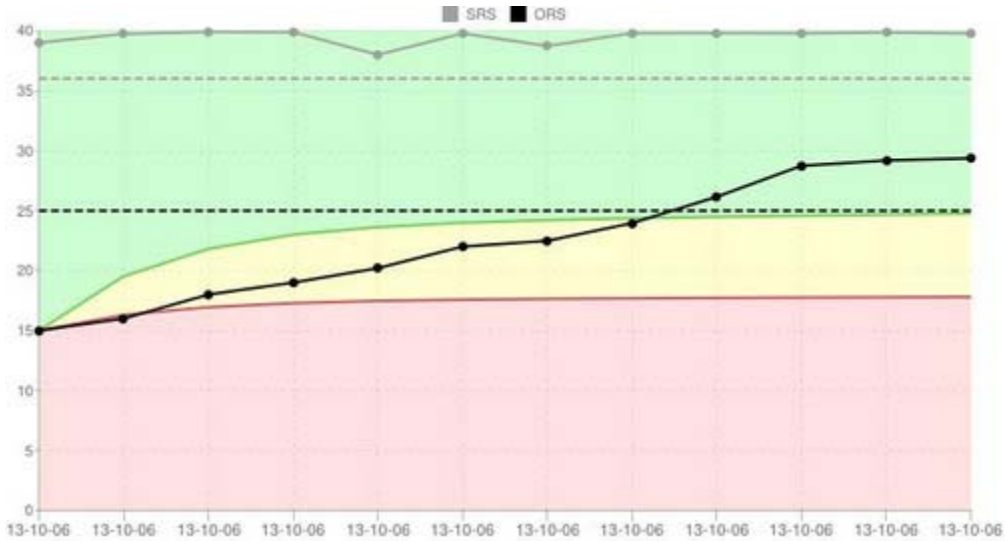

**Figure 2:** A plot of Eric's treatment progress. The green area represents successful outcomes; the red area represents unsuccessful outcomes. The solid black line represents the actual ORS score plotted session by session from left to right, while the gray line indicates the actual SRS scores (Screen shot courtesy of fit-outcomes.com)

This case example shows how the measures can work in improving outcomes. However, Eric's case also shows how they can be used to detect cases at risk of dropout or non-investment. Had Eric's numbers fallen, the measures may have provided an early warning that Eric's situation was getting worse. This would be particularly helpful in Eric's case when one considers that Eric, like many other clients, was not always forthcoming with concerns and responded better to therapeutic elicitation of concerns.

**Now That We Have Feedback, What Next?**

As effective as feedback has proven to be in improving engagement and outcome, it is not enough for development of expertise. Consistent with the literature on superior performance, the evidence shows that clinicians do not necessarily learn from the information provided. For instance, De Jong, van Sluis, Nugter, Heiser, and Spinhoven (2012) found that not all therapists benefit from feedback. In addition, Lambert reports that practitioners do not get better at detecting when they are off track or their cases are at risk for drop out or deterioration, despite being exposed to "feedback on half their cases for over three years" (Miller et al., 2004, p. 16). In effect, feedback functions like a GPS, pointing out when the driver is off track and even suggesting alternate routes, while not necessarily improving overall navigation skills or knowledge of the territory and, at times, being completely ignored.

Learning from feedback requires an additional step: engaging in deliberate practice (Ericsson, Charness, Feltovich, & Hoffman, 2006). Deliberate practice, as the term implies, means setting time aside time for reflecting on feedback received, identifying where one's performance falls short, seeking guidance from recognized experts, and then developing, rehearsing, executing, and evaluating a plan for improvement. Research indicates that elite performers across many different domains devote the same amount of time to this process, on average, every day, including weekends. In a study of violinists, for example, Ericsson and colleagues found that the top performers devoted two times as many hours (10,000) to deliberate practice as the next best players and 10 times as many as the average musician. In addition to helping refine and extend specific skills, engaging in prolonged periods of reflection, planning, and practice engenders the development of mechanisms enabling top performers to use their knowledge in more efficient, nuanced, and novel ways than their more average counterparts (Ericsson & Stasewski, 1989).

Results from psychotherapy outcome psychotherapy research are in line with findings on factors that account for the development of expertise. For example, Chow, Miller, Kane, and Thornton (in preparation) examined the relationship between outcome and practitioner demographic variables, work practices, participation in professional development activities, beliefs regarding learning and personal appraisals of therapeutic effectiveness. Consistent with previous findings (c.f., Anderson, Ogles, Patterson, Lambert, & Vermeersch, 2009; Wampold & Brown (2005), they found that therapist gender, qualifications, professional discipline, years of experience, and time spent conducting therapy were unrelated to outcome or therapist effectiveness. Furthermore, similar to findings reported by Walfish, McAlister, O'Donnell, and Lambert (2012), therapist self-appraisal was not a reliable measure of effectiveness. Instead, as illustrated in the Figure 3, the amount of time therapists spent engaged in solitary activities intended to improve their skills predicted differences in outcome.

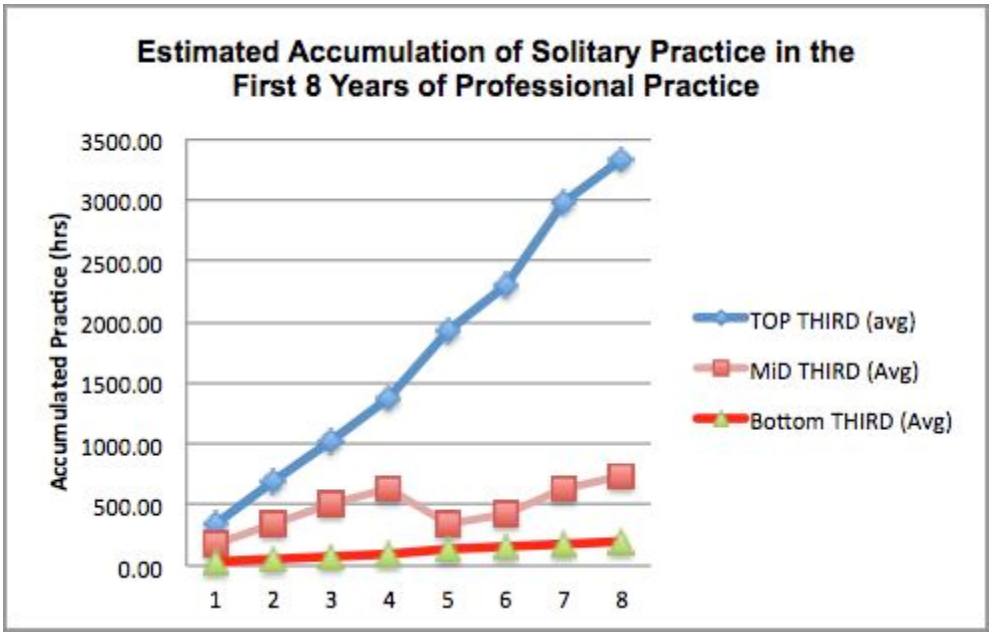


**Figure 3**: Therapists Grouped into Thirds based on their Adjusted Scores as a function of their accumulative time spent on solitary practice in the first eight years of clinical practice.

Such findings provide important support for the key role deliberate practice plays in the development of expertise.

**Conclusion**

Therapists have long desired to make interventions more meaningful to clients and the community alike. Addressing risk factors, acquiring and enacting skills, balancing client beneficence and community safety and many other components of current sexual offender treatment programs are vital to long-term change. FIT is not a replacement to other forms of treatment, but rather offers new ways to reach clients, improve one's performance, reduce variability between therapists within agencies, and detect cases at risk for dropping out or participating at a superficial level. Ultimately, it also offers clinicians new structures for reaching beyond their current therapeutic limitations.

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