

Evaluating social work clinical practice in the real world: Feedback informed treatment

*A szociális munka klinikai gyakorlatának értékelése valós
körülmények között: A visszajelzéseken alapuló kezelés módszere*

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Abstract

Roughly speaking there are at least 1.5 million and possibly over 2 million social workers in the world, many of whom work with individuals. This article focuses on one type of evaluation of social work practice, the evaluation of the outcome of help seeking for personal problems that is called clinical practice usually provided by social work case managers and therapists. The article primarily discusses Feedback Informed Treatment (FIT) developed in the early 2000s. It is a formal structured approach utilizing two validated very brief measures employed during every client session that can be graphed and is designed to evaluate the client's wellbeing and the worker's intervention throughout the course of treatment. The article argues that this is the best way for social workers to assess whether or not the client is benefitting from their work as well as evaluating the approach of the helping professional even though this well studied and effective approach is almost nonexistent in social work either in Europe or the United States. We also discuss single subject design that is the mainstay of social work evaluation of clinical practice courses taught for decades even though it is almost never used in actual practice.

Keywords: social work, social work research, evaluation research, evaluation of clinical practice, feedback informed treatment, social work education, single subject design

Absztrakt

Körülbelül másfél, de akár kétmillió szociális munkás is működhet világszerte, akiknek nagy többsége egyénnel dolgozik. Ez a tanulmány a szociális munkás praxis egy lehetséges értékelési módszerére összpontosít. E klinikai praxis keretei között a segítséget kérő saját személyes problémáira keresi a megoldást, a szakember – az esetmenedzser vagy tanácsadó – pedig a klinikai munka eszközeivel válaszol. A tanulmány elsősorban a visszajelzéseken alapuló kezelés (Feedback Informed Treatment (FIT)) lehetőségeit tárgyalja. Ezt a formális, strukturált módszert a 2000-es évek elején fejlesztették ki. Két validált, rövid mérőeszközt tartalmaz, amit a kezelés folyamán minden egyes ülés során alkalmaznak. Ezek révén a kliens előrehaladása és a szakember intervenciónak eredménye értékelhető, vizuálisan is ábrázolható. A tanulmányban amellet érvelünk, hogy ez a módszer a legalkalmasabb annak eldöntésére, hogy a kliens számára vajon hasznos-e a szakember munkája, megközelítése – még akkor is, ha ezt a sokat kutatott és hatékony módszert ma még szinte egyáltalán nem alkalmazzák sem Európában, sem pedig az Egyesült Államokban. Ezzel összefüggésben tárgyaljuk az egyalanyos kutatási elrendezés (pl.

esettanulmány) kérdéskörét, ami a szociális munka klinikai gyakorlatának kurzusaiban évtizedek óta a fő értékelési módszerként szerepel, annak ellenére, hogy a tényleges gyakorlatban szinte soha nem alkalmazzák.

Kulcsszavak: *szociális munka, szociálismunka-kutatás, értékelő kutatás, a klinikai gyakorlat értékelése, visszajelzéseken alapuló kezelés, szociálismunkás-képzés, egyalanyos kutatási elrendezés*

Introduction

Roughly speaking there are at least 1.5 million social workers (SWs) in the world. A rapid online Google search (2021) found that the United States had approximately 713,000, China 300,000, Brazil 194,000, Russia 150,000, United Kingdom 108,000, Canada 50,000, Australia 32,000 and the Philippines 6700 social workers totaling 1,553,700. So, without easily accessible data for such important countries as India, Germany and France nor any data for most countries in Eastern Europe or the rest of the world we can still be fairly confident that the actual total worldwide is nearer to 2,000,000 social workers. Extrapolating from US data approximately 40% of SWs are doing clinical work and social work is the principal profession providing mental health services (interpersonal work to relieve individual or personal problems) in the US (Gomory et al., 2011). We need to be careful in our assuming that this 40% of clinical social work practice found in the US translates to other countries of the world. It may be that other countries have fewer professional social workers doing clinical work and some countries may not have any social workers doing clinical work. The specification of how many social workers throughout the world are doing clinical practice remains for another time. But regardless, we can be sure that hundreds of thousands are doing clinical work and therefore their work justifies careful consideration.

Before proceeding let's provide a definition of mental health that can serve as a benchmark for our efforts at treating the problem. One recent European Report (Leka & Jain, 2017: 4) captures the international consensus definition well:

“Probably the most well-known definition of mental health is that of the World Health Organization (WHO) that defines mental health as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.”

Based on the given definition of the problem, one immediate question might arise. How do we know that these clinical professionals are doing effective work at treating the problem and how would we know that the claims of effectiveness are empirically legitimate? The simple answer is we don't. We currently have little idea about how effective clinical social work or any of the other helping professions are in ameliorating the personal problems of the clients we see.

In the US for example we have Joel Fischer's work back in the early 1970s (Fischer, 1973) arguing no evidence of effective case work in the then current literature to Eileen Gambrill's 2021 demolition of social work as a caring profession in the US and also internationally in the 21st century particularly pointing out the continuing failure to assess whether we are actually helping clients some 50 years after Fischer's analysis. As she states:

“Monitoring outcome is required to make timely changes in plans and contributes to positive outcomes. Millions of opportunities have been forgone to find out whether clients benefit from or are worse off as a result of social work services via single-case reports of outcome. I have been continually surprised by the lack of caring about client outcomes, not only in the United States, but other countries as well. In one case (in Australia), a social work educator who taught practice did not seem to understand what I was talking about when I asked “What outcomes do your students pursue with their clients?” In Germany when I asked a social work professor who ran many programs for youth “Could I take a look at related outcome data?” he never replied and the director and others were equally uninterested” (p. 4).

In Europe we find several problems in doing good mental health treatment in the literature some similar to the US issues some a bit different. Ian Cummings (2019: ix) a British social work scholar argues:

“[T]hat mental health social work has lost its way. Core social work values have been marginalized the original aims and values of community care – properly resourced community based resources to support citizens in acute distress – have been lost in a world of managerialist doublespeak and risk assessment. (...) [And] that the social work role has been marginalized within mental health service provision. This has been partly due to social work professional identity being subsumed within multi-disciplinary community mental health teams.”

This results in the diminishing use of exactly the clinical skills most needed for treatment (empathy, the development of the therapeutic alliance and the value base focused on inclusion and diversity) which are most responsible for successful client outcomes (Wampold & Imel, 2015)

The previous discussion identified what’s more uniquely a European set of challenges for clinical social work. What is a shared difficulty both in the US and Europe is a lack of structured client driven outcome assessments. The UK Department of Health’s 2016 report *Social work for better mental health* in offering some innovative implementations for the near future states that it is:

“[O]ffering two key development resources under the banner of ‘Social Work for Better Mental Health’ – a self-assessment resource How are we doing? and a service user and carer feedback and co-production framework, Making the difference together” (DH, p. 21).

So, by 2016 there was nothing in place to formally solicit client treatment feedback in either Europe or the US.

Further evidence regarding questionable treatment effectiveness might be found by considering that nearly 1 in 5 adults (51.5 million) were considered to be “mentally ill” in the US in 2019 (NIMH, 2019) which was a significant increase numerically from the 49.9 million adults considered “mentally ill” in 2010 (SAMHSA, 2010). Such empirical data suggests that treatment had no significant role in reducing that problem. As Kirk, Gomory, and Cohen (2013) argue the medical model of mental illness has been a total failure in addressing severely troubling human behaviors and requires a non-medicalized alternative conceptualization and corresponding approaches that should be implemented and tested worldwide (Gomory et al., 2017).

Despite the failure of conventional therapeutic approaches to reduce the overall social problem of existential suffering it still may be possible that there are individual cases where

treatment improvements could be had and may also have appropriate tools to validly assess those efforts.

However, instead we have a number of articles in the current literature on client dropout that are suggestive of individual treatment failure as well, based on client drop out as an indirect indicator or a proxy for efficacy. Especially noteworthy since client dropout is associated with the level of therapeutic alliance. Some relevant examples are Sharf, J., Primavera, L. H., & Diener, M. J. (2010) regarding client dropout and therapeutic alliance and Zimmermann, D., Rubel, J., Page, A. C., & Lutz, W. (2017) demonstrating that therapists' skills and behaviors directly affect non-consensual client dropout. This continuing failure to find treatment efficacy warrants little optimism but "we should keep hope alive" because we have found that an essential component of good therapeutic work is a provision by workers to clients a large element of hope (Frank & Frank, 1991).

The balance of this article considers a validated assessment approach, feedback informed treatment (FIT), for clinical social workers to consider and adopt for their work. (For the purpose of this article I consider all interpersonal work done by individual social workers with clients to be clinical social work.)

Tools for evaluation in clinical social work

A nonsystematic but detailed google review of US social work practice evaluation course syllabi in 2021 yielded no syllabi that taught or referenced FIT as an evaluative tool but found that all referenced and taught single subject design as the principal clinical evaluation method in social work university graduate programs. Single subject design (SSD) evaluation is the pedagogical choice of social work academics but there seems to be scarce evidence that clinicians utilize it. SSD efforts are especially laborious and require specialized training that are not provided even by the graduate courses that promote it.

Usually, the semester long evaluation courses devote at most a week or two to SSD, far too few sessions to adequately train students to understand and implement this method. One often used text authored by the venerable social work academics Martin Bloom, Joel Fischer and John G. Orme in its 6th edition (2009) focuses principally on SSD methodology and its analysis is 640 pages long. Most students in fact find generally that the evaluation courses they take in their academic programs are irrelevant to their actual work in the field after graduation and report when asked that systematic evaluations of client outcomes especially as reported by the clients are very rare in their actual employment situations and rarely found to be funded by their work sites (Groton & Gomory, 2021). Dr. Stephen E. Wong, one of the few social work academics who taught and did rigorous research on SSD (Wong, 2010; Macgowan & Wong, 2014; Wong & O'Driscoll, 2017) very recently had this to say regarding SSD's current status in social work:

"Regarding single-subject designs: There has been a general decline in their usage, including by social workers who only used them very rarely and very briefly. So, I doubt you will find data to answer your question, since no one else bothered to ask it. Another trend killing single-case evaluation is the shift toward larger and larger N studies, which I see as part of a consolidation of the control over the manufacturing of knowledge by elites (who were annoyed by independent researchers and the notion of scientist-practitioners)" (S. E. Wong, personal communication, May 11, 2021).

My own “practice wisdom” corroborates Dr. Wong’s comments. I have found after years of teaching graduate level evaluation of clinical practice courses and questioning my students, many currently with professional SW jobs, that there are vanishing few systematic clinical evaluations regarding clients’ outcomes taking place in practice and even fewer based on direct client feedback about their observed clinical outcomes.

One recently conducted survey by Lisa R. Baker, Frederick Stephens and Laurel Hitchcock (2010: 969) found these reasons for the almost nonexistent utilization of clinical evaluations:

“To capture information about potential barriers to conducting practice evaluation, all respondents were asked to examine four barriers: administrative support, caseload, lack of training, and time constraints. In terms of administrative support, only 22.3% (n = 29) of respondents indicated that lack of administrative support as a barrier to evaluation. Caseload (number of clients served) was noted as a barrier with 36.4% of respondents, and lack of training was a problem for 26.5% of respondents. The most problematic barrier was time constraints, which was indicated by 62.6% of respondents as being a barrier to implementing practice evaluation.”

So apparently social work academia either out of ignorance or lethargy continues to teach totally irrelevant evaluation methodology rather than offer any innovative alternative even if it has been hiding in plain sight.

FIT developed about two decades ago specifically to utilize client feedback to improve the professional clinical relationship in order to promote positive client outcomes was pioneered by psychologist Scott Miller and associates (Miller et al., 2006). The present article recommends the integration of FIT into all clinical work because of its demonstrated success, ease of implementation into clinical work, and its scientific validity (Bertolino & Miller, 2012, see FIT Manual 1).

What is FIT

The FIT model intentionally elicits regular structured feedback by way of two brief four item validated measures from the client regarding the current wellbeing of the client. They take less than 5 minutes each to complete and are; firstly, the outcome rating scale (ORS) measuring the overall wellbeing of the client at the time of the treatment session. And secondly, the session rating scale (SRS) measuring the experience of the client regarding the worker’s behavior and activities in the session that are perceived by the client to be helping, interfering or having no impact on wellbeing improvement as well as indicating the quality and strength of the working alliance (Miller, 2011).

It is these shared elements or common factors, and the complementary and essential graphable feedback process regarding the general wellbeing of the client and the activities of the worker that facilitates and fosters the self-learning process that is at the core of successful clinical work. The SRS in particular serves to provide essential information for the worker to alter their future behavior and techniques to more appropriately respond to the needs of their client based directly on the client’s feedback.

The research findings regarding the importance of the therapeutic alliance (firm trust and belief in the skills of the professional by the client) and other common factors identified by the field of psychological science for creating the openness and vulnerability in the learner/client that is necessary for new learning and problem-solving are clear and unequivocal (Wampold & Imel, 2015).

The routinized embedding of these two scales in the clinical work (whether case management or therapy) making them integral parts of the clinical process as opposed to seeing it as an add on evaluation removes it as being perceived as an additional burden on the worker since FIT shapes and enhances the work. This reframing of the actual clinical process should be helpful for the successful adoption of FIT by social workers and their organizations.

Most importantly, according to the empirical literature it is these shared or common factors, not any particular treatment approach evidence-based or not, that is the most impactful element of the clinical change work (Bertolino & Miller, 2012, see FIT Manual 1).

These mutually determined common factors that include the therapeutic alliance are the fundamental clinical skills that social work programs claim to teach and therefore these elements should be a natural fit and an essential part of the core curricula of all social work masters programs for their clinical classes. Anecdotally, after teaching FIT for many years in my evaluation classes I can attest to the students' preferring it to SSD for implementing and evaluating their clinical work.

Conclusion

This article confronts the dirty little secret of social work that no systematic clinical outcome research or valuations are being implemented in the profession. It argues that structured formal clinical practice evaluations are rarely done or used by social work clinicians in their actual practice regardless if in the US or Europe, even though most graduate level programs provide clinical practice evaluation courses most often as part of the required course work. SSD methodology was found to be the predominant model taught but was also found to be hardly ever used in actual practice due to its complexity and impracticality in most work environments. More specifically, because it was too complicated and difficult to implement in routine practice and because of its time intensive nature and associated costs. As an alternative, this article presented FIT, a well validated brief approach that can easily be integrated into routine social work practice. It is based on the direct self-report of clients during each and every session regarding their wellbeing along with their perception of the worker's behavior and interpersonal approach during treatment.

The FIT process according to the empirical literature can improve the wellbeing of clients along with enhancing their sense of autonomy and self-control. It also helps the workers to become more skilled social workers by receiving direct helpful critical feedback from the clients they are serving regarding their approach, providing an opportunity to hone their interpersonal skills and enhance the therapeutic alliance to help meet their clients where they are at in effectively addressing their interpersonal existential life travails.

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