



Feedback on patient progress and clinical support tools for therapists: Improved outcome for patients at risk of treatment failure in psychosomatic in-patient therapy under the conditions of routine practice[☆]

Thomas Probst^{a,b}, Michael J. Lambert^{c,*}, Thomas H. Loew^a, Reiner W. Dahlbender^d, Richard Göllner^e, Karin Tritt^a

^a University Clinic of Regensburg, Department of Psychosomatics, Germany

^b University of Regensburg, Clinical Psychology and Psychotherapy, Germany

^c Brigham Young University, Department of Psychology, United States

^d University Clinic of Ulm, Clinic for Psychosomatic Medicine and Psychotherapy, Germany

^e Eberhard Karls University of Tübingen, Center for Educational Science and Psychology, Germany

ARTICLE INFO

Article history:

Received 6 February 2013

Received in revised form 2 July 2013

Accepted 6 July 2013

Keywords:

Inpatient treatment

Outcome

Psychosomatics

Psychotherapy

Routine clinical care

Treatment failure

ABSTRACT

Objectives: Although psychosomatic in-patient treatment is effective, 5–10% of the patients deteriorate. Providing patient progress feedback and clinical support tools to therapists improves the outcome for patients at risk of deterioration in counseling, outpatient psychotherapy, and substance abuse treatment. This study investigated the effects of feedback on psychosomatically treated in-patients at risk of treatment failure.

Methods: At intake, all patients of two psychosomatic clinics were randomized either into the experimental group or the treatment-as-usual control group. Both groups were tracked weekly with the “Outcome Questionnaire” (OQ-45) measuring patient progress and with the clinical support tool “Assessment of Signal Cases” (ASC). Therapists received feedback from both instruments for all their experimental group patients. “Patients at risk” were defined as patients who deviated from expected recovery curves by at least one standard deviation. Of 252 patients, 43 patients were at risk; 23 belonged to the experimental group, 20 to the control group. The feedback effect was analyzed using a level-2-model for discontinuous change, effect size (d), reliable change index (RCI), and odds ratio for reliable deterioration.

Results: For patients at risk, the experimental group showed an improved outcome on the OQ-45 total scale compared to the control group ($p < 0.05$, $d = 0.54$). By providing feedback, the rate of reliably deteriorated patients at risk was reduced from 25.0% (control group) to 8.7% (experimental group) – odds ratio = 0.29. All reliably improved patients at risk belonged to the experimental group.

Conclusion: Feedback improves the outcome of patients at risk undergoing psychosomatic in-patient treatment.

© 2013 Elsevier Inc. All rights reserved.

Introduction

In psychosomatic in-patient therapy, a multi-professional team uses multi-modal and multi-method treatments on patients with mental and behavioral disorders too severe for outpatient treatment [1]. Many studies have proven the effectiveness of psychosomatic in-patient treatment (e.g. [2–4]). Nevertheless, 5–10% of the patients with mental health problems deteriorate during psychosomatic in-patient treatment [5,6]. Inspired by Bergin's first study on deterioration effects in psychotherapy [7], research has identified patient-, therapist-, and treatment-related variables that might put patients

at risk of deterioration [8,9]. Managing these risk factors and reducing deterioration rates are relevant issues for clinical practice and for psychotherapy health service research [10]. To prevent deterioration, risk of treatment failure must be detected before patients at risk withdraw from treatment, so that countermeasures can be implemented. To detect risk of deterioration early on in psychotherapy, algorithms (rational and empirical algorithms) were formulated [11–13] using the self-report “Outcome Questionnaire” (OQ-45) [14]. Based on the initial severity of psychological distress (OQ-45 total score) of a given patient, these algorithms provide an expected individual recovery curve for this patient. For every further measurement point, the individual patient's progress is then tracked against the expected recovery curve. If a patient's score deviates negatively from the expected recovery curve as defined by the algorithms, the patient is classified as at risk of treatment failure. While patients not labeled as at-risk patients have deterioration rates between 0.3% and 1.3%, at-risk patients show deterioration rates between 8.4% and 19.4%

[☆] The work was conducted at the Psychosomatics Department of the Hospital in Donaustauf, Germany, and the Psychosomatic Hospital “Am Schönen Moos” in Bad Saulgau, Germany.

* Corresponding author at: Brigham Young University, Department of Psychology, 272 TLRB, Provo, 84602, USA. Tel.: +1 801 422 6480.

E-mail address: Michael_Lambert@byu.edu (M.J. Lambert).

(results for the empirical algorithm [12,13]). Hence, patients classified as at risk have a much higher risk of leaving psychotherapy deteriorated. Furthermore, using the OQ-45 algorithms to identify patients at risk proves to be a much more accurate predictor of negative treatment outcome than subjective evaluations provided by clinicians [15]. The software OQ-Analyst [16], rated as an evidence-based practice with excellent reviews for its training material and easy implementation [17], can be employed to classify patients at risk by comparing individual progress against expected curves. To do so, the patient's progress should be tracked on a weekly basis using the OQ-45. Using the OQ-Analyst, therapists receive weekly feedback on patient progress, the expected recovery curve, and a warning signal if the patient is labeled as at risk. Tracking the patient progress, also known as monitoring, and providing (patient progress) feedback, originate from patient-focused research, aiming at improving the outcome of individual psychotherapies [18].

Providing patient progress feedback to therapists has been shown to improve the outcome of patients at risk in counseling [19,20], outpatient psychotherapy [21], and psychiatric care [22]. At-risk patients whose therapists received patient progress feedback also stayed longer in treatment [23], probably contributing to the improved outcome. The outcome of patients at risk can be further improved when therapists not only receive feedback on patient progress, but also are given clinical support tools (CST). CST can be described as an empirically based problem-solving strategy, helping therapists to focus on important factors which can influence the outcome of psychotherapy [24]. The CST instrument within the OQ-Analyst is the so-called "Assessment of Signal Cases" (ASC) and includes feedback on therapeutic alliance, motivation for change, social support, critical life events, and a decision tree for handling related problems [25]. The existing studies involving feedback on patient progress and CST took place in counseling [24,26,27], outpatient psychotherapy [28], substance abuse treatment [29], and in-patient eating-disorder therapy [30]. This study employed the OQ-Analyst for the first time in German psychosomatic in-patient clinics to investigate the effects of feedback on patient progress and CST for psychosomatically treated in-patients at risk of a negative outcome.

Methods

Questionnaires

Outcome Questionnaire (OQ-45): The OQ-45 was used to track patient progress. This self-report questionnaire includes 45 items measured on a five-point Likert scale. Each item pertains to the previous week. There are three subscales (symptom distress, interpersonal problems, and social role performance) and one total scale; the higher the values, the higher the distress level. This study used the total scale which comprises all 45 items and indicates the general severity of psychological distress. The total scale of the German OQ-45 version has an internal consistency of 0.93 and a retest-reliability of $r = 0.88$ [31].

Assessment of Signal Cases (ASC): The ASC served as the CST instrument. This self-report questionnaire consists of 40 items. Each item is answered on a five-point Likert scale and covers the previous week. The ASC consists of four scales: therapeutic alliance, social support, motivation for change, and life events. These four areas are considered to significantly influence patient progress [25]. The ASC used in this study was translated into German via a back-translation method. To ensure the quality of the translation, cognitive debriefing interviews with ten in-patients were done with the German version of the ASC before the study began [32]. In contrast to former studies [24,26–30], the CST was used not only for at-risk patients in this study; wanting to gather further experience and collect data with the instrument, all patients were encouraged to complete the ASC every week during the course of their psychosomatic treatment. Testing the reliability of the four ASC scales of the German ASC version with the internal consistency coefficient Cronbach's alpha, the following coefficients were found for

all patients (not only at-risk patients) with an intake ASC: therapeutic alliance scale: 0.89; social support scale: 0.76; motivation for change scale: 0.78; and life events scale: 0.71.

Study design

All patients of the Psychosomatics Department of the Hospital in Donaustauf, Germany, starting treatment from 10/01/2010 to 07/06/2012 were asked to participate in the study. At the Psychosomatic Hospital "Am Schönen Moos" in Bad Saulgau, Germany, all patients with private health care who entered treatment between 01/16/2012 to 04/06/2012 were encouraged to take part in the study. Both clinics provide multi-modal and multi-method psychosomatic in-patient treatment with more than 24 treatment hours per week, including individual and group psychotherapy, relaxation and mindfulness training, physical activity therapy, creative therapy (art, dance, music), and – if required – crisis intervention, visitations by nurses, medical consultations, etc. The multi-professional teams consisted mainly of psychologists, physicians, and nurses. At clinic intake, all patients (not only at-risk patients) were randomized either into the experimental group or the treatment-as-usual control group. All patients of both treatment groups were monitored: Every patient was asked to complete the OQ-45 and the ASC (paper and pencil versions) each week sometime between Friday and Sunday during the course of their stay. After the OQ-45 and ASC data was transferred to the OQ-Analyst, the feedback reports of the OQ-Analyst were printed on the following Monday. The feedback reports were given on a weekly basis to the therapists in a closed envelope only for the patients of the experimental group. The therapists received feedback only for those experimental group patients that they worked with in individual therapy. The feedback on patient progress and CST was provided to therapists for all experimental group patients, not only for at-risk patients. As feedback on patient progress requires at least two OQ-45 scores, the therapists received the weekly feedback starting with the second measurement point of a given experimental group patient. The therapists could freely choose to discuss the feedback information with the patient, the clinic team and/or supervisors. Before the study commenced, interpretation of the feedback reports was explained in detail to the therapists. They were also motivated to view the feedback information not as prescriptive, but as a possibility to broaden clinical problem solving with their patients.

Focusing on the effects of feedback on patients at risk of deterioration, the empirical algorithm of the OQ-Analyst was applied to classify patients at risk: If the patient's progress deteriorated by at least one standard deviation from his expected recovery curve at any week during treatment, the patient was considered as being at risk and the therapist received a warning signal in the weekly feedback report, implying that this patient is at risk of treatment failure. The expected recovery curve of a given patient is based upon a norm derived from a large group of U.S. patients with a similar intake OQ-45 total score, calculated with at least 220 patients for each specific expected recovery curve [11]. Patients without an intake OQ-45 score and patients without at least three measurement points were excluded from this study: The intake OQ-45 score constitutes the baseline of the expected recovery curve. Since giving feedback requires at least two measurement points, three or more measurement points are a prerequisite to study the effects of feedback on patient progress.

Statistical analysis

The statistical analysis was performed with SPSS 19.0 FP2, applying a significance level of ≤ 0.05 . All tests were performed two-tailed. Means (M) and standard deviations (SD) were calculated for the sample description. To explore differences between the two treatment groups in regard to age, gender, education, comorbidity, treatment duration, and assessment points with first at-risk signal,

Download English Version:

<https://daneshyari.com/en/article/10469471>

Download Persian Version:

<https://daneshyari.com/article/10469471>

[Daneshyari.com](https://daneshyari.com)