

IMPROVING PROGRAM EFFECTIVENESS

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1

IMPROVING PROGRAM EFFECTIVENESS




UNDERSTANDING, BUILDING, & MAINTAINING BETTER SERVICES



2

WHY PROGRAM EFFECTIVENESS & PROGRAM EVALUATION ARE IMPORTANT ...


- IN THE NEW *MINISTRY OF CHILDREN AND YOUTH SERVICES*, **ALL SERVICES WILL BE EVALUATED ON EFFECTIVENESS & OUTCOMES** – AND CONTINUED FUNDING WILL DEPEND UPON THE RESULTS OF SUCH EVALUATION. [IN THE YOUTH JUSTICE SECTOR, MCYS WILL USE THE *CORRECTIONAL PROGRAMMING ASSESSMENT INVENTORY (CPAI)*.]
- *YOUTH JUSTICE ONTARIO* INTENDS TO DEVELOP AND PROVIDE **ACCREDITATION** FOR MEMBER AGENCIES – AND KEY STANDARDS WILL REQUIRE MEASURE OF EFFECTIVENESS.

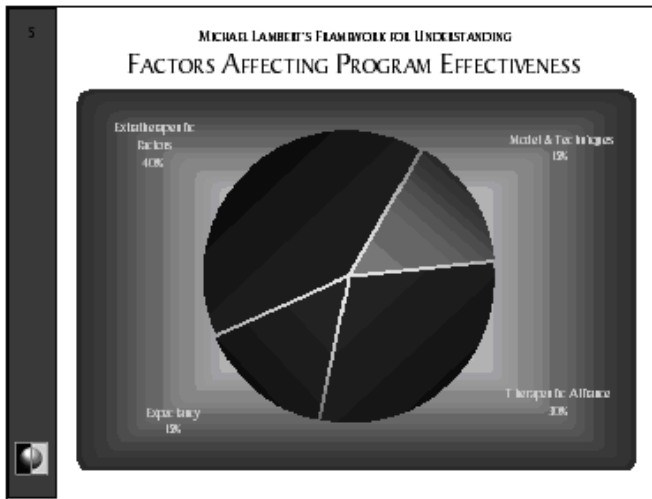


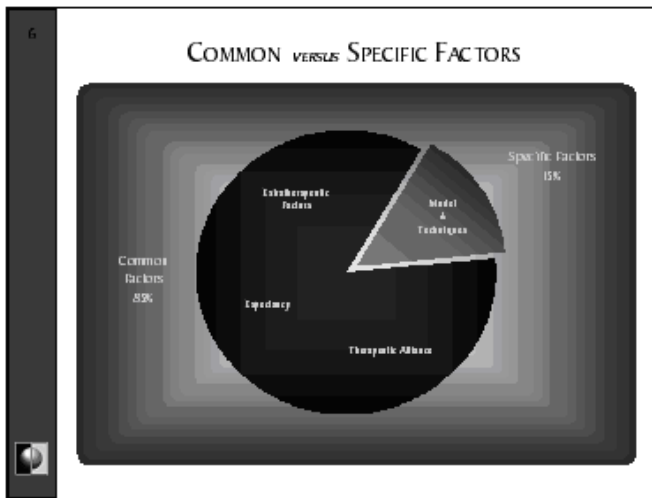
4

THE FRAMEWORK

MICHAEL LAMBERT







7

COMMON VERSUS SPECIFIC FACTORS

SPECIFIC FACTORS = 15% OF "WHAT WORKS"

- THOSE FEATURES OF A **TYPE** OF PROGRAM (THERAPY, TREATMENT, INTERVENTION, ETC.) THAT MAKE IT DIFFERENT FROM OTHER TYPES – E.G., COGNITIVE-BEHAVIORAL IS PSYCHODYNAMIC IS SYSTEMS THEORY IS SOLUTION-FOCUSED IS REALITY THERAPY IS TRANSACTIONAL ANALYSIS ...
- USUALLY, THESE DIFFERENCES CENTER ON:
 - MODEL** of HUMAN BEHAVIOR (WHAT CAUSES & SUSTAINS PROBLEMS); AND
 - TECHNIQUES** NEEDED TO SOLVE THESE PROBLEMS.

COMMON FACTORS = 85% OF "WHAT WORKS"

- THOSE FEATURES THAT ALL TYPES OF PROGRAMS (THERAPIES, TREATMENTS, INTERVENTIONS, ETC.) SHARE.

8

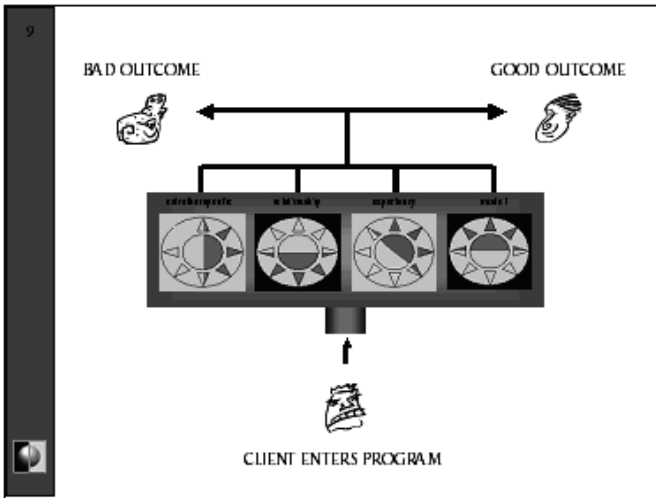
COMMON VERSUS SPECIFIC FACTORS

IMPORTANT POINT #1

- IF 85% OF WHAT MAKES PROGRAMMING EFFECTIVE IS THE **COMMON FACTORS** SHARED BY ALL THERAPIES, IT WOULD MAKE THE MOST SENSE TO FOCUS STAFF TRAINING & STAFF DEVELOPMENT ON THESE FACTORS; HOWEVER, THE OVERWHELMING AMOUNT OF SUCH TRAINING & DEVELOPMENT GOES INTO THE SPECIFIC FACTORS (e.g., Model philosophy, techniques, and manuals).

IMPORTANT POINT #2

- EVEN THOUGH ALL THERAPIES (PROGRAMS) SHARE THESE COMMON FACTORS, **THEY DON'T SHARE THEM EQUALLY**. EACH TYPE OF THERAPY MAKES USE OF THE COMMON FACTORS IN DIFFERENT WAYS AND TO DIFFERENT DEGREES.



11

MODEL & TECHNIQUES

WHAT IS A MODEL OF THERAPY?

The system of **ASSUMPTIONS** about human behaviour and human problems that the therapy is based on, including:

- what **CAUSES** behaviour
- what **CHANGES** behaviour
- what **CAUSES** and **MAINTAINS** problems
- what **CHANGES** problems

EXAMPLES of MODELS:

• Cognitive-Behavioral	• Narrative Therapy
• Psychodynamic/Psychanalytic	• Strategic Psychotherapy
• Solution-Focused Therapy	• Reality Therapy
• Conjoint Family Therapy	• Neuro-Linguistic Programming
• Systemic Therapy	• Self Psychology
• Transactional Analysis	• Gestalt Therapy
• Moral Reconciliation Therapy	• ... more than 400 other types ...

MODEL & TECHNIQUES

WHAT ARE **TECHNIQUES** OF THERAPY?

The **PROCEDURES, INTERVENTIONS, or TACTICS** used by practitioners of a **MODEL** to effect **CHANGE** in a client.

EXAMPLES of **TECHNIQUES**:

- cognitive restructuring
- active listening
- "I" messages
- flooding
- confronting irrational beliefs
- goal setting
- externalizing the problem
- scaling
- rolfing
- dream interpretation
- role playing
- biofeedback
- self-disclosure
- prescribing the symptom
- logging / negative inquiry
- role modeling
- finding exceptions
- level systems
- rewards (incentives) / punishments
- logical consequences
- regression
- reframing
- identifying triggers
- free association
- psychodrama
- ... and countless more ...



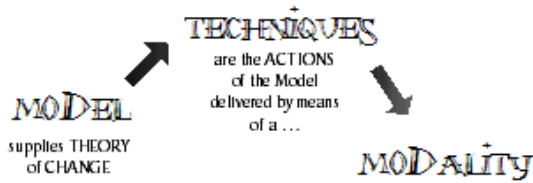
MODEL & TECHNIQUES

WHAT IS A **MODALITY** OF THERAPY?

The general **FORM** that a **MODEL's TECHNIQUES** are delivered in.

TYPICAL **MODALITIES** ARE:

- INDIVIDUAL
- COUPLE
- FAMILY
- GROUP
- SYSTEM (e.g., MST, Wrap-Around, RI)
- SELF-HELP (e.g., bibliotherapy, videos/tapes)



MODEL & TECHNIQUES

HOW DOES A **MODEL** CONTRIBUTE TO EFFECTIVE THERAPY?

ANSWER:

STRUCTURE
&
FOCUS



THERAPEUTIC ALLIANCE

WHAT IS THE THERAPEUTIC ALLIANCE?

Also known as the THERAPEUTIC RELATIONSHIP, this alliance is the CONNECTION, RAPPORT, or BOND that is formed between the Client and Counselor during the course of therapy.

ASPECTS OF THE THERAPEUTIC ALLIANCE INCLUDE:

- POSITIVE REGARD (seeing the client as a human being with essential goodness)
- CONGRUENCE (agreement on problem, seriousness, solutions)
- WARMTH & GENUINENESS (feeling is a "person" not a "case")
- PURPOSEFULNESS (issues specified concretely and in measurable terms)
- TRUST & CONFIDENCE (reliability, truthfulness, and following through)
- ENCOURAGEMENT of RISK-TAKING (support for change)
- BEING 'COOL' (role-model that is relevant & 'informed'; worky of emulation ...)
- EMPATHY (cognitive, affective, sharing, mirroring)



THERAPEUTIC ALLIANCE

4 TYPES of EMPATHY:

- COGNITIVE = feeling understood
- AFFECTIVE = participating in the same emotional state
- SHARING = disclosing personal experiences & information
- NURTURANT = supportive, caring, & security-enhancing responses

Clients favour one type over others. Relating to a client with the wrong type can impede successful outcomes.



THERAPEUTIC ALLIANCE

HOW DOES THE THERAPEUTIC ALLIANCE CONTRIBUTE TO EFFECTIVE THERAPY?

ANSWER:

"Whatever its outward form, the fundamental essence of any relationship is the desire to be attractive to the other person. When we are in a relationship with someone else (and I am not restricting this to only sexual or physical relationships), we are highly motivated to display those characteristics that we believe the other person will be attracted to. This is doubly true for those relationships we voluntarily choose. [Obviously what characteristics we want to display depend upon the nature and context of the specific relation.] Conversely, we are attracted into relationships by those characteristics we find attractive. Wanting to be attractive applies the willingness to make changes."

"Crying Shame", Talbot J. Zentgraf, Volume 2, #1



20

THERAPEUTIC ALLIANCE

"Whenever a child is brought to me for treatment because he steals, lies, disobeys adults, and is aggressive, my first task is to gain the child's respect and ~~make sure the child likes me~~. Building a relationship with a problem child may be made easier because many of them strongly desire approval. Once this rapport has been established and a strong relationship develops, such a child will generally want to please the adult. At this point, the child is still externally motivated; responsibility comes later." *[emphasis added]*

"Small Criminals Among Us", Gad Gardner, 1990



21

EXPECTANCY

WHAT IS EXPECTANCY?

Knowing that he/she is in a "program" (or "treatment", "therapy", "counselling", "supervision", etc., etc.), the client forms certain EXPECTATIONS for improvement ... and these expectations become SELF-FULFILLING PROPHECIES.

THE ASPECTS OF THIS FACTOR INCLUDE ...



22

EXPECTANCY

EXPECTATION of IMPROVEMENT

The degree to which the Client and/or Counsellor BELIEVES therapy (or the program) to be EFFECTIVE.

This degree is affected by:

- RITUALS (e.g., confidentiality, assessment, collecting information)
- SOCIALLY-DEFINED SPACES (e.g., offices, appointments)
- JARGON (e.g., labels, diagnoses)
- SYMBOLS (e.g., certificates, files, forms)



EXPECTANCY

PATHWAYS THINKING

The degree to which the Client and/or Counsellor BELIEVES a solution to be possible – i.e., that there exist concrete and definite ways for the Client to change.



EXPECTANCY

AGENCY THINKING

The degree to which the Client and/or Counsellor BELIEVES the Client has the CAPACITY, ABILITY, or SKILLS needed to make change happen.



EXPECTANCY

PLACEBO

The degree to which the Client is motivated to PLEASE the Counsellor or to meet the Counsellor's POSITIVE expectations. [Also known as the Sugar Pill Effect.]

NOCERO

Opposite of placebo, this aspect is the degree to which the Client or Counsellor has HARMFUL expectations. [e.g., students labeled as lower IQ, or admissions to mental health treatment clinics]



EXPECTANCY

PLACEBO instead ...

It used to be assumed that approximately one-third of clients responded to placebos. Now it is understood that placebo response can vary from near 0% to near 100% depending on a myriad of treatment factors. These include:

- counsellor-related factors (i.e., counsellor's attitude towards therapy and the client)
- client-related factors (i.e., client's attitude towards therapy and the client)
- the context of the interaction (e.g., setting, cost, reputation)
- the form of the treatment (e.g., modality)



EXPECTANCY

HOPE

The emotional state that results from believing that one's future state can be significantly better than one's current state.



EXPECTANCY

HOW DOES EXPECTANCY CONTRIBUTE TO EFFECTIVE THERAPY?

ANSWER #1:

There is a tendency in all living beings towards self-healing. That's why the body forms scabs when it is cut, responds to foreign substances with antibodies, or knits broken bones. It's the same with our emotional, cognitive, & behavioural functions ... there is a tendency to "return to normal" (technically, this tendency is called *homeostasis* or *regression to the norm*). Problems happen, however, when people get stuck in unhealthy (or dysfunctional) emotional responses, cognitions, or habits. To the extent that this state of being "stuck" is reinforced by psychological processes (as opposed to being caused by physiological or chemical imbalances), reducing such negative psychological attitudes/emotions/expectations and increasing positive ones frees the individual up to return to normal ... this, in turn, creates a self-fulfilling prophecy of positive reinforcement.

CAUTION: once it's movement gets going, it becomes so natural people don't quickly adjust their positive expectations and becomes a counter-productive force in therapy. To avoid this, the counsellor must introduce the "expectation of failure".



EXPECTANCY

HOW DOES **EXPECTANCY** CONTRIBUTE TO EFFECTIVE THERAPY?

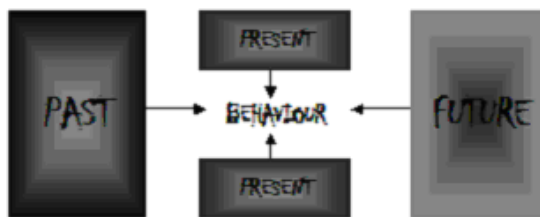
ANSWER #2:

Human behaviour is "caused" by:

- (A) PAST experience (the person as "object");
- (B) PRESENT context (the person as "subject"); and
- (C) FUTURE expectations (the person as "project").

All three causal influences are present in the client's cognitions, emotions, and behaviours. However, there is a bias towards PAST experience in most Models of therapeutic change (e.g., problems as caused by family dynamics, parenting style, poverty, learned beliefs, childhood traumas, etc.). EXPECTANCY simply engages the FUTURE causal capacities of the client.

"Causal" Determinants of Behaviour



EXTRATHERAPEUTIC FACTORS

WHAT ARE **EXTRATHERAPEUTIC FACTORS**?

Also referred to as **CLIENT FACTORS**, these are factors that are an inherent part of the client or of the client's life context. They exist 'outside' the (normal) therapeutic process – i.e., they are part of the client's *biological/psychological constitution* and/or his *social environment*. "In short, they are what clients bring to the therapy room and what influences their lives outside it." [Hubble et al. (1999)] In short, these factors affect the client's behaviour, emotions, and cognitions independently of the therapeutic process.

Well, maybe not in all cases ...

CYC professionals, while frequently conforming to standardized therapy, often (a) go places with clients that other professionals don't (e.g., the school, home, neighbourhood, community, camping trips, court, hospital, etc.) and (b) interact with clients for longer periods of time (e.g., shifts, overnights, weekends, outings, etc.). In short, what is often considered 'extratherapeutic' for most helping professionals is not for CYC professionals. Consequently, we have a 'natural' advantage over other professionals in accessing more of the Client's Factors.

ASPECTS INCLUDED IN THIS CATEGORY ARE:

EXTRATHERAPEUTIC FACTORS

SOCIAL & ENVIRONMENTAL FACTORS ...

- family relations (boundaries, parenting style, generations, etc),
- school experiences
- employment experiences,
- networks of friends,
- religious affiliations,
- faith/spirituality,
- cultural ties,
- hobbies, sports, recreation,
- mentors, role models,
- etc., etc.

We should understand and analyze these in all three causal dimensions:
PAST, PRESENT, and FUTURE.



EXTRATHERAPEUTIC FACTORS

FORTUITOUS EVENTS ...

- moves,
- deaths
- injuries/accidents
- illnesses
- etc., etc.



EXTRATHERAPEUTIC FACTORS

CLIENT HISTORY ...

- divorce,
- abuse/neglect,
- racism,
- prejudice,
- poverty
- drug use,
- achievements,
- etc., etc.



EXTRATHERAPEUTIC FACTORS

CLIENT PSYCHOLOGY & BIOLOGY ...

- motivation,
- temperament (sociability, emotional lability, risk level, impulsivity),
- disability (physical, learning, FASD),
- persistence,
- resilience,
- character,
- mental health (anxiety, depression, sexual dysfunction ...),
- etc., etc.



EXTRATHERAPEUTIC FACTORS

CLIENT'S STAGE OF CHANGE-READINESS ...

- 1. PRECONTEMPLATION** - means the client doesn't really see that s/he has a problem (so the strategy is to introduce 'doubt' and 'new information', getting the client to explore the 'possibility' that a problem exists, to observe & record for him/herself the 'pros' and 'cons' of changing);
- 2. CONTEMPLATION** - means the client sees a problem, knows something should be done about it, and intends to change eventually (so the strategy is to explore the costs & benefits of changing and to shift toward the latter);
- 3. PREPARATION** - means the client is ready to take action soon, in days or weeks not months (so the strategy is to develop an action plan, identify supports & resources, plan contingencies for setbacks, etc.);
- 4. ACTION** - means the client is experimenting with change, following the action plan (so the strategy is to gauge the change as it occurs, highlight successes, etc.); and
- 5. MAINTENANCE** - means the client has achieved his/her goals and is working to consolidate change and prevent relapses (so the strategy is to identify (i) the new experiences that change has brought into existence and (ii) vulnerabilities that threaten change - e.g., times of distress, anxiety, boredom, or anger - and methods for dealing with them).



EXTRATHERAPEUTIC FACTORS

HOW DO THE EXTRATHERAPEUTIC FACTORS CONTRIBUTE TO EFFECTIVE THERAPY?

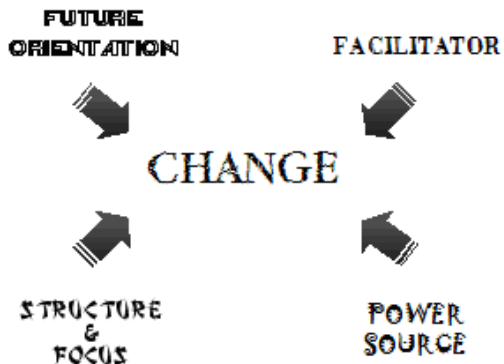
ANSWER:

POWER SOURCE

The Extratherapeutic Factors are the repository of all the Client's RESOURCES and CAPACITY for change.



THE CHANGE PROCESS ...



THE PRINCIPLES

PRINCIPLE #1

ALL of the preceding FACTORS need FIRST to be understood and implemented (as practices & policies) *from the perspective of the Client*, not from the perspective of the Counsellor!!!

CAVEAT!

The idea here is NOT to discount or ignore the Counsellor's Perspective, but to use it as background information that can be introduced if or when the Client needs it.



PRINCIPLE #2

The act of EVALUATING (or MEASURING) increases the EFFECTIVENESS of any intervention we do with our clients ...
provided that the evaluation (or measurement) does not impede Expectancy or the Therapeutic Alliance.

[In this regard, evaluation (measurement) acts like any other Technique – i.e., it provides STRUCTURE & FOCUS to the therapeutic process.]



TYPES of EVALUATION

1. CLIENT OUTCOMES (i.e., client goals)
2. CLIENT PROCESSES (e.g., satisfaction with/awareness of the counselor, the counseling process, practice skills, extratherapeutic relationships)
3. PROGRAM OUTCOMES (e.g., impact on well-being, client satisfaction levels, client goal achievement levels, etc.)
4. PROGRAM PROCESSES (e.g., accreditation standards, quality assurance)



FORM of EVALUATION

1. FORMAL (e.g., checklists, scales, questionnaires, numeric quantification)
2. INFORMAL (e.g., comparisons, using charts and metaphors and terms)