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The Kaupapa Outcome Rating Scale

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Abstract

Over the past decade, the need to make outcome evaluation a routine part of mental health services has become more apparent. This article describes the move to develop brief outcome tools for clinicians that increase effectiveness.In line with this movement a New Zealand Māori ultra-brief outcome measure is described here (the Kaupapa Outcome Rating Scale – KORS), and the results of a preliminary validation study against the Outcome Rating Scale (ORS) are given. In keeping with the call for 'cultural safety' the KORS is an instrument that gives the power to the client or family to define the quality of service or progress.

Cultural safety

Cultural safety in Aotearoa New Zealand has its roots in the response of Māori to difficulties with western-based nursing practices (Wepa, 2004). It is a call to transfer power from service providers to 'consumers' (Cooney, 1994). That is to say, 'safe service' is to be defined by those who receive the service. As we shall see, there is a body of research that shows that greater success is to be had in psychotherapy when therapeutic progress and the therapeutic alliance are monitored by the client. Coup (1996) notes that all interactions are bicultural by definition, and hence cultural safety is called for in all therapy. This is also congruent with the call from the consumer movement in mental health for empowerment. Unfortunately an increasingly dominant voice in mental health would have us 'colonise' clients with 'empirically validated treatments', on the grounds that this is 'scientific' and 'best practice' (Andrews, 2007; Lohr et al., 2002). This form of colonisation can be countered through the development of scientific tools that monitor client progress and the alliance from the client's viewpoint, thus meeting cultural safety standards better and allowing the clinician to employ a wide variety of therapeutic options. The Kaupapa Outcome Rating Scale (KORS) is one such tool.

'Speed cameras'

In an editorial in the *Australian and New Zealand Journal of Psychiatry*, Andrews and Page (2005) note that the HoNOS suite (Health of the Nation Outcome Scales) are

being used in Australia for monitoring outcomes for third parties, but are not used by clinicians as a clinical tool for monitoring progress. In an apt metaphor, Andrews and Page describe this as the HoNOS being used as a speed camera rather than a speedometer. They note that this may be unethical, reasoning that while the collection of data for clinical care does not require permission, gathering data for research or third parties requires informed consent.

They further note that the original purpose of the HoNOS was to monitor progress, citing the findings of Lambert et al. (2001b) that routine feedback to clinicians of progress doubled the rate of satisfactory outcomes. This call for regular feedback to clinicians has stemmed from numerous studies on progress and outcomes. Most successful psychotherapy has a high degree of predictability, because most change occurs early rather than late in treatment (Brown et al., 1999; Duncan et al., 2004; Hansen & Lambert, 2003; Lambert, 2005). Howard et al. (1986) found that 60–65% of clients experienced significant improvement within one to seven sessions, and 85% within a year. Howard and his colleagues also noted that 'a course of diminishing returns' (p. 160) begins to occur as time in treatment lengthens. Brown et al. (1999) found that if no improvement had occurred by the third session then there was little likelihood of improvement over the entire course of treatment, and the probability of 'dropout' was twice as high. Diagnosis, severity of symptoms, social support and type of treatment were not as important in predicting success 'as knowing whether or not the treatment being provided [was] actually working' (p. 404).

The need for 'speedometers'

Further studies of early improvement, especially *the client's subjective experience* of meaningful change in the first few sessions, predicted whether a particular treatment system was likely to be successful (Haas et al., 2002; Lueger, 1998; Lueger et al., 2001). In their editorial, Andrews and Page (2005) omit to mention that the feedback referred to by Lambert et al. (2001b) was of the client's subjective experience of meaningful change, and not the clinician's. Hunter et al. (2004) similarly found that a tool which allowed clients to self-rate their own outcomes was superior to the HoNOS in detecting problems the clients found important to work on. As the study of Brown et al. (1999) showed, more telling than the presence and severity of symptoms in predicting outcome was whether clients believed that the treatment being provided was actually working.

Clinicians have been found to be poor at rating how well clients themselves perceive they are doing (Cohen & Cohen, 1984; Moos, 2000), and this includes the HoNOS (Brooks, 2000). Tools that can provide ongoing feedback about how clients

perceive their progress are useful to clinicians. Lambert et al. (2003) commented that while therapists strive to be sensitive and responsive to clients, the research indicates they are not alert to treatment failure. Reviewing this literature, Duncan et al. (2004) state that there is now ample evidence to show that clinical judgements about the therapeutic alliance and progress in treatment are inferior to formal client feedback of their perception.

Feasibility

In today's climate of increased accountability, feedback tools for measuring the client's perception of the process and progress of therapy need to be reliable, valid and feasible. As Miller et al. (2003) note, there are no 'perfect' instruments. Simple and brief tools will be more user-friendly (feasible in the context of day-to-day therapy) but at the cost of losing some reliability that larger measures enjoy. The OQ45.2 (Outcome Questionnaire) has been shown to have a high degree of reliability and validity (Lambert et al., 1996; Mueller et al., 1998), and is considered to be the 'gold standard' of clients' perception of progress (Duncan et al., 2004). Unfortunately, research also shows that this measure suffers a feasibility problem. Brown et al. (1999) have found that measures that take more than five minutes to complete and interpret will not be used by the majority of therapists. Lambert et al. (2001a) write that 'treatment systems cannot tolerate expensive and time-intensive markers of change, especially when used as a start up procedure or where patient progress is reported to therapists on a weekly schedule' (p. 160).

The OQ45.2 (Lambert et al., 1996) was designed to assess change in three areas of client functioning which have been considered valid indicators of progress in therapy: individual (symptomatic) functioning; interpersonal relationships, and social role or career performances (Lambert & Hill, 1994). Miller et al. (2003) translated these three areas into a simple visual analogue form, the Outcome Rating Scale (ORS), with instructions for clients to place a mark on a 10-cm line, with low estimates to the left and high to the right. A fourth item was added asking for an overall or global rating of well-being. Miller et al. (2003) report a Pearson product correlation between the ORS and the OQ45.2 of .58, which is respectable given the four-item brevity of the ORS compared to the 45-item length of the OQ45.2. However, any loss of reliability and/or validity was more than compensated for by a massive increase in feasibility (i.e., likelihood that clinicians would administer the ORS form). In their study Miller et al. (2003) found a compliance rate of 86% at the end of a year for the ORS, whereas the OQ45.2 dropped to 25% over the same period. This is because the ORS takes less than a minute for the client to score and the therapist to interpret. Thus the ORS can

be considered a highly useful and valid tool for providing feedback to clinicians of client progress.

Monitoring the alliance

Miller and Duncan also developed a similar four-item tool for assessing the client's perception of the therapeutic alliance – the Session Rating Scale (SRS) (Johnson et al., 2000). On the basis of a number of meta-analytic studies of therapy outcome (e.g. Lambert & Hill, 1994; Wampold, 2001), Duncan et al. (2004) reasoned that as much as 25–45% of outcome variance can be attributed to the quality of the alliance. Further, the client's ratings of the alliance provided a better predictor of outcome than the therapist's ratings (Bachelor & Horvath, 1999). Referring to Bordin's (1979) definition of the therapeutic alliance, Miller and Duncan itemised the following to develop the SRS, a visual analogue scale: quality of the relational bond; degree of agreement between therapist and client on the goals or topics of therapy; agreement on method or approach, and perception of the overall value for the client of the therapeutic session. As with the ORS, Duncan et al. (2003) found favourable reliability and validity comparisons with other longer instruments for assessing the alliance. Again the edge for the SRS was in its compliance rate (feasibility), attaining a 96% rate, while the longer WAI (12-item Working Alliance Inventory) was only used 29% of the time.

Client-directed, outcome-informed therapy

With these two tools, the ORS and the SRS, Duncan and Miller have developed what they call a client-directed, outcome-informed (CDOI) approach to therapy. Therapists are encouraged to deliver and score the ORS at the commencement of each session, and to complete the session with the SRS. In one study of over 6000 clients, Miller et al. (2006) found that this 'practice-based evidence' (rather than 'evidence-based practice') approach not only produced significantly higher retention rates, but also halved the number of sessions necessary for clients to reach satisfactory outcomes. It is noteworthy that these findings were obtained without any attempt to train the therapists in any new techniques or procedures, other than to utilise client feedback. They were free to treat the clients as they saw fit. Similarly, Whipple et al. (2003) also found that therapists were twice as likely to achieve clinically significant change when they had regular access to outcome and alliance information.

The CDOI approach has found appeal among experienced psychotherapists who identify as 'eclectic' in their work. Researchers consistently find that experienced clinicians are not attracted to following the treatment manuals of evidence-based practice models, claiming that treatment needs to fit the client rather than the client

fit the treatment (Najavits et al., 2003; Norcross et al., 2002). Growing numbers of psychotherapists are becoming 'postmodern', having no allegiance to any one school of therapy (Shawver, 2006). With over 400 different schools of psychotherapy (Garfield, 1994), many of which are competing in the claims to show they are empirically supported, scientific emphasis appears to be largely misdirected. A review of outcome research by M.J. Lambert (1992) led him to estimate that 40% of client changes are due to extratherapeutic influences, 30% are due to the quality of the therapeutic relationship, 15% are due to expectancy (placebo) effects, and only 15% are due to specific techniques. Thus Lambert estimates that 85% of therapeutic change is due to factors common to all therapies. Wampold (2001) goes further by claiming that the effects of the specific model may be as low as 1%, due to the confounding influence of the therapist's allegiance to the model effect. Wampold asks, 'Why do researchers persist in attempts to find differences [between models], when they know that these effects are small?' (2001, p. 211). Valid, reliable and feasible outcome tools, such as the ORS and SRS, allow us to utilise 'practice-based evidence', where the scientific emphasis is on acknowledging the centrality of the 'common factors' to all therapy. This does not exclude the use of so-called 'empirically validated treatments', it just consigns them to a secondary role. It is more important to know that this particular treatment is working with this client at this time.

The Hua Oranga

By the late 1990s the New Zealand Ministry of Health began supporting efforts to develop a Māori mental health outcome tool (Kingi & Durie, 1998). The Hua Oranga was developed based on Durie's Whare Tapa Whā model of health (Durie, 1994; Kingi & Durie, 2000). Te Whare Tapa Whā is the best known Māori model of health in New Zealand. It is often referred to as the four cornerstones of health, an approach comparing health to the four walls of a house, with all four being necessary to ensure strength and symmetry (Durie, 1994). Te Whare Tapa Whā consists of taha wairua (spiritual), taha hinengaro (mental and emotional), taha tinana (physical) and taha whānau (family) considerations. Currently, the Hua Oranga outcome tool is in the process of being validated. A review is also underway of a modified version of the tool (Tupu Ranga), suitable for tamariki (children) and rangatahi (adolescents). The plan is that the Hua Oranga will be available for use by mental health clinicians in 2007.

At this stage, the Hua Oranga consists of three separate questionnaires asking essentially the same body of questions from tangata whaiora ('seekers of health'), caregivers/whānau, and clinicians. The assumption is that a triangulated approach between these three participants in the drama of psychotherapy will provide a more

robust measurement. Each of the four taha (walls of the house) is assessed by four questions, where the participant chooses one of five points on a Likert scale. Thus there are 16 questions for the participants to complete, and the suggestion appears to be that the clinician score and cross-tabulate the responses from the various participants to arrive at a comprehensive assessment of the health status of the tangata whaiora.

Besides the obvious feasibility question for clinicians, the tool raises another concern. The formatting of the questions seems to imply that any change is due to clinical interventions, seemingly overlooking Lambert's findings that most changes are due to clients' strengths and happenstance events. The Hua Oranga questions place the therapist at the centre of the drama of change, rather than the 'heroic client' (Duncan et al., 2004).

The Kaupapa Outcome Rating Scale

The Kaupapa Outcome Rating Scale (KORS) was developed from the four taha of Te Whare Tapa Whā and the Hua Oranga (see appendix 1). The format emulates the ultra-brief visual analogue form of Miller et al.'s (2003) Outcome Rating Scale (ORS). The four questions of each taha on the Hua Oranga have been converted to a brief description of the particular quality. Tangata whaiora are asked to make a mark on the 10-cm line beneath each taha and description, with low estimates to the left and high to the right. The clinician scores the form by simply measuring the mark with a ruler. Like the ORS, the KORS will yield a total score out of 40 (or 400). While tangata whaiora make a self-assessment, whānau, caregivers and other clinicians rate where they see the tangata whaiora on each taha.

The instrument has been used by the author for the past three years in a DHB Kaupapa Mental Health Service at the outpatient psychology clinic. During this time 40 consecutive clients have, for clinical purposes, completed both the ORS and the KORS at each session. This data has allowed me to explore the relationship between the two measures. This provided a sample of 125 paired administrations for the 40 subjects. A correlation was computed with the Pearson two-tailed correlation test (Cohen & Cohen, 1983). The overall correlation between the ORS totals and the KORS totals is .915, which is significant at the 0.01 level. Both scales may be measuring a 'distress–well-being' continuum. A correlation was also found between the 'interpersonal' item on the ORS and the 'whānau' item on the KORS of .870 with the same test, which is also significant at the 0.01 level.[1]

It would be useful to conduct further testing of this instrument by comparing a non-clinical sample with a clinical sample for means and standard deviations, as well

as test and retest reliability. Measuring the degree of correlation between the KORS and the Hua Oranga on a large population, once the Hua Oranga research is complete, would provide added reliability. Moreover, it would be useful to measure the compliance rate among clinicians if both the KORS and the Hua Oranga were made available to a similar group of clinicians with a similar group of clients. Because of its brevity, the KORS appears to be a more feasible instrument.

Clinical use of the KORS

The KORS (like the ORS) is administered and scored at the commencement of each session, and progress (or lack thereof) begins the conversation. Although many meta-analytic studies (e.g. Clum et al., 1993, on panic disorder) have found no significant differences between various treatment approaches, Durie (2003) has suggested it is often helpful to remain mindful of other taha of an individual's health when treating a mental health problem. Marital therapy and exercise, for example, have both been found effective in the treatment of 'depression' (Leff et al., 2000; Tkachuk & Martin, 1999). Thus the KORS highlights taha that the client may wish to explore, which may at first seem unrelated to the presenting problem.

The best outcome figures for the treatment of people attracting a diagnosis of 'schizophrenia' in recent years come from the work of Seikkula and his colleagues in Finland (Seikkula & Arnkil, 2006; Seikkula & Trimble, 2005). In light of their emphasis on social networks, their approach may have particular appeal to Māori. Seikkula and his colleagues take the view that an individual, 'wounded' in some way, has taken refuge in an exaggerated state of isolating internal monologue (Trimble, 2002). In turn the social network also becomes embedded in monological positions (where the listener is positioned as passive and the conversation is dominated by a single viewpoint). This results in spiralling isolating monologues. The social network is seen as being in crisis at the time of referral, and engagement with the whole network is critical from the start. Monologue is the crisis, and dialogue is the aim of therapy. Open treatment meetings are held in the community, often at the client's home, where a deliberating atmosphere is generated so that different and even contradictory voices can be heard. Medication is viewed as an aid to dialogue, not as treatment in itself. Poorer outcomes have not been associated with severity of symptoms, but with the paucity of the pre-existing social networks.

The KORS can be of assistance in these 'open dialogue' meetings, as scores of all participants' perceptions of the tangata whaiora are compared and the more polarised 'monological' positions readily identified. The therapeutic conversation begins with a comparison of the results.

Conclusion

The Kaupapa Outcome Rating Scale (KORS) has been developed as a feasible clinical tool to be utilised in a CDOI approach. Initial findings are indicative of a high degree of correlation with the validated and reliable Outcome Rating Scale (ORS).

Note

1. For the non-statistically minded, a correlation of 0.9 is usually regarded as very high in the social sciences.

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Appendix 1

Kaupapa Outcome Rating Scale (KORS)

Name _____ Age (Yrs): ____

ID# _____ Sex: M / F

Session #_____ Date:_____

Looking back over the last week, including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels.

Wairua:

(Feeling valued, strong, and content within yourself as a person. Healthy from a spiritual point of view.)

I——————————————————————————————————I

Hinengaro:

(Thinking, feeling, and acting clearly in a manner which allows you to set goals for yourself.)

I——————————————————————————————————I

Tinana:

(Looking after your physical health in a manner which will maximise your ability to move without pain or distress.)

I——————————————————————————————————-I

Whānau:

(Communicating and relating with your whānau in a manner which is confident and clear.)

I——————————————————————————————————-I

Designed by Nick Drury