Evaluation of Wesley Community Action's *Client Directed Outcome Informed* demonstration project

Final Report – October 2011

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The author would like to thank the Wesley Community Action teams and the people they work with who took part in this evaluation.

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SUMMARY

This report presents the findings of a small-scale evaluation of Wesley Community Action's first year of using the Client Directed Outcome Informed (CDOI) approach. In this approach clients use an Outcome Rating Scale (ORS), and a Session Rating Scale (SRS) to provide feedback to practitioners about their wellbeing and the service received. At Wesley, CDOI was used by seven teams providing health and social services, working with a range of clients.

The evaluation assessed:

- how well the CDOI tools had been implemented
- what factors contributed to staff successfully using the CDOI tools, and
- whether there were benefits for staff, clients, and Wesley associated with the use of the tools.

The evaluation findings are based on staff surveys, interviews with staff and clients, and the very limited amount of administrative data available. The international literature on the use of the ORS and SRS measures was also reviewed. Evaluative criteria were developed based on the CDOI research literature and Wesley's objectives in using the ORS and SRS tools. These criteria address the quality of the project over four areas: staff knowledge, skills and attitudes; management and support for staff; the use of CDOI with clients, and the outcomes experienced (see Appendix 2 on page 51 for details of the evaluative criteria). The evaluation findings should be considered within the context of Wesley being in the early stages of implementing CDOI – a process generally considered to take about three years.

Overview

Overall, the evaluation found there had been a positive impact for both staff and clients from using the CDOI approach. This impact was related to the tools systematically facilitating client-focused conversations that sometimes led to positive changes for clients. The evaluation findings and the literature on using CDOI suggest that there are opportunities for the initial gains seen from the use of CDOI to have a greater positive impact for Wesley staff and clients over time. These opportunities relate to the ongoing support of staff, establishing protocols for which clients CDOI will be used with, and understanding and working with the data generated by the tools.

The evaluation findings and the literature also suggest that CDOI can be successfully used in a variety of settings outside of the more usual psychotherapy services. However, the evaluation found that client and workplace factors indicate that the standard approach to using CDOI needs to be amended for aged care services, particularly residential aged care.

Implementation

S**taff knowledge, skills and attitude** - The training, and consequently staff confidence in using CDOI, concentrated on the immediate use of the tools with clients. An earlier focus on training staff to analyse the data from the ORS and SRS would enhance their understanding and use of the tools. Staff supported the principles of CDOI, although the ORS and SRS were not considered by all staff to be the most appropriate tools to use in pursuit of these principles with all clients. Having a protocol for transparent decision making about which clients to use the tools with is likely to promote more consistent use of CDOI.

Management and support - Staff received encouragement from their team leaders to use CDOI, and found the practice manager generally constructive and accessible. Further definition of the team leaders' and managers' roles in relation to implementing CDOI is also likely to contribute to more consistent use of the tools. As might be expected, most staff experienced a gap between what they learnt in the initial training and their own working environment. There is a need for active, regular and ongoing monitoring in the use of the ORS and SRS. For some staff, this could be done through integrating the client feedback received through the tools into clinical supervision.

Staff use of the tools - Almost all staff in the pilot were using the tools to some extent, and use increased over the course of the project. Use of the tools varied somewhat between teams; those working with elderly clients used the tools less often largely due to the cognitive impairment of some clients. The Rangatahi team (working with young adults and their whanau) was exceptional in largely choosing not to use the tools at all with their clients. In general, Wesley's clients engaged with the CDOI process in most of the situations in which Wesley staff used it.

Factors affecting use of the tools - The management directive was generally a strong driver of staff using the tools; whether staff considered that the tools were appropriate for clients was also an important factor – one that was related to staff attitudes, knowledge and skills in using the tools. There are some minor logistical issues to address to improve data collection through ASIST (program to manage data from the ORS and SRS); more critically, staff need training in analysing the collected data (over time) to inform their practice.

Outcomes

In general, staff considered that using CDOI added a small degree of satisfaction and engagement to their work. Staff and clients considered that CDOI had benefits for clients associated with having a channel to give feedback, and having considered conversations about achieving clients' goals. Staff working with elderly clients in the community saw that the tools helped some clients develop their coping skills. In residential aged care, using the ORS was thought to build better relationships between staff and residents, and the ORS was associated with identifying appropriate interventions for clients. The use of the CDOI tools and data collection and entry into ASIST has not been systematic enough to generate data that could be used to assess clients' psycho-social outcomes and reductions in service time. There were indications from the qualitative data of productivity benefits relating to more effective use of time and staff retention, and data from one team suggesting that use of the tools markedly reduced the proportion of clients who did not keep appointments. Inconsistent use of the tools across sites combined with the lack of centralised data held by Wesley meant productivity outcomes could not be further explored in the evaluation.

1 INTRODUCTION

In October 2010 Wesley Community Action (Wesley) introduced the Client-Directed and Outcome Informed (CDOI) approach to their workforce of social and health service providers. This initiative was financially supported by Health Workforce New Zealand through the Workforce Innovation Fund. In return, Wesley committed to:

- testing the effectiveness of the CDOI approach to client care at seven Wesley sites[1]
- monitoring progress of the initiative over a year (the project period) and undertaking an independent evaluation of the implementation and effectiveness of CDOI, and
- if appropriate, working with Health Workforce New Zealand to support further implementation of CDOI.

The CDOI approach to client care places the client's voice and views foremost in any service or treatment. The approach uses two tools – an Outcome Rating Scale (ORS), and a Session Rating Scale (SRS). These are brief, four-question scales intended to measure, respectively, the client's view of general well-being outcomes and the client's perception of the relationship between him or herself and the service provider. Very broadly, the CDOI approach is based on research that has shown that the key predictor of good outcomes for psychotherapy clients is the relationship between client and practitioner: the CDOI approach ensures that this relationship is measured, as is the client's view of outcomes. The overall aim of Wesley's project was to trial the CDOI approach within the health and social services they deliver.

1.1 Evaluation purpose and method

Health Workforce NZ and Wesley wanted to assess the extent to which CDOI was an effective mechanism for improved staff satisfaction and development, with the potential to increase the attractiveness of services using CDOI as a place to work. In addition Wesley was interested in clients' experiences and outcomes. The purpose of this evaluation, then, is to assess how well the CDOI tools were being implemented; what the outcomes were for staff, clients and the organisation; and whether the findings from the Wesley sites indicate the CDOI tools could be successfully implemented out of the more usual psychotherapy settings.

The evaluation used a combination of formative and summative evaluation approaches[2] in two phases:

- an initial phase, which took place in the first few months of the initiative, focused on documenting the implementation, and

[1] Health Workforce New Zealand supported Wesley to introduce CDOI to the four Wesley teams that operate with health-related funding as a demonstration project, however, Wesley introduced CDOI to all seven of their teams.

[2] Formative (or implementation) evaluations are generally conducted during the implementation stage of a project or initiative and aim to document and assess how well a programme is being delivered, and identify practices that can be improved in relation to programme delivery. Summative evaluations focus more on the overall effectiveness of the project or programme and whether there have been demonstrable effects (both intended and unintended) as a result of the project.

- a second phase, conducted about nine months later, to follow up on any implementation issues and to assess the short term outcomes of the CDOI initiative.

The evaluation methods included:

- two surveys of staff, administered at the beginning and end of the project, questioning both attitudes and use of the tools
- face to face interviews with managers, team leaders and a sample of staff at the pilot sites carried out at the beginning and end of the project, and
- face to face interviews with a sample of clients carried out at the end of the project.

It was intended that the evaluation would also draw on data generated by use of the CDOI tools with clients. However, for reasons detailed within this report, this was not possible. Details of the sources of evidence, data analysis and limitations of the method are discussed in Appendix 1.

Evaluative and merit criteria against which the implementation and outcomes of the CDOI pilot were assessed are detailed in Appendix 2. These criteria were developed with reference to the literature on the use of CDOI, the goals that Wesley have for using CDOI and feedback from initial staff interviews. The evaluation questions are listed in the table below.

Table 1: Evaluation questions

How well are the CDOI tools being implemented?	What CDOI activity is actually undertaken at the pilot sites? Are actions undertaken at the pilot sites consistent with the project plans? Are there issues arising for staff or clients during the delivery of these tools?
What factors contribute to successful (or otherwise) delivery of the CDOI tools?	Are changes necessary to improve the delivery of the CDOI tools, and if so, how could the tools and the process be improved?
What are the benefits for staff associated with the use of the CDOI tools?	Are training and clinical supervision more closely targeted to specific areas of need through staff use of CDOI? Are staff more engaged and satisfied with their work through using CDOI?
What are the benefits for clients in utilising the CDOI tools and process?	Does the rating scale used in CDOI indicate that clients psycho-social health improved as a result of using the CDOI tools? Do clients perceive/experience benefits for themselves after using the CDOI tools? What are the unintended outcomes for staff and clients that are related to the use of the CDOI tools? What benefits do staff perceive clients experience as a result of using the CDOI tools?
What are the organisational benefits?	Is there a reduction in the number of sessions that staff work alongside clients, without compromising positive outcomes? Can CDOI be used in sectors outside of psychotherapy to achieve successful outcomes?

1.2 Background to the project

1.2.1 Wesley Community Action

Wesley Community Action, the social action arm of the Methodist Church in New Zealand,[3] is a longstanding provider of social services in Wellington, delivering health and social services through seven teams, as listed below.

Table 2: The Wesley teams

Community Care Team	Provides support to older people in the community, including those with mental health issues.
Counselling Team	Provides counselling to people on low incomes. (The administration and team leader functions receive payment, all counselling time is volunteered.)
Foster Care & Family Action	Provides a supportive home environment and foster parenting for young people. Wesley's Family Action social worker provides additional support for families/whanau aiming for reintegration of the young people into a home environment.
Rangatahi & WATCH	Rangatahi workers provide services to young adults and their whanau in communities such as the Mongrel Mob and Black Power gangs with multiple health issues including those associated with drug and alcohol use, violence, and poor nutrition; WATCH staff work with 17 to 25 year olds with alcohol and drug issues who have criminally offended.
Te Whare Whakapakari (Tawa)	Provides residential care for young people are no longer able to live at home.
Wesley Porirua	Wesley's service centre in Cannons Creek delivers counselling, social work, and budgeting advice.
Wesleyhaven	Residential aged care facility providing supported care in Strand and Deckston Rest Homes and continuing care in Wesley Hospital.

1.2.2 Wesley & the CDOI approach

Wesley's approach to social action draws on a number of principles, including:

- seeking innovative solutions as well as continuing to respond to immediate need, and
- enabling people to achieve their own goals, rather than imposing goals upon them.

As indicated by these principles, Wesley take a strengths-based approach. In such an approach, people are active participants in the change process, and are motivated by the acknowledgement of their strengths. Similarly, CDOI is aimed at ensuring that the service consumer's voice is privileged, social justice is embraced, recovery is expected, and workers purposefully form strong partnerships to:

- enhance the factors across theories or medical models that account for success
- use client's ideas and preferences to guide choice of technique and model, and

[3] Wesley Community Action has been working in the greater Wellington region for over 130 years. In Wellington, Wesley employs more than 200 staff, and has over 70 regular volunteers. Wesley's work is funded through government and local body agencies, health care providers and charitable organisations.

- inform the work with clients with reliable and valid measures of the client's experience of the relationship (alliance) between worker and client and with the outcome of the work.

Using the tools

The CDOI tools (the ORS and the SRS) do not involve using particular therapeutic techniques, nor do they contain any causal theory about what brings people to services. The tools are based on research showing that the key predictor of good outcomes in psychotherapy is the alliance or relationship between the client and their worker.

Using the ORS and the SRS, this relationship between practitioner and client is measured, as is the client's view of his or her situation. In the CDOI approach, using these tools is viewed as part of the therapy process or service being provided, not an administrative task. The tools are used in every session, with every client, allowing for immediate response within the session.

A client is given the ORS at the beginning of every session with the practitioner present. The questions asked in each measure are shown below in Table 3. Negatively and positively phrased statements reflecting these questions are separated by a 10 cm line. Clients' rate their responses by making a mark somewhere on the line between each statement (there are no numbers on the line).

Table 3: The ORS & SRS questions

ORS	SRS
How have you been doing personally?	To what degree did you feel heard and understood today?
How have things been going in your relationships?	To what degree did we work on the issues that you wanted to work on today?
How have things been going for you socially?	How well did my approach, the way I worked, make sense and fit for you?
How would you rate how things in your life are going overall?	How would you rate how things were in today's session overall?

Source: Melczak & Pringle (2011)

After completing the ORS (which takes about one minute), the practitioner uses a ruler to measure the client's mark to the nearest centimetre, and totals up the items. A total score below 25 indicates that a client has a level of distress consistent with people typically found in therapy.

The scores can be used to frame content or to give the practitioner an area to focus on in the session. During sessions the practitioner and client examine the feedback data together. Practitioners decide how to best integrate the scores within a given session. The items are charted on a graph (either at the time or after the session) that indicates a client's progress, or lack of, across the course of the service provided. See Miller & Duncan (2004) for a complete description of how practitioners might proceed, depending on client feedback. Reese et al (2009) provide a summary, paraphrased below:

- **No change** (less than a gain of 5 points). For a client that has not shown reliable change (a gain of 5 points) after three sessions, practitioners are directed to address the alliance and the course of treatment or service provided. If the client has not demonstrated reliable improvement after six sessions, consultation with peers, and reviewing the service in supervision is suggested.

- **Deteriorating** (scores go down at least 5 points). Clients in this category are considered to be at-risk for ending the service prematurely or having a poor outcome. Practitioners should discuss possible reasons for the drop in score with the client, review the SRS items with the client to assess the alliance or consider changing the approach, frequency, mode, or even practitioner if no improvement is noted after three sessions.
- **Reliable change** (a gain of 5 or more points). The treatment or service is going accordingly. Practitioners are advised to reinforce changes and to continue treatment or service until progress begins to plateau, then a practitioner should consider reducing the frequency of sessions.
- **Clinically significant change** (at least a 5 point gain and crossing the ORS cut-off score of 25 during treatment). The client is probably no longer struggling with issues that led to him or her seeking services. Practitioners are advised to consolidate changes, anticipate potential setbacks, and to consider reducing the frequency of sessions.

Toward the end of every session, the SRS is administered to the client and again scored by the practitioner. If the total score is below 36 or one of the items is below 9, the practitioner intervenes and inquires about the reason for the lower scores.

Appendix 3 provides more information on the interpretation of the ratings. Further information about the CDOI approach and copies of the ORS and SRS and can be found at *heartandsoulofchange.com*.

Wesley considered that the CDOI approach had the potential to improve training and feedback provided to staff, staff engagement, satisfaction and ultimately, staff retention, and client outcomes, as described below:

- **Awareness of impact** – many staff are unaware of the impact they have in their work; they make assumptions about how the work is progressing. CDOI puts rigour into this process – weekly feedback from the client ensures that both the staff and client are able to track outcomes and successes weekly, and can adapt services if they are not effective.
- **Training** – CDOI ensures that training and clinical supervision have direct meaning for the staff and training can be closely targeted to specific areas of need.
- **Recruitment and retention** – If staff are receiving constructive feedback and clinical support to address issues as they arise, their satisfaction is likely to improve, they are likely to remain in their positions longer, and the reputation of the workplace will make it easier to recruit high quality applicants.
- **Productivity** – studies of CDOI show a reduction in client non-attendance, a decrease in the length of time clients have spent in therapy, and improved outcomes for clients (Wampold et al 1997, Elkin 1999, Anker et al 2009).

1.2.3 The pilot

Wesley provides services other than counselling; however, the core elements of CDOI – relationships between workers and clients, and clients' capacity to contribute to their desired outcomes are common factors across health services. For this reason it was considered that the approach could be applicable in a range of health and social service settings.

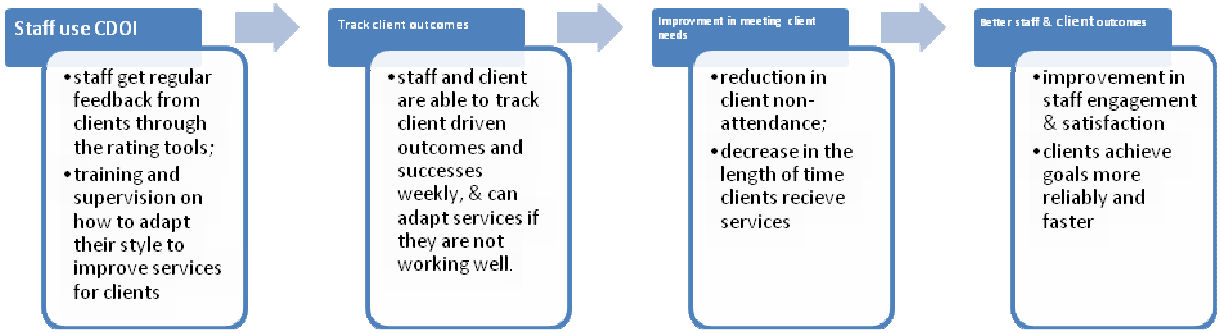
Wesley had been initially introduced to the CDOI approach in 2008 when staff attended a strengths-based conference at which Dr Barry Duncan was a keynote speaker. Following further

training with Dr Duncan in 2009, some Wesley staff trialled the tools. However, the use of the CDOI tools within Wesley was sporadic. In 2010 when Wesley applied for the Health Workforce New Zealand innovation funding, it was seen as an opportunity to comprehensively test and evaluate the CDOI approach through a year-long demonstration project (October 2010-September 2011). The specific objectives of the pilot were to:

- monitor the implementation of CDOI to determine factors that helped or hindered the achievement of successful outcomes for staff and for clients
- consider the extent to which CDOI acted as a mechanism for improving staff satisfaction and, ultimately, productivity
- gain feedback from staff on their perceptions of the benefits of CDOI – both for themselves in the workplace, and for clients, and
- determine the extent to which the effectiveness of the CDOI approach could be expanded from the mental health/psychotherapy environment to other areas of health care provision (for example, aged care).

In October 2010, Dr Barry Duncan, an international expert in CDOI, trained staff across the pilot sites to work with clients using the CDOI tools and processes. Over the pilot period, staff from these sites were to use the CDOI tools and processes in their work with clients. Ongoing support was to be provided to staff by Wesley's practice manager, an accredited CDOI trainer. Figure A below shows broadly how CDOI is intended to work.

Figure A: Model for using CDOI in Wesley's work



1.3 Overview of the literature

The growing body of literature on the use of the CDOI approach may be categorised into three broad fields. There are experimental studies exploring differences in client outcomes associated with using the SRS and ORS measures (Anker et al 2009, Miller et al 2006, Pringle et al 2011, Reese et al 2009, Sorrell 2007). There are also a number of reviews of the evidence supporting the principles behind CDOI (Blow et al 2007, Kiekar et al 2004, Miller & Duncan 2000, Saggese 2005, Sparks & Munro 2009, Tilsen & Nylund 2008). In addition, there are studies assessing the reliability and validity of the instruments used in CDOI – the ORS and SRS (Bringhurst et al 2006, Campbell & Hemsley 2009, Duncan et al 2003, Miller et al 2003, Miller et al 2006).

Outcomes

The published research shows statistically significant treatment gains for adults using the CDOI tools in psychotherapy when compared to clients receiving treatment as usual (Anker et al 2009, Miller et al 2006, Reese et al 2009). The ORS and SRS have been developed for use in

psychotherapy in a number of areas (relationship counselling, problem drug and alcohol use, obesity). The effectiveness of these measures has also been indicated in a small scale study of pharmacists using them to improve adherence to medication regimes (Pringle et al 2011). Experimental studies also show that clients using the ORS and SRS with their therapists are more likely to experience reliable change, in fewer sessions. Improvements in outcome in these studies have occurred without any other control of the treatment process (for example, alterations to therapeutic models, treatment techniques, or diagnostic procedures).

The experimental studies cited show that providing formal, ongoing feedback to therapists regarding the clients' experience of the alliance (the relationship between the practitioner and client) *and* progress in treatment resulted in significant improvements in both client retention and outcome. Reese et al's study (2009) also shows that while high alliance scores (on the SRS) were only weakly related to outcome, improving a poor alliance at the beginning of treatment was correlated with significantly better outcomes at the conclusion. In this study, clients of therapists who did not seek feedback regarding the alliance as assessed by the SRS were three times less likely to return for a second session and had significantly poorer outcomes.

The tools can identify differences in effectiveness between practitioners, through comparison of the effect size achieved by a practitioner compared to the average effect size for the agency as a whole (Miller et al 2005). The authors point out that little is known about the cause(s) of the differences between practitioners – or how to close the gap between more and less effective clinicians. However, outcomes for practitioners are hypothesised in the research literature. These outcomes include more effective training and supervision, improved satisfaction, and ultimately better staff retention and easier staff recruitment. However no studies examining these hypotheses could be located.

Similarly while productivity outcomes for organisations have been extrapolated from results for clients (related to reductions in session times, clients not attending appointments, and the number of long term clients who experience no change), there appear to be no studies as yet that quantify productivity gains for organisations.

Experience of using the tools

Some studies have noted high rates of compliance among therapists using the ORS and SRS in treatment (Miller et al 2003, Campbell & Hemsley 2009). The same studies observe the lack of client complaints and the ease with which the scales can be integrated into treatment. These findings aside, the literature contains very little reflection on practitioners' or clients' experience of using the tools. However both Noonan (2005) and Reese et al (2009) note the issue of practitioners not using the SRS at intake (the first contact) with clients. In relation to Reese et al's study, some possible reasons for this are canvassed by the authors; for example, the practitioner thought the client was too angry to be asked about the alliance or believed the session did not go well and chose not to complete the SRS. Melczak & Pringle's study (2011), based in community pharmacies, also discusses the practitioners' initial concerns with using the ORS and SRS. These include clients being able to understand the instruments, the time it would take, whether the encounter would be 'authentic,' and concern about asking clients 'personal questions.' These concerns were largely resolved during use of the instruments.

Several points of interest for organisations also emerge from observations of the implementation of CDOI (Bohanske & Franczak 2010). These suggest organisations should:

- start by piloting the tools in one site
- have a transition/oversight group made up of people from throughout the organisation
- have an organisational champion for CDOI
- use CDOI results to inform ongoing training, consultation and, critically, supervision with staff, and
- involve all aspects of service delivery (such as administration and intake forms) in the change to a client directed, outcome informed service.

Overall

Overall the published research shows that having the client's view of both progress and the therapeutic relationship (as measured through the ORS and SRS) can as much as double the effect size of treatment and also improve client retention, the efficiency of services and presumably cost-effectiveness. However, the literature on CDOI is grounded in psychotherapy with adults, and awaits an evidence base in relation to work with other groups. The research is also somewhat limited by a general (but not exclusive) reliance on client self-report measures in relation to client outcomes (Miller et al 2005).

2 FINDINGS

This section is structured around the key processes and outcomes set out in the logic model (Figure A on page 12). These are:

- staff knowledge and attitudes (Section 2.1)
- management and support staff received using the CDOI tools (Section 2.2)
- how staff were using the tools, and client engagement with the process (Section 2.3)
- the factors that affected use of the tools (Section 2.4)
- the outcomes for staff, clients and Wesley (Section 2.5).

2.1 Staff knowledge, skills and attitudes

Key points

- After the training, most staff felt confident about their ability to use the tools with most of their clients, but identified some specific areas where ongoing training would be useful.
- Staff were generally positive about using the CDOI tools, with reservations about how appropriate the tools were in some circumstances.

2.1.1 Staff knowledge and skills

To ensure that staff would have the skills and knowledge to use the CDOI tools in their work, Wesley provided two days of training in October 2010. This was followed by ongoing support to use the tools from the practice manager and team leaders, and further information from webinars and other internet resources (available to the international network of CDOI users).

Almost all Wesley staff attended the CDOI training in October 2010. This covered how to introduce the rating scales to clients, how to ensure and monitor ongoing feedback, tracking the clients' 'theory of change' and having conversations with clients in relation to this. Staff interviewed found the training useful; in particular several noted that the training had given them an understanding of making the link between the clients' feedback on the ORS and the reason they were using Wesley's service.

> *What happened in the most recent training, I heard [the trainer] clearly saying this feedback is linked to why they walked in, not how they've been feeling for the last week or today, but linking the ORS to their issues and how it relates to all areas of their life.*

A small number of staff involved in the evaluation were unavailable to attend the October 2010 training or joined Wesley after that date. These staff participated in training periodically provided by Wesley's practice manager, an accredited CDOI trainer. However in at least one case a staff member felt expected to use the tools after a colleague had outlined their purpose and application, but prior to receiving training.

> *[CDOI] was explained in general terms by [a colleague] when I started, later I went to half-day training run by the practice manager. I was using CDOI from the beginning of my work at WCA, though I didn't fully understand it prior to training. The training gave clarity. I had been ambivalent wondering if*

clients would benefit, I thought of it in terms of giving a form to clients to fill out, I wasn't thinking of it as therapeutic, I thought it may put people off. In the training, it made sense – how it could work.

Similarly, the foster parents working for Wesley were reportedly encouraged to attend the training in order to learn about the CDOI approach Wesley would be using with young people in care; however the foster parents did not immediately understand they were not intended to use these tools. These few incidents suggest the need for a comprehensive policy covering who uses the tools and when; this would contribute to consistent use of the tools in Wesley.

Soon after the training about two-thirds (70%) of staff were 'very confident they had the knowledge and skills to use CDOI in their work, and the remaining third (spread across the seven teams) considered they had 'some basic knowledge and skills but were not sure they could use CDOI without support.'

It was, of course, expected that learning to use CDOI would be an iterative process. By the end of the pilot, as staff experienced using the tools with a range of people in various circumstances, about half of the staff interviewed reported confidently using the tools with all or most clients. Others, largely but not exclusively those working with elderly clients, identified specific areas where further training with the tools would be useful. These areas are listed in Table 4 below.

Table 4: Examples of areas for further training

Broad categories	Specific situations
Working with various environmental attributes	Clients have multiple caregivers. Staff see clients in a variety of settings (eg, when driving clients somewhere, or waiting with clients at other appointments).
Working with various client attributes	Clients require ongoing care. Clients are unable to concentrate on or understand the tools due to cognitive impairment (eg, fetal alcohol syndrome, Alzheimer's).
Questions about clients' goals or their 'theory of change'	Clients have self-destructive or unrealistic goals Situations where it would be beneficial to focus on 'inner process' goals about coming to terms with a situation rather than externally focused, practical goals. There is a conflict between Wesley's reason for providing a service and clients' goals.
Other areas	Clients have multiple issues. Integrating the tools into specific therapeutic models.

In addition, as will be discussed further, interpreting clients' ORS and SRS data over time was an issue for all staff. The training provided in October 2010 was focused on introducing the tools to clients and how to respond to clients' feedback at the time clients used the ORS and SRS. Staff received training to use ASIST[4] at various times during the pilot, which was useful in relation to

[4] ASIST is software used to administer the measures, provide real time feedback regarding the client's score compared to the target score, and aggregates data to analyse provider and programme effectiveness. ASIST provides a low cost method to begin collecting and using data to inform and tailor services. For more information, see www.clientvoiceinnovations.com

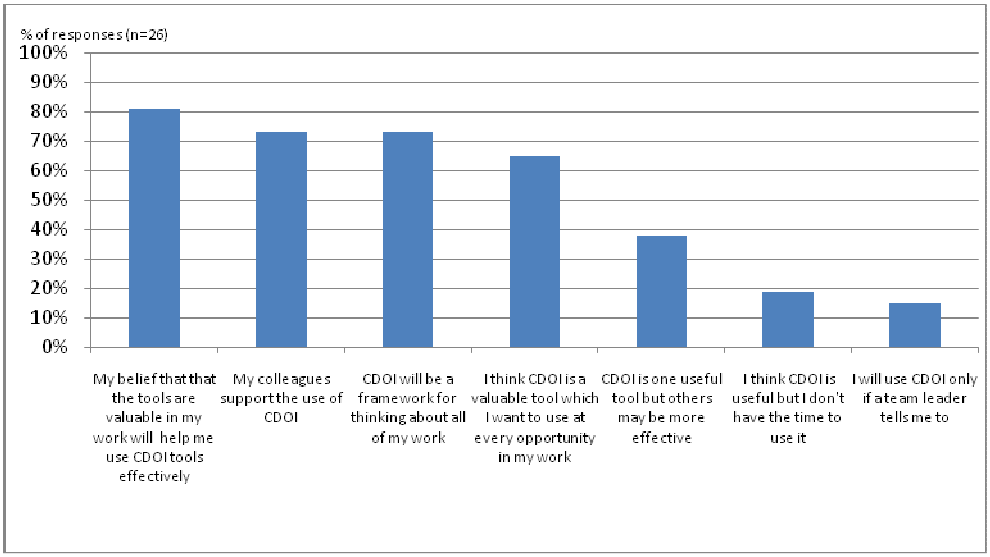
entering data, but staff did not have a comprehensive understanding of what the data collected in ASIST meant. It would be useful to have a stronger focus on data analysis during the initial training as understanding the data is integral to the value of the CDOI process.

2.1.2 Staff attitudes - expectations of the value of the CDOI tools in their work

Wesley have used a strengths-based approach to their work for some years. It was expected therefore that staff would have a positive attitude to CDOI, which would facilitate the implementation of the CDOI tools.

All staff interviewed expressed a clear understanding that Wesley was using CDOI because it had the potential to develop the organisation's commitment to client-centred work, and better quantify outcomes from their services. The survey and interview data collected at the beginning of Wesley's project suggest that the client-focused principles behind CDOI were universally supported by staff, although the ORS and SRS were not always considered the most appropriate tools to use.

Figure B: Staff attitudes towards using CDOI at the beginning of the project



Attitudes about the value of tools were generally mediated by the situations the tools would be used in. Most prominently, staff working with clients with some cognitive impairment (mainly elderly but also some young clients) appreciated that in 'essence the tools have value' but questioned how applicable the tools would be with people who could not concentrate on or remember conversations.

In the Community Care team, where it was common to have long term elderly clients, staff questioned whether it was appropriate to use the CDOI tools to identify long term clients who are achieving no change after a certain number of interventions:

> *Change can happen very slowly; it may be a year or two before a client trusts you to work with them so nothing obvious can happen for two years. For example, it has taken that long to develop a care plan with one client. This time can be spent just visiting – this timeframe is accepted by funders – it is acknowledged to be a long term service. You have to develop a relationship first before you can do anything.*

In interviews staff clearly expressed their openness to reflection on practice and to trying new tools and techniques, reflecting the nature of their work and the culture of the organisation. Several staff though considered that the CDOI tools were culturally a product of the United States and thus inappropriate for use in New Zealand where 'people are reticent to rate others.' This contributed to a feeling amongst some staff across sites that the tools had been imposed upon them and 'don't feel like our vision.' Others acknowledged the cultural overtones but focused on the value they expected from the tools.

2.1.3 Overview

The following table provides an overview of the key dimensions against which the evaluation assessed staff's knowledge, skills and attitude across the Wesley teams. (The evaluative and merit criteria are explained in Appendix 2 on page 51.)

Table 5: Summary of findings – staff knowledge, skills & attitude to the CDOI tools

Evaluative criterion	**Dimensions of merit**	*Poor*	*Adequate*	*Good*	*Very Good*	*Excellent*
Staff have the appropriate knowledge, skills and attitudes to use CDOI	***Overall rating***					
	Staff have the knowledge and skills to use CDOI in their work					
	Staff have positive expectations of the value of CDOI in their work					

2.2 Management and support

Key points:

- Staff received support from managers and colleagues in their use of the tools but managers' roles require definition
- CDOI has yet to be integrated into supervision and training.

2.2.1 Support from managers & colleagues

The literature suggests that staff require extensive and ongoing support when the CDOI approach is introduced to an organisation (Bohanske & Franczak 2010, Noonan 2005). At Wesley, it was intended that staff would have ongoing support from the Practice Manager and team leaders, from their colleagues and through using the internet resources available.

The staff surveys found that almost all staff expected their use of CDOI to be monitored, either by the practice manager or their team leader. In interviews, though, it was clear that individual use of the tools was not routinely monitored. Rather, help was available from the practice manager at regular meetings and if staff requested it.

The practice manager

Staff interviewed found the practice manager accessible and constructive. Some staff interviewed – but not all – had help from the practice manager directly related to the ORS/SRS ratings of individual clients, either because staff asked for advice or because she had observed their clients' data in ASIST. The practice manager regularly came to team meetings to discuss use of the tools and this was considered useful. Occasionally, as might be expected during the introduction of a tool that is used in various circumstances, staff considered that they had received conflicting messages about whether they must use the tools with every client, which clients' data to enter into ASIST and at what point to stop or start entering clients' data.

> *It has been confusing about not needing to do it with, for example, clients with dementia but on the other hand... the insistence on using it on everyone.*

Team leaders & managers

Staff interviewed – including team leaders – were not clear what the team leaders' or managers' roles were in terms of implementing CDOI. Across sites, their actual role was consistently described as a mixture of encouraging use by reminding staff to use the tools and enter data, making general enquires about 'how it was going?,' and dealing with logistical issues such as access to a computer. Critically, most team leaders and managers did not have access to ASIST and did not receive any summary reporting from ASIST.

> *It was not clearly defined who would oversee staff; staff do come to see me with problems such as a lack of time [to use the tools], ... managers have been hands off, as it's been a bit vague about who was supporting the staff in this.*

Staff also observed that it might be useful if the operations manager, who has charge of the day to day operations, could have a stronger role in promoting Wesley's CDOI approach. This would foster a sense that the CDOI approach was being integrated into the whole organisation.

These experiences of managerial support were common to all staff interviewed. Across Wesley there was a need for active regular and ongoing monitoring and support of staff in the use of the tools; but in those occupations where there is not a tradition of enquiry and reflection (for example, where there is no clinical supervision), opportunities to provide this monitoring and support will have to be created.

Support from colleagues & the CDOI network

Two-thirds of staff responding to the survey agreed that having support from colleagues was a factor in helping them to use the tools effectively. In interviews, though, it was apparent that discussions with colleagues at team meetings and informally were valued as supportive, but did not resolve the questions or issues staff had with the tools. Similarly, the few staff who reported using the internet resources available, described them as 'a bit helpful' but these resources did not necessarily address the specific issues staff had.

2.2.2 Supervision & training

Observations of implementation reported in the literature have found that ongoing training and supervision are critical for the successful ongoing use of CDOI (Bohanske & Franczak 2010). Where organisations are using the CDOI tools, using clients' feedback in supervision provides a way to monitor individual client welfare and progress, and enhance the practitioner's professional growth (Kelly et al 2010). Ideally, the supervisor uses the client's feedback on the ORS and SRS to discuss with the staff member the extent to which:

- progress is occurring toward the client's desired outcome
- the client perceives the relationship as positive
- service is following the identified goals of the client, and
- the client's views of change are being implemented (Duncan & Sparks 2010).

At Wesley, all staff who received clinical supervision (counsellors and social workers) said that while using CDOI may 'come up' as a topic at supervision, client feedback on their practice (derived through their use of CDOI) was not discussed in supervision. Nor, obviously, were training opportunities being identified through discussions of clients' feedback at supervision.

The evaluation found that there was not a well developed understanding of how supervision could support staff to integrate the feedback they get from clients into their practice. For example, several staff commented that their use of CDOI was not discussed in supervision because their 'SRS ratings are high.'

Over the evaluation period, Wesley's practice manager has become aware of this issue and has discussed Wesley's use of CDOI with all external clinical supervisors and asked that CDOI be at the forefront of supervision. Training in CDOI had been offered to all external supervisors, but (during the project period) none of them had taken up this offer (though some may have been independently aware of the ORS and SRS). Interviews with counselling staff indicated that few of their external supervisors were familiar with the CDOI approach, and that there was not a great deal of interest in learning more.

These findings suggest the need for Wesley to develop an understanding amongst staff and supervisors of how and why CDOI should be used in supervision.

2.2.3 Overview

The following table provides an overview of the dimensions against which the evaluation assessed the management and support staff received to use the tools. (The evaluative and merit criteria are explained in Appendix 2 on page 51.) Note that the evaluative criterion developed did not include a dimension related to monitoring, but this would be a useful addition.

Table 6: Summary of findings – effective management and support of staff using CDOI

Evaluative criterion	**Dimensions of merit**	*Poor*	*Adequate*	*Good*	*Very Good*	*Excellent*
Staff receive effective management and support	***Overall rating***					
	Staff have support from managers & colleagues to use the tools (eg, issues are addressed)					
	Staff supervision (& training) is enhanced by discussion of clients' ORS & SRS ratings					

2.3 Application of the ORS and SRS

Key points:

- Almost all staff were using the tools, but not generally in the standard manner as trained. That is, not at the first contact with a client, not necessarily with all clients, nor every time they met with a client.
- Almost all staff discussed ratings with clients at the time of administering the ORS and SRS but staff were not always clear whether ratings data should be entered into ASIST, or what the implications of the collected data (over time) were.
- Reportedly, most clients have engaged with the CDOI process in most of the situations in which Wesley staff use it.

2.3.1 Using the tools with clients

Wesley expected staff to use the ORS and SRS with their clients at every meeting, and to use the ratings data to monitor both the relationship and the outcomes experienced by their clients. It was intended that staff, alongside their clients, would reflect on the ratings at each session and engage clients as leaders in making the changes they wanted, with services and practitioner style adapted as necessary to best support this. Staff were also intended to enter the ORS and SRS ratings into ASIST to help them analyse clients' progress.

Using the tools at the first contact with clients

Duncan & Sparks (2010) suggest that, ideally, staff would use the CDOI tools from the first contact with clients in order to:

- convey commitment toward improving a client's situation
- convey commitment to the highest quality of care
- build a culture of feedback, and
- begin the partnering process.

Wesley do not have the data that would make it possible to assess the point at which all staff introduced the CDOI tools to clients; however, in interviews most staff across the sites said they did not use the ratings scales from the first meeting with individual clients.

There were several reasons for this: in sites where clients could casually drop in, there was some confusion amongst staff as to whether they should be using the tools from the first contact if people just 'turned up' without an appointment. In addition, in this situation staff were less prepared.

> *In my work I get a lot of walk-ins, and I'm not prepared for them. If I've got a set appointment I use the tools; sometimes I don't get the opportunity because the client is in crisis and they're halfway through before I'm organised.*

Generally, though, there were other factors involved in staff not using the tools at the point of first contact with a client. Despite the theory and research behind the CDOI approach, overall, almost all staff interviewed considered that using the ORS and SRS when they first met a client would not necessarily contribute to building a constructive relationship.

It's on paper – I don't want to start out with that... we have a one to one relationship, then there's this evaluative aspect introduced – it jars with them.

The clients were vulnerable when I stepped in as a stranger, they [had seen] a number of people [previously], I need to build a relationship before using CDOI.

Team leaders also did not necessarily see that the tools would be effective in engaging with people initially. One team leader told staff that they were to encourage the use of CDOI with clients, but if they knew it was a 'no go zone, then don't go there, as we are trying to build relationships. If it doesn't happen initially, it will happen later.'

Notably, where the tools were used in a group situation (in Wesley Porirua) staff were comfortable with using the tools at the first meeting. This appeared to be related to factors that might also be present in meetings with individual clients such as the clients' expectation that the facilitator will take the lead (at least initially) and ask the client to do something, and the structure that using the tools added to the sessions.

How regularly the tools were used and with whom

By July 2011, almost all staff in the project reported using the tools, but not necessarily with all clients, nor every time they saw a client. Interviews with staff and results from the July 2011 staff survey show that while the pattern of usage of CDOI by staff varied; overall, staff across the sites were using the tools with some of their clients some of the time.

The following tables show that across Wesley, there were differences between teams in the proportion of clients staff considered they could and actually did use the tools with. Across teams, about half of the staff thought they could use CDOI with all of their clients, and about a third of staff actually did this. The factors associated with staff use of the tools are discussed in Section 2.4 (page 31).

Table 7: The proportion of clients staff considered they could use CDOI with

	Proportion of clients			
Team	*<25%*	*26-50%*	*51-75%*	*76- 100%*
Community Care (n=4)		2	2	
Counselling (n=5)			1	4
Foster Care & Family Action (n=3)				3
Te Whare Whakapakari (n=1)				1
WATCH & Rangatahi (n=2)	1			1
Wesley Porirua (n=3)				3
Wesleyhaven (n=5)	4	1		
Total (n=23)	**5**	**3**	**3**	**12**

Source: Staff survey July 2011

Table 8: The proportion of clients staff actually used CDOI with

	Proportion of clients					
Wesley teams	*0%*	*<25%*	*25-50%*	*51-75%*	*76-100%*	*Notes & examples*
Community Care (n=4)			4			Staff working with the elderly used CDOI with less than half of their clients, not necessarily every time they saw these clients
Counselling (n=5)				1	4	Use varied, eg, one counsellor used it with 'just about every client give or take a session or two,' while another said the scales were used with everyone but would not necessarily be used in every session with long term clients, and one didn't use them at all.
Foster Care & Family Action (n=3)		2			1	One of the staff members (working with the biological families of children in care) used the tools with each family at least once a month, other staff used them more sporadically with young people
Te Whare Whakapakari (n=1)					1	The social worker responsible for the care plans done with each client used the tools with each young person, at almost every fortnightly meeting, other staff (for example, the youth worker) used it periodically to get feedback on particular activities.
Rangatahi /WATCH (n=2)		1			1	A staff member working with people and families in 'hard to reach' communities had used the tools once with about four clients ; another staff member (working with people with drug and alcohol issues who have criminally offended) used the ORS and SRS with every client but not every time they met
Wesley Porirua (n=3)				1	2	The tools were used with every person in two different group sessions (a men's counselling group and a budgeting support group) and for most individual counselling and social work clients.
Wesleyhaven (n=5)	1	4				Selected caregivers[5] used CDOI with clients they judged could respond to it and who initially rated the ORS under the 'clinical cut off of 25.'[6] The caregivers used the ORS once every month but used the SRS less frequently, or not at all. Wesleyhaven staff also modified the approach to delivering the tools, asking clients for a verbal rating rather than asking them to mark the forms.
Total (n=23)	**1**	**7**	**4**	**2**	**9**	

Source: Figures from the staff survey July 2011

When in the session the tools were administered

Ideally the ORS is administered at the beginning of a meeting with a client, and the SRS a few minutes from the end. In the Wesley teams, meetings with clients are not necessarily made by appointment nor do they always follow a predetermined schedule. However, almost all staff gave the ORS to clients at the beginning of a meeting (or in the case of Wesleyhaven, asked the questions). One worker did not want to start any meeting with a piece of paper, and so used

[5] Wesleyhaven managers allocated five caregivers to the CDOI, with staff selected based on their confidence, and understanding of CDOI concepts, and their full time status.

[6] In psychotherapy settings, clients who score below 25 are more typically found to benefit from therapy, whereas those scoring above 25 are more consistent with a nonclinical population and less likely to improve in psychotherapy (Reese et al 2009).

both measures together at the end of the session with a client – an approach that limits opportunities for reflecting on the client's ratings during the session.

In relation to the SRS, staff considered it logical to ask for feedback on the session at the end of the session. They had been told in training that they could 'expect the SRS score to stay high, you're just checking in every time you use it,' and this was their general experience of it. However, when clients' feedback suggested a more considered response, this was problematic at the end of a session. 'With the SRS I might be with the client for another half hour afterwards. You can't just get up and leave when they've marked it.' One approach used was to decide when to have the conversation depending on the nature of the feedback: 'Some feedback suggests a discussion would be appropriate before the client leaves, but other feedback discussion can wait until the next session.'

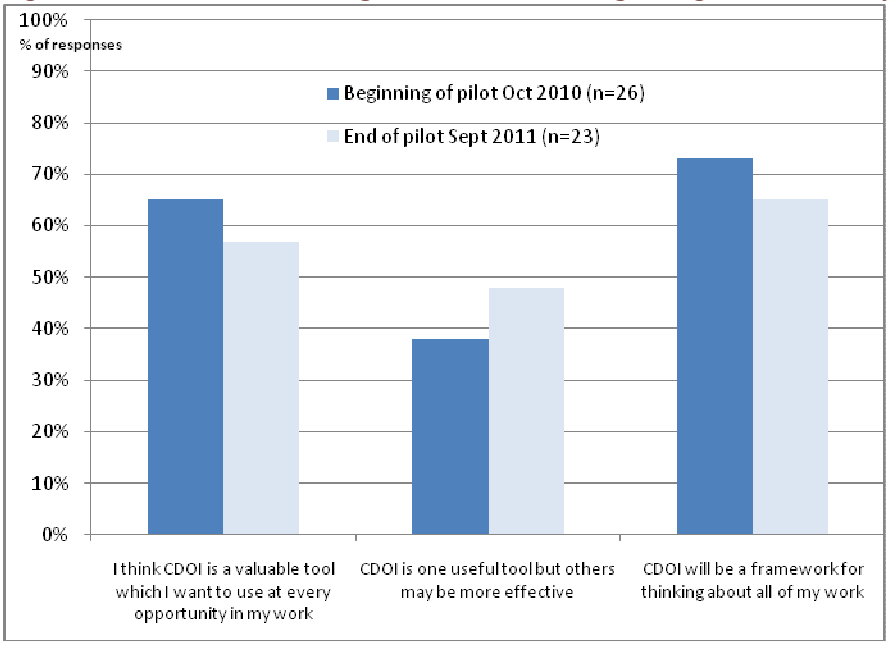
Integration with work

As the above discussion suggests, by the end of the project, feedback from the staff survey (see Figure C below) and interviews showed that the tools had yet to be fully integrated into the work of all Wesley staff. At the most extreme end of non-integration, the Rangatahi team had in effect not used the tools throughout the project. At Wesleyhaven, the only site where the tools actually introduced a new activity for staff, staff shortages could override use of the tools, suggesting they were not fully integrated into the caregivers' work. At other sites the extent to which the tools were integrated with their work depended more on staff attitudes and on experiences with individual clients.

> *At best – it prompts really good conversation, and it informs practice – give me 'ah ha' moments – then I think it's great – when it works well it's integrated with my work – but there are times when I feel it's just stuck on.*

Despite the value that staff could see in the CDOI tools, and the reported increase in use of the tools over the year, at the end of the project most staff interviewed said they would probably not use the CDOI measures as much or at all without the management directive.

Figure C: Staff views on using the tools at the beginning & end of the project



2.3.2 Using the ratings data

It is intended that staff use the ORS and SRS ratings to track the relationship with clients and the changes experienced by clients. The ratings should guide discussions with clients, with staff adapting their services and style to best support clients. In addition to using the data to monitor change for individual clients, an agency's CDOI database should enable staff to compare a specific client's rate of change to the rate of change typical for clients seeking service with the agency. The agency should be able to see the client outcomes achieved by each staff member, and how well the agency compares with others in achieving client outcomes.

Logistical issues

In interviews staff described problems with the collection and interpretation of data from the ORS and SRS. Some of these problems were logistical. The Wesleyhaven caregivers interviewed did not have access to a computer to enter the data into ASIST nor did they see any computer generated data over time, or see any feedback from ASIST. Some counselling staff have not looked at the graphs generated by the data because they volunteer their time to Wesley and tend to be at the Wesley site only for the duration of their counselling appointment (and do not have access to ASIST outside of the site). Further, one counsellor worked from a general medical practice with no access to ASIST. Some of the counsellors compiled data manually from the completed ORS and SRS forms and showed these graphs to clients instead.

Some staff were able to enter data into ASIST easily, but others have had technical problems with the software. A lack of familiarity with the program and with data entry generally contributed to the disinclination of a few staff to enter the data on a regular basis. Features of the software also deterred some staff from using it: ASIST archives data after a certain period if no new data has been entered for a client; staff cannot show the actual dates of sessions with clients as each new data entry appears under Week 1, Week 2, and so on; staff cannot add comments and consequently some feel that the data lacks important context (for example, a client having been hospitalised and unavailable for several weeks).

Entering the data into ASIST was viewed by some staff as yet another administrative task. At one site an administrative assistant entered a backlog of data into ASIST, although the team leader acknowledged it was helpful for staff to enter the data themselves so that they can see clients' patterns.

Understanding the data

More significantly, staff were not clear about whether ratings data should always be entered into ASIST, what the collected data (over time) meant for their clients, or themselves, nor the implications of the data in terms of ongoing service delivery. Part of the confusion with interpreting the data over time stemmed from staff's uncertainty about whether they were using the tools correctly or whether clients really understood the use of the scales:

> *There is that disconnect between high scores on the rating scale and the verbal reports they give. I talked to him about that but he didn't want to change the scores.*
>
> *I have clients with serious difficulties who rank themselves highly [on the ORS]. The practice manager says to use this as a talking point – and it does open conversation – but I'm not sure what the clients' patterns with data means.*
>
> *I have tried it with a new client [who can't see]. I asked him to tell me the numbers but I'm not sure that worked – I won't enter that data.*

Advice about which data to enter did not always clarify issues:

> *One is supposed to start a new set of data for each issue but this doesn't work in our setting, it's not as simple, with our clients – their memory and cognition.*
>
> *The team has been told to enter only data in ASIST for the project for new clients and existing clients below the clinical cut off. I wonder if excluding existing clients above the clinical cut off yet who still – in the opinion of [the staff member and the client] – require services might skew the data?*
>
> *I was told ... not to enter data from long term clients because it 'skews results.'*

Connecting ratings to clients' goals/reasons for service

The need to relate clients' ORS ratings to the clients' goals (and the reasons they were using Wesley's services) had been absorbed by staff in the training. Staff working with the elderly found it more difficult to see how to do this 'Clients here don't have a single issue – it's about loss of home and independence and living individually, loss of freedom around food and so on. Also there are mental health issues and dementia.' Staff also questioned how this could be done for clients who had multiple issues.

Adapting services

There was evidence from interviews with staff and clients that staff adapted their services in response to feedback from clients using the tools. Sometimes this involved quite minor adjustments to when or where services were delivered, at other times staff introduced new elements to their service. There were particularly strong examples of this from the caregivers at Wesleyhaven, who had after using the ORS with residents, arranged to record family visits in a notebook for a resident who could not remember the visits and thought his family had not been

to see him; and arranged counselling for another resident with illness related depression. These actions resulted in the residents rating the ORS more highly (ie, improved psychosocial health).

Reflection on the clients' ratings from previous sessions

Some staff interviewed said that they reflected on the clients' ratings from previous sessions with clients; others did not do this: 'it's more of a self reflection for me to think about for next time.' Clients interviewed (who used the tools in an individual rather than a group situation) also said that staff generally focused on the current session's ratings. Similarly some staff said they showed clients graphs of their ratings over time, and others did not. Neither of the clients who used the tools in individual settings had seen graphs of their ratings over time. Whether staff did these things appeared to be related to the accessibility of ASIST, and staff understanding of the implications of the data rather than any characteristics of the clients.

> *I do keep the forms and refer back to the previous one or two with clients and show them and discuss their progress. But I need to do the graphs.*

Checking progress

CDOI is built upon research suggesting that, in psychotherapy, change happens for people early or is increasingly unlikely to happen at all.[7] At two points during the course of the client-worker interaction, it is recommended that there should be serious evaluation of whether a change of service or provider is needed (Duncan & Sparks 2010). These session are typically the third ('a crucial "check point" for progress ') and the sixth ('the critical "last chance" for change'). If an agency, as Wesley generally does, works longer with clients than for example 10 sessions, the numbers may be different, but nonetheless the check point and last chance sessions should be identified and acted upon. This was a feature of the CDOI approach that no staff mentioned, but is an important element of the approach that should be referred to in supervision.

The implications of the 'clinical cut off'

Staff were aware that the clinical 'cut off' (a collective rating of 25 over the four measures on the ORS and 36 on the SRS) had significance for clients and for service delivery but were not necessarily clear what it meant in relation to any particular client. In some situations staff found the cut off point a useful concept and understood the cut off ratings as a prompt to have conversations about ending the service; others were clear that this was not always appropriate, and that clients would not necessarily stop receiving services despite reaching the clinical cut off.

> *The tools help us cut the cord – when they score 30+ I show them, they're blown away by their journey.*

> *At the moment, the ORS is being used so that when a client reaches the clinical cut off, [we have] a discussion around the continuing need ..., and look at the frequency of attending and the continuing benefits of how often the client attends.*

The sites that had the most difficulty with the 'cut off' concept were those working with the elderly, both in residential and community care.

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[7] 'A large scale study of 2000 working therapists found that if clients didn't report some change by the third session, then they would be 75% likely to report no change by the end of therapy; if clients didn't report change by the sixth meeting, then they would be 90% likely to report no change at termination' (Duncan & Sparks 2010).

> *Our clients are not necessarily going to get 'better'. If they need us in the first place they probably will need us for the long term, the need doesn't go away, however if we are obliged to provide a shorter service, better that it comes from us rather than being imposed – I don't know how CDOI fits into that.*

> *We do struggle with the question about where our service ends... we find [it] ends when people die or go into residential care.*

Clearly caregivers at Wesleyhaven cannot cease providing services if residents are rating above the clinical cut off on the ORS. Caregivers were unsure whether to continue administering the ORS in this situation.

Overall

Staff from all sites struggled to understand the logic of continuing to collect data if it was not going to be entered into ASIST.

> *I don't get the logistics of the data entry , I understand if data is above the cut off with longer term clients then I don't use it but I'm not asking for data from people then not entering it.*

Overall, the lack of engagement with the data whether through technical difficulties, disinclination or lack of understanding has been an impediment to successful implementation of CDOI at Wesley.

> *Maybe if I was more involved in the interpretation of data I would be more interested [in using CDOI].*

2.3.3 Client engagement with the process

The literature contains limited references to clients' views about using the ORS and SRS, noting that client compliance with using the ORS and SRS is high, but little else.

Staff and client interviews suggest that Wesley's clients (a range of people in terms of gender, age and ethnicity) have generally engaged with the CDOI process in most of the situations in which Wesley staff use it. Some staff reported clients 'asking for the forms from the team.' One client had started asking family members the same sorts of questions as those on the scales 'I've started using it on my granddaughter, asking her how she's doing with those things.'

Staff and clients also reported that initially hesitant clients quickly accepted the tools.

> *The tauira are wary but once I have the conversation they see it as a tool as well.*

> *One [person] didn't speak to me for an hour, I ... got him to rate his feelings verbally and then I went through the questions on the ORS, changing the wording. Now I have a starting point for our next conversation – now we know what to talk about next time. I have to reword it a bit, but eventually all clients come round to it, including one who screwed up the form at the first encounter.*

Exceptions to the general acceptance of the tools were noted by staff from several teams. For example, Community Care staff reported that 'mental health clients won't touch it, they refuse, possibly because of all the forms they have previously encountered.' This is an interesting finding

given the use of CDOI with mental health clients elsewhere.[8] Some of the counselling team also reported that clients did not want to use the tools. In some cases this was ascribed to clients' mistrust of any information gathering 'despite being told about confidentiality and the value of the exercise.' Clients' refusals were not explored in any detail by staff.

> *One client didn't want to use it – I don't really know why; they just declined to use it.*

However, their own attitudes and behaviour were thought by some staff to influence client engagement with the tools. One of the counsellors 'was dubious initially about showing the [cut off scale] to clients but one asked, and now I do.' One staff member observed that his clients distrusted putting anything on a piece of paper but also considered that his own perceptions of the tools affected clients' views. Because staff in this team had scarcely used the tools with clients it is not possible to comment on whether clients would have come to engage with the tools.

It is possible, as some staff suggested, that clients may use the tools only to 'do the worker a favour.' This element to client engagement with the tools was present to a small degree in the client interviews. Nonetheless, the clients interviewed appreciated the purpose of the tools and were happy to continue using them.

> *Scales [ORS] are used to indicate how I'm feeling, or dealing with things socially, and the other [SRS] for assessing the session with [the worker], and whether it has dealt with the things I wanted to.*

> *With the forms, it comes straight out how I feel, a spur of the moment rating is more honest than when you think through things. It's a good idea for yourself to know how you feel – you don't ask yourself those questions when you're by yourself.*

In addition, even if clients did fill out the forms as a favour to staff, this did not render the ratings meaningless.

> *Whatever people say can be measured with CDOI – and is helpful even if the client tells me they're filling out the form as a favour to me or tells me to f off. I say 'thanks, that's helping me figure out where you are at.'*

> *Residents do want to please you, but when you sit one to one and focus on things relevant to them, that's when they start to share (their real concerns).*

Most staff interviewed were using CDOI only with clients they judged could understand the purpose of the tools; although there were some staff using it with clients while feeling uncertain how much understanding the clients had. In Wesleyhaven, staff working with the elderly in rest home and hospital care had modified their approach, delivering the ORS verbally, and often omitting the SRS. Despite their efforts to ensure residents were comfortable using the tools, caregivers reported that some elderly clients had expressed anxiety 'about the [ORS and SRS], one person thought that it was 'a type of assessment meaning he would have to move'; there

[8] For an example see the webpage of Community Health and Counseling Services (www.chcs-me.org), a private non-profit organisation that provides community-based home health, hospice and mental health services to adults and children in Maine, US. The CDOI tools are also included as possible measures in the NZ Ministry of Health's (2009) draft guidance paper *Towards optimal primary mental health care in the new primary care environment*.

was also some client concern about staff sharing information with the clients' families. These incidents underscore the need for ongoing monitoring and training.

It should also be noted that the reported experiences of clients with the tools has been quite narrow – there was, for example, no information from clients who have used the tools and finished with Wesley's services.

2.3.4 Overview

Table 9 below provides an overview of the dimensions against which the evaluation assessed how well CDOI was being applied across the project sites. (The evaluative and merit criteria are explained in Appendix 2 on page 51.)

Table 9: Summary of findings – the application of CDOI with clients

Evaluative criterion	**Dimensions of merit**	*Poor*	*Adequate*	*Good*	*Very Good*	*Excellent*
Staff & clients engage with CDOI	**Overall rating**					
	Staff systematically use the ORS and SRS tools with their clients; CDOI is integrated with their work					
	Staff analyse the ORS and SRS data over time with clients to track the relationship and the levels of change clients experience;					
	Staff adapt both services and style to best support clients, informed by the rating tools					
	Clients are engaged with the process (ie staff received feedback from clients measuring the relationship and clients' view of their situation and issues)					

2.4 Factors affecting delivery of the CDOI tools to clients

This section summarises the factors that facilitated or hindered staff using the tools.

Key points:

- The management directive had a strong positive effect on staff using the tools.
- A further factor was whether staff considered the tools appropriate for their clients and their work environment. To some extent this factor was related to staff knowledge, skills and attitude.
- Staff working with elderly clients reported more barriers than other staff, related to clients' cognitive ability and, for those working in residential aged care, their work environment.

In interviews with staff, levers to using the tools were associated with whether staff considered the tools were appropriate for their clients and their work environment, as described below. To some extent these were related to staff knowledge, skills and attitude. As can be seen when comparing Figure D and Figure E below, relatively few staff considered that organisational barriers prevented effective use of the CDOI tools.

Management direction: the staff survey suggested that being directed by a team leader to take CDOI seriously was the least important factor in effective use of CDOI (see Figure D), yet interviews with staff found that being directed by Wesley management to use CDOI was a very important factor for most staff using the tools – a finding that is not uncommon for organisations in the early stages of implementing CDOI.[9] Despite the value that all staff could see in the CDOI tools, most staff interviewed said they would probably not use the CDOI measures as much or at all without the management directive. The Rangatahi team was an exception to this, having largely chosen not to use the tools despite the directive.

Whether clients could understand the tools: staff working with the elderly, found clients' inability to understand the tools was a major barrier to their use, particularly at Wesleyhaven, where staff noted that it was increasingly common for residents coming in to the rest home to have some degree of dementia.

Whether the concepts inherent in the tools were appropriate for clients: staff working with the elderly wondered how suitable the tools were for clients who would not cease to receive services when they had reached a particular rating on the ORS. These staff and others questioned how useful the ORS was for clients who had multiple issues.

How much training or experience staff had in eliciting clients' views and having 'considered conversations:' Wesley's social workers and counsellors were used to reflecting on practice, and experienced in having considered conversations with clients. The caregivers at Wesleyhaven did not have this training and some were uncomfortable asking probing questions.

[9] Barry Duncan (email to CDOI network 21/6/11): 'Very few therapists will think that routine monitoring of outcome and the alliance is a good idea right from the beginning. Only one quarter to one third of therapists will implement on their own.'

No one's refused but when you hear them say 'it's all fine' you feel that they want the discussion to be over.... The rating is always the same and you don't like to poke and jab people for information.

Whether there was uninterrupted time with clients: At Wesleyhaven, staff found there were so many interruptions when sitting talking with residents that they were unable to give the process their full attention. When managers arranged for an additional half hour of paid time (outside of regular shifts) caregivers found it easier to use the tools (although half an hour was not thought by staff to be enough additional time). Outside of Wesleyhaven, Wesley's staff saw their clients in a variety of settings: the client's home, driving to other appointments, waiting at court, or in cafes. Staff from these services pointed out that they were using CDOI in environments different to that of a client coming to see a therapist in an office, and that this did not always facilitate using the CDOI tools.

There are all the other things going on – we're in the client's home, not in a counselling room – it's their space and we can't control it – sometime you are literally crouching down because they hoard and there is no space to sit down, or we're in the car or a cafe or on the way to an appointment and the client is thinking about the appointment.

Having sufficient time to use the tools – Staff and clients interviewed agreed that actually filling out the ORS and SRS took minutes. Entering the data into ASIST also took only a few minutes. However by the end of the project, over half of staff responding to the survey still considered that having time to use the tools was a factor in whether they were used effectively. Interview data suggests that 'having sufficient time' was related to the degree to which staff felt the tools were integrated into their work, and affected by various circumstances. For example, time spent explaining the tools to clients with cognitive impairment when the purpose had to be explained repeatedly at every session; and extra time required at the end of a meeting to discuss SRS ratings.

Figure D: Factors that staff agreed enabled them to use the CDOI tools effectively

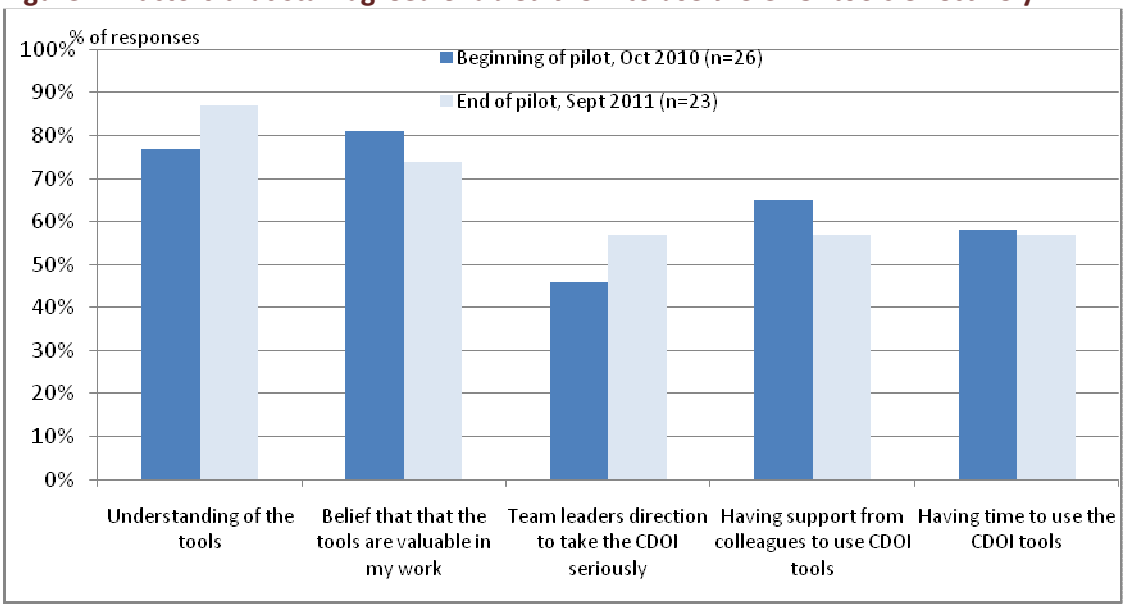
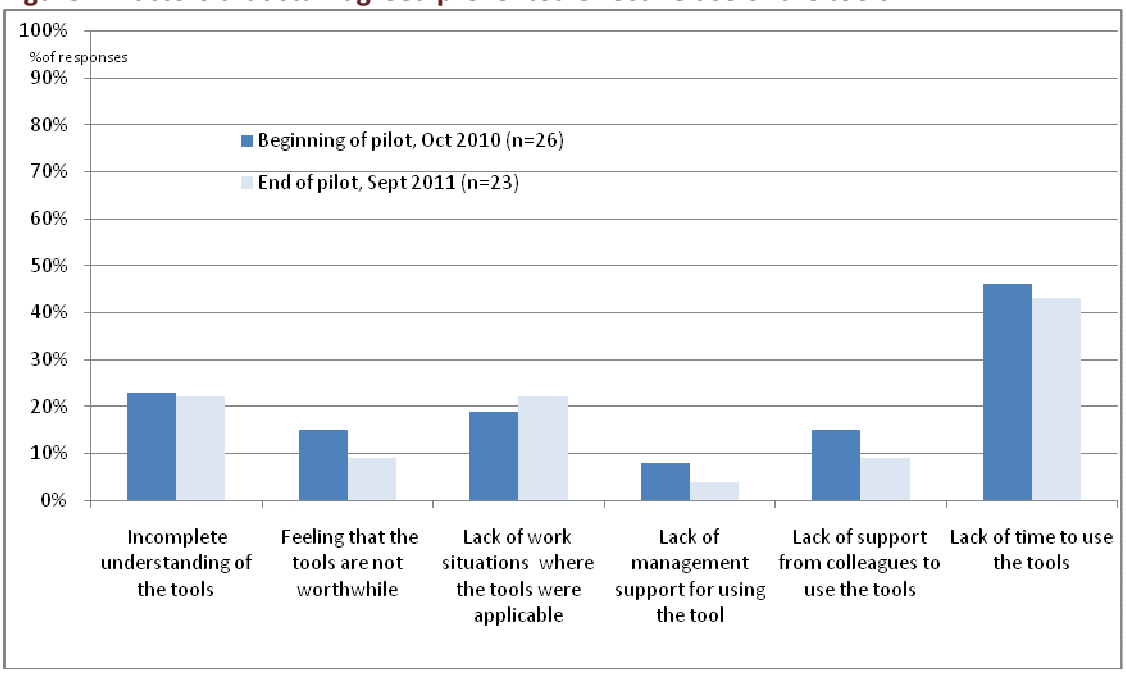


Figure E: Factors that staff agreed prevented effective use of the tools



2.5 Outcomes

This section of the report looks at the outcomes for Wesley, their staff and for clients from using CDOI.

Key points:

- Overall, staff and clients considered that CDOI added some value for both parties associated with the focus on 'considered conversations,' and maintaining the connection between clients' goals and Wesley's service.
- Productivity gains for Wesley are emerging.
- The approach to CDOI with elderly clients, particularly those in residential aged care, should be amended.

2.5.1 Staff satisfaction

Overall, most staff considered that using CDOI added a small degree of satisfaction and engagement to their work. In interviews staff described this satisfaction as deriving from the focus CDOI maintained on clients and client outcomes, and the useful conversations the tools facilitated that resulted in positive change for clients.

In the end of project survey, 74% of respondents agreed that CDOI enhanced their practice. Examples of this described in interviews centred on using all of the time available on clients' concerns, getting to issues that had previously been missed, and accountability.

> *[The tools] hold us really accountable, when there is a change in the ratings, it holds us accountable for following things up – which is important – to do what you say you will.*

Through increased staff engagement, one team leader could see that CDOI could have a positive effect on staff retention.

> *There are potential professional benefits for staff – for example, [a staff member] who was going to leave has now said there's more to be learnt.*

Because Wesley have long used a strengths-based philosophy in their work; some staff felt CDOI did not add a lot to their practice in relation to their ability 'to have conversations about my fit as a provider, or about ending the service.'

> *In a different work environment CDOI might add a lot to my sense of satisfaction, but client focus, and a strengths-based approach has always been the Wesley way.*

At Wesleyhaven (where the working environment is rather different to that of Wesley's other teams) managers expected that through using CDOI staff would be more engaged with the residents and their wellbeing, and would be able to see the difference their work made; staff's view of work as a 'production line' of tasks would alter and they would develop greater pride in their work. The staff survey and interviews show that this has largely happened.

> *It has added to my satisfaction with work in a way, made me more aware of residents' individual needs – just by talking and sharing you can find out [things] that are beneficial for residents. It does make a difference – people open up and give us a better understanding.*

Overall, the literature suggests that there are opportunities for the initial gains seen from the use of CDOI to have more impact on staff satisfaction and engagement at Wesley over time. The evaluation findings indicate that this could be achieved through more consistent data collection, training in analysis of the data, and having CDOI integrated into supervision, with staff training directed to areas identified through client feedback.

2.5.2 The value for clients

Originally the evaluation was intended to examine whether the ORS and SRS ratings showed improvement in clients' psycho-social health. As quantitative data collection and data entry during the pilot period has not been systematic, this could not be explored. However, the qualitative data collected for the evaluation indicates that overall most staff and all clients interviewed considered that CDOI did add value for clients.

Client perspectives

The four clients that were interviewed (clients of the Community Care and Wesley Porirua teams) considered that there were benefits from using the ORS and SRS, associated with being provided with a channel to give feedback, being asked to have considered conversations, and to think about how well personal goals were being incorporated into everyday living.

> *I haven't really directed my mind to [any benefits]. I'm sure [the worker] takes [the forms] into account; can't say there's been an impact; although at the last session, on the SRS I indicated I would like longer with [the worker] and he agreed next session would be longer – perhaps prior to using the scales, I would have been reluctant to give that feedback.... Sometimes I'd rather not admit how I'm really doing in certain areas, the forms do force you to confront such issues.*

> *The ORS is good – gives you a clearer understanding of where others come from, it's useful, gives a clearer picture of myself and relationships with family and others, and social life – how well I incorporate my goals into everyday living.*

Staff perspectives

By the end of the project 91% of staff surveyed thought that using the CDOI tools had benefits for clients. As with the clients' views, staff considered these benefits centred on making 'considered conversations' a regular feature of their work, and maintaining the connection between clients' goals and Wesley's service.

> *Having the connection between goals and [the service] – it is helpful for clients – to teach them to think that way; having the conversation [using CDOI tools] makes clients more open to having such a conversation anytime.*

The graphed data was also generally seen to be valued by clients as it demonstrated their progress.

> *It is useful for clients to see movement; it empowers long term clients in particular, when they see a plateau, it's part of moving them along, getting them to try a further challenge.*

Staff from both sites that work with the elderly considered that CDOI appeared to have 'a very individual impact' depending on the cognitive ability of the client, and to a lesser extent the 'mental space' they were in. Client benefits were considered to be the acquisition of coping skills, and new ways of thinking about their situation.

> *Using CDOI does get older people to concede that forward movement is possible.*
>
> *CDOI does add value to [client-centred work] – where the client is really open to using the tool and has an understanding of what the tool is for – those with a reflective aspect to the personality, and generally being more open to trying new things even if they don't fully understand.*

At Wesleyhaven, managers and staff observed that using the ORS did help to build better relationships between staff and residents: 'When I sit one to one and we focus on things relevant to them, that's when they start to share; it wouldn't happen without the sit down.' Staff had been able to improve daily life for clients by acting on client feedback – adjusting a bed rail, instigating extra exercises – 'which we wouldn't have found out without CDOI.' In this sense, the ORS was associated with identifying appropriate interventions for clients.

> *I find it has been an amazing tool in getting to the heart of a matter when a resident is having a down day...discussing their issues at handover or with my manager and keeping records in their progress notes, it has been very beneficial in helping to enhance the daily life of some of our residents.*

During the project the ORS became an addition to the client goal planning that took place previously at Wesleyhaven but that 'was pretty ad hoc before.' Using the ORS systemised a process that could otherwise become irregular or lost in the busy work day of caregivers.

2.5.3 Impact on productivity

The published research into the use of the ORS and the SRS has shown benefits for organisations in relation to a reduction in non-attendance, cancellations and drop outs, reduced length of service time per client (with improvements in client outcomes), a reduction in the number of very long term clients who experience no change, and a reduction in staff time spent on administrative work (Anker et al 2009, Bohanske & Franczak 2010, Miller et al 2006).

At the time of preparing the evaluation report, Wesley had yet to compile a complete set of data from individual staff files to enable a comparison of drop out/ non-attendance /cancellation rates before and after the introduction of CDOI at all sites. Similarly, client contact data (number of sessions per client) from individual staff members was unavailable for the evaluation. However, there is data from one site where CDOI is being used with all clients (not necessarily at every encounter). Table 10 below shows that the number of non-attending clients in a six month period has declined from over half of all clients to 15%. In addition the number failing to attend early on in the service has also declined markedly.

Table 10: Non-attendance of appointments with WATCH team

Number of days since service initiated	Clients not attending	
	Jan-June 2010 (pre CDOI)	*Jan-June 2011 (using CDOI)*
7	8	1
14	2	1
21	2	-
30	-	2
60	1	-
90	1	1
Total number of clients not attending	**14**	**5**
Total number of clients	***24***	***34***
'No shows' as a proportion of total clients	***58%***	***15%***

Overall, Wesley staff interviewed were unsure whether their use of the tools was contributing to a reduction in drop outs/no shows or cancellations, a decrease in the length of service provided, a reduction in paper work, or a decrease in the number of long term clients they had where there was no change/progress. One team leader noted that:

> *We have vastly increased client turnover, people who sat on our books for years are now off our list and having informal support. CDOI is a tool in that but the trend is linked to our understanding of economic pressures on our service.*

However, staff did refer to CDOI providing a stronger focus to work with clients, and hence more productive use of time.

> *It has led to better use of the time. Before we use to talk about everything under the sun, now straight away we are onto the client, their issues, and we get to issues I'd missed, the conversation we have brings it out, all the issues for clients.*

Reduction in paperwork

In their (2010) guide to using CDOI, Duncan & Sparks state 'partnering with clients to monitor the alliance and outcome on just two brief forms is the only paperwork required... no more diagnostic work ups, treatment plans, intake forms, or any other form or practice that doesn't have any relevance to outcome.' However Wesley staff (who have not been instructed by managers to the contrary) continue to use care plans, write notes after sessions, and in some cases continued to use client satisfaction forms. In interviews, staff stated that using CDOI had not replaced any aspect of administrative work or client notes.

Project costs

Originally the evaluation was intended to assess whether the project was cost effective for Wesley by looking at any productivity gains in relation to the costs of implementing CDOI. Given the early stage of implementation, and the data available, it is not possible to make this assessment. However, some of the costs of implementing CDOI are identified in Table 11.

Table 11: Project costs[10]

Item	Cost	Notes
Initial training	$9,500	Costs of the two-day training in 2010 include the trainer's fees, flights, accommodation and food, and the catering and room hire for the training.
CDOI tools (ASIST software)	$3,500	There are no fees for using the ORS and SRS which are freely available. Note that it is possible to simply use Excel to manage the data.
Staff time	$29,900	The cost of staff time has been calculated on the basis of 20 staff (excluding the volunteer counsellors). Across the Wesley sites managers estimate that staff spent 5% of their time on implementing the CDOI tools over the nine month project period. Wesleyhaven was the only site where the tools involved staff in doing something they had not done previously. The caregivers involved were paid for an extra half hour each per month to help them manage using the measures with five residents (using the tools once each month with each of the five residents). Note that caregivers estimated that each session with a resident could actually take up to three-quarters of an hour.
Management time	$30,437	Wesley's practice manager (0.8 FTE) spent approximately 20% of her time on the implementation, including directly supporting staff (for example, carrying out additional half-day training sessions for new staff, answering staff queries, and attending team meetings). Team leaders also had a role supporting staff, dealing with queries, and liaising with the Practice Manager. It was estimated that the seven team leaders spent approximately 5% of their time on implementing CDOI.
Administration/overheads	$7,000	The administrative overheads include the overall Project Management time, and the Wesley Business Manager undertaking ASIST training.
Total cost	**$80,337**	

[10] Note that this cost is exclusive of the evaluation.

2.5.4 Overview

The table below provides an overview of the key dimensions against which the evaluation assessed the outcomes for staff, clients and the organisation. (The evaluative and merit criteria are explained in Appendix 2 on page 51.)

Table 12: Summary of outcomes (nine months after the training)

Evaluative criterion	**Dimensions of merit**	*Poor*	*Adequate*	*Good*	*Very Good*	*Excellent*
CDOI has positive outcomes for staff, clients & Wesley	Overall rating					
	Staff are more satisfied and engaged with their work due to using CDOI					
	Using CDOI adds value for clients, eg, keeps focus on clients, privileges client voice, clients' goals achieved more rapidly					
	Increase in productivity, eg, decrease in no-shows and cancellations; less time delivering services with enhanced client outcomes					

3 OPPORTUNITES TO IMPROVE THE EFFECTIVNESS OF DELIVERY

This section summarises some of the lessons from the first nine months of Wesley's implementation of CDOI.

Although there is little detail in the research literature describing the implementation of CDOI using the ORS and SRS in agencies, Wesley's adoption of CDOI appears to be comparable to the experiences of other organisations. Bohanske & Franczak (2010), for example, reflecting on several cases in the United States, report that no agency has taken less than three years to fully implement CDOI.[11] At Wesley, almost all staff interviewed reported an increasing use of CDOI tools, and have already implemented practices to resolve minor problems, such as carrying a supply of the ORS and SRS forms in the car. There are other issues though that require more systematic change to improve the delivery of the tools:

Develop a protocol for transparent decision making about which clients the tools are used with. Staff clearly consider that CDOI cannot be used with people who do not understand what they are being asked to participate in, and attempted interviews for the evaluation with residents at Wesleyhaven support this view. There needs to be a protocol for transparent decision making about which clients the tools are used with. Having such a protocol is also likely to improve the consistency of staff use of the tools and data collection.

Train staff in the analysis of data in ASIST. In training and ongoing guidance with the tools, there should be a focus on both using the tools with clients and analysing the data, as understanding the data is integral to the value of the process.

Actively monitor the use of the tools. To maximise the benefits from the CDOI approach, client feedback delivered through the ORS and SRS must be actively monitored. This can be done through integrating it into the clinical supervision of social workers and counsellors; where staff do not have supervision, a system of active regular support needs to be provided. Establishing a system of monitoring and support will also help to clarify the responsibilities of team leaders and managers in relation to CDOI.

Amend the CDOI approach at Wesleyhaven. The CDOI experience at Wesleyhaven has, overall, been valued by staff and reportedly by residents; however, administration of the tools was sporadic, and caregivers were required to collect data that they could not easily access and about which they received no feedback to inform their work. Given the work environment in residential aged care, it is difficult to see how the staff could be making fuller use of the CDOI tools. Staff and managers feel that change is necessary and have made several suggestions, all of

[11] See also the short video of Community Counselling Services Director Bob Moneysmith and Crawford-Marion Alcohol, Drug Addiction & Mental Health Board Associate Director Shirley Galdys (Ohio, US) discussing the implementation of CDOI at www.scottmiller.com

which reflect both that they do value client feedback and their desire to have some parameters put round the use of the tools:

- incorporate the ORS into the care plan – use the ORS every six months with residents, their families and the registered nurses; discuss the feedback with residents and update residents' care plans
- use the ORS with every new resident i.e. to assist the transition to residential care
- have one caregiver use the ORS with residents, and
- define more clearly which residents to use the measures with.

In addition, staff working with elderly clients were interested in adapted or additional tools that used the principles of CDOI, particularly that of immediate feedback, for people with dementia.

Rangatahi team in or out of Wesley's CDOI approach? The Rangatahi team have chosen not to use the tools. No evidence was available for this evaluation to suggest that the tools would or would not work if they were actually used by staff. This is an issue for Wesley's management team.

4 CONCLUDING COMMENTS

This section brings together the main themes from the literature and the evaluation findings on the implementation and impact of the CDOI tools at Wesley.

Drawing on Wesley's logic model for introducing CDOI and the application of the evaluative criteria, the evaluation has assessed the implementation and outcomes of CDOI at Wesley – at what is a comparatively early stage – between 'adequate and good.' That is, a fair performance with some areas that need to be addressed, as shown in Table 13 below.

The CDOI training focused on the practical implementation of the tools with clients, and provided the theory and research behind the approach. Staff, in general, found the training useful and had positive expectations of the value of CDOI. Most staff were confident in their knowledge and skills to use CDOI and all staff could see value in the tools (even those who did not use them). The experiences of staff using the tools though, strongly suggests, that the training should include more information about analysis of the data collected. It would also be useful for Wesley to have a systematic approach to new staff being trained prior to using the ORS and SRS with clients.

The literature shows that staff require ongoing support when the CDOI tools are introduced to an organisation. This is also true for the Wesley sites, where staff have, as might be expected, found gaps between the theory of using the ORS and SRS and their own working environment. In general, most staff concentrated on the conversations the tools facilitated during the sessions with clients, and gave less attention to the implications of clients' data over time. Logistical issues with data entry and retrieval somewhat inhibited staff from using the data, but more critically, Wesley need to develop staff understanding of why and how the data can be analysed.

Staff had the support of their team leaders to use CDOI, and found Wesley's practice manager accessible and constructive, but team leaders' and managers' roles in terms of supporting CDOI need to be clarified. There is a need for active regular monitoring of use of the tools, and for ongoing training as issues emerge. Using the data from the ORS and SRS in supervision is a critical aspect of CDOI and a key area for attention in Wesley's ongoing implementation.

Managerial direction might be described as a necessary but not sufficient factor to drive staff use of CDOI. Staff, in general, used the tools according to their judgement with variability between sites depending on the extent to which they considered the tools were appropriate in particular circumstances. Wesley's clients reportedly engaged with the CDOI process in most of the situations in which Wesley staff used it. There was very little information available for the evaluation about the circumstances in which some clients did not engage with the tools. It appeared likely, though, that some of the barriers to staff using the tools could be addressed through training.

The evaluation looked at what difference (if any) using CDOI has made for staff, clients and for Wesley as an organisation. The evaluation found there had overall been a positive impact for both staff and clients related to the tools systemically facilitating client-focused conversations

that sometimes led to positive changes for clients. As CDOI has not yet been integrated into supervision and training, it has not, to date, had an impact on staff development.

The use of the CDOI tools and data collection and entry into ASIST has not been systematic enough to generate data that could be used to assess clients' psycho-social outcomes and reductions in service time. However, the few clients interviewed, CDOI had a positive impact related to the systematic focus on clients' goals and providing a regular channel for client feedback.

Only one of the expected productivity outcomes (relating to reductions in clients not attending appointments) was visible for one team from the quantitative data. However indications from the qualitative data show benefits relating to staff satisfaction, more effective use of time and staff retention. The tools have not yet led to changes in Wesley's assessment and review practices in relation to their clients, or in reporting or applying to funders – thus the impact of CDOI has yet to be felt at an organisational level.

It must be reiterated that Wesley are in their first year of implementation, and that the implementation of CDOI might be expected to take several years. Wesley's experiences in this first year provide some lessons in relation to the ongoing support required, establishing protocols for which clients CDOI will be used with, and understanding and working with the data generated by the tools.

Table 13: Summary of the findings overall

	Poor	*Adequate*	*Good*	*Very Good*	*Excellent*
Overall rating					
Staff knowledge, skills & attitude					
Management and support					
Application of CDOI					
Outcomes for staff, clients & organisation					

Could CDOI be rolled out on a wider basis to achieve successful outcomes?

One of the objectives of the evaluation was to determine the extent to which the effectiveness of the CDOI approach could be expanded from the mental health/psychotherapy environment to other areas of health care and social services. At this early stage, staff and client attitudes are broadly positive in all sites where CDOI is being used; there are also indicators that (with attention to some implementation issues) using CDOI will deliver the outcomes for staff and clients, and for productivity, that Wesley are seeking. There is also a growing body of research describing the successful use of CDOI in a range of situations, including weight reduction, problematic alcohol and drug use, and improving adherence to prescription medicine regimes. Together, this evidence suggests that CDOI could be rolled out into other social service contexts, such as work with young offenders.

In relation to aged care, a sector not covered in the literature, Wesley staff also consider there are some benefits, both for themselves and clients. However, they have identified a number of issues: staff have had great difficulty using the tools with cognitively impaired clients; they have also questioned how to work with some of the concepts embedded in the CDOI approach such as services ending. In addition, at Wesley's residential aged care facility, factors relating to the workplace environment meant caregivers have struggled to use CDOI in the standard manner, as trained. These factors include pressures on staff time, dealing with a number of people more or less simultaneously, and a workforce untrained in having the 'considered conversations' that are the stock in trade of counsellors and social workers. The evaluation findings support the view of staff and managers that Wesley needs to amend the standard approach to CDOI when working with elderly clients, particularly those in residential aged care.

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APPENDIX 1 SOURCES OF EVIDENCE, DATA ANALYSIS & LIMITATIONS

Sources of evidence

The literature

An overview of the literature was carried out to inform the evaluation reporting. This involved a search of PubMed, ProQuest and Google scholar using keywords related to CDOI, the ORS and SRS. The search was limited to English language publications, over the past decade. No study design criteria were used in the selection for inclusion.

Staff surveys

After the training in October 2010 and towards the end of the project in July/August 2011 brief surveys of staff were carried out to gauge staff attitudes towards using the tools and to gauge the extent to which staff were using the tools. The number of responses received is shown below.

Table 14: Number of survey responses

	Approximate number of staff	Number of survey responses	
		Nov 2010	July 2011
Counselling Services	9	6	5
Newtown Community Service Centre	7	5	4
Porirua Community Service Centre	3	3	3
Wesley Foster Care & Family Action	4	4	3
Wesley Tawa – Te Whare Whakapakari	3	3	1
Wesleyhaven Village	5	5	5
Rangatahi /WATCH	4	0	2
Total	**33**	**26**	**23**

Interviews

Participants were selected to cover all of the Wesley teams involved in the demonstration project and to hear from those who were the most and least enthusiastic users of CDOI within those teams. Staff were asked to contact clients they thought would be willing to be interviewed – all proposed clients were interviewed. Interviews could not be completed with the two suggested clients at Wesleyhaven as the clients were not able to discuss the ORS and SRS measures. Participants were interviewed using topic guides based on the research questions. If in the course of interviews, further topics arose, these were explored in subsequent interviews. Table 15 details the interviews contributing to the evaluation. In addition to these interviews and meetings, several meetings were held with the practice manager. Note that it was agreed with participants that they would not be identified by name or position in the report, so no attributed quotes are used; similarly particular teams are identified only if it was salient to do so .

Table 15: Interviews held

	Staff interviews Nov 2010	Attendance at team meetings during the project period	Staff interviews July 2011	Client interviews July 2011
Counselling Services	1	1	2	
Newtown Community Service Centre	1	1	3	2
Porirua Community Service Centre	2		2	2
Wesley Foster Care & Family Action	1		2	
Wesley Tawa – Te Whare Whakapakari	1		2	
Wesleyhaven Village	1	1	2	[2 incomplete]
Rangatahi /WATCH	1		2	
Total	**8**	**3**	**15**	**4**

Data analysis

Staff surveys were analysed with simple descriptive statistical methods. The interview data was coded using NVivo qualitative analysis software. Analysis was carried out using an approach designed for policy relevant qualitative research in which the objectives of the research are established before the research is carried out and are shaped by the information requirements of the funder (Bryman & Burgess 1993). Although this approach reflects the original accounts and observations of the people studied (that is, they are grounded in the data and inductive), analysis starts deductively with the aims of the research. Codes were generated from both the data and the research questions and under these all of the data were accounted for. The coded data was then applied to matrices derived from the evaluative criteria and the research questions in order to compare findings between and within groups.

Limitations of the evaluation

The review was a small-scale project which ultimately relied heavily on data from staff interviews. Data from ASIST could not be analysed because of the inconsistent use of the tools and sporadic data entry. Wesley had very limited data available which might have, for example, enabled comparisons to be made of client contact time before and after the use of the CDOI tools.

APPENDIX 2 EVALUATIVE AND MERIT CRITERIA

This section sets out the way evaluative judgements were made. The table below shows the key dimensions of merit or performance.

Table 16: Evaluative & merit criteria

Evaluative criteria	Dimensions of merit
Staff have the appropriate knowledge, skills and attitudes to use CDOI	Staff have the knowledge and skills to use CDOI in their work
	Staff have high expectations of the value of CDOI in their work
Staff receive effective management and support	Staff have support from managers & colleagues to use the tools (eg, issues are addressed)
	Staff supervision (& training) is enhanced by discussion of clients' ORS & SRS ratings
Staff & clients engage with CDOI	Staff systematically use the ORS and SRS tools with their clients; CDOI is integrated with their work
	Staff analyse the ORS and SRS data over time with clients to track the relationship and the levels of change clients experience; staff adapt both services and style to best support clients, informed by the rating tools
	Clients are engaged with the process (ie staff received feedback from clients measuring the relationship and clients' view of their situation and issues)
CDOI has positive outcomes for staff, clients & Wesley	Staff are more satisfied and engaged with their work due to using CDOI
	Using CDOI adds value for clients – eg, keeps focus on clients, privileges client voice, clients' goals are achieved
	Increase in productivity, eg, decrease in no-shows, cancellations and drop outs; less time spent delivering services with enhanced client outcomes

To arrive at a single rating of performance, a synthesis methodology was used to allow overall evaluative conclusions to be drawn from multiple findings (Davidson 2005). This was done by converting each data source (both quantitative and qualitative) into ratings from *excellent* to *poor*. Where the dimensions of merit involved more than one contributing factor, the ratings were averaged over all factors. The following table (adapted from Davidson 2005) shows the process used to make those conversions. All interview and survey questions that related to the respective merit dimensions were synthesised to give a composite rating for that dimension. These composite ratings appear in the findings in the report. The discussion in the findings shows the reasoning for these ratings.

Table 17: Synthesis of the qualitative and quantitative data

Rating	Quantitative data	Qualitative data	Overall
Excellent	90% or more (of staff and/or clients) do this or agree with this	Evidence of a strong positive impact: Very positive comments, with a substantial number that indicate a very strong impact	Clear example of model performance in this domain, with no weaknesses
Very good	80% – 89% (of staff and/or clients) do this or agree with this	Evidence of a noticeable positive impact: a good number of positive comments (few neutral or negative) clearly showing a noticeable positive effect	Strong overall on virtually all aspects; any weaknesses are not of major consequence
Good	60% – 79% (of staff and/or clients) do this or agree with this	Evidence of some positive impact: a mix of positive and negative comments, skewed toward the positive	Reasonably good overall; a few weaknesses to be addressed but nothing critical
Adequate	51% – 59% (of staff and/or clients) do this or agree with this	Little or no impact either way: a mix of comments with no clear trend either positively or negatively	Fair performance; with some serious weaknesses that need addressing
Poor	Less than 50% (of staff and/or clients) do this or agree with this	Evidence of some negative impact: a mix of positive and negative comments, skewed toward the negative	Clear evidence of unsatisfactory functioning; critical weaknesses in crucial areas

APPENDIX 3 INTERPRETATION OF THE ORS & SRS

The following description of how practitioners can interpret the information provided by clients on the ORS and SRS is adapted from Miller et al (2005).

Practitioners of CDOI can graph and discuss the measures with an individual client at each session. The general pattern of relationship formation and change in treatment established by existing outcome research can then be used as a guide to interpretation of the results (Duncan, Miller & Sparks, 2004). For example, a score of 36 or below on the SRS warns of a potential problem in the alliance, as it falls below the 25th percentile. Because research indicates that clients frequently drop out of treatment *before* discussing problems in the relationship, a practitioner would then use the information from the SRS to open discussion and work to restore the relationship. Similarly, this approach is used for the ORS. Given research showing that the majority of change in treatment occurs earlier rather than later, lack of improvement in the first few visits warns the practitioner to talk to the client about the service.

If practitioners prefer, this analysis can be done using an automated Windows-based system that provides 'real-time' warnings to practitioners when an individual client's ratings of either the relationship or the outcome fall significantly outside established norms. The figure below gives an example of the feedback that practitioners receive when a particular client's outcomes fell outside the expected parameters:

- The dotted line represents the expected trajectory of change for clients whose total score at intake on the ORS is 10. Consistent with previous research and methodology, trajectories of change in this system are derived via linear regression and provide a visual representation of the relationship between ORS scores at intake and those of subsequent administrations.
- Bands corresponding to the 25th and 10th percentiles mark the distribution of actual scores *below* the expected trajectory over time.
- The horizontal dashed-dotted line at 25 represents the clinical cut off score for the ORS. Scores falling above the line are characteristic of individuals who are not seeking treatment, and scores below are similar to those of people who are in treatment and likely to improve.
- The remaining solid line designates the client's actual score from session to session.

As seen in the figure below, this particular client's score at the second session falls below the 25th percentile. By session 3 the score has fallen even further, landing in the black area representing the 10th percentile in the distribution of actual scores. As a result, the practitioner receives a *red* signal, warning of the potential for premature dropout and an increased risk for a negative or null outcome should the service continue unchanged. An option button provides suggestions for addressing the problem: (1) talking with the client about problems in the alliance, (2) changing the type and amount of treatment being offered, and (3) recommending consultation or supervision. Client feedback regarding the alliance is presented in a similar fashion at the end of each visit.

Figure F: Example of an outcome feedback screen in ASIST