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'WHAT SEEMS TO BE THE ~~PROBLEM~~ SOLUTION?'

EVALUATING A SOLUTION-FOCUSED APPROACH IN (PRIMARY) HEALTH CARE PRACTICES

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Abstract

Background: The solution-focused approach (SFA) is an innovative approach to addressing health issues, which gives the client a central role. The SFA takes an individualized approach to health care by taking into account what works for each individual client, at a certain moment in time, within a specific context. Here, the approach distinguishes itself from the traditional medical model. However, since the SFA is an individualised approach to health care, there exists no 'golden standard' for the evaluation of such an approach. This research aims to investigate what an appropriate measure to evaluate the SFA in (primary) care practices would look like.

Method: Data was collected in the context of the 'Gezondhuizen' project, a project working with the SFA in primary care. First, a literature study focused on the role of client-experience in the evaluation of the quality of health care. Based on the findings in the literature, a feedback-tool was developed to collect client-experiences with the SFA in practice. Through semi-structured interviews, the experience of both clients and health care professionals with the use of this feedback-tool, as well as feedback as an evaluative measure in general, was inventoried.

Results: In the literature, it was found that client-experience is a valuable source of information regarding the quality of health care. Routinely monitoring this experience is essential and can be done by making use of a feedback-tool. From the interviews it became clear that both clients and professionals are positive about feedback. Both health care professionals and clients had mixed experiences with the use of a feedback-tool. It was found to be prone to misinterpretation from the clients' end, while for professionals, time and context were found to be the main barrier.

Discussion: Feedback was found to be a valuable, if not essential part of the evaluation of the solution-focused approach in health care practice. The applicability of a feedback-tool as a way to collect client-feedback was found to be dependent on context, as well as personal characteristics of both clients and professionals. Therefore, the feedback-tool should be seen as a passkey: it can be applied to evaluate 'what works' in health care practices, at the right time, in the right context and setting.

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Chapter 1: Introduction

In 2016, the Veldhuizen health care centre in Ede, the Netherlands, started the Gezondhuizen project. The Gezondhuizen project (see Box 1) works with an innovative approach to address health issues, by giving the client a central role. Building on the concept of *positive health,* the Gezondhuizen project is an example of *positive health care:* shifting the focus from the health problem to everything that *does* work in clients' lives in order to work towards their desired future (Bannink & Jansen, 2017). This way, the approach distinguishes itself from the traditional medical model of health. This innovative method is called the solution-focused approach (SFA) (Mura Zorgadvies, n.d.).

Nowadays, the Gezondhuizen project has successfully expanded to two other health care centres in Ede and has gained increased interest on a policy level (Mura Zorgadvies, n.d.). However, in order for the SFA to gain broader municipal support, the Gezondhuizen project needs to evaluate the impact of such an approach on a larger scale. This increased demand for scientific evidence is not an unknown phenomenon in the medical world. According to the Dutch Council for Public Health and Society, a focus on Evidence-based Practice (EBP) has become evident throughout all areas of health care, both nationally and internationally (Raad voor Volksgezondheid en Samenleving, 2017). However, as of yet, little research has been done on the 'effects' of an SFA in (primary) health care settings, and there exists no 'golden standard' for the evaluation of such an approach. Therefore, this thesis aims to contribute to the development of a suitable evaluation measure of the SFA in medical practice. Before introducing the research question accompanying this aim, the current challenges with evaluating the SFA will be discussed further.

Box 1: Gezondhuizen, the SFA in a primary healthcare setting

The traditional medical model has been the dominant health paradigm for multiple decades (Mold, 1995). It is a positivistic approach to health care that focuses on health problems and their possible causes. A key concept in the traditional medical model is *evidence-based medicine*, which focuses on providing the best possible evidence on what is the most adequate treatment to remove health problems. This evidence comes from standardised studies and experiments (Bensing, 2000). In the traditional approach, a central role is given to the health care provider, who has a leading role in both diagnosing the health issue and taking decisions on appropriate treatment methods (Mold, 1995).

The solution-focused approach is complementary to the traditional medical model, but has a different starting point; with the SFA, the client (in the SFA, it is preferred to talk about 'clients' instead of 'patients') determines what their need is. The role of the solution-focused health care professional is to join in with, and support this need. Within this framework, the caregiver helps the client to look for possibilities to achieve their desired future (Bannink & Jansen, 2017). The solution-focused caregiver asks the client about their goals and searches, in collaboration with the client, for ways to achieve this desired future. These goals are personal, value-driven and are different between individuals (Mold, Hamm & Scheid, 2003; Mold, Blake & Becker, 1991). The focus of the SFA on designing care from the viewpoint of the client is in line with a larger development in the field of health care towards '*patient (or person)-centred care'* (Delaney, 2018). Whereas in the traditional medical model, clients are often placed in the role of passive and un-knowing recipients of care delivered by all-knowing health experts, nowadays recognition is starting to grow on the importance of including clients' needs and values in health care decisions (Kvåle & Bondevik, 2008; Poochikian-Sarkissian, Sidani, Ferguson-Pare & Doran, 2010). As recipients of health care, clients can provide new and valuable insights into the care process that providers do not have access to (Grol et al., 2000; Wensing & Elwyn, 2003).

Considering these key differences, the challenges with evaluating the SFA become clear. Whereas in the traditional medical model decisions are based on 'evidenced' health criteria and protocols, the SFA is based on matching the clients' situation, at a certain moment in time, within a specific context (Bannink & Jansen, 2017). This way, the SFA provides an individualised approach to health care; what defines 'good' care may vary between each individual client. This makes standardized evaluations of an SFA difficult. In other words: there is no 'one-size-fits-all' measure to evaluate the impact of a solution-focused approach in practice. Simultaneously, little to no research has focused on what factors would be essential to take into account in such an evaluation process. Therefore, before strong claims can be made about the 'effect' of an SFA in health care practices, it is important to provide insight into ways how a solution-focused approach could be evaluated while taking into account the specific situation, time and context of each client. Therefore the research question of this thesis can be formulated as follows:

"*What are appropriate methods for the evaluation of a solution-focused approach in (primary) health care practices?"*

The goal of this research was to find out what measure(s) could be applicable for the evaluation of a solution-focused approach in a (primary) health care setting, while taking into account context and the individual client. This was done in two steps: First, an explorative literature study was performed regarding the role of the client in evaluating the quality of health care. Second, based on the results of the literature study, a feedback-tool was designed to capture client-experiences with a solution-focused approach. This feedback-tool was used by health care professionals in practice. Then, with semi-structured interviews, a preliminary inventory of the experiences of both clients and professionals with using a feedback-tool was made.

Chapter 2: Theoretical framework

As described previously, the SFA is complementary to the traditional medical model, but has a different starting point: with the SFA, the client determines the goal of health care. This research aims to find appropriate methods to evaluate the SFA. To provide a background to this search, the next section outlines the gap between the traditional medical model and the SFA in terms of outcome evaluation. This is done by placing the two approaches within the context of their analytical paradigms: the *paradigm of analysis* and the *paradigm of synthesis*.

2.1 Two analytical paradigms

The key differences in attitudes towards health between the traditional medical model and the SFA are also reflected in their attitudes towards evaluation. The main distinction here is that the traditional medical model falls under the *paradigm of analysis,* whereas the SFA is an example of the *paradigm of synthesis* (Bannink & Jansen, 2019).

In the paradigm of analysis, understanding a subject is thought to come from dissecting all its different elements and studying them in isolation from each other, in order to reduce uncertainty. It is a reductionist lens through which one sees the world, asking the question '*why* are things the way they are?' (Bannink & Jansen, 2019). In contrast, the paradigm of synthesis assumes that researching the different parts of a subject separately is not helpful in understanding it. Instead, it accepts that the world is always changing and dynamic, making it unpredictable in nature. Therefore, to understand a subject one must examine it *within* its context. It is a functional approach, asking the central question, '*how* can I create new possibilities that connect with these changing circumstances?' (Bannink & Jansen, 2019).

Both analysis and synthesis are necessary in practice. However, they have a different way of addressing problems (see Figure 1). Therefore, also in the field of health, a differentiation must be made which lens is most fitting in which context. When placed within the framework of their analytical paradigms, it becomes understandable that the traditional medical approach and the solution-focused approach should also differ in terms of methods for outcome evaluation. The application of these analytical paradigms to evaluations is discussed next, followed by a review of key ingredients for an evaluative measure of the SFA.

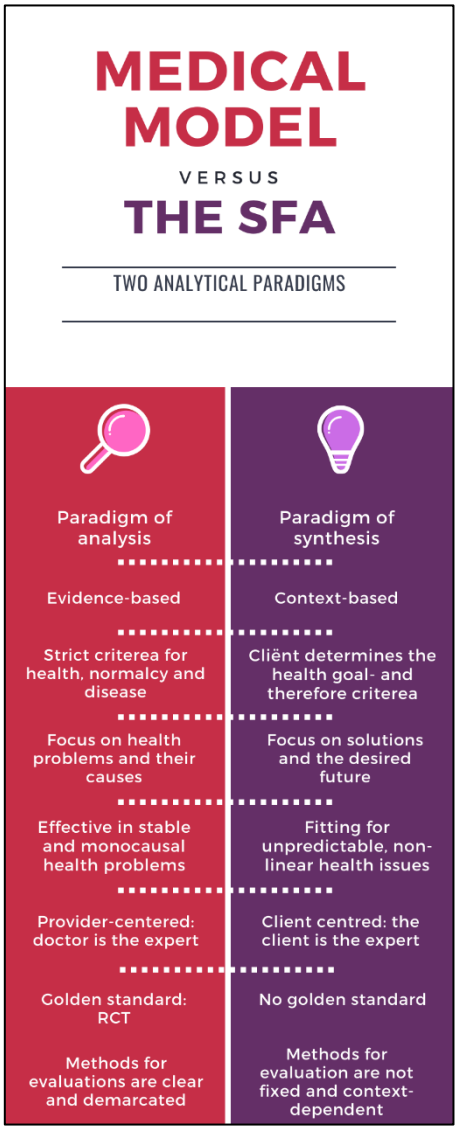


Figure 1 : The Traditional Medical Model versus the SFA: two analytical paradigms. *Created by the author, based on: Bannink & Jansen, 2017a; Bannink & Jansen, 2017b*

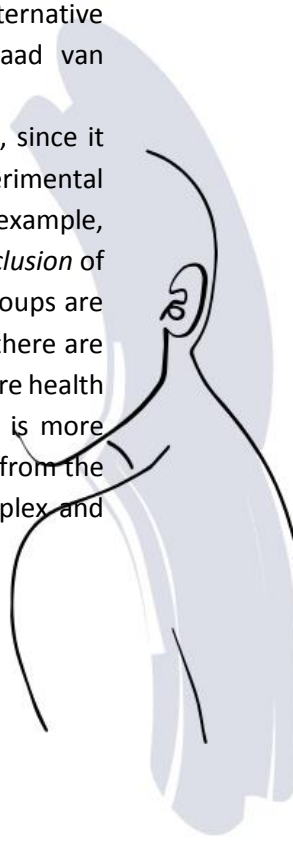
2.2 The Traditional medical model

Also often referred to as the *problem-focused approach* or *evidence-based approach,* the traditional medical model has been the dominant paradigm in the field of health for the past century (Mold et al., 1991). Although it has been the driving factor behind many key developments in terms of diagnosis, treatment and medical research, the idea that this analytical model is less suitable for addressing increasingly complex modern health issues is growing. This can largely be attributed to its linear attitude towards health and health problems (Reuben & Tinetti, 2012; Mold et al., 1991). These considerations will be discussed next.

Firstly, the *paradigm of analysis* is reflected by the characteristics that are central to the traditional medical model (see Figure 1). First and foremost, it assumes that there exists an ideal state of health, and any deviation from this state is seen as problematic (hence the approach is also referred to as the 'problem-focused approach'). Following from this, it is assumed that this deviation (the health 'problem') has one or more identifiable causes, which, when taken away, will lead to the solution of the health problem (Mold et al., 1991). Thirdly, health care providers are considered to be the experts and take the lead in health care decisions, which clients are expected to understand and accept (Mold et al., 1991). Lastly, 'successful' health care is measured by the degree to which the health problem is correctly recognised and fixed (Mold et al., 1991). This approach to health problems seems functional. However, in reality, many health issues turn out not to follow such a linear process and also the input from the client is left out of this equation. For example, in practice, doctor and client may disagree on what is the correct 'solution' to the health problem, or even on whether there is a problem that should be fixed to begin with. This approach becomes even more problematic when 'taking away' the cause of a problem is impossible (e.g. chronic disease, medically unexplained symptoms (SOLK) or disability) (Mold et al., 1991).

Secondly, the *paradigm of analysis* is also clearly reflected by the standard evaluation methods used in the traditional medical model. For instance, the concept of health is strictly defined by guidelines (Mold, 1995). The reduction of health, normalcy and disease to a set of standardized criteria makes it possible to quantitatively evaluate outcomes. The health of a person is compared to an ideal state of health based on the presence or absence of symptoms (Mold et al., 1991). This has also led to the development of a 'golden standard' in terms of outcome evaluation; the randomised controlled trial (RCT) (see Figure 1). In this study design, a certain treatment can be compared to an alternative by assigning two groups of participants 'at random' to either of the conditions (Raad van Volksgezondheid en Samenleving, 2017).

An RCT is particularly suited to evaluations as seen from the *paradigm of analysis*, since it excels at isolating individual elements of a subject and at reducing uncertainty through experimental control. However, there is increasing attention to the costs of this experimental control. For example, RCTs employ strict criteria both for the *inclusion* of participants in RCTs, as well as for the *exclusion* of specific groups that could influence the statistical power of the study. Examples of these groups are children, elderly or people suffering from chronic health issues (Bensing, 2000). Therefore, there are always groups of clients that 'do not fit the bill' of the outcomes of RCTs. For those cases wehere health issues do not fit in with the traditional, analytical model, the solution-focused approach is more suitable. However, the 'standard' approach to evaluating health care processes that follows from the *paradigm of analysis* does not fit here. Particularly in cases where health issues are complex and interactive, the *paradigm of synthesis* is likely to be more useful.



2.3 The Solution-focused Approach (SFA)

"*One hundred years ago, the doctor was the only expert in the consultation room. At the end of the previous century, evidence-based medicine arose. This became the new authority. Now it is time to introduce the unique characteristics, competences and context of the client*"

(Bannink & Jansen, 2019, p.1)

The quote by Bannink and Jansen (2019) describes the position of the solution-focused approach in the medical world. In a field where the focus has come to lie on 'provable' measures, protocols and research all meant to reduce uncertainty in medical processes, the individual client has slowly disappeared into the background (Reuben & Tinetti, 2012; Bannink & Jansen, 2019). The SFA looks at health from a different perspective: the *paradigm of synthesis (*see Figure 1). With the SFA, the focus shifts from the health problem and its possible causes to the client's desired future, as well as the resources and competences they bring to the table that could help them achieve this goal (Reuben & Tinetti, 2012).

Also called the strengths-based approach, in the SFA the client investigates in collaboration with their provider which strengths they already possess that can be used to improve their situation. This is explored by asking solution-focused questions that invite the client to look for positive exceptions and possibilities. By doing so, the SFA takes a pragmatic, experience-based approach (Bartelink, 2013; Bannink & Jansen, 2017). Also, whereas the traditional medical model follows a set of strict criteria for health, normalcy and disease, in the SFA the client determines the goal and therefore the health criteria (Mold et al., 1991). These goals are influenced by personal norms and values which are different for each individual. Because of this, the solution-focused method is an individualised approach to health care (Mold et al., 1991).

In the *paradigm of synthesis,* the *context* is key. The SFA looks at health by taking into account the specific context of each individual client, therefore taking a holistic approach to addressing health issues (see Figure 1). Following this perspective, rather than focusing on standardized outcomes among groups of individuals that are assumed or selected to be as identical as possible, evaluations of an SFA should focus on outcomes that relate to the goals of the individual client and should take into account each clients unique circumstances. As a consequence, in solution-focused approaches, there is no golden standard for outcome evaluation. As of yet, there are no existing guidelines or prescriptions on what a fitting evaluative measure for the SFA *should* look like. However, in the literature on the SFA several clues can be found regarding the key components of the SFA that should be taken into account in the process of developing a solution-focused evaluation measure. These components will be discussed next.

2.3.1 Use of scale-questions

''*Scale-questions can help make complex, intuïtive experiences understandable*"

(Bannink & Jansen, 2017, p.130)

In the SFA, 'care' takes place within the communication between professional and client (Bartelink, 2013). In the SFA, the solution-focused health care professional works with a set of communicative techniques and questions to guide the client towards their goal. Here, scale-questions can help to visualise and discuss complex client experiences. They can be used, for example, to talk about feelings of hope, trust, or the client's view of their progress (Bannink & Jansen, 2017; Lee, 1997).

The scale is often built up from 0 to 10, in which 10 is the ideal future: everything the client could hope for has come true. In contrast, 0 stands for the worst possible scenario a client could imagine. During a consult, the solution-focused practitioner begins by asking where on the scale the client would like to end up as a result of the care process. From here, follow-up questions can be asked, such as what will be different at this point, followed by what it would take to bring the current score up by one point (Bannink & Jansen, 2017). Apart from visualising complex experiences, according to Lee (1997) scale-questions can be a useful tool for clients to evaluate their situation and progress.

Both the traditional problem-focused approach and the SFA make use of scale-questions. However, whereas in the problem-focused approach the 'highest' score correlates with the worst experience (e.g. an anxiety scale), in the SFA it is the other way around (Bannink & Jansen, 2017). Even from this simple example, the difference in thinking between the problem-focused and the solution-focused approach to addressing health problems can be recognised. While seemingly minor, by continually asking clients to focus on and rate their pain, depression or anxiety, they are invited to focus on the problem rather than how they would like to see this changed (Bannink & Jansen, 2017). Therefore, the scale-question can be seen as a multi-functional tool that can be applied at different moments in time to address various issues, including evaluative purposes. However, its 'effect' is sensitive to framing and context, so deliberate effort should be taken to use solution-focused language when applied in practice. The importance of language in the SFA will be discussed in more detail in the following section.

2.3.2 Use of language

As the example of scale-questions illustrated, the way a question is framed can have a large impact on how it is answered and perceived. This is especially true in the SFA, where asking the right questions is given a central role (Dijkhuizen, Wiegant & Schulling, 2013; Bannink & Jansen, 2017). Therefore, language is an important, if not essential part of the SFA. In a problem-focused approach, conversations are often focused on the past, problems and their possible causes. However, this places an emphasis on the negative and can create the impression that these problems are there to stay (Bannink & Jansen, 2019). Instead, language in the SFA is positively oriënted and speaks of the future and ways to overcome these problems. It uses action-language, is encouraging and invites the client to 'take charge' in deciding the course and pace of action (De Shazer & Dolan, 2009; Bannink & Jansen, 2019).

An example of the effect of language is the word 'intervention': in essence this word states that it is necessary to 'intervene' in a persons' life in order to fix it (Hobma, 2019). Similarly, whereas 'patient' refers to a person passively awaiting treatment, 'client' refers to a more empowered, customer-like role (Deber, Kraetschmer, Urowitz & Sharpe, 2005). Therefore, a core element of the SFA is to avoid placing emphasis on health problems and their causes by making a deliberate effort to avoid problem-focused language and by asking solution-framed questions. This element should be taken into account in the development of a possible evaluative tool or measure. Additionally, in this thesis, deliberate effort is taken to avoid problem-focused language, as part of the process to adopt a more solution-focused mindset.

2.3.3 The role of the client

The SFA can be seen as an approach in which the experience of the client is given a central role, which is in line with a larger worldwide trend of health care services increasingly searching for ways to achieve *'patient (client)-centred care'*. A quote often used to describe client-centred care is 'no decision about me, without me' (Kramer et al., 2014; Delaney, 2018). This statement resonates well with the solution-focused approach to health care. In the SFA, clients are seen as experts to their own life, meaning they 'know best' about their own competences, resources and personal context. The health care professional is there to join in with, and let themself be informed by, the perspective of the client. This is in contrast to the traditional, 'all-knowing' technical health expert (Bannink, 2005).

Instead of leading the medical process, in the SFA the provider 'leads from one step behind'. This means that the provider looks over the shoulder of the client, asking guiding, but not defining questions that invite the client to explore all possible solutions and choose which approach suits them best (Bartelink, 2013). These characteristics of the SFA resonate well with the definition of client-centred care as defined by Delaney (2018): "*This approach emphasises partnerships in health between patients and healthcare professionals, acknowledges patients preferences and values, promotes flexibility in the provision of health care and seeks to move beyond the traditional paternalistic approach to health care*" (p.1). Thus, the central role of the client also belongs to the set of key ingredients of (an evaluative measure of) the SFA, which will be summarised in the next paragraph.

2.4 Key ingredients for evaluating the SFA

This chapter outlined the gap between the traditional medical model and the solution-focused approach in terms of outcome evaluation by placing them within the framework of their analytical paradigms: the *paradigm of analysis* and the *paradigm of synthesis*. From this comparison followed a number of key ingredients to the SFA. First, a concept that is central to the *paradigm of synthesis* is *context*. The SFA provides an individualised approach to health care by taking into account what works for each individual client, at a certain moment in time, within a specific context. Second, this context can be explored in the communication between health care professional and client, by using solution-focused language and questions. Thirdly, by doing so, a central role is given to the individual client. In the search for an appropriate evaluative measure for the SFA, these key components should be taken into account.

However, the question remains *how* these key ingredients can be combined into an overarching, appropriate evaluation measure. In the *paradigm of analysis*, the corresponding method is clearly defined, namely the RCT. However, this approach does not seem to fit the characteristics of the SFA. In a recent report by the Dutch Council of Public Health and Society, the shortcomings of the exclusive application of *evidence-based medicine* (EBM) without taking into account the importance of *context* are emphasised further (Raad voor Volksgezondheid en Samenleving, 2017). According to this report, although scientific *evidence* as used in EBM is important in making health care decisions, other important sources of knowledge are often underutilised. Here, a key source of information is the specific knowledge (expertise) coming from the client, which holds information regarding their personal context, norms, values, needs and preferences (Raad voor Volksgezondheid en Samenleving, 2017). Because every health care decision takes place in a specific context and relates to the specific characteristics of the health care seeker, taking into account these different sources of information is vital in the decision making process in order to provide fitting care (Raad voor Volksgezondheid en Samenleving, 2017).

This is especially true for those clients and health problems that fall outside the scope of the traditional medical model and its corresponding 'golden standard' for evaluation purposes: the RCT. Here, context plays a role in two ways: 1) the effectiveness of a treatment as 'proved' by an RCT does not have to be the same for every individual client, because not every group is equally represented in the standardised, controlled environment of such a study. Also, some individuals and health problems are permanently excluded because their symptoms are inherently 'non-standardisable' (e.g. SOLK, disability, comorbidity). 2) RCTs create the impression that evidenced care equals good care. However, on an individual level, personal norms and values also play a strong role in making health care decisions. To illustrate, in practice a client may reject a treatment suggested by their provider as the 'best' choice, or choose another less effective one because it conflicts with their personal norms and values (Raad voor Volksgezondheid en Samenleving, 2017). Additionally, different clients may also have very different ideas of what conditions they see as acceptable, or in other words, in their goals for health care (Delbanco & Gerteis, 2013). For example, someone suffering from knee problems may have as a goal to be pain-free, which would lead to the prescription of painkillers, but another client with the same knee problems may want to be able to play golf again, which would require a knee surgery (Bannink & Jansen, 2017). Here, an RCT can provide the best information on which painkillers would be the most effective in reducing pain, but it cannot help a client decide whether pain reduction should be their end-goal and if this is more important to them than regaining mobility.

Therefore, in the report, *context-based care* is advocated (Raad voor Volksgezondheid en Samenleving, 2017). In practice, this means that instead of exclusively outsourcing the monitoring of health care quality to external parties and sources of information (the *evidence)*, health care professionals should enter into dialogue with their clients on what defines 'good care' for them. Only then can health care be attuned to the individual clients' needs and lifestyle, thus creating client-centred care (Raad voor Volksgezondheid en Samenleving, 2017). Building on these findings, in the remainder of this thesis, the search for an appropriate evaluative measure of the SFA will focus on the dialogue between professional and client, with due consideration of individual *context* and the other key ingredients of the SFA. To do so, first the literature on client-centred care will be consulted to see which developments have been made in this field regarding the inclusion of the individual clients' voice in the evaluation of the quality of health care.

Chapter 3: Methods

The research question '*What are appropriate methods for the evaluation of a solution-focused approach in (primary) health care practices*?' was examined in two parts. First, a literature study was performed regarding the role of the client in the evaluation of health care. Second, taking the results from the literature into consideration, a feedback-instrument was developed to collect client-feedback in day-to-day health care practice. The experiences of both clients and health care professionals were inventoried regarding the use of the feedback-tool, as well as being asked for feedback/asking for feedback in general. This was done through semi-structured interviews.

3.1 Setting

The data was collected in context of the 'Gezondhuizen' project. The Gezondhuizen project started on January 1st, 2016, and was initiated by a health care centre in Veldhuizen, Ede in collaboration with health care consultancy bureau Mura (Mura Zorgadvies, 2018). The goal of the project is to apply the SFA to promote a healthy lifestyle in primary health care, originally with a focus on clients from low SES-neighborhoods and young parents-to-be. Part of the project are different types of training for health care staff working with the SFA, such as inspirational discussion-sessions, a three-day training called 'positive health-care: a solution-focused method in primary care', as well as in-company and personalised training sessions (Mura Zorgadvies, 2018). Since the start, the 'Gezondhuizen' project has spread to two other health care centres in Ede due to its success. Additionally, many health care practitioners from different disciplines have attended the different training sessions led by professionals of the solution-focused method associated with the Gezondhuizen-project (Mura Zorgadvies, 2018).

Due to the growing interest in the Gezondhuizen project by the municipality of Ede, as well as the SFA as an acknowledged form of health care in general, there is an increased need to systematically evaluate the impact of the SFA in order to receive further support on a policy-level. The increasing demand for scientific evidence is in line with the larger trend of '*evidence-based practice'* in the field of health care. This was the setting in which the current research took place.

3.2 Literature review

In an explorative literature study, the role of client-experience in the evaluation of the quality of health care was researched. Two fields of interest were selected in which research has focused on this subject, which were the fields of patient (client-)centred care and psychotherapy. Inclusion criteria for studies were those that focused on client-centred care, the role of the client in psychotherapy, as well as more specific studies in this field that focused on client-experience as an evaluative measure or criticism on this approach.

To do so, different scientific databases were consulted, which were the WUR library database, Web of Science, PubMed, Scopus and Google Scholar. Relevant combinations of search terms were 'patient-centred' OR 'patient-centred care', OR 'patient-experience' OR 'psychotherapy' OR 'therapy' AND 'evaluation' OR 'monitoring' OR 'feedback' AND 'health care' AND 'quality'. Inclusion criteria were: peer-reviewed Dutch or English studies, studies or reviews involving either the role of the client in client-centred care/psychotherapy or the combination of client-experience and evaluation. Excluding criteria were studies whose subjects were outside the scope of the research, non-peer-reviewed studies or studies published in a different language than Dutch or English. No exact exclusion criteria were followed regarding year of publishing, since both the field of client-centred care and

psychotherapy have a long history starting as early as the 1950's literature, and its fundamental principles have remained the same (Rogers, 1951; Bordin, 1979). Thus, there is no reason to assume that only recent publications would be relevant.

First, a general selection of studies was made based on subject, title and summary (abstract). After this initial selection, the potentially relevant studies were screened as a whole to see if they were applicable. From here, the snowball-method was used, which meant the researcher looked at the references of the selected articles to find other relevant studies. In total, a number of 22 studies were included. The data-analysis of the literature was organised as follows: first, the researcher read through the selected studies in detail and analysed them to pinpoint key arguments and concepts. These findings were then summarised and divided into chapters. To conclude the findings and their implications for practice, a summary of key findings in the literature was written.

3.3 The feedback-tool

Based on the findings of the literature review, a feedback-tool was designed, in coordination with a general practitioner at the Veldhuizen medical centre in Ede. The tool has been included in Appendix 6 of this report. The feedback tool was loosely based on the design of the Session Rating Scale (Duncan et al., 2003) used in the field of psychological therapy to collect ongoing client feedback during the therapeutic process, as discussed in Chapter 4. It was designed as a scale-question, similar to the type of scale-questions used in the SFA to visualise complex client experiences (Bannink & Jansen, 2017).

The tool was designed as a plasticized A4 paper with the text '*how does the approach fit?*', a very open and general question aimed to start up a conversation about the clients' experience with 1) the solution-focused approach of their health care provider in general, 2) the relationship between provider and client and/or 3) specifically with the past consultation. The client could mark an indication of this experience on the scale, after which provider and client could discuss the implications of this mark together. The broad and open character of the question allowed care professionals to shape the way they applied this question in practice as they saw fit.

3.4 Data collection

To investigate the applicability of a feedback-tool as an instrument to evaluate a solution-focused approach in a day-to-day clinical setting, experiences of health care professionals and clients with the use of this tool were collected through semi-structured interviews. The interviews took place at four different moments in time, in December 2019. The interview sessions were planned in accordance with the schedule of the health care professionals, since the selection of clients was linked to the consultations led by the professionals.

In a solution-focused consultation, the health care professional was asked to use the feedback-tool provided by the researcher. This was done through several steps. Starting off, health care professionals who agreed to participate in the research were provided with the feedback-tool and its necessary accessories (a black marker, ruler to indicate a 'score'). The professionals were told the goal

of the tool was to start a conversation on 'what works' from the experience of the client. They were then asked to apply the feedback-tool during a (solution-focused) consultation.

After the consultation, the health care professional personally asked their client if he or she would be willing to answer a few questions regarding the feedback instrument. If the client agreed, the researcher performed a short, semi-structured interview to map out the experience of the client with the feedback-tool. On the same day, at a moment of the care professionals choosing, a semi-structured interview was also held with the professional to investigate their perception of the usability and applicability of the tool in a day-to-day clinical setting.

After the interviews, the professionals were invited to keep using the tool in their consultations. A few weeks after the interview sessions, the researcher sent a follow-up e-mail to each health care provider regarding their current experience with the tool. The e-mail consisted of three questions: 1) '*are you still using the feedback-tool at this moment in your consultations and if yes, how do you feel about it*?'; 2) '*did the use of the feedback-tool lead to adapting future consultations*?' (meaning: did the feedback given by clients lead to actual points of improvement, or instead, to retaining certain actions that were perceived as helpful?); 3) '*are you planning to continue using the feedback-tool in the future and why*?'.

3.5 Selection of participants

The participants for the interviews were identified through close collaboration with a general practitioner from the health centre in Veldhuizen, who is one of the initiators of the Gezondhuizen project. Contact between potential health care professionals and the researcher was intermediated by this practitioner, who approached a number of suitable professionals from the various health care centres taking part in the Gezondhuizen project. The selected professionals had all followed the training on solution-focused health care or had experience with working with the SFA. The professionals worked in different health care disciplines, a summary of which can be found in Figure 2. In total, four health care professionals participated in the interview sessions. An overview of the selection process of care professionals can be found in Figure 2.

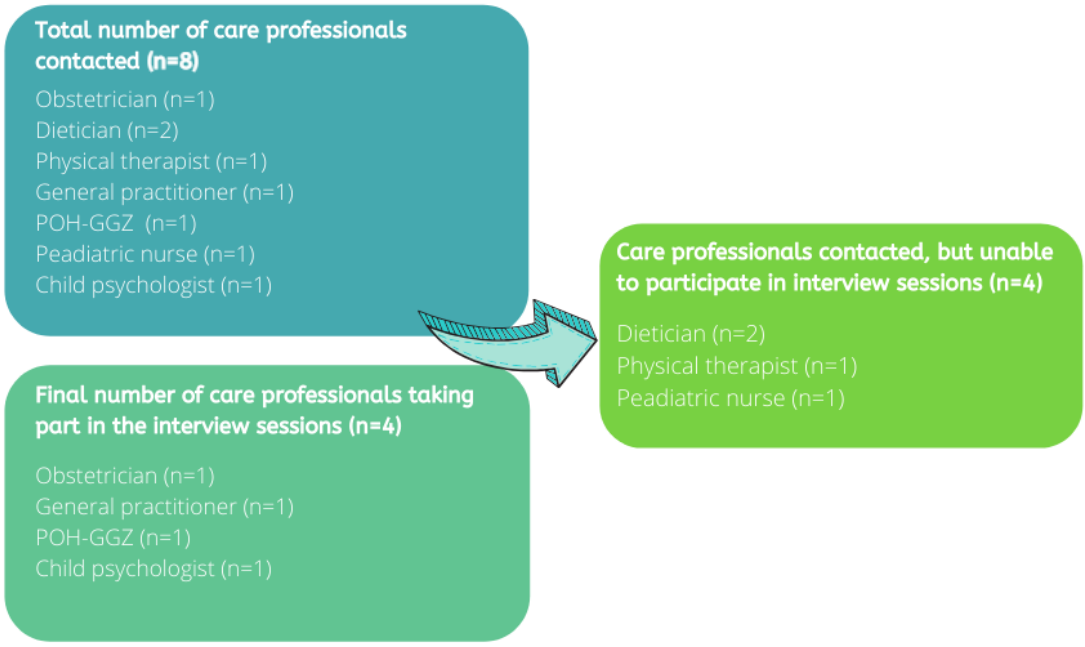


Figure 2 Selection process of health care professionals

The clients who participated in this research were selected by the above-mentioned health care professionals. After the professionals had agreed to participate in the research, they were asked to agree on a suitable day for the researcher to be present at their workplace, preferably a day on which they would have one or more solution-focused consultations. On this day, the researcher was present during a previously agreed time-slot, if necessary encompassing multiple consultations. After a solution-focused consult, in which the feedback-tool was used by the professional, the professional asked the client if he or she would be willing to answer a few questions regarding the feedback-tool. If the client agreed to participate, the researcher held a short, semi-structured interview with this client following the consultation. In some instances, a professional opted to inform clients they deemed suitable beforehand about the possibility to participate in an interview. This way, interviews with clients could be planned in a more regulated fashion. However, this was not possible for every professional or in every context. Also, because the researcher wanted to capture clients' immediate experience with the feedback-tool, they decided to give participants the chance to decide in the moment if they wanted to participate or not.

If clients were unable to participate at the moment, they were asked if they would be willing to be interviewed through the phone at a later time. Three clients were unable to participate at the time of the consultation, one because of personal reasons and two because of time constraints. One of these clients agreed to a telephone interview at a later time. In total, three clients participated in the research. The selection process of clients can be found in Figure 3.

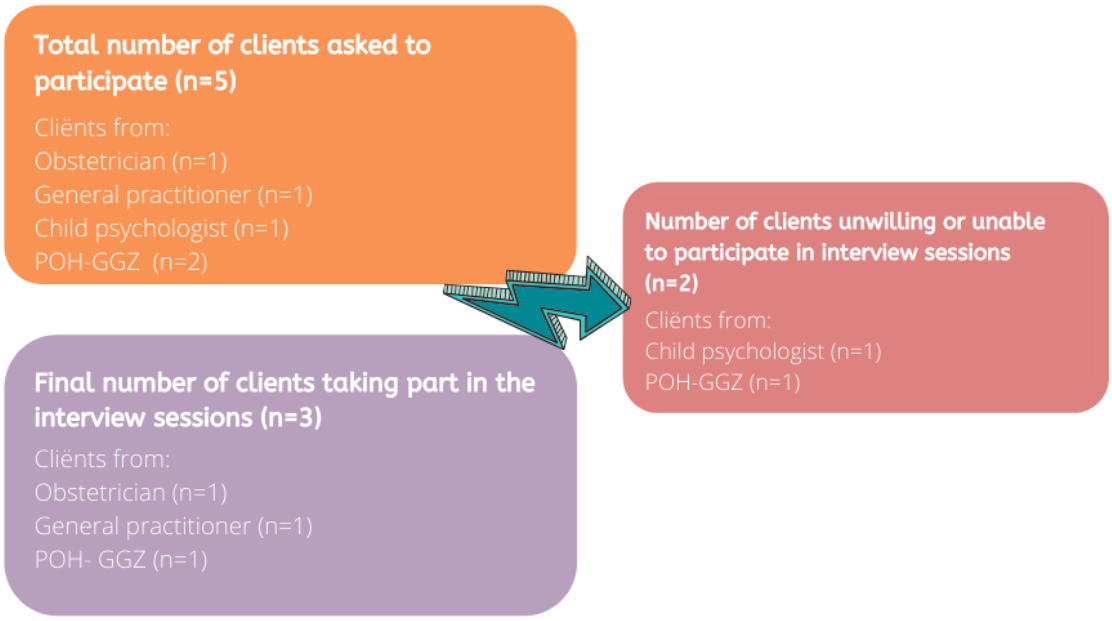


Figure 3 Selection process of clients

3.6 The interviews

The interviews with clients took between 11-15 minutes. The client interviews were most subject to time constraints since they took place right after a consultation. The interviews were held in Dutch since this was the native language of all the participating clients, which was thus expected to provide for the most natural and substantive answers. Questions in the interviews were based on an interview scheme (Appendix 1). The researcher made use of semi-structured interview questions, which is more

suitable for the current research compared to a questionnaire or survey (Low, 2013). For example, because the SFA is an individualised approach, it is important to capture the more subjective experiences of individuals. This is possible by using a semi-structured format, which allows for taking an inductive approach to data collection (Low, 2013). Also, the SFA aims to appreciate the expert role of the client and to include them in health care decisions. Since semi-structured interviewing gives interviewees more power and control over what is discussed during the interview as well as how it is discussed, it is very fitting within the context of the SFA (Low, 2013).

The interview sessions with health care professionals took between 24-48 minutes. These interviews were also semi-structured and were also held in Dutch, taking into account the same methodological considerations as the client interviews. Questions in the professional interviews were based on a similar, but slightly different interview scheme (Appendix 2), with questions specified to a user-perspective of the feedback-tool. Here, questions focused on the suitability of using feedback as an evaluative measure, the applicability of feedback in a solution-focused approach, and aspects of user-friendliness associated with the feedback-tool. The questions of both the professional- and client interviews were also designed to have an 'open' nature and some SF-techniques (asking follow-up questions: 'and what else?') were used as well. Also, the researcher made a deliberate effort to avoid any problem-focused language.

3.7 Data analysis

The interview sessions with both clients and professionals were recorded. After the interview sessions were completed, the gathered data was analysed following the six steps of qualitative data analysis by Creswell (2003), as summarised by Plochg and van Zwieten (2007). The use of this method of analysis is frequently recommended and used in qualitative research. The first step of this analysis was to transcribe the recorded data to prepare it for analysis. Additionally, observantly listening to and typing out the content of the interviews helps becoming familiar with the data, which may contribute to the correct and in-depth interpretation of what is said (Plochg & Van Zwieten, 2007). The second step was to create a global overview of the generated information (Plochg & Van Zwieten, 2007). To do so, the researcher read through the transcripts of the interviews multiple times to see how the data relates to the general research question and see what subjects and ideas stand out from the data at a first glance.

The third step was making a detailed analysis of the data through coding. The coding process was supported by making use of the programme MAXqda, a software programme which helps systematize and organise the retrieved data. This can help keep the data manageable and can lead to new insights (Plochg & Van Zwieten, 2007) by clarifying the structure in the data, as well as highlighting connections between multiple pieces of information. During the coding stage, the researcher read through the transcripts and coded different fragments of text in order to create an initial organisation of pieces of data. Coding terms were chosen deductively, based on the interview schemes as well as the main research question. For each interview, every piece of text that resonated with certain constructs from the interview schemes was assigned with a code. These codes were then grouped together in MAXqda to create a general overview.

The fourth step of the analysis involves a further deepening of the categorised data (Plochg & Van Zwieten, 2007). The codes assigned to segments of text were refined by the researcher and were used to look for relationships and common themes among sets of codes. The codes were then sorted by the researcher into the most important, overarching themes. By doing so, a total of three main themes was found in the data.

Chapter 4: Results

4.1 Introduction of the results

In this chapter the main findings of this research will be presented. First, the findings of the literature study will be discussed. These findings resulted in the development of a tool to gather client feedback on the solution-focused approach. This tool was then applied by health care professionals in practice. In the second part of this chapter, the results of the interview sessions with both clients and health care professionals regarding the use of this tool will be presented.

4.2 Results of the literature study

In the SFA, the client is given a central role. In order to evaluate what defines 'good care', it is important to take into account the specific time, context and situation of the individual client. For this, client-participation in the decision-making process of care is essential. From the literature study, two relevant fields of study emerged in which research has focused on giving clients a central role in determining the quality of health care. These are the fields of client-centred care and psychotherapy. In the following section, the possibilities for including the 'expertise' of the client in the evaluation of the SFA are explored based on the methods used in these fields.

4.2.1 Client experiences in the evaluation of client-centred care

Health care services across the world are increasingly taking efforts to include clients in the health care process and give a central role to their experiences and needs, thus adopting a client-centred model of care. In its original terminology, this model was referred to as 'patient-centered' care (Poochikian-Sarkissian, Sidani, Ferguson-Pare & Doran, 2010). However, in the context of solution-focused approaches, the word client is used rather than the word patient. Client-centred care has been defined as follows by Delaney (2018): "*This approach emphasises partnerships in health between patients and healthcare professionals, acknowledges patients preferences and values, promotes flexibility in the provision of health care and seeks to move beyond the traditional paternalistic approach to health care*" (p.1). This conceptualisation of client-centred care resonates well with the core values that are at the basis of the SFA. In both models, the aim is to provide care that is tailored to the individual client. Because of the similarity in intended outcomes, literature on the evaluation of client-centred care is likely to be relevant when designing evaluations of a solution-focused approach. In this body of literature, the importance of *routinely* collecting and using client experiences in achieving this aim is emphasized (Frosch, 2015). Client experiences are used as a tool for monitoring whether the care received by clients actually contributes to the goals set by them for improving their health (Frosch, 2015). There are different methods to collect these experiences, whose applicability will be discussed next.

4.2.2 Methods for collecting client-experiences in client-centred care

According to Wensing and Elwyn (2003), there are three main types of client-experiences with health care. These are measures of *preferences, evaluations by users* and *reports*. Preferences are clients' subjective ideas on what SHOULD occur in healthcare systems. Evaluations are individual clients' reactions to their direct experience with health care; here a subjective evaluation is made of whether the care process or the outcome is perceived as good or bad. Reports are objective observations of

clients regarding the organisation of care or the care process overall. There is no subjective evaluation made of whether this is good or bad, for example reports on 'waiting time' (Wensing and Elwyn, 2002).

According to Wensing and Elwyn (2003), a distinction can be made between the appropriateness of qualitative and quantitative measures when collecting these experiences. Qualitative research methods were found to be most suitable for expressing different *preferences*, because of their appropriateness for in-depth examination of different individual experiences. The same was true for *evaluations*. Qualitative measures were also found to be particularly useful for exploring clients' views in areas that have not yet been thoroughly studied previously (Wensing & Elwyn, 2003).

However, in practice experiences of clients are mostly captured in the form of PROMs (Patient-Reported Outcome Measures) (Black, 2013; Snyder et al., 2012). According to Black (2013), PROMs routinely measure and compare clients' health at different moments in time in order to determine the outcome of the care received. In practice, PROM-results are most often used to evaluate health care on an overarching level: they are used to assess the outcomes achieved by health care providers and compare them, evaluate the quality of care within a practice or even compare health care quality across practices (Snyder et al., 2012; Black, 2013).

The most common form of collecting PROMs is through questionnaires (Snyder et al., 2012; Black, 2013). However, the appropriateness of exclusively using quantitative measures (questionnaires, surveys) to collect client-experiences to evaluate and improve health care is questioned for several reasons, which will be discussed next.

4.2.3 Critique on the use of quantitative data to collect client-experiences

According to Frosch (2015), for clients the most important function of medical care is "*restoring or maintaining our ability to do stuff, to be free of functional impairments or symptoms that interfere with our ability to pursue our life goals*" (p.1). For measures capturing client-experiences with the care received, there is an increasing body of researchers that argue that quantitative data-collection methods (which are the current standard) are unfit to adequately capture what clients perceive as 'good quality care'.

For instance, Wensing, Vingerhoets and Grol (2001) provided general practitioners with (questionnaire) feedback of their client's evaluations of the care received. They found that after the GP's had the chance to improve their practices based on this feedback, there was no change in client evaluations of the care received. In later research, Wensing, Vingerhoets and Grol (2003) also found that health care providers, after having been provided with feedback (gathered through questionnaires), were not found to change their communication behaviour. They also had less favourable views of the relevance of client-feedback for their practice after they were presented with the results in this form and saw little reason to change. Additionally, practitioners found that using (the results of) a client-survey was too time- and energy-intensive (Wensing et al., 2003).

Valderas et al. (2008) also found that using quantitative measures for collecting client-experiences has many barriers in practice, both practical and attitudinal. Firstly, questionnaires are often lengthy and may be perceived as burdensome by both practitioners and clients. Secondly, in order for the data coming from client-questionnaires to be quickly available, useful and interpretable for practitioners to improve their practice, time and possibly additional resources are necessary (Valderas et al., 2008). Also, scepticism exists, especially among practitioners, regarding the clinical meaning and legitimacy of questionnaire data in assessing the quality of health care (Valderas et al., 2008; Manary, Boulding, Staelin & Glickman, 2013).

According to Asprey et al. (2013), although practitioners generally have positive attitudes towards client feedback, the exclusive use of quantitative data to capture client-experiences, as well as the lack of individualised feedback to practitioners, are found to be limiting the potential for practitioners to actually improve their practices. An alternative to the strict use of quantitative data to evaluate and improve health care practices is offered by Tsianakas et al. (2012), in the form of client narratives. Narratives are described as inviting clients to tell their 'stories' on the care they received, rather than simply answer questions. These narratives, then, would allow for the development of an understanding grounded in experience and context (Tsianakas et al., 2012; Wilcock, Brown, Bateson, Carver & Machin, 2003; Luxford & Sutton, 2014). Collecting people's stories is done by asking open questions, which leads to a new type of evaluative dynamic:

> *The trick is to engage customers in a different kind of conversation, to ask them how they are doing.…To say, we don't want to talk about us. In fact, try to forget that we're even here. We want to talk about you. We want to understand what your wants and needs are, what makes you tick. Because if we understand those things more, we think we'll be able to apply our skills and expertise in ways that will better meet the needs you express, as well as some needs you may not even know you have* (Wilcock et al., 2003, p.3).

According to Wilcock et al. (2003) and Tsianakas et al. (2012), there are several advantages to collecting narratives as an evaluative measure. Firstly, 'storytelling' gives clients more control, thus supporting autonomy. Secondly, using clients' stories provides feedback that is grounded in experience, which can contribute to the generation of new ideas and insights for improvement (Wilcock et al., 2003). In contrast, surveys addressing the quality of care assume that clients know exactly what standards of care they should want and expect, while this is mostly not the case. Additionally, surveys are often focused on evaluating limited aspects of a health care service, instead of the service as a whole (Wilcock et al., 2003). Thus, although survey data could help to locate potential problems on a general level, exploring client 'narratives' is valuable for finding important clues on what aspects of care could be improved *as well as* possible solutions for this (Wilcock et al., 2003).

4.2.4 Client experiences in the evaluation of psychotherapy

Acknowledging the value of client-experience is also central to the work of researchers Millar, Duncan and colleagues (2003; 2003; 2004; 2005; 2011; 2015). In line with the increasing focus on outcome that has been discussed thoroughly in this report, also the field of mental health has seen a surge of interest in the 'effectiveness of treatment'. In practice, this meant that routine outcome monitoring (ROM) became the primary approach to benchmarking health care quality by routinely monitoring treatment outcomes (Miller, Hubble, Chow & Seidel, 2015). However, it was found that the most important factor in the *effectiveness* of monitoring outcomes was often overlooked: what the therapist does with this valuable information. In response to this, the Session Rating Scale (SRS) was developed (see Appendix 3), an evaluative measure of different working elements of a therapeutic session (Duncan et al., 2003). Central to this measure are two concepts, the *working alliance* between professional and client, and the *clients' theory of change.*

The *working alliance* is defined by Bordin (1979) as consisting of three main elements: the relational bond between professional and client, the level of agreement on goals for therapy and agreement on the types of tasks necessary to achieve this goal. A positive alliance was found to be one of the best predictors of (successful) outcome (Duncan et al., 2003).

The *clients' theory of change* is defined by Duncan and Sparks (2004, in Robinson, 2009, p.1) as follows: ''*the clients' theory of change is not an anatomical structure in the client's head to be discovered by your expert questioning. Rather, it is a plan that coevolves via the conversational unfolding of the clients' experience, fuelled by your caring curiosity''.* This theory of change involves the ideas clients have with regards to their problems and, more importantly, their possible solutions. The role of the professional is, then, to find out what these are by entering in a conversation with the client in which these ideas can be expressed. Miller, Duncan and Sparks (2011) suggest that therapy becomes more successful when practitioners pay close attention to the clients' ideas about 'what works' for them, and follow the clients' lead in what steps should be taken.

In order for therapists to be able to put these concepts to use, *deliberate practice* is key (Miller et al., 2015). With deliberate practice, the researchers mean taking time, as a practitioner, to reflect on one's performance. This can be done by consciously considering the (clients) feedback received and using it as guidance to improve specific parts of therapeutic practice, or instead build further on those factors that are perceived as useful and/or helpful (Miller et al., 2015). As discussed in Miller et al. (2015), routine outcome monitoring (ROM) is useless if practitioners do not engage in *deliberate practice*, or in other words, actually adapt and improve their practices based on the received feedback. Building on these considerations, Duncan et al. (2003) developed the Session Rating Scale, to be used as a practical, clinical tool for health care professionals to evaluate sessions in a day-to-day setting. The tool encompasses all three elements of the working *alliance*, with a focus on the *clients' theory of change* (Appendix 3). It allows for the professional to address the clients view on the *interpersonal relationship* between provider and client*, goals and topics* (did we address everything you wanted to address?), *the overall approach or method* (of the provider) and *the experience with the session overall* (Duncan et al., 2003).

The major barriers for the routine collection of client-feedback were found to be time and comprehensibility (Miller, Duncan, Sorrell and Brown, 2005). Multiple studies found that the majority of practitioners do not consider any measure that can be used for feedback that requires more than five minutes to use, score and interpret. The same tolerance was found for clients, who quickly lose focus with measures that take longer than 5 minutes to complete, besides the point that a longer instrument will take up valuable time with their practitioner (Miller et al., 2005; Duncan et al., 2003). Therefore, the SRS was designed as an ultra-short measure that could be completed in under 1 minute. With the SRS, Miller et al. (2005) demonstrate that collecting client feedback does not have to be complicated and overly time-consuming, and can be used to systematically monitor and adapt the quality of an ongoing care process.

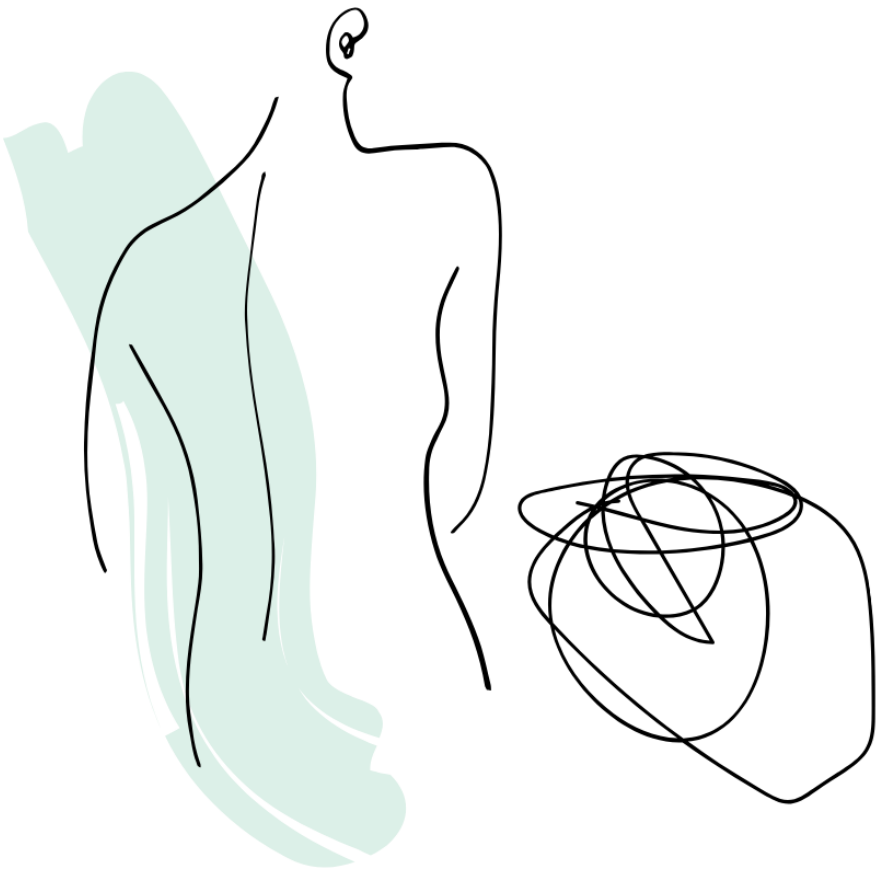
4.2.5 Summary of the literature

What becomes clear from the literature regarding the role of the client in the evaluation of health care practices is that increasingly, the clients' evaluation of care is accepted as a valuable marker of health care quality in itself. However, the exclusive use of quantitative measures to gather this data is critiqued. It was found that in order to adequately explore what makes health care 'good' according to clients, the use of client narratives is useful in gathering information on health care quality that is grounded in direct experience and is sensitive to context. This feedback helps to create a deeper understanding of clients' needs and expectations, and more importantly, how these can be incorporated in the improvement of care.

It was found that the *alliance* between health care professional and client, as well as the *clients' theory of change* are two central concepts to be taken into account in the evaluation of 'what works'

from a clients' perspective. Building on these concepts, the Session Rating Scale was developed (Duncan et al., 2003), an evaluative measure of client-experience to be used in day-to-day clinical practice. However, in order to be able to use the valuable information provided by client-experiences effectively, *deliberate practice* by health care professionals is key. Without professionals deliberately reflecting on the feedback received and realising the implications for one's performance, the information provided by client-feedback is powerless. Therefore, apart from gathering client-experiences on a routine basis, *deliberate practice* by practitioners is equally important in the evaluation of health care.

These findings have a few implications regarding the evaluation of the SFA. Firstly, in the process of evaluating the SFA, client-feedback can be a valuable marker. Here, it is important that there is room to capture clients' narratives, to allow for a deeper understanding of the implications of these experiences. Secondly, it is important to gather this feedback on a routine basis, in order to allow for *deliberate practice* on the end of the health care professional. Thirdly, to gather this feedback systematically, a tool similar to the Session Rating Scale could be applied to the evaluation of the solution-focused approach. Following these implications, a feedback-tool was developed based on the Session Rating Scale, aimed to capture client-experiences with the solution-focused approach in practice (Appendix 6). Experiences of both health care professionals and clients with the use of this tool, as well as their experience with feedback in general are discussed in the next chapter.



4.3 Results of the interviews

The results of the interviews with both clients and professionals can be divided into three overarching themes that both followed deductively from the interview schemes as well as inductively during the coding process. These themes were: 1) the subjective experience of being asked for feedback (client) and asking for feedback (professional), 2) the user-friendliness of the feedback-tool as experienced by the client as well as the professional and 3) the perceived suitability of asking for feedback with a solution-focused approach as experienced by clients and professionals. Experiences of clients and professionals were documented separately for clarity purposes, apart from Theme C: the suitability of asking for feedback in the SFA, because this topic yielded no detailed responses from the clients' end.

4.3.1 Theme A1: Client experiences of being asked for feedback

The client interviews focused in part on the subjective experience of being asked for feedback by their health care professional. All of the respondents (n=3) expressed that they felt that being asked for feedback by their provider was a positive experience. Reasons why this experience was seen as positive varied from being able to mention things that they run into during their consultations (n=1), being able to vent/speak their mind (n=1) and seeing things from a different perspective after expressing them to their provider (n=1). In addition, two of the three respondents specifically mentioned feeling heard and involved in the care process as a result of being asked for feedback.

"Well, its kind of nice, because well, you can vent a little bit on, well, things you run into, you can express them so to say. And talking about them, it makes you see things a bit differently, yeah. That feels pretty nice".
-Client obstetrician

"Yeah, it feels pleasant, actually, it gives you the feeling that you, that you are more involved with the treatment that is going to start, and that there is um, room for my experience, to express my experience as well"
-Client primary care assistant GGZ

In addition, one respondent mentioned that being asked for feedback explicitly during consultations may help in those situations where the client has a bit more of a closed character. She mentioned if someone is less of an expressive person, it may help to be explicitly asked for feedback by their provider. The use of a scale question, according to her, could contribute to this effect.

"Yeah, if you are a bit of a closed person or something, and you ask it like this (using the feedback-tool), of course that may help to express certain feelings or ideas, yeah, I think so".
-Client obstetrician

One respondent mentioned that being asked for feedback attributed to the bond of trust that existed between him and the health care provider. He expressed that he had had the same general practitioner for a long time, and being asked for feedback by this practitioner on both the care process as well as their cooperative relationship provided to this feeling of trust.

"Well, um, because he is a trusted person, I mean he is my general practitioner, and that gives us a good relationship. I have had (name general practitioner) for a long time as my doctor, um, my practitioner, and yeah, this is a very trusting relationship, which gives me a lot of inner peace, which is good for me. Talking about these things (the feedback) helps with this".

-Client primary care practitioner

On the experience of being asked for feedback by making use of a scale-question, one respondent expressed that she felt it was something she were not used to. The respondent said that she was used to knowing what to expect during a consultation, since all consultations had a similar planning. Therefore, she suggested that the scale-question could possibly be more fitting for new clients who did not yet know what to expect. However, after an explanation that the feedback tool is meant to evaluate an ongoing care process and keep track of progress, the client agreed that giving feedback could help concretize wishes and expectations during this time.

Something that is also worth mentioning about this respondent is that the type of health care provided by an obstetrician may also be a typical one, since many of the consultations for an obstetrician are routine visits in which certain tests are done and routine technical questions are discussed. This was also confirmed in the interview with the obstetrician, who mentioned that the usefulness of the feedback-tool relied largely on the type of consultation and setting. For example, if the consultations are more routine and focused on the physical aspects of pregnancy, asking for feedback may be less relevant or practical, due to time constraints.

"Well, in all this time, I am just not used to something like this. It is actually, you kind of know what to expect, a fixed schedule. So this is new. But maybe for someone that visits for the first time, this could be an option?"

-Client obstetrician

4.3.2 Theme A2: Health care professional experiences of asking for feedback

In the interviews with health care professionals, the respondents were asked how it felt to ask their clients for feedback. All of the respondents stated that asking client feedback was a positive experience (n=4). Something worth noting was that three out of four respondents mentioned that they already had experience with asking their clients for feedback in some way or another before they were introduced with the feedback-tool used in this research. One of these respondents had learned about asking for feedback in her previous coaching-training, which also relied on solution-focused techniques, and one respondent already used a different set of feedback questions (the full Session Rating Scale and related Outcome Rating Scale, as well as versions specified to children) in his consultations. These are included in Appendices 3, 4 and 5.

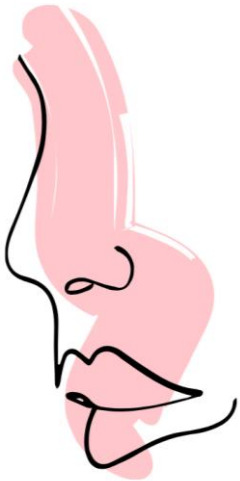
"Yeah, asking for feedback feels good to me. I do it regularly, not by placing a marker on a scale, but more like, 'was this conversation to your liking?', and um, 'do you have anything to add?', 'was this what you had in mind with this conversation?', you know, that is something I do a lot. So it is not entirely new, but letting clients place a marker on this scale is new to me, I have no experience with that".

-Interview obstetrician

"How does it feel to ask clients for feedback? Very good, I always do it. A bit like this (points at feedback-tool), but more elaborate. I have a different scale for children and adolescents, and after each consultation, I ask clients to fill them in".
-Interview child psychologist

When asked about what makes the experience of asking for feedback positive, three out of four respondents mentioned the collaborative relationship between professional and client. According to the respondents, by asking their clients for feedback the relationship becomes more equal. This equality, according to the respondents, related to making the clients feel heard and stimulated to share their own experiences, which another respondent referred to as 'information'. According to them, the flow of information should not be one-sided but both parties should have equal input in the care process, and asking for feedback explicitly could contribute to this.

"Yeah, I think it (asking for feedback) is a very good approach, one of the things with asking for feedback is that it helps improve the collaborative relationship, it becomes more equal, as a result. And this helps, because the more equal the relationship, the more information I receive from the client. And this information is, of course, crucial to me to improve the result of our sessions (…) With equality I mean mostly that I want to use the expertise of the client; whereas I am an expert in the field of health care and treatment, I don't know the background of the client, I do not know anything about their situation, I don't know where the possibilities and resources are. So this information must come from the client. And the more equal the relationship, I think, the more you get it all out on the table . And I think this is beneficial but also results in better outcomes".
-Interview general practitioner



"Well, asking for feedback is essential for the relationship, you know, because you just need to know if you are on the right track, with the contact, and the reciprocity, and that they feel heard. So that is the value of asking for feedback. And once all that is secured, well, then you can move on with looking for solutions and just fully utilize the (solution-focused) method as it is supposed to. And only then you can also expect that they (the clients) contribute fully and honestly as well".
-Interview child psychologist

Apart from the collaborative relationship, the positive experience of the respondents was linked to the consults becoming more 'fun', natural and enjoyable when more emphasis was put on the clients' experience. One respondent also mentioned that asking for feedback led to a very open, first-hand reaction from the client, which is something he enjoyed during the consultations.

"Well, I haven't used it (the feedback tool) that many times yet, but um, since two weeks I am using it regularly and I have to say, I have become very enthusiastic about it. Because it elicits such enjoyable feedback conversations. You really get a first-hand, open reaction. And yeah, I really like that, openness, if possible. As Frederike (SFA-trainer) said, 'the difference between good health care and excellent health care is always trying to see if you can improve yourself a bit more'.
And then I thought, yeah, she's right, that's what this does".
-Interview primary care assistant GGZ (POH-GGZ)

When asked about her experiences with asking clients for input, one respondent stated that it helps open up a natural and positively oriented conversation:

"And so I asked, so what is different this time (than with previous care providers)? Well, she said, that I can just say everything and give input on what I think. And I thought to myself, how hard can it be? I mean, it's just asking; 'What do YOU want? How do you see it happening? What DOES work for you?'. And then, people start to blossom. Like, oh yeah, this ís going right for me, and what is going better than when I did it before? And what is needed to make it a little bit better? Yeah, you know (she leans back, spreads her hands), I don't have to do anything! It just comes naturally then!"
-Interview obstetrician

When inquired further about their experience with asking their clients for feedback, a different experience was expressed by multiple professionals, namely that they felt asking for feedback felt a bit egoïstic (n=2). They felt that asking for feedback could feel like a procedure that benefits the development of the professional and places emphasis on the professional and less on the client.

"Um, no, the feedback is more for myself. Clients like to be able to speak their minds, expressing their goals. But asking for feedback is more for ME, I don't know if the client is always that keen for it (…) It (asking for feedback) must not REPLACE the client. You know, the client is CENTRAL, and the tool must not become an instrument in that sense that the client feels like, um, 'oh this obstetrician is after something, this is part of some sort of test meant to develop herself…'. The first thing a client must feel like is that they are the only person in the world right now that is pregnant, and the rest of my life she (the obstetrician) will be there for ME. Like that. That feeling, you know, that is what they should feel like, and um, if you can bring that across during a consultation, I think that's important".
-Interview obstetrician

This feeling of selfishness was also connected to the factor of time by the respondents, who expressed that they felt like asking for elaborate feedback during an already short consultation felt like pushing the boundaries of the conversation. Therefore, they expressed that it is vital to be able to discern in which situations asking for feedback is suitable and appropriate. Also, another respondent expressed that elaborating too much on the client feedback could create the feeling (for the client) that you are trying to rationalise subjective feelings or emotions, which he felt is not beneficial to the conversation.

"So I think in that sense it is very important to be able to sense that, whether you can pull this (asking for feedback) off or not in this situation. Yesterday, I had someone who's baby had a development abnormality, so we talked about that for a while, and I could see she was really putting on a good face, these are also the type of people that are not very expressive, so then I am not going to ask a scale-question in such a moment, you know. Then I think to myself, we just had a good conversation, I have a good sense of how they feel right now, let's leave it at that".
-Interview obstetrician

"Yeah, because it (asking for feedback) is not a priority you know, at least not for the client. So it would be more for myself, and then, keeping in mind the time, I think you have to choose for the most efficient way (of asking for feedback), I think. If the results (of the scale-question) are notable, then I take a bit more time for it, but then I would ask 'is it alright with you if I ask some more questions about this, because it is not totally clear to me yet'. And even then I keep it short, you know, because um, you immediately end up thinking in abstractions. And I don't think that is very solution-focused, it

instantly becomes such a 'weird' conversation if you ask your clients to take a helicopter-view to look at their relationship, and if the doctor (himself) did it all right and whatnot. There is just so much… And often it is more like a feeling, a raw experience they are talking about, and then you go and rationalise that in a conversation".
-Interview child psychologist

4.3.3 Theme B1: User-friendliness of the feedback-tool as experienced by the client

Additionally, clients were asked about their experience with the user-friendliness of the tool. The questions regarding this subject were mostly focused on the understandability of the feedback-tool, its goal, and the length of the feedback-session. All respondents stated that the tool was understandable and easy to use (n=3). However, from the answers in the interviews, it became apparent that two out of three respondents had trouble interpreting the exact purpose of the feedback instrument. The sub-theme that arose inductively out of these interviews was that of 'misinterpretation of the feedback-tool', since this experience came forward in both the client as well as the caregiver interviews. For example, when asked which question they were asked by their provider with the feedback-tool ('*how does the approach fit?*'), none of the respondents could exactly remember what they were asked. Also, especially when asked about their experience with filling in the scale-question as a means to provide feedback for their provider, two out of three respondents gave answers that indicated they interpreted this question as a 'rating' of their provider. When asked what they liked about the scale-question as a way of asking for feedback, one respondent answered:

"Well, you know how they (the obstetricians) are and how they do their work, and how they listen to you, so then you just know what kind of mark you should give. What kind of grade. But... I don't know, do you do anything with this rating, like, do you communicate this with them (the obstetricians)? Like, do they get to see this mark as well?"
-Interview client obstetrician

When told that the 'marks' on the scale-question were solely for the caregiver itself, to discuss if anything could be improved about the consultations or the relationship, the respondent answered:

"Well, more improvement is impossible because there is no higher grade than a 10 (laughs). No, because I am just, well, very satisfied. Yeah, you know, especially with how in the past she (the obstetrician) has helped with the others (previous children) and also, how she picks it up now. So it (the grade) is really just, well deserved, yeah".
-Interview client obstetrician

At the end of the interview, the same respondent stated:

"Now I just hope that they will get.. keep, a good score. I mean, it's like, just to see what they score averagely or something, right?".

Although the researcher explained specifically at the start of the interview that the questions asked in the interview were not meant as an evaluation of the care provider, it seemed as if some respondents did interpret it this way. Another respondent, when asked how he would describe the feedback session to a friend or family member, stated the following:

"Umm, well then I would tell them, well, yeah, what I thought about doctor (name general practitioner), and um, how I expressed myself, and that it turned out positively, and that I um, gave positive feedback and that I have given a high, like really high score, and that the conversation um, was really pleasant"
-Interview client general practitioner

In contrast, the third respondent stated that it was very clear that the feedback-tool was meant as an instrument to evaluate the overall approach. When asked how this became clear, he stated that their health care provider gave a clear explanation of the goal of this tool beforehand.

"Um, well (name provider) explained the tool very clearly, like, what its purpose was, and for me it was clear after that that this was a tool to look at um, if I agreed with the treatment method that we would be following, so to speak".
-Interview client primary care assistant GGZ (POH-GGZ)

When asked about their experience with the length of the feedback moment, all respondents stated that they were satisfied with the duration. When asked to define what they thought to be an appropriate length, the responses varied from 3 to 10 minutes. Although all respondents said that such a feedback moment could be kept short, one respondent mentioned that she appreciated that their caregiver had taken a bit more time to talk to her and wasn't 'hasty' about it, and one respondent mentioned that the feedback moment could have lasted even longer if it was up to them.

"Yeah, so today she (the obstetrician) really took ample time for it, not hasty at all, really took her time. But yeah, what would be normal, around 5 minutes? Yeah, I think you can discuss a lot in that time".
-Interview client obstetrician

"Oh, well I thought, it was not long at all, no, I mean, it may have lasted longer if it were up to me you know (laughs), yeah definitely. Then I could have, perhaps, elaborated more on why I had given this feedback, I could have explained it a bit more. I think like, ten minutes would be good, maybe?"
-Interview client general practitioner

4.3.4 Theme B2: User-friendliness of the feedback-tool as experienced by the health care professional

The interviews with the health care professionals also inquired about the user-friendliness of the feedback-tool in day-to-day clinical practice. The care providers were also asked about their experience with registering and applying the client-feedback in the following consultations. When inquired about the user-friendliness of the tool, apart from time and understandability (for the client), two sub-themes also arose inductively from the interviews, namely; applicability of the tool in different contexts and the general impression of the (design of the) scale question.

Regarding the time-efficiency of the feedback-tool, all of the respondents mentioned that these moments of feedback could be kept short and to-the-point, and estimations of appropriate lengths varied between 1 to 5 minutes. Out of the total respondents (n=4), two mentioned specifically that time constraints were a major factor in their approach to asking feedback. One respondent mentioned that because of the time pressure, it was very important to recognise in which context and with which types of persons it could be fitting to use the feedback-tool.

"I have used it (the feedback-tool) a couple of times, yes, but what I run into is that our times are pretty.. sometimes really every minute counts, and you have a fixed number of hours, and you think, 'I'm running late', and then you have to use the feedback-tool, and some people are like 'oh that's fine, I'll do that' (she pretends to quickly fill in the scale-question). But there are also people that say, 'Oh, what's that for? Ooh, how does it work?' (she makes a surprised face). And then I think, 'oh dear, hurry up, put on your coat, because my waiting room is filling up!'. Do you understand? So time is a pretty important point (…) And within 2 seconds, when they walk in, you have to know if you can use such a tool or not. Because if someone walks in, you have already had 30 seconds of your consult, and I think I would already start determining if I will be able to use it or not".

-Interview obstetrician

The other respondent was used to using a different set of questions (the Session Rating Scale and the Outcome Rating Scale, Appendix 3 & 4) altogether, which could be completed in 1 minute. He mentioned that he preferred these more specific lists of questions over the one, more general question from the feedback-tool ('*how does the approach fit?*'), because of time constraints. When asked how long would be appropriate for a feedback-moment, he answered:

"Well, it should be possible within one minute. So I don't think you should be having an elaborate conversation about the feedback, therefore I think this (points to own questions) is more valuable than this (points at feedback-tool). Because that is not what they (the clients) are coming for, you know, so talking about feedback is another ten minutes, and yeah, we have a session of half an hour, and it must all happen within that time frame, so you cannot afford to lose ten minutes of that to an evaluation".

-Interview child psychologist

It was striking that all respondents (n=4) also specifically made comments about the (un-)suitability of the feedback-tool in certain contexts. Firstly, two respondents mentioned that they thought the feedback-tool would be more useful and applicable in situations where clients are higher-educated and have more structured character traits. The respondents stated that in this case, clients are more inclined to quickly understand what is expected of them and using the feedback-tool will take up less time because there is less explanation needed. One respondent also linked this understanding of the feedback-tool to the mental state of their clients, where she differentiated between those that feel confident and those that have a more dependent, wait-and-see attitude.

"Yeah, so, the people that are really, um, often a bit more intellectual, people that are consciously pregnant, that um, have more structured character traits, but also sometimes for people that are a bit more expectant and have a fear of failure, they like to have something to.. (pretends she places a marking on the scale). While there are also people who are very afraid and have many worries... Then I would not immediately use this (points at feedback-tool). Then I would just say, gosh, tell me what's on your mind, you know, just very open like that. And often then something comes up, like, I'm afraid that something's not right, or, I'm not completely happy, or I am really anxious or something like that".

-Interview obstetrician

"Yeah, and he (the client) does not have a high education, you know, so I think with people who are a bit more higher educated this (using the feedback-tool) will be a bit easier and smoother than with people who have lower education. In that case it is often necessary to make a few additional explanatory comments and ask a few extra questions to ensure they understood what you want from them".

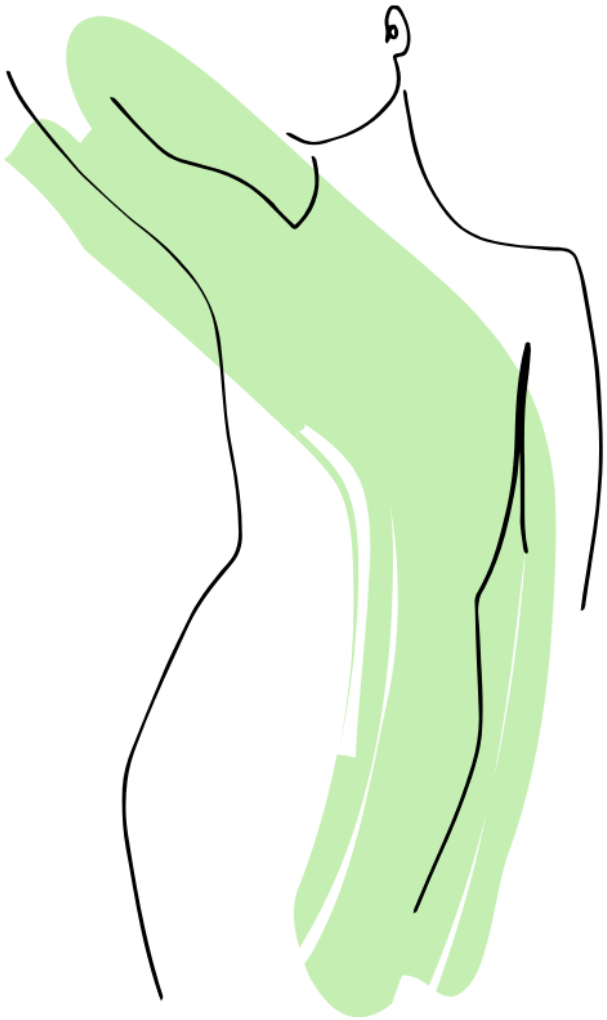
-Interview general practitioner

Secondly, the other two respondents also made comments about the usefulness of asking for feedback, but in the positive sense; they stated that they felt asking for feedback was fitting in their line of work. For example, the child psychologist said that in the field of youth health care, making use of scale-questions is very applicable because of its ease and understandability for children. He also expressed to often have to deal with the parent's feelings as well. Here, visualising the child's experience contributed largely to opening up a positive conversation with both parents and child.

The primary care assistant GGZ (POH-GGZ) also mentioned the use of feedback to be very helpful in his line of work (primary care), since the meetings with his clients are often short-term (with an average of three meetings per client). Here, using a feedback-tool helped to pinpoint more specifically what goes right and wrong, but also at which point clients feel like they are satisfied with leaving the care-trajectory. He felt like it was especially fitting in his line of work as a method to efficiently organise the care-trajectory, because clients are always able to make a new appointment should need arise.

"And you know what's nice about it, if you are talking about children and youth, then you also have to deal with development and upbringing, and the parents' are there too, and often I have much more to do with the parent than with the child. And for the child it's like, this makes sense to me, I have placed this marker and I understand what is expected of me. And the child, they think it's fun too, they think like, oh wow, now I can tell my story. And for the parents, they are often very anxious about their child, like, oh my child has a learning problem, or trouble sleeping, or whatnot. And then what happens is, after I have validated the parents for their worries, I go and talk with the child like this (points to scale-question), and then it turns out they give high marks. And then you see the parents look to each other like; 'what is happening? But I thought it was much worse?'. But it turns out, it isn't. And not just the marks, but also the explanation. So they hear things, why the child gives this mark, that they have never heard before. So the lens through which the parents look at their child, through their own fear, is corrected on the spot".

-Interview child psychologist



"Yeah, so it can help to discuss; 'is this good enough? Is it good enough, or do you want even better?'. And then, often you are surprised that they (the clients) say, 'no, this is good enough for me'. Well, absolutely right! Very well. And you know, in this line of work I can also simply say well, all the best to you and goodbye, because, people know that if they ever want to come back, they just need to make a new appointment. And that is the difference with many other GGZ-trajectories. Because there, 'it's good enough', means alright, we are done, here is your evaluation-questionnaire, the gate is locked behind you and there is no going back. So with me, people don't have to worry about saying, I have made progress and for now, this is good enough for me!".
-Interview primary care assistant GGZ (POH-GGZ)

With regard to the understandability of the feedback-tool, all respondents agreed that the tool is very easy and quick to use. Three out of four respondents also stated that the tool is understandable for clients, although in some contexts some preparatory explanation of its goal and use is necessary. Especially the use of a scale-question was thought to possibly contribute to misinterpretations of the goal of the tool since it was linked with giving a 'grade'. This could be overcome by explaining the goal clearly beforehand.

"Yeah, sometimes there is some confusion, because um, people tend to think like; 'if I go too low that's a bad thing', or something. I think that one lady also thought that. She found it so difficult to answer this question, because 'this scale-question, it has cónsequences!', you know, sometimes people think that. So I always try to make it as value-free as possible. 'Whatever you answer, it's always good!'. Every answer is fine, and then we can see like, how can we make it even bétter. Yeah. And that is not on you, and it's not on me, but it has to do with what we are doing. But sometimes you do have to clarify that a bit, that it's not a matter of value-judgement. No, it's about what direction you want to take, and how we can work towards that in small steps. Yeah".
-Interview primary care assistant GGZ (POH-GGZ)

According to this same respondent, the use of a smiley face to indicate 'unsatisfied' and 'satisfied' could help with taking clients' attention off' of the idea of giving a 'rating' as well.

"And then the um, the scale question with the smileys and, the frownies, or what you'd call it, the frowning one (laughs), you know, sometimes that is a little easier because then people don't think about the 6, or the 7, or the 5 or 5. They don't think of it as a literal 'score' but more like, where on this line would I be? And where would I want to go?
-Interview primary care assistant GGZ (POH-GGZ)

One respondent felt the question '*how does the approach fit'* is too ambiguous and is often misunderstood by clients. A side note here is that this respondent was used to his own set of questions (the outcome rating scale and session rating scale) and felt like this more general question, although meant to encompass the elements of the ORS and SRS, set clients on the wrong foot:

"Yes, because um, the client does not understand this question correctly (points at tool), they do not understand the question, because they think like, that the 'approach' must lead to a solution. So to them, they are answering the question 'do I already have a solution to my problem?'. So they answer this question like, if they (the clients) have the feeling that the problem has already lessened. And that is not what you are asking".
-Interview child psychologist

The respondent mentioned that the reason clients misunderstand this question is because you are asking them about something they are not aware of, namely the solution-focused approach. When asked if this problem could be evaded by giving a more detailed explanation of the goal and use of the tool beforehand, the respondent answered:

"Well, yes, you should do that yes. But I don't do that, but because of that I keep seeing that this question (points at tool) is given a lower score (than his own questions). So the question (from the tool) is interpreted like, if they have the feeling that their problem is lessened, and that is not what you want to ask (…) For this question to work, you first need to explain what you want from them. Because this question implicates that they know what you are talking about, but they don't. They have no idea that I have structured the consult this morning along the lines of a method (SFA). No idea. So to understand this question, you need an explicit explanation of the solution-focused method. And I don't do that, because if time is of the essence, you need to choose the most efficient method, I think. And that is why I think this (points at ORS and SRS) is more valuable than this (points at feedback tool)".
-Interview child psychologist

The researcher explained that the idea of the question '*how does the approach fit*' is also that it is based on the broader themes of the Session rating scale, and that it is meant to give the provider the opportunity to discuss multiple components of a solution-focused approach such as the collaborative relationship between professional and client. To this, the respondent answered that he thought the question *'how does the approach fit'* is too broad to encompass all those factors. When asked what the respondent thought could improve the question, he answered that you need to ask more questions to accurately capture all those factors that shape the 'approach'.

'You cannot measure all this (points at SRS) with óne thing. You need to elaborate, ask multiple different questions. Because if you say all those factors could be encompassed by this one question,

and clients give a mark, what exactly have you measured?'
-Interview child psychologist

Contrastingly, three out of four respondents had stated that they found the tool very easy and understandable to use. They actually emphasised the benefits of a single question as opposed to multiple, because it made the conversation more open and accessible.

"Yeah, because, you also have those kinds of instruments that measure like what, 20 to 50 questions you know, and I think that feels like such a big thing. But this is just a kind of summary of everything. And yeah, I think that's very convenient. Because we always say, scale-questions make complex matters simple, you know, instead of questioning about several different components, this way, you ask about the overall picture. I wouldn't know how you could do it better".
-Interview general practitioner

"(…) And I think I will definitely use this tool more often. Why? Because it's so straightforward. Because if you have, like, three or four of those questions, then well, I don't always have, or take the time to discuss áll of them. Yeah".
-Interview primary care assistant GGZ (POH-GGZ)

When asked if they thought the client-feedback could lead to concrete points of action for later consultations, all respondents (n=4) stated that they thought it would. When asked how they would keep track of the client feedback, two respondents stated they would make note of it in the 'journal', one mentioned they mostly kept track of what was discussed in their head. The respondent who made use of the ORS and SRS scale-questions stated that they mostly kept track of 'deviations', which meant ratings that turned out lower than expected.

"Yes, of course! Yes, immediately. Because you see, then I hear what I should stop doing, no more of what doesn't work, and móre of what DOES work. So yeah. And then, for each client I keep track of, um, what steps they take. So instead of, because you have been educated with 'the patient must follow me, because I am the expert, the specialist'. But I'm not, really. Yeah".
-Interview primary care assistant GGZ (POH-GGZ)

"Well I think its a good thing that I use them (the ORS and SRS), but I am mostly alert for deviations, exceptional cases. So if I think a score is notable, then I act on it. Anyway, if you are in this line of work for a couple of years, you just know how these conversations go, how it works, so then, I just expect it (the feedback) to turn out normally, that is, the client feels heard and whatnot, nothing unusual, well then I just know. And if that turns out differently than expected, I become curious".
-Interview child psychologist

Lastly, when asked if they had other comments regarding the user-friendliness of the feedback-tool, two respondents specifically mentioned the design of the feedback-tool. One respondent specifically mentioned that she thought a plasticized instrument could come across as more 'technical' or intimidating, however, she did emphasize that this was a personal preference. Interestingly, another respondent stated the exact opposite, namely that using a plasticized tool with erasable marker adds to the accessibility and openness of the question.

"Um, I think that perhaps an ordinary piece of a-4 paper could suffice as well. Instead of the plasticized… That's a bit, how do I say it, a bit more technical, like; 'this is something we work with here'. And I think that with some people, that fits perfectly, because some people are fond of

following the rules and being organised; this is what we work with, look, here you can place a marker. I am more of the; let's just see what happens. So I would approach it more like; 'so, could you just show me how you experienced the consultation?' (pretends to grab paper and sketch a scale). 'This is unhappy, this is very happy, give it a mark for me please'. Like that, to make it a bit more um, spontaneous. But this is just for me personally, a preference thing".
-Interview obstetrician

"I think the plasticized sheet adds to the accessibility of the tool, that it's just a piece of plastic on which people can place a marker which can then be erased just as quickly. Then, it becomes 'normal' I think. You just, pull it out of your drawer, so to speak, put it in front of them and say; 'place a marker on this, if you will'. Ok, great, back into the drawer, done. It makes it simple, not a whole 'thing'. It's just a short moment of: 'Are we doing good? Can we make it even better?'. That's what I'm interested in, that's all, and then we move on".
-Interview general practitioner

4.3.5 Theme C: Suitability of feedback in a solution-focused approach

Both clients and professionals were also asked about the suitability of asking for feedback with the SFA. Although this question was mostly relevant for the health care professionals, since they had the best understanding of a solution-focused approach, the researcher was also interested in clients thoughts on this. However, because these questions required taking a meta-viewpoint of the SFA, in the client-interviews the researcher only asked these questions when there was enough time.

From the client interviews it became apparent that all respondents (n=3) agreed that they thought being asked for feedback by their health care provider was fitting within a solution-focused approach, especially because it made them feel heard and involved with the care process. However, a more detailed discussion on the suitability of feedback in a solution-focused approach turned out to be too complicated and not fitting within the available time for the client-interviews. From the interviews with the health care professionals it became clear that all respondents agreed that asking for feedback was suitable, or even an essential component, in a solution-focused approach (n=4). Two respondents mentioned that asking for feedback was fitting in a solution-focused approach because it contributes to the equality in the relationship between professional and client.

"Yeah, well, it surprises me, that almost EVERYBODY likes it. Even people that say at first, 'it doesn't matter to me how we do it, you just tell me what to do'. But if you DON'T do that, if you just say to people, tell me what YOU want.. Then it turns out that people really appreciate it, to be able to express themselves, express their own goals".
-Interview obstetrician

"Yeah, it has mostly to do with the relationship. So its like, asking for feedback makes just that little bit of difference, you can be a good therapist, and I repeat here what Frederike says about it, you can be a really good therapist, but you'll only be an excellent therapist if you ask for feedback. So it's in that last 10 percent. (…) And it (asking for feedback) also indicates that you are not in the medical model, but in the model of equality. Asking for feedback, just about how I do what I do, what I can do better, well those are questions that.. that you don't get that often I think, as a client".
-Interview child psychologist

Another factor that was found to be fitting with a solution-focused approach that asking for feedback could help to make complex matters more open to discussion, and to help pinpoint exactly which factors could help take the care process to an even higher level. Here, the respondent also emphasised the usefulness of asking direct client feedback to adjust an ongoing care process. With direct client feedback, the respondent stated, it is possible to elaborate in the moment on what adjustments could benefit the care process and client experience and make them directly applicable in future sessions.

"I think it (asking for feedback) is an invaluable part of the care process. I think its almost impossible to be solution-focused without it. And it (asking for feedback) could also be done more indirectly, there are also other ways to get feedback on if the approach fits, or about your own role in it, but this (using the tool) is just a very straightforward, direct way to do it, and I think that can be very useful. Especially in those cases where you think, how can we improve the approach, then its better to just ask it directly. This makes it concrete. Because a scale question can make complex matters understandable. And then you can start discussing; what is needed to make it better?"
-Interview general practitioner

4.3.6: Follow-up on feedback-tool

A few weeks after completion of the interviews, the researcher sent out a follow-up email regarding the use of the feedback-tool to each professional. The follow-up focused on their experience with the tool after they had been able to try it out in their own time. A set of three questions focused on whether they were still using it in day-to-day practice and why (not), if using the tool led to concrete points of improvement for future consults and if they were planning to keep on using it in the future.

The responses were varying. Two out of four respondents were not convinced about the benefits of the tool. One of them answered that she had not yet used the tool on a day-to-day basis, because it still felt a bit unnatural to her and she would need more practice. However, she specifically mentioned that the fact that the main reason she had not used it more often was due to time constraints, though she did recognise the usefulness of the tool. The other respondent had not used the feedback-tool further and continued to prefer more specific questions.

The other two respondents were positive about the tool and had continued to use it on a regular basis. One of them mentioned he thought the tool helped improve the collaborative relationship and autonomy of the client. The other respondent stated to have become enthusiastic about the use of the tool. He stated to use it often, mostly when in doubt if a certain approach was appropriate. He stated '*in a way, by using the tool you make even more use of the clients' expertise*'. The respondent had also encouraged colleagues to experiment with the tool and stated he carried a copy of the tool in his bag to have it prepared.

Chapter 5: Discussion

The goal of this research was to find out what measures could be applicable for the evaluation of a solution-focused approach in a (primary) health care setting, while taking into account the specific context of the individual client. This was done in two steps: first, an explorative literature study was performed regarding the role of the client in evaluating the quality of health care. Second, based on the results of the literature study a feedback-tool was designed to capture client-experiences with a solution-focused approach. This feedback-tool was used by health care professionals in practice. Then, with semi-structured interviews a preliminary inventory of the experiences of both clients and professionals with using a feedback-tool was made. In this chapter the most important findings of this report will be discussed and compared to the literature. Then, some methodological considerations will be discussed followed by the conclusion and recommendations for future research.

5.1 Interpretation of the results

5.1.1 Findings of the literature

Reviewing the literature, a case was made for the importance of including client experiences in the process of evaluating an SFA in health care practice. It was found that in the field of health care, client experience is gaining increased interest and recognition as a useful indicator of health care quality. In the literature, the appropriateness of using quantitative methods (surveys, questionnaires) to collect client-experiences in a holistic and complete way was questioned (Tsianakas, 2012; Wilcock et al., 2003). From the literature then followed a number of findings on what factors are important when designing an appropriate measure to incorporate client experiences in the evaluation of the quality of health care.

Firstly, the power of using client *narratives* to evaluate and improve health care, as well as to generate new ideas and insights, was emphasised because they allow for deeper reflection on the needs and experiences of clients. To do so, asking open questions to open up the way to clients 'stories' and to create a more open, equal conversation dynamic was found to be important. Secondly, the *working alliance* between professional and client, which includes the (agreement on) goals, necessary steps to achieve this goal and the development of a personal relationship between professional and client, was also found to be a key predictor of successful therapeutic outcome. Thirdly, the *clients' theory of change* was found to be essential to take into account when evaluating 'what works' from a client's perspective. Lastly, it was found to be important that feedback is gathered on a systematic basis to allow for '*deliberate practice'*, which means practitioners take time to consciously reflect on the received feedback. Only by doing so, the full potential of client feedback can be realised.

For a feedback-measure to be applicable in a day-to-day clinical setting, practical constraints were found to be a key factor to take into account, such as time and comprehensibility. In light of these considerations, the Session Rating Scale (Duncan et al., 2003) was found to be suitable to collect client feedback on 'what works' in therapeutic sessions on a day-to-day basis.

5.1.2 Findings of the interviews

Building on these results from the literature, for this research a feedback instrument (Appendix 4) was designed in the form of a scale-question with the text '*how does the approach fit?'.* The tool was loosely based on the SRS and was meant to capture the experience of clients with a solution-focused approach (SFA). This feedback instrument was then tested in practice to make a preliminary inventory

of clients' and health care professionals' experiences with such a tool, as well as the experience of being asked for/asking for feedback in general. This resulted in three overarching themes which will be interpreted next: A) *client- and professional experiences with feedback*, B) *user-friendliness of the feedback-tool* and C) *suitability of feedback within the SFA*.

Theme A: Client- and professional experiences with feedback

It became clear that both clients and health care professionals are positive about being asked for feedback (client) and asking for feedback (practitioners). Key factors that created a positive experience among clients were feeling heard an involved by their practitioner, coming to see things in a new and different perspective, being able to express experiences they were otherwise uncertain to share and the fact that being asked for input contributed to the bond of trust between client and practitioner. These findings resonate with the literature on client-centred care; clients appreciate being involved, asked for their opinions and be able to discuss different options with their care provider (Kvåle & Bondevik, 2008).

Additionally, according to the literature practitioners routinely misjudge how much their clients want to be involved and informed (Delbanco & Gerteis, 2013). This was undesirable, because it was found that provider and client may have very different ideas of what should be the health 'goal', as well as acceptable solutions. Therefore 'shared decision-making', which includes openly discussing the values and preferences of the client, can contribute to the clarification of goals, values, options and uncertainties, leading to new insights for both sides (Delbanco & Gerteis, 2013). Clients were also found to feel closer to their practitioner when they were more involved in the care process and decisions. They also found it important to be able to influence choices of treatment if they wanted. This involvement leads to a feeling of 'partnership' between practitioner and client (Kvåle & Bondevik, 2008). Research by Larsson, Sahlsten, Segesten & Plos (2011) also confirms that when clients feel insecure, they are inclined to hand over the responsibility for care and become passive. This is undesirable, because active client participation can contribute to increased motivation to improve their condition, adherence to treatment and greater satisfaction with the care received. Therefore, it is important to actively invite and support the client to participate (Larsson et al., 2011; Delbanco & Gerteis, 2013). No negative experiences regarding being asked for feedback were mentioned by clients, apart from one who felt it was something new and unusual. However, the same respondent had also interpreted the feedback-instrument wrongly and thought it was linked to their appreciation of their caregiver, therefore the instrument may have invoked discomfort among this respondent.

Health care providers were also positive about asking their clients for feedback. According to them, key factors that made this experience positive were that asking for feedback contributes to a collaborative, equal relationship between professional and client and that the conversations became more natural and enjoyable. This is supported by Bartelink (2013) who found that when caregivers and clients search together for resources and solutions, they are more likely to build a strong, collaborative relationship. Also, talking about the needs and preferences of the client was found to create a lighter and more enjoyable atmosphere (Bannink & Jansen, 2019). Contrastingly, some professionals also experienced that asking for feedback during a consultation could feel selfish. This experience was mostly linked to a lack of time and to the fact that asking for feedback could feel like centralizing the professional instead of the client. This experience resonates with findings in the literature that client-centred care, in general, takes up more time than traditional approaches (Pelzang, 2010). However, for both psychotherapy ('supershrinks') as in medicine, Miller, Hubble and Duncan (2008) found that those practitioners that excelled distinguished themselves from their colleagues in terms of their

attentiveness to direct client feedback. Therefore, although it may feel awkward at first, taking time to ask for feedback for '*deliberate practice'* could eventually lead to an overall increase in efficiëncy, simultaneously creating a more accommodating environment for the client.

Theme B: User-friendliness of the feedback-tool

In terms of user-friendliness, an interesting finding was that although all clients stated that the tool was easy and understandable in use, two out of three respondents showed to have misinterpreted the goal of the feedback-tool to some extent. This was mostly because clients perceived the scoring of the scale-question as a rating of their health care provider. The respondent that did answer they understood the tool correctly mentioned that their practitioner had given a clear description of the tool and its use beforehand. Misinterpretation was also mentioned in the provider interviews, who stated that a scale-question could contribute to the misinterpretation of the question as a rating of appreciation. This resonates with the findings of Bannink & Jansen (2017) who state that it is advisable to explain the goal and use of a scale-question beforehand, to ensure mutual understanding. This is confirmed by Kiser, Piercy and Lipchik (1993), who state that only by asking the right and correctly formulated questions, the question-response process in the SFA can contribute to developing a helpful coöperative relationship between health care provider and client.

Misinterpretation of the tool was also linked by professionals to personal characteristics and context of the clients. Some providers mentioned that the tool might be easier to use with clients who had received higher education or had more intellectual characteristics. In the literature, Ahmed, Burt & Roland (2014) also found that when measuring client-experience, there is some evidence that different population groups may have different expectations of care, as well as different approaches to answering health care evaluations. For instance, higher educated respondents were found to be less inclined to choose the extreme end of a response option, such as a scale (Ahmed, Burt & Roland, 2014).

Providers mainly mentioned time constraints as an inhibiting factor in the user-friendliness of the tool. Because of this, one respondent felt the suitability of the tool was dependent on the context and type of client (e.g. if they would quickly understand its goal and use) and one respondent preferred their own set of questions (the ORS & SRS) to the feedback tool because it could be completed in one minute. However, in line with the SFA-mantra 'what works for this client, in this context, in this moment in time' (Bannink & Jansen, 2017), the tool should be seen as a passkey: a guiding instrument that can be used at the appropriate time (to be determined by the professional) and in the right context to help start and guide a conversation on 'what works'. This was true for one respondent who felt like the tool was helpful in the efficient and timely organisation of the care process because he could clearly track what clients found helpful or unhelpful.

The fact that the feedback tool consisted of one, overarching open question (*'how does the approach fit')* received mixed responses. Whereas one respondent thought that the question was too broad and ambiguous, the other three respondents emphasised the benefits of one open question as opposed to multiple ones, with the main argument being that it allows to discuss the overall picture and makes asking for feedback less intimidating. This resonates with the findings of Wilcock et al. (2003), who state that when collecting client feedback, asking open questions is important to create an inviting dynamic in order to wholly capture people's narratives. Also, when asking clients to score the providers' approach without discussing the implications of the given mark, *deliberate practice* (adapting one's practices in response to the clients' feedback) becomes more challenging (Miller et al., 2015).

Apart from these findings, two contrasting experiences arose from the provider interviews regarding the design of the feedback-tool, which where that the plasticized tool could give off a more 'technical' and serious impression, as well as on the other hand that the plasticized tool with erasable marker actually contributed to the accessibility and simplicity of asking for feedback. Thus, context and personal preference seem to play a large role in the acceptability of the tool as a feedback-measure among health care professionals.

Theme C: Suitability of feedback in the SFA

On whether asking for feedback is suitable in an SFA, the respondents gave mixed responses. The researcher asked both clients and professionals about their thoughts, but on the clients' end the question turned out to be too theoretical. For professionals however, all respondents clearly felt like asking for feedback was a valuable, perhaps even *essential* component of the SFA. The main arguments for this experience from the professionals end were that it helped equalize the relationship between professional and client and made complex matters more open to discussion. Larsson et al. (2011) confirm that an emotionally safe and open environment is necessary for clients to feel safe enough to freely express their own needs and wishes and exercise a level of control on the care process. Here, the power (im-)balance between professional and client plays a large role. An equal power-balance can be achieved by 'sharing power' through good communication and chasing mutual goals, thus creating a safe, equal power dynamic (Larsson et al., 2011). By asking for feedback, clients are actively invited to express their own needs and preferences. This way, clients are given more control over the situation, thus creating a safe and equal space for discussion.

From the follow-up email regarding the feedback-tool, it became clear that health care professionals' attitudes varied largely regarding the use of the tool. Whereas two professionals still felt uncertain about its use or even preferred their own tools, the remaining two respondents were very positive about its use and felt it helped to apply SF-techniques even more. However, all practitioners were convinced about the value of feedback in the health care process. Thus, the attitude of providers towards the applicability of a feedback-tool in an evaluation process is not related to their attitude towards feedback as an evaluative measure in general. Additionally, the usefulness of the tool seems to be dependent on many factors, such as time, setting, as well as the individual characteristics of both clients and professionals.

5.2 Strengths and limitations of the current research

There are some methodological limitations to be considered for this research. To begin with, some strong points of the research are that all participating health care professionals had experience with the SFA and were therefore well-informed to answer the questions on the suitability and user-friendliness of the feedback-tool/asking for feedback. Also, the researcher made a connection between theory and practice, by focussing specifically on the importance of context and the value of client experience in the evaluation of the quality of health care.

However, the number of participants in this study is quite limited. This was largely due to the recruitment method used by the researcher, which was chosen because the researcher wanted to capture direct client experiences after a consultation in which the tool was used. However, this research aimed to make a preliminary inventory of health care professionals and clients' experiences with using feedback as an evaluative measure. Generalisation to larger populations was thus not necessarily the overarching goal, which makes the number of participants a less limiting factor. Also, the relatively small number of participants allowed for the use of semi-structured interviews, retrieving a more in-depth exploration of the participants' experiences with the feedback-tool.

Related to these personal experiences, it is important to note that one of the four health care professionals is an initiator of the 'Gezondhuizen-project'. The same participant was also involved in developing the feedback-tool that was applied in this research. Therefore, this participant may already have had a more positive attitude towards the chosen evaluation measure and could therefore have given answers that are not completely objective, due to his personal involvement in this project.

Clients participating in this research were not randomly selected, but instead chosen by their own health care provider. Often, these health care providers mentioned that they had to look for consultations that were 'suitable' to test the feedback-tool. Unknowingly, providers may have selected those clients that have a more positive attitude on giving feedback in general, or clients who were better able to comprehend the goal of the feedback-tool. However, from the client interviews it became clear that two out of three respondents had misinterpreted the goal of the tool to some level, which indicates that on avarage the clients included in this study were not exclusively positive about the tool beforehand, or more inclined to quickly understand its goal. Another consideration to take into account is that clients might have been inclined to give socially acceptable answers because they were selected by their own health care providers and did not want to negatively influence their relationship. An indication for this may be the misinterpretation of the tool by two respondents who interpreted it as a 'rating' of their provider in general.

The misinterpretation of the tool in general could have been a limiting factor in the client interviews. Some answers may have been based on a wrongful understanding of the tool, which influences the results. However, when the researcher noticed the misinterpretation, they took deliberate effort to correct this and after this, tried to ask the misinterpreted questions again, thus hopefully largely overcoming this effect. Also, the finding that the respondents misinterpreted the tool as a rating was considered a valuable finding in itself.

5.3 Conclusion and recommendations

This study investigated the question '*What are appropriate methods for the evaluation of a solution-focused approach in (primary) health care practices*?'. Based on the findings in this report, it can be concluded that the routine collection of client-feedback in day-to-day clinical practice is a promising measure to evaluate a solution-focused approach while taking into account the specific situation, time and context of the individual client. Client-experience is a valuable source of information that can be used to evaluate (and improve) the client-provider *alliance*, especially by allowing for *deliberate practice* on the professionals' end. Both clients and professionals are positive about using feedback as an evaluative measure. For clients, feedback contributes to feeling involved in the care process, build a trusting relationship with their provider and feeling invited to express sensitive issues. For health care professionals, feedback enables them to fully utilize the clients' expertise in the monitoring, as well as improvement of their approach. Additionally, for professionals feedback contributes to building a collaborative relationship, creating a more equal power-dynamic and opening the way to a more natural, enjoyable conversation with their clients. To collect client-feedback, providers can make use of a feedback-tool. However, the suitability of using a feedback-tool as an evaluative measure is largely dependent on time, personal characteristics of both clients and professionals, as well as context. Therefore, the tool should be seen as a passkey: a guiding element that can be used at an appropriate time and in the right context, to help start a conversation about 'what works' in health care practices.

Several recommendations for practice can be made based on the findings in this report. To start, findings from the interviews indicated that for some clients, the use of the feedback-tool in its current form could lead to the misinterpretation of its goal among clients.

Therefore, it is recommended that professionals give a clear explanation of the tool before using it, but also have a clear understanding themselves, in order to be able to correctly explain its goals and use to their clients. Following from this, it could be recommended that a training or a clear set of instructions (or a combination of both) for health care professionals is designed, devoted to the correct use and goal of the feedback-tool. Optionally, the use of a feedback-tool in day-to-day clinical practice could be taken up in the 'curriculum' of the training sessions organised by the initiators of the Gezondhuizen project. This way, all participating health care professionals could be made aware of the option to use a feedback-tool to collect client-feedback (as well as the value of feedback in general) and simultaneously learn how to utilize this tool most efficiently. Of course, practitioners are still free to decide for themselves if using a tool suits them or not.

The appreciation of the tool in its current form varied largely between care professionals. Some perceived the tool as suitable only in specific contexts, whereas others found it too ambiguous in general. With regard to its design, some found the plasticized design 'too serious', whereas others found that its design gave an open and accessible impression. Therefore, it could be well possible that the applicability of a feedback-tool is sensitive to context and personal preference of the user, as well as the setting in which health care takes place. The SFA-mantra 'what works for this individual, in this context, at this moment in time', seems to be also true for the professional. For some, the tool may be a guidance, for others it may be a barrier. Future research could focus on exploring different types of designs to see what accommodates best to this variance in preferences.

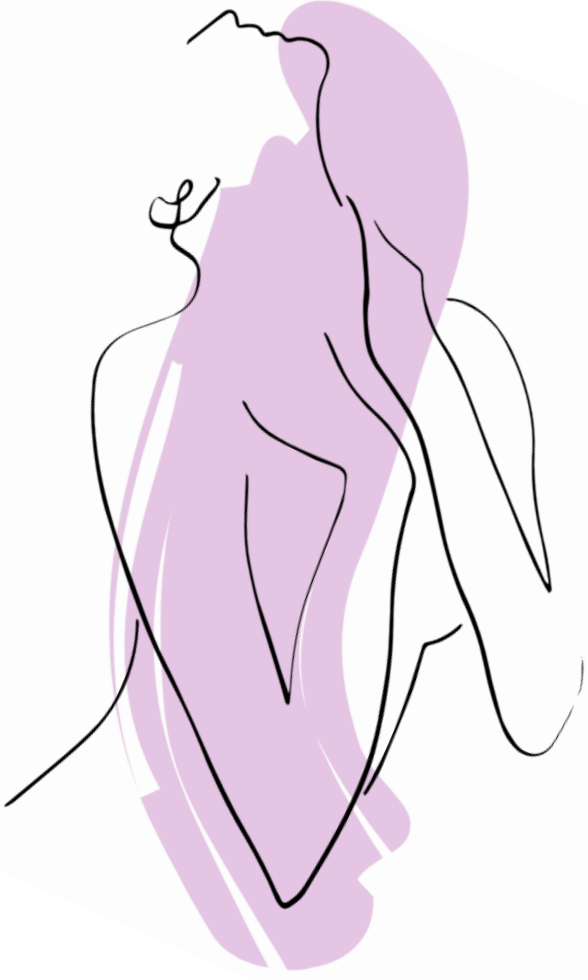
In relation to this, apart from the Session Rating Scale the Outcome Rating Scale was designed by Miller and Duncan (2000) for similar feedback-purposes (Appendix 4). In this research, emphasis was put on including elements of the SRS in the feedback-tool due to the specific focus of the SRS on evaluating the approach of the practitioner. However, it could be of interest for future research to look into the (added) value of adding elements of the ORS to a future feedback-tool, to address clients' wellbeing and progress hereof. The areas adressed by the ORS include personal wellbeing, interpersonal wellbeing (close relationships), social wellbeing (school, work) and general wellbeing, which could be explored through feedback to further tailor the approach of the provider to the clients' personal context. Additionally, possibilities for combining different tools for different contexts could be explored.

Since time constraints were mentioned as the main barrier for professionals to fully utilizing the tool, future research could also focus on how to address this issue. Since the tool in its current form is already designed as an ultra-short measure, it may be more relevant to explore in which contexts and situations the tool could best be used, rather than investigating how to further decrease the application-time of the tool. For example, for those professions that have to balance the more technical aspects of care with talking to their clients about their preferences (in this report: the obstetrician), recognising which moments are suitable for using the feedback-tool may be more pressing than for those professions in which a more significant proportion of the care provided revolves around talking with clients (in this report: POH-GGZ, GP, child psychologist).

However, perhaps the most important finding is that in general, the routine collection of client feedback is considered to be a valuable, or even essential part of the SFA and therefore of a fitting evaluation method. Following this finding, it is recommended that health care professionals working with the SFA take a deliberate effort to enter into dialogue with their clients and use this information to monitor, as well as improve their practices on a routine basis. Future research should explore further the use of collecting client-feedback to evaluate an SFA in practice and apply this on a larger scale, in order to draw further conclusions. This could be done by using the tool, in its current form or a different

one, among a larger number of primary care professionals and professions (e.g. dieticians). It could also be of interest to look beyond the health care centers who are associated with the Gezondhuizen project. Because the Gezondhuizen project mostly takes place in vulnerable, low SES neighborhoods, it may be relevant to see how the tool can be applied in other sectors in the Netherlands and if a differentiation in approaches to feedback-collection is necessary between different socio-economic groups. This is especially relevant in light of the finding in this report that different population groups have different expectations of care, as well as different strategies to answering health care evaluations.

The findings of this research are even more relevant in light of recent developments in the field of health care where the importance of the individual client in making health care decisions is increasingly recognised. The findings in this report show that including the clients' voice is not only important for making specific decisions during the ongoing health care process (e.g. treatment options), but also in establishing a shared understanding of what defines 'good care', for which client, in which context. This is especially true for new, upcoming areas of health care that have not (yet) established a solid reputation because standard evaluative measures are unfit, but have regardless shown promise in what they have to offer. Here, the solution-focused approach makes a good example.



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Appendices

Appendix 1: Interview instrument client

Subject	Process	Content
Opening	-Greeting participant -Explaining the aim of the research -Starting the recording	-Good afternoon. Thank you for allowing me to ask some questions. Shall we start the interview? -As discussed, the goal of this talk is to discuss your experience with the feedback tool used by your health care provider in the previous session. It is important to know that it is **not** about your experience with your care professional or the care in general, but of the way your provider used this tool. -The information provided by you will be processed anonymously and will only be used for this research. The only information I will ask for is your age and how often you visit your care provider. If you do not want to answer a certain question, this is not a problem. The interview will last approximately 10-15 minutes. -For convenience purposes I would like to record this interview. Do you have any objections to this?
General information	-Inquiring about demographics; age, number of visits	-What is your age? -How often do you consult with (name of professional in question)?
Experience of being asked for feedback	-Inquiring about the experience of being asked for feedback -Asking **follow-up questions**	-In your consult, your provider used a tool to ask you for feedback. Do you remember what question you were asked? Was it understandable for you that this tool was meant as a tool to ask for your feedback? *Examples of follow-up questions* → If yes: -What did your provider say or do that made it clear that he/she would like your feedback? →If no: -Can you describe what made it unclear for you? -Can you describe what your provider could have done to make it more clear that he/she wanted your feedback? -How did you feel about being asked for feedback by your care provider? *Examples of follow-up questions* →If positive: -What made the experience positive/what do you like about being asked for feedback? -Can you give examples of what made you feel.. (description of positive feeling) →If negative: -What could have made the experience more positive?
Experience with the feedback tool	-Inquiring about the experience of using the scale-question -Asking **follow-up questions**	-How did you feel about the use of a scale-question as a method to ask for your feedback? *Examples of follow-up questions* -Did you understand what was expected of you with the scale question? -Did you feel like the conversation that resulted from the scale-question accurately captured your experience? -Did the use of a scale-question allow you to say what you wanted to say? -Do you feel like the use of the scale-question allowed you to talk about what you wanted to talk about? -Do you feel like you have been heard? →If not: -What could your provider do differently next time to make it better?

		-How did you feel about the length of the feedback-session? Examples of follow-up questions → If not: -What would be an acceptable duration for you? -What did you think about using a visual aid (the scale) to represent your experience in a feedback session? *Examples of follow up questions* -Can you describe what you liked/didn't like about it? -Did it contribute to the conversation about your experience? →Can you describe what was helpful?
General questions	-Inquiring about the feedback-session in general	-If you go home after this consult and a friend/family member asks you about the feedback moment with your provider, how would you describe to them what happened?
Connection with the solution-focused approach	-Inquiring about the 'fit' of the feedback-tool with a solution-focused approach	-The Veldhuizen health centre is working on a project called 'Gezondhuizen'. Have you heard about it? *Examples of follow-up questions* →If yes: what do you know about it? →If no: explanation. -The Gezondhuizen project means that health care providers use a solution-focused method in their care practices. A solution-focused method focuses attention on the personal goals that their clients may have and less on the health problem and its possible causes. This way, health care becomes a collaboration between client and provider to work towards these personal goals. Have you recognised this approach in your meetings with.. (provider)? *Examples of follow-up questions:* →If yes: -In which ways do you notice this? - Can you provide examples? →If no: -What would a solution-focused consult have looked like for you? -Do you think asking for feedback fits with the solution-focused method? *Examples of follow-up questions:* →If yes: - What makes it suitable for a solution-focused consult? Why does it fit according to you? - Can you explain how you recognise the solution-focused approach in this feedback session? → If no: why not? -Do you think the scale-question used by your provider fits within the solution-focused method? *Examples of follow-up questions:* →If yes: -What aspects of the tool made it suitable for a solution-focused method? →If no: -What made it unsuitable? -How would it have been more fitting with a solution-focused method for you?
Close	-Asking about missed information -Thanking for participation	-Do you have anything you want to add to this conversation or do you feel like I have skipped anything you wanted to talk about? -Thank you very much for your participation, it was very helpful!

Appendix 2: Interview instrument health care professional

Subject	Process	Content
Opening	-Greeting the participant -Explaining the aim of the research -Starting the recording	-Again, thank you so much for agreeing to participate. Shall we begin? -As discussed, the aim of this interview is to talk about your experience of the usefulness and applicability of the feedback-tool, which you used in this consult, in a solution-focused approach. -The information provided by you will be used anonymously and will only be used for this feedback. The interview will last about 15-20 minutes. For convenience purposes, I would like to record this interview. Do you have any objections to that?
General information	-Inquiring about the use of a solution-focused method	-How much experience do you have with the solution-focused approach?
Experience of asking for feedback	-Inquiring about the act of asking for feedback -Inquiring about the applicability of feedback in a solution-focused approach	-How did you feel about asking your client for feedback? *Examples of follow-up questions* -Can you elaborate on this experience? Why was it positive? Do you have experience with asking for feedback already? →If not: What could have made the experience more positive? -Recap SFA (if necessary): In the solution-focused method the focus lies on 'what works' for each client in order to achieve personal goals, instead of focusing on the health problem and its possible causes. In a solution-focused approach client and provider collaborate in finding possibilities and exceptions to work towards these goals. Do you feel like asking for feedback fits within the solution-focused approach and why? *Examples of follow-up questions* -What makes it suitable? What aspects of it are helpful? How do you recognise the SFA in asking for feedback? →If not: what do you think would be a more suitable approach? Do you feel it is helpful to ask your clients what they think of your approach? - What makes it helpful? Or not? How could it be improved? -Do you feel that asking for feedback could help you adjust future consults by focusing on your clients' experience of what works/doesn't work? *Examples of follow-up questions* -Did the feedback gathered with the feedback-tool provide you with concrete opportunities for adjustment? -Do you think you will apply them in the next session? -How would you keep track of the clients' feedback?
Experience of the feedback-tool	-Inquiring elements of user-experience when making use of the feedback tool	-What did you think about using a scale-question as a feedback tool? *Examples of follow-up questions* -What was helpful about the use of a scale-question? -Was it understandable? -Did it help start up the conversation about the clients' experience?

		→If negative: -What would have made it easier to use? Can you provide concrete examples? -Can you describe how you felt about the user-friendliness of this tool as a feedback tool? *Examples of follow-up questions* -What are key aspects of user-friendliness for using such a tool for you? -What did you think about the duration of the feedback session by using this tool? -Was the tool easy to use? →If yes: can you describe what made it easy/practical to use? What were useful/successful elements? →If no: what made it complex? What could have made it less complex in use? -Other than duration and complexity, are there other factors that made the tool easy/difficult to use? -Do you think the tool helped you capture the clients' experience in a complete and accurate way?
Close	-Ask about missed/additional info -Thank professionals for participation	- Do you have anything you want to add to this conversation or do you feel like I have skipped anything you wanted to talk about? -Thank you very much for participating in my research, it was very helpful!

Appendix 3: the Session Rating Scale (SRS)

APPENDIX

Session Rating Scale (SRS V.3.0)

Name _____ Age (Yrs):____
ID# _____ Sex: M / F
Session # ____ Date: _____

Please rate today's session by placing a hash mark on the line nearest to the description that best fits your experience.

I did not feel heard, understood, and respected.	Relationship I——————————I	I felt heard, understood, and respected.
We did not work on or talk about what I wanted to work on and talk about.	Goals and Topics I——————————I	We worked on and talked about what I wanted to work on and talk about.
The therapist's approach is not a good fit for me.	Approach or Method I——————————I	The therapist's approach is a good fit for me.
There was something missing in the session today.	Overall I——————————I	Overall, today's session was right for me.

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Appendix 4: the Outcome Rating Scale (ORS)

Outcome Rating Scale (ORS)

Name _____Age (Yrs):____ Sex: M / F
Session # ____ Date: _____
Who is filling out this form? Please check one: Self_____ Other_____
If other, what is your relationship to this person? _____

Looking back over the last week, including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels. *If you are filling out this form for another person, please fill out according to how you think he or she is doing.*

Individually
(Personal well-being)

I----------I

Interpersonally
(Family, close relationships)

I----------I

Socially
(Work, school, friendships)

I----------I

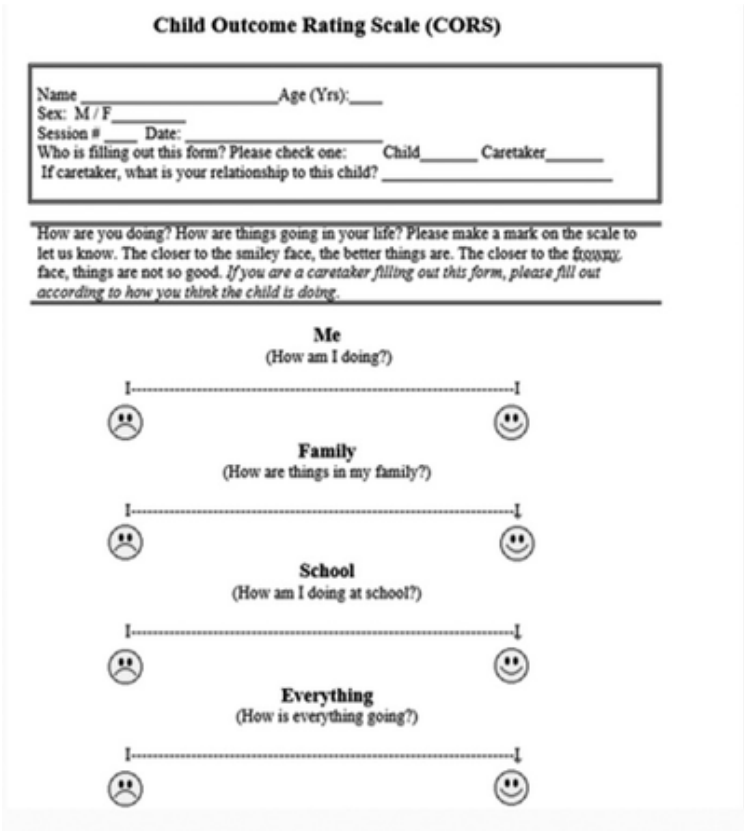
Overall
(General sense of well-being)

I----------I

The Heart and Soul of Change Project

https://heartandsoulofchange.com

Appendix 5: Child Outcome Rating Scale (CORS) and Session Rating Scale (CSRS)



Child Outcome Rating Scale (CORS)

Name _____ Age (Yrs):____
Sex: M / F_____
Session # ____ Date: _____
Who is filling out this form? Please check one: Child_____ Caretaker_____
If caretaker, what is your relationship to this child? _____

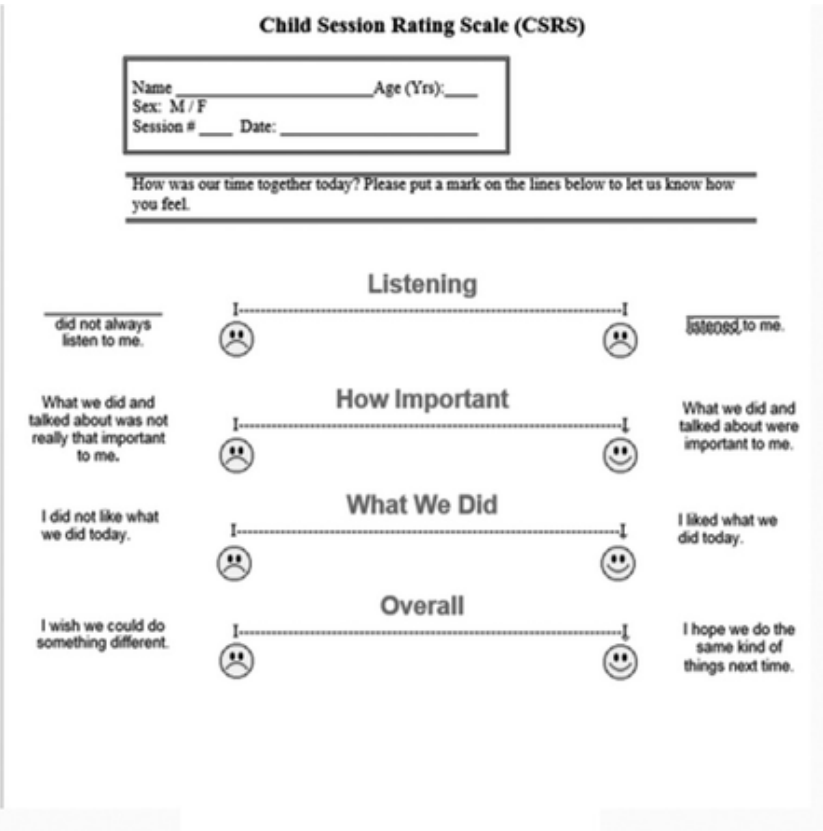
How are you doing? How are things going in your life? Please make a mark on the scale to let us know. The closer to the smiley face, the better things are. The closer to the frowny face, things are not so good. *If you are a caretaker filling out this form, please fill out according to how you think the child is doing.*

Me
(How am I doing?)

Family
(How are things in my family?)

School
(How am I doing at school?)

Everything
(How is everything going?)



Child Session Rating Scale (CSRS)

Name _____ Age (Yrs):____
Sex: M / F
Session # ____ Date: _____

How was our time together today? Please put a mark on the lines below to let us know how you feel.

Listening
did not always listen to me. — listened to me.

How Important
What we did and talked about was not really that important to me. — What we did and talked about were important to me.

What We Did
I did not like what we did today. — I liked what we did today.

Overall
I wish we could do something different. — I hope we do the same kind of things next time.

Appendix 6: The feedback-instrument