ISSN: 2998-8179

Columbia Journal of Health Sciences and Nursing

Research Article

CLIENT FEEDBACK IN FOCUS: HOW FIT DATA HIGHLIGHTS THE INITIAL SESSION'S SIGNIFICANCE

Sarah Elizabeth Anderson

College of Health, Education and Human Services, Wright State University

DOI: 10.5281/zenodo.14898760

Abstract

In contemporary mental health practices, the assessment of treatment outcomes has become imperative, driven by the need for accountability and effective allocation of healthcare resources. This demand for "returns on investment" is a shared responsibility, integral to the therapeutic alliance. Feedback-Informed Treatment (FIT) is an empirically supported methodology for assessing and enhancing the quality and efficacy of behavioral health services. Grounded in Solution-Focused Brief Therapy, FIT involves systematic feedback collection from clients to inform and tailor service delivery. Ongoing outcome evaluations not only inform clinical decision-making but also enhance treatment outcomes. Early client perception of improvement emerges as a significant predictor of treatment success. Incorporating client feedback into counseling supervision has additional advantages, such as improving counselor self-efficacy and ensuring ethical and competent treatment. Various professional organizations, including the British Association for Counseling and Psychotherapy (BACP) and American Counseling Association (ACA), mandate supervision for ethical reasons, serving as an impartial oversight mechanism to reduce the risk of therapeutic oversights and facilitate counselor self-reflection.

Keywords: Feedback-Informed Treatment (FIT), Treatment Outcomes, Counseling Supervision, Therapeutic Alliance, Accountability

Introduction

In today's mental health practices, evaluation of outcomes is increasingly becoming mandatory because policy makers, third-party payers, government agencies, and consumers are concerned that precious healthcare dollars be spent on treatments that work (Miller et al., 2003). Accountability is the watchword of the time, and "returns on investment" is the ultimate goal (Miller et al., 2004, pg. 1). However, accountability must be a joint effort, integral to therapeutic alliance.

Feedback-Informed Treatment (FIT) is an empirically supported approach for evaluating and improving the quality and effectiveness of behavior health services (Miller & Duncan, 2000; Schuckard et al., 2017). According to Miller and Duncan (2000), the theoretical foundation of FIT originates from Solution-Focused Brief Therapy, which involves routinely and formally analyzing feedback from clients regarding the therapeutic alliance and outcome of care and using the resulting information to inform and tailor service delivery.Wampold (2001) and Whipple et al. (2003) have explored how outcome evaluations can be used on an ongoing basis both to inform clinical decision making and enhance treatment effects. Whipple et al. (2003) provided evidence that clinicians receiving information about their client's weekly development, therapeutic alliance, and readiness for change will

observe better outcomes for their clients. A number of investigators have reported that a client's perception of improvement early in the treatment process is one of the best predictors of treatment outcome (Bashir et al., 2018; Duncan & Miller, 2000; Howard et al., 1996; Lambert & Bergin, 1994).

Using client feedback in counseling supervision can also serve another benefit to service delivery. Tracking client outcome and therapeutic relationship across treatments by the supervisor has been shown to improve counselor self-efficacy (Reese et al., 2009). The general purpose of supervision in counselor training programs and beyond is to ensure ethical and competent treatment and to promote skill and professional development (Reese et al., 2009). Many professional bodies, including the British Association for Counseling and Psychotherapy (BACP) and American Counseling Association (ACA), require supervision for ethical reasons (Mulhauser, 2019). Supervision provides an impartial third party to reduce the risk of serious oversight between therapist and client, and help counselors reflect on their own feelings, thoughts, behaviors, and general approach with the client (Mulhauser, 2019).

FIT utilizes two brief scales at each treatment session, an Outcome Rating Scale (ORS) and Session Rating Scale (SRS), with four items on each scale. The ORS is used to obtain information from the client's perspective on their therapeutic progress and perceived benefit of treatment and asks about the client's level of distress and function. The SRS assesses the client's perception of the therapeutic alliance.

Outcome Rating Scale (ORS)

The Outcome Rating Scale (ORS) was developed as an "ultra-brief" substitute for lengthier self-administered assessment tools (Miller & Duncan, 2000, p. 23). It is a four-item, visual analog instrument that asks the client about their personal, interpersonal, social, and overall well-being over the past week's ORS collects information from the client's perspective on their therapeutic progress and perceived benefit of treatment while asking about the client's level of distress and functioning. Miller et al. (2003) carefully examined the instrument's psychometric properties with both clinical and non-clinical samples, as well as the feasibility of the ORS at a variety of clinical sites. The results showed that the ORS is a reliable and valid outcome measure that represents a balanced trade-off between the reliability and validity of longer measures and the feasibility of this four-item instrument. Compared to longer, more established measures of treatment outcome and therapeutic alliance, ORS shows moderate to high reliability, moderate test-retest reliability, and strong concurrent validity (Miller et. al, 2003).

Session Rating Scale (SRS)

The Session Rating Scale (SRS) is a four-item, visual analog instrument designed by Johnson in 1995 to measure the strength of alliance between the clinician and a specific client (Duncan et al., 2003). The importance of therapeutic alliance is foundational to any mental health counseling process. Therapeutic alliance is a significant predictor of successful counseling outcomes (Shaw & Murray, 2014). The four SRS questions ask about the client's satisfaction with: 1) his or her relationship with the clinician, 2) goals and topics for the session, 3) the

clinician's approach, and 4) the client's overall satisfaction with the session. Duncan and colleagues (2003) examined the psychometric properties of the SRS and its relationship to a widely used alliance measure, the 19item Revised Helping Alliance Questionnaire (HAQ-II) by Luborsky et al. (1996). Cronbach's alpha measure of internal consistency is nearly identical between the SRS and the HAQ-II (.88 for the SRS and .90 for the HAQ-II), and the same is true for the test-retest reliability (r = .64 for the SRS, and r = .63 for the HAQ-II). Concurrent validity analyses indicate that the SRS and HAQ-II are measuring the same constructs. Thus, the SRS works as well as the much longer HAQ-II to identify alliance problems and client dissatisfaction with the therapeutic process (Duncan et al., 2003).

Purpose of the Study

The present study involved a secondary analysis of FIT data collected from 2,283 adult clients in three counties in Ohio. With this large data set, we wanted to explore changes in the client's distress level, as measured by the ORS, and therapeutic alliance, as measured by the SRS, over the course of treatment. Clinical cut-off points for the ORS and SRS have been established. The clinical cut-off score for the ORS is 25 for adults 18 years and older, and this cut-off score provides a reference point for measuring the severity of distress a client is experiencing for the ORS measure, with lower scores indicating more distress(Miller et al., 2003). The clinical cutoff score for the SRS is 36 for adults 18 years and older. Total SRS scores above 36reflect a positive therapist client relationship, while scores below 36 suggest that the relationship is experiencing difficulties (Miller & Duncan, 2004). Given the different cut-off scores for clients above and below the age of 18, only data for clients ages 18 and over were used (n = 2,283) for these analyses. For this study we compared clients who moved from below the cut-offs for ORS or SRS scores to above the cut-offs (i.e., clients who improved) with those clients who stayed below clinical cut-off scores for the ORS and SRS (i.e., clients who did not improve).

Method

Participants

Participants in this study were 2,283 adult clients, ages 18 and over, who received counseling services from one of nine community mental health agencies in one of three counties in Ohio. One of the counties was classified as urban, and one was classified as rural in the 2010 US census. A tri-county Mental Health and Recovery Board (MHRB) contracted with the first two authors to evaluate the participants' FIT data. Before sharing the data with the evaluation team, MHRB staff de-identified the raw data to safeguard the privacy of the clients by deleting all personally identifying information. The names of the clients were changed into a random numeric code. For each client, the clients' ORS and SRS scores, gender, and age, as well as the de-identified (numerically coded) counselor and service agency, were provided to the evaluators.

Measures

ISSN: 2998-8179

Columbia Journal of Health Sciences and Nursing

Research Article

Client progress in this study was tracked using the Outcome Rating Scale (ORS) and Session Rating Scale (SRS). The ORS, as described in a preceding section, is used to obtain information from the client's perspective on their therapeutic progress, perceived benefit of treatment, and the person's level of distress and functioning. The SRS, which was also described above, is used to measure the client's perception of the therapeutic alliance.

Procedure

The clients were asked to complete the ORS and SRS scales either by paper and pen or electronically on a computer or tablet at each of their appointments. Clinicians administered the ORS at the beginning of each session and SRS at the end of each session. Each agency collected these ORS and SRS data and stored their clients' responses in a database called My Outcomes Pro Version 1.

Data Analysis. Independent-samples*t* tests were conducted to compare initial ORS and SRS scores of clients who went from below the clinical cut-offs for the ORS or the SRS at their first visit to above the cut-off at the last therapeutic session (i.e., clients who improved) with those clients who stayed below the clinical cut-offs from the first to last therapeutic session (i.e., clients who did not improve). Chi-Square tests of independence were used to analyze the effect of age and gender on failure to improve over time.

Results

For the first session, 1400 clients gave Total ORS ratings that were below the cut-off score, indicating significant clinical distress, whereas only 883 had Total ORS scores above the cut-off. By the last session, this ratio changed significantly, with only 727 below the cut-off and 1556 above the cut-off, X^2 (df = 1, n = 2283) = 307.8, p< .001. Comparing the 636 clients who stayed below the ORS cut-off from first to last visit with the 764 who went from below the cut-off at their first visit to above the cut-off at the last visit, independent-samples t tests were conducted for each of the four ORS questions. The group of 636 clients who stayed below the ORS cut-off from first to last session were significantly more distressed in the first session than the group that improved, as indicated by their significantly lower scores for ORS questions in the first session, for ORS question 1, t(1344) = 7.40, p< .001; for ORS question 2, t(1331) = -4.04, p< .001; for ORS question 3, t(1302) = -5.12, p< .001; and for ORS question 4, t(1351) = -8.71, p< .001 (Table 1).

The Total ORS score at the first session for the individuals who remained below the ORS cut-off from first to last sessions (M = 13.9, SD = 6.3) was also significantly lower than the Total ORS score at the first session for the individuals who went from below the cut-off of 25 at the first session to above 25 in the last session (M = 17.0, SD = 5.8), t(1398) = -9.54, p< .001. This finding suggests that counselors should attend closely to the distress levels of their clients, especially at the first sessions. Given these data, the distress level of any individual client who has a total ORS score below 17 at the first visit should be intentionally addressed at that first visit and at subsequent visits.

ISSN: 2998-8179

Columbia Journal of Health Sciences and Nursing

Research Article

With respect to SRS scores, 971 clients were below the Total SRS cut-off score and 1312 had SRS scores above the cut-off in the first session. In the last session, 634 had Total SRS scores below the cut-off, and 1649 had Total SRS scores above the cut-off, X^2 (df = 1, n = 2283) = 329.7, p< .001. The group of 467 clients who stayed below the SRS cut-off from first to last session reported significantly less therapeutic alliance in the first session than the group of 504 clients who improved, as indicated by their responses to SRS questions in the first session, for SRS question 1, t(941) = -4.25, p< .001; for SRS question 2, t(938) = -2.82, p = .005; for SRS question 3, t(936) = -3.49, p = .001; and for SRS question 4, t(934) = -2.73, p = .007as show in Table 1.

Table 1.*Mean (SD) SRS Scores at First Session for Participants*

SRS/ORS Measure	Group that remained below cutoff from first to last session	Group that improved above cutoff from first to last session
SRS Question 1	7.1 (2.0)[a]	7.6 (1.9)[a]
SRS Question 2	6.9 (1.9)[b]	7.2 (1.8)[b]
SRS Question 3	7.2 (1.8)[c]	7.6 (1.8)[c]
SRS Question 4	7.2 (1.7)[d]	7.6 (1.8)[d]
Total SRS score	28.4 (6.1)[e]	30.0 (5.7)[e]
ORS Question 1	3.6 (1.9)[f]	4.4 (1.8)[f]
ORS Question 2	3.8 (2.3)[g]	4.3 (2.2)[g]
ORS Question 3	3.4 (2.2)[h]	4.0 (2.2)[h]
ORS Question 4	3.6 (1.8)[i]	4.5 (1.9)[i]
Total ORS score	13.9 (6.3)[j]	17.0 (5.8)[j]

ISSN: 2998-8179

Columbia Journal of Health Sciences and Nursing

Research Article

Note: Numbers with the same superscript differ by p = .007 or less.

Total SRS scores at the first session for the individuals who remained below the SRS cut-off from first to last sessions (M = 28.4, SD = 6.1) was significantly lower than Total SRS scores at the first session for the individuals who went from below the cut-off of 36 at the first session to above 36 in the last session (M = 30.0, SD = 5.7), $t(952) = -3.93$, $p < .001$. This finding suggests that therapeutic alliance must be built upon and strengthened from the very first session. Given these data, the perceived therapeutic alliance of any individual client who has a Total SRS score below 30 at the first visit should be thoroughly and thoughtfully addressed at subsequent visits.

Effects of Gender and Age

Chi-square tests of independence were conducted comparing improvement versus no improvement in ORS and SRS scores from first to last session for: (1) men versus women, and (2) five age groups of clients (18 – 24 years, 25 – 34 years, 35-50 years, 51 – 64 years, and 65 – 84 years). With respect to gender and Total ORS scores, women were significantly more likely to stay below the ORS cut-off from first session to last, compared to men, who were significantly more likely to move from below the cut-off at the first session to above the cut-off in the last session, X^2 (df = 1, n = 1400) = 22.9, $p < .001$. With respect to gender and Total SRS scores, men and women showed the same pattern, with an equal percentage of men and women moving from below cut-off in the first session to above the SRS cut-off in the last session, X^2 (df = 1, n = 971) = 0.13, n.s.

A similar pattern emerged when comparing Total ORS and SRS scores for the five age groups identified for this sample in table 2.

Table 2*Number of clients in each age group who: (a) stayed below ORS or SRS cut-offs from first to last session, and (b) moved from below ORS or SRS cut-offs in the first session to above ORS or SRS cut-offs at the last session.*

Age Group (Years)	Group that remained below cutoff from first to last session		Group that improved above cutoff from first to last session	
	ORS (n)	SRS (n)	ORS (n)	SRS (n)

ISSN: 2998-8179

Columbia Journal of Health Sciences and Nursing

Research Article

18 – 24	79	79	119	82
25 – 34	175	176	257	166
35 – 50	263	152	264	189
51 – 64	105	57	114	60
65 – 84	14	3	10	7

With respect to age and Total ORS scores, significantly more young clients (ages 18 to 34 years) improved in terms of reported distress levels from the first to last sessions, compared to older clients (ages 35 to 84 years), who tended to stay below the ORS cutoff from first to last session, X^2 (df = 1, n = 1400) = 13.1, p = .011. However, no significant relationship was found when Total SRS scores were compared from first to last sessions for the five age groups, X^2 (df = 1, n = 971) = 4.64, n.s. As shown in Table 2, age of the client was not associated with improvement in therapeutic alliance for the sample in this study.

Discussion

Creating a culture of feedback-informed treatment in clinical practices is challenging. Feedback in any form can be difficult to receive and asking clients to give feedback about their session can be even more daunting. Feedback within the therapeutic relationship involves skill on the part of the therapist, supervisor, and administrators. Agency supervisors and administrators want to use the feedback from clients to better their therapists' clinical skills and clients' outcomes, but they do not provide the feedback structure to support clinicians**.** Many professional bodies require supervision for ethical reasons (Mulhauser, 2019). Supervision provides an impartial oversight between therapist and client, and help counselors reflect on how to help their clients (Mulhauser, 2019). Total ORS scores less than 17 at an initial session indicate that clients are at risk for deterioration and dropout from treatment. These clients experience less positive change throughout therapy (Maeschalck et al., 2012). Our

findings suggest that clients with the lowest Total ORS (below 17) scores at the first session require special attention to address their level of distress because these clients tend not to show improved ORS scores over time. In these instances, supervision can be helpful to encourage counselors to explore the client's reasons for coming in for therapy. Maeschalcketal.(2012) reported that the lower the ORS score at intake, the greater the sense of distress a client feels, and provision of appropriate support can promote faster change in the therapeutic progress. In our study, clients who entered therapy with ORS scores below 17 typically did not improve. Supervision is essential to support counselors' efforts to facilitate client growth in these at-risk cases for dropout or deterioration. A client with a low Total SRS score (less than 36) indicates that therapeutic alliance is unsatisfactory and the client is not responding well to the clinician. Clinical supervision can explore the goals for treatment, levels of care, and other additional services needed to improve the therapeutic alliance for this client (Maeschalck et al., 2012). Our findings indicated that a client with a Total SRS score below 30 will need more supervision, with an emphasis on improving the therapeutic alliance from the very first session. Improvement of therapeutic alliance is possible with a trusting, safe, and supportive administrative culture that promotes supervisory processing of difficulties, challenges, and mistakes of the clinician to help them grow in their professional development.

Effects of gender and age show that women with low Total ORS scores typically did not improve if their first session Total ORS score was below 17, whereas men did better and improved over time in therapy. Younger clients improved their ORS scores compared to older age groups. SRS findings showed no difference between gender and age.

Supervisors need to focus on lower ORS scores, especially for women and older clients in therapy, to help therapists assist those clients most at risk for lack of therapeutic progress. Our data showed women had more distress coming into therapy, and older clients were less likely to improve in therapy. A possible explanation for this finding may be that older individuals underutilize mental health services, and their symptoms become difficult to change (U.S. Department of Health and Human Services, 2001). Prolonged exposure to mental health issues could also make patients more resistant to change. FIT data can be one of various sources of feedback that a supervisor can utilize by creating a culture of collaboration and humility in supervision. Supervisees will be more open to discuss their doubts, anxieties, or insecurities about a client's issues and distresses. Feedback from multiple sources (e.g., clients, peers, supervisors) can help therapists create goals that improve his or her counselor competence (Borders et al., 2011). FIT data show change patterns and improve clinicians' understanding about what is happening in the lives of their clients. The more clinicians understand FIT, the better able they will be to make meaning of their clients' treatment goals.

Limitations

This study was not without limitations. The data analysis team did not know the counselors, the agencies, and reasons for terminating therapy. The team had no information on the no-show and dropout rates or the level of

experience of the counselors, which could have served as significant covariates. These are all issues that require further study in future investigations.

Conclusion

The purpose of implementation of FIT is to help clinicians make necessary adjustments to their performance to engage their clients for better outcomes, thus achieving quality in their professional life. Furthermore, the supervisor can use FIT data to make appropriate recommendations to counselors for failing cases. FIT measures the quality and effectiveness of mental health service providers. It requires routinely and formally asking feedback from the clients. FIT's client-centered approach is based on the principle that clients are best able to capture their ecological perspectives about their own lives. It is imperative for counselors to incorporate client feedback in the client's treatment. Client feedback will help inform and tailor service delivery methods, such as counselor's readiness, counselor supervision, and expenditures of the agency. Monitoring of client progress and feedback will have an impact on the treatment goals and therapeutic relationship and will be fiscally beneficial for the agencies. The lesson in this research is that FIT should be integrated into supervision. FIT-based supervision can improve the skills, awareness and alliances of counselors with clients and co-workers. Utilizing FIT-based supervision can ensure services being delivered are effective and engaged. Dropout rates are notoriously high in mental health settings, averaging 47% with adults (Bashir et al., 2018; Maeschalck et al., 2012) and between 28% to 85% for children and adolescents (Maeschalcketal., 2012), demonstrating an enormous failing on the part of clinicians to integrate clients' preferences and symptoms. Counselors are not immune from feedback, and sometimes it is difficult for clients to give providers feedback, good or bad. However, it is equally difficult for counselors to receive feedback. Integrating feedback for professional development is crucial for effective treatment for our clients. This is how we improve and grow as seasoned counselors. Dealing with "at risk" clients and feeling safe discussing difficulties, challenges, and mistakes are all part of healthy feedback and professional growth (Bashir et al., 2018).

References

American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders, 4th edition.* Washington, DC.

Bashir, H. A., Wilson, J. F., &Meyer, G. H. (2018). Client engagement related to their satisfaction with treatment outcomes. *The Practitioner Scholar: Journal of Counseling and Professional Psychology* [Online Journal],*7.* Accessed at: http://www.thepractitionerscholar.com/article/view/18335

Borders, L. D., Deknyf, L., Fernando, D. M., Glosoff, H. L., Hays, D. G., Page, B., &Welfare, L. E. (2011) Best Practices in Clinical Supervision. *Supervision Best Practices*, 1-17.

Bringhurst, D. L., Watson, C. W., Miller, S. D., & Duncan, B. L. (2006). The reliability and validity of the Outcome Rating Scale: A replication study of a brief clinical measure. *Journal of Brief Therapy, 5*, 23-28.

Brown, J., Dreis, S., &Nace, D. K. (1999). PsycNET. Retrieved July 17, 2019, from https://psycnet.apa.org/record/1999-02137-012

Duncan, B. L., Miller, S. D., & Hubble, M. (2007). How being bad can make you better. *Psychotherapy Networker, 36*, 45-57.

Duncan, B. L., Miller, S. D., & Sparks, J. A. (2004). The heroic client: A revolutionary way to improve effectiveness (Revised). San Francisco: Jossey Bass.

Duncan, B. L., Miller, S. D., Sparks, J. A., Claud, D. A., Reynolds, L. R., Brown, J., & Johnson, L. D. (2003). The session rating scale: Preliminary psychometric properties of a "working" alliance measure. *Journal of Brief Therapy, 3(1)*, 3-12.

Harmon, C., Lambert, M. J., Smart, D. M., Hawkins, E., Nielsen, S. L., Slade, K., & Lutz, W. (2007). *Enhancing outcome for potential treatment failures: Therapist-client Feedback and Clinical Support Tools. 17(4)*, 379-392.

Harmon, C., Hawkins, E. J., Lambert, M. J., Slade, K., & Whipple. J. L (2005). *Improving outcomes for poorly responding clients: The use of clinical support tools and feedback to clients. 61(2)*, 175-185.

Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of counseling psychology, 38*, 139-149.

Howard, K. I., Moras, K., Brill, P. L., Martinovich, Z., & Lutz, W. (1996). Evaluation of psychotherapy. Efficacy, effectiveness, and patient progress.*American Psychologist, 51*, 1059– 1064.

Johnson, L. D. (1995). *Psychotherapy in the age of accountability.* New York: Norton.

Lambert, M. J., Harmon, C., Slade, K., Whipple, J. L., & Hawkins, E. J. (2005). Providing feedback to psychotherapists on their patients' progress: Clinical results and practice suggestions. *Journal of Clinical Psychology*, *61*(2), 165-174

Luborsky, L., Barber, J., Siqueland, L., Johnson, S., Najavits, L., Franks, A., Daley, D. (1996). The revised Helping Alliance Questionnaire (HAq-II). *Journal of Psychotherapy Practice and Research, 5,* 260-271.

Maeschalck, C., Bargmann, S., Miller, S. D., Bertolino, B. (2012). ICCE Manuals on Feedback-Informed Treatment (FIT): Feedback-Informed Supervision. *Center for Clinical Excellence,* Chicago, IL.

Miller, S. D., & Duncan, B. L. (2000). *The Outcome Rating Scale.* Chicago: Author.

Miller, S. D., & Duncan, B. L. (2004). *The Outcome and Session Rating Scales.* Chicago: Author.

Miller, S. D., Duncan, B. L., Brown, J., Sorrell, R., & Chalk, M. B. (2006). Using formal client feedback to improve retention and outcome: Making ongoing, real-time assessment feasible. *Journal of Brief Therapy, 1(5),* 5-18.

Miller, S. D., Duncan, B. L., Brown, J., Sparks, J., & Claud, D. (2003). The Outcome Rating Scale: A preliminary study of the reliability, validity, and feasibility of a brief visual analog measure. *Journal of BriefTherapy, 2*(2), 91-100.

Miller, S. D, Duncan, B. L., Sorrell, R., &Brown, G. S. (2004). The partners for change outcome management system. *Journal of Clinical Psychology, 61*(2), 199-208.Mulhauser, G., &Mulhauser, G. (2019, April 27).

Supervision in Counselling and Therapy. Retrieved July 16, 2019, from https://counsellingresource.com/therapy/aboutcouns/supervision/

Miller, Scott &Bargmann, Susanne & Chow, Daryl & Seidel, Jason &Maeschalck, Cynthia. (2016). Feedback Informed Treatment (FIT): Improving the Outcome of Psychotherapy One Person at a Time.

10.1007/978-3-319-26209-3_16.

Mulhauser, G., &Mulhauser, G. (2019, April 27). Supervision in Counselling and Therapy. Retrieved July 16, 2019, from https://counsellingresource.com/therapy/aboutcouns/supervision/

Outcome Rating Scale. (2017, April). Retrieved July 20, 2019, from https://www.corc.uk.net/outcomeexperience-measures/outcome-rating-scale/

Reese, R. J., Norsworthy, L. A., & Rowlands, S. R. (2009). Does a continuous feedback system improve psychotherapy outcome? *Psychotherapy: Theory, Research, Practice, Training, 46(4),* 418-431.

Reese, R. J., Usher, E. L., Bowman, D. C., Norsworthy, L. A., Halstead, J. L., Rowlands, S. R., & Chisholm, R. R. (2009). Using client feedback in psychotherapy training: An analysis of its influence on supervision and counselor self-efficacy. *Training and Education in Professional Psychology*, *3*(3), 157-168.

Schuckard, E., Miller, S., &Hubble, M. (2017). Feedback-informed treatment: historical and empirical foundations, in *Feedback-Informed Treatment in Clinical Practice: Reaching for Excellence* (Prescott DS, Maeschalck CL, Miller SD eds) pp 13–35. American Psychological Association, Washington, DC.

Seidel, J., & Miller, S. D. (2012). ICCE Manuals on Feedback-Informed Treatment (FIT): Feedback-Informed Supervision. *Center for Clinical Excellence,* Chicago, IL.

Shaw, S. L., & Murray, K. W. (2014). Monitoring alliance and outcome with client feedback measures. *Journal of Mental Health Counseling, 36,* 43-57.

U.S. Department of Health and Human Services, Administration on Aging. (2001). *Older adults and mental health: Issues and opportunities*. Washington, DC: Author.

Wampold, B. E. (2001). The great psychotherapy debate: Models, methods, and findings. Mahwah, NJ: Erlbaum.

Whipple, J. L., Lambert, M. J, Vermeersch, D. A., Smart, D. W., Nielsen, S. L., & Hawkins, E. J. (2003). Improving the effects of psychotherapy: The use of early identification of treatment failure and problem solving strategies in routine practice. *Journal of Counseling Psychology, 50,* 59-68.