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Outcome oriented supervision: Advantages of adding systematic client tracking to supportive consultations

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Abstract
We argue in this paper that it is time for therapists and supervisors to incorporate outcome monitoring and brief client assessments into ongoing counseling supervision. Tracking client treatment response, comparing it to expected treatment response, and alerting counselors and supervisors when a client shows poor progress is described. It is suggested that such methods can maximize recovery in those individuals who are not responding to treatment as expected. The degree to which such methods facilitate the recovery of helpful client outcomes is summarized. Incorporating an outcome management system into routine counseling and supervision is encouraged to help actualize the goals of supervision.

Keywords: *Supervision, counseling and psychotherapy outcome, outcomes management, quality assurance, client deterioration*

Clinical supervision has two primary aims: (1) the facilitation of competency as a counselor and professional (i.e., developing theoretical coherence, case conceptualization skills, basic attending skills, understanding and adherence to ethical guidelines, developing multicultural competence, etc.), and (2) the monitoring of client welfare and progress towards beneficial outcomes (Bernard & Goodyear, 2004; Falender & Shafranske, 2004). Traditionally these key supervision purposes have been addressed by listening to or viewing tapes, live observation, and discussion of clients in supervision with primary reliance on therapist or supervisor empathic and observational abilities—a form of supportive consultation. Although much research and theoretical work has focused on maximizing the benefits that might come from various aspects of clinical supervision, very little is known about the effects of these supervision activities on client outcomes. Whereas most supervisory outcomes can be measured somewhat directly (e.g., assessing the supervisory working alliance, measuring skill development, adherence to treatment protocols, increased cultural sensitivity), improved therapy outcomes as a function of supervision has proven more difficult to measure. Thus, the most important task of supervision, maximizing positive client outcomes, is assumed to be occurring, but is in need of further research.

Defining ''good'' or ''effective'' supervision independent of client outcomes may give us a false sense of supervision efficacy and there is room for concern when considering some research findings. For example, how do we make sense of the frequent finding suggesting there is little difference in outcomes between experienced/trained clinicians and those that are less experienced even when the discrepancy between experience levels is quite large (Beutler et al., 2004; Lambert & Ogles, 1997; Sapyta et al., 2005)? There is also evidence that outcome differences that may be detected between experience levels may be moderated by differences in interpersonal skills, with those high on interpersonal skills accounting for better outcomes (Anderson, 1999). Besides the findings on experience, training, and outcomes, there are other research findings that suggest possible short comings in the quality assurance aspects of supervision. Falender and Shafranske (2004), for example, note that: ''Although client outcome is considered the acid test of supervision efficacy (Ellis & Ladany, 1997; Stein & Lambert, 1995), to date we do not have clear, methodologically sound data on client outcome and its relationship to supervision'' (p. 202).

In a review of the supervision literature and its effects on treatment efficacy over a decade ago, Holloway and Neufeldt (1995) concluded: ''. . . it is disconcerting that supervisors, who have the responsibility to insure the therapist's competent practice with clients, are perhaps more influenced by the trainee's interpersonal involvement in supervision than their effectiveness with the client'' (p. 211). If evaluations of therapeutic practice by supervisors are influenced more by interpersonal aspects of the

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What does this study explore?

The manner in which supervision is conducted.

- Regular monitoring of client outcome and using that outcome information in supervision
- Increasing the focus on clients not making the expected treatment progress according to the monitoring of their outcome
- The addition of assessment and problem solving strategies through clinical support tools for clients not making expected treatment progress

supervisory relationship than client outcome it stands to reason that adding contemporary methods of outcomes management (formally monitoring client treatment response) to traditional supervision may provide considerable benefit for the client.

In this paper we highlight data collected from a program of research on outcome monitoring to argue for the value of formally monitoring client treatment response and incorporating this data into supervision. First, we suggest that therapists and supervisors may be especially poor at identifying clients who have a poor treatment response. We next discuss what kind of monitoring is helpful, the consequence of feeding back progress information and problem solving strategies to therapists (and supervisors). In conclusion, we end with recommendations for future research on supervision.

The need for formal monitoring

It appears that counselors and supervisors, may have an overly optimistic view of client outcome, usually overestimating improvement and underestimating deterioration in relation to client self reports (Grove et al., 2000; Najavits & Strupp, 1994). Hannan et al., (2005), for example, asked 48 therapists (22 licensed professionals and 26 trainees) who saw 550 clients over a three-week period, to rate each client's progress and predict if the client would leave therapy having deteriorated. Therapists understood that the base rate of deterioration was likely to be 8%, and that their predictions were being contrasted with predictions based on statistical algorithms and the operational definition of deterioration. Even though they knew likely deterioration base rates, therapists rarely predicted a negative outcome (3/550) and were virtually unable to guess which cases would eventually end up as deteriorators (they accurately identified one out of 40 clients who deteriorated), whereas the algorithms identified 77% of deteriorated clients. Many of these professional therapists were also supervisors and none of these supervisors correctly anticipated a negative outcome. These results do not make us optimistic that therapists and supervisors will allocate appropriate attention to the most at-risk cases without formal actuarial methods.

Although we are not aware of another study that has directly replicated comparative predictions of outcome, early research on deterioration suggests that this is not a unique finding. For example, Yalom and Lieberman (1971) found group therapists seldom agreed with group members on which members were casualties of the group, whereas self and group member judgments showed considerable consensus. In addition to these findings, it appears, generally, that therapists hold an overly positive treatment efficacy bias as demonstrated by the finding that 66% of counselors rated themselves as A or better on an A to F scale (Dew & Reimer, 2003). Ninety percent of therapists considered themselves to be above the 75th percentile in delivering services.

This ''optimism'' may serve to help us persist in challenging therapy circumstances. But, it may also obscure lack of therapy progress and influence us to overlook and under appreciate indicators of potential treatment failure. The failure of therapists to be able to identify a course of treatment that is ''off-track'' is highly problematic for high risk clients. This is compounded by the fact that clinicians are inclined to devalue actuarial/statistical data in relation to their subjective impressions (Garb, 2005). Confidence in our own therapeutic efficacy may be unwarranted at times and lead us to undervalue other sources of information on treatment outcome, particularly client generated outcome responses. This suggests the need for systems for regular collection of therapy outcome data as well as openness to accepting and using outcome data in supervision, rather than complete reliance on clinical judgment. Regular use of client treatment progress data in our supervision efforts will help shift our profession's attitudes away from the exclusive reliance on a possibly self-confirming system of clinical intuition, to a multi-perspective informed clinical decision making. In our opinion it holds great promise for enhancing both counselor competence as well as assuring quality care, the two primary aims of supervision.

Tracking client treatment response in relation to expected response

We are beginning to see the use of systems aimed at providing real-time feedback on client progress during therapy (e.g., Barkham et al., 2001; Kordy et al., 2001; Lambert, Hansen, & Finch, 2001). In our own system we require clients to fill out a weekly outcome measure, the Outcome Questionnare-45 (OQ-45; Lambert et al., 2004) that assesses symptoms, interpersonal problems, social role functioning, and well being. From this data, algorithms were created using statistical modeling of client treatment response based on week-by-week counseling sessions across the United States (Finch et al., 2001). These modeling procedures essentially assess whether a client is ''on track'' (OT) for a good outcome or has deviated, ''not on track'' (NOT), from what would be expected for a beneficial outcome. Methodologies for determining

clinically meaningful change have also been coupled with this information in order to quantify meaningful change in the individual client (Jacobson & Truax, 1991).

In order to provide useful feedback to therapists and supervisors, outcome trajectories using these algorithms are provided to therapists using a color coding scheme: (1) White – client is functioning in the normal range and termination should be considered, (2) Green – client appears to making expected progress that would lead to a good outcome, (3) Yellow – client appears to be making less than adequate change and there is some chance of a negative outcome, and (4) Red – client is not making adequate change and there is a high chance for a negative outcome. In order to deliver this information in a timely manner a software program–OQ Analyst©– was developed. Clients come to their session 10 minutes early, and complete the OQ-45 through the use of handheld computers. After pushing the ''enter'' button a graph and color coded messages (i.e., Red, Yellow, Green, White) as well as critical items, full item responses, distress level, and norm comparison group information for both the total OQ scores as well as the three subscale scores are instantaneously delivered to the therapist (see Figure 1 for an illustration, colour version available online).

The impact of feedback on outcomes

As a consequence of conducting four clinical trials in which progress feedback in relation to expected change trajectories, as illustrated in Figure 1, was compared with treatment as usual (TAU) with no formal feedback, we are quite confident that such feedback results in improved outcomes for NOT clients (Hawkins et al., 2004; Lambert et al., 2002; Lambert et al., 2001; Whipple et al., 2003). Summing across these studies, the difference between providing feedback and withholding it was not only statistically significant but produced effect sizes around .34 (Lambert et al., 2005). In addition, classification of clinically significant change across these studies indicated that on average deterioration rates in the NOT clients were reduced from the TAU baseline of 20% to 15% in the feedback condition. Reliable and clinically significant change rates went from 22% in TAU to 33%. The effect size for feedback is much smaller for clients progressing towards positive treatment outcomes (On-Track cases; OT), indicating that feedback to clinicians about potential failing cases (NOT) is particularly helpful.

Although these improved outcomes are impressive, still many NOT clients did not enter the ranks of

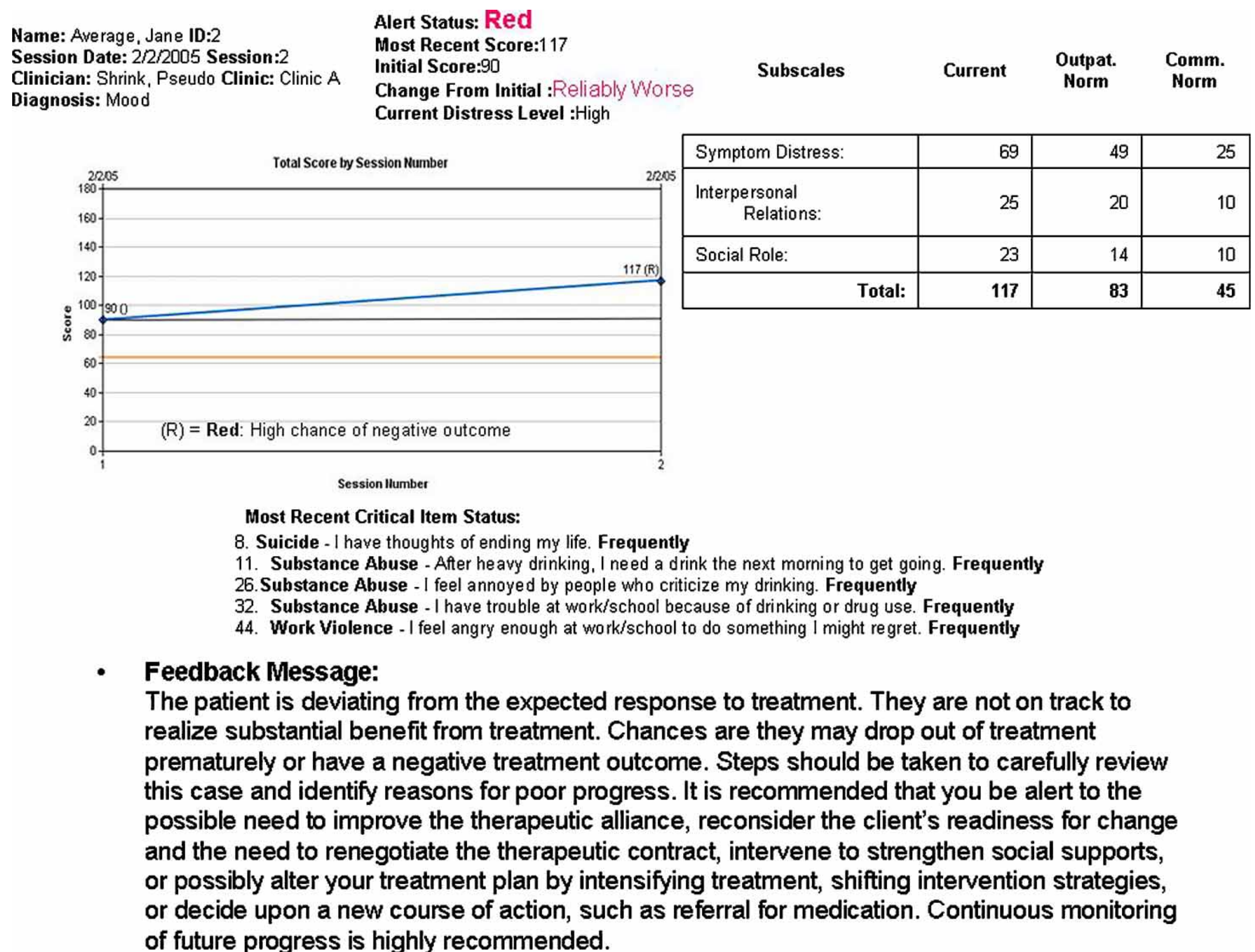

Figure 1. OQ-Analyst screen shot illustrating feedback graph and report of patient progress.

normal functioning. These ''treatment resistant'' individuals seem to need a stronger intervention if they are to benefit from counseling. In an attempt to provide a stronger intervention for these NOT cases, in addition to feedback about progress, it was decided that factors that have been previously identified as contributing to poor outcomes would be assessed. The information from these assessments would then be provided to therapists along with a problem solving decision tree and recommendations for possible interventions. We labeled these clinical support tools (CSTs) and provided a manual (Lambert et al., 2004) and brief training to therapists for its use. The measures given to clients in the experimental groups operationalized the constructs that were thought to be most important for clinical problem solving: the therapeutic alliance, motivation to engage in therapy, the clients' social support network, and maladaptive perfectionistic attitudes. We also included suggestions about the possible need for referral for use of or change in medication, and alternate therapeutic modalities (such as specific therapy techniques). Existing measures were used to measure the first four of these constructs and were administered to clients after the first time they received a yellow or red alarm: Revised Helping Alliance Questionnaire (HAq-II; Luborsky et al., 1996), Client Motivation to Change Scale-Shortened Version (CMOTS-S; Pelletier et al., 1997), the Multidimensional Scale of Perceived Social Support (MSPSS; Zimet et al., 1988), and the Perfectionism Inventory (PI) (Hill et al., 2004).

Cut scores on each measure were used in conjunction with the decision tree to direct the therapist's attention to potentially problematic areas that the therapist might consider addressing. For example, the first potential problem area identified was the therapeutic alliance. The HAq-II, which measures three aspects of the alliance: therapeutic bond, and collaboration on therapeutic tasks and goals, was administered. A below average therapeutic alliance score, as signified by a cut-score one or more standard deviations below the mean, indicates to the therapist that negative progress may be due to a poor alliance and the therapeutic relationship improved through the use of methods aimed at repairing an alliance rupture. Therapists are also encouraged to explore any item response that is endorsed in a negative manner. Through these actions it is hoped that the therapeutic relationship will improve and the patient will experience an increased sense of collaboration. The therapist continues down the decision tree further identifying potentially problematic areas that might become the focus for intervention. Our expectation was that the identified measures, decision tree, and listed interventions would enable therapists and possibly supervisors to more rapidly identify specific problems and some techniques that have been shown to help in resolving them. For example, the manual provides concrete suggestions for repairing ruptured alliances based on the work of Safran and Muran (2000). Among their suggestions are discussing the relationship, welcoming negative feedback, refraining from explaining, justifying, or defending, and possibly apologizing for therapist errors. The manual is not prescriptive, but suggestive, and intended to provide ideas for problem solving, a kind of automated supervisory guide. Therapists are also encouraged to discuss NOT cases and intervention strategies with their supervisor.

An initial study was conducted to test the effects of adding this enhanced feedback (Whipple et al., 2003). The combined intervention consisting of weekly outcome feedback plus CST feedback for NOT clients showed that the average NOT client reliably improved. They found that recovery rates improved from 25% in TAU to 49%, and deterioration dropped from 19% to 8%. In a replication study (Harmon et al., in press), deterioration rates decreased from a baseline of 21% in the NOT no feedback/archival controls, to 7% when the CST interventions were used. The effect size for this intervention compared to TAU delivered by the same therapists was approximately .63. This means that in a client population of 1000 NOT clients, recovered/improved clients would increase from 250 to 490 and clients that deteriorate would decrease from 190 to 80.

As this summary of research suggests, it is possible to assess client treatment response on a weekly basis, compare progress with average response, identify cases that deviate significantly from this expected response, deliver this feedback to therapists instantaneously, and provide problem solving strategies for these off track cases. As a consequence, clients who are showing negative change have significantly better outcomes. What are the implications for supervision?

Supervision and progress feedback

Progress feedback and clinical support tools were designed as assists for therapists in their psychotherapy practice with the intention that they could function independently of supervision. Therefore, we did not pay attention to supervision in the design of the forgoing studies. For example, no record of the extent to which therapists sought supervision for help with cases identified as NOT exists and it is not possible to analyze the role of supervision in the positive outcomes that we attribute to feedback. All of the studies conducted were designed to intrude as little as possible on routine care and to be implemented with minimal controls and maximum facilitation of therapist autonomy. In this regard, we positioned ourselves as researchers supplying what we hoped would be useful information for therapists to incorporate as they saw fit into their own practice.

In the early stages of implementing progress feedback in a university counseling center in the U.S., we conducted an informal assessment of attitudes towards collecting and using outcome data in supervision and counseling (Isakson et al., 2002). The sample consisted of both full-time licensed profes-

What does this study tell us?

- Systematically and regularly monitoring client outcome and providing outcome feedback to counselors and supervisors can enhance client outcomes, especially for clients not making expected treatment progress
- Use of a client outcome monitoring system in supervision can enhance client outcomes and provide for enriched and focused supervision activities

sionals in their roles as supervisors (N = 19) as well as students in training in their role as supervisees (N = 20). When asked ''How do you feel about your clients' OQ results being given to your supervisor?'' supervisees reported a score between ''Comfortable'' and ''Extremely comfortable'' on a 5 point scale from ''Extremely uncomfortable'' to ''Extremely comfortable.'' Supervisors were asked ''How useful to supervision do you feel it is to be given OQ results of your supervisee's clients?'' Supervisors reported on a 5 point scale from ''Extremely non-useful'' to ''Extremely useful'', a score representing ''Useful.'' In a question addressing the frequency of use of OQ scores in supervision, both supervisors and supervisees reported ''Sometimes'' on a 5 point scale from ''Not at all'' to ''Always,'' with ''Sometimes'' representing the midpoint. In regards to the usefulness of having this client progress feedback with NOT cases, supervisors and supervisees were similar in their responses. Both indicated on a 5 point scale between ''Not at all'' to ''To a great degree'' the midpoint statement of ''Somewhat.'' Although, admittedly not a sophisticated evaluation of attitudes towards using progress feedback in supervision, attitudes were generally positive. This survey was conducted before the general use of outcome graphs to track client scores. The most frequently recommended suggestion from this same survey for how to improve feedback to counselors and supervisors was the use of a graph to chart OQ scores. We now have those graphs as illustrated in Figure 1.

Since this early beginning counselors and supervisors have become increasingly positive about the usefulness of feedback, culminating in the decision by this staff to discontinue treatment as usual — all therapy in the center is now offered only with feedback reports. Counselors simply considered the evidence of client benefit too persuasive to ignore. We have continued to use progress feedback in supervision but increased the likelihood of discussion of this information by notifying supervisors each time a NOT client of a supervisee is identified, so that the case will be considered in supervision as a matter of routine practice.

The use of progress feedback in supervision provides at least 5 important contributions to training and treatment. First, it provides a source of standardized performance feedback that is critical for training purposes. Since this feedback is generated by client responses, it has the advantage of reflecting the client's experience. Second, the evidence suggests that as counselors we are often inaccurate in our clinical predictions of treatment failures, tending towards overly optimistic appraisals of our clients' progress (Hannan et al., 2005; Norcross, 2003). While we view therapist optimism as highly valuable to client outcome, especially with difficult and unstable clients, we also believe it is important to have an independent source of information that identifies NOT clients that will provide a focus for supervision where the attention is most needed, since OT cases typically progress well without modifying interventions. Third, feedback from clients provides information we may have unintentionally overlooked or underemphasized. Systematic progress feedback may allow supervisors to become quickly aware of factors that impede treatment progress and may point to effective interventions. Fourth, the use of CSTs for NOT clients may enhance our treatment efficacy by identifying problematic domains that may hinder progress (e.g., therapeutic alliance, motivation for therapy, social support, perfectionism, need for medication) and point towards potential interventions. Fifth, the use of additional information beyond our own clinical intuition may provide another window on therapy. Since the CST domains are atheoretical they broadly apply regardless of the therapist's theoretical orientation and may serve to broaden problem solving strategies. It is the combination of clinical wisdom informed by standardized sources of information that may ultimately contribute to improved outcomes and give us a powerful new focus in supervision (see Lambert & Hawkins, 2001 for a case example).

Supervision Research Recommendations

Priority studies for research on supervision would include a study of whether combined counselor and supervisor judgments about which cases are headed for a negative outcome compare with actuarial methods. If actuarial methods are not better at predicting deterioration there is little need for therapist feedback that relies on such methods. Another study of interest would be to contrast supervision-assisted outcomes with actuarial-based methods coupled with CSTs. If an automated method that relies on software that can produce instantaneous feedback with alarms and problem solving strategies for problematic cases leads to better client outcomes than traditional supervision-assisted counseling, it would be wise for such systems to be routinely used along with supervision.

We believe the use of feedback as it has been implemented in the studies reviewed in this paper will significantly assist our mandate as supervisors to monitor client welfare and through supervision, enhance client outcomes. Thus, outcome oriented

supervision can help facilitate the two primary aims of supervision, enhanced practice and improved client outcomes.

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