

Client Engagement Related to Their Satisfaction with Treatment Outcomes

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Abstract

Feedback-Informed Treatment (FIT) is an evidence-based method for appraising and improving the effectiveness of mental health service delivery. It is a client-driven, outcome-based approach designed to produce better client commitment and to enhance treatment outcomes. This study examined the role of client perception of treatment outcome and therapeutic alliance on client retention in treatment. Data from 11 participating agencies, 2,297 clients, and 55 counselors were collected and analyzed. Results demonstrated that a client's satisfaction with treatment outcome was significantly associated with engagement in treatment, as measured by the number of treatment sessions that the client completed. However, the client's perceived alliance with the counselor was not associated with engagement in treatment. The agencies that contributed data to this study only collected FIT data without using the data in counselor supervision. Future research should examine the use of FIT data to improve clinical skills and client outcomes.

Keywords: Feedback Informed Treatment, Outcome Rating Scales, Session Rating Scales, Counselor, Mental Health

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Accountability is the watchword of the time (Miller, Duncan, Sorrell, & Brown, 2004). 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, Duncan, Brown, Sparks, & Claud, 2003). In 2018, the Joint Commission is requiring organizations to use standardized tools and instruments in behavioral health services (<http://www.samhsa.gov>). Dropout rates are notoriously high in mental health settings, averaging 47% with adults and between 28% to 85% for children and adolescents (Maeschalck, Bargmann, Miller, & Bertolino, 2012), demonstrating problems in the alliance, perhaps not attending to clients' preferences and resistance to treatment (Maeschalck et al., 2012). Additionally, Maeschalck et al. (2012) found that clinicians can take measures to address decline in treatment outcomes versus externalizing it to the extra-therapeutic factors.

Currently, a variety of approaches and feedback ratings exist for evaluating the outcome of therapy. However, some are long and/or costly such as the Outcome Questionnaire-45 (OQ-45) and the Helping Alliance Questionnaire (HAQ-II) (Harmon, et al., 2007; Harmon, Hawkins, Lambert, Karstin, Slade, & Whipple, 2005). For these reasons, they are not feasible for many

service providers and settings because the average clinician's caseload is already overloaded with multiple responsibilities. Brown et.al (2004) found that the majority of clinicians did not want any evaluations to be part of their work if they took more than five minutes to complete, score, and understand (Brown, Dreis, & Nace, 1999; Miller, Duncan, Sorrell, & Brown, 2004). Therefore, a tool that is brief, reliable and valid is most suitable for evaluating the effectiveness of providers.

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, Lambert, Vermeersch, Smart, Nielsen, & Hawkins, 2003). A growing body of research indicates that the client's subjective experience of change early in the treatment process is one of the better predictors of treatment outcome (Harmon et al., 2007; Duncan & Miller, 2000; Howard, Moras, Martinovich, & Lutz, 1996; Garfield, 1994). In response to this demand, Miller and Duncan (2000) developed what is now called *Feedback Informed Treatment* (FIT).

Feedback-Informed Treatment

FIT is an evidence-based practice (EBP) that involves routinely and formally collecting feedback from clients regarding their perception of the therapeutic alliance and outcome of treatment and using the resulting information to inform and tailor service delivery. Miller and Duncan (2004) incorporated parts of the HAQ-II and OQ-45 to create an ultra-brief measure called the FIT (Janse, Boezen-Hilberdink, van Dijk, Verbraak, & Hutschemaekers, 2014). 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 (Bringinghurst, Watson, Miller, & Duncan, 2006). The ORS seeks information from the client's perspective on their therapeutic progress, perceived benefit of treatment, and the client's level of distress and function. The SRS assesses the client's perception of the therapeutic alliance.

Outcome Rating Scale (ORS)

Bringinghurst, Watson, Miller, and Duncan (2006) reported a widening trend toward making outcome evaluation a routine part of therapeutic services. Miller and colleagues (Miller, Duncan, Brown, Sorrell, & Chalk, 2006) found that ongoing outcome feedback to clinicians increased overall effectiveness in a sample of over 6,000 clients. The Outcome Rating Scale (ORS) was developed as an "ultra-brief" substitute for the longer, validated instruments available at the time (Miller & Duncan, 2000). It is a four-item, visual analog instrument that asks the client about their personal, interpersonal, social, and overall well-being in the last week.

Miller et al. (2003) carefully examined the ORS'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 embodies a balanced trade-off between the reliability and validity of longer measures and the practicability of this four-item instrument (Miller et al., 2003). ORS has high internal reliability for adults (.93) and test-retest reliability (.97). Correlations reported between the OQ-45 and the ORS have ranged -.53 and -.74 with validity at -.69 (Seidel & Miller, 2012).

Session Rating Scale (SRS)

The importance of the therapeutic alliance is foundational to any mental health counseling process. It is also important to note that this quality of counseling relationship is the predictor of successful counseling outcomes (Shaw & Murray, 2014). Originally, in 1995, Johnson created a ten-item session rating scale (SRS) to measure the strength of his own alliance with clients (Miller, Duncan, Brown, Sorrell, & Chalk, 2006). In 2000, Johnson, Miller and Duncan worked on an ultra-brief alliance measure designed precisely for every session use. The SRS is a four-item, visual analog instrument designed to measure the strength of alliance between the clinician and a specific client (Duncan et al., 2003). The four questions ask about the client's satisfaction with his or her relationship with the clinician, goals and topics for the session, the clinician's approach, and 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 19-item 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).

Cut-off Scores

The clinical cut-off scores for adults are 25 for ORS and 36 for SRS. Cut-off scores are used as a compass to steer the explanation of the results (Miller, Duncan, Sorrell, & Brown, 2004). They represent the expected track of change for clients, and usually clients seeking counseling are below the 25 on their intake ORS (Miller et al., 2004). A score below the clinical cut-off of 25 on the ORS means that the counseling services are needed and likely to improve for the client (Duncan, Miller, Reynolds, Sparks, Claud, Brown, & Johnson, 2004; Miller et al., 2004). Intake score is expected to be lower than 25 for someone starting therapy and clients falling below the intake score during their treatment represent a problem and potential for early dropout or no change in treatment.

The clinical cut-off score for SRS is 36 out of 40, which represents a positive alliance with the clinician (Duncan et al., 2003). According to Duncan et al. (2003), a robust connection between change for client and alliance predicts an effective treatment outcome. The goal of the cut-offs is to identify any problems with the alliance and the therapeutic process. A SRS score below 36 warrants concern for the clinician and inviting the client for any feedback about the session would be welcome at this point (Duncan et al., 2003). Many factors such as clinician's ability to build rapport, skills set, unwillingness to address goals, and eagerness to use feedback for professional development, are all contributing factors when alliance is at risk (Miler, Hubble, Chow, & Seidel, 2015).

Purpose of the Study

This study examined data from 11 participating agencies with 2,297 clients and 55 counselors. The data were collected by a tri-county mental health and substance abuse Recovery Board in Ohio and were analyzed by faculty at a local university to assess the relationship between the engagement of the client (as measured by the number of sessions retained in

treatment) and SRS and ORS scores. This was the first time for the Recovery Board to use FIT. Recovery Board administrators were uncertain about how to use FIT data and did not use the FIT data in supervision practice with the counselors. Thus, this was an opportunity to examine client perceptions of therapeutic alliance and treatment outcome over time in the absence of systematic evaluation and feedback by supervisors.

Method

Participants

Participants in this study were counselors recruited from 11 clinical mental health agencies in local communities in three counties in Ohio. Altogether, 55 counselors provided treatment to 2,297 clients over a one-year period. Table 1 shows the number of counselors and clients from each agency, as well as the ages and self-identified gender of the clients. For each counselor, only FIT data for clients 18 years of age and over were analyzed. Approval to conduct this study was received by the Institutional Review Board of Wright State University.

Table 1
Number of Clients, Counselors, Agencies, and Client Demographics

Type of Agency	Number of Counselors	Number of Clients	Type of Client Served	Age Range (Years)	Mean Age (Years)	Female (%)
Community Mental Health	21	1,140	General Population	5-84	29.5	56.4
Community Mental Health	5	232	General Population	5-84	32.0	55.9
Community Mental Health	3	48	General Population	9-59	36.5	51.1
SUD Treatment	2	17	Women Only	18-51	29.8	100
Domestic Violence Services	5	404	Women and Children	6-80	33.3	100
SUD Group Treatment	3	113	Men Only	20-60	32.9	0
Residential Mental Health	24	954	Youth	5-21	15.6	74.6
SUD Group Treatment	5	221	Women Only	18-70	33.0	100
SUD Group Treatment	5	392	General Population	18-62	34.5	74.9

Measures

The clients were asked to complete the ORS and SRS at every session (Miller & Duncan, 2000). Clinicians administered the ORS at the beginning of each session and the SRS at the end of each session, either electronically or by pen and pencil. The agency supervisors or administrators monitored the entered data for quality of services but did not provide supervision based on FIT data.

Procedure

The tri-county Recovery Board CEO decided to implement FIT in their respective agencies. In 2014, Miller trained the counselors on how to use FIT. After the initial training, licenses and implementation guidelines were purchased for the agencies. The data used is from March 2015 to March 2016.

Once all counselors in the 11 agencies began utilizing the ORS and SRS scales, the data were collected and stored in a database called My Outcomes Pro Version 1. The tri-county Recovery Board that wanted to monitor and promote a culture of feedback for assessing treatment and outcome funded this database. The Recovery Board contracted with faculty members from Wright State University to serve as evaluators in the last phase. Before sharing the raw data with the evaluation team, the raw data were de-identified 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, race, ethnicity, gender, number of sessions, and age were tracked.

Data Analysis

Changes in FIT scores for all clients from first to last session were analyzed using *t* tests. To investigate the relationship between client engagement and SRS and ORS scores, total ORS and SRS scores from the first and last sessions were compared with analyses of variance (ANOVAs). Two independent variables were used, a within-group variable (first session versus last session) and a between-group variable (engaged versus non-engaged). This second independent variable was based on the definition of early termination by Goldberg, Rousmaniere, Miller, Whipple, Nielsen, Hoyt, & Wampold (2016), in which early termination (not engaged) was defined as retention in only one or two sessions. Total ORS scores and Total SRS scores for all clients served as dependent variables in separate ANOVAs. The next analyses examined correlations between the number of sessions and Total ORS and Total SRS scores. Finally, to compare the number of people who were engaged and non-engaged and whether their Total ORS scores at the last session was above or below the ORS cutoffs, chi square analyses were conducted.

Results

For the entire sample of 2,297 clients, significant increases in all FIT scores from the first appointment to the last appointment were found. For ORS Question 1: $t = -8.73, p < .001$; ORS Question 2: $t = -30.22, p < .001$; ORS Question 3: $t = -30.82, p < .001$; ORS Question 4: $t = -33.31, p < .001$; Total ORS: $t = -38.94, p < .001$; SRS Question 1: $t = -6.44, p < .001$; SRS Question 2: $t = -10.02, p < .001$; SRS Question 3: $t = -7.34, p < .001$; SRS Question 4: $t = -5.60, p < .001$; Total SRS: $t = -8.67, p < .001$. These findings reflect a significant improvement in outcome ratings and session ratings from the first to last session.

ANOVA Results

For Total ORS scores, three significant findings were obtained: a significant main effect for time (first session versus last session), a significant main effect for engagement (not engaged versus engaged), and a significant Engagement X Time interaction. Total ORS scores increased

significantly from first to last session, $F(1, 2281) = 411.44, p < .001$. Clients who were engaged (i.e., were retained in treatment for three or more sessions) had significantly higher mean Total ORS scores than those who were non-engaged, $F(1, 2281) = 35.69, p < .001$. The significant interaction is illustrated in Table 2. Whereas all clients had similar ORS scores at the first session, clients who were engaged and remained in treatment had much higher Total ORS scores at the last session, $F(1, 2281) = 116.50, p < .001$.

Table 2
Mean Total ORS Score

Engagement Level	Time	Mean Total ORS Score
Not Engaged	First Session	21.75
	Last Session	24.12
Engaged	First Session	21.66
	Last Session	29.41

For Total SRS scores, a significant main effect for time, $F(1, 2235) = 10.18, p = .001$, and a significant Engagement X Time interaction, $F(1, 2235) = 14.39, p < .001$, were found. Table 3 illustrates the significant interaction and shows quite clearly that this interaction, as well as the effect of time, are statistically different but not clinically different, as all means were between 34.48 and 36. In addition, no significant main effect for engagement was detected, $F(1, 2235) = 0.79, n.s.$ That is, Total SRS scores did not differ between engaged and non-engaged clients.

Table 3
Mean Total SRS Score

Engagement	Time	Mean Total SRS Score
Not Engaged	First Session	35.56
	Last Session	35.43
Engaged	First Session	34.48
	Last Session	36.00

Correlational Analyses

Correlations were assessed between the number of sessions that clients were retained in treatment and Total ORS and Total SRS scores at the first and last sessions. Only the Total ORS score at the last session correlated with number of sessions; that is, the more sessions with the counselor, the higher the total ORS score at the last session, $r(N = 2,292) = .169, p < .001$. Total SRS scores at the last session do not improve with an increased number of sessions, $r(N = 2,292) = .034, n.s.$

Chi Square Analyses

Chi square analyses were conducted to compare the number of engaged and non-engaged clients who were above or below the cutoff scores for ORS and SRS. For the last session, there was a significant effect, with significantly more people retained in treatment with ORS scores

above the cutoff, $X^2(N = 2292, df = 1) = 79.54, p < .001$ (Table 3). At the last session, 71.7% of engaged clients were above the ORS cutoff, and only 49.5% of non-engaged clients were above the cutoff score for Total ORS. For the first session, there was no relationship between engagement and the number of clients above the Total ORS cutoff, with 37.1% of non-engaged clients and 37.5% of engaged clients having Total ORS scores above the cutoff in the first session.

With respect to the SRS cutoff score, a chi square analysis that compared the number of engaged and non-engaged clients who were above or below the SRS cutoff indicated no significant relationship between client engagement and being above the SRS cutoffs, supporting that therapeutic alliance was not an important factor in early termination of treatment by the client. Of the 439 clients who were not engaged, 67.2% had Total SRS scores above the SRS cutoff at the last session; similarly, 68.4% of the 1,857 engaged clients had Total SRS scores above the cutoff in the last session. However, a chi square analysis revealed a significant relationship between engagement and Total SRS score in the first session, $X^2(N = 2292, df = 1) = 8.88, p = .003$, with 61.8% of non-engaged clients having Total SRS scores above the SRS cutoff in the first session and 53.8% of engaged clients having Total SRS scores above the SRS cutoff in the first session.

Discussion

FIT data from 11 agencies and 55 counselors were analyzed to evaluate the relative effectiveness of FIT in predicting engagement in treatment. At the first session, the non-engaged clients had significantly higher SRS scores, but not ORS scores, than engaged clients. At the last session, the non-engaged had significantly lower ORS scores than engaged clients, with no significant difference for SRS scores at the last session. Engaged clients showed improvement in their wellbeing with higher ORS scores (mean of 21.7 at the first session vs. mean of 29.4 at the last session).

The “no change” for the SRS scores at the last session may show that the non-engaged clients were not invested to give honest or critical feedback to establish the therapeutic alliance (Maeschalck, Bargmann, Miller, & Bertolino, 2012). All things considered, engagement appears to be predicted by ORS scores, rather than SRS scores. The SRS score in the first session is negatively related to engagement in treatment, whereas SRS scores in the last session are not related to engagement. High SRS scores in the first session were associated with early termination in this study.

Other investigators have reported that Total SRS scores improve with the number of sessions (Duncan et al., 2003; Seidel & Miller, 2012). Our correlational analyses indicate that, for over 2200 clients, the number of sessions is only significantly correlated with Total ORS scores at the last session. SRS scores do not improve with an increased number of sessions, although outcome (ORS) scores at the last session do improve with an increased number of sessions.

Using FIT Scores to Improve Supervision

The data for the present study were collected from counselors who did not receive supervision based on FIT scores by clients. The results of this study may have been drastically different if supervisors had used clients' SRS and ORS scores to guide improvement of counselors' therapeutic technique. Scores higher than 25 for the total ORS score at an initial session may indicate that clients are at risk for deterioration and dropout from treatment, and less change in therapy has been reported for these clients (Maeschalck, Bargmann, Miller, & Bertolino, 2012). In these instances, supervision can be helpful to encourage counselors to explore the client's reasons for coming in for therapy. Maeschalck et al. (2012) reported that the lower the ORS score at intake, the greater the sense of distress a client feels, and the faster the change in therapy will be seen.

A client with a low Total SRS score (less than 36) may indicate that the therapeutic alliance is unsatisfactory or destabilized, and, therefore, the client is not responding well to the clinician due to a weak therapeutic alliance. Clinical supervision can explore the goals for treatment, levels of care, and what other additional services are needed to improve the therapeutic alliance for this client (Maeschalck et al., 2012). All of this 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. The supervisor's role is to point out what is working in the session, therapeutic alliance, and the overall effectiveness of services being provided by the supervisee (Borders, Deknyf, Fernando, Glosoff, Hays, Page, & Welfare, 2011). After all, counselors are trained to build and attend to the therapeutic alliance with their clients, and these strength-based interventions are all part of formal feedback.

According to the Association for Counselor Education and Supervision (ACES), a supervisor is supposed to gather feedback for the supervisee from multiple sources. A strong supervisory relationship that is based on trust and safety is crucial to the supervisee's exploration of personal and professional growth (Erford, 2018). FIT is one effective way to provide informal and formal feedback to the supervisee (Borders et al., 2011), which creates a culture of deliberate practice. Clinically significant change is designed to measure the clients who are in the "clinical" range and those who are in the "normal" range (Seidel & Miller, 2012, p. 20). The results show a pattern of change and improve clinicians' vision and not only hearing but 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 the clients' treatment goals. This can also be facilitated by a developmental supervision approach to move the supervisee through a series of awareness of self and others, motivation, and autonomy stages (Erford, 2018).

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. There was no control group to compare the data on effectiveness of FIT with these agencies. There was a lack of information on the nature of supervision and how it was provided to the clinicians. The evaluation team was also unaware of the follow-up

procedures/protocols for no-show or drop-out for each agency, socio-economic status of the clients was unknown, and as well as diagnosis and presenting problems.

Conclusion

The purpose of implementation of FIT is to help clinicians make necessary adjustments to their performance to engage their clients for better outcomes and improve clinical skills. Furthermore, the supervisor can use FIT data to make appropriate recommendations to counselors for failing cases as well as challenging cases. Creating a culture of Feedback-Informed Treatment (FIT) in clinical practices is challenging. Feedback in any form can be difficult to receive, and asking clients receiving treatment to give their counselor's feedback about their session can be even more daunting and at times impossible. Feedback within the therapeutic relationship involves skill on the part of the therapist, supervisor, and administration. At times, an agency's supervisor and/or administrator would want to use the feedback from their clients about their session to improve their therapists' clinical skills and client outcomes.

FIT measures the quality and effectiveness of mental health service providers. It requires routinely and formally asking feedback from the clients. Its 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. The lesson in this research is to integrate FIT 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 engaging. Corey, Corey, Corey, and Callanan (2014) explained supervision in four major goals: (1) to promote supervision growth and development, (2) to protect the welfare of the client, (3) to monitor supervisee performance and to serve as a gatekeeper for the profession, and (4) to empower the supervisee to self-supervise and carry out these goals as an independent professional (p. 366). Counselors can learn from FIT feedback to improve clinical skills and client outcomes. Constructive feedback is equally difficult for counselors to receive due to their own defensiveness or lack of awareness about a certain intervention or condition. Integrating feedback for professional development is crucial for effective, efficient, and accountable treatment for our clients (Miller, Duncan, Brown, Sorrell, & Chalk, 2006). This is how we improve and grow and become seasoned counselors. Dealing with clients and feeling safe discussing difficulties, challenges, and mistakes are all part of healthy feedback and professional growth. According to Miller, Hubble, Chow, and Seidel (2015), "when it comes to therapists' professional development, it is not a matter of will. Rather, it is a matter of way" (p. 452).

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