Toward an Evidence-based Standard of Professional Competence

Scott D. Miller, Joshua W. Madsen, and Mark A. Hubble

The Oxford Handbook of Psychotherapy Ethics
Edited by Manuel Trachsel, Jens Gaab, Nikola Biller-Andorno, Şerife Tekin, and John Z. Sadler

Subject: Philosophy, Philosophy of Mind Online Publication Date: Sep 2020
DOI: 10.1093/oxfordhb/9780198817338.013.79

Abstract and Keywords

Psychotherapists are ethically bound to provide services within the boundaries of their competence traditionally delimited by their education, training, and supervised experience. Throughout this chapter, two historical examples illustrate the shortcomings of the current standard as well as the promise of an alternative. The guidelines now in place are critiqued in light of the empirical evidence. The authors propose that effectiveness become the foundation of any formulation and assessment of competence. Developments over the last two decades make it possible for clinicians to measure their results and compare them to international norms—a process known as routine outcome monitoring. However, mere measurement and comparison to benchmarks are insufficient. To be ethical, to protect public welfare, practitioners must also *act* on the data provided by routine outcome monitoring. Using feedback informed treatment and deliberate practice therapists can both enhance their responsiveness to individual clients and continuously improve their outcomes. Challenges of implementation are discussed. A case study of an agency that successfully adopted routine outcome monitoring coupled with deliberate practice using best practices gleaned from the implementation science literature is offered.

Keywords: competence, routine outcome monitoring, feedback informed treatment, deliberate practice

> “The only ‘good’ learning is that which is in advance of development.”
>
> —Lev S. Vygotsky

Introduction

Competence killed George Washington. It was December 1799. A physician had been summoned to the Mount Vernon estate to treat the former, first president of the United States. For reasons unknown, a minor sore throat had suddenly and unexpectedly worsened. The family and household staff were worried.

Three doctors eventually made the trek through the snowy, winter weather to Washington's bedside. After examining their patient and agreeing on the diagnosis, one administered the accepted therapy of the day. By all accounts, it was executed with the utmost skill. When no results were observed, the three healthcare professionals conferred and agreed more treatment was necessary. Several hours and two additional applications later, the president was dead.

The cause of death? Historians agree George Washington likely did not die of some strange or exotic disease. Rather, like many of his contemporaries, the care he received killed him. The intervention, of course, was bloodletting, the "best practice" of its day, the chief tool of which remains the title of one of medicine's leading research journals, i.e., *The Lancet* (Flexner 1974).[1] The question is, did Washington's physicians act ethically?

According to the ethical codes of the four largest mental health provider organizations in the United States—the American Psychological Association, American Counseling Association, National Association of Social Workers, and American Association for Marriage and Family Therapy—the answer is an unsatisfying and deeply disconcerting, yes. Standard 2.01 of the *Ethical Principles of Psychologists* (APA 2017), for example, merely requires practitioners "provide services … with populations and in areas … within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional expertise"—conditions easily met by Washington's physicians.

Before objecting that professionals should *not* be held accountable for standards of care yet to be developed, vetted by science, and accepted by peers and regulatory bodies, consider another historical example. The year is 1846. Hungarian-born physician Ignaz Semmelweis is in his first month of employment at Vienna General Hospital when he notices a troublingly high death rate among women giving birth in the obstetrics ward. At 25–30 percent, many expectant mothers prefer to give birth in the street rather than the clinic.

Medical science at the time attributes the problem to "miasma," an invisible, poisonous gas believed responsible for a variety of illnesses. Semmelweis has a different idea. Having noticed midwives at the hospital have a death rate six times lower than physicians, he concludes prevailing medical beliefs cannot possibly be correct. The final breakthrough comes when a male colleague dies after puncturing his finger while performing an autopsy. Reasoning that contact with corpses is somehow involved he orders physicians to wash their hands prior to interacting with patients. In no time, the mortality rate on the maternity ward plummets, dropping to the same level as that of midwives. Similar results obtain when he implements the same practice in another hospital in Pest, Hungary.

Nowadays, of course, handwashing is considered a "best practice." Decades of research show it to be the single most effective way to prevent the spread of infections. Science has also provided an explanation in the form of "germ theory." Such information was not available, however, during Semmelweis's day. His was merely a hunch—one which, by the way, fell outside the boundaries of then current medical standards, his professional experience, education, and training. What's more, he continued to promote the practice even after it was deemed unscientific by his peers and the broader professional community. Re-

turning to the earlier question, did Semmelweis act ethically? Once again, the answer is both unsatisfying and unsettling. According to the field's current codes, it is no.

If "ethics" is the "systematizing, defending, and recommending [of] principles for right and wrong conduct," it's hard to defend a standard that deems a practitioner who competently delivers an *unhelpful*, even deadly service (e.g., Washington's physicians) morally superior to one who is actually helpful but working beyond the limits of their "education, training, supervised experience, consultation, study or professional expertise" (e.g., Semmelweis) (Fieser 2005). That said, equating competence with education, training, supervision, and experience is nothing new. Neither is it unique to the practice of psychotherapy.

What is more, the current competence criterion may not align with accepted definitions of competence. For example, the definition provided by the *American Psychological Association Dictionary of Psychology* is "one's developed repertoire of skills, especially as it is applied to a task or set of tasks. A distinction is sometimes made between competence and performance, which is the extent to which competence is realized in one's actual work on a problem or set of problems" (https://dictionary.apa.org/competence). A repertoire of skills is ostensibly distinct from education, training, supervised experience, consultation, study, or professional expertise, although presumably these experiences contribute to skill development. With respect to the second half of this definition, even if "competence" and "performance" are not conflated, can an adequate standard of the former not incorporate serious consideration of the latter?

Philosophical and historical discussions aside, one way to evaluate the validity of the current standard is to examine it in light of the empirical literature.

The Empirical Status of the Current Competence Criterion

> "Nor would a wise man, seeing that he was in a hole, go to work and blindly dig it deeper."
>
> —The Washington Post, October 25, 1911

What does the evidence show regarding education, training, supervision, and experience? In short, none are strongly or unequivocally related to outcome. At best, the data are mixed. Consider supervision. To become a licensed practitioner, most jurisdictions in the United States require between 1,500 and 3,000 hours of supervised experience in the form of practica, internships, postgraduate training, and oversight. And yet, after reviewing a century of literature and research on the subject, Watkins (2011: 235) concluded, "We do not seem any more able to say now (as opposed to 30 years ago) that psychotherapy supervision contributes to patient outcome.".

More recently, Rousmaniere et al. (2016) examined the impact of supervision on outcomes using hierarchical linear modeling (clients nested within therapists and therapists nested within supervisors). Data were gathered for more than five years on 23 supervisors working with 175 trainee therapists in a real-world setting. Supervision was not found to be a significant contributor to outcome, accounting for less than 1 percent of variability. Neither did the supervisors' experience level, profession (social work versus psychology), or qualifications predict differences between supervisors in client outcomes. Put bluntly, supervisors did not matter much, if at all.

Educational level, pre- and postgraduate training, and experience in the field fare no better (Atkins and Christensen 2001; Hill et al. 2017; Malouff 2012). For example, despite the years-long training process and required coursework, no evidence exists connecting any specific class or classes to the outcome of students' future clients (Malouff 2012). More, the research that does exist shows no relationship between the amount of graduate training (i.e., years, degrees earned) and therapist effectiveness (Anderson et al. 2016; Boswell et al. 2010; Fals-Stewart and Birchler 2002). Finally, and perhaps most damning, studies, meta-analyses, and reviews have found minimally trained paraprofessionals achieve results equal to or better than licensed service providers (Berman and Norton 1985; Durlak 1979; Hattie et al. 1984; Montgomery et al. 2010; Weisz et al. 1995).

Worldwide, most clinicians are required to engage in postgraduate, continuing education to maintain their license or certification. Available research shows practitioners are generally satisfied with such experiences. Unfortunately, attending these events has never been shown to improve either the quality or outcome of psychological services (Neimeyer et al. 2009). Worse, studies have found an association between participation and practitioner *perception* of enhanced competence (Neimeyer et al. 2012)—an unfortunate state of affairs that may contribute to, and even exacerbate, therapists' well-documented tendency to overestimate their effectiveness (Chow 2014; Walfish et al. 2012).

Finally, what about professional experience? Not surprisingly, large, multinational surveys show therapists link professional growth and development to the amount of time they spend performing psychotherapy (Orlinsky and Rønnestad 2005). Here again, the evidence provides a different picture. Instead of improving with time and experience, the effectiveness of the average practitioner tends to plateau early, followed by a slow deterioration (Miller et al. 2017). For example, in the largest study on the subject to date, Goldberg et al. (2016b) documented an erosion in performance in a sample of 170 therapists working with more than 6,500 clients, tracked over a five-year period. Importantly, the decline was shown to be unrelated to client severity, number of sessions, early termination, caseload size, or a host of other therapist factors (e.g., age, years of experience, theoretical orientation).

In sum, the evidence simply does not support treating education, training, supervision, or experience as proxies for competence (Grus and Rozensky 2019). More, doing so, as Muir et al. (2019) point out, gives rise to a conflict with Standard 2.04 of the APA's ethical code which mandates "Psychologists' work is based upon established scientific and profession-

al knowledge of the discipline" (APA 2017: 5). If, as psychologist John Malouff (2012: 29) argues, "the ultimate goal of standards is to benefit clients," then current ethical codes of the major mental health provider organizations fail completely. They must be changed.

Adding Effectiveness to the Criteria for Competence

> "The proof of the pudding is in the eating."
>
> —William Camden

Fortunately, an evidence-based alternative exists for ensuring the "maintenance of competence … and the protection of the public" (Neimeyer et al. 2019: 63). Known in the literature as Routine Outcome Monitoring, it involves using standardized measures to assess formally and routinely clients' experience of the process and outcome of care. Then, by comparing the results to established norms for quality and progress, it is possible to determine in real time whether an individual practitioner's clinical work meets or exceeds empirically derived standards for effectiveness.

To date, two routine outcome monitoring systems—the Partners for Change Outcome Management System (PCOMS) and the Outcome Questionnaire Psychotherapy Quality Management System (OQ-Analyst)—have been the focus of the largest amount of research on tracking the performance of mental health practitioners (Lambert 2010; Prescott et al. 2017). Both were purposefully designed to be used across treatment modalities, diagnoses, client populations, and professional disciplines. They are simple in construction, require little time to administer and score, and yield valid and reliable measures of client engagement and progress. Computerized systems are available which automate data aggregation and interpretation and permit comparison of practitioner results to national and international norms.

The availability of tools for monitoring performance in real time provides an opportunity to move beyond definitions of competence which have always aimed at, but ultimately failed to, ensure the quality or outcome of care. In place of the proxies of education, training, supervision, and experience, routine outcome monitoring offers facts, permitting a new, evidence-based standard; namely, determining whether a practitioner is working within the boundaries and limits of their own and the field's known level of effectiveness. In fact, based on the available evidence, professional and regulatory bodies in the United States and abroad have already deemed routine outcome monitoring a "standard" of care in the delivery of psychological services and clinical supervision (American Psychological Association Presidential Task Force on Evidence-Based Practice 2006; Association of State and Provincial Psychology Boards 2019; Joint Commission 2018, Tasca et al. 2019).

The Trouble with Thresholds

> “Be careful what you wish for, you may receive it.”
>
> —W. W. Jacobs

In 2015, researchers Imel, Sheng, Baldwin, and Atkins reported the results of a provocative thought experiment. Using a statistical procedure, they simulated the impact of replacing poorly performing therapists—those falling in the bottom 5 percent of clinical effectiveness—with clinicians randomly drawn from the overall population of practitioners. Turns out, performing this procedure on a quarterly basis over a ten-year period resulted in dramatic improvements in the number of people ultimately benefiting from psychotherapy. Even when the difference in outcome between clinicians was small, thousands more ended up being helped over time when the worst performers were removed. When more liberal estimates of therapist differences were employed—consistent with the variability in therapist outcomes reported in naturalistic and experimental studies (cf. Johns et al. 2019)—the impact was far greater, with up to a third more clients experiencing recovery (see Table 1). The authors conclude, “it is ethically questionable to continue to expose patients to therapists who provide them little opportunity for improvement,” suggesting, “performance-based retention of therapists could improve the … average response rate and decreas[e] the probability that a patient will be treated by a therapist who has little chance of helping” (Imel et al. 2015: 329).

Table 1. Change in total responses after removing lowest performing therapists

	Total responses (%)*
No removal	30,000 (50)
ICC = 0.05 (Small)	34,266 (57)
ICC = 0.10 (Medium)	36,404 (61)
ICC = 0.20 (Large)	39,307 (66)

(*) Note: Total number of potential responses over 40 iterations (10 years) is 60,000.

Reproduced from Imel, Z. E., Sheng, E., Baldwin, S. A., and Atkins, D. C. (2015). “Removing Very Low-Performing Therapists: A Simulation of Performance-Based Retention in Psychotherapy.” *Psychotherapy* 52: 329–336, https://doi.org/10.1037/pst0000023 Copyright © 2015, American Psychological Association.

Several surveys reveal practitioners harbor concerns about routine outcome monitoring that directly impact their willingness to employ measures in their clinical work. One that stands out for many is fear about the misuse of the resulting data (Boswell et al. 2015; Gleacher et al. 2016; Johnston and Gowers 2005; Unsworth et al. 2012). Despite evidence that most clinicians achieve outcomes on par with those obtained in randomized controlled trials (Minami et al. 2008; Saxon et al. 2017; Stiles et al. 2008; Wampold and Brown 2005), it is safe to assume Imel et al.'s (2015) proposal, summarized in the previous paragraph, would likely exacerbate such worries—a fact the authors acknowledge, noting their "basic premise might be troublesome for some therapists and health care professionals" (Imel et al. 2015: 329). Indeed, in a recent study on the implementation of routine outcome monitoring in Britain's National Health Service, Waldron et al. (2018) found clinician concerns did not abate over a six-month period despite the adoption of formal outcome monitoring policies, training in how to use measures, and the reassurance of management.

Beyond the concerns of clinicians, equating competence with practicing within the boundaries and limits of a therapist's and the field's known level of effectiveness inadvertently perpetuates the same static, either/or quality of the current standard. In effect, one threshold—producing results equivalent to colleagues—is simply replacing another—having the requisite training, supervision, and practice experience. Ultimately, both approaches treat competence as a state *achieved* rather than an active, dynamic process of continuous *achieving*.

On reflection, neither standard would have "served to protect" the women of Vienna or former first president of the United States. Indeed, an argument can easily be made that the professionals in both circumstances were practicing within the accepted norms of the time. For history to have been different, Washington's physicians and Semmelweis's contemporaries would not only need to have been held accountable for the effectiveness of their practices, but also been *ethically bound to work at improving their results*. Had such a standard been in place, those treating the president would have been compelled to regard his deterioration as "feedback," a signal to change their treatment and possibly seek outside consultation (Babins-Wagner 2017; Lambert 2010; Maeschalck and Barfknecht 2017). In the case of Semmelweis, guided more by outcomes than by conventional wisdom, physicians of the period would have been encouraged to embrace his innovative hygiene practices, thereby preventing the deaths of many future Viennese mothers, and potentially hastening the discovery and acceptance of germ theory. In sum, the truly competent practitioner not only works within, but also continuously to extend, their own *and* the field's effectiveness.

Operationalizing a Dynamic, Evidence-Based Competence Standard

> "Certain therapists are *more* effective than others … *because* [they are] appropriately responsive … providing each client with a different, individually tailored treatment."
>
> —Stiles and Horvath (2017: 71)[2]

On the heels of what was just discussed, we should note that mere measurement and comparison to effectiveness benchmarks are insufficient to ensure either competence or the public welfare. To be ethical, practitioners must also *act* on the data that routine outcome measures make available. Specifically, when client engagement or progress falls short, several options must be considered: adjusting services, seeking consultation, making a referral, and exploring innovative and promising practices (Lambert 2010; Prescott et al. 2017).

Dozens of randomized controlled trials and multiple meta-analyses now show that providing clinicians with feedback, generated by ongoing measurement of the quality and outcome of care, leads to better results (cf. Knaup et al. 2009; Lambert and Shimokawa 2011; Lambert et al. 2003; Shimokawa et al. 2010; Østergård et al. 2018). Individual studies document, for example, significant increases in the amount of client improvement as well as the efficiency of treatment while simultaneously reducing the risk of dropout and deterioration (Lambert 2010; Schuckard et al. 2017). Evidence supporting what is termed "feedback informed treatment" continues to mount, appearing in the literature with increasing frequency (Goodman et al. 2013; Pinner and Kivlighan 2018).

As an example, the PCOMS system, introduced earlier in this chapter, tracks client scores in real time using two brief, easy-to-use scales. The first, administered at the outset of each session, is the *Outcome Rating Scale* (ORS; Miller and Duncan 2000). It is designed to assess client progress. The second is the *Session Rating Scale* (SRS; Miller et al. 2000a). Given at the end of the visit, this tool measures the quality of the relationship or working alliance, an essential component of all effective psychotherapy (Bachelor and Horvath 1999; Norcross 2011). Together, the two scales take a minute or less to complete and score. Both are free to use in paper and pencil format and available in more than 30 languages.[3]

Multiple, proprietary computer-based platforms are available that use predictive algorithms derived from a large and growing normative database to provide immediate alerts to clinicians whenever treatment deviates from expected rates of progress or levels of client engagement (Miller 2011; Schuckard et al. 2017). As an example, consider the chart presented in Figure 1 showing the results of two treatment sessions with an adult. The client's scores on the ORS are represented with a thick black line. Two lines emerge from the first session ORS score, dividing the graph into three differently shaded areas. Over the course of treatment, scores falling in the topmost section are predictive of even-

tual success; in the darker gray area, a negative or null outcome; and in between, in the light gray area, an indeterminate result.

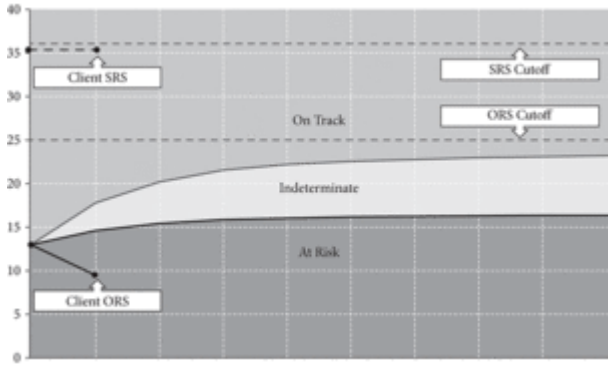

Figure 1. Graphic representation of two sessions of psychotherapy using the PCOMS progress and alliance scores

In this instance, the client's scores have declined from the first to the second visit. Now in the dark gray area, they indicate treatment is "at risk" for a negative or null outcome (e.g., lack of progress over time or dropout). The darker, dotted line on the graph represents the client's scores on the SRS. Falling below the established clinical cutoff of 36 (represented by a light gray, dashed line), such results provide additional evidence that action is required (Miller and Bertolino 2011). Indeed, an inquiry into the client's experience of the relationship would be in order. Multiple studies, in fact, document that improving SRS scores results in increases in both retention and outcome (Goldberg in press; Miller et al. 2007; Owen et al. 2016).

Recently, researchers Brown and Cazauvielh (2019) provided novel and compelling evidence that feedback, in the manner described above, improves outcomes by increasing clinician responsiveness to the needs and characteristics of the individual client. Using frequency as an indication of engagement, they found therapists who most often logged into a computerized routine outcome monitoring system to check client progress were significantly more effective than their peers, with an average effect size difference of 0.2 between the two groups. That is, clients of responsive practitioners were better off than close to 60 percent of those seen by their less engaged peers (McGough and Faraone 2009). Although a third variable—such as trait responsivity or conscientiousness producing both more engagement with the monitoring system and outcome—cannot be ruled out, randomized designs of routine outcome monitoring suggest that its impact is not due merely to therapist variables (Schuckard et al. 2017). It is therefore reasonable to suspect that degree of engagement with these procedures is similarly not fully explainable by therapist traits.

New and promising research on the subject of deliberate practice points to one additional pathway for operationalizing a dynamic, evidence-based standard of competence. The research to be reviewed next, documents reliable and valid improvement in the effective-

ness of agencies, clinics, and individual therapists. Moreover, if implemented as part of a new ethical standard, deliberate practice has the potential to increase the outcomes of the profession as a whole.

Improving the Outcome of Psychotherapy One Clinician at a Time

> “Most people never run far enough on their first wind to find out they’ve got a second. Give your dreams all you’ve got and you’ll be amazed at the energy that comes out of you.”
>
> —William James

Until very recently, no reference to deliberate practice could be found in the clinical psychology or psychotherapy literature (Miller et al. 2020). Originally coined by psychologist K. Anders Ericsson in 1993, the term refers to the process by which individuals across a wide range of human endeavors can continuously improve their performance. Deliberate practice has been researched for decades in many fields, including medicine, teaching, sports, music, and chess and enjoys substantial empirical support (Miller et al. 2018).

In brief, deliberate practice involves continuously and systematically pushing performers to reach for objectives just beyond their current abilities. It relies on four specific components (see Figure 2; Miller et al. 2018). The first is the identification of individualized learning objectives—specifically, focusing on behaviors that consistently undermine or detract from success. Next is involvement of a coach, a person whose job is to design practice activities which either correct or serve to enhance a performer’s skills or abilities. Ongoing feedback is the third. In their recent review of the research on this component, Miller et al. (2020) report feedback is most likely to be effective when it is timely, continuous, individualized, focused on specific goals, and designed for remediating deficits versus reinforcing existing strengths. Fourth and final is successive refinement. Here, the difference between deliberate practice and traditional definitions of practice becomes most apparent. In place of mindless repetition, emphasis is intentionally directed to continuous improvement, pushing the envelope of performance to a “just noticeable difference” in every episode of practice.

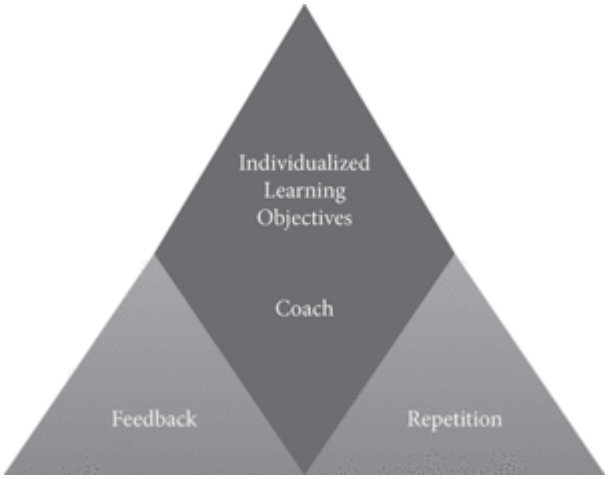

Figure 2. The four components of deliberate practice

Miller et al. (2007) were the first to discuss deliberate practice in relation to psychotherapy, introducing the concept to explain a finding that had long defied understanding; namely, some therapists are consistently more effective than others (cf. Ricks 1974; Okiishi et al. 2003; Saxon and Barkham 2012). Within a few short years, Chow et al. (2015) had provided the first empirical evidence that the time therapists spend engaged in deliberate practice predicts effectiveness. Based on data gathered in real-world treatment settings, the study showed the best therapists spent two and a half times more hours engaged in deliberate practice in a typical work week than their less effective counterparts. One year later, Goldberg et al. (2016a) reported gradual but significant improvements in outcome over a seven-year period resulting from the combined use of routine outcome monitoring, feedback-informed treatment, and deliberate practice. Importantly, their study, also conducted in an actual clinical setting, was the first in the history of the field to document improvements in effectiveness at both the agency and individual therapist level. Finally, and most recently, Miller et al. (2020) provided detailed, transtheoretical guidelines practitioners can use to evaluate their results, improve their responsiveness to clients, and identify targets for deliberate practice, thereby enabling them to meet the new standard of working within and continuously to extend their own and the field's effectiveness.

To recap, routine outcome monitoring is designed to assess the quality and effectiveness of treatment. Feedback informed treatment prompts therapists to take action when the work with a particular client is at risk for a negative or null outcome. When employed, the evidence indicates, it increases a clinician's responsiveness, a quality research suggests is characteristic of highly effective therapists (Stiles & Horvath 2017). If routine outcome monitoring is thought of as a smoke detector—a device constantly monitoring for evidence of a fire—feedback informed treatment is the alarm, signaling immediate attention and investigation are required. The final element for facilitating an improvement in performance is deliberate practice. It works either by remediating recurring errors or fostering growth beyond current levels of effectiveness. Staying with the analogy, deliberate

practice represents both the effort invested in improving the response to fires when they inevitably occur, and investing the time, energy, and effort necessary to create the conditions (i.e., innovative practices and structures) that make their outbreak less likely in the future.

The potential benefits of the new standard notwithstanding, the stories of Washington and Semmelweis, along with contemporary findings from implementation science, illustrate the very real challenges of putting routine outcome monitoring/feedback informed treatment/deliberate practice into practice.

Implementing an Evidence-Based Standard of Professional Competence

> "In theory, there is no difference between theory and practice. In practice, there is."
>
> —Walter J. Savitch

Translating healthcare-related research findings into standards of care is known to take time. In medicine, a figure often cited is seventeen years—a number one might consider overly hopeful given that handwashing remains, nearly two centuries after Semmelweis's discovery, a significant challenge in healthcare (Joint Commission 2015; Morris et al. 2011; Rodak 2013). Studies show, for example, that medical providers clean their hands less than 50 percent of the times they should (Centers for Disease Control and Prevention 2019). The result? Annually, a million people in the United States acquire an infection while hospitalized, resulting in thousands of deaths (Reed and Kemmerly 2009).

On the subject of routine outcome monitoring and feedback informed treatment, while a recent study found clients of therapists who used measures to inform their clinical work were 2.5 times more likely to experience benefit from treatment, the impact on outcomes was not immediate (Brattland et al. 2018). Indeed, during the first two years of implementation, measures and feedback made little difference. Only at year four did the practice begin to exert a significant effect—a figure consistent with findings from the broader implementation literature (Fixsen et al. 2005).

Other studies have revealed additional challenges. Evidence indicates, for instance, therapists do not appear to learn from the information provided by routine outcome monitoring and feedback informed treatment. In a series of ingenious experiments, Lambert et al. (2001, 2002) provided progress feedback to clinicians on half of their cases. With the other half, measures were administered, but the results withheld. Consistent with findings already cited, outcomes improved when information regarding client progress was made available to clinicians in real time. However, when the data were not shared, no improvement obtained. The results were troubling given that therapists in the study were all experienced and understood the purpose of the investigation: to identify clients at risk for deterioration or dropout and then take steps to prevent these undesirable outcomes.

What is more, the measures were simple and straightforward, so much so a reasonable person would expect that, with time and experience, clinicians would come to recognize the “tells” indicative of potential negative results. Still, Lambert reported, “even though therapists ha[d] gotten feedback on half their cases for over three years, [they did] not learn how to detect failing cases” on their own (Miller et al. 2004: 16).

Finally, several studies indicate the effects of routine outcome monitoring and feedback informed treatment are not distributed equally across practitioners. As is true of therapists in randomized controlled tests of specific treatment approaches, the impact of routine outcome monitoring and feedback informed treatment on outcome varies by clinician. In some as many as half do not benefit from measurement and receiving feedback about their results (de Jong and De Goede 2015; Lutz 2014; Simon et al. 2012). Not surprisingly, those who experience the greatest impact have been found: (1) to be receptive to feedback; (2) actively incorporate it in their work; (3) possess higher self-efficacy; and (4) put less stock in their own assessment/feelings regarding client progress (de Jong et al. 2012).

Altogether, the foregoing results make clear that broad utilization of routine outcome monitoring/feedback informed treatment/deliberate practice will take time and considerable effort. Findings from the emerging field of “Implementation Science” further indicate addressing the variability in therapist receptiveness—what is learned and applied, and its ultimate impact on performance—will require much more. Evidence shows successful adoption is more likely when the focus of implementation initiatives is on cultural and structural change within organizations, when any training provided is composed of practice, feedback, and “live,” on the job coaching, and finally, when leaders, rather than practitioners, are held accountable for putting new practices and standards into effect (Fixsen et al. 2009).

The Goldberg et al. (2016a) study of routine outcome monitoring/feedback informed treatment/deliberate practice cited earlier provides an excellent example of applying the findings from implementation research. Recall, this study is the first to show it is not only possible for therapists to document they are working within, but also to extend continuously their own and the field’s effectiveness. As a first step, agency management committed to creating a practice environment conducive of professional growth. Following a period of exploration, consensus building, training, and piloting, a policy was adopted requiring the collection of progress and outcome measures at each and every session. It is worth noting, during the exploratory phase of implementation, when therapists were simply asked to try routine outcome monitoring, the majority (60 percent) used the measures inconsistently. Following formal adoption, 40 percent of the licensed staff left the agency within four months despite explicit reassurance from management that staff outcomes would not be linked to performance evaluations. While the “exodus” may, at first blush, strike one as alarming, the agency was soon fully staffed with individuals who were interested in working in an agency setting that made effectiveness and continuous profession-

al growth, through routine outcome monitoring/feedback informed treatment/deliberate practice, the standard of competence.

As the implementation continued, agency leaders also used the data resulting from routine outcome monitoring to enact structural and procedural changes friendly to a "culture of feedback." For example, an expert in routine outcome monitoring/feedback informed treatment/deliberate practice was hired to provide monthly two-hour videoconference clinical consultations. At each meeting, practitioners brought cases identified by the measures as "at risk" for dropout or a negative or null outcome. As opposed to the traditional focus on diagnosis and treatment techniques, special attention was directed to understanding and acting on the feedback clients gave regarding their experience of the therapeutic alliance. Together with colleagues, the therapist and consultant openly shared ideas for improving responsiveness to the individual client. When a recurring error or potential areas for professional growth became apparent, specific suggestions for subsequent skill practice and refinement were provided which could later be addressed during in-house supervision.

In sum, beyond any efforts aimed at securing practitioner compliance, successful implementation of an evidence-based competence standard will necessitate change at the professional organizational level. The old way is the wrong way. That is, the customary approach of just drafting rules, demanding adherence, and dispensing discipline for infractions ignores the evidence about "what works" in sponsoring change. As Boswell et al. (2015: 11) assert, the undue focus on the behavior of the individual practitioner fails to consider systemic and contextual factors which "facilitate or inhibit … adoption, implementation, and sustainability." True, too, "overly authoritative dissemination methods may reduce the chance a practice change is successfully implemented" (Creason et al. 2019: 410).

Summary Conclusions

A key plank in the ethical codes of all of the major mental health provider organizations in the United States is that practitioners "provide services … with populations and in areas … within the boundaries of their competence, based on their education, training, supervised experience, consultation, study, or professional expertise" (APA 2017: 5). Presently, competence is equated with educational attainment and professional experience; however, research reviewed in this chapter shows clearly that neither ensures skillful or effective practice. Replacing the field's current definition of competence with a standard of "working within and continually to extend the field's and one's own level of effectiveness" would serve to protect public welfare and facilitate ongoing improvement in the results of clinical services, meeting this new ethical standard. This would also resolve the inconsistency between standards equating competence with indicators that do not hold up under empirical scrutiny (e.g., supervision, continuing education, experience) and those dictating that "scientific and professional knowledge of the discipline" (APA 2017: 5) guides

professional practice (e.g., Standards 2.01 and 2.04, respectively, of the APA *Ethical Principles of Psychologists and Code of Conduct*).

The combination of routine outcome monitoring, feedback informed treatment, and deliberate practice, as reviewed in this chapter, provides an evidence-based approach for operationalizing and meeting this new ethical standard—one which, research is showing, enhances outcomes at both the agency and practitioner level. Regardless of the possibilities, significant challenges to implementation exist. Should the profession wish to move forward, the responsibility for success cannot be placed on the shoulders of individual therapists. Organizational leadership, informed by evidence-based implementation principles, will be needed to create the cultural shift necessary to place effectiveness at the forefront of clinical work and professional identity.

References

American Psychological Association (2017). *Ethical Principles of Psychologists and Code of Conduct*. Retrieved from **https://www.apa.org/ethics/code/ethics-code-2017.pdf**

American Psychological Association Presidential Task Force on Evidence-Based Practice (2006). "Evidence-Based Practice in Psychology." *American Psychologist* 61: 271–285.

Anderson, T., Crowley, M. E. J., Himawan, L., Holmberg, J. K., and Uhlin, B. D. (2016). "Therapist Facilitative Interpersonal Skills and Training Status: A Randomized Clinical Trial on Alliance and Outcome." *Psychotherapy Research* 26: 511–529.

Association of State and Provincial Psychology Boards (2019). *Supervision Guidelines for Licensed Psychological Associates*. Retrieved from **https://cdn.ymaws.com/www.asppb.net/resource/resmgr/guidelines/supervision_guidelines_for_l.pdf**

Atkins, D. C. and Christensen, A. (2001). "Is Professional Training Worth the Bother? A Review of the Impact of Psychotherapy Training on Client Outcome." *Australian Psychologist* 36: 122–130.

Babins-Wagner, R. (2017). "Feedback-Informed Treatment in Agency and Clinic Settings." In *Feedback-Informed Treatment in Clinical Practice: Reaching for Excellence* (ed. D. S. Prescott, C. L. Maeschalck, and S. D. Miller, pp. 167–185). Washington, DC: American Psychological Association.

Bachelor, A. and Horvath, A. (1999). "The Therapeutic Relationship." In *The Heart and Soul of Change: What Works in Therapy* (ed. M. A. Hubble, B. L. Duncan, and S. D. Miller, pp. 133–178). Washington, DC: American Psychological Association.

Berman, J. S. and Norton, N. C. (1985). "Does Professional Training Make a Therapist More Effective?" *Psychological Bulletin* 98: 401–407.

Boswell, J. F., Castonguay, L. G., and Wasserman, R. H. (2010). “Effects of Psychotherapy Training and Intervention Use on Session Outcome.” *Journal of Consulting and Clinical Psychology* 78: 717–723.

Boswell, J. F., Kraus, D. R., Miller, S. D., and Lambert, M. J. (2015). “Implementing Routine Outcome Monitoring in Clinical Practice: Benefits, Challenges, and Solutions.” *Psychotherapy Research* 25: 6–19.

Brattland, H., Koksvik, J. M., Burkeland, O., Gråwe, R. W., Klöckner, C., Linaker, O. M., … Iversen, V. C. (2018). “The Effects of Routine Outcome Monitoring (ROM) on Therapy Outcomes in the Course of an Implementation Process: A Randomized Clinical Trial.” *Journal of Counseling Psychology* 65: 641–652.

Brown, J. and Cazauvielh, C. (2019). “Clinician Engagement in Feedback Informed Treatment (FIT) and Patient Outcomes.” Retrieved from **https://acorncollaboration.org/blog/2019/2/12/therapist-engagement**

Centers for Disease Control and Prevention (2019). “Hand Hygiene in Healthcare Settings.” Retrieved from **https://www.cdc.gov/handhygiene/index.html**

Chow, D. (2014). “The Study of Supershrinks: Development and Deliberate Practices of Highly Effective Psychotherapists.” Doctoral dissertation, Curtin University, Perth, Australia.

Chow, D. L., Miller, S. D., Seidel, J. A., Kane, R. T., Thornton, J. A., and Andrews, W. P. (2015). “The Role of Deliberate Practice in the Development of Highly Effective Psychotherapists.” *Psychotherapy* 52: 337–345.

Creason, A. H., Ruscio, A. C., Tate, K. E., and McGraw, K. L. (2019). “Accelerating Psychological Health Research Findings into Clinical Practice through the Practice-Based Implementation Network Model.” *Military Medicine* 184: 409–417.

de Jong, K. and De Goede, M. E. E. (2015). “Why Do Some Therapists Not Deal with Outcome Monitoring Feedback? A Feasibility Study on the Effect of Regulatory Focus and Person–Organization Fit on Attitude and Outcome.” *Psychotherapy Research* 25: 661–668.

de Jong, K., van Sluis, P., Nugter, M. A., Heiser, W. J., and Spinhoven, P. (2012). “Understanding the Differential Impact of Outcome Monitoring: Therapist Variables that Moderate Feedback Effects in a Randomized Clinical Trial.” *Psychotherapy Research* 22: 464–474.

Durlak, J. A. (1979). “Comparative Effectiveness of Paraprofessional and Professional Helpers.” *Psychological Bulletin* 86: 80–92.

Fals-Stewart, W. and Birchler, G. R. (2002). “Behavioral Couples Therapy with Alcoholic Men and their Intimate Partners: The Comparative Effectiveness of Bachelor’s- and Master’s-Level Counselors.” *Behavior Therapy* 33: 123–147.

Fieser, J. (2005). “Ethics.” *Internet Encyclopedia of Philosophy*. Retrieved from **https://www.iep.utm.edu/ethics/**

Fixsen, D. L., Blasé, K. A., Naoom, S. F., and Wallace, F. (2009). “Core Implementation Components.” *Research on Social Work Practice* 19. Retrieved from **https://doi.org10.1177/1049731509335549**

Fixsen, D. L., Naoom, S. F., Blasé, K. A., Friedman, R. M., and Wallace, F. (2005). *Implementation Research: A Synthesis of the Literature*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network (FMHI Publication #231).

Flexner, J. T. (1974). *Washington: The Indispensable Man*. Boston: Little, Brown, & Company.

Gleacher, A. A., Olin, S. S., Nadeem, E., Pollock, M., Ringle, V., Bickman, L., … Hoagwood, K. (2016). “Implementing a Measurement Feedback System in Community Mental Health Clinics: A Case Study of Multilevel Barriers and Facilitators.” *Administration and Policy in Mental Health and Mental Health Services Research* 43: 426–440.

Goldberg, S. B., Babins-Wagner, R., Rousmaniere, T., Berzins, S., Hoyt, W. T., Whipple, J. L., … Wampold, B. E. (2016a). “Creating a Climate for Therapist Improvement: A Case Study of an Agency Focused on Outcomes and Deliberate Practice.” *Psychotherapy* 53: 367–375.

Goldberg, S. B., Rousmaniere, T., Miller, S. D., Whipple, J., Nielsen, S. L., Hoyt, W. T., and Wampold, B. E. (2016b). “Do Psychotherapists Improve with Time and Experience? A Longitudinal Analysis of Outcomes in a Clinical Setting.” *Journal of Counseling Psychology* 63: 1–11.

Goldberg, S. B., Rowe, G., Malte, C. A., Ruan, H., Owen, J. J., and Miller, S. D. (in press). “Routine Monitoring of Therapeutic Alliance to Predict Treatment Engagement in a Veteran Affairs Substance Use Disorders Clinic.” *Psychological Services*.

Goodman, J. D., McKay, J. R., and DePhilippis, D. (2013). “Progress Monitoring in Mental Health and Addiction Treatment: A Means of Improving Care.” *Professional Psychology: Research and Practice* 44: 231–246.

Grus, C. L. and Rozensky, R. H. (2019). “Competency-Based Continuing Education in Health Service Psychology: Ensuing Quality, Recommendations for Change.” *Professional Psychology: Research and Practice* 50: 106–112.

Hattie, J. A., Sharpley, C. F., and Rogers, H. J. (1984). “Comparative Effectiveness of Professional and Paraprofessional Helpers.” *Psychological Bulletin* 95: 534–541.

Hill, C. E., Spiegel, S. B., Hoffman, M. A., Kivlighan, D. M., Jr., and Gelso, C. J. (2017). “Therapist Expertise in Psychotherapy Revisited.” *The Counseling Psychologist* 45: 7–53.

Imel, Z. E., Sheng, E., Baldwin, S. A., and Atkins, D. C. (2015). “Removing Very Low-Performing Therapists: A Simulation of Performance-Based Retention in Psychotherapy.” *Psychotherapy* 52: 329–336.

Johns, R. G., Barkham, M., Kellett, S., and Saxon, D. (2019). “A Systematic Review of Therapist Effects: A Critical Narrative Update and Refinement to Baldwin and Imel’s (2013) Review.” *Clinical Psychology Review* 67: 78–93.

Johnston, C. and Gowers, S. (2005). “Routine Outcome Measurement: A Survey of UK Child and Adolescent Mental Health Services.” *Child and Adolescent Mental Health* 10: 133–139.

Joint Commission (2015). “Sustaining and Spreading Improvement in Hand Hygiene and Compliance.” *Journal on Quality and Patient Safety* 41(1).

Joint Commission (2018). *New Outcome Measures Standard*. Retrieved from **https://www.jointcommission.org/accreditation/bhc_new_outcome_measures_standard.aspx**

Knaup, C., Koesters, M., Schoefer, D., Becker, T., and Puschner, B. (2009). “Effect of Feedback of Treatment Outcome in Specialist Mental Healthcare: Meta-Analysis.” *British Journal of Psychiatry* 195: 15–22.

Lambert, M. J. (2010). *Prevention of Treatment Failure: The Use of Measuring, Monitoring, and Feedback in Clinical Practice*. Washington, DC: American Psychological Association.

Lambert, M. J. and Shimokawa, K. (2011). “Collecting Client Feedback.” *Psychotherapy* 48: 72–79.

Lambert, M. J., Whipple, J. L., Hawkins, E. J., Vermeersch, D. A., Nielsen, S. L., and Smart, D. W. (2003). “Is it Time for Clinicians to Routinely Track Patient Outcome? A Meta-Analysis.” *Clinical Psychology: Science and Practice* 10: 288–301.

Lambert, M. J., Whipple, J. L., Smart, D. W., Vermeersch, D. A., Nielsen, S. L., and Hawkins, E. J. (2001). “The Effects of Providing Therapists with Feedback on Patient Progress during Psychotherapy: Are Outcomes Enhanced?” *Psychotherapy Research* 11: 49–68.

Lambert, M. J., Whipple, J. L., Vermeersch, D. A., Smart, D. W., Hawkins, E. J., Nielsen, S. L., & Goates, M. (2002). “Enhancing Psychotherapy Outcomes via Providing Feedback on Client Progress: A Replication.” *Clinical Psychology and Psychotherapy* 9: 91–103.

Lutz, W. (2014). “Why, When and How do Patients Change? Identifying and Predicting Progress and Outcome in Psychotherapy.” Presentation delivered at the Calgary Counseling Center. Calgary, Canada. Retrieved from **https://www.scottdmiller.com/wp-content/uploads/2016/09/Lecture-Wolfgang-Lutz-Calgary2014_send.pdf**

McGough, J. J. and Faraone, S. V. (2009). “Estimating the Size of Treatment Effects: Moving beyond *P* Values.” *Psychiatry (Edgemont)* 6: 21–29.

Maeschalck, C. L. and Barfknecht, L. R. (2017). “Using Client Feedback to Inform Treatment.” In *Feedback-Informed Treatment in Clinical Practice: Reaching for Excellence* (ed. D. S. Prescott, C. L. Maeschalck, and S. D. Miller, pp. 53–77). Washington, DC: American Psychological Association.

Malouff, J. (2012). “The Need for Empirically Supported Psychology Training Standards.” *Psychotherapy in Australia* 18: 28–32.

Miller, S. D. (2011). “Cutting Edge Feedback.” Retrieved from **https://www.scottdmiller.com/cutting-edge-feedback/**

Miller, S. D. and Bertolino, B. (eds.) (2011). *The Feedback-Informed Treatment and Training Manuals* (Vols. 1–6). Chicago, IL: ICCE.

Miller, S. D., Chow, D., Wampold, B. E., Hubble, M. A., Del Re, A. C., Maeschalck, C., and Bargmann, S. (2018). “To Be or Not to Be (an Expert)? Revisiting the Role of Deliberate Practice in Improving Performance.” *High Ability Studies* (December). Retrieved from **https://doi.org/10.1080/13598139.2018.1519410**

Miller, S. D. and Duncan, B. L. (2000). *Outcome Rating Scale*. Chicago, IL: ICCE.

Miller, S. D., Duncan, B. L., and Hubble, M. A. (2004). “Beyond Integration: The Triumph of Outcome over Process in Clinical Practice.” *Psychotherapy in Australia* 10: 2–19.

Miller, S. D., Duncan, B. L., and Johnson, L. (2000a). *Session Rating Scale*. Chicago, IL: ICCE.

Miller, S. D., Duncan, B. L., Johnson, L. D., & Hubble, M. A. (2000b). “Jurassic Practice: Why the Field is on the Verge of Extinction and What We Can Do to Save It.” *Professional Counselor* 15: 28–35.

Miller, S. D., Hubble, M., and Chow, D. (2020). *Better Results: Using Deliberate Practice to Improve Therapeutic Effectiveness*. Washington, DC: American Psychological Association.

Miller, S. D., Hubble, M., and Chow, D. L. (2017). “Professional Development: An Oxymoron?” In *The Cycle of Excellence: Using Deliberate Practice in Supervision, Training, and Independent Practice* (ed. T. Rousmaniere, R. K. Goodyear, S. D. Miller, and B. Wampold, pp. 23–47). Hoboken, NJ: Wiley.

Miller, S. D., Hubble, M. A., and Duncan, B. L. (2007). “Supershrinks: Learning from the Field’s Most Effective Practitioners.” *The Psychotherapy Networker* 31: 26–35, 56.

Minami, T., Wampold, B. E., Serlin, R. C., Hamilton, E. G., Brown, G. S. J., and Kircher, J. C. (2008). “Benchmarking the Effectiveness of Psychotherapy Treatment for Adult De-

pression in a Managed Care Environment: A Preliminary Study." *Journal of Consulting and Clinical Psychology* 76: 116–124.

Montgomery, E. C., Kunik, M. E., Wilson, N., Stanley, M. A., and Weiss, B. (2010). "Can Paraprofessionals Deliver Cognitive-Behavioral Therapy to Treat Anxiety and Depressive Symptoms?" *Bulletin of the Menninger Clinic* 74: 45–62.

Morris, Z. S., Wooding, S., and Grant, J. (2011). "The Answer is 17 Years, What is the Question: Understanding Time Lags in Translational Research." *Journal of the Royal Society of Medicine* 104: 510–520.

Muir, H. J., Coyne, A. E., Morrison, N. R., Boswell, J. F., and Constantino, M. J. (2019). "Ethical Implication of Routine Outcomes Monitoring for Patients, Psychotherapists, and Mental Health Care Systems." *Psychotherapy*. Advance online publication. Retrieved from **http://dx.doi.org/10.1037/pst0000246**

Neimeyer, G. J., Minniti, A., and Taylor, J. M. (2019). "Critical Conversations in Continuing Education: Contemporary Memes, Themes, and Dreams." *Professional Psychology: Research and Practice* 50: 63–69.

Neimeyer, G. J., Taylor, J. M., and Cox, D. R. (2012). "On Hope and Possibility: Does Continuing Professional Development Contribute to Ongoing Professional Competence?" *Professional Psychology: Research and Practice* 43: 476–486.

Neimeyer, G. J., Taylor, J. M., and Wear, D. M. (2009). "Continuing Education in Psychology: Outcomes, Evaluations, and Mandates." *Professional Psychology: Research and Practice* 40: 617–624.

Norcross, J. C. (ed.) (2011). *Psychotherapy Relationships That Work* (2nd ed.). New York: Oxford University Press.

Okiishi, J., Lambert, M. J., Nielsen, S. L., and Ogles, B. M. (2003). "Waiting for Supershrink: An Empirical Analysis of Therapist Effects." *Clinical Psychology & Psychotherapy* 10: 361–373.

Orlinsky, D. E. and Rønnestad, M. H. (2005). *How Psychotherapists Develop: A Study of Therapeutic Work and Professional Growth*. Washington, DC: American Psychological Association.

Østergård, O. K., Randa, H., and Hougaard, E. (2018). "The Effect of Using the Partners for Change Outcome Management System as Feedback Tool in Psychotherapy: A Systematic Review and Meta-Analysis." *Psychotherapy Research*. Advance online publication. Retrieved from **https://doi.org/10.1080/10503307.2018.1517949**

Owen, J., Miller, S. D., Seidel, J. A., and Chow, D. L. (2016). "The Working Alliance in the Treatment of Military Adolescents." *Journal of Consulting and Clinical Psychology* 84: 200–210.

Pinner, D. H. and Kivlighan, D. M., III (2018). “The Ethical Implications and Utility of Routine Outcome Monitoring in Determining Boundaries of Competence in Practice.” *Professional Psychology: Research and Practice* 49: 247–254.

Prescott, D., Maeschalck, C., and Miller, S. D. (eds.) (2017). *Feedback-Informed Treatment in Clinical Practice: Reaching for Excellence*. Washington, DC: American Psychological Association.

Reed, D. and Kemmerly, S. A. (2009). “Infection Control and Prevention: A Review of Hospital-Acquired Infections and the Economic Implications.” *The Ochsner Journal* 9: 27–31.

Ricks, D. F. (1974). “Supershrink: Methods of a Therapist Judged Successful on the Basis of Adult Outcomes of Adolescent Patients.” In *Life History Research in Psychopathology* (ed. D. F. Ricks and M. Roff, pp. 275–297). Minneapolis: University of Minnesota Press.

Rodak, S. (2013). “Why is Hand Hygiene Still a Problem in Healthcare? Four Common Culprits.” Retrieved from **https://www.beckersasc.com/asc-quality-infection-control/why-is-hand-hygiene-still-a-problem-in-healthcare-4-common-culprits.html?goback=%2Egde_1805565_member_229507621**

Rousmaniere, T. G., Swift, J. K., Babins-Wagner, R., Whipple, J. L., and Berzins, S. (2016). “Supervisor Variance in Psychotherapy Outcome in Routine Practice.” *Psychotherapy Research* 26: 196–205.

Saxon, D., Ashley, K., Bishop-Edwards, L., Connell, J., Harrison, P., Ohlsen, S., … Barkham, M. (2017). “A Pragmatic Randomised Controlled Trial Assessing the Non-Inferiority of Counselling for Depression versus Cognitive-Behaviour Therapy for Patients in Primary Care Meeting a Diagnosis of Moderate or Severe Depression (PRaCTICED): Study Protocol for a Randomised Controlled Trial.” *Trials*. Retrieved from **https://doi.org/10.1186/s13063-017-1834-6**

Saxon, D. and Barkham, M. (2012). “Patterns of Therapist Variability: Therapist Effects and the Contribution of Patient Severity and Risk.” *Journal of Consulting and Clinical Psychology* 80: 535–546.

Schuckard, E., Miller, S. D., and Hubble, M.A. (2017). “Feedback-Informed Treatment: Historical and Empirical Foundations.” In *Feedback-Informed Treatment in Clinical Practice: Reaching for Excellence* (ed. D. S. Prescott, C. L. Maeschalck, and S. D. Miller, pp. 13–35). Washington, DC: American Psychological Association.

Shimokawa, K., Lambert, M. J., and Smart, D. W. (2010). “Enhancing Treatment Outcome of Patients at Risk of Treatment Failure: Meta-Analytic and Mega-Analytic Review of a Psychotherapy Quality Assurance System.” *Journal of Consulting and Clinical Psychology* 78: 298–311.

Simon, W., Lambert, M. J., Harris, M. W., Busath, G., and Vazquez, A. (2012). “Providing Patient Progress Information and Clinical Support Tools to Therapists: Effects on Patients at Risk of Treatment Failure.” *Psychotherapy Research* 22: 638–647.

Stiles, W. B., Barkham, M., Mellor-Clark, J., and Connell, J. (2008). “Effectiveness of Cognitive-Behavioural, Person-Centred, and Psychodynamic Therapies in UK Primary-Care Routine Practice: Replication in a Larger Sample.” *Psychological Medicine* 38: 677–688.

Stiles, W. B. and Horvath, A. O. (2017). “Appropriate Responsiveness as a Contribution to Therapist Effects.” In *How and Why Are Some Therapists Better than Others? Understanding Therapist Effects* (ed. L. G. Castonguay and C. E. Hill, pp. 71–84). Washington, DC: American Psychological Association.

Tasca, G. A., Angus, L., Bonli, R., Drapeau, M., Fitzpatrick, M., Hunsley, J., and Knoll, M. (2019). “Outcome and Progress Monitoring in Psychotherapy: Report of a Canadian Psychological Association Task Force.” *Canadian Psychology/Psychologie canadienne* 60: 165–177.

Unsworth, G., Cowie, H., and Green, A. (2012). “Therapists’ and Clients’ Perceptions of Routine Outcome Measurement in the NHS: A Qualitative Study.” *Counselling and Psychotherapy Research* 12: 71–80.

Waldron, S. M., Loades, M. E., and Rogers, L. (2018). “Routine Outcome Monitoring in CAMHS: How Can We Enable Implementation in Practice?” *Child and Adolescent Mental Health* 23: 328–333.

Walfish, S., McAlister, B., O’Donnell, P., and Lambert, M. J. (2012). “An Investigation of Self-Assessment Bias in Mental Health Providers.” *Psychological Reports* 110: 639–644.

Wampold, B. E. and Brown, G. S. (2005). “Estimating Variability in Outcomes Attributable to Therapists: A Naturalistic Study of Outcomes in Managed Care.” *Journal of Consulting & Clinical Psychology* 73: 914–923.

Watkins, C. E., Jr. (2011). “Does Psychotherapy Supervision Contribute to Patient Outcomes? Considering Thirty Years of Research.” *The Clinical Supervisor* 30: 235–256.

Weisz, J. R., Weiss, B., Han, S. S., Granger, D. A., and Morton, T. (1995). “Effects of Psychotherapy with Children and Adolescents Revisited: A Meta-Analysis of Treatment Outcome Studies.” *Psychological Bulletin* 117: 450–468.

Notes:

(1.) The story of George Washington originally appeared in Miller et al. (2000b) and is retold here with permission of *Professional Counselor* magazine.

(2.) Reproduced from Stiles, W. B. and Horvath, A. O., ‘Appropriate Responsiveness as a Contribution to Therapist Effects’, in L. G. Castonguay and C. E. Hill (eds.), *How and Why*

Are Some Therapists Better than Others? Understanding Therapist Effects, p. 71, https://dx.doi.org/10.1037/0000034-005 Copyright © 2017, American Psychological Association.

(3.) Clinicians in independent practice can access the measures at: https://scott-d-miller-ph-d.myshopify.com/collections/performance-metrics/products/performance-metrics-licenses-for-the-ors-and-srs

Scott D. Miller

International Center for Clinical Excellence

Joshua W. Madsen

Department of Psychology, University of Calgary

Mark A. Hubble

Institute for the Study of Therapeutic Change