

# Counseling and Family Therapy Scholarship Review

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Volume 4 | Issue 1

Article 6

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February 2022

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### Recommended Citation

Mahon, Daryl BA, MA (2022) "Using Client and Supervision Feedback to Improve Supervision in Health Care," *Counseling and Family Therapy Scholarship Review*: Vol. 4: Iss. 1, Article 6.

Available at: <https://epublications.regis.edu/cftsr/vol4/iss1/6>

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## Using Client and Supervision Feedback to Improve Supervision in Health Care

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This paper seeks to establish a conceptual model of client and supervisee feedback that can be used to improve supervision processes and outcomes in health and social care settings. Supervision is a beneficial practice development endeavor that practitioners find rewarding for various reasons. However, the impact of supervision on client outcomes in health and social care settings is scant and not all supervision is helpful; indeed, harmful and inadequate supervision is also prevalent. Using supervisory measures of the alliance between supervisor and supervisee may be one method to help improve processes and outcomes. In addition, providing client feedback to practitioners in health and social care settings has been established as an evidence-based method to improve psychosocial outcomes. Using this feedback data during supervision may help the supervisory process to focus on practitioner development objectively, and limit the extent of negative client experiences in systems of care. A conceptual model describing bidirectional feedback based on objective assessment is articulated; client to practitioner/practitioner to supervisor. A lack of primary data poses limitations to this review. Thus, future research may like to establish whether integrating these processes together as a conceptual model provides added value.

**KEYWORDS:** supervision, feedback, health and social care

### Improving Supervision in Health Care

Watkins (2020) considers supervision the key signature pedagogies of psychiatry and other related mental health professions such as psychology and counselling. At the same time, supervision within the wider health and social care setting is seen as an intrinsic part of development and essential to quality services and client safety (Carpenter et al., 2013; Milne et al., 2011; Social Care Institute for Excellence, 2017). While the roles and tasks of practitioners across the broader health and social care setting can vary significantly, the practice of supervision is considered more generic in nature. Although several definitions of supervision are in the literature, many share similar themes and functions. Specifically, supervision is described as a learning and development endeavor, provided by a more senior person of similar profession. Supervision is a reflective and developmental environment, relationship-focused, and focuses on the accusation of skills, knowledge, and competencies. Supervision has as a main concern ethically sound work, the achievement of organizational goals, and that the supervisees' wellbeing and needs are being considered (Hawkins & Shoheit, 2012; Morrison, 2005; Watkins, 2020).

Consistent with the above summary of supervision, Proctor (2001), outlines a popular model of supervision, with the three functions of, normative (managerial), formative (educational), and restorative (supportive). This model was extended by Morrison (2005) to the social care sector, and is often described as the gold standard of supervision for this setting. Bernard and goodyear (1992, p.8) provide the following definition of clinical supervision; "This relationship is evaluative, extends over time and has the simultaneous purposes of enhancing the professional functioning of the more junior person and monitoring the quality of the professional services". Considering the vast overlap across the wider health and social care professions when it comes to supervision practice I see no need to differentiate. Therefore, this paper takes a generic approach to exploring how to improve

client outcomes through the use of feedback measures in supervision. While much of the research on using client feedback comes from the psychological and therapy literature, it equally applies to those professions who deliver clinical or psychosocial interventions to young people and adults across allied health and social care settings.

### **Supervision and correlations**

Those in practitioner roles such as supervisors and supervisees tend to believe in the benefits, power and efficacy of supervision (Rast et al., 2017). Yet, belief does not necessarily mean an empirical reality, at least as far as client outcomes are concerned. Supervisors explained less than 1% of the variance in client psychotherapy outcomes in a study of 175 therapists with five years of data (Rousmaniere, 2016). In a replication study, Whipple et al. (2020) examined the amount of variance in client outcome that is attributable to supervision. Based on a longitudinal dataset of 3030 clients, 80 therapists and 39 supervisors. Similar to the Rousmaniere et al. (2016) study, they found that supervisors accounted for 0% of the variance in client outcome. Both studies had one to two hours per week of individual supervision, with the Rousmaniere (2016) study having two-hour weekly group supervision, in addition to the individual supervision.

Wrape et al. (2014, p.36) posit that the “criteria by which to evaluate supervision’s efficacy lies in its power to bring about favorable client changes”. Watkins (2020) reviews the supervision evidence from 1995 to 2019. Not pulling any punches, Watkins suggests that ‘evidence-based supervision appears to be more a hope and dream than supervision-based reality at present’. He goes further and suggests that supervision models generally lack empirical foundation and evidence supporting supervision impact of any type is weak at best, especially so for practitioner and client outcomes. Snowdon et al. (2017) systematic review found there was no correlation between supervision and client experience.

After reviewing 690 articles about supervision in child welfare Carpenter et al. (2013, p1843), concluded that, 'the evidence base for the effectiveness of supervision in child welfare is surprisingly weak'. They note that there are many models of supervision, but few of them have been subjected to rigorous research. For Carpenter et al. (2013), much like Watkins (2011; 2020), the most obvious gap is in evidence that models of supervision lead to improved outcomes for workers and, in particular, clients of practitioners.

Supervision has found to be positively correlated with several individual and organizational factors, such as job satisfaction, job retention and ability to manage workload (Carpenter et al., 2013; O’Donoghue & Tsui, 2015). In addition, Kühne et al. (2019) in a systematic review found that supervision appears to be seen as helpful by supervisees. In another systematic review Alfonsso et al. (2018) found that supervision may benefit novice practitioners’ competency, but reflecting previous studies no evidence of impact on client outcomes. Likewise, Bogo and McKnight, (2006) and Carpenter et al. (2013) draw similar conclusions, contending that supervision's positive impact on practitioner outcomes is weak at best. Moreover, the client continues to be neglected in supervision research (Buus & Gonge, 2009; Carpenter et al., 2013; Ellis et al., 1996; Hardy et al., 2017) with studies focusing on non-outcome variables such as supervisee satisfaction, such as those found in Wheeler and Richardson’s (2007) systematic review; ‘therapist self-awareness, skills, self-efficacy, theoretical orientation and support ‘are the benefits derived from supervision.

## **Progress monitoring**

Progress monitoring, routine outcome monitoring, also referred to as Feedback Informed Treatment (FIT) has been discussed as one of the most promising interventions for improving clinical outcomes (Langkaas et al., 2018; Wampold, 2015). Progress feedback generally uses standardized measures of process and outcome administered on a session to session basis as conversational tools. Although there are many different types of measure that can be utilized for this purpose, practitioners may wish to base their decisions on factors such as the group they work with, or organizational and commissioning body mandate. However, the present paper will make use of the two protocols used in FIT as they are measures of the therapeutic alliance, and a general global measure of distress. As such, they can be used with all populations and supervisory processes, as they are trans-theoretical. According to Bertolino et al. (2011);

“Feedback informed treatment is an empirically supported, pan theoretical approach for evaluating and improving the quality and effectiveness of behavior health services. It involves routinely and formally soliciting feedback from clients regarding the therapeutic alliance and outcome of care and using the resulting information to tailor and inform service delivery”.

Feedback involves the use of two ultra-brief scales that assess the clients experience of the therapy process, and the benefits that they experience on a session to session basis; namely, the Outcome Rating Scale (ORS) and the Session Rating Scale (SRS) as discussed by (Hafkenscheid et al., 2010; Miller et al., 2006).

The resulting feedback is used by the practitioner to adapt care based on the clients need and stated preferences in real time, addressing issues as they arise and adapting care for those at risk of negative outcomes. The utility and brevity of the ORS and SRS is connected to their ultra-short time to administer, thus, practitioners may be more likely use them routinely (Miller et al., 2006).

## **Feedback research**

Dozens of randomized control trials have been conducted demonstrating positive outcomes across measures such as drop out, symptom reduction, identifying not on track cases, deterioration, and less session needed. (e.g. Brattland et al., 2018; Delgadillo et al., 2018; Janse et al., 2020a; Janse et al., 2020b). In addition, several meta-analysis and Cochrane Reviews with youth and adults have demonstrated differential results from no effect, to moderate effect sizes (Bergman et al., 2018 ; Kendrick et al., 2016 ; Knaup et al., 2018; Lambert et al., 2003; Lambert et al., 2018; Østergård, Randa & Hougaard, 2018; Shimokawa et al., 2010; Tam & Ronan, 2017).

However, in many of these studies methodological and intervention issues make it difficult to draw consistent conclusions. The latest meta-analysis may bring us closer to a reliable conclusion regarding the benefit of feedback on clinical outcomes. A multilevel metanalysis of 58 studies (de Jong et al., 2021), analyzing 110 effect sizes in a total sample of 21,699 clients found that when feedback was used, early attrition were reduced by 20%, it also found a small benefit for symptom reduction, and for improving outcomes for those deemed not on track and at-risk null outcomes.

While the mechanisms by which feedback approaches work is still not fully understood, using measures of outcome and process to help practitioners identify those at

risk of poor outcomes is one-way feedback may get its prowess. Practitioners are generally poor at identifying clients not benefiting from service (Hannan et al., 2005; Hatfield et al., 2010; Lambert et al., 2005; Lambert, 2013). Indeed, it is proposed that practitioners routinely and vastly overestimate their effectiveness (Chow et al., 2015; Hannon et al., 2005; Walfish et al., 2012). Therefore, using feedback to identify these clients so that practitioners can change approach in real time, in order to become more aligned to the client's goals and needs, may be one mechanism through which feedback works (de Jong et al., 2021).

### **The need for client feedback**

Individual practitioners and systems of care across the allied health and social care sectors experience both similar and different types of negative outcomes when their service provision is not working as effectively as it could do, were it at optimal performance. For example, the psychotherapy literature across the last 50 years is reliably consistent with outcome data relating to negative outcomes. Meta-analysis demonstrates that early attrition from treatment is 47% for adults attending community outpatient services (Wierzbicki et al., 1993). With young people early attrition is anywhere between 17% to 85% (de Hann et al., 2013 Garcia and Weisz, 2002). At the same time deterioration rates for adults are 5-10% (Cuijpers, 2018; Hansen et al., 2002; Lambert, 2013). For young people these numbers average about 24% (Nelson et al., 2013). Moreover, as many as 70% of individuals in outpatient mental health settings drop out after the first or second session (Olfson et al., 2009).

It becomes a little more difficult to capture negative outcomes in other settings, such as inpatient care, or residential treatment or childcare. Many people who are having negative experiences may not be able to 'drop out' and their experiences may thus be acted out in some other way causing harm to themselves and those working with them in supportive roles. When client feedback was utilized by practitioners and their supervisors in a statutory child protection service in Denmark, 50% less children were placed outside of the home; there was a 100% reduction in complaints made by families about practitioners and services; and there was 100% decrease in employee turnover and sick days (International Centre for Clinical Excellence, 2021). Summarizing the findings from meta-analysis and individual randomized control trials, Miller (2011) demonstrates that feedback informed care reduces visits to hospital; reduces the length of stay by 66%; and significantly reduces the cost of care compared to non-feedback groups.

### **Client feedback in supervision**

There is a relative dearth of research exploring the use of client feedback in the supervisory relationship, and what studies there are, contain small samples. Bambling et al. (2006) compared a supervision group of practitioners to inactive controls, the supervision group when taught to focus on alliance process and monitor client feedback, resulted in the supervision group doing better than the control group across factors and processes such as working alliance, symptom reduction and treatment retention. At the same time, Grossl et al. (2014) report that practitioners who used client feedback data during supervision reported greater satisfaction with supervision. Reese et al. (2009) demonstrated that practitioners who discussed their data with supervisors improved more than the control group, and the relationship between self-efficacy and outcome was stronger.

Worthen and Lambert (2007) suggest incorporating an outcome management system into supervision in order to help actualize the goals of supervision. One study of note, although not exclusive to the use of feedback alone, demonstrated that when feedback systems are utilized as a part of deliberate practice, therapists improve outcomes at a small but meaningful  $d = 0.034$  each year (Goldberg et al., 2016). However, as this study was examining deliberate practice we can't conclude that it was only feedback approaches that produced these results. Yet, deliberate practice based on feedback data is a promising field of study with emerging research indicating the role feedback plays in expertise (see Mahon, 2021) for a synopsis of this literature.

Supervision using feedback informed care is focused on integrating the feedback practitioners receive from the Outcome Rating Scale and the Session Rating Scale, and discussing this with their supervisors. Cases considered at risk of drop out, deterioration and poor outcomes should be focused on (Bargmann, 2017; Worthen & Lambert, 2007). Given its predictive validity of treatment outcome (Eubanks et al., 2018; Flückiger et al., 2018; 2020) the therapeutic alliance with clients should be focused on during supervision using data from the SRS. Problems in the alliance are associated with higher drop out and treatment failure rates. Specifically, the supervisory dyad will focus on the bond between practitioner and client; the extent of agreement on goals and purpose of service, and the methods and approach used by the practitioner. For cases making no progress over the medium term, the supervisor may also wish to explore with the practitioner if different levels of care are needed, or additional services, or indeed, a different practitioner would be better suited to working with the client. Worthen and Lambert (2007, p.186) inform us that the use of "continuous client outcome data during the supervision process may help to provide the practitioner with the specific feedback he or she desires and finds helpful.

Because supervisors are sometimes hesitant to provide this feedback for fear it will damage the supervisory alliance". Thus, it is the voice of the client who is coming into the supervision room in order to 'speak to the practitioner' objectively. Worthen & Lambert, (2007) suggest that supervisory feedback may be perceived as more "value neutral" when based on client data, meaning there may be less likelihood of an alliance rupture in the supervisory relationship.

### **Supervisee feedback in supervision**

The relationship in supervision has been found to be an important variable to consider in effective supervision (Grossl et al., 2014). Specifically, Ellis (1991) found that supervisees rated the relationship with their supervisor as the most important factor in positive supervision. In addition, the supervisory alliance has been found to be correlated with supervision satisfaction and practitioner self-efficacy (Reese et al., 2009; Son & Ellis, 2013) and supervisor feedback to supervisee (Lehrman-Waterman & Ladany, 2001). Nelson et al. (2008) found that supervisors who were rated very highly by supervisees had characteristics such as openness to conflict, they focused on the supervisory alliance and sought regular feedback from supervisees. In their study, Cook and Ellis (2021), found that 77.7% of supervisees were receiving inadequate supervision and 62.3% were currently receiving harmful supervision.

Much like the alliance in practitioner and client work, the supervisor/supervisee alliance when ruptured can ruin the relationship and work if left unchecked. Thus, Watkins (2021) informs us that "opening up discussion about and collaboratively processing the rupture – have been identified as central to increasing the likelihood of successful repair". Just as the practitioner endeavors to create a culture of feedback with clients, so to should

the supervisor with the supervisee. Wilson et al. (2016) meta-synthesis findings illustrate that it is important that the supervisor was both able to provide feedback, and also receive it themselves. It is essential that supervisees feel safe with their supervisors, and that they are allowed to make mistakes, and be encouraged and nurtured by their supervisor to discuss such issues, difficulties and challenges that they face in their client work.

At the same time, supervisors should act as role models and they too should be willing to solicit and receive feedback from practitioners on their practices. Patton and Kivlighan (1997) and Reese et al. (2009) found a strong positive relationship between supervisor and supervisee alliance, and practitioner and client therapeutic alliance. Thus, it makes empirical sense to utilize a measure of the supervision alliance for the supervisee to provide feedback on the process and outcomes of supervision.

The Leeds Alliance in Supervision Scale (LASS), Wainwright, (2010), is the supervisory equivalent of the Session Rating Scale. Like the SRS it is a three-item measure with 10cm Visual Analogue Scales. The LASS is administered by the supervisor towards the end of the session and asks the supervisee about their experience of the relationship, the approach to supervision, and if the supervision session met the supervisee's needs. The purpose of the LASS is to promote feedback and discussion about the supervisory alliance so it can be used as an effective component of clinical supervision (ibid). Ultimately, the desire and willingness to solicit and take feedback from supervisees, may also be indicative of humility on the part of the supervisor, a characteristic that has been demonstrated to underpin effective supervision (Jones and Branco, 2020; McMahan, 2020; Watkins, et al., 2019).

## Discussion

The purpose of this paper is to describe a conceptual model of supervision in the health and social care settings based on the use of client and supervisee feedback. A targeted review of the literature was undertaken in order to assess the elements that could be used to inform this conceptual model of supervision based on bidirectional feedback.

The research suggests that practitioners find supervision in health and social care settings helpful. While there is some evidence to support the effectiveness of supervision on supervisee satisfaction and development, there is scant research on the impact supervision has on client outcomes in health and social care settings and some experience supervision as harmful. One way to help make the supervision process and outcomes more effective is to incorporate measures of the supervisory alliance into supervision practice. Using feedback derived from such measures can improve the supervisory experience for supervisees and some research suggests that this may mediate stronger practitioner/client alliances.

At the same time, similar evidence-based progress feedback measures are available for practitioners to utilize with clients. The research suggests that the effective use of feedback can improve outcomes for clients in health and social care settings.

In addition, bringing this feedback into the supervisory process can be helpful for practitioners to gain objective understanding of their practices, supported by their supervisor in a developmental manner. Bidirectional feedback provides the opportunity for the supervisor to model a reflective and proactive response to receipt of input on supervision (Falender, et al, 2014). Using client feedback in this way, client/practitioner and supervisor/supervisee informs the bidirectional feedback conceptual model discussed in this paper.

## Conclusion

The author sought to address whether using client and supervisee feedback can improve supervision processes and outcomes in health and social care settings. Supervision in these settings is viewed as an important gatekeeping and developmental endeavor, however, there is mixed research as to its effectiveness across outcome metrics, with some supervisees experiencing it as harmful. Similarly, clients of health and social care settings experience differential outcomes, with some experiencing negative outcomes from services. Using feedback in a bidirectional manner, client to practitioner, supervisee to supervisor is proposed here as a conceptual model in order to improve the supervisory experience of practitioners in health and social care settings. I argue that practitioners using measures of process and outcome and using the resulting information to inform supervision and development can help improve the negative outcomes some clients experience in health and social care settings. In addition, the use of a supervisory alliance measure offers the supervisee an opportunity to provide feedback to supervisors on their experience of supervision, thus improving the chance of having a more satisfactory supervision experience and the benefit this entails for development.

While both elements of this conceptual model are independent and have a large body of evidence supporting their utilization, the limitations are concerned with no primary data supporting its use or in adding value above their current use, although intuitively one may see the benefit. Thus, future research may like to examine this conceptual model empirically using a dataset in a health and social care setting.

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