



Acknowledgements

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**Using Data in Supervision
to Enhance Consumer Outcomes**

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INTRODUCTION

The Ohio Mental Health Consumer Outcomes System: The Big Picture

The Ohio Mental Health Consumer Outcomes System is an ongoing effort to obtain outcomes measures for persons served by Ohio's public mental health system, including adults, children and adolescents, and their families or caregivers. In other words, it is designed to measure the outcomes (or results) of treatment and services, consumer-directed recovery effects and family supports. These outcomes are NOT, however, an end product, but are ever-changing indicators of individual well-being. The Outcomes System is built on the foundation of the recovery concept.

Consumer outcomes provide important information which can be used in many ways. On the individual level, it brings forward consumers' perceptions and allows their input in their treatment plan so that they can drive their own recovery. At the provider or system level, outcomes information can provide the basis for management of consumer care; the improvement of the service delivery system; and accountability for public resources.

Starting in 1996, the Outcomes Task Force (OTF), made up of a diverse group of constituents, developed an approach to outcomes measurement for the state of Ohio. The OTF identified four domains to be measured: Symptom Distress, Quality of Life, Functional Status, and Safety and Health. They also developed a list of outcomes fitting these domains.

The structure of the Outcomes System can best be understood by looking at how information flows through the system. First, the consumer and his/her worker or clinician each complete an outcomes survey. This data is checked for accuracy and completeness and entered into the agency database. It can then be used to produce a summary report that helps in the development of a treatment plan targeted to individual needs. The data is stored in the agency database and may then be used to create aggregate outcomes reports to be used in care management, quality improvement, and accountability for resources. The data is also sent to the board database, where it is once again checked and it can be used to meet similar system needs. The board forwards the data to the State Consumer Outcomes section of the Multi-Agency Community Services Information System (MACSIS) where it is stored. Once the data is received by the state, ODMH can produce

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aggregate reports allowing local systems to compare themselves with the rest of the state, and allowing the development of statewide benchmarks to address quality improvement, accountability for resources and system planning.

The surveys used for outcomes measurement for adult consumers include: The Adult Consumer Form A, for adults who use multiple mental health services over a long period of time and Adult Provider Form A. The Adult Provider Form A covers only “functional status” and “safety and health” and is completed by the case manager or therapist. Adult Form B is for adults who seek mental health services for a brief period of time to resolve a specific issue.

There are also forms for children and adolescents. These include: the Ohio Scales Form for youth over the age of 12 (Y Form); the parent or caretaker form (P Form); the worker/case manager form (W Form); and the option of using the Child and Adolescent Functional Assessment Scale (CAFAS) or the Preschool or Early Childhood Functional Assessment Scale (PECFAS).

Family members of adult consumers will not be asked to fill out a form, but they can educate and encourage their family member consumer to take part in the outcomes measurement and use the results in treatment planning. Families can also encourage adult consumers to welcome family participation in discussing, with the treatment provider, how the family can support the consumer’s recovery. Families of children and adolescents will be asked to fill out the Ohio Scales Parent Form and take part in treatment planning.

Consumers should remember that individual questions may have more importance in planning treatment than would a subscale or total score. For example, symptom distress items requiring immediate attention should be noted first. Looking for strengths identified can also help in planning how to use those strengths to improve other areas. Recognize

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that one of the best uses of outcomes measurement is to monitor change over time. This will be shown through administering the surveys over again at later dates. In other words, the results of the first survey can be compared to one taken six months later and both of those can be compared to the one taken six months after that. All can use their knowledge of the Outcomes System and of aggregate outcomes data to advocate responsibly and knowledgeably for improved programs and services.

Using Data in Supervision to Enhance Consumer Outcomes

With the implementation of a statewide, standardized system of data collection, clinical supervisors in Ohio have the opportunity to enhance supervisory processes (and ultimately consumer outcomes) through the routine use of outcomes data in supervision. Although much has been written about psychotherapy supervision (e.g., Bernard & Goodyear, 1992; Stoltenberg & Delworth, 1987; Watkins, 1997) and a considerable amount of research has been conducted about the effectiveness of supervision (c.f., Lambert & Ogles, 1997), little has been written regarding the potential use of outcomes data to inform clinical supervision. This manual, along with the training video, was developed to suggest potential methods for integrating outcomes data collection into the day-to-day workings of clinical supervision. The Ohio Department of Mental Health has labeled this process of modifying clinical processes to incorporate outcomes data - "clinical re-engineering."

Many of the suggestions presented in this manual are common sense methods for using outcomes data. Other suggestions are based on findings in the treatment or supervision research literature. For the most part, however, little research has investigated the effects of supervision on consumer outcomes and no research has been conducted on the impact of using consumer rated outcomes measures to inform clinical supervision. As a result, the suggestions presented here must be considered pragmatic possibilities that warrant further study.

This manual is organized to match the video presentation created as a training guide for using outcomes data in supervision. The video provides footage of a workshop including slides that cover many of the ideas discussed in this manual. (The slides are also reproduced in the Appendix). In addition, the use of outcomes data, with the example cases, is illustrated via four role-plays that are included on the video tape. This manual covers the same material with some added detail.

The example cases incorporate reports generated by the ODMH ACCESS database template. For agencies using the template, identical reports can be generated using the template. Agencies using other technologies or developing custom reports will need to adapt this manual to suit their purposes.



Nevertheless, the basic principles of integrating outcomes into supervision will remain intact – different reports will be used to facilitate similar purposes. Within this manual, the ODMH report names will be used where applicable. Reports for the example cases seen on the video tape are included in the Appendix of this manual.

Brief Overview of the Consumer Outcomes System

The Ohio Mental Health Consumer Outcomes System is more thoroughly described in a procedural manual (Ohio Department of Mental Health, 2000). A brief review is presented here for readers who may receive this manual in isolation from the other materials.

The Ohio Department of Mental Health under the direction of Director Michael F. Hogan, Ph.D. convened a task force to develop an initial set of critical consumer outcomes along with recommending a standard, statewide approach to measuring outcomes for consumers served by Ohio's Public Mental Health System. The task force included representatives from a broad array of constituencies. The task force identified a core set of values followed by defining outcomes and selecting a model of outcomes domains (Rosenblatt & Attkisson, 1993). The task force then reviewed a large number of proprietary and publicly available instruments. Finally, the task force developed three instruments for measuring the outcomes of adult consumers and selected three instruments for measuring the outcomes of children and adolescents and their families. These recommendations were summarized in a final report (Vital Signs, 1998).

An implementation task force was selected from among the Outcomes Task Force members and the instruments were piloted in several counties. Beginning in the Spring of 2000, ODMH conducted regional training sessions to begin the process of implementing the collection of standardized outcomes data statewide.

The final adult consumer measures include: Adult Consumer Form A, Provider Adult Form A and Adult Consumer Form B. Adult Consumer Form A is rated by consumers who have severe and persistent mental illness. Adult Consumer Form B is rated by adults with less severe illnesses (generally individuals seeking services for short-term difficulties). The provider rates the consumer using the Provider Adult Form A. More detailed information regarding the instruments and decision making about which form to use is provided in the ODMH procedural manual (ODMH, 2000).

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The final child measures include two options. Option A includes the Ohio Scales Parent, Youth and Agency Worker Forms (Ogles, Melendez, Davis, and Lunnen, in press). Option B includes the Ohio Scales Parent and Youth Forms with the Child and Adolescent Functional Assessment Scales (CAFAS; Hodges & Wong, 1996). Parents of youth 5 to 18 and youth 12 to 18 years old rate the Ohio Scales. Agency workers rate the youth using either the Ohio Scales or CAFAS.

Outcome assessment forms are administered to consumers at intake, 6 months following intake, 12 months following intake, and every year thereafter while receiving services. Consumers who discontinue services are asked to rate the measures at termination (along with providers rating the consumers). The data is tabulated for clinical use and entered into a standard database format for transmission to the Ohio Department of Mental Health. Thus, a statewide database of outcomes is created that will be used to examine the effectiveness of services.

In addition to the statewide aggregate use of the data, a variety of potential uses for the data are available in the clinical setting for the individual consumer or provider. The ODMH procedural manual describes many of these potential uses (ODMH, 2000). Other tools and manuals are also being designed throughout the state to facilitate the use of the data for consumers, clinicians, supervisors, and administrators. This manual focuses on potential uses of the data in clinical supervision. Before addressing the possible uses of outcomes data in clinical supervision to enhance consumer outcomes, a brief overview of supervision roles, formats and models is presented for context.

Supervision Roles, Models, and Formats

A huge literature is available that describes the various roles and functions that are served by the clinical supervisor. Many theoretical models of supervision and models of supervisee development have been proposed. In addition, supervision may take one of many formats. While the intent of this manual is not to review the vast literature on clinical supervision, a brief overview of some relevant issues may provide context and lead to suggestions about tailoring the integration of outcomes data into the process of supervision.

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Roles

The clinical supervisor serves in various roles. Sometimes the supervisor is a teacher or educator providing direct instruction about philosophies (e.g., recovery model), practices (e.g., cognitive behavioral techniques), or processes (e.g., administrative procedures within the organization). Other times the clinical supervisor serves as an administrator through monitoring and maintaining paperwork or through the assignment of cases and the handling of other procedural issues. When supervisees become more advanced, the clinical supervisor may function in the role of a peer who provides support, camaraderie and a sense of belonging. Clinical supervisors also provide mentoring for their supervisees. When supervisees have strong clinical skills, the supervisor may serve as a consultant who provides feedback and an exchange of ideas with the supervisee. Finally, the supervisor may find themselves in a counselor role with the supervisee when personal issues are involved in the provision of service.

Formats

In addition to serving various roles during supervision, the supervisor has various formats of supervision available to them to aid in the development of the supervisee. The most commonly used format of supervision is the verbal report in which the supervisee reports on the progress of clinical work verbally to the supervisor individually or in a group setting. Especially when in training, the verbal report is often supplemented by some form of first hand information about the supervisees interactions with the consumer, such as, audiotape, videotape or live observation. It is also possible for the supervisor and supervisee to deliver services together (e.g., co-treatment) as a way of both modeling service delivery and observing supervisee interventions.

Models

A variety of models have been proposed for the supervisory process and for the description of supervisee development. The video workshop explores one developmental model of supervisee development (Stoltenberg & Delworth, 1987). In this particular model of supervisee development, the supervisee gradually moves through four levels of development enroute to functioning as an interdependent clinician.

While the brief overview of supervisor roles, formats and models presented in the video and in this manual is clearly insufficient to illustrate the complex picture

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of clinician training and development, the main point is that formats, roles and models of supervision must be considered when attempting to integrate data into the typical supervisory process. Unfortunately, most models of clinical supervision ignore the potential use of outcomes data to inform supervision. Indeed, most supervisory models are focused on the supervisee's development while ignoring the ultimate consumer outcomes. It is implicit in the models that better supervisee functioning will ultimately result in enhanced outcomes yet no evidence of this is presented. Nevertheless, the use of data can be incorporated into the current models, roles, and formats of supervision.

For example, a supervisor may instruct a clinician to take the red flag report back to the next meeting with the consumer. The clinician's job is to review the report with the consumer and to identify two or three central issues that can be targeted for intervention as part of the recovery management plan over the next few months. With an inexperienced clinician (lower developmental level) the formats and roles of the supervisory process may be different. The supervisor may ask the clinician to audiotape the visit so it can be reviewed during the next supervisory meeting. In the current supervision meeting, the supervisor may be more likely to serve in the educator role through a discussion of the recovery philosophy and the importance of seeking the consumer's preferences and viewpoints. Or similarly, the supervisor may role play the conversation with the clinician in order to demonstrate the method of conversing with the consumer. With a more advanced clinician, the supervisor may use different formats (e.g., verbal report) and roles (consultant) when considering a similar case.

When incorporating outcomes data into the clinical supervision process, the roles, formats and models of supervision must be considered by the supervisor. In the future, it is hoped that theoretical discussion of supervision will not neglect the potential utility of collecting and using outcomes data as an important part of the supervisory process.



Applications of Supervision Research Findings

An extensive body of empirical literature has been generated regarding the effectiveness of clinical supervision. Some general findings summarized from Lambert and Ogles (1997) are presented below.

- Training is superior to no training. In studies comparing clinical training to control groups, training is superior for improving clinician performance.
- Systematic training is superior to “traditional supervision.”
- Simple behavioral skills are learned quickly.
- Complex skills require more time, modeling and more components of training.
- Therapist attitudes and behaviors are related to treatment outcomes and can be modified by training (recovery model).
- Treatment manuals and protocols are double-edged swords. When clinicians are trained to deliver a highly specific treatment, they learn how to deliver the treatment effectively but may sacrifice some flexibility.

Importantly, most of the research on clinical supervision has ignored consumer outcomes. This is surprising since “the impact of clinical supervision on client outcomes is considered by many to be the acid test of the efficacy of supervision” (Ellis & Ladany, 1997, p. 485). Nevertheless, there is little attention given to client change in the clinical supervision research literature (Lambert & Ogles, 1997; Watkins, 1995).

As a result, the integration of outcomes data into supervision that is presented here must be based largely on good intentions. Research is needed to investigate the premise that having data to inform supervision and practice can be useful. Given the findings noted above, however, one might expect that systematic training in the use of data to inform supervision is likely to be superior to no training and no data.

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Using Outcomes Data in Supervision

Outcomes data may be integrated into many of the routine tasks of clinical supervision. Three specific time points are especially relevant: the initiation of services, periodic review of ongoing cases and ending services.

Initiation of services

The collection of outcomes data at intake can be informative for the consumer, the clinician, and the supervisor. Depending on the intake process at a given agency, initial outcomes data may be useful to the supervisor when making decisions about case assignment, treatment planning and allocation of services.

If initial outcomes data is available to the supervisor prior to case assignment, the supervisor may review the reports (e.g., red flag, summary) along with the completed outcomes measures to identify consumer strengths, problems and preferences. This descriptive information may be useful for making decisions about **case assignment**. For example, the supervisor may note that the consumer reports periodic thoughts of self-harm and minor self-inflicted injuries. As a result, a clinician who has a record of high-quality work with individuals, in this circumstance, may be assigned. Similarly, clinicians who are in training, or new to the agency may be assigned cases with fewer potential difficulties based on the initial assessment and the standardized outcomes data – matching clinician level of experience with case difficulty. In short, the initial data on the outcomes measures can be combined with other assessment data and modified by consumer preference, then used to aid the decisions about matching consumers with clinicians.

The outcomes data (and reports) also provide important **assessment information**. The supervisor may review the reports and forms with the clinician to identify consumer concerns that might be targeted for treatment. Generally, the supervision may take the form of examining the reports with the clinician, identifying potential issues (strengths and target problems), planning with the clinician an approach for reviewing the issues with the consumer (including soliciting the consumer's feedback and preferences), and projecting the potential treatment issues and services that may be provided. Identifying the types of needed services and determining the appropriate intensity of services are especially important issues to consider.

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Conveniently, the outcomes forms give the supervisor first-hand information regarding the **consumer's view** of their most pressing problems and concurrent strengths. In agencies where clinician verbal report is the primary format of supervision, the outcomes data supply additional information regarding the consumer perspective. These sources of information are combined to form the recovery management plan (adults with chronic mental illness) or individualized service plan.

The outcomes data can also be used to project the **need for various services** across the treatment spectrum and the **intensity of services**. Individuals may report needs, problems or strengths in a variety of domains that indicate potential provision of vocational, recreational, therapeutic, medical, or other services. Clinical supervisors can review the intake outcomes ratings to help supplement other assessment data and supervisee reports when determining the types and intensity of services that the clinician will offer to the consumer.

To this point in the discussion, the suggestions are general uses of outcomes data without mention of the specific information that is available in the ODMH reports and by examination of the measures. A brief description of the domains and items divided by adult and youth measures may be helpful.

For adults, the Consumer Form A contains information regarding a number of domains. Items can be examined on the actual forms completed by the consumer or within the red flag or summary reports. Many of the items or domains match up with areas of the Emerging Best Practices for Mental Health Recovery (ODMH, 1999). The table below illustrates how the domains match up with some of the nine essential components of effective community services.

Consumer Form A Domains Matched to Emerging Best Practice Components

Consumer Form A	Emerging Best Practices in Mental Health Recovery
Quality of life	Peer & support relationships, family support, work or meaningful activity
Financial status	Access to resources
Safety and health	Stigma
Symptom distress	Clinical Care
Empowerment	Power and control
Residence and employment	Access to resources, work or meaningful activity

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For youth, the Ohio Scales include 20 items covering typical problems and 20 items covering various areas of functioning that are rated by a parent or primary caregiver, the youth (if 12 or older) and the agency worker (Option A). In addition, the parent and youth rate four items regarding their satisfaction with services and inclusion in the service planning process. Finally, the parents rate four items regarding their hopefulness about raising and caring for their child and the youth rates four items regarding their hopefulness and overall well-being. In addition, the items can be totaled within each area to give a total score for problem severity, functioning, hopefulness, and satisfaction. These items and scores can be examined to get more detailed information.

Ohio Scales Domains and Raters

Domain	Parent (primary caregiver)	Youth (12-18)	Agency Worker
Problems	X	X	X
Functioning	X	X	X
Hopefulness	X	X	
Satisfaction	X	X	

For agencies or board areas selecting the option B, the CAFAS will be rated by the agency worker and provides some additional information regarding youth functioning in specified areas: social role (home, community, school/work), moods/emotion, self-harm, thinking, behavior toward others, and substance abuse. Each item is rated using objective referents (e.g., specific behaviors). In addition, caregiver resources can be rated.

This brief overview of the instruments describes the level of detail that can be potentially tapped by the clinical supervisor when seeking information regarding the consumer's strengths, problems and perspective. Because the data is gathered in a standardized format it provides a **unique vantage point** regarding the initial assessment that informs consumer self-evaluation, clinician interventions and the supervisory process. An example of the potential use of outcomes data for the initial assessment and case assignment is portrayed in the video (Example 1, April). Reports for the example case are included in the Appendix. In this case, the supervisor uses the data to match a clinician with the consumer and to identify potential issues for the clinician to review with the consumer.



In short, the outcomes data provide a standardized rating of various domains that can supplement other clinical sources of data. This data can be used to match service providers with consumers, develop service plans and project the need for various types and intensities of service.

Periodic Review

Tracking consumer progress on goals and treatment issues using outcomes instruments is the primary function of ongoing outcomes assessment. Not only is this data useful for the consumer and clinician, the clinical supervisor may also use the data to inform the supervisory process. A review of outcomes tracking data may reveal cases in which consumers are making progress, remaining stable, or deteriorating. This information allows the supervisor to make decisions regarding the **selection of cases for review** during supervision. High priority cases can be identified for review based on both supervisee verbal report, outcomes tracking data, or using other information. Using the data to evaluate consumer progress may be one of the biggest potential benefits of collecting standardized outcomes data with every consumer.

Once ongoing data entry procedures are in place, clinical supervisors can ask clinicians to bring the comparison summary report (and Ohio Scales short form report for youth) with them to supervision for each case. The clinical supervisor can then **review the progress** of each consumer to identify progressing, deteriorating or plateauing cases. Clearly, cases in which the consumer is reporting more symptoms, poorer quality of life, or dissatisfaction with service, may require immediate focus with a greater portion of supervision time directed to making plans regarding appropriate interventions.

For cases in which examination of the reports suggests that the consumer (or parent) is reporting **improvement** in symptoms, quality of life and satisfaction with services, clinical supervision may focus on the contributors to success. Clinical supervisors and supervisees may discuss how to continue the process of empowering the consumer and furthering their recovering. Potentially less supervisory time may be allocated to cases in which progress is occurring (especially with clinicians who are experienced). With less experienced clinicians, careful examination of the road to recovery through reviewing consumers who are improving may be beneficial. The video vignettes provide an example (Example 4, April) of a consumer who made substantial progress during treatment and who is now being considered for termination of services. When the supervisor examines the comparison report or graphs of progress

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(Ohio Scales Report) and notes **deterioration** in symptoms, quality of life, or other critical domains or when the supervisor notes dissatisfaction with services, extra time and attention can be devoted to problem solving during supervision. A variety of potential environmental and other events may contribute to a consumer's deterioration. Many mental illnesses have a fluctuating course that may result in periods of increased symptoms and decreased quality of life. Environmental circumstances that increase levels of stress may also result in deterioration. Problems with services may also result in lack of progress or deterioration.

For some consumers, the course and nature of their mental illness may result in periods of increased symptoms, decrements in functioning or diminished quality of life. During these periods of poorer functioning, increased support and intervention may be necessary. Supervisors and clinicians will need to work together to identify the most helpful strategies for working with the consumer to provide them with meaningful choices and opportunities for growth that are consistent with the recovery management plan.

A seemingly infinite variety of events occur in daily life that can influence the effectiveness of treatments and disrupt an individual's life. Sometimes increases in symptoms or poorer functioning may be the result of unfortunate events in the consumer's life such as the death of a loved one, the loss of a job, the need to move, or other environmental circumstances. Identifying the environmental stressors and developing plans for helping the consumer to cope with these circumstances may be a particularly useful supervisory task.

Sometimes problems with the treatment hinder progress. Indeed, a portion of individuals participating in treatments may worsen as the result of the intervention. Similarly, the treatment-consumer match is sometimes poor and may prevent progress. Problems with the therapeutic relationship or engagement between the consumer and the provider may be one of the most frequently encountered treatment difficulties. The importance of a strong collaborative relationship between the clinician and consumer has been demonstrated for psychotherapy, case management and delivery of medications. When ruptures occur in this relationship, consumers may not progress as hoped. Items 15 and 16 on the Consumer Form B or the satisfaction items on the Ohio Scales may provide some indication of the relationship between the clinician and the consumer. Supervisors may examine these specified items to see if the consumer-clinician relationship appears to be healthy.

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Problems with medications may also contribute to the lack of progress in treatment. Side effects and medication problems may be endorsed by the consumer on the Consumer Form B items 13 and 14. Supervisors may encourage the supervisee to coordinate with the physician when health problems or potential side effects surface on the scales.

Upon noting consumer deterioration, the supervisor can examine the various scales, items and reports to identify potential reasons for the decline. This standardized data can be integrated with the clinician's verbal report and other source of information to help revise or modify the current recovery management plan. The ODMH comparison report may be especially useful in this case. The report shows a graph for each item showing their current rating and the most recent rating. In this way, the two most recent data collection points are compared. Items that have especially large declines may be identified and targeted for further discussion and intervention. An example case is portrayed in the video (Example 3, Ryan). In this vignette, the supervisor reviews the consumer's deterioration with the supervisee and charts out a course of action that might change the direction of the case.

When reviewing cases, the supervisor may notice that a consumer improved early upon receipt of services, but the progress has stabilized. For consumers who reach a **plateau**, review of the circumstances in supervision may be helpful. Indeed, the essence of the strength-based approach is to use a treatment team to brainstorm and generate enthusiasm and energy for potential ideas that might continue the progress. Through an examination of the consumer's responses on the outcomes measures or through examination of the reports, the supervisor and team may be alerted to some of the areas that would be useful to consider. For example, the video vignette portrays a supervisor and clinician reviewing the circumstances of a consumer who has had a prolonged period of stability (Example 2, Steve), but who is still reporting some dissatisfaction in the areas of recreation, financial concerns and employment. A plan to seek vocational options or educational possibilities may be the ideal next step for this consumer's path to recovery. Clearly, the clinician should continue the development of this idea with the consumer. Yet a review of the forms in supervision provided the impetus for a revision of the focus in the recovery management plan.

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In review, clinical supervisors may use data to evaluate the progress of ongoing cases to identify cases for review during supervision, noting potential contributors to deteriorating or plateauing cases, or identifying consumers who are making progress.

Ending services

When consumers report improved functioning, fewer symptoms (or the capacity to cope with current symptoms), better quality of life, etc., clinical supervisors may be alerted to the possibility that services might be gradually diminished or ended. Of course, some consumers will require medications or clinical support for extended periods of time. Nevertheless, the outcomes data provide objective evidence of prolonged progress and may help the supervisor and clinician when making decisions regarding decreasing the intensity of services or terminating services. The video vignettes include an example of this (Example 4, April) that is combined with a periodic review of improvement (above).



Summary and Conclusions

During the last decade, both public and private mental health service providers have been required to produce evidence of the effectiveness of their services. The decade-long focus on accountability has resulted in the implementation of standardized outcomes assessment in many locations. In Ohio, the Ohio Department of Mental Health is implementing a statewide system for collecting consumer outcomes data for individuals receiving publicly funded mental health services. Not only will this data be useful at the state level for examining the usefulness of services statewide, but the consumer-by-consumer data can be used to enhance the delivery of services for each person served. Indeed, the Ohio Department of Mental Health funded several “clinical re-engineering” projects to produce tools to help service providers, consumers and others to integrate the data into daily service processes.

Within this manual, the potential integration of the outcomes data into routine clinical supervision was illustrated. Clinical supervisors can use the consumer ratings or ACCESS reports to inform the clinical supervision. The reports and data provide potentially valuable information for initial assessment and case assignment, periodic review of ongoing cases, and when ending or decreasing the intensity of services. Clinical supervisors may adapt the use of outcomes data to match their preferred format of supervision. In addition, some roles and models of supervision may be better suited to the incorporation of outcomes data. At the same time, standardized data provides first-hand evidence of the consumer’s point of view that can help the supervisor identify cases for review and issues for discussion.

While the integration of outcomes data into supervision may be extraordinarily useful, no research has examined the impact of using consumer outcomes data to inform the supervisory process. It is hoped that the practices that are outlined in this manual will not only spur changes in clinical processes (especially changes in attitudes about the utility of outcomes assessment), but also encourage research on the practical benefit of using outcomes data to enhance clinical services. While the benefits of collecting aggregate clinical data for the state may be sufficient to warrant the implementation of the Consumer Outcomes System, the potential usefulness of data for each individual consumer is much more appealing and demands further study.

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GLOSSARY

This Glossary is based on the operational definition of terms used in the Outcomes Task Force Final Report (Vital Signs). These terms may be used differently in different settings and some of the terms are still emerging (i.e., recovery, empowerment). This Glossary is not intended to be used as a way to redefine an area of practice or to provide meanings with universal acceptance. When in doubt about whether a term is being used in the sense described here, you should ask the individual(s) to clarify their meaning. This Glossary is included as a reference for Trainers.

Access

The ability to obtain needed services.

Aggregate Data

A combined whole or collective set of data at a level above the individual consumer, e.g., a combined set of data from one agency, from multiple agencies in a board area, or from many boards at the state level.

Benchmarking

The process of comparing local data at different points in time or comparing it to a larger database at the local, regional, state or national level for the purpose of identifying areas for improvement.

Best Practices

Clinical services and supports recommended to consumers and families via individualized planning that are based on the most recent validated research and expert consensus about clinical evidence and outcomes.

Board

County or multi-county authority responsible for managing local mental health service system; most boards also manage substance abuse services and are referred to as Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Boards or Community Mental Health and Recovery Services (CMHRS) Boards, although seven of the ten largest boards manage mental health systems only, and are referred to as Community Mental Health (CMH) Boards.

Care Management

A collection of information driven methods for facilitating the best consumer outcomes in the most cost-effective manner.



Client Satisfaction

One indication of the extent to which the mental health system meets the needs and expectations of consumers and families, usually including such items as responsiveness and respect shown by personnel, cleanliness and accessibility of the facility and overall sense of the program's value.

Consumer

Person receiving mental health services and/or supports, including adults, children and adolescents and their families. Sometimes used to include families of adults (as in "secondary consumer"). Also referred to as client or patient. A term sometimes, but not always, preferred by persons with serious mental illness and their advocates.

Consumer Quality Review Terms (CQRT)

Service satisfaction teams composed of consumers, family members and providers, currently operating in two areas of the state. These teams interview consumers, family members and providers using a standard set of instruments that capture both satisfaction with services and system performance.

Continuous Quality Improvement (CQI)

Ongoing and incremental system improvement through problem identification, solution development and evaluation.

Cultural Sensitivity

An awareness, understanding and appreciation of the beliefs (family, religious, etc.) and ethnic heritage of a group of people, particularly those of race, ethnic group or life-style different from one's own.

Cultural Competence

The extent to which a person, organization or system is characterized by recognition and respect for cultural differences and similarities, attention to the dynamics of difference, expansion of cultural knowledge and resources, commitment to hiring minority staff, consultation with the community regarding service provision and delivery, provision of cross cultural training, and development of policies and practices that enhance programs for diverse populations.

GLOSSARY continued...

Data

Factual information, such as measurements or statistics, used as a basis for reasoning, discussion, calculation, and decision making.

Domains

In outcomes, a part or area of a person's life which should be considered in designing treatment or services.

Empowerment

The experience of feeling in control of or being able to affect the important decisions in one's life.

LCO

The Longitudinal Consumer Outcomes research project conducted by ODMH to study outcomes for a group of consumers over time. This project was originally conceived by ODMH and funded by the National Institute of Mental Health as the "Services in Systems" or SIS research grant.

MACSIS

The Multi-Agency Community Services Information System, an encounter-level information system being developed to manage mental health/substance abuse system information for use at multiple levels.

ODMH

Ohio Department of Mental Health

ORYX (not an acronym)

Community mental health outcomes reporting system in development by the Joint Commission on Accreditation of Healthcare Organizations.

Outcomes (as used by the Ohio Mental Health Consumer Outcomes System) Indicators of health or well-being for an individual or family as measured by statements or observed characteristics of the consumer/family, not characteristics of the service system. These measures provide an overall consumer status measure with which to better understand the life situation of a consumer or family. Outcomes evaluation is conducted with methods similar to research, but its primary purpose is improvement of the effectiveness or impact of services being delivered.



Outlier

A piece or trend of data that stands out as significantly different from average, usually defined as a percentage, e.g., 25% higher or lower than the average.

Performance

A measure of how well a system does in providing mental health services to consumers, often including rates of treatment, cost per consumer, degree of satisfaction with services, and extent of consumer access.

Provider

An organization that provides services and supports for consumers of mental health services.

Psychometric Properties

The technical and scientific characteristics of a research or evaluation instrument that demonstrate its appropriateness for the topic and population surveyed. Primary elements include validity, or the likelihood that the instrument measures what it is intended to measure; reliability, or the likelihood that it will continue to measure the topic accurately over time and that similar items measure the same aspects of the topic; and norming, or the likelihood that the instrument is appropriate for the population it is intended to survey.

Publicly Funded System

The system of services and supports that is funded in whole or in part by federal, state and/or local monies. This system exists in order to compensate for the lack of adequate insurance coverage (public or private) for persons who experience mental illness. In Ohio the publicly funded mental health system includes ODMH, local ADAMHS/CMH Boards and a set of providers that contract with these boards.

Quality

The degree of excellence characteristic of a practitioner, service, program, provider, or system.

GLOSSARY continued...

Quality Assurance

Activities conducted by providers or payers and reviewed internally to improve services and supports and to ensure that they meet established standards, are appropriate to the person's need and contribute to a person's recovery.

Recovery

Defined by the Ohio Outcomes System as a highly personal process of adaptation to severe mental illness that allows a person's life to go forward in a satisfying and meaningful way. Various authors believe recovery involves a personal transformation that includes (according to some) acceptance of the illness, a sense of responsibility or control over one's life, hope, the support of others, and treatment and rehabilitation in collaboration with providers. The ODMH publication, "Emerging Best Practices in Mental Health Recovery," defines recovery as: "a personal process of overcoming the negative impact of a psychiatric disability despite its continued presence."

Recovery Management Plan

A plan developed collaboratively by the consumer and clinician, with the focuses on the interventions that will facilitate recovery and the resources (not necessarily within the mental health system) that will support the recovery process.

Risk Adjustment

A research method used to understand baseline differences between groups that may account for differences in outcomes or other aspects of care.

Service Utilization

The extent and pattern in which individuals or groups of consumers use particular services or clusters of services.

Stakeholder

A person or group of persons, who are entrusted with representing a specific group of people.



APPENDIX

Benjamin McKay Ogles, Ph.D.

Department of Psychology

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Current Employment

Associate Professor, Department of Psychology, Ohio University
(1990 - Present).

Director of Clinical Training, Department of Psychology, Ohio University
(July 1999 - present).

Consultant, Southern Consortium for Children & Integrated Services for Youth
(1992 - present).

Licensed Psychologist, Ohio #4625.

Education

Ph.D., Clinical Psychology, Brigham Young University, APA accredited (1990)

Clinical Internship, Indiana University Medical School, APA accredited
(1989-1990)

B.S., Accounting, Brigham Young University (1985)

APPENDIX continued...

Teaching Experience

Undergraduate Courses:

Introduction to Psychology, Abnormal Psychology, Psychological Theories of Motivation, Psychological Tests & Measurement, Introduction to Clinical and Counseling Psychology.

Graduate Courses:

Individual Psychotherapy, Clinical Practicum, Objective Assessment, Projective Assessment, Advanced Measurement Theory, Treatment Survey, Applications of Psychotherapy Research, Seminar on Managed Behavioral Health Care

Clinical and Consulting Experience

Clinical and evaluation consultant, Health Recovery Services (Jun. 1996 to Sep. 1998). Outpatient counseling, psychological assessment, outcomes evaluation, and clinical supervision.

Clinical and evaluation consultant, Horizons: The Counseling Center (Aug. 1992 to Jun. 1996). Outpatient counseling, psychological assessment, outcomes evaluation, and clinical supervision.

Post-Doctoral Trainee, Health Recovery Services. (Jan. 1991 to Aug. 1992). Residential drug and alcohol rehabilitation for adolescent substance abusers. Included group therapy, individual therapy, and psychological assessment.

Pre-Doctoral Intern, Indiana University Medical School (APA accredited; Sep. 1989 to Sep. 1990). Included four major rotations: Outpatient Adult at Gallahue Community Mental Health Center; Child Consultation at Riley Children's Hospital; Inpatient Child at Larue Carter Hospital; and Inpatient and Outpatient Pain Clinic at Community Hospitals of Indianapolis.

Graduate School Trainee, Brigham Young Comprehensive Clinic and other local placements (Jan. 1986- Aug. 1989). Included multiple placements involving individual therapy and assessment of adults and children; marital therapy; group therapy; assertiveness and parent effectiveness training with inpatient adults and children, outpatient adults and children, and incarcerated adults.

CLINICAL SUPERVISORS



Psychiatric Aide, Part-time. Utah Valley Hospital. (Nov. 1985- Aug. 1986)
Supervision and care of inpatient psychiatric and behavioral medicine patients in a private psychiatric hospital.

Group Home Parent, Full-time. Timpanogas Community Mental Health Center. (Jan. 1984- Aug. 1985) 24-hour care, intake/exit interviewing, record keeping, treatment planning, crisis intervention, treatment coordination with school and recreational personnel, and supervision of home visits in a home for delinquent juvenile males.

Mental Health Worker, Full-time. Timpanogas Community Mental Health Center. (Apr. 1982- Jan. 1984) Supervision of job training placements, individual/group therapy, behavior modification and physical education instruction at an alternative Jr. High/High School for youth with severe emotional and behavioral disturbances.

Scholarship

GRANTS

Sponsor: Ohio Department of Mental Health, Office of Program Evaluation and Research

Investigators: David Carlston & Benjamin M. Ogles

Amount: \$5,000 **Year:** 2000-2001

Title: A Preliminary Exploration of the Underlying Processes Involved in Parent-Child Discrepancy on Reports of Child Problem Behaviors.

Sponsor: Ohio Department of Mental Health, Office of Program Evaluation and Research

Investigator: Gregorio Melendez & Benjamin M. Ogles

Amount: \$8,614 **Year:** 2000-2001

Title: Effects of Feedback to the Therapist on Child Clinical Outcomes.

Sponsor: Ohio Department of Mental Health, Office of Program Evaluation and Research

Investigators: Benjamin M. Ogles, Scott A. Fields, & Gregorio Melendez

Amount: \$111,437 **Year:** 1999-2001

Title: The Role of Treatment Fidelity and Continuous Feedback in the Wraparound Approach.

APPENDIX continued...

Sponsor: Ohio Department of Mental Health, Office of Program Evaluation and Research

Investigator: Benjamin M. Ogles

Amount: \$4,238 **Year:** 1999

Title: Addendum to the Continuing Development of the Ohio Scales.

Sponsor: Ohio Department of Mental Health, Office of Program Evaluation and Research

Investigator: Benjamin M. Ogles

Amount: \$90,325 **Year:** 1996-98

Title: The Continuing Development of the Ohio Scales.

Sponsor: Ohio Department of Mental Health, Office of Program Evaluation and Research

Investigators: Leslie Hermann & Benjamin M. Ogles

Amount: \$2,700 **Year:** 1997

Title: Therapist and Client Values: A look at Similarity and its Relations to Client Change.

Sponsor: Ohio Department of Mental Health, Office of Program Evaluation and Research

Investigators: Alana Steffen & Benjamin M. Ogles

Amount: \$5,000 **Year:** 1995-1996

Title: An Empirical Typology of People Who Have Severe Mental Illness.

Sponsor: Ohio University Research Challenge Grant

Investigators: Benjamin M. Ogles & Donald Gordon

Amount: \$6,000 **Year:** 1992

Title: School vs. Family Centered Case Management.

Sponsor: Community Hospitals Medical Research Institute

Investigator: Benjamin M. Ogles

Amount: \$1,000 **Year:** 1990

Title: Effectiveness of Self-Help Books for Divorce or Love Loss.



Editorial Assignments

Editorial Board

Journal of Consulting and Clinical Psychology

Ad Hoc Reviewer

Journal of Counseling Psychology; Psychotherapy Research

Journal of Sport and Exercise Psychology

Professional Service/Honors

Board of Directors. Health Recovery Services (*Oct. 1999 - Present*).

Chair, Committee on Outcomes Assessment.

Ohio Psychological Association (*1996-97*).

Member, Outcomes Task Force. Ohio Department of Mental Health (*1996-97*).

Psychology Department Nominee for Outstanding Graduate Faculty (*1993*).

Articles

Masters, K. S., & Ogles, B. M. (submitted). A typology of marathon runners based on cluster analysis of motivations.

Fields, S. A., & Ogles, B. M. (submitted). An empirical typology of children with severe emotional disturbance.

Fields, S. A., & Ogles, B. M. (submitted). Least restrictive care: Legal origins, current mandates and the relationship between restrictiveness of care and youth functioning.

Ogles, B. M., Melendez, G., Davis, D. C., & Lunnen, K. M. (in press).

The Ohio Scales: Practical Outcomes Assessment.

Journal of Child and Family Studies.

Ogles, B. M., Marsden, K. M., Bonesteel, K., & Holdridge, P. (submitted).

Running addiction, competitiveness, and goal orientation: Motivational correlates of training habits and injury.

Ogles, B. M., Lunnen, K. M., & Bonesteel, K. (in press). Clinical significance:

History, application, and current practice. Clinical Psychology Review.

Melendez, G., & Ogles, B. M. (2000). Improving the Ohio Scales:

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Development of a short form. In Roth, D. (Ed.). New Research in Mental Health: 1998-1998 Biennium, 14, 283-289.

Ogles, B. M., Fields, S. A., & Melendez, G. (2000). The role of treatment fidelity and adherence in the wraparound approach. In Roth, D. (Ed.). New Research in Mental Health: 1998-1999 Biennium, 14, 290-294.

Ogles, B. M., & Masters, K. S. (2000). Older versus younger adult male marathon runners: Participative motives and training habits. Journal of Sport Behavior, 23(3), 1-14.

Stoll, O., Wuerth, S., & Ogles, B. (2000). Zur Teilnahmemotivation von Marathon und Ultramarathonlufnern. [Participation motives of marathon and ultra-marathon runners] Sportwissenschaft, 30(1), 54-67.

Anderson, T. A., Ogles, B. M., & Weis, A. (1999). Creative use of interpersonal skills in building a therapeutic alliance. Journal of Constructivist Psychology, 12, 313-330.

Ogles, B. M., Davis, D. C., & Lunnen, K. M. (1999). Inter-rater reliability of four measures of youth functioning. In C. Liberton, K. Kutash, & R. Friedman (Eds.), The 11th Annual Research Conference Proceedings, A System of Care for Children's Mental Health: Expanding the Research Base (pp. 321-326). Tampa, FL: University of South Florida, Florida Mental Health Institute, Research and Training Center for Children's Mental Health.

Ogles, B. M., Davis, D. C., & Lunnen, K. M. (1998). The continuing development of the Ohio Scales. In Roth, D. (Ed.). New Research in Mental Health: 1996-1997 Biennium, 13, 186-195.

Masters, K. S., & Ogles, B. M. (1998). Associative and dissociative cognitive strategies in exercise and running: Twenty years later what do we know? The Sport Psychologist, 12, 253-270.

Masters, K. S., & Ogles, B. M. (1998). Cognitive strategies relate to injury, motivation, and performance among marathon runners: Results from two studies. Journal of Applied Sport Psychology, 10, 281-296.

Ogles, B. M., Trout, S. C., Gillespie, D. K., & Penkert, K. (1998). Managed care as a platform for cross system integration. Journal of Behavioral Health Services and Research, 25, 253-269.

Lunnen, K. M., & Ogles, B. M. (1998). A multi-perspective, multi-variable evaluation of reliable change. Journal of Consulting and Clinical Psychology, 66, 400-410.

Ogles, B. M., France, C. R., Lunnen, K. M., Bell, M. T., & Goldfarb, M. (1998). Computerized depression screening and awareness. Community Mental Health Journal, 34, 27-38.

Lunnen, K. M., & Ogles, B. M. (1997). Satisfaction ratings: Meaningful or meaningless? Behavioral Healthcare Tomorrow, 6(4), 49-51.

Ogles, B. M., & Lunnen, K. M. (1996). Outcomes measurement: Tools for clinical practice. The Ohio Psychologist, 42(6), 21-26.

Ogles, B. M., Lunnen, K. M., Gillespie, D. K., & Trout, S. C. (1996). Conceptualization and initial development of the Ohio Scales. In C. Liberton, K. Kutash, & R. Friedman (Eds.), The 8th Annual Research Conference Proceedings, A System of Care for Children's Mental Health: Expanding the Research Base (pp. 33-37). Tampa, FL: University of South Florida, Florida Mental Health Institute, Research and Training Center for Children's Mental Health.

Ogles, B. M., & Lunnen, K. M. (1996). Assessing outcomes in practice. Journal of Mental Health, 5, 35-46.

Ogles, B. M., Masters, K. S. & Richardson, S. A. (1995). Obligatory running and gender: An analysis of participative motives and training habits. International Journal of Sport Psychology, 26, 233-248.

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Masters, K. S., & Ogles, B. M. (1995). An investigation of the different motivations of marathon runners with varying degrees of experience. Journal of Sport Behavior, 18, 69-79.

Ogles, B. M., Lambert, M. J., & Sawyer, J. D. (1995). The clinical significance of the National Institute of Mental Health collaborative depression study data. Journal of Consulting and Clinical Psychology, 63, 321-326.

Leddy, M. H., Lambert, M. J., & Ogles, B. M. (1994). Psychological consequences of athletic injury among high level competitors. Research Quarterly for Exercise and Sport, 65, 347-354.

Ogles, B. M., Lynn, S. J., Masters, K. S., Hoefel, T., & Marsden, K. (1993-94). Runners' cognitive strategies and motivations: Absorption, fantasy style, and dissociative experiences. Imagination, Cognition, and Personality, 13, 163-174.

Coen, S. P., & Ogles, B. M. (1993). Psychological characteristics of the obligatory runner: A critical examination of the anorexia analogue hypothesis. Journal of Sport and Exercise Psychology, 15, 338-354.

Masters, K. S., Ogles, B. M., & Jolton, J. A. (1993). The development of an instrument to measure motivation for marathon running: The motivations of marathoners scales (MOMS). Research Quarterly in Exercise and Sport, 64, 134-143.

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Lambert, M. J., Masters, K. S., & Ogles, B. M. (1992). Measuring counseling outcomes: A rejoinder. Journal of Counseling and Development, 70, 538-539.

Lambert, M. J., Ogles, B. M., & Masters, K. S. (1992). Choosing outcomes assessment devices: An organizational and conceptual scheme. Journal of Counseling and Development, 70, 527-532.



Ogles, B. M., Lambert, M. J., & Craig, D. E. (1991). A comparison of self-help books for coping with loss: Expectations and attributions. Journal of Counseling Psychology, 38, 387-393.

Ogles, B. M., Lambert, M. J., Weight, D. G., & Payne, I. R. (1990). Agoraphobia outcomes measurement in the 1980's: A review and meta-analysis. Psychological Assessment, 2, 317-325.

Ogles, B. M., & Lambert, M. J. (1989). A meta-analytic comparison of twelve agoraphobia outcomes measures. Phobia Practice and Research Journal, 2, 115-125.

Burlingame, G. M., Fuhrman, A. J., Paul, S., & Ogles, B. M. (1989). Implementing a time-limited training program: The effects of experience and training. Psychotherapy, 26, 303-313.

Howell, R. J., & Ogles, B. M. (1989). Privileged communications for the fifty states: Duty to report and duty to warn. American Journal of Forensic Psychology, 7, 5-24.

Lambert, M. J., & Ogles, B. M. (1988). Treatment manuals: Problems or promise. Journal of Integrative and Eclectic Psychotherapy, 7, 187-204.

Chapters

Ogles, B. M., Anderson, T. A., & Lunnen, K. M., (1999). The contribution of models and techniques to therapeutic efficacy: Contradictions between professional trends and clinical research. In M. A. Hubble, B. L. Duncan, & S. D. Miller (Eds.) The Heart and Soul of Change: What Works in Therapy (pp. 201-226). Washington, DC: American Psychological Association.

Lambert, M. J., & Ogles, B. M. (1997). The effectiveness of psychotherapy supervision. In C. E. Watkins (Ed.), Handbook of Psychotherapy Supervision (pp. 421-446). New York: Wiley.

Lambert, M. J., Masters, K. S. & Ogles, B. M. (1991). Outcomes research in counseling. In C. E. Watkins & L. J. Schneider (Eds.), Research in Counseling (pp. 51 - 83). Hillsdale, NJ: Lawrence Erlbaum.

INTRODUCTION continued...

Books and Manuals

Ogles, B. M., Lambert, M. J., & Masters, K. S. (1996). Assessing Outcomes in Clinical Practice. Boston: Allyn and Bacon.

Ogles, B. M., Melendez, G., Davis, D. C., & Lunnen, K. M. (1998). The Ohio Youth Problem, Functioning, and Satisfaction Scales: Technical Manual. Columbus, OH: Ohio Department of Mental Health.

Ogles, B. M., Melendez, G., Davis, D. C., & Lunnen, K. M. (1999). The Ohio Youth Problem, Functioning, and Satisfaction Scales (Short Form): Users Manual. Columbus, OH: Ohio Department of Mental Health.

Book Reviews

Ogles, B. M., & Lunnen, K. M. (1996). The evolution of psychotherapy process research [Review of Reassessing Psychotherapy Research]. Psychotherapy Practice and Research, 5, 84-85.

Unpublished Technical Reports

Ogles, B. M. (2000). An Evaluation of the Knox County Community Team. Athens, OH: Integrated Services for Youth.

Ogles, B. M. (2000). An Evaluation of Pike County Juvenile Court Programs: RECLAIM Ohio Challenge Grant Report. Athens, OH: Integrated Services for Youth.

Ogles, B. M. (1999). An Evaluation of Ross County Juvenile Court Programs: RECLAIM Ohio Challenge Grant Report. Athens, OH: Integrated Services for Youth.

Ogles, B. M. (1999). An Evaluation of Morgan County Juvenile Court Programs: RECLAIM Ohio Challenge Grant Report. Athens, OH: Integrated Services for Youth.

Ogles, B. M., & Looney, B. A. (1998). An Evaluation of Lawrence County Juvenile Court Programs: RECLAIM Ohio Challenge Grant Report. Athens, OH: Integrated Services for Youth.



Ogles, B. M., & Cervantes, N. N. (1998). An Evaluation of Washington County Juvenile Court Programs: RECLAIM Ohio Challenge Grant Report. Athens, OH: Southern Consortium for Children.

Ogles, B. M. (1998). Integrated Services for Youth: Outcomes After the First Six Months of Operation. Athens, OH: Integrated Services for Youth.

Dahn, M., & Ogles, B. M. (1998). An Overview of the Center for Mental Health Services Initiative in Southeastern Ohio: Families, Services, and Outcomes. Athens, OH: Southern Consortium for Children.

Published Abstracts

Ogles, B. M., Lambert, M. J., & Sawyer, J. D. (1995). The clinical significance of the National Institute of Mental Health collaborative depression study data. Journal of Consulting and Clinical Psychology, 63, 321-326. Summary reprinted May 1996 in The Clinician's Research Digest, 14(5), 2.

Ogles, B. M., Masters, K. S., & Gurney, V. W. (1996). Adult fitness program participants ten years later [Abstract]. Medicine and Science in Sports and Exercise, 28, S135.

Masters, K. S., Ogles, B. M., & Gurney, V. W. (1996). Characteristics that discriminate between regular exercisers, minimal exercisers, and non-exercisers [Abstract]. Medicine and Science in Sports and Exercise, 28, S135.

Bonesteel, K. R., Ogles, B. M., Marsden, K., & Holdridge, P. (1996). Running addiction as a predictor of injury [Abstract]. Medicine and Science in Sports and Exercise, 28, S135.

Lickliter, K. L., Ogles, B. M., & Heath, E. M. (1996). Effect of mood manipulation on physiologic variables during submaximal exercise [Abstract]. Medicine and Science in Sports and Exercise, 28, S136.

Gurney, V. W., & Ogles, B. M. (1996). Body image and eating disturbance in distinct groups of female exercisers[Abstract]. Medicine and Science in Sports and Exercise, 28, S137.

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Cohen, D. M., Ogles, B. M., & Garske, J. P. (1994). Personality traits in high school athletes associated with academic achievement [Abstract]. Medicine and Science in Sports and Exercise, 26, S156.

Marsden, K., Garske, J. P., & Ogles, B. M. (1994). Explanatory styles, mood, and performance in response to false feedback: A study using collegiate swimmers [Abstract]. Medicine and Science in Sports and Exercise, 26, S198.

Metcalf, K., Lockard, A., & Ogles, B. M. (1994). Does running addiction affect dyadic adjustment? [Abstract]. Medicine and Science in Sports and Exercise, 26, S55.

Ogles, B. M. (1994). Running addiction: The search for construct validity [Abstract]. Medicine and Science in Sports and Exercise, 26, S155.

Ogles, B. M. (1989). Outcome measurement in agoraphobia research: A review and meta-analysis. Dissertation Abstracts International, 53(12), B, 4230. (University Microfilms No. AAI90-00845).

Conference Presentations and Workshops

Ogles, B. M. (2000, December). Using the Ohio Scales and the CAFAS in Practice. Stark County Mental Health Board workshop. Canton, OH.

Ogles, B. M. (2000, May). The Clinical Use of the Ohio Scales. Ohio Department of Mental Health Outcomes Systems. Columbus, OH.

Ogles, B. M., Melendez, G., and Fields, S. (2000, October). Does Wraparound Adherence and Outcomes Feedback Improve Services for Children. Ohio Department of Mental Health Research Results Briefing. Columbus, OH.

CLINICAL SUPERVISORS



Ogles, B. M., & Gillespie, K. (2000). Wraparound Services for Community-Based Treatment: Integration of Financial and Service Components Among Child Serving Agencies. Morgan County Family Stability Workshop. Granville, OH.

Lambert, M. J. & Ogles, B. M. (2000, August). Outcomes in Clinical Practice: Selection and Implementation. American Psychological Association, Washington, DC.

Johnson, M. J., Tsanadis, J., & Ogles, B. M. (2000, August). A Survey of Coaches' Attitudes About Athletes' Eating Behavior. American Psychological Association, Washington, DC.

Vermeersch, D., Anderson, T., Ogles, B. M., & Lambert, M. J. (2000, June). Brigham-Young Study on the Efficacy of Therapist Facilitative Skills. Society for Psychotherapy Research, Chicago.

Okiishi, J., Ogles, B. M., & Lambert, M. J. (2000, June). Waiting for Supershrink: An Empirical Analysis of Individual Therapist Effects. Society for Psychotherapy Research, Chicago.

Tsanadis, J., Johnson, M. J., & Ogles, B. M. (2000, March). The Relationship Between Competitive Orientation and Cognitive Strategies. Eastern Psychological Association Conference, Baltimore.

Ogles, B. M. (2000, March). Practical Use of the Ohio Scales. Cuyahoga Community Mental Health Board Training on Outcomes, Cleveland.

Ogles, B. M., Melendez, G., & Carlston, D. (2000, March). Natural Tensions and Possible Solutions: A Primer on Outcome Assessment. Paper presented at the Research and Training Center for Children's Mental Health's 13th Annual Research Conference, Tampa.

Melendez, G. & Ogles, B. M. (2000, March). Improving the Ohio Scales: Development of a Short Form. Paper presented at the Research and Training Center for Children's Mental Health's 13th Annual Research Conference, Tampa.

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Ray, K. D., & Ogles, B. M. (2000, March). Self-Reported Therapy Outcome by Adolescents in a Managed Care Environment. Paper presented at the Research and Training Center for Children's Mental Health's 13th Annual Research Conference, Tampa.

Fields, S. A., & Ogles, B. M. (2000, March). Restrictiveness of Living Environments and Child Functioning. Paper presented at the Research and Training Center for Children's Mental Health's 13th Annual Research Conference, Tampa.

Dowell, K., & Ogles, B. M. (2000, March). Clinical Significance: History, Definitions and Applications. Paper presented at the Research and Training Center for Children's Mental Health's 13th Annual Research Conference, Tampa.

Masters, K. S., Shearer, D. S., & Ogles, B. M. (2000, April). MMPI-2 cluster profiles predict one year lumbar surgery outcomes. In M. S. DeBerard (Chair), Psychosocial Predictors of Back Surgery Outcomes: Implications for Clinical Practice. Symposium presented at the 21st Annual Convention of the Society of Behavioral Medicine, Nashville, TN.

Lambert, M. J. & Ogles, B. M. (1999, November). Clinical Significance in Clinical Practice and Research. Association for the Advancement of Behavior Therapy, Toronto.

Ogles, B. M., Davis, D. C., & Lunnen, K. M. (1999, February). The Continuing Development of the Ohio Scales. Paper presented at the Research and Training Center for Children's Mental Health's 12th Annual Research Conference, Tampa.

Fields, S. & Ogles, B. M. (1999, February). An Empirical Typology of Children with Serious Emotional Disturbance. Paper presented at the Research and Training Center for Children's Mental Health's 12th Annual Research Conference, Tampa.

CLINICAL SUPERVISORS



Masters, K. S., Shearer, D. S., Ogles, B. M., & Schleusener, R. L. (1998, August). MMPI-2 Cluster Profiles Predict Low Back Surgery Outcomes. Paper presented at the 106th Annual Convention of the American Psychological Association, San Francisco.

Lunnen, K. M. & Ogles, B. M. (1998, June). A Multi-Perspective, Multi-Variable Evaluation of Reliable Change. Paper presented at the Society for Psychotherapy Research, Snowbird, UT.

Lunnen, K. M., Ogles, B. M., Anderson, T., & Baker, S. (1998, June). An Evaluation of CCRT Pervasiveness in the Vanderbilt II Psychotherapy Project. Paper presented at the Society for Psychotherapy Research, Snowbird, UT.

Masters, K. S., Shearer, D. S., Ogles, B. M., & Schleuseuer, R. (1998, March). Presurgical MMPI-2 Cluster Profiles in Low Back Pain Patients. Paper presented at the Society of Behavioral Medicine Conference, New Orleans.

Ogles, B. M., Davis, D. C., & Lunnen, K. M. (1998, March). The Interrater Reliability of Four Measures of Functioning. Paper presented at the Research and Training Center for Children's Mental Health's 11th Annual Research Conference, Tampa.

Ogles, B. M., McGlone, A., & Lynd, J. (1998, March). A Year in the Life of a Juvenile Court Liaison. Paper presented at the Research and Training Center for Children's Mental Health's 11th Annual Research Conference, Tampa.

Ogles, B. M., Nelson, D., Gillespie, D. K., & Trout, S. C. (1998, March). Managed Care and System Integration: Operations and Outcomes. Paper presented at the Research and Training Center for Children's Mental Health's 11th Annual Research Conference, Tampa.

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Masters, K. S. & Ogles, B. M. (1997, August). Cluster Analysis of Motivations for Running. Paper presented at the American Psychological Association Conference, Chicago, IL.

Howard, K. I., Lambert, M. J., Ogles, B. M. (1997, May). Outcomes Assessment and Quality Assurance in Outpatient Psychotherapy. Workshop presented at the North Carolina Psychological Association Conference, Atlantic Beach, NC.

Ogles, B. M. (1997, May). Can Managed Care Facilitate Cross-System Integration of Child and Adolescent Services? Public Psychology: Present Realities and Future Challenges, Columbus, OH.

Ogles, B. M. & Trout, S. C. (1997, March). Outcomes Measurement: Practical Suggestions. Workshop presented at the Albert E. Trieschman Center's 1997 Finding Better Ways Conference, Cambridge, MA.

Ogles, B. M. (1996, November). Assessing Outcomes in Clinical Practice. Workshop presented at the Ohio Psychological Association Conference, Columbus, OH.

Masters, K. S. & Ogles, B. M. (1996, August). Cognitive Strategies Predict Injury Among Marathon Runners. Paper presented at the American Psychological Association Conference, Washington, DC.

Ogles, B. M., Masters, K. S., & Gurney, V. W. (1996, May). Adult Fitness Program Participants Ten Years Later. Paper presented at the Annual Meeting of the American College of Sports Medicine, Cincinnati.

Masters, K. S., Ogles, B. M., & Gurney, V. W. (1996, May). Characteristics that Discriminate Between Regular Exercisers, Minimal Exercisers, and Non-exercisers. Paper presented at the Annual Meeting of the American College of Sports Medicine, Cincinnati.

Bonesteel, K. R., Ogles, B. M., Marsden, K., & Holdridge, P. (1996, May). Running Addiction as a Predictor of Injury. Paper presented at the Annual Meeting of the American College of Sports Medicine, Cincinnati.

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Lickliter, K. L., Ogles, B. M., & Heath, E. M. (1996, May). Effect of Mood Manipulation on Physiologic Variables During Submaximal Exercise. Paper presented at the Annual Meeting of the American College of Sports Medicine, Cincinnati.

Gurney, V. W. & Ogles, B. M. (1996, May). Body Image and Eating Disturbance in Distinct Groups of Female Exercisers. Paper presented at the Annual Meeting of the American College of Sports Medicine, Cincinnati.

Lambert, M. J. & Ogles, B. M. (1995, August). The Effectiveness of Psychotherapy Supervision. Paper presented at the American Psychological Association Conference, New York.

Ogles, B. M., Lunnen, K., Gillespie, D. K., & Trout, S. C. (1995, May). Outcomes Instruments for Ongoing Evaluation in a Rural Mental Health System for Children and Youth. Paper presented at the Rural and Appalachian Youth and their Families Conference, Columbus, Ohio.

Ogles, B. M., Lunnen, K., Gillespie, D. K., & Trout, S. C. (1995, March). Conceptualizing and Implementing an Outcomes Evaluation Plan in a Rural Mental Health System for Children and Youth. Paper presented at the Research and Training Center for Children's Mental Health's 8th Annual Research Conference, Tampa.

Ogles, B. M. (1994, June). Clinical Significance: Fact or Artifact. Paper presented at the Society for Psychotherapy Research Conference, York, England.

Cohen, D. M., Ogles, B. M., & Garske, J. P. (1994, June). Personality Traits in High School Athletes Associated with Academic Achievement. Paper presented at the Annual Meeting of the American College of Sports Medicine, Indianapolis.

Marsden, K., Garske, J. P., & Ogles, B. M. (1994, June). Explanatory Styles, Mood and Performance in Response to False Feedback: A Study Using Collegiate Swimmers. Paper presented at the Annual Meeting of the American College of Sports Medicine, Indianapolis.

APPENDIX continued...

Metcalf, K., Lockard, A., & Ogles, B. M. (1994, June). Does Running Addiction Affect Dyadic Adjustment? Paper presented at the Annual Meeting of the American College of Sports Medicine, Indianapolis.

Ogles, B. M. (1994, June). Running Addiction: The Search for Construct Validity. Paper presented at the Annual Meeting of the American College of Sports Medicine, Indianapolis.

Yatsko, C. K., Garske, J. P., & Ogles, B. M. (1993, June). Effects of Time-Limited Therapies: Meta-analyses of Controlled and Comparative Studies. Paper presented at the Society for Psychotherapy Research Conference, Pittsburgh.

Ogles, B. M., Lambert, M. J., & Sawyer, J. D. (1993, June). The Clinical Significance of the NIMH Collaborative Depression Study Data. Paper presented at the Society for Psychotherapy Research Conference, Pittsburgh.

Masters, K. S., & Ogles, B. M.. (1992, August). Dissociation and Injury Revisited: There is Still no Relation. Paper presented at the American Psychological Association Conference, Washington, DC.

Ogles, B. M., & Masters, K. S. (1992, August). Obligatory vs. Recreational Runners. Paper presented at the American Psychological Association Conference, Washington, DC.

Ogles, B. M., Masters, K. S., & Jolton, J. S. (1992, May). Motivations of Marathoners Scales: A Confirmatory Factor Analysis. Paper presented at the Midwestern Psychological Association Conference, Chicago.

Masters, K. S., & Ogles, B. M.. (1991, August). Differences Among First Time and Repeat Marathon Runners' Motives. Paper presented at the American Psychological Association Conference, San Francisco.

Ogles, B. M., & Masters, K. S. (1991, May). Differences in Marathon Runners' Motives: A Cluster Analytic Approach. Paper presented at the Midwestern Psychological Association Conference, Chicago.

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Lundervold, D., Ogles, B. M., Masters, K. S. (1991, May). Older Adult Runners: Motives for Running and Training Habits. Paper presented at the Midwestern Psychological Association Conference, Chicago.

Masters, K. S. & Ogles, B. M. (1990, August). Measuring Marathon Motives: MOMS Method. Paper presented at the American Psychological Association Conference, Boston.

Ogles, B. M., Lambert, M. J., & Craig, D. E. (1990, June). The Comparative Effectiveness of Self-Help Books for Dealing with Love Loss: Expectations and Attributions. Paper presented at the Society for Psychotherapy Research, Wintergreen, Virginia.

Ogles, B. M. & Wells, M. G. (1989, August). Training Neophyte Therapists in Suicide Risk Management: A Computerized Approach. Paper presented at the American Psychological Association Conference, New Orleans.

Howell, R. J. & Ogles, B. M. (1989, August). Privileged Communications for the Fifty States. Paper presented at the American Psychological Association Conference, New Orleans.

Ogles, B. M. & Lambert, M. J. (1989, June). A Review and Meta-Analysis of Agoraphobia Outcomes Measures. Paper presented at the Society for Psychotherapy Research Conference, Toronto.

Ogles, B. M. (1989, April). Will Treatment Manuals Contribute to Eclectic Practice? Paper presented at the Society for the Exploration of Psychotherapy Integration Conference, Berkeley.

Ogles, B. M. & Lambert, M. J. (1989, April). A Meta-Analytic Comparison of Twelve Agoraphobia Outcomes Measures. Paper presented at the Western Psychological Association, Reno.

Ogles, B. M. (1988, October). Integrating Computer Technology with Mental Health Services: Products and Applications. Paper presented at the Symposium on Computer Applications in Medical Care, Washington D.C.

APPENDIX continued...

Burlingame, G. M., Behrman, J. & Ogles, B. M. (1988, August). Comparative Processes in Group Psychotherapy: Professionals vs. Natural Helpers. Paper presented at the American Psychological Association Conference, Atlanta.

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