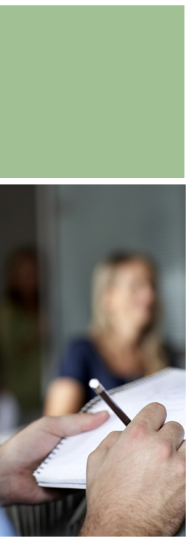



Manual 2

Feedback-Informed Clinical Work: The Basics

ICCE Manuals on Feedback-Informed Treatment (FIT)

INTERNATIONAL CENTER
FOR CLINICAL EXCELLENCE

The ICCE Manuals on Feedback-Informed Treatment (FIT)

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The ICCE Manuals on FIT were a collaborative effort. The development team included: Rob Axsen, Susanne Bargmann, Robbie Babbins-Wagner, Bob Bertolino, Cynthia Maeschalck, Scott D. Miller, Bill Robinson, Jason Seidel, and Julie Tilsen.

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Manual 1: What Works in Therapy: A Primer
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Manual 2: Feedback-Informed Clinical Work: The Basics
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Manual 3: Feedback-Informed Supervision
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Manual 4: Documenting Change: A Primer on Measurement, Analysis, and Reporting
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Manual 5: Feedback-Informed Clinical Work: specific populations and service settings
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Manual 6: Implementing Feedback-Informed Work in Agencies and Systems of Care
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Introduction to the Series of Manuals

The International Center for Clinical Excellence (ICCE)

The International Center for Clinical Excellence (ICCE) is an international online community designed to support helping professionals, agency directors, researchers, and policy makers improve the quality and outcome of behavioral health service via the use of ongoing consumer feedback and the best available scientific evidence. The ICCE launched in December 2009 and is the fastest growing online community dedicated to excellence in clinical practice. Membership in ICCE is free. To join, go to: www.centerforclinicalexcellence.com.

The ICCE Manuals on Feedback-Informed Treatment (FIT)

The ICCE Manuals on Feedback-Informed Treatment (FIT) consist of a series of six guides covering the most important information for practitioners and agencies implementing FIT as part of routine care. The goal for the series is to provide practitioners with a thorough grounding in the knowledge and skills associated with outstanding clinical performance, also known as the ICCE Core Competencies. ICCE practitioners are proficient in the following four areas:

Competency 1: Research Foundations

Competency 2: Implementation

Competency 3: Measurement and Reporting

Competency 4: Continuous Professional Improvement

The ICCE Manuals on FIT cover the following content areas:

- Manual 1: What Works in Therapy: A Primer
- Manual 2: Feedback-Informed Clinical Work: The Basics
- Manual 3: Feedback-Informed Supervision
- Manual 4: Documenting Change: A Primer on Measurement, Analysis, and Reporting
- Manual 5: Feedback-Informed Clinical Work: Specific Populations and Service Settings
- Manual 6: Implementing Feedback-Informed Work in Agencies and Systems of Care

Feedback-Informed Treatment (FIT) Defined

Feedback-Informed Treatment is a pantheoretical approach for evaluating and improving the quality and effectiveness of behavioral health services. It involves routinely and formally soliciting feedback from consumers regarding the therapeutic alliance and outcome of care and using the resulting information to inform and tailor service delivery. Feedback-Informed Treatment (FIT), as described and detailed in the ICCE manuals, is not only consistent with but also operationalizes the American Psychological Association's (APA) definition of evidence-based practice. To wit, FIT involves "the integration of the best available research…and monitoring of patient progress (and of changes in the patient's circumstances – e.g., job loss, major illness) that may suggest the need to adjust the treatment…(e.g., problems in the therapeutic relationship or in the implementation of the goals of the treatment)" (APA Task Force on Evidence-Based Practice, 2006, pp. 273, 276-277).

Manual 2

Feedback-Informed Clinical Work: The Basics

In this manual, the basics of implementing Feedback-Informed Treatment are described and illustrated through case examples and scripts. The manual details how to introduce the Outcome Rating Scale (ORS) and the Session Rating Scale (SRS) in clinical work and how to integrate it as part of ongoing treatment to improve the outcome of service. A short quiz, Frequently Asked Questions (FAQ), and a list of references are also included in this manual.

The basics of Feedback-Informed Clinical Work

The information is divided into six sections:

1) Psychometrics of the ORS and SRS;
2) Creating a Culture of Feedback;
3) Administering the ORS;
4) Administering the SRS;
5) Integrating Feedback into Care; and
6) Working in a Feedback-Informed way with Couples, Families and Children, Groups, and Mandated Clients

1) Psychometrics of the ORS and SRS

The ORS and SRS are very brief, feasible measures for tracking client well-being and the quality of the therapeutic alliance, taking less than a minute each for clients to complete and for clinicians to score and interpret. The ORS has been shown to be sensitive to change among those receiving services. Numerous studies have documented concurrent, discriminative, criterion-related and predictive validity, test-retest reliability, and internal-consistency reliability for the ORS and SRS (e.g., Anker et al., 2009; Bringhurst et al., 2006; Campbell & Hemsley, 2009; Duncan et al., 2003; Duncan et al., 2006; Miller et al., 2003; Reese et al., 2009). The significant impact of using these measures on the outcome of services has similarly been well-documented by numerous researchers (e.g., Anker et al., 2009; Miller et al., 2006; Reese, Norsworthy, & Rowlands, 2009).

The Outcome Rating Scale

The Outcome Rating Scale (ORS) is a brief, client-rated, four-item visual analogue scale measuring the client's experience of well-being in his or her individual, interpersonal, and social functioning. The ORS is designed and normed for adults and adolescents (ages 13+). The Children's Outcome Rating Scale (CORS) has been normed for ages 6-12. The Young Children's Outcome Rating Scale (YCORS) is a "clinical engagement" tool for children below 6 years. The YCORS is not scored by the clinician; it is used to provide very young children a way of expressing their well-being and satisfaction with a therapy session, as do the older children and/or adults with whom they may be in treatment.

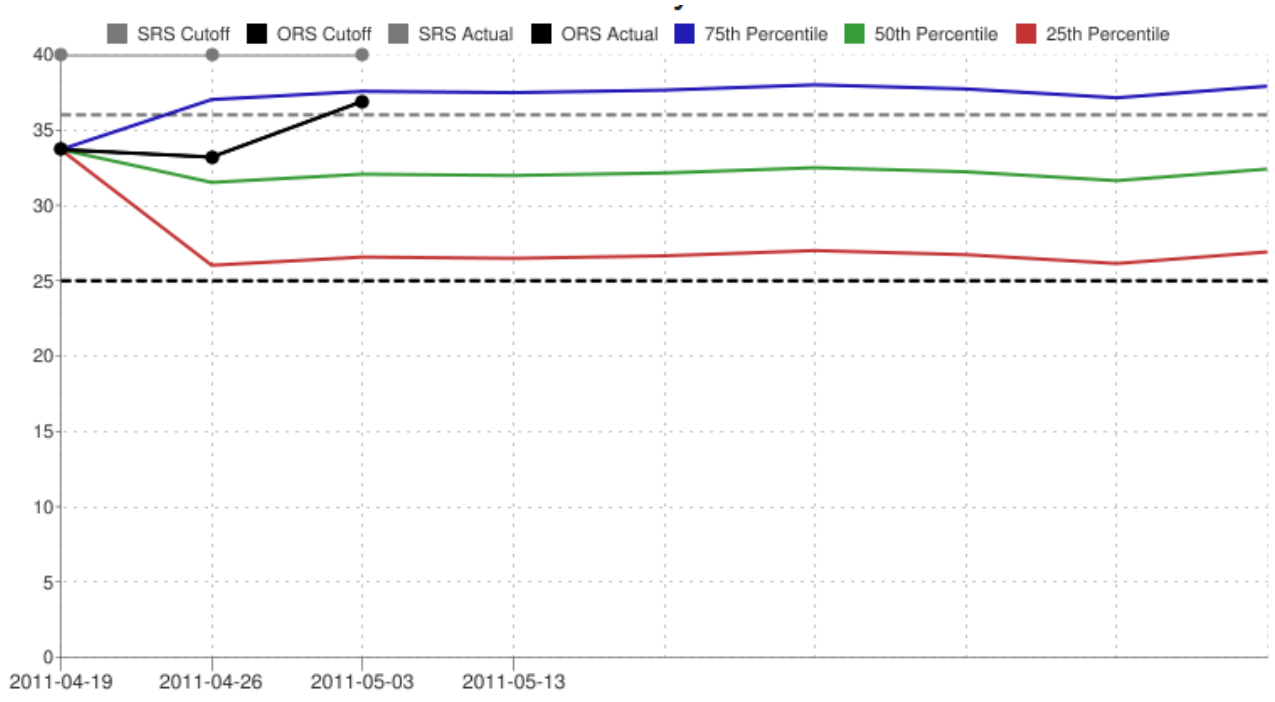
Clinical Cutoff of the ORS

Determining the clinical cutoff for an outcome measure accomplishes two related objectives: (1) It defines the boundary between a normal and clinical range of distress; and (2) it provides a reference point for evaluating the severity of distress for a particular client or client sample. Using the method described by Jacobson and Truax (1991), the clinical cutoff for the ORS was determined to be 25 (Miller, Duncan, Brown, Sparks, & Claud, 2003). The sample on which this score is based is quite large (n=34,790) and comparison with other well-established

measures shows it to be a reasonable differentiator between "normal" and "clinical" levels of distress. For example, the clinical cutoff score for the OQ-45 falls at the 83rd percentile of the nontreatment sample, and the clinical cutoff for the ORS falls at the 77th percentile of the nontreatment sample. Miller and colleagues have reported that between 25-33% of people presenting for treatment score above the clinical cutoff at intake (Miller & Duncan, 2000; Miller, Duncan, Sorrell, & Brown, 2005). While the clinical cutoff for adults is 25, younger clients tend to score themselves higher. Therefore, the clinical cutoff for adolescents (age 13-18) is 28, and for children (age 6-12) the cutoff is 32.

FIGURE 1:

The dotted lines on the graph (on 25 and 36) represent the clinical cutoff for the ORS and the alliance cutoff for the SRS. The green line represents the expected treatment response (ETR) for this particular client. The solid black line is the actual ORS score for the client, and the solid gray line is the actual SRS score.



The Reliable Change Index

When treatment is successful, scores on the ORS should increase over time. To be able to attribute such changes to nonrandom, substantial changes in well-being, the difference between any two scores must exceed a statistical index known as the reliable change index (RCI). Briefly, the RCI indicates change that is very likely to be greater than chance or day-to-day variation in a person's scores (Jacobson, 1988; Jacobson, Folette, & Revenstorf, 1984; Lambert & Hill, 1994). Change that both exceeds the RCI and crosses the clinical cutoff from a clinical to a nonclinical level is called "clinically significant change" (Jacobson & Truax, 1991). With regard to the ORS, the RCI is 5 points (Miller, Duncan, Brown et al., 2003).

Trajectories of Change

In addition to the clinical cutoff, clinicians can receive feedback comparing a client's score on the ORS to a computer-generated "expected treatment response" (ETR) for that session number. As researchers Wampold and Brown (2006) have observed, "Therapists are not cognizant of the trajectory of change of patients seen by therapists in general… that is to say, they have no way of comparing their treatment outcomes with those obtained by other therapists" (p. 9). Using a large and diverse normative sample that included 300,000 plus administrations of the ORS, Miller et al. (2004) produced algorithms capable of plotting an average trajectory of change over time based on a person's initial score (e.g., level of functioning) on the measure. The resulting graphs resemble and serve a similar function as growth curves used in medicine to assess height, weight, and head circumference. Having access to individual client trajectories in comparison to the average for a large sample enables clinicians to quickly identify those at increased risk for a null or negative outcome so the clinician and client can alter, augment, or refer for other services before the client drops out of treatment or spends too much time in a direction of treatment that does not optimize the chance of treatment success. Clinicians can access the information in three computer-based applications supporting FIT that are already available (ASIST, MyOutcomes) or in development (FIT-Outcomes) at the time of this manual's publication.

The Session Rating Scale

The Session Rating Scale (SRS) is a four-item, client-completed therapeutic-alliance measure. Like the ORS, the SRS is a visual analogue scale that takes less than a minute to administer, score, and interpret. Items on the scale reflect the classical definition of the alliance first stated by Bordin (1979). The scale assesses four interacting elements, including the quality of the relational bond, as well as the degree of agreement between the client and therapist on the goals, methods, and overall approach of therapy. The SRS is for ages 13 and up, the CORS (Children's Outcome Rating Scale) is for ages 6-12, and the Young Children's Session Rating Scale is for ages

6 and below. The SRS is also available in a group version, the Group Session Rating Scale (GSRS). The SRS measures are available in over a dozen languages and there is a script available for oral administration.

SRS Alliance Cutoff

The cutoff for an alliance measure is the point at which clinicians should be especially alert to the possibility of a rupture in and potential failure of the working relationship. The alliance cutoff enables clinicians to identify those therapeutic relationships that are at a statistically greater risk for client drop outs or experiencing a negative or null outcome from treatment. On the SRS, a score of 36 or below is considered cause for concern because fewer than 24% of cases score lower than 36 (Miller & Duncan, 2004).

2) Creating a Culture of Feedback

Soliciting clinically useful feedback from consumers of therapeutic services requires more than administering the ORS and SRS. Clinicians must work at creating an atmosphere where clients feel free to rate their experience of the process and outcome of services: (1) without fear of retribution; and (2) with a hope of having an impact on the nature and quality of services delivered. Beyond displaying an attitude of openness and receptivity, creating a "culture of feedback" involves spending time to introduce the measures thoughtfully and thoroughly. Providing a rationale for using the tools is critical, as is including a description of how the feedback will be used to guide service delivery (enabling the therapist to catch and repair alliance breaches, to prevent drop out, to correct deviations from optimal treatment experiences, etc.).

To elicit accurate and relevant feedback from the client, it is important that the therapist introduces the measures carefully, being extremely clear about the questions being asked on the forms and why the client's answers are important. It can be useful to let clients know that research on the effectiveness of therapy suggests that their experience of early improvement in their situations and their experience of satisfaction with the services they are receiving from their therapists are of prime importance in achieving a successful outcome. It is therefore important that they understand that the therapist is not going to be offended or go on the defensive in response to any negative feedback. On the contrary, the therapist must genuinely feel, and effectively communicate, that he really needs to know if the client does not feel he or she is being helped or if there is something the client wants to be different about the treatment so that he can be responsive to the client. Naturally, this attitude on the part of the therapist requires a real belief that the client's view of treatment is paramount in importance for effectively driving the process of therapy, and that a client's concerns or desire for a change in the process deserves to be taken seriously and humbly by the therapist rather than being treated as clinical fodder to be understood within a frame-of-reference with which the client has just expressed dissatisfaction.

It is also important to stress to clients that this is not just another form designed to assess them and decide what diagnostic category they fall into, nor is it just a bureaucratic requirement. The main purpose of the feedback measures is to help the therapist to stay on track and to avoid doing or saying things that are unhelpful or harmful. It is a way the therapist can demonstrate his or her commitment to being accountable to the client.

Introducing the scales to the client

The following is one example of how to introduce FIT to your clients. Please use the example to inspire you to find your own words when introducing the scales to your clients.

"I work a little differently at my practice than many therapists do. One of my top priorities is to make sure that the clients who come to see me benefit from our work and achieve the results they are wanting. For this reason, it is very important that you are involved in monitoring the progress of services from beginning to end. For this reason I use two brief tools to track your experience of the outcome of our work together and your experience of the way we work – the first scale is one we use in the beginning of the session, the second scale is one we use at the end of the session. Your feedback is critical in ensuring that our work together is useful to you.

"One of the things we know that often happens in successful treatment is that the client experiences change early in the treatment. This doesn't mean that we have to stop working together quickly, but actually means that there is a good prognosis that our work is going to have a positive effect in the long-term, so the early change is telling us that we are probably on track. If our work is successful and useful to you, we can continue as long as it makes sense to you. If you don't experience an early change, then I'm likely to talk with you about whether we should try to change or modify the services. If things still don't improve, then I may bring up whether we should try something more dramatically different, including perhaps trying to find someone or someplace else for you to get the help you want. Does this make sense to you?"

Superior Therapists and the Culture of Feedback

There is growing evidence that the process of responding to a client's negative feedback, even about an aspect of therapy that may seem relatively trivial, can contribute to the strength of the therapeutic alliance and set in place a strong foundation for future work. There is also evidence that better therapists elicit more negative feedback from their clients. This suggests that these therapists are able to forge a strong enough alliance with their clients that the clients feel safe in giving them honest feedback. It also illustrates that in building a culture of feedback it is important that the therapist recognizes and believes in its importance. In summary the quality and usefulness of the feedback therapists get from clients will depend on the degree to which the therapist genuinely wants honest feedback and the extent to which this is communicated effectively to the client.

3) Administering the ORS

Introducing the ORS to clients

The ORS is administered at the beginning of the session. The scale asks consumers of therapeutic services to think back over the prior week (or since the last visit) and place a hash mark (or "x") on four different lines, each representing a different area of functioning (e.g., individual, interpersonal, social, and overall well-being). The ORS is used at every session (or once a week – at the first clinical contact of the week – if the treatment is more intensive than weekly, or in residential settings). Typically the scale is completed in the presence of the therapist. In order to get the most accurate baseline score (also called the intake score) you should administer the ORS as soon as the client has a clear understanding of the ORS so that he or she can connect his or her experiences in the last week (and very likely their reasons for treatment) with the scale items.

It is important that the clinician explains clearly to the client that the score must be an average of the last week (or the time that has passed since the last session) since it is often tempting to score the scale to reflect how he or she is feeling "here and now." Getting a score that represents an average of the last week is critical in terms of getting a valid baseline or intake score. It is important to make sure that the client feels that the score is a good representation of his or her experience and sense of functioning, to ensure that the client feels that the ORS accurately tracks and connects with his or her experience. If the client experiences the score to be disconnected from his or her own sense of functioning, let the client review the ORS and rescore it to make sure the score accurately reflects his or her sense of well-being on all four items.

The following is one example of how to introduce the ORS to your clients. Please use the example to inspire you to find your own words when introducing the scales to your clients.

"This scale is the ORS. As you can see the scale has four items: Individual, Interpersonal, Social, and Overall. These are the areas of your life that could show improvement if the work you and I do together is effective. I'd like you to score this form every time we meet, giving us a sense of how things are progressing in

your life. Today, when we are meeting for the first time, we need to get a "start score" that tells us how things have been in your life before you and I started meeting. I would like you to look back on the last week, including today, and rate how you have been feeling on each of the four items. Does that make sense to you?"

If the client asks for clarification of one of the four subscales on the ORS, they can be explained in the following ways:

Individually: If the client asks for clarification, you should say "yourself," "you as an individual," "your personal functioning."

Interpersonally: If the client asks for clarification, you should say "in your family," "in your close personal relationships."

Socially: If the client asks for clarification, you should say, "your life outside the home or in your community," "work," "school," "friends and acquaintances," "church."

Overall: "So, given your answers on these specific areas of your life, how would you rate how things are in your life overall?" It can also be helpful to clients to make it clear that they can score the scale to suit their perception of their life, for example by saying:

"*For some clients, work is really important, so if their functioning is really good socially that reflects on their overall sense of well-being. Other clients may see their individual functioning as the most important area when scoring their overall sense of well-being. I want you to show me how these three areas of your life influence your overall sense of well-being."*

Some clients may find it hard to give you an average of the whole week because they are so influenced by how they are feeling right at this moment. For those clients, it is often a good idea to help them remember a bit more about what has been going on in their life the past week (or since the last visit). This can be done by briefly asking the client about the different parts of the week and what they were doing, for example:

"Today is Thursday, so if we look back on the last week, what was going on at the end of last week … Friday? (allow the client to answer) And if you then think about the weekend … what did you do this weekend? …. Whom did you spend time with? …. What else did you do? (allow the client to answer) And then thinking back to the beginning of this week … (and so on, giving the client the chance to recall the week in a bit more detail before administering the ORS)."

After this initial administration, which may require only a little or a great deal of the foregoing detail and explanation, you will likely not need to provide much more guidance at subsequent sessions; but it is a good idea to risk "overtraining" your client if there is any doubt about how well he or she may have retained your initial discussion about how to complete the form.

Scoring the ORS

When using or making copies of the ORS for hand-scoring, you should be certain that the lines are 10 centimeters in length (10 cm). To score the ORS, determine the distance in centimeters (to the nearest millimeter, e.g., "5.7") between the left pole and the client's hash mark on each individual item. Add all four numbers together to obtain the total score. The score can either be plotted on a paper graph (see Appendix 1) or can be entered into one of the computer-based applications that are available. The computer-based applications allow you to administer, score, and aggregate data from the ORS and SRS on your computer or tablet (e.g., iPad).

Interpreting the score

The ORS is scored in the session right after the client has filled out the form, and is plotted on a graph. In many agency settings or computer applications, the graph will show how the client's score compares to the clinical cutoff (see section 1 for a definition of the clinical cutoff). Low scores on the ORS correspond to low well-being (or high distress). Note that the average ORS intake score in outpatient mental health care treatment settings is between 18 and 19. The first step in interpreting your client's intake score is simply to describe to the client what the possible range of well-being is, and/or what the clinical cutoff means, and how the client's score relates to these scores. For example, with a client who has a total ORS score of 16.5 at the first session:

"I've plotted your score on the ORS on this graph, and as you can see there is a dotted line on 25. What we know is that generally people who score below the dotted line are more like people who seek treatment. They are more like people who are saying, "There are things in my life I would like to change; things that are bothering me"; and generally people who score above the dotted line are more like a broad range of people who have not chosen to be in treatment. So your score is here, on 16.5, so you are below the dotted line, does that make sense to you? (client nods) So it seems that coming here to see me … that you're feeling pretty bad, pretty distressed. A 16.5 on a scale of 0 to 40. Does that sound right? Does that match how you're feeling?"

The last question in that example is designed to act as a check on whether the score does seem to them that it accurately matches their experience of well-being.

As mentioned in section 1, about 25-33% of clients will score above the clinical cutoff at intake. In section 6, we will review how to respond to scores that are above the clinical cutoff.

When using one of the computer software applications, you also can see how your client's score compares to a computer-generated "expected treatment response" (ETR) (see figure 1, page 5). The ETR gives the therapist and client the chance to assess if the outcome of the treatment is similar to the average trend of change across a very large number of people, or whether your client's trajectory of change is markedly different. Section 5 describes how to integrate the feedback into care. Manual 3 of

this series describes how to use different data patterns as a guide to clinical supervision.

Scores above the clinical cut off

When talking with clients who score above the clinical cutoff, it is always important to be mindful of the risk for deterioration. To prevent deterioration here are a couple of tips for responding to scores above the clinical cutoff.

There are a couple of reasons for intake scores above the clinical cutoff on the ORS. The most common reason for a score above the clinical cutoff is that the client is mandated into treatment. This will be covered in more detail in section 6 of this manual. Another common reason for scores falling above the clinical cutoff at intake is that the client wants help with a very specific problem – one that does not impact the overall quality of life or functioning but is troubling nonetheless. Given the heightened risk of deterioration for people entering treatment above the clinical cutoff, clinicians are advised against "exploratory" and "depth-oriented" work. The best approach in such instances, is a cautious one, using the least invasive and intensive methods needed to resolve the problem at hand.

Finally, less frequent, although certainly not unheard-of, causes for high initial ORS include: (1) high functioning people who want therapy for growth, self-actualization, and optimizing performance; and (2) people who may have difficulties reading and writing or who have not understood the meaning or purpose of the measure. In the latter instance, time can be taken to explain the measure and build a "culture of feedback" or, in the case of reading or language difficulties, the oral version (available at: scottdmiller.com) can be administered. For high functioning people caution is warranted. A strength-based, coaching-type approach focused on achieving specific, targeted, and measurable goals is likely to be most helpful while simultaneously minimizing risks of deterioration.

4) Administering the SRS

Introducing the SRS to clients

The way the therapist introduces the Session Rating Scale plays a major role in the quality of feedback obtained and in the strength of the therapeutic alliance per se. Like the ORS, the SRS is designed not only to measure but to positively impact what it measures through our careful use of the information it provides. The SRS is administered just before the end of each session, and it is important to frame the SRS by emphasizing the importance of the relationship in successful treatment and encouraging negative feedback. Many clinicians wonder about clients who may for cultural reasons find it difficult to give any kind of critical feedback to a professional whom they perceive to be in a position of authority. These clinicians often suggest that clients can feel uncomfortable and pressured by an invitation to provide critical feedback to somebody with whom they feel especially humble. A way to address this can be to frame the SRS introduction in a positive light. Instead of the client feeling they are being asked "What was wrong with the service I received?" the therapist can ask, "What could have made this service even more helpful to you?" This process can be described as a standard way of doing clinical work, making it easier for the client to offer his or her feelings, by framing the feedback as critical for us to ensure that we do our job well.

The following is one example of how to introduce the SRS to your clients. Please use the example to inspire you to find your own words when introducing the scales to your clients.

"I'd like to ask you to fill out one additional form. This is called the Session Rating Scale. Basically, this is a tool that you and I will use at each session to adjust and improve the way we work together. A great deal of research shows that your experience of our work together – did you feel understood, did we focus on what was important to you, did the approach I'm taking make sense and feel right – is a good predictor of whether we'll be successful. I want to emphasize that I'm not aiming for a perfect score – a 10 out of 10. Life isn't perfect and neither am I. What I'm aiming for is your feedback about even the smallest things – even if it seems unimportant – so we can adjust our work and make sure we don't steer off course. Whatever it might be, I promise I won't take it personally. I'm always learning, and am curious about what I can learn from getting this feedback from you that will in time help me improve my skills. Does this make sense?"

Scoring the SRS:

The SRS is scored in the same way as the ORS. The lines are (should be) 10 centimeters in length (10 cm), and are scored in centimeters to the nearest millimeter between the left pole and the client's hash mark on each individual item. Add all four numbers together to obtain the total score. The score can either be plotted on a paper graph (see Appendix 1) or can be entered into one of the computer-based applications that are available. The software applications allow you to administer, score, and aggregate data from the ORS and SRS on your computer or tablet (e.g., iPad).

Interpreting the score:

Research to date on the SRS shows that the majority of clients will score 9 or more out of 10 on each line (Miller & Duncan, 2000). If they do this on all four lines, the total score will be 36 or more out of 40. This score is referred to as the cutoff for the SRS and is depicted by the dotted line on the SRS graph (see figure 1, page 5). If the client scores above 36, it is important to keep in mind that this score doesn't confirm that you have a strong alliance with your client. It may mean this or it may mean that at this point in the therapy he or she does not feel safe enough with us to give negative feedback. The best response to a score above 36 is to thank the client for the feedback and to add that you would really appreciate if the client would let you know if he or she thinks of something later on about the session that he or she would like you to change a bit.

Scores that fall at or below 36 are considered "cause for concern" and should be discussed with clients prior to ending the session. Single-point declines in SRS scores from session to session have also been found to be associated with poorer outcomes at termination – even when the total score consistently falls above 36 – and should therefore be discussed with clients (Miller, Duncan, & Hubble, 2007). In sum, the SRS helps clinicians identify problems in the alliance (e.g., misunderstandings, disagreement about goals and methods) early in care, thereby preventing client dropout or deterioration.

Whatever the circumstance, openness and transparency are central to successfully eliciting meaningful feedback on the SRS. When the total score falls below 36, for example, the therapist can encourage discussion by saying:

"Thanks for the time and care you took in filling out the SRS. Your experience here is important to me. Filling out the SRS gives me a chance to check in, one last time, before we end today to make sure we are on the same page – that this is working for you. Most of the time, about 75% actually, people score 37 or higher. And today, your score falls at (a number 36 or lower), which can mean we need to consider making some changes in the way we are working together. What thoughts do you have about this?"

When scores have decreased a single point compared to the prior visit, the clinician can begin exploring the possible reasons by stating:

"Thanks so much for being willing to give me this feedback. As I've told you before, this form is about how the session went; and last week (using the graph to display the results), your marks totaled (X). This week, as you can see, the total is (X – 1). As small as that may seem, research has actually shown that a decrease of a single point can be important. Any ideas about how today was different from prior visits and what, if anything, we may need to change?"

Finally, when a particular item on the SRS is rated lower compared to the other items, the therapist can inquire directly about that item regardless of whether the total score falls below the cut off:

"Thanks for taking this form so seriously. It really helps. I really want to make sure we are on the same page. Looking at the SRS gives me a chance to make sure I'm not missing something big or going in the wrong direction for you. In looking over the scale, I've noticed here (showing the completed form to the client), that your mark on the question about "approach and method" is lower compared to the others. What can you tell me about that?"

When seeking feedback via the SRS, it is important to frame questions in as "task-specific" a manner as possible. Research shows, for example, that people are more likely to provide feedback when it is not perceived as a criticism of the other person but rather about specific behaviors (Coyle, 2009; Ericsson, Charness, Feltovich, & Hoffman, 2006). For example, instead of inquiring generally about how the session went or how the client felt about the visit, the therapist should frame questions in a way that elicits concrete, specific suggestions for altering the type, course, and delivery of services:

- "Did we talk about the right topics today?"
- "What was the least helpful thing that happened today?"
- "Did my questions make sense to you?"
- "Did I fail to ask you about something you consider important or wanted to talk about but didn't?"
- "Was the session too (short/long/just right) for you?"
- "Did my response to your story make you feel like I understood what you were telling me, or do you need me to respond differently?"
- "Is there anything that happened (or did not happen) today that would cause you not to return next time?

Case example

Sarah has sought counseling to decide whether or not she is going to stay in her marriage. She mentioned in the first session a period in her childhood when, due to her parents separating, she spent four years being cared for by an uncle and aunt and was separated from siblings. In session 4, the therapist refers back to this and spends about half the session questioning the client about this phase of her life. Sarah says she was well cared for and felt nurtured during this time; and although she missed her brothers and sisters, she feels now that it has made her value them more and they are now very close.

At the end of session 4, the client's SRS score is 34.5. This compares with scores of 38 or higher in previous sessions. The therapist looks at the individual lines and notices that the top "Relationship" line has gone from 9.8 at the last session to just under 8 at this session.

On the basis of this decline in the score, the therapist asks Sarah about this. Sarah refers to the questioning about her early life. She feels the therapist did not hear and understand her as well as in previous sessions because she seemed to assume that the separation from family and the time with her uncle and aunt must have been unpleasant and traumatic when, in her experience, it was not. She states that she wants future work to focus in more depth on the present situation. The therapist apologizes for persisting with a subject that Sarah clearly feels she has dealt with and is not seen by her as relevant to the present situation. She promises that future sessions will focus predominantly on the current situation as requested by her. At the same time the therapist also checks with Sarah about whether it would be appropriate to check with Sarah if the therapist felt that her current decision-making process was being affected by past experiences. Sarah agrees. Sarah has two more sessions, keeping the focus on aspects of her present situation after which she makes her decision about her marriage, and terminates therapy by mutual agreement with the therapist. The SRS ratings have returned to the 38/39 range.

Case example

Steve has sought therapy because he has become increasingly irritable and short-tempered with other family members. His wife has told him she is starting to question the future of their relationship because of the angry outbursts aimed at her and the children. A friend has suggested to Steve that he is suffering from depression and he wonders if his irritability is an expression of this.

The therapist introduces Steve to some stress and anger management techniques and explores, at Steve's request, possible meanings of and reasons for his anger and depression.

At session 3, Steve comes in visibly distressed having just had a major argument with his 14-year-old son. The majority of this session is then given over to looking at his son's behavior and how Steve can understand and manage it better.

In the first two sessions, Steve has scored the SRS at a maximum 40 but at the end of session 3 he scores the goals and topics line at 7. Although the scores of 10 in the other three areas push Steve's score over the cutoff, his therapist asks him about the lower score on this line. After a pause Steve says he has just spent most of the session talking about his son's issues when his reason for coming was to address his own. The therapist asks him if in the future he would like him to be more directive and bring him back to his reason for attending if he drifts off track again. Steve says he would like him to do this. In future sessions the therapist is careful to remind Steve if he has wandered off track and to help him to refocus on his reason for attending. Steve's SRS scores return to 40, his ORS scores rise and he says that he is less prone to anger and happier with the way he is relating to his family.

It is important to note here that no general rules of therapy practice can be drawn from these case examples. Sarah's therapist did not take from Sarah's feedback that it is never a good idea to explore the effects of a client's early life on her current situation. She simply learned that it was not helpful to do this with Sarah at this time. Likewise, Steve's therapist did not take from his experience that he must be more directive with all his clients and not allow them to drift away from their stated goals. He learned that this client wanted him to do this in order to get the most out of this particular therapy experience. In other words, it is important always to remember that feedback from the SRS is relevant only to the person who gives it and the context in which it is given.

5) Integrating Feedback into Care

ICCE Service Delivery Agreement

The ICCE "Service Delivery Agreement" (see Appendix 3) is designed to be completed together with the person in treatment at the time services are delivered. When meeting for the first time with clients, the first document to be completed after the administration of the Outcome Rating Scale (ORS) is the ICCE "Service Delivery Agreement" (ICCE SDA).

Consistent with the principles of FIT, the purpose of the ICCE SDA is to insure that treatment is organized around the interests, motivations, goals, and preferences of the person seeking services. Take care to use the language and words of the person in treatment, avoiding diagnostic and treatment terms or jargon.

As an example, consider a man who presents for treatment because his partner has threatened to leave if he does not quit drinking. When asked, he readily admits that drinking is a problem. At the same time, his stated reason/motivation for seeking services is to "keep his wife from leaving him." Therefore, in the box "Consumer's stated reasons/motivation for seeking services," the helping professional would write, "To keep his wife from leaving" or "To maintain his marriage."

The same principle is used when filling out "Agreed upon goals/meaning/purpose/preferences for services." Using the example of the man presenting for treatment because his partner has threatened to leave if he does not quit drinking, a potential goal could be "decrease drinking to an amount that is acceptable to my wife." With this statement, the goal is directly related to the man's stated motivation for services rather than the interpretation or therapeutic aims of the provider.

Returning once again to the example of the man hoping to save his marriage, the clinician would write the specific services that will constitute treatment in the box "Agreed upon means/methods (including type, frequency, provider). For example, "Weekly individual sessions focused on harm reduction and controlled drinking strategies" or "Attendance at three Alcoholics Anonymous meetings per week."

The clinician marks on the form that he has explained the feedback process to the client. Once completed, the ICCE SDA is signed by both the service provider and the person seeking treatment.

The ICCE Progress Note

Consistent with the principles of FIT, the purpose of the ICCE Progress note is designed to insure that any services offered are informed by ongoing feedback about the outcome of treatment and the alliance between the provider and recipient of services.

Determining whether services are working is fundamental to Feedback-Informed Treatment. As a result, the ORS must be administered at or near the beginning of each and every session or "unit of service." The helping professional must also determine whether or not the scores on the ORS indicate that the person in care is making progress.

Scores on the ORS can go up, down, or stay the same, indicating improvement, deterioration, or maintenance of progress, respectively. If scores have gone up since the prior measurement, the provider details the nature of the improvement and how the progress was addressed during the visit. In the case of improved scores in the treatment of a person with depression, for example, the therapist might write, "Client stated she got up rather than lying in bed by setting her alarm clock." In the case of deterioration, the therapist might write, "Client reports that lower scores are the result of experiencing more isolation during the week" or "of having been unable to get up and out of bed despite having set the alarm clock as recommended in the last visit." The key is documenting the reason for the results in as concrete and specific terms as possible.

In the "Between-session plan" box, the plan developed by the provider and recipient of services during the visit aimed at reinforcing progress, maintaining gains, or addressing deterioration is summarized. Here again, the key is to provide concrete and specific actions that will be taken by the client, provider, or both. In the case of the depressed person whose ORS scores were worse than in the prior visit, the therapist might write, "An appointment will be made with the (physician, psychologist, nutritionist, etc.) to evaluate for potential (physical illness, medications, psychological assessment, etc.)." If progress is made, the therapist describes what the client will do between visits to maintain or consolidate changes.

Tracking the status of the relationship between the provider and recipient of treatment services is a critical component of Feedback-Informed Treatment. As a result, the SRS must be administered at the end of each and every session or "unit of service." The helping professional must also determine whether or not the scores on the SRS indicate a problem exists in the relationship. Scores below 36 should always be discussed as well as scores that have decreased (even by a single point) as compared to the prior

measurement. As a result, the provider should also indicate whether scores below 36 or those which have decreased (even by a single point) as compared to the prior measurement were addressed directly with the client prior to ending the session.

Once completed, the ICCE Progress Note is signed by both the service provider and the person seeking treatment.

The ORS and SRS are dialogue tools

The primary purpose of the ORS and SRS is to provide the therapist with information that can be enquired further. The ORS and SRS are dialogue tools that will inform and improve the way the therapist focuses on the outcome and alliance of the service provided. Having a graph that is available for both the client and the therapist allows for an open and transparent conversation that includes the client's perspective in the decisions about the service delivery. This will ensure that the service is adjusted and tailored in response to the client's feedback and the conversation between the client and the therapist. The graph of the ORS and SRS scores will result in patterns of the progress and development over time that can stimulate hypothesis and ideas that can be explored to make sure the client is getting the help he or she wants. Knowledge of specific patterns will also make it possible for the therapist to respond if there are signs of "threats" to treatment outcome or alliance (and risk for drop-out), and can be used to inform the decision to seek consultation on a particular case. In this sense the ORS and SRS can be viewed as quality assurance instruments. Manual 3 will detail some of the most common patterns and describe ways of responding to these patterns in supervision.

Case example

Mia is 24 years old and seeks counseling because of severe depression. Mia's intake score on the ORS is 7.5 (a significantly lower score than average, which makes the therapist check about suicidal thoughts and intentions) and over the next three sessions her scores are dropping down to 1.2 on the ORS (see figure 2, page 23). Mia has no suicidal thoughts or intentions. On the SRS Mia scores between 39.5 and 40 at every session and expresses relief that "I am finally seeing somebody that understands my pain." During the first three conversations the therapist has checked in regularly with Mia about her low ORS, and Mia has said that she is sure change will come, but "things like this takes time." At session 4 the therapist spends a little more time addressing the scores on the ORS with Mia:

Therapist: "I would like to talk with you a bit more about the way things are in your life, and how you have been feeling these last weeks, and how our work is influencing the way you are feeling, would that be okay for you?" (Mia nods quietly while crying) "So, it seems that things have actually gotten worse for you since you started coming here … does that make sense?" (Mia nods, still crying) "So there are a couple of things that come to mind for me about this … and a couple of things that I find a bit concerning that I would like to check with you … First of all, as you can see, the system is telling us that most people in treatment will have experienced progress after four sessions … and your score is below this red line telling us that you are not getting the help from our conversations that could be expected … And I worry that continuing like this could prevent you from getting the help you want … does that make sense to you?"

Mia: "Yes …. Hm … I mean … I've been thinking the same … that I feel worse and that the stuff we talk about just makes me feel worse … I mean … I really like coming and it's like you really understand me and how I am hurting … and I think my relationship with my mum is important and that it's been good to talk about it … but it's like talking about it makes me really upset and sad … and it's just hard to get out of bed … I just have no energy …"

Therapist: "Yeah … so we've not really talked about things in a way that helps you getting out of bed and helps you get your life to work … (Mia nods) So I'm wondering a couple of things here … I am wondering if perhaps coming to see me is not enough … that perhaps we need to talk about what more you could do to be supported in getting out of bed … (Mia nods) And also I'm thinking that you and I need to figure out which

topics would be more helpful for you to discuss in order for you to feel that you get some energy back … does that make sense?"

Mia: "Yeah … I think I need us to be more future oriented … talk about what I can do to get out of the house, what I can do to meet more people and get out more … I think the stuff with my mum is probably not going to help me much …."

Therapist: "So I'm wondering … if we give these new ideas a try … talking more about the future and getting out and seeing more people … and if we figure out ways for you to get more support to get out of bed … how long do you think we would need to meet to be able to see if we are on track with these new ideas?"

Mia: "I think perhaps three or four more weeks is okay … then things HAVE to be better…."

Comment: The therapist makes sure to check the understandings of the graph with the client and invites the client into a conversation about adjusting the service in light of the deterioration on the ORS. The therapist also makes sure to negotiate a time frame for trying out the new ideas to make room for the possibility of having a new conversation within 3-4 weeks if the client still isn't experiencing progress.

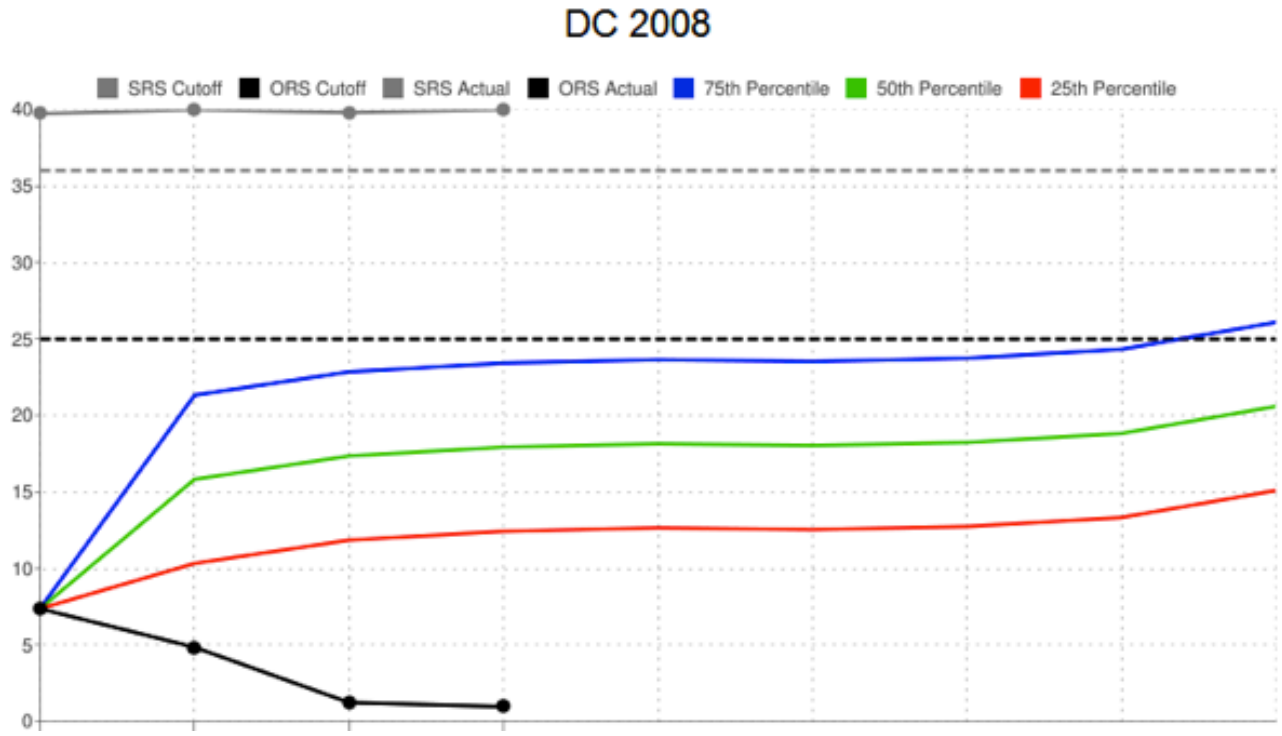


Figure 2: 24-year-old female seen in outpatient counseling once a week.

Case example

Robert is a 19-year-old male and seeks counseling because he wants to move out of his parents' home and become more independent. He feels insecure, especially because it's hard for him to develop friendships with his peers. He is afraid that he will end up lonely and depressed when he moves out. His intake score on the ORS is 21.5 (see Figure 3, page 25), and at the second session he experiences a large improvement (ORS 29.5) that crosses the 75th percentile (the blue line), followed by a drop at session 3 (25.1). At session 5 his score on the ORS (31.2) crosses the 75th percentile again, and the therapist uses this information to talk in a bit more detail with Robert about the meaning of this score:

Therapist: "It looks like your scores have really jumped up since last week." (Robert nods) "So what makes sense to this progress .. what has been going on since our last conversation?"

Robert: "Well it's been a really great week actually … I was invited to a party Friday … and usually I say no to parties because I feel so uncomfortable at parties … but I tried to think about the things you and I have talked about … and I said yes …. It was really scary and I was SO nervous … but I kept reminding myself 'I can go home whenever I want … I don't have to stay if I don't like it here' and that helped a lot. And then at the party it was actually fun … I talked with some of the guys from the basketball club … and they were really easy to talk to and were into many of the things I like … so I talked with this one guy for a really long time and we agreed to hang out some more … and I also had some beers …(laughing) … quite a lot of beers … and I had fun…. That's never happened before…"

Therapist: "Wow … it sounds like you have really challenged yourself … and that you've done what you have been wanting to do for a long time … that you've lived a normal life of a 19-year-old …." (Robert smiles) "… so going back to your scores they have crossed this blue line … that we talked about in the beginning when your scores jumped up … and that is telling us that what has happened since last week is a really large change … and it really does sound like a big change … so what you and I need to remember is that these really big changes might not be possible to sustain in the long run … that perhaps the scores will go down a bit over time and be closer to this green line." (Robert nods) "So I was wondering if perhaps it would make sense for us to talk a bit about all the things you have done to make this change happen, and what could challenge this progress … and perhaps also talk a bit about what strategies you have if things start going down a bit … so that you still hold on to as much of the change as possible … would that make sense?"

Robert: "Yeah … I'd like that … I really want to hold on to this as much as possible …. "

Comment: The therapist makes sure to connect the scores to the client's experiences by asking the client to interpret and explain the developments on the graph. Also, the therapist uses the percentiles to inform the discussion about progress and how to achieve sustainable changes. This will hopefully also prevent the client from feeling very discouraged if the scores drop over the next sessions.

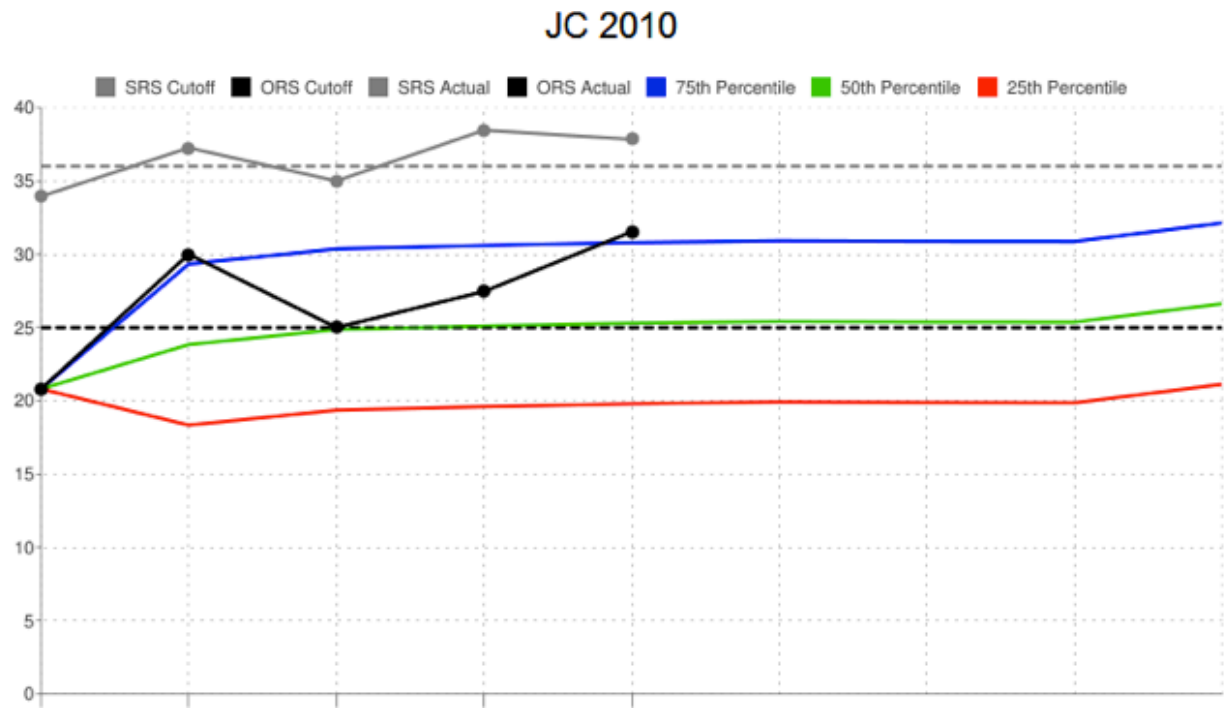


Figure 3: 19-year-old male seen in outpatient counseling once a week.

General Guidelines

There are certain general guidelines that guide the timing of the dialogue about the ORS and SRS with clients. These rules are intended to serve as guidelines, but can never replace the clinician's judgment of the situation or the client's explanations of the scores.

"Check-in" conversation

If there is a lack of progress on the ORS, it is recommended to have a "check-in" conversation with the client at session 3 or 4. The purpose of this conversation is to explore the elements of the alliance (preferences, goals, means, and bond) to investigate possible adjustments of the treatment to improve the chance of a good outcome for the client. This conversation also serves the purpose of preventing the client from dropping out of treatment because of the lack of progress – to keep the client engaged in the alliance with the therapist

and help the client work out how to reach the goals for seeking treatment. At this point it is also an option for the clinician to seek consultation with a colleague or supervisor to get new ideas about how to help the client.

"Last stop" conversation

If there is a lack of progress on the ORS at session 6 – 7 it is recommended to have a more serious conversation with the client about the treatment. At this point the likelihood of a good outcome decreases, and the risk of continuing an ineffective treatment and creating a dependency relationship increases. The goal of this conversation is to explore ideas for changing the services – either by adding other elements to the treatment or by changing the provider. It is also recommended that the clinician seeks input from peers or a supervisor about the case to get more ideas about what other options might be available for this particular client.

Failing Successfully

If the alliance drops dramatically, or if the scores are descending slowly, it is important that the clinician responds immediately by exploring the reasons for the sudden or slow drop in the scores. It is also important to work out a plan for how to get back on track with the client to increase the likelihood of a good outcome and decrease the risk of drop out. For examples of conversations about the alliance you can review section 4.

Case example

Diane is 20 years old and seeks consultation because of depression. She lost her mother two years ago who died suddenly from a brain hemorrhage. She lives at home with her father, but describes their relationship as distant and cold. Diane scores 15.4 on the ORS at intake. During the first three sessions the therapist works from a hypothesis that the depression is actually grief following the death of her mother. Diane is interested in exploring the different techniques for dealing with grief, and likes working with the therapist (SRS around 38.5) but her ORS scores are not progressing. At session 4 the therapist has a "check-in" conversation with Diane:

Therapist: "So, looking at your graph, it seems that despite our efforts to work on relieving your sadness by talking about your mother, you are not feeling any better than when we started working together … does that make sense?"

Diane: "Yeah … it's like the sadness won't go away … and somehow it feels like I'm actually not that troubled by Mum's death … it's fine to talk about her, but it's not really where the problems come from I think …."

Therapist: "Ok … so it sounds like you have a sense that the problems lie elsewhere …. Do you have a sense of what we might need to talk about instead of your mother to make the sadness go away?"

Diane: "Well… I'm not sure … it just feels like the real problem is my life here and now … not the past … I'm really unhappy living at home with Dad because he doesn't seem to really care about me … it's like nobody really cares about me … and that hurts … (crying)."

Therapist: "Ok … so it seems that what would make more sense is for us to talk more about how things are in your life right now … and how things may improve in your life going forward?" (Diane nods) "So do you think perhaps it would make sense to talk about your relationship with your father … and perhaps invite him to join us for a conversation about that?"

Diane: "You know … after Mum died … Dad really changed … we used to be much closer when Mum was still here … actually people always said I was Daddy's girl … I think … I would really like Dad to come … I don't know if he would be willing to come …"

Therapist: "Well maybe we should call your father right now to see if he would be willing to participate in our conversation next week."

Case example

Stacey is 18 years old and seeks counseling because of severe anorexia. Stacey scores 11.5 on the ORS at intake. Despite different attempts to change and adjust the treatment, Stacey still scores 11 on the ORS at session 6, and the therapist initiates a "last stop" conversation:

Therapist: "It looks like things haven't really changed for you despite all your efforts to get away from anorexia … if you look at the graph it looks like your score today is almost exactly the same as your score the first time we talked together (points at the two scores on the graph) … does that make sense?"

Stacey: "Yeah … it's like … we talk about all these great things … but when I get home anorexia hits me … and everything we talked about here seems to be wrong ... and I just end up thinking that you are wrong about all the things you say … and I decide not to eat after all …"

Therapist: "Right … it really does seem like coming here once a week is just not enough to support you in fighting anorexia … it's like my influence lasts … what … a couple of hours? … and then anorexia is back."

Stacey: (laughs) "Actually it's about 12 hours … and some of the things you say seem to stay with me even if anorexia comes back … but I think I need somebody to sit with me while I eat … because it's those meals that are really killing me…"

Therapist: "That sounds right … and you know that I can't help you with that … I can't provide you with that level of support … probably the best place for you to be to get that level of support would be an inpatient eating disorder clinic … how does that sound for you?"

Stacey: "I really don't like the idea of not coming to see you … I like talking to you and I think you really get me …"

Therapist: "I really like talking to you as well … but I'm just really worried about you not getting any better … and worried that if we continue to work together I may actually be standing in the way of you getting better … because coming here will get in the way of you getting referred to another type of treatment…"

Stacey: "I know that you are right … it's just … it's just hard …"

6) Working in a Feedback-Informed Way with Couples, Families and Children, Groups, and Mandated Clients

Feedback Informed work with couples

Using the alliance and outcome measures in couple work can be more complicated than in individual sessions but also can open up more possibilities. It can be more complicated in that the partners may disagree over the progress they are making and over whether the therapist and the therapy are meeting their needs. It can open up possibilities in that the discussion the therapist initiates around the partners' differing perceptions can guide them to a deeper understanding of the experience of each person and the interaction between them.

The ORS is a very valuable tool in couple work when it's integrated into the work of each session. The following examples illustrate this.

1) At an intake session one partner scores above the clinical cutoff while the other scores well below it. The therapist will immediately be curious about this difference and want to explore why it is that their perceptions are so different. This discussion can be of great value to the therapist in understanding the different positions and perceptions the clients are experiencing and expressing.
2) After five sessions the ORS graph for one partner shows clinically significant change while the other one shows no change or slight deterioration. The discussion with the client not experiencing positive change can take place in conjunction with his or her partner which in turn can identify issues that need addressing either between the clients or between the nonimproving client and the therapist.

The SRS can also be used creatively in couple counseling. As in individual counseling we are mainly interested in negative feedback and how this can function as a corrective to the therapy process. In couple counseling the client's partner can be involved in the discussion and his or her view sought about what the therapist may need to change in order to better meet this person's needs. It can also function as a good guide as to how the therapist is maintaining impartiality in the perception of the client. A combination of a positive and a negative SRS alerts the therapist to the possibility that he or she is dealing with a "split alliance" which is shown to

be associated with negative outcome. The post SRS discussion provides opportunity for the therapist to reestablish neutrality in the eyes of the clients.

A further factor in couple therapy is the perception of one client of the alliance the therapist has with his or her partner. This can be important for a number of reasons. The client may feel the therapist is being overly sympathetic to the partner's position and therefore aligning him or herself against the client or he or she may be anxious and hoping that the therapist can connect well with the partner so that the partner stays engaged in the therapy process. Either way the discussion following administering and scoring the SRS can enable these perceptions to be expressed and responded to.

Case example

Consider the following example from a recent, first session of couples therapy where using the SRS helped prevent one member of the dyad from dropping out of treatment. At the conclusion of the visit, the man and woman both completed the measure. The scores of two diverged significantly, however, with the husband's falling below the clinical cutoff. When the therapist inquired, the man replied, "I know my wife has certain ideas about sex, including that I just want sex on a regular basis to serve my physical needs. But the way we discussed this today leaves me feeling like some kind of 'monster' driven by primitive needs." When the therapist asked how the session would have been different had the man felt understood, he indicated that both his wife and the therapist would know that the sex had nothing to do with satisfying primitive urges but rather was a place for him to feel a close, deep connection with his wife as well as a time he felt truly loved by her. The woman expressed surprise and happiness at her partner's comments. All agreed to continue the discussion at the next visit. As the man stood to leave, he said, "I actually don't think I would have agreed to come back again had we not talked about this – I would have left here feeling that neither of you understood how I felt. Now, I'm looking forward to next time."

Feedback Informed work with families and children

When working with children, the therapist uses the CORS and CSRS (see section 1). These forms are designed for children ages from 6 to 12 although this is not a hard and fast rule. As children and young people of the same age may be at different levels of maturity there will be 11- and 12-year-olds who are more comfortable with the adult version while there may be 13- and 14-year-olds who prefer the child version. The scores from these measures can be scored, tracked, and discussed with the client just as the adult version.

Often children are seen in the context of their entire family, and children will frequently present for counseling because a parent or another adult such as a teacher believes they need it. The key is to figure out which ORS score will be the best measure of the progress of treatment. In some instances everybody in the family is there because they experience distress, and in this case each family member scores the scale evaluating his or her own functioning.

In other situations the child is the "identified problem" and in this situation the CORS can be given to the child and at the same time a parent can be asked to fill out the ORS as he or she thinks the child is functioning from observation of the child (also known as a "collateral rating"). The two scores can then be compared and differences between them discussed. This discussion can be invaluable in clarifying how the presenting issue is seen by both or all involved parties. The progress as reported by both the child and the collateral rater can be tracked and used as a reference point for the therapy, with the collateral rating being the most reliable indicator of progress in the therapy.

If the child is being seen along with the parent or parents in the context of family therapy, then at the end of each session, the child completes the Child Session Rating Scale (CSRS) and the adults complete the adult SRS so all members of the family are given an opportunity to say whether or not the therapy session met their expectations. Note that in this situation the adults are responding for themselves and not on behalf of the child.

Introducing the scales to children is focused on using language to suit the age of the child, and often children like to participate in the scoring and graphing of the scores if the therapist uses paper and pencil versions of the scales.

Example of introducing the scales for 2 children, ages 9 and 12:

"I'd like to ask you for your help with something … In my work it's really important for me that I help the people I talk with, and to make sure that people are feeling helped I use these two short scales to keep track of things … The first one we use at the beginning each time we talk, and the second one we use at the end after we have talked. So to begin with I need your help showing me how things have been this last week, before you came here to see me … will you help me with that? (children nod – therapist shows them the CORS). "This scale is the one we use to see how you have been feeling … As you can see it has four lines with smileys at each side, happy smileys to the right, sad smileys to the left. And above the lines it says "me," "family," "school," and "everything." Your job is to think about the last week and how things have been in these four areas of your life, and then make a hash mark on the lines to show me how things are going. The closer to the happy smiley, the better things have been, the closer to the sad smiley, the worse things have been. Does that make sense to you?"

Groups

The ORS and GSRS are also very useful tools in group therapy contexts. Before each group meeting each group member fills out, scores, and graphs an individual ORS. These scores, in turn, are used to stimulate and manage discussions regarding the successes, struggles, and any mishaps that people have experienced between visits. At the end of group, each person completes and scores the GSRS. Any difference in scores can be used to generate discussion of what went well as well as what must happen in order to improve the experience for any member scoring below the cutoff. Alternatively the therapists can call the people with scores below the cutoff on the phone after the group has ended to have a conversation about how the therapist can help the person bring up the concerns about the group in the next group meeting.

Mandated clients

The most common reason given by clients for scoring above the clinical cutoff at the first visit is that someone else sent them to or believes they need treatment (e.g., justice system, employer, family member, partner, etc.). In such instances, the client can be asked to complete the ORS as if he or she was the person who sent him or her. Time in the session can then be usefully spent on working to improve the scores of the "concerned other." A recent session with a man referred for "counseling" by his physician illustrates how this process can work to build an alliance with people who are mandated into care.

Briefly, the man's score on the ORS at the initial session was 28, placing him above the cutoff and in the "nonclinical" or "functional" range of scores. The therapist plotted the scores on a graph saying, "As you can see, your score falls above this dotted line, called the clinical cutoff. People who score above that line are scoring more like people who are not in treatment and saying life is generally pretty good." The man nodded his head in agreement. "That's right," he then added.

"That's great," the therapist said without hesitation, "Can you help me understand why you have come to see me today then?"

"Well," the man said, "I'm OK, but my family – and my wife in particular – have been complaining a lot, about, well, saying that I drink too much."

"OK, I get it," the therapist responded, "they see things differently than you." Again, the man nodded in agreement.

"Would you mind filling this in one more time?" she asked, "as if you were your wife and family?" And when the items on the ORS were added up, the total had dropped to 15 – well below the clinical cutoff. Using a different colored pen, the therapist plotted the "collateral score" on the graph. Pointing to the man's score, the therapist said, "You're up here, at 28," and then continued, "but your family, they have a different point of view."

"Exactly," he said.

"What do you suppose it would take for your wife's and family's scores to go up?" the therapist asked. The first words out of his mouth were, "I'd definitely have to cut down the drinking…," followed by a lengthy and engaged conversation regarding the family's concern about driving while intoxicated and the man's frequent inability to recall events after a night of heavy alcohol consumption.

Manual 2 Quiz

Research indicates that people retain knowledge better when tested. Take a few moments and answer the following 10 questions. If you miss more than a couple, go back and reread the applicable sections. One week from now, complete the quiz again as a way of reviewing and refreshing what you have learned.

1. **Linda's initial intake ORS score was 10.4. Her SRS score at the first session was 36. After two months of weekly sessions, her ORS score is 11 and her SRS score is 39.5. What is the least appropriate action to take?**
   a. Consult with your supervisor or treatment team.
   b. Since the SRS score has improved, continue doing what you are doing.
   c. Talk to Linda about her ORS and SRS scores.
   d. Consider changing your approach or referring her to another counselor.

2. **Which of the following are false?**
   a. At the first session, a low rating on the Session Rating Scale means that I am not doing a good job as a therapist.
   b. A dip in SRS scores must fall below 36 to be of concern.
   c. Decreasing SRS scores over time indicate that clients are becoming more and more honest.
   d. All of the above.

3. **Clients are typically asked to complete the ORS:**
   a. At the end of the session.
   b. At the beginning of the session.
   c. At the end of the week.
   d. At the midpoint of the session.

4. **With mandated clients:**
   a. The ORS and SRS are not valid because these clients often lie.
   b. The ORS is valid but not the SRS.
   c. The SRS is valid but not the ORS.
   d. The ORS and SRS are both valid and useful for guiding service delivery.

5. **The clinical cutoff can be explained to clients as a way to:**
   a. Distinguish between those persons whose scores are more consistent with scores of people who start therapy than with scores of people who are not in therapy.
   b. Know whether or not someone should be in therapy.
   c. Separate who will or will not benefit from therapy.
   d. Distinguish between those persons who are being honest and dishonest about their life circumstances.

6. **Which of the following statements are true:**
   a. It is okay to tell your clients that they are marking the ORS too low because you think they are doing better than the scores they mark down indicate.
   b. It is always important to connect the clients' scores to their narrative in therapy.
   c. It is the therapist's job to create a "culture of feedback" so that clients feel free to complete the ORS in as open and honest a manner as possible.
   d. b and c.

7. **A score of 39 on the SRS:**
   a. Means there are no problems with the therapeutic alliance.
   b. Is not interpretable without more information.
   c. Indicates there is a concern about the therapeutic alliance.
   d. Indicates that the therapist is on track and the therapeutic alliance is strong.

8. **Clients are typically asked to complete the SRS:**
   a. At the end of a session.
   b. At the beginning of the session.
   c. At the beginning of the week.
   d. At the midpoint in the session.

9. **Situation: By session 4, a client's Session Rating Scale is consistently low (averaging about 33) but the Outcome Rating Scale reflects adequate positive change (movement from 15 to 23). When the clinician encourages and explores the reasons for the low SRS scores, the client says "It's not that big a deal, it's just me" and doesn't elaborate. What is the best course of action?**
   a. Dig deeper to identify what the real problem is in the therapeutic relationship.
   b. Encourage open feedback about what might be causing the low SRS scores and leave it at that because the ORS scores are reflecting positive change.
   c. Raise issues of the possibility of transference reactions and suggest that you engage in a process discussion during the next session.
   d. Suggest to the client possible reasons why he or she might be critical of your approach.

10. **A client has problems filling out the ORS because of a visual handicap. Can you still use FIT and enter the scores into MyOutcomes, ASIST or FIT-Outcomes?**
    a. No, this is one of the incidents where you have to work without using FIT.
    b. You can use the philosophy of FIT to inform your work but you won't be able to gather data that can be entered into your system.
    c. Yes, you can administer the ORS and SRS verbally using the oral script and you can enter the scores into ASIST, MyOutcomes or FIT-Outcomes.
    d. You can choose either to leave out the data or to fill out the forms for the client as a "collateral rater" and enter your rating into ASIST, MyOutcomes or FIT-Outcomes.

Answer Key

1. b	6. d
2. d	7. b
3. b	8. a
4. d	9. b
5. a	10. c

FAQ

Question:

A client completing the ORS for the first time says he doesn't know what to put for the "family, close relationships" line because he is getting on very well with his children but the relationship between the children and his partner is not going well. How should I advise him?

Answer:

Suggest he mark it according to the relationship that is not going well as this is the one he wants to improve and what the counseling will focus on.

Question:

A client scores the ORS well above the clinical cutoff but as the session proceeds it becomes clear that she is struggling with a number of difficult issues and the ORS score does not seem accurate in light of what I am hearing. How should I respond to this?

Answer:

Share your puzzlement with the client and suggest that she score the measure again in light of the things she has been telling you.

Question:

A client scores well above the clinical cutoff at a first session and when I query this he says that he is only seeing me because somebody else told him he needed to see a counselor. How should I respond?

Answer:

Ask him to complete the ORS again according to how he thinks this person would score it on his behalf. This can initiate a discussion about why this person thinks the client needs therapy and what the client thinks about this.

Question:

A client consistently scores the maximum score on the SRS but I suspect that she is not always happy with the service I'm giving. How should I address this?

Answer:

Thank the client for her feedback. Ask her to reflect if there is anything you can do differently to make the sessions even more helpful or to move the work to the next stage.

Question:

A client routinely marks an item on the SRS at around 6 to 7 out of 10, but when I ask him about this he says that this represents a good score from him and he is quite happy with the service. Should I keep asking him about it each session?

Answer:

Thank him for his feedback, accept his explanation and reiterate that you really want to know if there is something different you could be doing to make the therapy more helpful (e.g., that would increase the score to an 8 or 9). If the scores stay as they are, continue to accept his explanation and don't persist with questions about it. Monitor the SRS carefully though, and be ready to address it again if the score goes down.

Question:

A client refuses to complete the ORS and/or SRS. How should I respond?

Answer:

Accept his decision and his right to make it. Explain however that for the work to have the best chance of success, you need to be getting regular feedback from him and that you will be verbally checking this with him on a regular basis.

Question:

A client has been showing steady improvement on the ORS over four sessions but at the fifth one his score has fallen to only slightly above his intake score. How should I address this with him?

Answer:

Ask him if the sudden fall relates to his feelings about how he is dealing with the issues that brought him to therapy and that the therapy has focused on. If it does then review with him how he has experienced improvement previously and what has led to his change of view now. Also go over each item of the SRS and double check the strength of the therapy alliance. If the fall relates to another factor unrelated to the issues that brought him to therapy, ask him to do the ORS again in light of these issues.

Question:

A client scores the goals and topics line on the SRS at 4 out of 10 but in the subsequent discussion, insists on taking responsibility for this herself. She says there is nothing she wants the therapist to do differently and that it was her problem because she could not cover all the issues she wanted to in the time available. How should I respond?

Answer:

Be gently persistent without putting pressure on the client or invalidating what she is saying. Ask her to think if there is anything you can do differently, however small, to help her to manage the time better and cover the issues most important to her.

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Appendix 1

Outcome Rating Scale (ORS)

Name _____Age (Yrs):____ Sex: M / F
Session # ____ Date: _____
Who is filling out this form? Please check one: Self_____ Other_____
If other, what is your relationship to this person? _____

Looking back over the last week (or since your last visit), including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels. *If you are filling out this form for another person, please fill out according to how you think he or she is doing.*

Individually
(Personal well-being)

I----------I

Interpersonally
(Family, close relationships)

I----------I

Socially
(Work, school, friendships)

I----------I

Overall
(General sense of well-being)

I----------I

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| Appendix 1 (continued) |

Session Rating Scale (SRS V.3.0)

Name _____Age (Yrs):____
ID# _____ Sex: M / F
Session # ____ Date: _____

Please rate today's session by placing a mark on the line nearest to the description that best fits your experience.

Relationship

I did not feel heard, understood, and respected.	I----------I	I felt heard, understood, and respected.

Goals and Topics

We did *not* work on or talk about what I wanted to work on and talk about.	I----------I	We worked on and talked about what I wanted to work on and talk about.

Approach or Method

The therapist's approach is not a good fit for me.	I----------I	The therapist's approach is a good fit for me.

Overall

There was something missing in the session today.	I----------I	Overall, today's session was right for me.

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| Appendix 1 (continued) |

Child Outcome Rating Scale (CORS)

Name _____Age (Yrs):____
Sex: M / F_____
Session # ____ Date: _____
Who is filling out this form? Please check one: Child_____ Caretaker_____
If caretaker, what is your relationship to this child? _____

How are you doing? How are things going in your life? Please make a mark on the scale to let us know. The closer to the smiley face, the better things are. The closer to the frowny face, things are not so good. *If you are a caretaker filling out this form, please fill out according to how you think the child is doing.*

Me
(How am I doing?)

I----------I

Family
(How are things in my family?)

I----------I

School
(How am I doing at school?)

I----------I

Everything
(How is everything going?)

I----------I

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| Appendix 1 (continued) |

Child Session Rating Scale (CSRS)

Name _____Age (Yrs):____
Sex: M / F
Session # ____ Date: _____

How was our time together today? Please put a mark on the lines below to let us know how you feel.

Listening

_____ did not always listen to me.

I----------I

_____ listened to me.

How Important

What we did and talked about was not really that important to me.

I----------I

What we did and talked about were important to me.

What We Did

I did not like what we did today.

I----------I

I liked what we did today.

Overall

I wish we could do something different.

I----------I

I hope we do the same kind of things next time.

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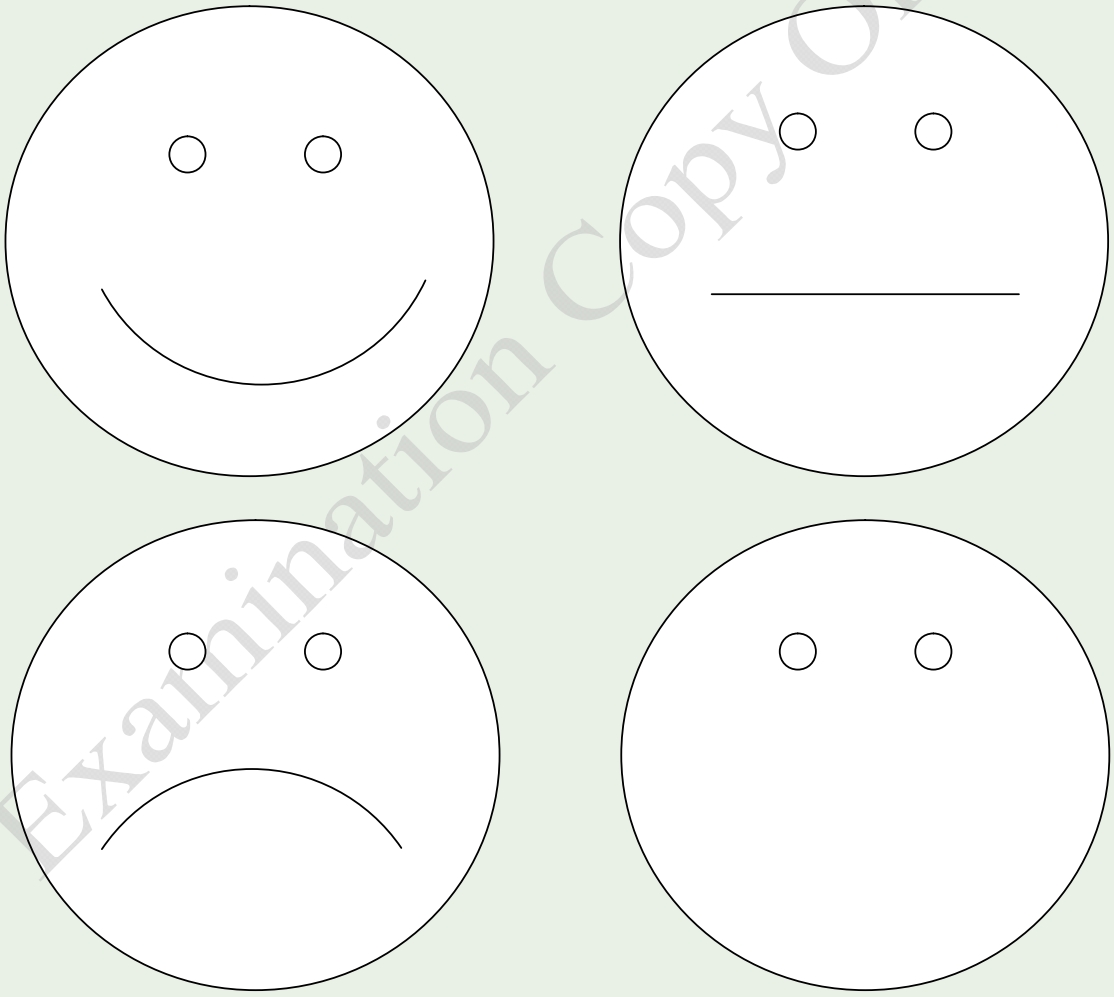
Appendix 1 (continued)

Young Child Outcome Rating Scale (YCORS)

Name _____Age (Yrs):____
Sex: M / F_____
Session # ____ Date: _____

Choose one of the faces that shows how things are going for you. Or, you can draw one below that is just right for you.



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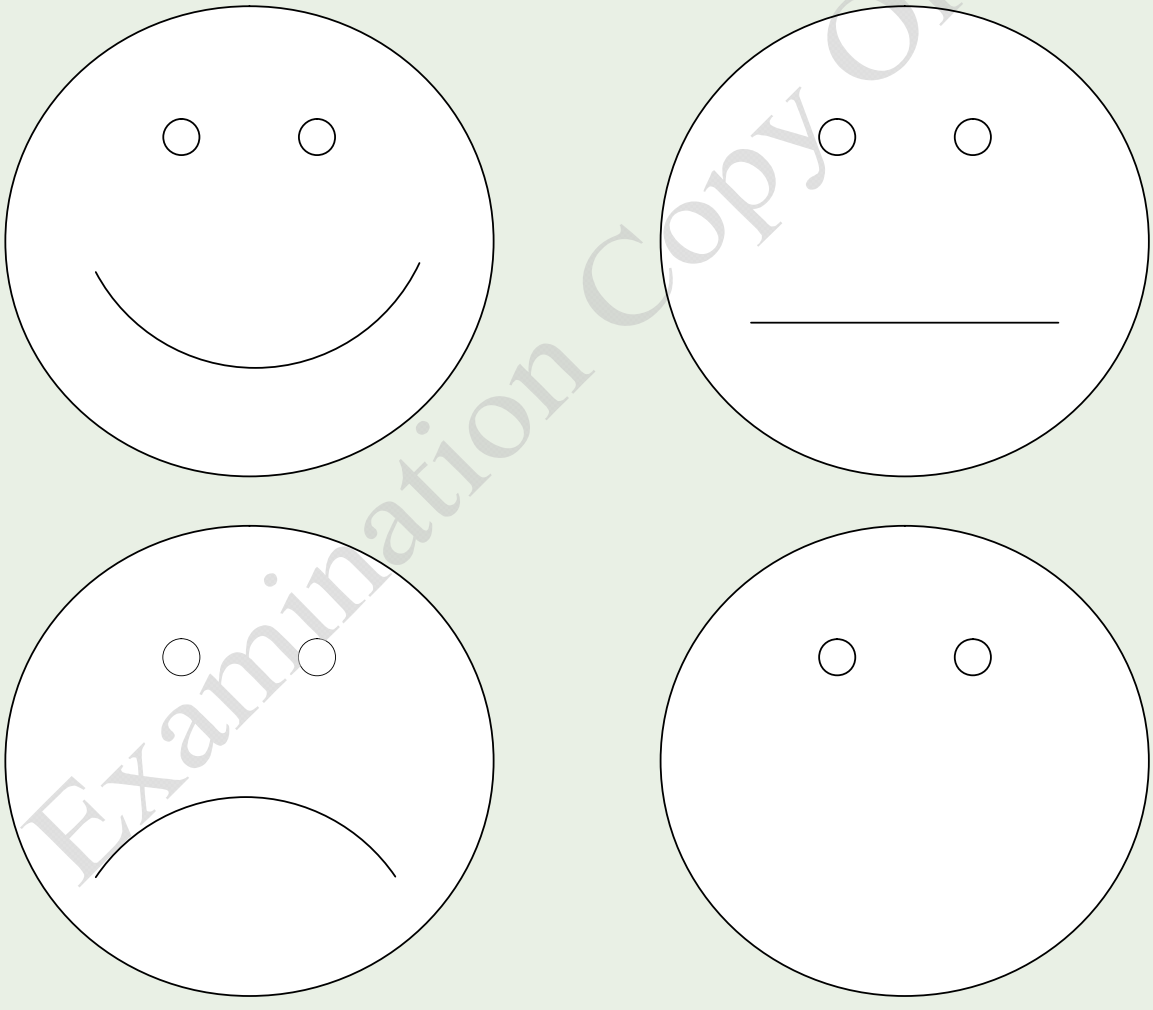
| Appendix 1 (continued) |

Young Child Session Rating Scale (YCSRS)

Name _____Age (Yrs):____
Sex: M / F_____
Session # ____ Date: _____

Choose one of the faces that shows how it was for you to be here today. Or, you can draw one below that is just right for you.



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Appendix 1 (continued)

Group Session Rating Scale (GSRS)

Name _____Age (Yrs):____
ID# _____ Gender_____
Session # ____ Date: _____

Please rate today's group by placing a mark on the line nearest to the description that best fits your experience.

Relationship

I did not feel understood, respected, and/or accepted by the leader and/or the group. I----------I I felt understood, respected, and accepted by the leader and the group.

Goals and Topics

We did *not* work on or talk about what I wanted to work on and talk about. I----------I We worked on and talked about what I wanted to work on and talk about.

Approach or Method

The leader and/or the group's approach is a not a good fit for me. I----------I The leader and group's approach is a good fit for me.

Overall

There was something missing in group today—I did not feel like a part of the group. I----------I Overall, today's group was right for me—I felt like a part of the group.

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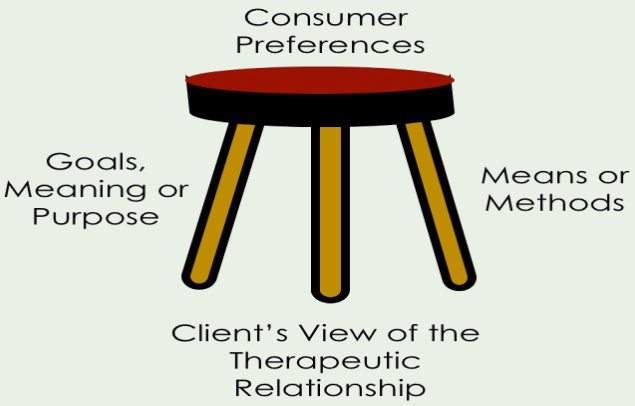
Appendix 2

Feedback-Informed Progress Note

Name:	
Date:	
ORS Administered: ❑ Yes ❑ No Collateral score:	Progress: → ↑ ↓
Progress addressed in session by:	
Between session plan: Maintain and Consolidate gains/Address Deterioration/Revise approach	
SRS Administered: ❑ Yes ❑ No	Above 36 Below 36 Increasing Same Decreasing
SRS Addressed directly: ❑ Yes ❑ No	
Clinician signature:	Consumer signature:

Appendix 3

Feedback-Informed Service Delivery Agreement



Name:	Date:
Consumer's stated reasons/motivation for seeking services:	
Agreed upon goals/meaning/purpose/preferences for services:	
Agreed upon means/methods (including type, frequency, provider):	
Feedback-Informed process explained (Outcome & Alliance Tracking): ❑ Yes ❑ No	
Clinician signature:	Consumer signature:

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