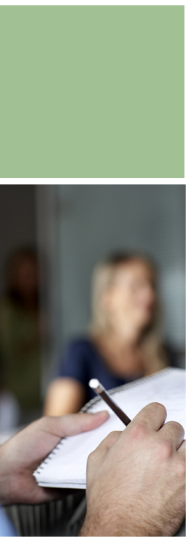

INTERNATIONAL CENTER FOR CLINICAL EXCELLENCE

Manual 3

Feedback-Informed Supervision

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.

Manual Authors:

Manual 1: What Works in Therapy: A Primer
Bob Bertolino, Susanne Bargmann, Scott D. Miller

Manual 2: Feedback-Informed Clinical Work: The Basics
Susanne Bargmann, Bill Robinson

Manual 3: Feedback-Informed Supervision
Cynthia Maeschalck, Susanne Bargmann, Scott D. Miller, Bob Bertolino

Manual 4: Documenting Change: A Primer on Measurement, Analysis, and Reporting
Jason Seidel, Scott D. Miller

Manual 5: Feedback-Informed Clinical Work: specific populations and service settings
Julie Tilsen, Cynthia Maeschalck, Jason Seidel, Bill Robinson, Scott D. Miller

Manual 6: Implementing Feedback-Informed Work in Agencies and Systems of Care
Bob Bertolino, Rob Axsen, Cynthia Maeschalck, Scott D. Miller, Robbie Babbins-Wagner

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 specifically 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 6 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 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 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)" (p. 273, 276-277).

Manual 3

Feedback-Informed Supervision

In this manual, the basics of integrating Feedback Informed Treatment (FIT) into supervision are described and illustrated. The manual lays out the key principles and practical applications of FIT in both clinical and administrative supervision, including the typical challenges encountered during implementation in diverse practice settings. The manual also addresses how FIT supervision can help clinicians improve the quality and outcome of treatment. Although the focus of the manual is on supervising clinicians' use of the FIT measures – the Outcome Rating Scale (ORS) and the Session Rating Scale (SRS) – the principles and practices in this manual are transferable to other outcome and alliance measures (i.e., Clinical Outcomes in Routine Evaluation [CORE], Outcome Questionnaire [OQ], the Working Alliance Inventory [WAI], etc.). A brief overview of core principles and practices of FIT can be found in Appendix 1 (detailed information is available in Manuals 1 and 2). The manual concludes with a quiz, list of frequently asked questions (FAQ) and references.

Manual 3 is divided into four sections:

1. Key principles of FIT supervision;
2. Practical applications of FIT supervision;
3. "Red flags" for supervisors;
4. Assisting clinicians with continuous professional development.

Key Principles of FIT Supervision

As is true of FIT in general, FIT supervision is a meta-theoretical approach. Where traditionally supervisors are guided by a particular treatment model or theoretical orientation, FIT supervision is guided by outcome and alliance feedback provided by clients. As such, FIT supervision may be applied across therapeutic modalities, disciplines, and service settings.

Why is it Important to Include Client Feedback in Supervision?

Three consistent findings from psychotherapy outcome research (each of which is reviewed in detail in Manual 1) underscore the importance of seeking and using client feedback about alliance and outcome to guide treatment:

- Dropout rates in behavioral health are notoriously high, averaging 47% with adults (Wierzbicki & Pekarik, 1993) and between from 28% to 85% for children and adolescents (Garcia & Weisz, 2002; Kazdin, 1996), indicating significant and consistent failure on the part of practitioners to engage many clients (Duncan, Miller, Wampold, & Hubble, 2010);
- A small percentage of clients (~10%) account for the largest percentage (~60-70%) of behavioral health care expenditures, indicating a continued use of services without successful outcomes (Lambert et al., 2003);
- Clinicians are not adept at identifying clients at risk for deterioration and/or dropout (Hannan et al., 2005).

Available evidence documents that routine monitoring of outcome and the alliance, helps clinicians identify and address "at risk" clinical situations thereby resulting in improved effectiveness, and decreased dropout and deterioration rates (Miller, 2011).

FIT supervision is guided by the following empirically supported principles:

- *The client's experience of the alliance and outcome are the best predictors of retention and progress in treatment;*
- *Because of the low correlation between client and clinician ratings of outcome and alliance, therapists must routinely seek client feedback via valid and reliable measures of the alliance and outcome;*
- *No one model, method, or clinician is sufficient for treating all problems;*
- *Feedback is crucial to addressing the diverse problems and people seeking behavioral health services.*

Whether clinical or administrative in nature, the primary objective of FIT supervision is to ensure services being delivered engage the client and are effective in each case. In some instances administrative supervision is independent of clinical supervision; in others, the two are combined. In the material that follows, the two types are covered separately to highlight tasks unique to each.

FIT Administrative Supervision

Implementing outcome and alliance measures in large practice settings can be challenging. Experience makes clear that administrative involvement and oversight are essential for maintaining FIT in routine clinical practice. Administrative supervision means providing the infrastructure necessary to insure that:

- Clinicians administer the measures correctly (i.e., adjusting introduction of the scales, timing of the scales, etc.);
- Barriers to administration and integration of the scales into clinical practice are identified and solutions explored and implemented;
- Compliance with FIT practice and principles is uniform across clinicians and treatment programs.

The primary task of the administrative supervisor is putting structures in place that will maintain the use of FIT. Making sure that the staff receives the necessary training in FIT, including the rationale, how to use outcome and alliance feedback, and how to interpret the data is an essential first step (covered in Manual 6, this manual, and Manual 4, respectively). Beyond that is the establishment of a work culture, including policies and procedures, conducive to FIT practice.

Without support from the top, including transparent and frequent communication about the importance of FIT in reaching agency goals and objectives (i.e., accountability to funders, to be able to work with clinicians falling below the agency average to improve their performance, to increase the overall performance of the agency, etc.), implementation almost always fails. Administrative supervisors must develop clear policies regarding how outcome and alliance data will and will not be used in the agency (e.g., to improve the care for clients, not to hire or fire staff). Rewarding or punishing clinicians for feedback received from clients via the measures is contraindicated by available evidence and, therefore, strongly discouraged. Reviewing therapist compliance with using the scales and feedback is, by contrast, strongly recommended and should be a formal part of any performance review.

Administrative supervisors are responsible for developing structures and processes which insure that outcome and alliance data are integrated across all contexts in which clinical work is discussed and treatment decisions made (e.g., intake meetings, case conferences, treatment planning sessions). Data should always be "front and center" any time a case is discussed in order to insure that client feedback guides service delivery. Encouraging and acknowledging efforts go a long way in developing a supportive environment for FIT as does requiring that everyone in contact with clients participates in gathering and reviewing data. No one should be

excused from asking for feedback: not supervisors, part-time clinical staff, nor consultants (including those providers limited to prescribing pharmaceutical products or conducting assessments).

Data are central to FIT. As such, the administrative supervisor must oversee data management and reporting procedures. Often, but not always, this includes managing the interface between clinicians and technology. If a computer-based outcome management product is employed, it is vital that clinicians know how to use the system and where to obtain help so that access to feedback in real time is not impeded. Many agencies have found it useful to invest in the creation of FIT "champions," local experts who have received special training and can address questions and barriers as they arise.

The FIT Administrative Supervision Checklist

- ❑ *Model the principles and practices of FIT in interactions with clients and clinicians;*
- ❑ *Monitor the involvement of clients and/or their feedback in all discussions about clients and treatment planning sessions;*
- ❑ *Establish clear policies regarding the use of data generated by client feedback (i.e., not for employee evaluation, rather for mentoring, coaching, and working toward positive outcomes for clients);*
- ❑ *Set clear standards for assessing compliance with FIT practices and principles;*
- ❑ *Provide the necessary oversight and leadership to ensure successful implementation and integration of FIT practices including:*
  - * *Providing clinicians with adequate and ongoing training in FIT;*
  - * *Identifying and addressing roadblocks to implementing FIT practices;*
  - * *Being available to support and consult with clinicians as needed.*
- ❑ *Establish clear standards and methods for data management and reporting.*

FIT Clinical Supervision

FIT clinical supervision is focused on integrating feedback obtained via the routine administration of outcome and alliance measures in clinical practice. Emphasis is placed on identifying and addressing services "at-risk" for drop-out, deterioration, or null treatment effects.

Given the importance of the therapeutic alliance in successful treatment, FIT clinical supervision is informed by the client's goals and preferences for treatment (see Figure 1). When alliance scores are low or progress is absent, slow, or uneven, the supervisor explores:

a. The client's goals for treatment;

b. Different methods or levels of care;

c. Additional services or providers.

Detailed information for dealing with "at risk" cases will be presented in section 3, "Practical Applications of FIT Supervision."

Establishing a culture in which clinicians feel safe discussing difficulties, challenges, and mistakes, is crucial and can be accomplished by responding openly to questions, validating clinician concerns regarding FIT, and seeking feedback from clinicians regarding the supervision process.

It is important to remember that supervisors are role models. As such, they need to use FIT in their own clinical work as well as be confident and possess a solid understanding of the research underpinnings, key principles, and practical application of FIT.

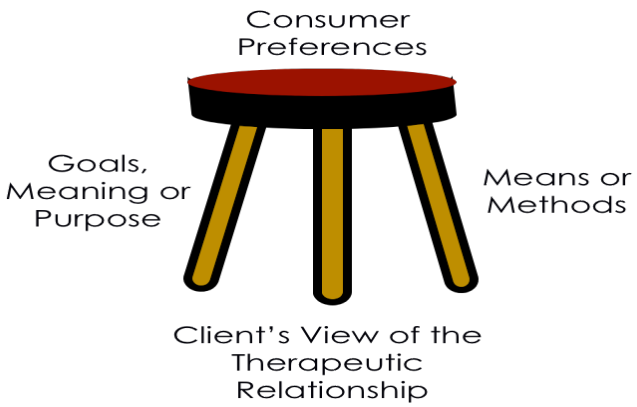

Figure 1: The therapeutic Alliance

FIT Clinical Supervision Checklist

- ❑ *Build trust with clinicians and teams by using client feedback constructively rather than punitively;*
- ❑ *Be open to acknowledging, validating, and addressing clinicians' fears and concerns about FIT;*
- ❑ *Acknowledge clinicians' efforts to use FIT ideas in their practice and commend clinicians' willingness to present cases for consultation;*
- ❑ *Emphasize the opportunities for learning that failing cases bring;*
- ❑ *Demonstrate a willingness to share and learn from their own failures;*
- ❑ *Encourage a balance between presenting successful cases and cases of concern in supervision;*
- ❑ *Provide clear guidelines for communication in the supervision group and model respectful communication;*
- ❑ *Act as a role model by demonstrating the introduction and integration of outcome and alliance measures;*
- ❑ *Encourage consultation on "at risk" cases;*
- ❑ *Acknowledge that there is a learning curve for clinicians as they start to employ a FIT approach and demonstrate patience, understanding, and support for clinicians as they learn;*
- ❑ *Inspire clinicians to establish baselines of performance, to learn new skills, and to increase their repertoire of treatment approaches thereby increasing their ability to match treatment approaches with client preferences.*

Practical Applications of FIT supervision

FIT supervision can be applied in both individual and group supervision formats. Group supervision can provide particularly rich learning opportunities, enabling clinicians to learn and share ideas with peers about how to introduce, integrate, and use the feedback tools to guide practice decisions. Group supervision has also proven helpful in addressing the skepticism and reluctance some clinicians display when asked to seek and use formal feedback in their work. It can be reassuring to hear about other clinicians' experiences of the benefits of using formal feedback in their work.

In particular, FIT clinical supervisors check:

- Are outcome and alliance measurement tools being completed at each session?
- Is client feedback about well-being and about the therapeutic alliance being used? If so, how?

Whether provided individually or in a group, FIT supervision begins with a presentation of the outcome and alliance data for the particular service recipient being discussed. Data regarding progress from session to session are reviewed. When progress is absent or uneven, alliance scores are reviewed and clinical information is explored to determine how services may be altered to better meet client goals and preferences (see Figure 1). When supervision occurs in a group, peers can work together as a team, helping explore options and possibilities for improving service delivery.

In discussing particular cases, the FIT supervisor probes for key information regarding the alliance:

- Do outcome scores indicate that the client is making progress?
- Do scores on alliance measures reflect positive relationships?
- If no progress is evident or alliance measures indicate possible concerns, is the clinician addressing this with the client? What is the plan to address lack of progress or alliance issues?
- Has the clinician explored what the client wants from treatment? Has the client stated a goal for treatment?
- Has the clinician asked the client what his or her ideas are about how change happens?

- Has the clinician asked the client about his or her preferences regarding the therapy relationship (i.e., gender preferences, cultural awareness, specialized approaches, etc.)?
- Has the clinician asked the client about his or her expectations regarding the clinician's role?
- Is the clinician discussing outcome and alliance scores and the meaning the client puts to those scores with clients?

Appendix 2 provides a more comprehensive checklist for supervisors for discussing outcome and alliance data with clinicians.

Identifying cases for review in supervision

One of the primary reasons for routinely tracking outcome and alliance is identifying cases at risk of deterioration or drop out while in care. Determining whether a case is "successful" or "at risk" involves comparing the progress made by individual clients to normative projections. Appendix 3 offers a glossary of essential terms to help supervisors interpret client feedback gathered on the ORS and SRS. Manual 4 of this series provides in-depth discussion of how to calculate and interpret outcome statistics, including normative projections. Differentiating successful from at-risk cases optimizes the impact of feedback for supervisees and their clients.

Successful cases

An episode of care is considered successful when the client's scores on the outcome measure (e.g., improved ORS scores) equal or exceed the benchmark established by the normative sample. Computerized systems provide a progress benchmark for each client that is equal to the amount of change in scores necessary to qualify as "reliable." Briefly, a change is considered reliable when it is greater than chance, measurement error, or other random variation in scores (Jacobson,1988; Jacobson, Folette & Revenstorf, 1984; Lambert & Hill, 1994). When working with the paper and pencil version of the scales, a difference in scores of 5 points between sessions may be used as an indication that a reliable change has occurred in client functioning (Miller & Duncan, 2004).

Reviewing successful cases is an important part of FIT supervision as doing so provides opportunities to highlight clinician successes, highlight the effectiveness of therapy in general, and consolidate knowledge about "what works" in treatment.

At-risk cases

In FIT, a case is considered at risk whenever the outcome or alliance scores indicate an increased probability of dropout or a null or negative outcome from treatment. Available evidence indicates that certain patterns of ORS and SRS scores are more frequently associated with risk for dropout or negative outcome. The patterns include:

1. Scores at or above the clinical cutoff;
2. Lack of progress on the ORS;
3. Fluctuating ORS scores;
4. Problematic alliance scores.

In the material that follows, each of these patterns is described and strategies presented for addressing them in supervision.

1. Scores at or above the clinical cutoff:

Clients scoring above the clinical cutoff at intake are at increased risk for deterioration and dropout from treatment. Consider the predicted trajectory of a client with an initial ORS score of 39 (see Figure 2). The predicted response (based on the normative sample data) follows a trajectory of increased distress over the course of treatment.

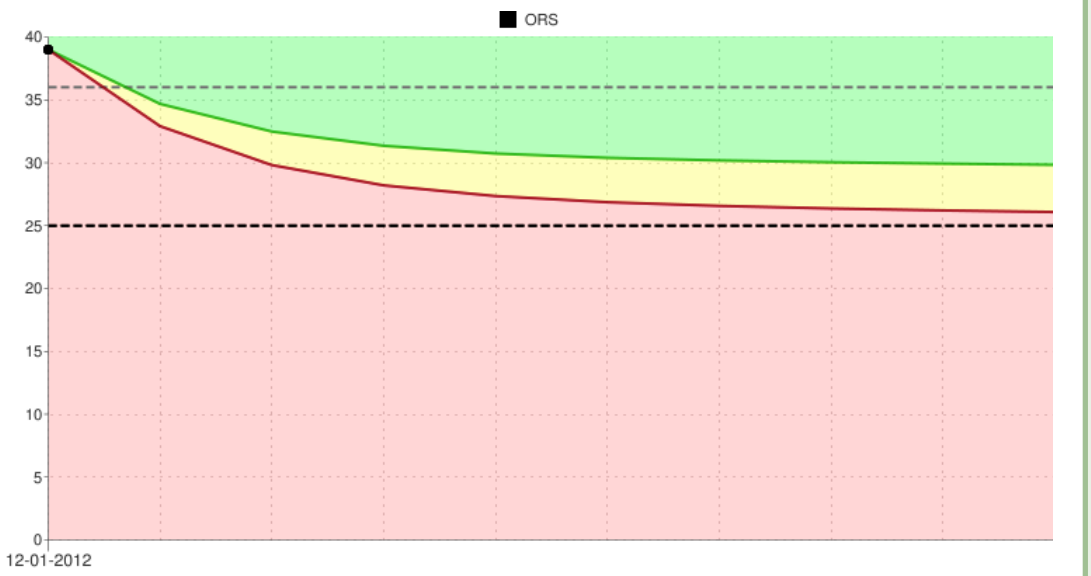

Figure 2: Sample Chart of the ORS

Caution is warranted when scores on the ORS fall above the clinical cutoff at the initial session. Supervisors should encourage clinicians to explore the client's reasons for seeking help. In situations where the client is mandated into care, clinicians can ask the client to fill out the ORS as if he or she was the referring agent. The resulting scores can be used, in turn, to engage the client in a conversation about addressing the goals of the mandating authority.

Clients presenting with a specific problem (e.g., simple phobia) can sometimes score above the clinical cutoff at intake. In such instances, supervisors should encourage the therapist to focus on addressing that particular problem and avoid depth-oriented and exploratory treatment strategies.

In those rare instances where a high score is not associated with a particular presenting complaint or an external mandate to seek services, the supervisor should strongly encourage the supervisee to clarify the purpose of therapy before proceeding in order to avoid engaging the client in a potentially countertherapeutic or harmful service. (Further information about working with clients scoring above cutoff on the ORS at intake is available in Manual 2.)

In general, the lower the ORS score at intake, the greater the sense of distress a client feels, and the faster he or she begins to report change. By contrast, the higher the ORS score at intake, the less the sense of distress a client feels, and the slower he or she is to report change. Considering where the score falls in relation to the clinical cutoff can provide guidance about the dose and intensity of services most likely to facilitate engagement and decrease the chances of deterioration and drop out:

- **When the score is at or close to the clinical cutoff:** Expect change to happen over time, consider lowering the dose of treatment, and space out the visits.
- **When the score is below the cutoff (around 18-19):** Expect change to happen sooner rather than later, with increased intensity / dose at the beginning of treatment, and spacing out visits after the ORS has increased.
- **When scores are much lower than the cutoff (around 5-10):** Expect large changes early in treatment and offer treatment with a high dose and intensity. Rule out risk to self and others.

2. Lack of Progress on the ORS:

A lack of progress in treatment is associated with: (1) higher no-show and drop out rates; and (2) the continued provision of ineffective services. The latter is associated with higher levels of clinician burnout and the tendency to assign blame to the client for the lack of progress. Supervisors help clinicians remain alert to these risks by comparing client scores to established benchmarks from session to session.

Since the majority of improvement and greatest risk of drop out occurs early in treatment, supervisors should review all cases showing deterioration or underperforming the predicted trajectory (or when using the paper and pencil instruments, the reliable change index). When scores indicate a lack of progress in the first 3 to 4 sessions, the supervisor should work with the clinician to generate ideas about adjusting the alliance (see Figure 1). At weeks 6 to 7, supervisors should encourage the exploration of other elements that may be added to the treatment (e.g., increasing the frequency or intensity of treatment, having a medical check-up, getting more specific help finding a job, seeing a psychiatrist, referral to a dietician). By weeks 8 to 10, supervisors should encourage clinicians to explore whether a referral to another provider, treatment type, or setting is advisable.

Figure 3 shows a client who is not making progress by his or her fourth session. In such circumstances, there is a strong temptation to attribute the lack of progress to external, extra-therapeutic factors. Supervisors help by identifying the actions that can be taken to address the failure of the current service to bring about progress including: (1) having an open and transparent discussion with the client about the lack of progress or deterioration; (2) identifying and addressing any problems in the alliance; (3) inviting a colleague or supervisor to join the session with the client; and (4) considering other service and support options (e.g., another service provider, different dose or intensity, alternative treatment approach, etc.).

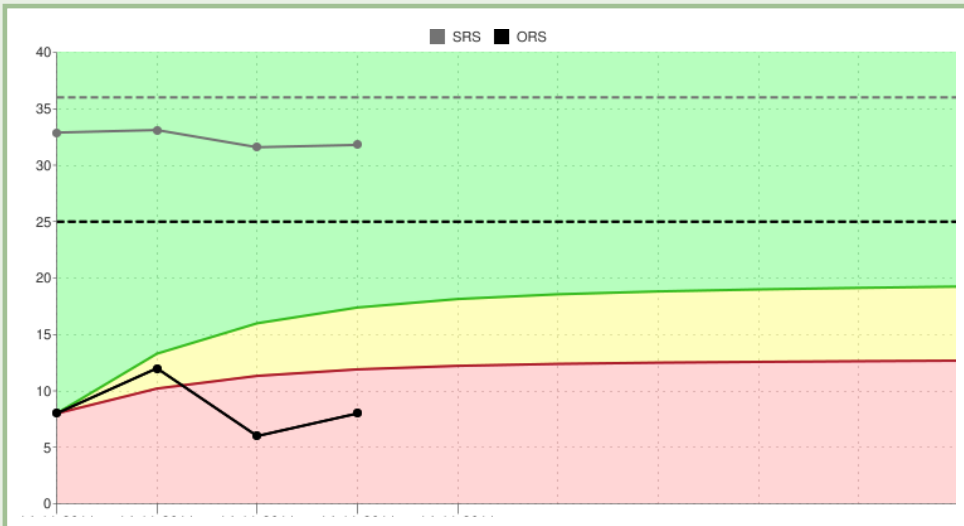

Figure 3: Sample Chart of the ORS

When ORS scores are high and flat, supervisors should encourage the supervisee to explore whether the pattern of scores is an indication that the maximum amount of progress has been achieved or if the ORS is no longer capturing the client's sense of well-being and progress. In the latter instance, supervisees can be instructed to help clients "recalibrate" the scale, redefining the numbers by asking the client to imagine how his or her vision of the best scores may have changed as a result of progress made and adjusting accordingly. For example, the client could be asked, "Pretend this is your first session in therapy, having never completed the ORS before, and you were here seeking help for how things are now, how would you fill in the ORS?"

Figure 4 is an example of a client whose scores on the ORS indicate that maximum benefit from services may have been reached. The client's scores on the ORS (as indicated by the black line) have exceeded the benchmark (as indicated by the green zone) for progress and remained at the highest levels for 7 visits.

If in consultation with the client, the client scores indicate a maximum benefit from treatment has been achieved, supervisors should encourage clinicians to: (1) work with the client to develop a plan to maintain gains after termination; and (2) talk with the client about decreasing the dose and intensity of services (i.e., spreading out sessions).

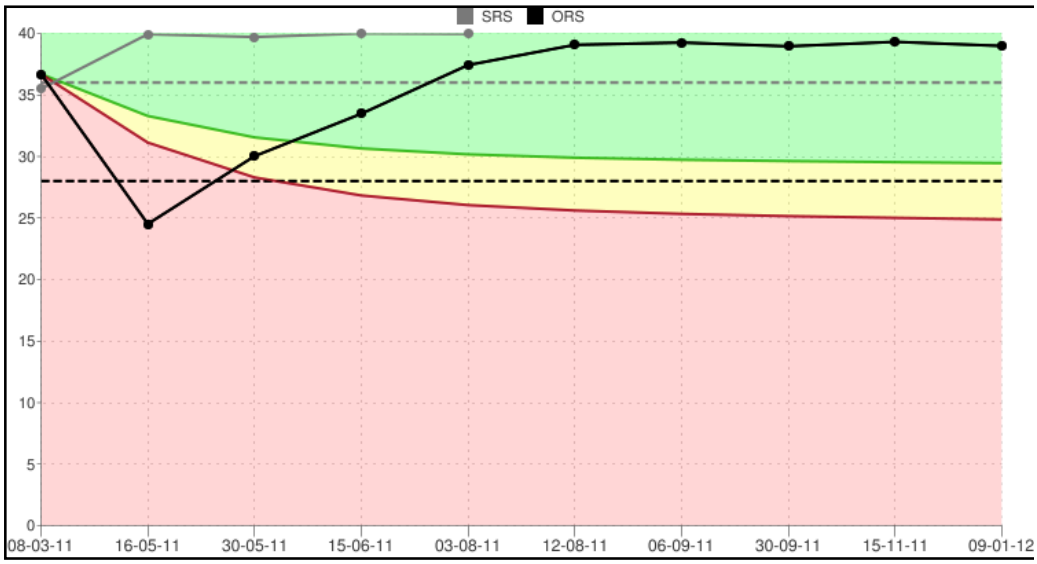

Figure 4: Sample Chart of the ORS

3. Fluctuating ORS scores:

Several patterns of fluctuating ORS scores are associated with poor treatment outcome and drop out from services, including: (1) see-sawing; (2) bleeding; and (3) ditching.

See-sawing, as the name implies, involves wide fluctuations in scores from visit to visit (see Figure 5). Experience indicates that up and down movements are attributable to: (1) clients not following the directions when completing the scale; (2) normal variation in nonclinical levels of functioning, typical of everyday life; (3) an expression of a life with large, dramatic, sudden changes in functioning; or (4) ineffective treatment. Each of these circumstances carries some risk of clients feeling disempowered over time and/or dropping out of services.

When supervisors identify a "see-saw" pattern of change they should first insure that the clinician read the directions for completing the ORS together with the client. See-saw scores are often a result of clients completing the form based on how they feel at the moment. The directions specify that clients complete the form while thinking back over the last week or since the last visit.

For clients who start above the clinical cutoff, or who have met or exceeded the benchmark of predicted change, some variation in ORS scores is typical and reflects normal day-to-day (or week-to-week) variation in functioning. The supervisor can suggest that the supervisee work to increase the length of time between sessions. Doing so minimizes the possibility of needlessly extending services thereby reducing the risk of discouragement and/or drop out. The supervisor can also encourage the clinician to shift the focus of services to aftercare planning.

Variation in ORS scores from session to session not attributable to either of the first two circumstances may indicate that treatment is not producing the desired progress. This lack of progress increases the client's risk of a negative or null outcome and/or dropping out. Here again, there is a strong temptation to attribute the overall lack of progress to external, extra-therapeutic factors or to the client (e.g., "resistance" to treatment). Supervisors help by identifying the actions that clinicians can take to address the failure of the current service to bring about a more stable pattern of change including: (1) having an open and transparent discussion with the client about the fluctuations; (2) identifying and addressing any problems in the alliance; (3) inviting a colleague or supervisor to join the session with the client; and (4) considering other service and support options (e.g., another service provider, different dose or intensity, alternative treatment approach, etc.).

Before reading on, consider whether the graph at right indicates that the client: (1) did not follow the directions when completing the scale; (2) is experiencing normal variation in nonclinical levels of functioning, typical of everyday life; (3) is experiencing large, dramatic, sudden changes in functioning; or (4) is not being helped by the treatment. See the answer below.[1]

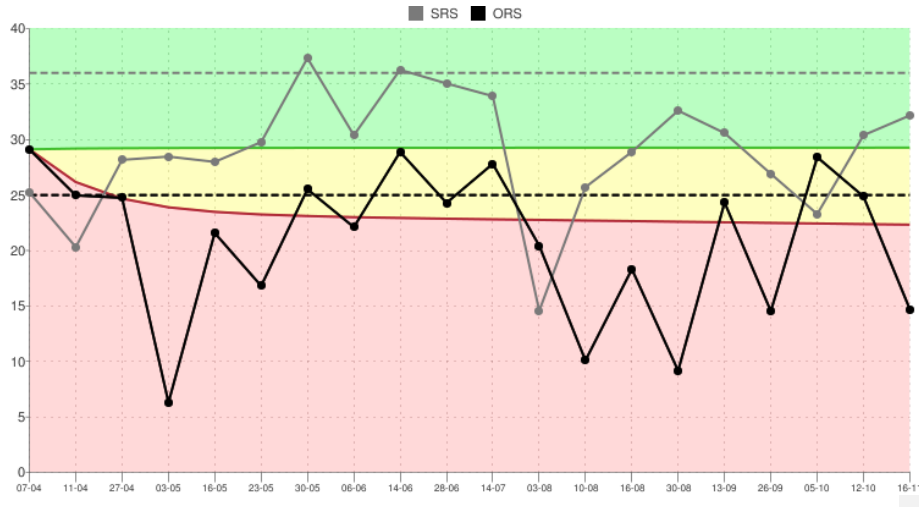

Figure 5: See-Saw Pattern

The next pattern of fluctuating scores is bleeding. This refers to a gradual decrease in ORS scores over time (see Figure 6). Often, though not always, gradual deterioration in scores follows an early and often pronounced improvement in ORS scores early in the treatment process. In such cases, the supervisor should encourage the clinician to explore the reasons for the decline as well as the structures and skills needed to help clients maintain gains between visits.

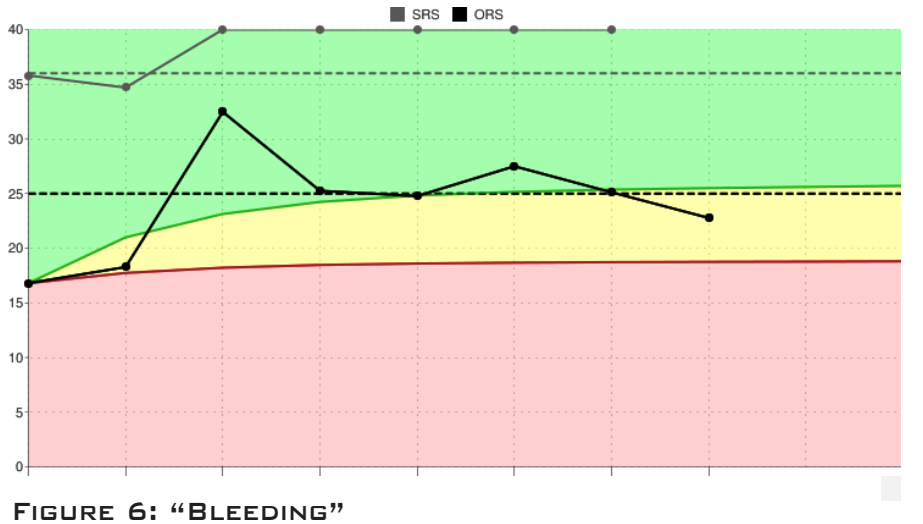

Figure 6: "Bleeding"

[1]The graph indicates not only that treatment is not helping but that the client is deteriorating.

Ditching refers to a dramatic drop in ORS scores (see Figures 7, 8, and 9). Often, though not always, ditches are attributable to external circumstances outside of the client's and/or therapist's control. Most often such downturns resolve quickly, returning to prior levels of functioning within a session or two (see Figure 7). In such instances, supervisors should encourage therapists to continue with treatment as usual rather than making the downturn a topic of treatment.

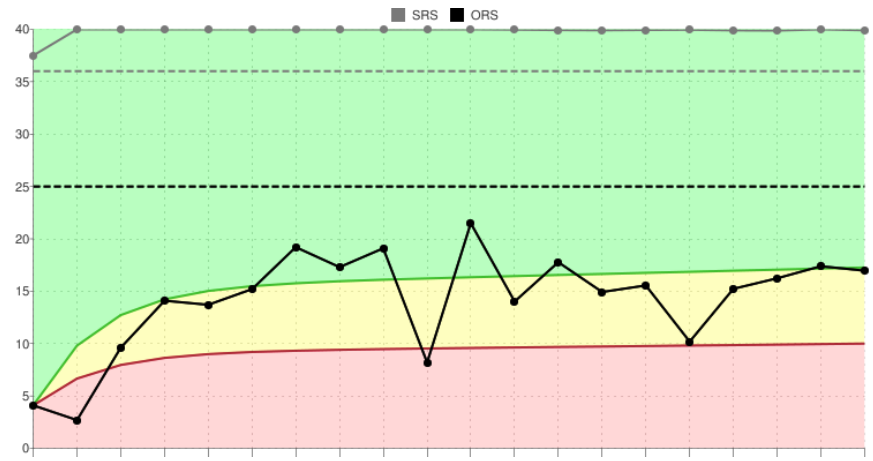

Figure 7: "Drop" in Session 10 and Session 16

Figure 8 shows a graph containing two patterns of fluctuating scores: ditching followed by bleeding. Although extra-therapeutic factors may be identifiable and responsible for the deterioration, it is important in this instance that supervisors get clinicians to take immediate action to alter services in order to avoid drop out or a risk of negative or null outcome, including: (1) discussing the deteriorating scores with the client; (2) identifying and addressing any problems in the therapeutic alliance; (3) inviting a colleague or supervisor to join the session with the client; and (4) considering other service and support options (e.g., another service provider, different dose or intensity, alternative treatment approach, etc.).

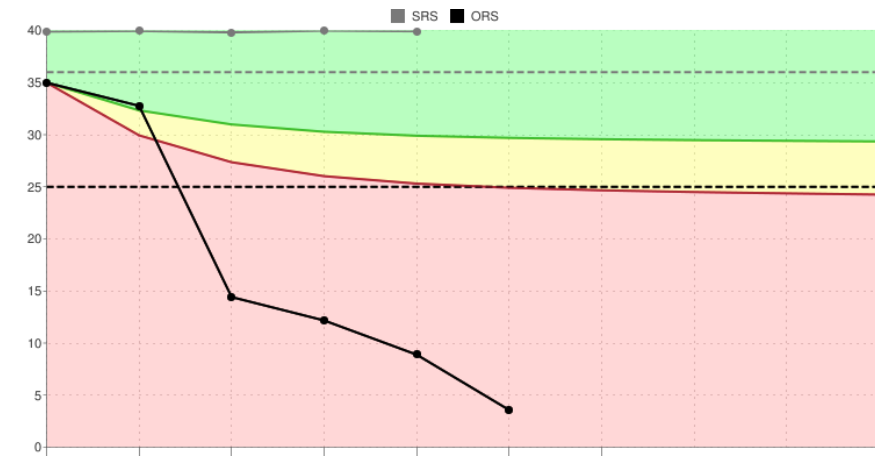

Figure 8: "Ditching Followed by Bleeding"

Before reading on, review the graph in Figure 9 at right and determine whether it is an example of see-sawing, bleeding, ditching, or some other pattern. What specific actions should the supervisor take? What should the supervisor have recommended the therapist do with the client at the second visit? Does the ORS score at the third visit indicate that the client is deteriorating or making progress? Answers and suggestions below.[2]

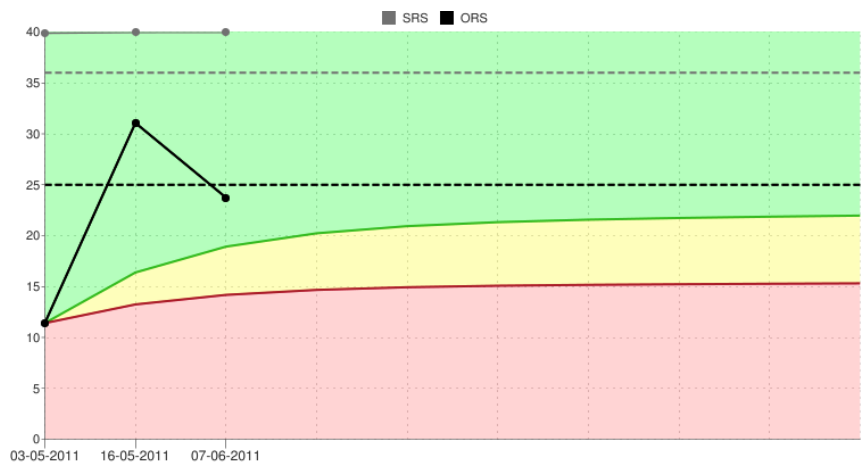

Figure 9

[2]The answer is: some other pattern. In this particular example, the client scored well below the clinical cutoff at intake, indicating a high level of distress. At session two, the client reported a dramatic improvement in functioning. It is not uncommon in such instances for scores to return more average levels of progress. Following significant improvement, supervisors should encourage therapists to prepare clients by predicting a future decrease and helping identify potential difficulties and strategies for maintaining change. As such, scores that return to more average levels of change can be seen as making progress that is more sustainable.

4. Problematic Alliance scores:

Problems in the alliance are associated with higher drop out and treatment failure rates. Addressing problems as reflected in SRS scores is, therefore, a critical component of FIT. Supervisors should encourage clinicians to explore the quality of the relationship whenever SRS scores: (1) fall below the clinical cutoff (see Figure 10); (2) decrease by a single point or more (see Figure 11); or (3) remain stubbornly high (see Figures 7 and 8).

Normative data indicate that 25 percent or fewer clients score below the SRS cutoff score of 36. The lower the score, the stronger the indication is of a problem in the therapeutic relationship. In such instances, supervisors should: (1) ask the clinician if the alliance scores were directly addressed with the client; (2) explore the clinician's reactions to client feedback about the alliance and stay alert to potential discomfort the clinician may have with negative feedback; (3) suggest that the clinician explore some changes in the treatment method in collaboration with the client if the low SRS scores are coupled with a lack of improvement in outcomes by the third session; (4) encourage the clinician to consider consulting with the rest of the team if they have not already done so; (5) consider changing therapists if the poor SRS scores are accompanied by a lack of improvement in outcomes by the sixth visit; and (6) monitor client progress carefully.

Single point decreases on the SRS are associated with poorer outcomes at the end of treatment. As such, supervisors should insure that therapists are alert to small movements downward on the SRS, encouraging exploration even when the total score falls above the cutoff.

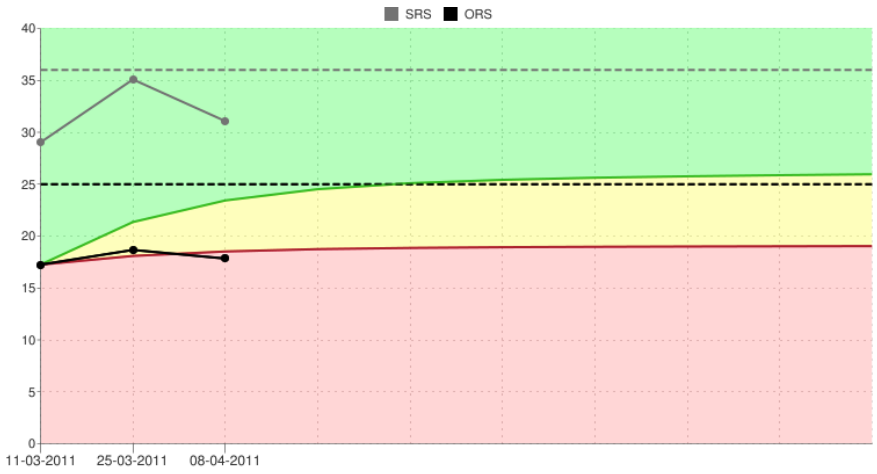

Figure 10: SRS Scores Below the Clinical Cutoff

Finally, high SRS scores from session to session accompanied either by a lack of clinical improvement or by deterioration indicate that a culture of honest and critical feedback from client to therapist may not have been achieved, and heighten the risk of long-term, ineffective care (see Figures 7 and 8). In such instances, supervisors can follow the same advice offered above for SRS scores falling below the clinical cutoff. Supervisors should also be prepared to work with the therapist to develop specific skills for eliciting negative feedback from the client.

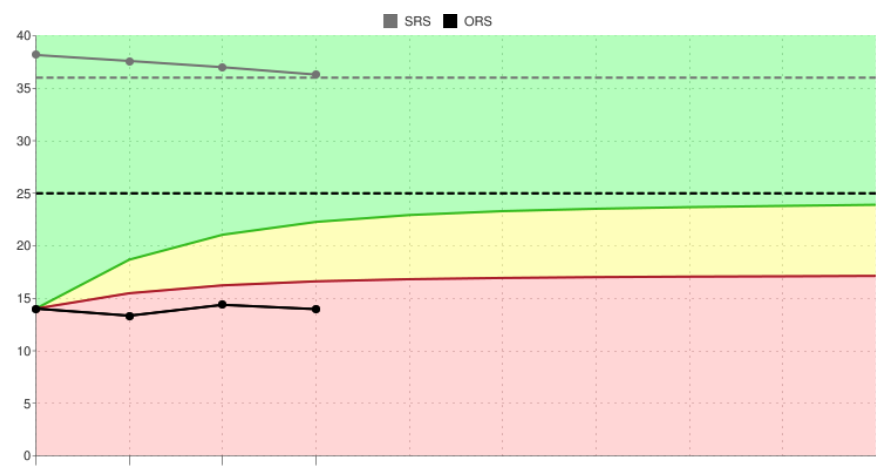

Figure 11: Decreasing SRS Scores

By contrast, if the ORS indicates that progress is being made, the supervisor should encourage the clinician to continue despite low alliance scores.

'Red Flags' for Supervision

A number of challenges emerge for clinicians when attempting to integrate FIT into clinical work. While not exhaustive, the list below summarizes a number of warning signs indicating potential problems for individual clinicians implementing FIT. Each is followed by suggestions for addressing the problem in supervision.

- Clinician uses language inconsistent with FIT practice (i.e., takes an overly diagnostic, distancing, client-blaming perspective).

  The supervisor highlights the inconsistent language and uses knowledge about psychotherapy outcome (reviewed in Manual 1 of this series) to suggest an alternative.

- When discussing nonprogressing cases, clinician is not able to describe client preferences or goals for treatment.

  The supervisor uses the three-legged stool (see Figure 1) to structure the supervision session, helping the clinician develop questions for soliciting information about the client's preferences and goals.

- Clinician is vague about how outcome and alliance measures are used in practice.

  The supervisor requires that therapists bring outcome and alliance measures to all supervision sessions. When absent, the supervisor explores possible obstacles or questions that are keeping the clinician from using the feedback tools.

- Clinician's no-show or drop out rates are higher than other clinicians at the agency or national benchmarks.

  The supervisor explores potential reasons for the higher than usual drop out rate directly with the clinician (e.g., problems in the alliance, poor treatment response, etc.) and helps the clinician develop strategies for improving the retention rates (i.e., work on introducing the culture of feedback, review videotapes from sessions).

- Clinician continues to see clients for long periods despite an absence of measurable progress by clients.

  The supervisor helps the clinician develop skills for talking with clients about ending treatment when progress has been achieved, including reviewing progress, spacing out visits, and stepping care down to a lower level of support (groups, self-help, etc.). The supervisor also encourages the clinician to develop a specific plan for ending treatment in collaboration with the client.

- Alliance scores consistently reflect problems with therapeutic relationships and client engagement.

  The supervisor works with the clinician to develop specific strategies for dealing with problems in the therapeutic alliance as reflected in SRS. The supervisor and clinician review video recordings of sessions with problematic alliance scores, stopping at various points and brainstorming engagement enhancing therapeutic behaviors.

- Clinician sees the formal use of outcome and alliance measures as an administrative rather than a relevant clinical task.

  The supervisor uses group supervision as a forum for sharing stories of how the outcome and alliance tools have helped clinicians in their work with clients. The supervisor organizes discussion around "at-risk cases," in order to demonstrate how outcome and alliance feedback can be used to inform and alter the course of treatment.

- Clinician outcomes are consistently lower than the agency norm or national benchmarks.

  The supervisor reviews the outcome data – including aggregate statistics (see Appendix 3) – with the clinician trying to identify patterns that reveal what might explain the lower outcomes (i.e., long-term nonprogressing clients). Based on this review the supervisor works with the clinician to develop specific strategies to improve his or her work (i.e., work on specific strategies and plans for ending the unsuccessful treatment episodes and referring to a different provider).

Assisting Clinicians With Continuous Professional Development

Supervisors can approach FIT supervision from both a "micro" and "macro" perspective. At a micro level, supervisors focus on helping clinicians improve individual client outcomes and integrate FIT practice into ongoing clinical work. The goal at the micro level is improving the outcome of treatment one client at a time.

At a macro level, supervisors focus on the ongoing professional development of clinicians. The goal at the macro level is helping to broaden supervisees' clinical skills and improve their overall effectiveness. According to research on expertise and expert performance (Miller, Hubble, & Duncan, 2007; Miller & Hubble, 2011), skill development and improved effectiveness result from the conscious and consistent application of three steps: (1) establishing a baseline level of performance; (2) seeking ongoing feedback; and (3) engaging in deliberate practice.

Supervisors contribute to clinicians' professional development when they help clinicians: (1) determine their overall rate of clinical effectiveness via the use of outcome measures and aggregation of the resulting data; (2) provide specific feedback for improving performance based on the identification of skill and knowledge deficits via routine application of outcome and alliance measures; and (3) develop and engage in deliberate practice designed to improve specific performance objectives.

Strategies used by supervisors to help clinicians in their professional development include:

- Establishing a baseline of performance and comparing this to national norms;

  A baseline level of performance is established by aggregating the results of outcome and alliance measures. Data aggregation for individual clinicians can be accomplished by using one of the existing web-based outcome management systems (e.g., fit-outcomes.com, myoutcomes.com, M2FIT.com) or engaging a statistics consultant. Use of a web-based system allows agencies to compare individual clinician effectiveness to agency norms.

- Developing plans for deliberate practice in order to bring outcomes up to, or beyond, national norms;

  Deliberate practice involves: (1) the identification of the limits of current knowledge and skills; and (2) the development of a specific, measurable, step-by-step plan for improvement.

- Nurturing an "error-centric" focus;

  Development occurs when small errors in the application of knowledge and skills are identified thereby allowing remedial action to be taken. FIT supervisors work to make the identification, discussion, and focus on errors safe and rewarding.

- Using ITAR (Identify, Think, Act, Reflect) as a strategy to improve the quality and outcome of clinical work;

  Supervisors help clinicians identify a specific knowledge or skill deficit or "at risk" clinical situation (e.g., deterioration, problematic graph). The supervisor and clinician think of and explore new ideas and/or methods. The clinician acts, applying the new knowledge or skill. The supervisor and clinician reflect and review, taking stock of what did and did not work. The process is repeated until the new knowledge, skill, or "at risk" situation is mastered.

- Providing training and support, targeting areas for improvement;

  Supervisors provide or arrange resources regarding FIT practice tied to specific supervisee needs (e.g., assigning articles or manuals to read, providing training and practice of FIT concepts).

- Helping clinicians to focus on what counts – a large proportion of the variability in clinician outcomes is due to clinicians' different abilities in forming an alliance.

  Supervisors help clinicians avoid shifting the burden of ineffective care to the client or external circumstances by focusing on alliance skills.

The following examples demonstrate how supervisors can assist clinicians with continuous professional development:

Example 1

While monitoring ORS and SRS scores, the supervisor observes that the majority of a clinician's clients score 40 at every session on the SRS. The supervisor works with the clinician to come up with a variety of ways to encourage clients to use the SRS as a true representation of any areas that could be adjusted to strengthen their therapeutic alliance. The supervisor suggests that the clinician use the ITAR (Identify, Think, Act, Reflect) sequence. The supervisor encourages the clinician to prepare for sessions by developing three scripts for what he or she will say to clients, writing the scripts out long hand, imagining what clients might say to each script, then scripting two additional responses for each. After preparing, the clinician tries out the approaches. After the session, the supervisor helps the clinician reflect on the process, noting whether the approach had the desired impact of getting clients to provide more feedback regarding their preferences. The clinician then rewrites the scripts making changes to approaches that did not work and continues to try new ways of encouraging clients to give honest feedback. Changes in the way clients score the SRS are monitored, providing evidence of whether the new approach works.

Example 2

Monitoring client progress on the ORS, the supervisor notes that many of the clinician's clients have ORS scores that have plateaued at or above benchmark (expected change) levels. Although client progress is positive, it appears as though clients are continuing to be seen for extended periods in the absence of further progress. Scores on the SRS indicate generally good alliances. The supervisor is concerned that some of these clients may have developed a dependence on therapy sessions. In discussing this with the clinician, the supervisor discovers that the clinician is having difficulty ending therapy with clients. The clinician says that he or she has difficulty talking to clients about ending therapy. The supervisor works with the clinician to identify what is making it difficult for him or her to talk with clients about ending therapy. The supervisor encourages the clinician to prepare for termination with clients by writing several scripts of what he or she could say to clients about ending therapy, anticipating what clients might say, and developing new scripts for what to say in response. The clinician then practices this with his or her clients. The supervisor reviews the process with the clinician discussing what worked well and what did not. The clinician makes adjustments and together the supervisor and clinician monitor the impact and continue this cycle until the clinician's ability to end appropriately with clients improves.

These examples demonstrate a continuous quality improvement cycle characteristic of deliberate practice strategies. Through continuous monitoring of outcome and alliance feedback and maintaining an "error-centric" approach, supervisors are alert to opportunities to work with clinicians to develop deliberate practice plans that aid supervisees' professional development. Establishing a baseline of performance and monitoring changes in outcomes and alliance provide a measure of the impact of deliberate practice on professional development. Ultimately, through FIT supervision, clinician effectiveness improves and clients reap the benefits.

Manual 3 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. **Which of the following is not a goal of FIT supervision?**
   a. Building a culture that is conducive to FIT
   b. Improving the quality and outcome of clinical work
   c. Monitoring clinician outcomes for the purposes of hiring and firing
   d. None of the above

2. **When client scores on the ORS are progressing but SRS scores indicate problems with the alliance, supervisors should:**
   a. Find out if the clinician has discussed the SRS scores with the client
   b. Suggest that the clinician transfer the client to another clinician because a good alliance is predictive of positive outcomes
   c. Encourage the clinician to continue working with the client in the same way he or she has been
   d. a and c above
   e. a and b above

3. **Which of the following is not a key task for FIT supervisors?**
   a. Ensuring clinician fidelity to treatment approaches and models
   b. Addressing clinician questions and concerns about FIT
   c. Integrating deliberate practice strategies into supervision
   d. Having familiarity with the research underpinnings of FIT

4. **In FIT, a case is not considered to be at risk when:**
   a. SRS scores drop by one point
   b. ORS scores drop below benchmark scores
   c. SRS scores are decreasing and ORS scores are increasing
   d. SRS scores are increasing and ORS scores are decreasing

5. **To help clinicians achieve clinical excellence, supervisors:**
   a. Monitor fidelity to evidence-based treatment models
   b. Help clinicians establish a baseline measure of their effectiveness
   c. Encourage clinicians to continue doing things that are working well, and eventually their areas of weakness will naturally diminish
   d. None of the above

6. **When a supervisee reports that some of his or her clients say they do not want to complete the ORS and SRS, the supervisor should:**
   a. Tell the clinician not to be concerned because some clients don't like paperwork
   b. Ask the clinician how he or she is explaining the measures to the clients
   c. Inquire about the clinician's comfort with receiving client feedback
   d. a and b above
   e. b and c above

7. **Which of the following should not be of concern to FIT supervisors?**
   a. Clinician sees the formal use of outcome and alliance measures as an administrative task
   b. Clinician is unable to describe client preferences or goals for treatment
   c. Clinician is vague about how outcome and alliance measures are used in practice
   d. Clinician's no show or drop out rates are high as compared to other clinicians at the agency or national benchmarks
   e. None of the above

8. **According to research on expertise and expert performance, skill development and improved effectiveness result from the conscious and consistent application of:**
   a. Establishing a baseline level of performance
   b. Seeking ongoing feedback
   c. Engaging in deliberate practice
   d. All of the above

9. **Which of the following would not typically be included in feedback-informed supervision sessions?**
   a. Discussion about client progress based on his or her feedback on the ORS and SRS
   b. Exploration of techniques that could be applied based on the clinician's diagnosis of the client
   c. Discussion about the clinician's alliance with the client, including whether the clinician's approach fits with the client's preferences
   d. A discussion about dose and frequency of treatment

10. **When a client's ORS scores drop dramatically, it is best for supervisors to advise clinicians to:**
    a. Listen, inquire about new clinical risks, and provide appropriate support
    b. Maintain the current type, level, and intensity of services
    c. Monitor to insure that progress resumes
    d. All of the above

Answer Key

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

FAQ

Question:

Some of the clinicians I supervise say that their clients do not like completing the measures. How do I address this?

Answer:

Often when clients are reluctant or refuse to complete the outcome and alliance measures it is because they do not understand the relevance of the feedback to the treatment process. When a clinician is experiencing an unusually high number of clients refusing to complete the measures:

- Find out how the clinician is introducing the measures. Is he or she providing a sound rationale to clients? Clients who understand the benefits of formalized collection of outcome and alliance feedback rarely refuse to complete the measures.
- Explore clinician comfort with receiving client feedback. When clients sense clinician discomfort with feedback, they may be less likely to complete the measures.
- Find out if the clinician is discussing client feedback with them or is simply using the measures to book-end sessions. If clients provide feedback regarding outcome and alliance, but it is not acted on, the measures lose relevance to them.

Question:

Clinicians complain that they do not have time to administer the outcome and alliance measures because they have a lot of required forms to complete. How do I deal with this?

Answer:

- Complaints about paperwork demands may be legitimate. Streamline paperwork requirements as much as possible.
- Remind clinicians that after the initial introduction of the measures to clients, actual administration of the ORS and SRS takes only a few moments.
- Suggest that clinicians teach their clients how to score and chart the measures themselves. This can reduce the work for clinicians and helps clients get engaged in monitoring their own progress.

Question:

One of the clinicians on my team says he/she does not believe that the feedback his/her clients give him or her is valid because the clients are mentally ill. How should I address this?

Answer:

- For some clinicians, openness to obtaining client feedback is a paradigm shift from a diagnostic and deficit-based perspective. Remind the clinician about the research evidence that supports the importance of obtaining client feedback.
- Consider having the clinician talk to a peer who has experienced success in using the measures with mentally ill clients. Hearing the benefits directly from peers challenges such myths.
- Evidence suggests that clinicians are poor judges of clients' experience of therapy. When client feedback on the measures does not match the clinician's perception of how well the client is doing, encourage the clinician to ask the client about why he or she chose to mark the measures the way he or she did.
- Find out how the clinician is introducing the measures to clients. Often when client feedback seems incongruent, it does not relate to client diagnosis but to how the therapist introduced, explained, and helped the client fill out the outcome measure. It is important that clients complete the measures in a way that connect to the way they experience life.

Question:

One of the clinicians whom I supervise says he/she feels awkward introducing the measures. What can I do to help him/her feel more comfortable with it?

Answer:

- Reassure the clinician that it can sometimes take a while before introducing the measures becomes routine.
- Demonstrate how to introduce the measures.
- Have the clinician observe a colleague who is experienced introducing the measures.

- Have the clinician practice introducing the measures to you or to peers.
- Suggest the clinician practices introducing the measures with clients with whom he or she feels comfortable rather than with new clients until the clinician feels more comfortable.
- Offer different ideas on how to explain the measures to clients.

Question:

You say that supervisors should build trust with clinicians by reassuring them that outcome and alliance measures will not be used for performance evaluation. What do I do when I notice that one of the clinicians I supervise has a lot of clients who drop out, client feedback on the alliance measure frequently indicates alliance problems, and the clinician's outcomes fall below agency norms?

Answer:

Remember, the goal of FIT supervision is not to be punitive; rather, it is to assist clinicians in improving the quality and outcome of their work. Here are some strategies you can try:

- Have the clinician establish a baseline of performance so that the effectiveness of strategies employed to assist the clinician in improving the quality and outcome of his/her work can be monitored.
- Consider having a clinician with high outcomes mentor the clinician.
- Offer training targeted at improving alliance with clients.
- Employ deliberate practice strategies targeting an area for improvement.
- Have the clinician use ITAR (Identify, Think, Act, Reflect) to explore different ways to interact with clients.

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Appendix 1

Overview of Feedback-Informed Treatment (FIT)

The FIT Approach

Any interaction with a client can be considered FIT whenever a purposeful effort is made to:

- enhance the client factors that account for successful outcomes;
- use whatever approach best achieves a successful outcome;
- use client goals and preferences to guide choice of therapeutic approach; and
- inform the work with reliable and valid measures of the client's experience of the alliance and outcome.

Foundations of FIT

- When fully implemented, FIT is intended to be of the same nature as gathering intake data and completing assessments – a standard practice.
- Using empirically-validated measures to gather real time feedback from clients, FIT is able to function as both a clinical tool and an outcome measurement tool. It does not take time away from or "book-end" the "real clinical work." Rather, it is a clinical tool focused on tracking and improving outcomes (effectiveness) and alliance (fit).
- FIT practice emphasizes client involvement in determining the nature, type, and scope as well as the evaluation of services. According to Orlinsky, Rønnestad, and Willutzki (2004), "The quality of the patient's participation… [emerges] as the most important determinant in outcome" (p. 324).
- Recognizing that clinical staff have the intention to provide effective services to clients, FIT capitalizes on significant research indicating that highly effective therapists have several common features:
  - seeking, obtaining, and maintaining more consumer engagement;
  - being exceptionally alert to the risk of drop out and treatment failure, and;
  - directly seeking feedback in order to improve individual performance (referred to in the literature as deliberate practice).

FIT Skills: (The three "I's")

1. Introducing the Measures – fidelity.
2. Integrating the Measures – eliciting the client's meaning about the scores so both client and therapist begin to understand how success will be measured.
3. Informing and tailoring services based on feedback by using the measures to guide practice. When using the ORS and SRS to guide clinical practice, a synthesis of the ORS and the SRS is important. One measure is not independent of the other; rather, the ORS and the SRS together provide a picture of the therapeutic journey and provide information that can be used as a compass to guide practice. One measure informs the other.

Appendix 2

Practical Application of FIT in Clinical Supervision: A Checklist

Practical application:

- ❑ Group and individual supervision
- ❑ Counselors are asked about the ORS and SRS scores routinely at each consultation
- ❑ Supervision focuses on outcome rather than technique
- ❑ Supervision focus is based on the principles of deliberate practice

Review ORS

- ❑ Completed?
- ❑ Is ORS information used? How?
- ❑ Do ORS scores indicate that the client is making progress?
- ❑ If not making progress, is the clinician addressing this with the client?

Review SRS

- ❑ Completed?
- ❑ Is SRS information used? How?
- ❑ Do SRS scores reflect positive relationships?
- ❑ If not, is the clinician addressing this with the client?

Probing for Key Information:

- ❑ What does the client want?
- ❑ What are the client's ideas about how best to work together?
- ❑ What are the client's expectations about treatment?

Listening:

- ❑ What has gone well?
- ❑ What changes are happening?
- ❑ What is the supervisee's experience?
- ❑ Do you hear the client's voice through the supervisee's presentation?
- ❑ What is the supervisee's preferred means of supervision?

Reminders:

- Use the measures to support what is working and challenge what is not.
- The measures allow clients to have a strong voice, allowing us to learn what they want, how they view the change process, and what they think about how the process is going.
- The majority of clients feel positive and hopeful that clinicians ask them to formally rate their progress.
- Clinicians' discomfort with the measures interferes with the relationship and with progress.

Appendix 3

Glossary of essential terms for FIT supervisors

Aggregate outcome scores: A collection of scores generated by administering an outcome measure to a number of clients. These scores are gathered together to form a total outcome score for the group (aggregate outcome score). The more clients in the aggregate pool the more accurate the measure of aggregate change will be. Aggregate outcome scores can be calculated at the clinician, program, or agency level. Aggregate outcome scores provide opportunities for supervisors and clinicians to set targets for effectiveness by comparing clinician effectiveness to national norms.

Baseline score: A baseline score is an initial, pre-treatment, or intake score on the ORS or SRS. To get an accurate measure of change, it is important for an initial or baseline score to be obtained as early as possible in the process (at first contact) so that change can be measured from start to finish of therapy.

Clinical Cutoff: The clinical cutoff for the ORS defines the boundary between a clinical and nonclinical range of distress. The clinical cutoff for the ORS was established based on a large sample N= 34,790 (77% score below). Clinical cutoffs for the ORS differ depending on age group:

- Adults = 25
- Adolescents = 28
- Children= 32

Raw and severity-adjusted effect sizes for the ORS: An effect size (ES) is a statistic that measures an amount of change in a standardized way. There are many kinds of ES statistics, but the ES commonly used in therapy effectiveness measurement is calculated by dividing the average difference in scores between groups (e.g., between a group of clients at their first intake treatment session, and that same group of clients at their last termination session) by the standard deviation (SD) of the measure (commonly, the SD of the intake scores is used). This is sometimes called a raw ES (the average amount of change divided by the variation of scores at intake). In contrast, a severity-adjusted ES is a more complicated statistic that takes into account the intake score by adjusting the amount of change for each client based on the degree of his or her distress at intake. It has been

widely shown that clients with low ORS scores (more distress) are likely to show more change than clients who come in already reporting that they feel good (i.e., high ORS scores). Some computer programs report severity-adjusted ESs based on how much better or worse clients' termination scores are than what would be expected based on their distress at intake. Therefore, in this method of reporting, clients who show the expected amount of change or reach the "benchmark" of change will have an adjusted ES of zero. Similarly, clients who improve more than expected will have ESs higher than zero; and clients who do not improve as much as would be expected based on their intake scores will have a negative ES (even if they changed in a positive direction!). Other programs or statisticians who calculate severity-adjusted ES will adjust the raw ES up or down based on these differences, so that the severity-adjusted ES is more similar to a raw ES, but affected by the amount of change in comparison to what's expected. The accurate interpretation of ES depends on knowing how a particular ES was calculated, whether raw or severity-adjusted (and the method of adjustment used).

Predicted change trajectory: The predicted change trajectory is the predicted amount of change in scores on the ORS over a period of time. Using thousands of administrations of the ORS, expected change trajectories based on initial ORS scores have been established. Similar to growth charts for infants, these change trajectories use percentiles to indicate the course of change for certain percentages of clients with different initial ORS scores. In general, the expected slope of change for clients with low initial ORS scores is steep whereas clients with higher initial ORS scores will have change trajectories that are not as steep. By using predicted change trajectories, supervisors and clinicians can compare client change to the normative sample.

Percentage of clients achieving predicted change or service targets: By comparing client change to the amount of expected change based on the average from a normative sample, the percentage of clients who achieve or exceed these averages (also called benchmarks or service targets) can be calculated for clinicians, programs, and agencies.

Reliable Change Index: The Reliable Change Index (RCI) is the amount of change that can be reliably attributed to therapy and not to normal regression toward the mean, typical day-to-day fluctuations in mood, or nontherapeutic variables. The RCI for the ORS is 5 points of change or greater.

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