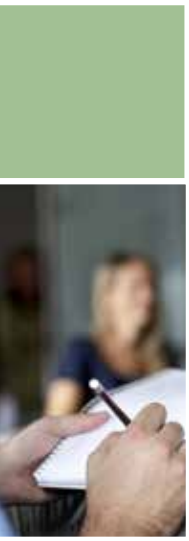



Manual 5

Feedback-Informed Clinical Work: Specific Populations and Service Settings

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 5

Introduction

The purpose of this manual is to provide readers with an easy to follow, practical guide for incorporating Feedback-Informed Treatment (FIT) in work with specific populations and across different service settings. While the material is organized around the use of the Outcome and Session Rating Scales (ORS & SRS), the principles and practices covered are transferable when outcome (e.g., Outcome Questionnaire 45.2 [OQ 45.2], Clinical Outcomes in Routine Evaluation [CORE]) and alliance measures (e.g., Working Alliance Inventory [WAI]) are used to inform and improve clinical work with specific groups or service delivery systems.

Information in this manual is organized into the following sections:

I. FIT with specific populations
   - A. People diagnosed as "Severely and persistently Mentally Ill" (SPMI)
   - B. People with learning disabilities or cognitive impairment
   - C. People who are mandated to treatment
   - D. People in substance abuse treatment
   - E. People who experience marginalization
   - F. People who experience partner violence

II. FIT in group work

III. FIT in "long-term" therapy

IV. FIT in specific service settings
   - A. Multi-service and multi-service provider
   - B. Outpatient
   - C. Intensive day treatment, residential, and inpatient treatment
   - D. Outreach

While at first glance, the populations and settings noted on the previous page may appear unrelated, consider that each presents a context that may challenge a helper's ability to understand clients who have experiences, ways of operating in the world, or ways of making sense of the world that are different from their own. Understanding people in context, including how they understand their life experiences, what matters to them, and what helps them make sense of their world, is crucial to creating a culture of feedback. Enhancing one's capacity for understanding is also essential to professional growth, the development of expertise, and achievement of excellence in service delivery. FIT provides a process that helps develop this capacity. Feedback-informed conversations allow clients to tell helpers what they need to understand about them so that the helper can be the most effective.

It is important to note that understanding clients does not necessarily mean agreeing with or endorsing what they are saying or doing. Understanding means "making room" for a way of making sense of the world that may be very different from – perhaps even in conflict with – the helper's way of making sense of the world. Most professionals endorse the idea of "meeting clients where they are at." In this manual, that is precisely the focus: meeting clients where they are, even if that means going somewhere that is unfamiliar or uncomfortable.

Much of Manual 5 is organized around questions specifically designed to enable the reader to develop the capacity for understanding differences and contexts, thereby enlarging the capacity to apply FIT across diverse treatment settings and clients. Specific suggestions are provided for responding to common client concerns or questions. Finally, consistent with the other manuals in this series, this volume ends with a list of frequently asked questions (FAQ), short quiz, references, and appendices.

I. FIT with Specific Populations

A. People Diagnosed as "Severely and Persistently Mentally Ill"

Around the world, numerous agencies and clinicians have been seeking feedback via the ORS and the SRS in their work with people diagnosed as "severely and persistently mentally ill" (SPMI). As with any person seeking services, the measures are administered and scored, the resulting numbers plotted and then discussed in relation to the client's specific goals for care. The dose and intensity of services are adjusted to fit the person's expected treatment response and changes are made in approach or relational style when progress is slow, uneven, or lacking.

A common concern of clinicians working with people labeled SPMI is whether they can provide valid, trustworthy feedback. Clinical experience, combined with available research evidence, makes clear that this specific population is as capable of providing useful feedback about their functioning and experience of the working relationship as any other. Indeed, helpers who work with this group routinely ask them how they are doing, what's going well, what problems they are facing, and what they need from services.

For reflection:

- Imagine that you are NOT using the ORS and SRS. How do you already ask clients about their lives? About your work together? What things do you take into consideration to determine how you ask them?
- What is important to you about asking your clients' perspective on how things are for them?
- Given that you do ask clients to report on how they are doing, what is it that has you thinking that they are incapable of participating in FIT?

Using the ORS and SRS is essentially a way to formalize, make routine, and bring to the center of the work, the feedback clients provide when asked such questions. In a sense, the process of reviewing formal client feedback offers a kind of language, both verbal/numerical and visual in nature, for drawing out clients' experiences – both in and out of the consulting room. As has been discussed throughout this series of manuals, asking clients what the numbers on the ORS and SRS represent is central to FIT.

Case example

Daniel has been diagnosed with schizophrenia. He has been in treatment with a variety of providers and in many different programs for many years. Currently, he sees a psychiatrist at a busy publicly funded mental health center. Management policy places strict limitations on the amount of time the psychiatrist is able to spend with patients. To assist in making the most of their time together and to get a quick snapshot of how things are going, Daniel's psychiatrist has adopted the ORS and SRS.

Since their last meeting, Daniel's score on the ORS had dropped significantly. The psychiatrist noted the drop in scores, asking Daniel in particular about the significant decreases on the "Individual" (personal well-being) and "Overall" (general sense of well-being) subscales. When Daniel reported an increase in auditory hallucinations and feelings of paranoia, the psychiatrist recommended increasing the dose of medication Daniel was currently taking.

At the end of the brief visit, Daniel completed the SRS, rating the "Approach and Method" item low. When asked about the score, Daniel told the psychiatrist that although the medications had been somewhat helpful, the side effects were very unpleasant. In fact, Daniel admitted he had not been taking the drug as recommended because it made him feel so bad. He also said that he had not said anything about this before because he noticed how busy the psychiatrist was and did not want to be a bother.

As a result of this feedback, the psychiatrist was able to discuss other medication options and strategies that Daniel could use to help manage some of the side effects. After thanking him for the feedback, the psychiatrist then reassured Daniel that they would find a way to have more time together in sessions. The psychiatrist arranged to contact Daniel between sessions by telephone to "check in" about how things were going. As a result of this new strategy, the medication was adjusted, resulting in both fewer side effects and better functioning.

A common challenge reported by helpers working with this specific group is when client feedback regarding progress conflicts with the assessment of the treating clinician, family, or other professionals involved. In such instances, the temptation to contradict or otherwise impose the view of concerned others can be particularly strong. Recall from Manual 1, however, that client engagement is the single best process-related predictor of outcome. Unless the person is an imminent risk to self or others, the first step must be working to understand the scores *from the client's perspective*. Doing otherwise risks disengagement. Once understood, the client and therapist can broaden the discussion, for example, exploring how others (e.g., family, physician, friends, etc.) might complete the measure and why.

Case example

Angela has been diagnosed with PTSD, Bipolar Disorder, and Conversion Disorder. She averages about three psychiatric hospitalizations per year. Recently, she was assaulted outside of her apartment and her purse was stolen. The assault triggered a series of dissociative experiences, flashbacks, and psychogenic seizures that led to a four-day hospitalization. Val, her caseworker, visited Angela on day two of her hospitalization. Val planned to have Angela fill out the ORS, something they routinely did in their monthly check-in meetings. An attending staff member expressed concern that Angela would not be able to "self-report in a useful way" because that morning she had been dissociating.

Val invited the staff member to share his perspective on how Angela was doing by filling out the ORS. The staff member's score about Angela was 3.7. When asked to explain the rating, he expressed strong concerns about Angela's level of functioning, stating that she was "very vulnerable to continued flashbacks and psychogenic seizures right now" and noting his belief that the assault "would set her back quite a bit."

Later, Val sat down with Angela.

"I hear you had a rough morning, is that right?"

"Yeah," Angela nodded. "I had, you know, some of those awful memories. They're so real. Now they seem far away. Staff said I got real loud up in the day room this morning, crying and screaming for help."

"You are feeling more yourself now? Enough to think about how you're doing overall since this all went down?" When Angela responded positively, Val gave her the ORS to complete.

Angela's ORS totaled 12.4. Val continued, "You've had a really scary last few days. Lots of people would call it traumatic and maybe expect a lower score." She asked

Angela if she wanted to know what others were thinking. Together, the two discussed the staff member's score.

"Joe, the nurse, I asked him how he thought you were doing, and he scored 3.7. What do you think Joe might be thinking or worried about for you? Can you help me understand what your score means for you?"

"Yeah, I get Joe scoring me low. He worries and I think, you know, he's a nurse and they can be looking out for the next shoe to drop. But I think, hey, you know? I was attacked but I'm alive and I got my licks in on that guy."

"So, being alive and fighting back counts for something?"

"Oh yeah, it does. Remember a couple of years ago when I was in that accident? That set me back big time. I know I'm having some of those spells right now, but the doctor's not drugging me up like they had to do two years ago."

"So, when you score this 12.4, are you saying you're thinking about how you're doing compared to how you've done before when something bad has happened to you?"

"Yeah, that's right."

"If you had scored this two years ago after that accident, how might you have scored it?"

"Well, I don't know that I could have – I was either sedated or carrying on! I'll bet Joe would've scored me a -10!"

Note

Before concluding this section, mention should be made regarding the use of the ORS and SRS with people who are actively psychotic. Once again, reflecting on one's own knowledge and experience can be helpful. For example, helpers should consider how they typically interact with someone in the midst of an acute psychotic episode. How much time do they spend asking questions versus providing support, decreasing agitation, and ensuring safety? Clearly, administering the measures may not be a first priority. Once ambulatory, stable, and safe, however, it is important and meaningful to engage them in the FIT process. Providing the person with an opportunity to participate directly in his or her own care increases client engagement and agency.

b. People with learning disabilities or cognitive impairment

The ORS and SRS do require a certain level of reading and comprehension ability. Flesch/Flesch-Kincaid tests on the readability of the adult versions of the ORS and SRS (including the GSRS) indicate that the measures fall at a 6th grade reading level. Consistent with the recommended age range, the adult scales should be easily understood by average readers 13 years of age and older.

When literacy is an issue, the oral versions of the scales may be administered (free copies may be downloaded at: www.centerforclinicalexcellence.com) or the Child Outcome Rating Scale (CORS), Child Session Rating Scale (CSRS) or the Young Child Outcome Rating scale (YCORS) and Young Child Session Rating Scale (YCSRS) substituted. Flesch/Flesch-Kincaid tests place the CORS and CSRS at the second grade reading level, consistent with the recommended age range for the scales (8 to 12 years). The YCORS and YCSRS contain few words and no complex sentence structure and, therefore, require the least amount of reading ability.

At this time, no formal research or testing of the measures have been conducted with people who have specific learning, cognitive, or neurological challenges or limitations. Given the required reading abilities noted above, professionals must, therefore, exercise judgment regarding the overall suitability of the scales for assessing progress and outcome. That said, if the level of ability required for the treatment being offered (e.g., talk therapy) equals or exceeds the reading and comprehension levels reported for the measures, there should be no reason not to use the scales. In those instances where the level or type of impairment precludes administration of the measures, clinicians should, at minimum, seek feedback from collateral sources. For example, the clinician can ask people most concerned about the client (e.g., parent, school officials, referring physician, etc.) to complete the scales on a regular basis.

Whether or not the measures are used, connecting with and understanding the world of people of varying cognitive or intellectual abilities requires creativity and skill. Professionals report making accommodations when administering the scales in order to obtain feedback that is meaningful to the person being served, including:

- Using the oral and children's versions
- Adding numbers or images (e.g., a series of smiley faces) to the scales
- Adding qualitative language (e.g., "small, medium, large, super-size," "really bad, bad, ok, good, really good," "freezing, cold, warm, hot," "red, white, blue," etc.)

Finally, it can be helpful to consider the many ways one currently works that are both accommodating and respectful of the humanity of clients who have a learning disability or cognitive impairment.

For reflection:

- Imagine that you are NOT using the ORS and SRS. How do you already ask clients about their lives? About your work together? What things do you take into consideration to determine how you ask them?
- What do you listen for and pay attention to about your clients' experiences? What helps you decide how to communicate with them? Be specific – what do you notice about their expressions, their level of engagement, their use of language, and what they are interested in?
- Think back to when you first started working with clients with learning disabilities or cognitive impairments. What concerns or beliefs did you have about their (lack of) ability to communicate their needs and preferences to you? What have you learned since? How have you learned that?

Case example

Ruben is a 37-year-old man who experienced a traumatic brain injury from a motorcycle accident. His injury affects much of his daily functioning, including: the length of time he is able to attend to conversations or tasks; his short-term memory; language comprehension and expression (formal assessment indicates a 6th grade reading level); and his ability to manage social situations. This last concern has been particularly problematic, as Ruben has experienced an increase in anxiety and self-consciousness that makes participation in conversations and social events difficult. At times, he is extremely despondent about his abilities. His tendency to lash out verbally at others has also left him increasingly isolated.

Marcus, the caseworker assigned to organize services for Ruben, uses the ORS and SRS. He explains that he has

a form for Ruben to fill out that will help him know if he is being helpful in the way that Ruben needs and desires. "You can either fill out the sheets yourself or I can read the questions to you. Either way," Marcus continues, "your answers will help me understand how I can help you best. Whichever way you like is fine with me."

Ruben replies that he would like to fill out the sheets himself as long as "they're not too hard or have too many words." He says he has always disliked "too many words" – even before the accident. Marcus agrees that, "too many forms have too many words," and then lets Ruben know that he can choose from among two different forms: one that has words and lines, and another that has pictures instead of some of the words.

Marcus shows Ruben both the adult and child versions of the ORS, stating, "Some guys find it helpful to use the sheet with the faces because it cuts down on the words. Other guys find they prefer the one without the faces. Either one is OK. Which kind of guy are you?"

Ruben falls silent as he looks at the scales. After a few moments, Marcus asks whether it is hard to choose or if Ruben has changed his mind and would rather have the questions read to him. When Ruben indicates that he has changed his mind, Marcus replies, "No problem, thanks for telling me," and proceeds to read the questions.

"Ruben, zero to 10, with zero being low, really low, and 10 being high, the top, if I asked you 'how are you doing?' how would you answer that?" They continue with the oral version of the ORS, with Marcus providing clarification and encouragement along the way.

At the end of their conversation, Marcus asks Ruben if he would answer some "0 to 10" type questions about the time they had spent together. When Ruben asks if there are "special forms" for these questions Marcus shows him both the adult and child SRS. "That's a lot of words," Ruben says pointing to the adult version, "Let's do the one with the faces." Marcus then explains how to complete the scale noting that the face with the frown on the left hand side of the measure is "like a zero," and the smiley face on the right hand side, "like a 10."

Pen in hand, Ruben first considers the scale and then proceeds to write numbers from 0 to 10 on each of the four lines of the SRS. When complete, he circles the smiley faces (10s) on the "listening" and "how important" items and "6" on the "what we did" and "overall" scales. Given that the total score (32) falls below the cutoff, Marcus talks with Ruben about what they could do differently next time so that Ruben feels better about how they use the time. Ruben says that he likes talking to Marcus, "because you listen and ask how I am, not just tell me what I have to do" but that he would like to talk more about "the problems I'm having at home."

Marcus thanks Ruben for letting him know, and writes a note to himself to remember to ask Ruben about problems at home the next time they meet. He also asks whether it would be helpful for Ruben to discuss these problems with his counselor. Ruben readily agrees.

c. People who are mandated to treatment

A common concern voiced by clinicians using the measures with people who are mandated to treatment is that the clients are not honest and, thus, do not provide "valid" feedback. High scores on the scales tend to be viewed with suspicion, interpreted as clients: (a) denying their problems, or (b) providing "socially desirable" responses in order to avoid the consequences of their actions. Whatever the case may be, it should be remembered that the key to success in treatment, as reviewed in Manual 1, is client engagement. Taking time to reflect on the practice of placing "honesty" above "understanding" in interactions with clients can be helpful in learning to "meet clients where they are." Without such reflection, the alliance is likely to be compromised and treatment outcomes put at risk.

For Reflection:

- Thinking about your own personal relationships, how do you make decisions about being honest with people in your life? What do people in your life do to encourage or discourage honesty?
- Thinking about your clients, what may be at stake for them if they are honest? What does it take for them to be honest?
- In what ways do you understand or appreciate your clients' caution around being honest?
- Thinking about your work with mandated clients without using the ORS and SRS, how do you already approach concerns about client honesty?
- When you imagine using the ORS and SRS, how do you see yourself working differently and how do you see yourself working as you do now?

In practice, clients mandated to treatment frequently score above the cutoff on the ORS at intake (Mee-Lee, McMillan, & Miller, 2009; Miller et al. 2005), reflecting a low level of distress about their overall life functioning. Rather than challenging such clients to acknowledge problems that others are concerned about, focus should be placed on understanding the discrepancy between their perspective and that of the mandating person or institution. Some suggestions for engaging clients in this type of discussion include:

- Discuss his or her understanding of and feelings about the reason for the mandate. Focus on understanding and creating room for the client's views, not on challenging or convincing the client otherwise.
- Ask the client to score the ORS from the perspective of the person(s) involved with the mandate. This could include the referring (mandating) source, others involved in or following the case, and those involved with making decisions about resolving the mandate.
- Explore the client's understanding of any discrepancies between his or her own scores and those of the others involved and focus on what the client understands needs to be done in order to resolve the mandate.
- Ask others to provide ORS scores and share these with the client along the way, continuing to address what needs to be done to resolve the mandate.
- Along the way, incorporate any concerns that the client may identify as issues that he or she would like to address, discussing with the client where these concerns are reflected in the ORS scores.
- Be attentive to SRS scores; the literature is especially clear about the need to form a collaborative alliance with clients who are mandated in order to keep them engaged and resolve the mandate.

Case example

Angela, 16, was court-ordered to a program for youth who have committed property offenses. Angela and her parents were required to attend weekly group sessions for 12 weeks. She was also required to perform eight hours of community service and have her teachers at school document attendance – she was not permitted any absences without a medical doctor's note during the 12 weeks. Three meetings with a therapist from the program were required in order to "assess" Angela for any chemical use and likelihood of further criminal involvement.

Angela had been caught with a group of friends spray-painting benches and playground equipment at a park. This was her first offense. She was given the option of completing the property offense program in lieu of time in juvenile detention. Upon successful completion of the program, the official record would be expunged – an outcome of interest to Angela and her mother.

Nearly two months had passed since her arrest by the time Angela entered the program. At the initial session with the therapist, her ORS score totaled 29.7. Reggie, the therapist, commented about the score, noting how well Angela thought she was doing.

"Yeah, actually, stuff is pretty good. All this court stuff sucks and it's embarrassing and my mom was pissed, but it's better now."

"So, it's better now? Was it not so good awhile back?" Reggie asked.

"Oh, yeah. It totally sucked when I got caught. I thought I was going to die when they took me to juvy. I had detention once before in school for arguing with a teacher and another when I was little and stole my big sister's Girl Scout cookie order and, believe me, I caught hell for that, but going downtown to juvy? That's not me..."

"Ok, yeah, so, if I had asked you to score this when you got busted..."

Angela jumped in before Reggie could finish, "Oh, gawd, like here on all of the lines!" She pointed to the ORS form, indicating she would have scored near a two on each line. Angela went on to explain that many changes had taken place since her arrest, the most important being that she was no longer spending time with the other youth involved in the property offense.

"Let me ask you this," Reggie said. "If I asked your mom to fill out the form, how would she say you are doing? And, how would your probation worker mark it? – what would she say?

"My mom would score it about the same as I did," Angela said, picking up the ORS and a pen. "My P.O.? Yeah, well that's another story..."

"OK, so your mom is pretty cool with how you're doing, and your P.O.?"

"She's such a jerk..."

"I'm not asking you to say you agree with how she'd fill this out, just how you think she would."

"OK, good, cuz I definitely don't agree." Angela marked the ORS as she thought her probation officer would. The total score was 14.8, with an especially low score on the "social" item. During what remained of the session, Reggie explored what Angela thought were the concerns and expectations of the probation officer. Together, they identified specific things Angela could do that would result in the P.O. rating the ORS higher.

A study by Miller, Duncan, Sorrell, and Brown (2005) documents the consequences of failing to use the ORS and SRS to engage mandated clients in treatment. Briefly, participants fell into one of four groups: (1) clients who entered treatment voluntary and completed the program successfully;

(2) clients who entered voluntarily but failed to complete treatment successfully; (3) clients who were mandated into care and completed treatment successfully; and (4) mandated clients who ended unsuccessfully. Of the four, only the last group – mandated clients who ended unsuccessfully – scored above the clinical cutoff at intake. Instead of working to engage this group as described above, participants were given the same type and amount of care as the other groups. As a result, dropout rates were higher and the clients were the only ones whose scores on the ORS were not significantly different from intake to the last recorded score. Clearly, by joining with clients around resolving referrers' concerns, clinicians increase the engagement of those who, were they not mandated, would not otherwise seek treatment.

D. People in substance abuse treatment

Research shows that existing treatment approaches for substance abuse achieve equivalent outcomes (Wampold, 2001; Imel, Wampold, Miller, & Fleming, 2008; Mee-Lee et al., 2009). Said another way, all approaches may work with a given client. The key is finding "what works" for the individual seeking help.

Consistent with the principles and practices of FIT, Project MATCH, one of the largest studies conducted to date, found that client ratings of the therapeutic alliance were the best predictors of: (1) treatment participation; (2) drinking behavior during treatment; and (3) drinking at 12-month follow-up (Project MATCH Research Group, 1993). Based on such findings, Mee-Lee et al. (2009) recommend that professionals work to align services with clients by:

1. Developing highly individualized service delivery plans;
2. Using formal, ongoing feedback to continually adjust the plan and process of treatment;
3. Integrating the plan and client feedback into a continuum of care that is maximally responsive to the individual client.

FIT provides a vehicle for operationalizing these recommendations through formalized, continuous monitoring of the therapeutic alliance and effect of treatment, allowing clinicians to tailor treatment based on the feedback, adjusting their approach when needed in response to the outcomes generated through the treatment process.

Helpers working with people in substance abuse treatment express many of the same concerns as those working with mandated clients (see section c). These include clients: (1) not providing "honest" feedback on the ORS and SRS; (2) denying that a problem with substances exists; (3) minimizing the severity or impact of the problem on themselves or others; and (4) resisting attempts to acknowledge or address the "underlying" causes of their drug or alcohol use.

Traditional beliefs and assumptions about this population are only likely to be reinforced when one considers research by Miller et al. (2005). This research found that average ORS intake scores of substance abusing clients were significantly higher (i.e., indicating less distress) than the general mental health population (24.1 versus 19.6). Importantly, however, the study also found that ORS scores of substance abusing clients improved over time regardless of whether they started above the cutoff or not (see Figure 1). By contrast, clients from a general mental health population tended to get worse over time when initial ORS scores fell above 25 (see Figure 2).

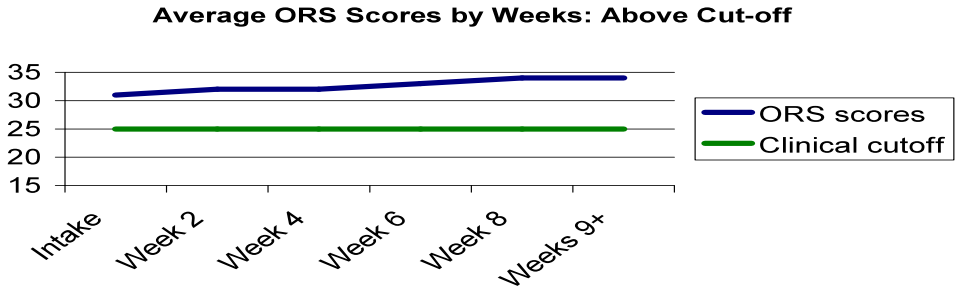

Figure 1: The Average Trajectory of Change for Substance Abusing Clients with ORS Scores Above the Clinical Cutoff at Intake

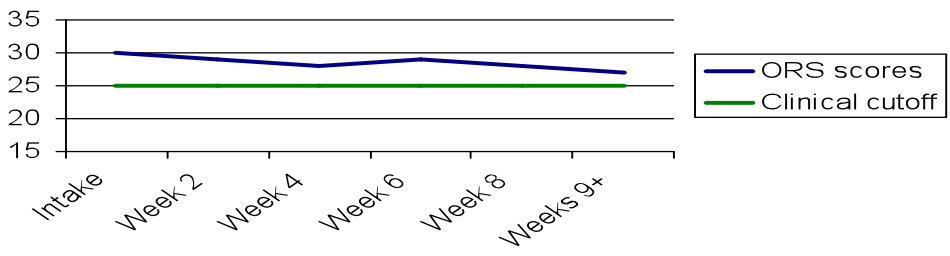

Figure 2: The Average Trajectory of Change of a General Mental Health Sample with ORS Scores Above the Clinical Cutoff at Intake

Not surprisingly, clients who completed treatment in the Miller et al. (2005) study averaged significantly more change than those who dropped out. Additionally, longer contact with substance abusing clients resulted in better outcomes while general mental health clients tended to plateau following rapid gains in the first handful of visits.

Such findings make it clear that the key to success in working with substance abusing clients is engagement. Dropout is a far greater threat to outcome than any of the common concerns noted above. As such, instead of "getting to the truth," the feedback-informed practitioner first aims to understand. Whether or not one agrees with the client's scores on the ORS and SRS, helpers should:

- Discuss their understanding of and feelings about being in treatment. Focus on understanding rather than challenging or convincing.
- Explore and use whatever motivates the client to participate in and complete treatment. What are his or her goals or hopes? How will he or she know that services have been helpful?
- Ask the client to complete the ORS from the perspective of others involved (e.g., partner, children, parents, work colleagues, friends, etc.). Explore the client's understanding of any differences between his or her own and others' scores.
- When mandated, ask clients to complete the ORS from the perspective of the mandating individual/institution. Focus on what the client believes needs to be done in order to resolve the mandate. If the client does not know or is uncertain, invite the mandating individual/institution to complete the ORS. Share the results scores with the client, addressing what needs to be done to resolve the mandate.

Case example

Audrey is a 48-year-old human resources director who entered a residential substance abuse program after months of pleading from her husband Doug and two daughters, Cassie, 21 and Kelly, 18.

When Audrey completed the ORS, her score was 34.1. When her counselor, Carlos, explained that such scores were typical of people whose lives were going well, Audrey agreed.

Carlos continued, "Sometimes scores above the line mean that things are generally going well but there could be one concern or specific problem to address. Either way, the obvious question is, what brings you here?"

Audrey immediately stated that being in treatment was her family's idea. "I'm not sure why they think I have a problem. They go through cycles of nagging me." She went on to explain that two weeks earlier, her husband Doug declared "the last straw" after a friend drove her

home after happy hour. "I was responsible! I had a friend drive me home. It was a colleague's 10 year with the company celebration – that's important to be at. It was a party for gods sake! I got up the next day, went to the gym, met Doug and our nephew for brunch, cleaned the house, had a weekend, and was at work Monday morning at 7:45. Everything is fine. My family is making mountains out of mole hills."

At this point, it might be tempting to confront Audrey or at a minimum begin a formal assessment, the focus of which would be determining the extent of her problems with alcohol. Carlos chose instead to focus on Audrey's motivations for treatment, using the ORS to tease out the actions she needed to take to mollify her family's concerns, "So, your family said they wanted you to come here for treatment, to talk with counselors – did they say what they want you to do, what we're supposed to talk about?"

"Apparently, they think I have a drinking problem and they want you and your staff to convince me of that. But I can tell you I don't. I don't drink that much. I'm here to appease them and put an end to this crap."

Picking up the ORS, Carlos asked, "So, if they were to fill this out, how would Doug and your daughters say you were doing?" Audrey completed the ORS, marking each line at the low end of the scale. "They're in this together," she said, handing the form back, "so one score for the three of them will do."

Scanning the form, Carlos first acknowledged the difference in perspective between Audrey and her family and then said, "So, to appease them, to satisfy them and put an end to this, they'll have to be believe things are as you say. They'll have to mark you up around 30 instead of down here around 10."

When Audrey agreed, Carlos continued, "So, what we need to figure out is what it's going to take to have them see things like you do. What is it that they don't know about you that you know about yourself, that if they began to know that stuff about you, their scores would be different? For example, I've learned already from what you've told me that you have friends, you enjoy celebrating their accomplishments, you don't drink that much."

Audrey agreed and the rest of the meeting was spent identifying what her family would need to know about her in order for their scores to go up.

At the end of the meeting, Carlos administered the SRS, explaining how very important it was to him to get her feedback about the visit. Audrey's score on the measure was 34.4. Carlos asked how he could do better, noticing in particular, that the mark on the first item regarding the relationship was the lowest. Audrey stated that, at times, she felt Carlos was "talking down to her," adding that she was a highly educated and experienced professional that didn't need every little detail explained so slowly and meticulously. After thanking Audrey for the feedback, he added, "It could have been easy for you to leave our meeting thinking 'great, this guy doesn't understand me either!' I have a better idea now of how you'd like us to talk together – please do keep telling me when I'm off track." At each visit, Audrey's engagement in treatment continued to increase.

e. People who experience marginalization

As a pantheoretical approach, feedback-informed treatment may be used to monitor and improve the effectiveness of treatment services across settings and with people who are experiencing a range of difficulties. Often helpers ask about the appropriateness and possible limitations of using tools of measurement with cultural groups that experience marginalization because of their race, class, gender expression, sexual orientation, immigrant or refugee status, ability, religious or spiritual affiliation, ethnicity, or any combination of such identifiers. While the specifics will vary, the challenge is the same: understanding people whose experiences and worldview differ from one's own.

Helpers, like those they serve, are shaped by their own social and economic class, race, ethnicity, sexuality, gender, ability, age, and spiritual/religious traditions. Simply put, it is not possible to "step outside" these experiences or forgo their influence on how one understands the world. To provide service that is responsive to the "patient characteristics, culture, and preferences," therapists must become aware of the impact their own culture and worldview has on what is seen or heard (or not seen or heard), deemed important (or not), and either given attention or ignored.

Becoming culturally responsive is central to achieving excellence. It requires ongoing learning, reflection, and consideration of feedback from others, as well as deliberate effort aimed at becoming better at understanding and less attached to knowing, or being certain. Importantly, a culturally responsive practice is not the same as "cultural tourism," where a "preferred view or method" is adopted for working with everyone in a particular group. In addition to reducing people to a stark level of sameness, cultural tourism requires no self-reflection or work toward understanding the experiences of people living on the margins.

Ultimately, being culturally responsive is central to creating a culture of feedback. Feedback-informed clinicians know that therapy will not be as engaging or effective when limited to their own knowledge, experiences, and cultural understandings. Client perspectives, even (perhaps especially) when challenging, are critical to successful and ethical treatment.

While there are a number of concerns that clients may express regarding the use of the ORS and SRS in clinical practice, the two most common are discussed below. Suggestions for understanding and self-reflection are provided to help clinicians become aware and culturally responsive.

Concerns about measurement and evaluation

Measurement and evaluation are commonplace in psychological services, as are comparisons to baselines and norms. The unfortunate reality, however, is that such practices have been used in harmful ways across time and around the world (Parker, 2007; Smith, 1999). Today, most people seeking therapeutic services are required to submit to "means testing" and psychiatric examination prior to receiving the services or resources that they want or need. While completely unrelated to the ORS and SRS, such experiences in part explain why some may be cautious about or resistant to being measured or "used" for the purposes of the medical/social service system (Jackson, 2002).

Another concern related to measurement and evaluation has to do with comparisons to "normal." The ORS clinical cutoff and expected treatment response trajectories are critical to determining whether an episode of care is helping a particular client. That said, people at the margins of the dominant culture have good reason for objecting to being compared to norms, baselines, and averages. For many, such comparisons evoke experiences of "not measuring up," of being denied, controlled, or otherwise placed outside what is considered socially or culturally acceptable.

For the FIT practitioner, the chief tasks are understanding what it means for the client to take the position he or she does, and working together to find ways to forward their relationship.

What to do:

- Learn about how research (in general and medical/psychiatric in particular) and measurement is understood from the perspectives of marginalized peoples, such as:
  - Histories of the use of research and evaluation with indigenous peoples;
  - Use of educational evaluations, intelligence testing, and psychological assessment with North American First Nations peoples, people of color, the poor, immigrants and refugees, people with disabilities, lesbian, gay, bisexual, transgender, and queer people;
  - In the U.S., government-sponsored medical testing on African Americans and other abuses of and by the medical system.

For reflection:

- If the concerns discussed in this section have never occurred to you, consider these questions for reflection:
  - What might that suggest about your experiences with and understandings of research-related practices?
  - Why do you suppose you have never learned about the history of oppression connected to research, evaluation, and measurement?
  - How might having this information impact how you work with people?

Measurement is alien or not culturally relevant

The ORS and SRS are products of Western empirical science. While research has shown them to be effective in improving the quality and outcome of behavioral health services, they are just one way of organizing, understanding, and talking about the world. In many cultures, quantifying (verbally or numerically) one's experience in the world and relationship with others is incomprehensible – it's simply not linguistically possible. Conceptualizing experience in a linear and finite fashion (e.g., straight lines with fixed start and end points as found on the ORS and SRS) is equally foreign. In some cultures, for example, it is impossible to answer the question, "how are you doing" outside the context of relationships or without inquiring about the well being of those close to the person being asked.

What to do:

- Hire a member of the community being served to work as a consultant. Because the challenge is learning how others make meaning, this person need not be a mental health professional.
- Participate in ongoing professional development training on issues of cultural competence and oppression. A list of suggested readings can be found at the conclusion of this manual.
- Make a mental shift from "learning about" to "learning from" the client.
- Focus on understanding the individual within their culture instead of taking a "cultural tourism" approach.

For reflection

- If you had never questioned the idea of a "self" independent of other important people in your life, consider how this and other cultural assumptions might unknowingly impact your clinical work.

Regarding the use of the measures with people who experience marginalization:

* Be curious and respectful about clients' caution, honoring it as an important act of resistance to their experience of oppression and/or an act of self-agency and critical thinking.
* Ask what meaning the client makes of measurement in general and of the ORS/SRS in particular:

  I'm really interested in your position on this and respect your caution – what kinds of experiences have you had with measures that lead you to question their use here?

  What concerns in particular do you have about how this may be harmful to you or others?

  How important is it and what does it mean for you to speak against its use?
* Do not try to persuade, explain, justify, convince. Do ask questions that communicate openness, respect, and interest in the client's experience:

  It sounds really important that you take a stand on this. What do you need me to understand about your position on this so that we may work together?

  Sounds like you have some really serious reasons for not trusting what this is about, is that right?
* When misunderstandings occur, be humble and accountable. Focus on understanding what was experienced rather than clarifying what was intended.
* If the alliance is at risk, set the measures aside. Find ways to work together that fit with the client's values and ways of making meaning.

  What are some things we can do or ways we can talk that fit for you, respect your concerns, and can help us work our best together?

  If we toss out the lines and the numbers, what ways would you suggest that we could use?

  How might we talk about and understand together how the concerns that have brought you here are impacting you and how our conversations are impacting those concerns?

  If we think of the lines and numbers on the forms as a kind of language, what language can we translate to that allows you to speak about your experience in a way that better fits for you? Is there a language of colors or shapes or images or…?

  In your relationships, how do people talk about these things and work things out in ways that are helpful, respectful, and meaningful?

f. Partner violence

Clinical work with people who have either been the victims or perpetrators of violence in intimate or family relationships carries with it many serious considerations. Moreover, there are many complex and varying ethical, political, and cultural perspectives regarding how best to engage in this work. In this context, it is important to remember that FIT is not a treatment approach. Regardless of the method used or problem being treated, enlisting client feedback via the ORS and SRS is designed to facilitate dialogue and strengthen the alliance between client and therapist.

Case example

Tim, 29, was court-ordered to a domestic violence program following his arrest for threatening his girlfriend with a knife. He is required to attend an eight-week psycho-educational group followed by 12 sessions of individual therapy. At an intake meeting, Tim announces that he's only there because he wanted to stay out of jail – not because he has "an anger problem."

Stephen, the intake counselor, explains the ORS and asks Tim to fill it out. After considering the form for a bit, Tim marks and hands it back to Stephen. Each of the four lines contains two marks!

When asked to explain, Tim says, "Well, the higher marks, that's when I think about how I know I REALLY am – I'm fine. The lower marks, that's how dealing with this shit affects everything."

Stephen marked up both sets of scores and color-coded them on the graph. He commented on how Tim's "real" score, 33.5, was certainly a score indicative of someone doing "fine." The ORS total for Tim's score when thinking about "dealing with this shit affecting everything" was 17.5. "Does it feel like as big a difference as those two scores make it sound?" Stephen asked.

"Yeah, I'd say my life is about half as good since she had to go and make something out of nothing."

"So, would getting the lower score closer to the higher one be one way of thinking about what could come from the program for you? Or, do you have other thoughts about that?"

"I'd like one score – the high one, and if my coming to this program is going to get rid of the low score, fine. I don't see how that's going to happen."

Stephen went on to ask Tim to score the ORS from the perspective of the court and his probation officer. He scored both of these as 7.7. Stephen asked Tim to explain what his thoughts were about why the people responsible for his mandate thought he was doing so badly.

"Because they think I'm a big freakin' monster with anger problems going around beating women, that's why!"

"So, getting them to think differently would be important?"

"You could say that."

Stephen and Tim talked awhile more about the various perspectives involved with Tim's situation. Stephen completed his intake and asked Tim to fill out the SRS. Tim scored the SRS at 38.7 and thanked Stephen for not "accusing me of all kinds of shit."

A common concern among those working with people on the receiving end of partner violence is that use of the ORS risks "blaming the victim." On this note, it is important to remember that the ORS was not designed to function as a diagnostic or evaluative tool. On the contrary, the measure is a means for the client to describe their overall experience of distress or well-being. As such, the ORS does not locate presenting problems "in" or "on" someone and can actually serve to purposefully and deliberately privilege the client's perspective.

Case example

William, 55, recently left his long-time partner Drew, after years of emotional and physical abuse. Following a particularly severe beating, Drew was arrested, served time in jail, and prohibited from having any contact with William. He currently is on probation pending further domestic violence programming and a psychological assessment.

For his part, William sustained injuries in the last assault that affected his ability to walk and work. His younger brother Mike and sister-in-law Debbie urged him to meet with a therapist. At the first meeting, Diana, the therapist, asked William to fill out the ORS, emphasizing in particular how his voice, perspective, and preferences were very important to her and to their work together. William's scores on the Individual, Social, and Overall items fell at the low end, ranging between 2.5 and 3.5. He'd rated the item about interpersonal well-being (a measure of close relationships) a zero.

Diana asked him if the interpersonal area, given its lower score, was what he might want to focus on during the session. William responded, "It's too late. That score just represents how I've lost Drew. I want him back but I guess you'd say I'm a 'zero' in relationships."

Crucially, the scores on the ORS provided an avenue to understand and process complex feelings related to his relationship with Drew. First, Diana acknowledged the loss, then she used the scores to clarify and extend the conversation.

"I'm wondering about that zero, William. Are you saying that you are 'a zero' and that you had something to do with Drew attacking you? Or that, in this area of your life, including all of your closest relationships, things are going really badly – they're a zero on the scale?"

After thinking a bit, William replied, "Well, I have been feeling like a zero. But the truth is I do have some really good close relationships. So many friends and all of my family, they are carrying me right now." He paused for a moment, then continued, "Maybe it's not... no it's definitely not a zero. And neither am I."

At the end of the session, William filled out the SRS, marking the "relationship scale" an 8.6. When Diana asked if there was anything she did or didn't do that led him to feel as though she wasn't hearing or understanding him, he quickly replied, "Oh, it's just me. I have walls up. It's me. You were fine."

Diana explained that the SRS was really about what she was doing and that she relied on his "most honest feedback (you can't hurt my feelings)" in order to be as helpful as possible. She also said that if he felt "walls" come up, she was interested in knowing what she may have done to invite the walls or what she could do to help keep walls from coming between them. She inquired briefly about the last time William was asked to tell someone that he was not satisfied. Diana let William know that she would continue to ask for feedback and clarification because his ideas and experiences were "most important."

Summary of the Recommendations for FIT with Specific Populations

- Being feedback-informed is about practicing responsively, flexibly, and reflectively thereby maximizing the fit between therapists and the diverse clients seeking help;
- FIT can be applied whenever, wherever, and with whomever feedback might prove helpful in improving service delivery;
- The ORS and SRS are conversational tools designed to facilitate conversation with rather than evaluate or diagnose clients;
- Understanding is not the same as agreeing; and
- Whether or not the ORS and SRS are used to guide practice, reflecting on the assumptions and ideas that inform and limit one's work is central to achieving clinical excellence.

II. FIT in Group Work

Both individual and group therapy have proven helpful in assisting distressed clients (McRoberts, Burlingame, & Hoag, 1998). Given the possibility of working with more than one person at a time, many agencies and practitioners have come to view the latter as a more efficient means of service delivery. Indeed, in some settings, staff and funding limitations have made group therapy the primary means for meeting the demand for treatment. A brief overview of applying FIT in group work was provided in Manual 2. The information that follows provides more detailed instructions as well as addresses a number of common issues that emerge when applying FIT in groups.

The essence of feedback-informed treatment is using information generated from the routine assessment of the therapeutic relationship and progress in treatment to guide service delivery. The standard ORS is used to measure progress in services delivered in groups. A special scale, the Group Session Rating Scale (GSRS), has been developed to monitor the quality of the alliance (Duncan & Miller, 2007). The GSRS not only provides information about the alliance between the individual client and group leader but also several additional variables associated with effective group treatment: (1) the quality of the relationship among group members; (2) group cohesiveness; and (3) group climate (Burlingame, McClendon, Theobald, & Alonso, 2011). In a large, multisite, international study, researchers Quirk, Miller, Duncan, and Owen (2012) found the GSRS to be reliable and valid as well as capable of predicting early treatment response – an important determinant of engagement and outcome.

The instructions for completing the scales are the same as when the measures are used in individual sessions (see Manual 2). Group leaders may decide whether to administer the ORS immediately prior to or during the group session based on the size of the group and time limits involved. Both approaches have been used in clinical practice. Teaching

participants how to score and plot their ORS scores at the initial group meeting is one strategy that has proven effective and efficient. A clipboard containing the measure, along with a pen and a ruler, can be made available to each participant at the outset of future meetings. As in individually delivered services, the GSRS is administered at or near the end of the meeting. Here again, members can be taught to complete, score, and plot their own results in order to maximize efficiency.

With regard to the interpretation of the measures, the meaning and use of the various statistical indices are the same in individual and group administered therapies. Thus, the clinical cutoff for the ORS is 25 for adults (18+), 28 for adolescents (13-17), and 32 for children (6-12). Scores below the clinical cutoff are typical of people seeking help. Initial client scores above the clinical cutoff are typically obtained by people who are not distressed, mandated into treatment, or asking for help for a single problem or complaint. The clinical cutoff on the GSRS is 36. Monitoring and discussing GSRS scores helps alert and provide opportunities to address alliance and cohesiveness problems among individual members and the group as a whole. In general:

- GSRS scores that start and remain low are associated with higher dropout rates and poor or negative treatment outcomes;
- GSRS scores that start and remain high are associated with positive treatment outcomes;
- GSRS scores that start low but improve are associated with lower dropout rates and superior outcomes;
- GSRS scores that start high but decrease are associated with higher dropout rates and poorer treatment outcomes.

Statistical indices aside, the key to using the ORS and GSRS effectively in groups is insuring that the process facilitates open discussion among the members. With regard to the ORS, group members can simply be asked to indicate by a show of hands whose scores have improved, whose have stayed the same, and which, if any, have experienced deterioration since the last session. Members can then be asked to decide where to start the conversation. Similarly, with GSRS, the group leader can ask members to indicate whether they fall above or below the clinical cutoff. Those scoring higher than 36 can then be encouraged to discuss what went well while those scoring below can present their concerns about the group and its members. Given both time constraints and the very real concerns that some members may have about giving negative feedback to the group or particular members, leaders should at a minimum follow up privately with anyone scoring below 36 on the GSRS following the group.

Case example

Susan is conducting a weekly therapy group for clients with depression. Recognizing the importance of obtaining client feedback, she decides to incorporate the ORS and GSRS into the process. At the first group, she provides each client with a clipboard, 10 cm ruler, pen, paper copies of the ORS and GSRS, and graph for charting scores. As the group begins, Susan works to create a "culture of feedback," explaining how the measures work and the importance of monitoring progress and the alliance to the success of the groups.

After completing the measures, Susan directs the group in a discussion of the scores, asking the members to discuss the specific areas that stood out for them. Near the end of the session, Susan introduces the GSRS and asks the clients to comment on their scores, paying particular attention to those falling below the clinical cutoff. The resulting feedback is used to facilitate a discussion about how the group process could be improved. In subsequent sessions, a similar routine is followed. Feedback regarding progress and the alliance is used to guide and improve each member's experience of the group.

III. FIT in Long-term Therapy

As reviewed in Manual 1, a sizable body of evidence documents that the majority of measurable change in successful episodes of care occurs earlier rather than later. An absence of change in the beginning of treatment is associated with higher likelihood of termination without a significant improvement in well-being. At the same time, research reviewed in Manual 4 showed that there can be substantial variation in progress among individual clients. Simply put, some clients improve rapidly while others take longer (Baldwin, Berkeljon, Atkins, Olsen, & Nielsen, 2009).

Balancing the expectation of early change with awareness about variation in individual rates of change is an important clinical skill. In all instances, the key to success is collaboration, seeking the client's view of his or her progress as compared to established norms. "Checking in" with clients communicates respect and concern. Recall that the purpose of seeking feedback is not to accelerate but rather accommodate treatment to the individual client.

A number of challenges arise when using the ORS to track progress in treatments that extend over longer periods of time. What clients deem important for discussion is, for example, likely to change. An initial focus on a particular problem or goal may give way to another. A client's perception of his or her overall well-being may change as more challenging or complex material emerges and is discussed. Clients starting with rather modest expectations might alter their view of the highest or best score possible as progress is made. With some clients, scores might actually lower or stagnate even while verbally reporting progress from session to session. It can be tempting to spend less time discussing the scores as they plateau or become "fixed" at a particular level. At times, scores on the outcome and alliance scales can be congruent and at other times conflict with clients' within session reports of progress and process. In all such instances, checking in is essential for insuring that the measures accurately reflect the client's experience of progress and alliance.

Case example

Carl was referred by his primary care physician for treatment of long-standing problems with agoraphobia. His score on the ORS dropped from 14.3 to 6 over the course of eight sessions. When asked about what might be causing the decline, Carl cited increasing conflicts in his marriage. He further noted that all four scales on the ORS were lower because the difficulties he experienced with his wife impacted all areas of his life.

Despite additional sessions and a change of focus in treatment, Carl's scores remained low. When Carl said that he was beginning to wonder whether therapy could really help him, the therapist initiated a conversation about the SRS. How, she wondered, could Carl consistently rate the sessions so high given the doubt he was feeling about the process? After reviewing the items on the SRS, Carl replied that, although he was not certain how, perhaps the approach needed some adjustment. Together, Carl and his therapist explored what might increase Carl's sense that treatment was moving in the right direction. Few, if any, new ideas emerged. Scores on the ORS remained unchanged over the next few visits.

Eventually, Carl's therapist returned to an earlier suggestion about travelling together to a local shopping mall for "in vivo exposure." Although he had balked when the idea was first presented, he now expressed a willingness to try. Several months later – along with substantial improvement – Carl reported to his therapist that without the earlier discussion and struggle regarding the low ORS and high SRS scores, he would not have been willing to risk going to the mall – an experience he considered central to his improvement – and more than likely would have dropped out.

Note

Discussions about a lack of progress or problems in the alliance do not always lead to the development of remedial action steps. Some clients need time to think or experiment. Others may never be able to identify a specific difficulty in the therapeutic relationship responsible for the lack of progress. In such instances, therapists will need to focus more on process and less on content, using the measures as a common reference point for discussion rather than tool for guiding service delivery.

Case example

Several previous treatments had failed to help Sabrina manage her mood swings. She expressed wariness about starting again given her prior experiences, claiming that therapists never seemed to get her, and always ended up pushing her to take medication or engage in some other "canned" treatment. More than once, she claimed, therapists had tried to get rid of her when she refused to do "something stupid" they recommended.

Not surprisingly, Sabrina expressed hesitation about using the ORS and SRS. Following an in-depth discussion about the nature and purpose of the scales, she agreed to their use on a "trial basis." The first 10 to 12 sessions went very well. Sabrina commented about the difference between her current and prior experiences, noting in particular how the scales helped her to overcome impasses and feel understood. Then Sabrina's ORS scores began to change, sometimes vacillating by 15 or more points from session to session. Sabrina maintained that the graphs accurately represented her experience, with high scores indicating that she was really excited, and low scores a response to events that left her feeling utterly hopeless.

Helping Sabrina regulate her emotions – "holding onto the good in the midst of the bad" – became the focus of therapy for the next 30 visits. Over time, the wide swings in scores tightened. Her average score steadily moved higher and into the nonclinical range. Looking back, Sabrina mentioned how monitoring her scores at each session had contributed to her success, helping her accept the fleeting nature of intense feelings and be "less taken in" by the highs and lows. She no longer felt defined by the feeling she was having at any given moment, bouncing between exuberance and despair. Feet firm on the ground, she was finally feeling more balanced.

IV. FIT in specific service settings

A. Multi-service and multi-service provider

It is not uncommon for clients to access multiple services or treatment providers within a given agency or treatment setting. For example, a client may receive individual counseling while simultaneously attending weekly groups and meeting on occasion with another service provider. In such instances, administration of outcome and alliance measures remains important but can be complicated. The key to success is coordination; specifically, when will the scales be administered, by whom, and how will access to the results be managed?

The ORS was originally designed to be administered at each session or "point of service." At the same time, there is little value in administering the scale more than once a week. Doing so not only risks clients experiencing "measurement fatigue," but is also likely to reflect daily ups and downs rather than change over time. To avoid these complications, agencies providing multiple services delivered by different providers should use the ORS to track overall client progress rather than the effectiveness of any one particular program or clinician. The situation is not unlike a hospital setting where different procedures are provided by diverse providers and all have access to test results regarding the patient's overall health and functioning.

The following are some ideas for coordination of administration of FIT measures in shared care settings:

- Some agencies use electronic records that link services and providers thereby enabling communication about ORS and SRS scores;
- Clear practice guidelines should be in place so that clinicians know when to administer the measures and who is responsible for tracking and discussing progress with clients;
- A key service provider or case manager may be assigned the role of administering the measures to the client and communicating with other programs and service providers regarding the client's progress and any issues emerging regarding the fit of services being provided;

- A special group can be organized for administering and discussing the ORS and SRS. Results can be summarized and recorded in the client record and access given to all providers and programs.
- Clients can be asked if they are seeing other clinicians in an agency and if so, if they have been completing the measures with those other clinicians. A decision can be made collaboratively with the client to determine which clinician will be responsible for administering and tracking the client's FIT measures.
- If the agency uses one of the computerized FIT data management systems (e.g., fit-outcomes.com, myoutcomes.com, M2FIT.com, the Therapeutic Outcome Management System app, etc.), the system can be set up so that all providers share access to all clients through one shared log in. Such systems make transferring records regarding progress and the alliance easy when clients move to different providers and programs.

B. Intensive day treatment, residential, inpatient, and withdrawal management settings

FIT can and is being used effectively in more intensive treatment settings including day treatment, residential, inpatient, and medical detox. Consistent with the information presented above, frequency of administration of the measures in these settings needs to be considered. Recall that the ORS is designed to measure progress, not clients' day to day experiences. The scales can be administered individually or in group, the ORS being given at the beginning of each week and the SRS at the end.

Utilizing outcome and alliance measurement in a detox setting presents its own unique challenges. Selecting the appropriate time to introduce the measures to clients in withdrawal is an important consideration. Length of stay may vary from a few days to a couple of weeks depending on the type of substance involved and overall health of the client at admission. Clinical experience indicates that administering the ORS and SRS to clients in the acute stages of withdrawal is not particularly helpful. Many in the acute stages of withdrawal experience a variety of debilitating physical symptoms and varying levels of cognitive impairment. That said, most are capable of completing the measures within 48 hours of admission. It is always a good idea to administer the ORS prior to discharge or transfer. In fact, by providing information about the amount of change and current client functioning, such a score can aid in making decisions about the level and intensity of aftercare needed.

Case example

A poly-substance abusing client is admitted to the local residential detox center. After 48 hours, the client's acute symptoms of withdrawal have subsided and the detox clinician introduces the ORS. Based on a discussion of the results, the clinician determines that the primary challenge facing the client at discharge is housing. Much to the client's satisfaction, a housing placement is located that will accept the client when discharged from detox.

During the remainder of the client's stay, she participates in a number of services including an early recovery support group and acupuncture. The ORS and SRS are administered every few days and time is taken to review progress and address any issues with the alliance between the client and detox service providers. Ten days following admission, a discharge planning meeting is held during which time the ORS and SRS are administered. The ORS scores indicate that the client is still experiencing a significant amount of distress. A higher level of care is discussed with and accepted by the client.

c. Outpatient

FIT is and has been used widely in outpatient settings. Generally, sessions occur less frequently than in intensive day treatment and residential settings, thereby reducing the likelihood of "measurement fatigue." Still, clinicians wonder when and how often to administer the scales. The answer is at least once a week, the ORS at the beginning and the SRS at the end of the session.

Some clinicians voice concern about using the measures at the first appointment, fearing that the scales may interfere with the development of rapport. Research and clinical experience indicate otherwise. Administering the measures early in the process establishes a culture of feedback that strengthens the alliance as well as increases the probability of a successful outcome. Moreover, the first administration of the measures establishes a baseline against which future progress and development of the alliance can be assessed.

D. Outreach

The brevity of the ORS and the SRS make them ideal for use in nontraditional settings such as street outreach. Some suggestions for administering the measures when working outside of a formal office include:

- Creatively adapt to the situation (e.g., cutting the paper measures down to a size that fits in a pocket);
- Administer the ORS and SRS measures orally;
- Keep a pocket book handy to keep track of client scores;
- Find a quiet corner or park bench to discuss progress and alliance with clients;
- Attach the measures to a clipboard to make completion of the forms easier;
- Use an existing web-based system or app to administer the measures on a smartphone or tablet.

Manual 5 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. Refer to page 38 for the answers.

1. The current cutoff for the Group Session Rating Scale (GSRS) is:

   a. 26

   b. 32

   c. 36

   d. No clinical cutoff has currently been established for the GSRS

2. When clients access multiple services from multiple clinicians within an agency:

   a. Outcome and alliance measures such as the ORS and SRS should not be used because it is too complicated

   b. Outcome and alliance measures such as the ORS should not be used because outcomes are not valid when more than one service or clinician is involved

   c. Coordination of data collection and tracking is essential

   d. Tracking the effectiveness of individual clinicians may have to be sacrificed in order to determine effectiveness of all services the client accesses

   e. a and c

   f. c and d

3. When using the ORS and SRS with clients who have been identified as severely persistently mentally ill (SPMI), discrepancies between what a clinician observes and how the client completes the measures:

   a. is indicative of the lack of validity of the measures when used with this population

   b. is often related to the type of diagnosis the client has

   c. is a sign that the client is actively psychotic or incapable of accurately assessing his or her level of distress in the various areas of functioning or the experience of therapy

   d. None of the above

   e. All of the above

4. When a client is illiterate or cognitively impaired:

   a. Outcome and alliance measures should not be used

   b. The ORS and SRS can be administered orally

   c. The versions of the ORS and SRS designed for children or young children can be administered instead of the adult versions

   d. b and c

5. When using FIT with mandated clients it is important for clinicians to keep in mind that:

a. Mandated clients rarely show improvement
b. Mandated clients often score below the clinical cutoff on the ORS
c. Keeping these clients engaged in treatment is nearly impossible
d. Keeping these clients engaged in treatment is key to achieving positive outcomes

6. Clients who are receiving treatment for substance abuse issues tend to:

a. Deteriorate if their intake score on the ORS is above the clinical cutoff
b. Show improvement in the first few sessions but typically don't change much after that
c. Improve regardless of whether their intake ORS score falls above the clinical cutoff or not
d. None of the above

7. In residential withdrawal management settings:

a. The ORS should be administered at intake and discharge
b. The ORS should not be administered
c. The ORS can be administered when acute withdrawal symptoms have passed, usually after about 48 hours
d. The ORS should be administered just before discharge when withdrawal is complete

8. Which of the following statements is true? When using FIT in the treatment of domestic violence:

a. The ORS should not be administered to the victim of violence because it implies the victim has a deficit
b. The ORS should not be administered to a client who is mandated by the court for domestic violence because the client is likely to lie
c. The ORS can be used to negotiate goals for treatment for clients mandated due to domestic violence but the goals of the court and the victim should also be considered
d. The ORS can be used to negotiate goals for treatment for clients mandated due to domestic violence but not the goals of the court and the victim

9. In residential treatment settings it is recommended that:

a. The ORS and SRS are administered at admission and discharge
b. The ORS is administered at the beginning of the week and the SRS is administered at the end of the week
c. The ORS is administered at the beginning of each day and the SRS is administered at the end of each day
d. None of the above

10. FIT Practitioners can become more culturally responsive by:

a. Learning about how research and measurement is understood from the perspective of marginalized peoples
b. Take a course on cultural competence
c. Ask clients about the meaning they attach to measurements such as the ORS and SRS
d. All of the above

Answer Key

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

FAQ

Question:

Is there a group outcome rating scale?

Answer:

No, the ORS is a measure of each individual client's distress whether they are in a group or not. If one is trying to determine the effectiveness of a particular group (i.e., how effective is the anxiety and depression group?), it may be possible to determine this by aggregating the group scores and determining an average change score for the group.

Question:

Why are there no numbers on the scales of the measures?

Answer:

There are no numbers on the scales because numbers influence how people interpret the items. Both the ORS and the SRS are visual analog scales (VAS). As the name implies, a VAS translates a construct or concept into a simple visual representation. In the case of the adult ORS and SRS, that visual symbol is a line. On the YCORS and YCSRS, a series of faces is used.

Question:

Is it okay to allow clients to write a number on the scales to represent how they are doing? Some of my clients write numbers on the scales even after I explain to them how to fill in the measures. How can I avoid having my clients write numbers on the scales? Why can't I just put the numbers on the scales?

Answer:

Clinicians should not add numbers to the scales. It is not only a violation of the licensing agreement but more importantly, it affects the validity and reliability of the measures. One way to help clients understand how to complete the measures is to have a sample of a completed measure available to show the client. That said, if a client puts numbers on the scales, simply use their numbers when determining the total score. Alternately, use a ruler to measure to the client's mark and then compare and discuss the difference between that number and the measured score. Remember, the ORS and SRS are tools for engaging the client.

Question:

Can I add extra questions to the ORS to measure progress in dealing with specific issues or problems? For example, asking domestic violence clients if they are more confident about remaining nonviolent or substance abuse clients if they are more confident of remaining drug free?

Answer:

As noted earlier, therapists should not alter the ORS and SRS. There is, however, nothing stopping clinicians from using other measures specific to the issue being addressed.

Question:

Are the ORS and SRS measures available in other languages?

Answer:

Yes, the adult, child, young child, and group versions of the Outcome Rating Scale and Session Rating Scale have been translated into many different languages. The translated measures are available for download at www.centerforclinicalexcellence.com.

Question:

Should the ORS and SRS be administered to existing clients?

Answer:

Be cautious. If a client who has been in treatment for some time before the clinician incorporated the scales into their practice complains about a lack of progress or difficulties in the alliance, then it can be helpful to introduce the scales. If, however, the client is not complaining and progress is being made, introduction of the scales may be disruptive.

Question:

Is it advisable to administer the ORS and SRS to clients who come to sessions in highly agitated states?

Answer:

Clinicians may fear that introducing the measures to clients who are upset or in crisis might be disruptive. Here again, research and clinical experience indicates otherwise. Typically, the more comfortable and natural a clinician is with the measures, the easier it is for him or her to utilize the measures in situations where clients are highly charged emotionally. 911 operators who frequently deal with people in extreme distress are able to elicit necessary details in order to dispatch the appropriate assistance. Likewise, clinicians can use the ORS to elicit information from highly distressed clients to identify immediate concerns. If paper and pencil or electronic administration seems problematic, the oral versions of the measures can be used.

Suggested reading for working with marginalized people

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