The Outcome Rating Scales (ORS) & Session Rating Scales (SRS): Feedback Informed Treatment in Child and Adolescent Mental Health Services (CAMHS)

Prepared for CYP-IAPT by: *David C. Low, Norfolk & Suffolk NHS Foundation Trust, Scott D. Miller, International Center for Clinical Excellence (ICCE), Brigitte Squire, Cambridgeshire & Peterborough NHS Foundation Trust.*

Introduction

Monitoring the young persons and carers feedback on progress with the Outcome Rating Scale (ORS) and the alliance with Session Rating Scales (SRS) is a natural fit for clinicians who strive for a collaborative clinical practice. The ORS and SRS gives young people and carers a voice in treatment as it allows them to provide immediate feedback on what is working and what is not. This section details how clinicians can use the ORS and SRS for real time feedback to inform treatment thereby improving the outcome of services they offer to young people and families. A brief overview of the empirical evidence of both scales, and the research of their combined use will be provided. In addition, the majority of this section will be practical and provide an introductory illustration to the use of the ORS and SRS throughout the therapy process. At the end you will be sign posted to how to access the measures and resources available to support your use of them.

Key Evidence Base Findings

Since the introduction of the ORS and SRS in 2000, research has progressed from instrument validation to randomized control trials (RCTs).

- Research on the ORS and SRS demonstrate impressive internal consistency and test-retest *reliability* (Miller et al., 2003; Duncan et al., 2003; Bringhurst et al., 2006; Duncan et al., 2006; Campbell & Hemsley, 2009).

- In those studies the ORS and SRS show moderately strong concurrent *validity* with longer, more established measures of treatment outcome and therapeutic alliance.

- *Feasibility* (i.e. the degree to which it can be explained, completed, and interpreted quickly and easily) of the ORS and SRS is high as they are ultra brief. As a result clinicians and clients don't mind using them and so their utilization rates are higher than other measures (Miller, et al. 2003; Duncan et al., 2003). If session by session measures do not meet the time demands of real clinical practice, clinicians and clients alike may use them with reluctance at best, and resistance at worse. Much of the fear and loathing involved in doing session by session measures is not there with the Outcome and Session Ratings Scales as they usually take on average a minute for administration and scoring.

- Over 3000 young people participated in the four year validation study of the ORS with adolescents aged 13 -17, and the Child Outcome Rating Scale (CORS) for children aged 6-12 (Duncan, et al., 2006). The ORS with the adolescents and CORS significantly correlated with the Youth Outcome Questionnaire (YOQ 30), and both showed robust reliability, validity and feasibility.

- Four studies, including three RCTs, support the efficacy of using the ORS and SRS as a client feedback intervention across various treatment approaches (Miller, et al., 2006; Anker et al., 2009, Reese et al. 2009a & 2009b).

The three RCT's and several quasi-experimental studies to date provide ample evidence that routine use of the scales improves retention and outcome (in terms of functioning) while decreasing deterioration, length of stay and costs. Shortly, the ORS & SRS: Feedback Informed Treatment (FIT) will receive designation as an evidence-based practice by the U.S. federal government.

ORS and CORS

The ORS is a simple, four-item session by session measure designed to assess areas of life functioning known to change as a result of therapeutic intervention (see appendix). To encourage a collaborative discussion of progress with clients, Miller and Duncan (2000) developed the ORS as an ultra brief alternative to longer measures whose length of administration, scoring, and interpretation made them less practical. The ORS assess

four dimensions of client functioning that are widely considered to be valid indicators of successful outcome (Lambert et al., 1996):

1. ***personal or symptom distress*** (measuring individual well being).
2. ***interpersonal well-being*** (measuring how well the client is getting along in intimate relationships)
3. ***social role*** (measuring satisfaction with work/school and relationships outside of the home).
4. ***overall well being***.

The ORS translates these four dimensions of functioning into four visual analogue scales which are l0cm lines, with instructions to place a mark on each line with low estimate to the left and high to the right (see appendix). The ORS rates at a 13 year old reading level, making it feasible for adolescents and adults. Clients are asked to fill in the ORS at the beginning of each session.

The Child ORS (CORS) was developed for children age 6-12 (see appendix). It has the same format as the ORS but with more child friendly language and smiley and frowny faces to facilitate the child's understanding when completing the scales (Duncan et al., 2003). Some young teens might prefer the CORS format over the ORS. You can use your clinical judgment here to consider which version will engage the young person the best. So, some teenagers might fill in the CORS and some older children may fill in the ORS.

For children 5 or under there is also Young Child Outcome Rating Scale (YCORS) which has no psychometric properties but can be a useful way of engaging small children regarding their assessment of how they are doing (see appendix).

Other Ways the ORS is Different

- One source of potential confusion is that the ORS/CORS, unlike other measures, is not designed to predict what diagnosis a young person is likely to have, nor is it measuring symptom reduction. The research makes it clear that people do not seek, or stay in services when they experience symptoms, but rather when those symptoms begin to impact on their functioning (Hill & Lambert, 2004). The purpose of the ORS/CORS is to provide real time feedback on progress in client functioning.

- The ORS also has a Reliable Change Index (RCI) that provides a useful guide to help identify when change is clinically significant and attributable to therapy rather than chance. On the ORS the RCI = 5 points. So, change that exceeds the RCI and crosses the clinical cut off scores can be considered reliable change.
- Most important, unlike other existing measures, the ORS provides session by session predictive trajectories to let clinicians know at a given session if their client is at risk of drop out or negative outcome. To help make this clinical judgment, the client's current ORS scores can be compared to similarly scoring individuals in treatment.

Deciding Who Fills out the ORS/CORS

If two clinicians from a multi disciplinary team are separately seeing the young person and carers within the same week, you will need to decide between you who will be administering the ORS/CORS.

"Where is the Distress?"

The ORS/CORS is designed to assess distress and help measure progress. So in deciding who in the family is to fill out the ORS/CORS, ask yourself: Where is the distress? In most first interviews you won't know where the distress is, so you can ask all family members to complete the measures on themselves to see who is distressed.

Child and Young Person

The young person who is referred or is seeking help, is always asked to fill out the ORS (ages 13 to 18) or CORS (ages 6-12) on themselves.

Carer

The carer is always asked to complete the ORS/CORS on the young person. For instance, if the young person is 13 or over and fills out the ORS, the carer fills out the ORS on how they perceive the young person doing. Similarly, if the young person is 12 and under and fills out the CORS, than the carer fills out the CORS on the young person.

N.B. Even if the carer is invited to fill out the ORS on themselves, they still fill out the ORS or CORS on the young person.

Carer and/or Other Family Members who are Distressed

If it turns out that the carer and/or other family members are distressed, and the distress is related to problems in the family (including the child), then you can continue to have the

carer and family members filling out the ORS/CORS on themselves. Your plan and approach should consider how those individual family members' needs will be met.

If the distress of a carer seems separate and/or beyond what your service can provide, discuss and plan with the carer what individual services they would find beneficial.

Teachers and Other Professionals

Teachers or other professionals closely involved, and who can attend periodic meetings, can also be asked to fill out the ORS/CORS on the young person.

Mandated or Involuntary Clients

Mandated or involuntary clients, who frequently present as not distressed or report they have no problem, can be asked to fill out the ORS/CORS from the point of view of the person who is distressed and who has concerns for them. Similarly, you can ask them to fill the ORS/CORS from the perspective of the referrer who has concerns about how they are doing. At the same time, ask the client to fill out the ORS/CORS on themselves, with the rational that you want to make sure that whatever you do together doesn't impact their stated functioning negatively.

Introducing the ORS/CORS at the First Session

Avoid clinical jargon and explain the purpose of the ORS or CORS and its rational in a common sense way. For instance, you can introduce the ORS/CORS by saying that it is designed to assess distress and help measure progress. The specific wording is not important. When administering the ORS and CORS it is useful to read the instructions out to the clients and ask if they have any questions before they start. The following are a couple examples:

To young person and carer: *Before we get started I would be grateful if could help me out by taking a minute to fill out a very brief questionnaire to help me understand how things are going for (young person's name). Every time we meet I will ask you to fill the form again to help us track progress. Are you ok with that? Ok, so let me go over the instructions with you.*

However, at most first interviews you won't know where the distress is, so you can ask **all** family members present to complete the ORS on themselves. This allows you to "see" who is distressed.

To carer and other family members present: *I would also be grateful if all of you can fill the form out on yourselves to help me understand how things are going for you too. Even if things are going ok with you, I would be grateful if you could do this today and on a periodic basis, to ensure that whatever we do together doesn't impact you negatively.*

When the carer is asked to fill out the ORS on themselves, they are still asked to complete the ORS about the young person. This may sound cumbersome, but remember the measure is ultra brief and takes a minute to do.

Discussing the ORS/CORS Results

You can ask family members to feel free to talk amongst themselves for a couple minutes while you score the ORS. Scoring is done in front of the client using a centimeter ruler. Each of the four visual analogue scales is 10cm, so the score for each of the four visual analogue scales is the measurement length on the ruler (e.g. 3.3cm = score of 3.3) with 10 being the highest score for each scale. You simply write the score in the right margin, and then add the four scores for the overall score. The total possible score is 40. If working with families, you can teach family members how to do the scoring to help save time and as a way of engaging them in the process.

Next plot each person's overall score on a graph (see appendix) or entered into an electronic data base to monitor the trajectory of progress.

The ORS/CORS cutoff scores between the clinical population and the non-clinical population are different depending on the age of the client:

- 13-17 year olds (self reporting & carer reporting on teen) = 28
- 18 and over = 25

The CORS (ages 12 and under) cutoff scores are:

- Child Self Reporting = 32
- Carer Reporting on Child = 28

It is important to explain these cutoff scores to the young people and carers.

To young person and carer: *Great, thanks. Let me show you what I have done. The four lines on the form are each 10cm. I have used the ruler to come up with a score for each line. I then have added the numbers for a total score and plotted them on this graph.*

(Young person's name) I have put your score here, and (mum's name) I have placed your score here. Scores above this line represent young people who seem to be plodding along all right in life and don't seek help. Scores below this line, like yours, are typically young people who are having problems and wanting help to make some changes. Is that true for you?

Ok, so when we fill out this form each time we meet I will be putting your scores on the graph and connect the dots, and hopefully we will soon see a line going up which will tell us we are on the right track. If it does not go up, or goes down, we will know about it right away and we can talk about it, and together work out what might need to be different and what might be more helpful.

Collaborative Formulations and the ORS/CORS Scores

It is important to help the young person and carer connect the problems that brought them to you with their ORS and CORS scores. You can incorporate this within your usual style of doing assessments and/or how you construct collaborative formulations with young people and carers.

To young person and carer (laying out the ORS or CORS in front of them). *I would be grateful if you both tell me a bit about why you put the marks where you placed them so I can better understand the problems that brought you here.*

This will often end up with a narrative about the problem which is fine. Such discussions can be apart of your normal interviewing style and how you come up with shared formulations with clients. For example:

To the young person: *It sounds like you are spending a lot of your day worrying and avoiding places out of fear, does that explain your mark here on the Me (How am I doing?) scale?*

To the parent: *It sounds like there is a lot of arguing and anger amongst family members including (young person's name), does that explain your mark here on the Family (How are things in my family?) scale?*

To teacher: *It sounds like running out of class and not knowing where he is going is your biggest concern for Kevin. Does that explain your mark here on the School (How am I doing at school?) scale? Is there anything else that helps explain your mark?*

Explore Differences in Perceptions

It is common for the young person and carer to have very different scores on the different scales which can be useful perceptual differences to explore:

"Sebastian, I noticed you rated how things are going in the family closer to the frowny face, and Emma (mother) you rated your son closer towards the smiley face. What do you both make of that?"

"Lucy, I noticed that you rate you rated yourself high on Individual (Personal well being), and Sarah (mother) you rated her quite low. Lucy, what do you suppose you know about yourself and what has changed that your mother doesn't know?"

Working out Shared Goals and Exploring Strong Preferences

You can use the scales to help establish what kind of changes and goals the young person and carers want from your help. If they have any strong preferences and ideas about treatments try to accommodate their preferences.

To young person or carer: *a) What will you and others notice that will be different when your marks on this line move from where you placed it to over here at this end near the smiley face? b) What ideas do you have about what needs to happen to move your mark from here to there (pointing at the smiley face)?*

Carer's Distress and Needs

In situations where it seems the carer's distress goes beyond the problems related to the young person, and you are concerned it is negatively impacting the young person's ORS/CORS scores, consider meeting with the carer separately to help them explore how to have their needs met e.g., using their own network of family and friends, parenting groups, couple therapy, individual therapy and doctor etc.

SRS and CSRS

Researchers have repeatedly found that the therapeutic alliance –i.e. agreement on goals, agreement on tasks in therapy & emotional bond (Bordin, 1979)—is one of the best predictors of outcome across different types of therapy including psychopharmocology (Symonds, 1991; Martin et al., 200; Wampold, 2001; Norcross, 2010). Evidence regarding alliances contribution to outcome is reflected in more than 1,000 studies (Orlinsky, Ronnestad, & Willutzki, 2004). A strong therapeutic alliance may be even more critical for youth psychotherapy than adult therapy, given that the child and young

people are typically not self-referred, and the carers or extended family usually play a vital role in treatment (Shirk & Karver, 2003).

The quality of the therapeutic alliance with the carer impacts treatment outcome for the young person. (Kelley, Bickman, and Norwood, 2010). For instance, a strong therapeutic alliance with the carer will be critical when treatment requires a focus on the carer making some direct changes to positively impact the young person. In individual therapy that is focused on the young person, a strong therapeutic alliance with the carer will be important because it is the carers who schedule and keep the appointments, provide information needed about the young person, and encourage the young person's treatment adherence in between therapy sessions (Fields, Handelsman, Karver & Bickman, 2004). Further, a strong therapeutic alliance with a carer is likely to convey hope and other positive attitudes about treatment that may encourage the young person's participation in treatment, which then in turn will positively influence youth outcomes (Kelley, et al., 2010).

In family work, establishing multiple alliances simultaneously with each individual can be a formidable task (Friedlander, Escudaro, & Heatherington, 2006). Even agreeing with one family member on the need for therapy can alienate another family member who may have come to the session unwillingly. Gaining shared agreements on the *goals* and *tasks* of therapy is an enormous challenge when family members have differing developmental needs, hidden agendas, highly variable motivations for treatment, are in conflict with one another, or have contrasting views of the problem and differing views about who and what needs to change. For instance, validating the goal of one party can alienate another. The challenge is to try to align simultaneously with all members in the pursuit of a common goal (Friedlander, Lambert, Muniz de la Pena, 2008).

Research has shown that clinicians are poor at gauging their client's experience of the alliance (Norcross, 2010) and they need to request real time alliance feedback. The benefits of requesting real time feedback on the therapy alliance include: empowering clients, promoting collaboration, making necessary adjustments to therapy, and enhancing outcomes (Lambert, 2005).

The Session Rating Scale (SRS) was developed for exactly these reasons. The SRS is a simple, 4-item pencil and paper alliance measure designed to assess key dimensions of effective therapeutic relationships (see appendix). The SRS is administered, scored and discussed at the end of each session to get real time alliance feedback from young people and carers so that alliance problems can be identified and addressed (Miller et al., 2002).

The SRS translates what is known about the alliance into four visual analogue scales (see appendix) to assess the clients' perceptions of:

- Respect and understanding
- Relevance of the goals and topics
- Client-practitioner fit
- And overall alliance.

The SRS is used with young people age 13 to adults (see appendix). The Child Session Rating Scale (CSRS) is for young people aged 6-12 (Duncan, et al. 2003).There is also a Group Session Rating Scale (GSRS) for ages 13 to adults, and Child Group Session Rating Scale (CGSR) for ages 6-12.

The cutoff score on the SRS, CSRS and GSRS is 36 out of a possible 40.

For children 5 or under there is also the Young Child Session Rating Scale (YCSRS) which has no psychometric properties but can be a useful way of engaging small children regarding their assessment of the alliance.

Introducing the SRS/CSRS at the First Session

Everyone who attended the session is invited to fill out a SRS or CSRS. In introducing the SRS/CSRS you want to convey that you are really interested in everyone's feedback about how the session went for each of them. You can explain that scores on the forms provide an opportunity for you to learn what to keep doing that is useful, and importantly what you might need to do different next time to make it better for them.

To young person and carer: *Ok, we need to end, but before we do I would be grateful if you would take a minute to fill out this form which asks your opinion about our work together today? Now, I rely on this feedback to keep me on track, and let me know when*

I am off track and need to make some changes for you. So, please give me your honest opinion when filling this out. Ok?

NB: Recall that when giving the CORS to young people you also give CORS to the carer. Here when you give the CSRS to young people, you give the ORS to those 13 and over. If you are working with a family, have everyone fill out the SRS or CSRS as your alliance with each of them is important.

Discussing the SRS/CSRS Results

Score the SRS/CSRS in front of the client. If you are working with more than one person in a session, to save time you can teach the family to score their SRS/CSRS so there is more time for discussion about the scores and address any difficulties in the alliance.

Positive feedback is valuable as it helps you know what to do more of that matches the sensibilities of a specific client and family. Although we all prefer positive feedback as it feels nice, you have to convey to clients that negative feedback is like gold to you, as it gives you a chance to make adjustments to make a better fit for them.

When scores are at the cutoff score of 36 and above:

These marks are way over to the right which suggests you are feeling understood and that we are working on the right things that are important for you, and how we are doing seems to fit for you? Is that right? Can you think of anything at all that I might be able to do different to make these meetings even better for you?

Scores that go down even a single point are significant and should be checked out with the clients. It is important to discuss any downturn on the SRS even when scores are above the cutoff. Any scores less than 9 on the four scales is an invitation for you to check out if you might have done or said something that did not sit well with them and/or how you can improve the sessions for that young person or family member.

When scores are below 36 (or one scale is significantly below 9)*:*

When you are getting scores below 36 it helps to adopt a posture of gratitude versus disappointment. Treat low SRS scores as a gift from your clients as they allow you the opportunity to repair ruptures to the alliance, and make the necessary adjustments in therapy to help improve your client's outcomes.

Ok, it seems that I could be doing better. I am grateful for you being honest and giving me a chance to try to make some changes. What could I do different next time to make things better for you?

Subsequent Sessions

Each session the ORS or CORS is given out at the beginning of the session to compare current ORS and CORS scores with previous ratings. If individual therapy is being offered to the young person, it is still important to try to capture the carer's scores by having a few minutes before each session. It can be very useful to have periodic review sessions where the carers (e.g., parent or teacher) and possibly other family members can fill out the ORS or CORS.

In each session the SRS or CSRS is given at the end of the session. It is important to leave yourself enough time for the clients to fill it out and pick up on any alliance difficulties. In many cases there might not be a next time as if there is a poor alliance the clients are likely to not attend, or come back with no change as what you are doing together is not a good fit.

To the young person and/or carer: *These scores suggest that for the past few weeks I have not been getting things quite right for you? Can you help me understand what I need to do different to make these sessions fit better for you?*

Role of Supervision and Team/Peer Reviews

Supervision is a key mechanism for supporting supervisee's integration of feedback into their clinical practice. Supervisees should bring the clients' ORS/CORS and the SRS/CSRS and graphs to supervision. The measures and the graphs bring the feedback and voice of the young person and carer directly into the supervisory session which is an invaluable addition to the clinician's perceptions of progress and the alliance. The measures can be used in a similar way in multi-disciplinary team/peer reviews and Care Plan Approach (CPA) reviews.

Further, supervisors can also utilize the measures and graphs across multiple cases to incorporate the voice and feedback of young people and carers to help the supervisee

reflect on patterns of strengths and shortcomings to assist in the targeting areas for professional growth and development.

ORS/CORS Scores Increase

When scores increase we can help clients see their hand in the changes.

To the young person: *That is encouraging: your total score increased 4 points! What did you do different to make that happen? What have you learned about yourself?*

To carer: *Your rating of (young person's name) has gone up. What have you and/or others been doing different to make things better (young person's name)? What have you noticed (young person's name) doing different that is helping?*

Young people with complex problems might only make slight improvements and need longer interventions, but a discussion of alternatives remains an important intervention at recurrent stages.

ORS/CORS scores that exceed the RCI (5 points) and cross the clinical cut off scores can be considered reliable change. This is a good time to review the progress towards the therapeutic goals with the young person and carer, and consider starting some consolidation and response prevention and end therapy.

ORS/CORS Scores Don't Improve or Go Down

In general, discuss any lack of progress or downturn on the ORS/CORS with the clients.

Look Closely at the SRS/CSRS Scores

The following are possible things to consider with clients, supervisors and multidisciplinary/peer and CPA reviews:

- Is there a problem in the alliance with the young person or carer that is getting in the way of progress?
- Review the treatment goals to see if they still fit. Are you working on the clients' goals versus the referrers? Do the goals need to be revised from the absence of symptoms (e.g., less depressed) to improvement in functioning (e.g. going out with friends and doing usual pleasurable activities).
- If you are working with more than one member of the family and there is blaming and conflict, consider using empathic messages to both sides of a conflict along

with pointing out everyone's good intentions. You may also want to transform individual goals that involve others changing, to common shared goals involving improved family relationships (e.g., "to get the family back on track" or "to restore intimacy, closeness or trust") emphasizing mutual collaboration.

- Check out that the approach is fitting and whether you need to adjust, or change to another approach.
- If there is a rupture in the alliance that you don't seem able to overcome, consider referring to a colleague.

ORS/CORS Scores Show No Progress after 3rd Session

When you have had no progress on the ORS/CORS after the 3rd session, discuss with the client and carers, and with supervisor.

To young person and carer: *The scores have not gone up, what are you hunches about why that is? These scores indicate we might need to try to do something quite different as you don't seem to be benefitting. What are your thoughts about that? What do you think we need to do differently to increase the chances of this line moving in an upward trend?*

At this point you might consider:

- Do you need to expand the work to include different members of the family, and/or school?
- Do you need to meet with the carer (e.g. parent and/or school) to ensure they understand how they can best help the young person, and/or better understand what support and help they need?

ORS/CORS Scores Show No Progress after 5th or 6th Session

If there is no improvement by the 5th or 6th visit consider adding additional services with young person, carer, and supervisor. This may involve a referral to another agency.

ORS/CORS Scores Show No Progress after 8th-10th Session

If no progress by the 8th-10th visit discuss with the client and carer about whether they need to see someone else such as another clinician with a different approach, and/or a higher level of care.

To the young person and/or carer: *I am wondering if I might not be the best person to help with this problem. Would it be useful for me to go over different types of therapies*

and clinicians we have and maybe what one of them has to offer might be a better fit with you than what I can offer?

ORS & SRS Together Facilitate Better Outcomes in CAMHS

Using the ORS and SRS provides an outcome management process to monitor and adjust treatment as a result of client feedback. The ORS/CORS and SRS/CSRS measures are clinical tools that both facilitate better outcomes IF used together to enhance engagement and participation in the care provided as the measures are discussed with young people and carers. The following is how CAMHS clinicians from different disciplines have found using the ORS/CORS and SRS/SRS to help their clinical practice:

"The ORS/SRS measures fit incredibly well into the Cognitive Behaviour Therapy (CBT) model of working, allowing monitoring of progress in functioning in a measurable way, which is explicit to clients, and also enabling monitoring of the therapeutic alliance as part of the process of obtaining feedback from clients. The young people I work with have engaged well in adopting these measures as part of the work, and have benefited from the opportunity for self-reflection and celebration of progress which these measures facilitate. For me, as a Clinical Psychologist, the measures have furthered my self-reflection, enabling me to better tailor my work to the needs' of my clients on the basis of their feedback, thus promoting the client centred, idiosyncratic approach." -- **Maria Loades, Clinical Psychologist, CAMHS, Suffolk**

"I have been using the ORS and SRS in both my Cognitive Behaviour Therapy work and in my role as a Primary Mental Health Worker. In both roles it gives me a true sense of how the client is finding our work, rather than my best (and usually inaccurate) guess. In the PMHW role, where work is often brief, the ORS has the added benefit of helping to quickly identify which areas the client is finding most difficult so that intervention can be targeted to this. I have found both measures easy to use and that they can quickly be adopted into my routine with clients. Parents and children find the visual representation of progress on the ORS very useful, and combining this with monitoring the therapeutic relationship through the SRS can give great clarity on what to do when therapy runs into problems. It is also a great aid for supervision discussions, helping aid reflection on

factors affecting progress." – **Rebecca Light, Primary Mental Health Worker & Cognitive Behavioural Therapist, CAMHS, Suffolk**

"I have found the ORS and SRS really useful in my Specialist Nurse practice. The measures have been a significant aid in supporting me with keeping client focused and this has had the knock on effect of enhancing client motivation and engagement. The measures have also been useful in facilitating conversations about what's not been quite right in sessions and challenged unhelpful assumptions that I have made within sessions, in a non confrontational manner. The measures are also great for clinician's self esteem as they provide 'evidence' of when you have done a cracking job, or are simply needing reassurance that you are doing 'ok' with a case." **– Rachael Ewan, Specialist Nurse, CAMHS, Suffolk.**

"The ORS and SRS fit very well with family work. The ultra brief design and formats for different age groups including small children, allows all members of the family an important feedback voice into the therapeutic system, and enhances everyone's engagement and participation in family work. As the measures are ultra brief they do not take much time out of the session. Families are generally curious about each others ORS scores. Where differences of opinion exist, a graph on which each family members outcome score is plotted in different colours provides a useful structure for a manageable inclusive discussion about the problem and its resolution from different perspectives. The feedback from the SRS helps clinicians make the necessary adjustments to align simultaneously with all family members in the pursuit of common agreement on goals and tasks in therapy." **-- David C. Low, Family and Systemic Psychotherapist, CAMHS, Suffolk**

"I've been using the ORS/CORS and SRS/CSRS in my day to day clinical practice for many years now. It's hard for me to imagine practice without using them these days. There is no magic about them of course, but they have really helped me think a lot more carefully about what I do and how I do it. Whether in short term work or longer term treatment, from the very first meeting the young people and their families are being included in an active way giving me feedback about what is important to them and teaching me about what I need to reconsider. It is a bit daunting at first, particularly getting the feedback through the SRS/CSRS. Not many of us like to be confronted with feedback about what our patients see needs to change with what we are doing, but this is

the aspect of using feedback that has most influenced and challenged my practice. Whether using individual or family meetings, prescribing medication, liaising with other agencies, or deciding on frequency of meetings, the feedback you get about what works and what is helpful is invaluable. In fact so inspired I have incorporated the rating scales and the philosophy around them into a whole service model for Lincolnshire CAMHS known as the Outcome Orientated CAMHS (OO-CAMHS) Project." -- **Sami Timimi, Consultant Child and Adolescent Psychiatrist, CAMHS, Lincolnshire,** sami.timimi@lpft.nhs.uk. www.oocamhs.com

"The introduction of the ORS (CORS) and SRS (CSRS) in the Cambridgeshire Early Intervention Service in CAMH enthused clinicians as it enriched their practice by obtaining so much more relevant information of their clients. Children and young people made it their own story of what was upsetting for them, which could not be captivated in by a symptom measure. They were able to express what they like or not like about the session and the therapists were very positive about any negative feedback as they change their approach. Clinicians want to continue using the measures because of their clinical significance." **Brigitte Squire, Clinical Psychologists and MST Programme Manager, Cambridgeshire.**

Additional Guidelines and Examples

- Additional guidelines and examples can be found in the ORS/SRS manual (Miller & Duncan, 2004).
- There are also 6 newly developed manuals covering every aspect regarding the use of the ORS and SRS measures in clinical practice. These were developed as part of the International Center for Clinical Excellence's (ICCE) application to the National Registry of Evidence Based Programs and Practices (NREPP) in the United States. Each service will find the manuals a valuable resource.
- These manuals and other resources are available at www.scottdmiller.com.

How to Get the Measures Free

The ORS/CORS and SRS/CSRS measures are licensed for members of CORC and CYP IAPT by Scott D. Miller and ICCE (www.centerforclinicalexcellence.com). CORC and

IAPT may distribute the measures to their practitioners. Users may also obtain the measures in English and languages other than English at www.scottdmiller.com.

Note: When down loading the measures for the first time, you may need to adjust the analogue scales to make sure they are exactly 10cm. Beyond that adaptation the license agreement involves no alterations to the ORS/CORS and SRS/CSRS.

For Comments or Information on Training in using the ORS/CORS and SRS/CSRS

For comments or information about training on skills for improving client engagement in treatment services, and how to integrate real time outcome and alliance feedback using the ORS & SRS to improve clinical effectiveness with young people and families contact:

- David C. Low, Family and Systemic Psychotherapist, Norfolk and Suffolk, NHS Foundation Trust, CAMHS, -- david.low@nsft.nhs.uk
- Brigitte Squire, Consultant Clinical Psychologist, Cambridgeshire & Peterborough NHS Foundation Trust, CAMHS-- brigitte.squire@cambridgeshire.gov.uk
- Scott D. Miller, Ph.D., Director of the International Center for Clinical Excellence -- info@scottdmiller.com

- **Appendix 1: ORS & SRS Samples**

Outcome Rating Scale (ORS)

(Ages 13 to Adult)

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

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

Individually
(Personal well-being)

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

Interpersonally
(Family, close relationships)

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

Socially
(Work, school, friendships)

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

Overall
(General sense of well-being)

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

SCORING

Each line is 10cm.

Score with ruler e.g. 3.5cm = score of 3.5.

Write the scores for each of the four lines here in the margin.

Add the four scores for a total score.

Plot overall score on the graph.

Session Rating Scale (SRS V.3.0)

(Ages 13 to Adult)

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

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

Relationship

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

Goals and Topics

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

Approach or Method

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

Overall

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

Child Outcome Rating Scale (CORS)

(Ages 6 to 12)

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

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

Me
(How am I doing?)
I----------I

Family
(How are things in my family?)
I----------I

School
(How am I doing at school?)
I----------I

Everything
(How is everything going?)
I----------I

SCORING

Each line is 10cm.

Score with ruler e.g. 3.5cm = score of 3.5.

Write the scores for each of the four lines here in the margin.

Add the four scores for a total score.

Plot overall score on the graph.

Child Session Rating Scale (CSRS)

(Ages 6 to 12)

Name _____Age (Yrs):____Session # ____ Date: _____

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

Listening

did not always listen to me. I----------I _____ listened to me.

How Important

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

What We Did

I did not like what we did today. I----------I I liked what we did today.

Overall

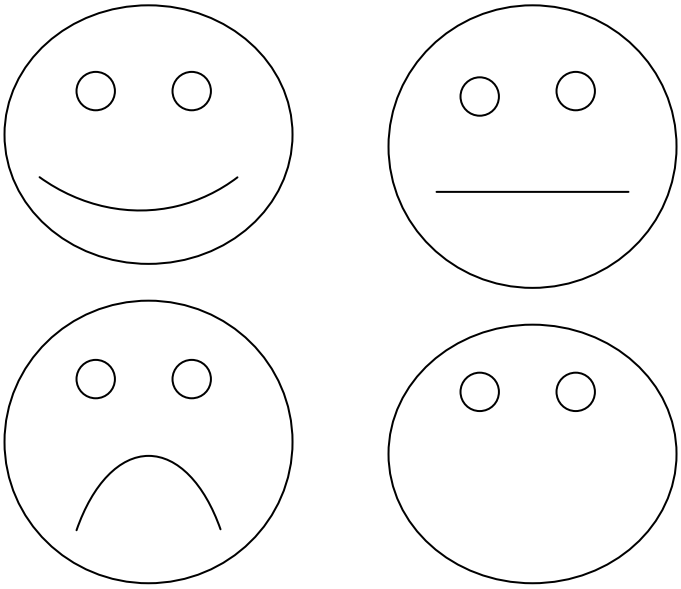
I wish we could do something different. I----------I I hope we do the same kind of things next time.

Young Child Outcome Rating Scale (YCORS)

(Age 5 and under)

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

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

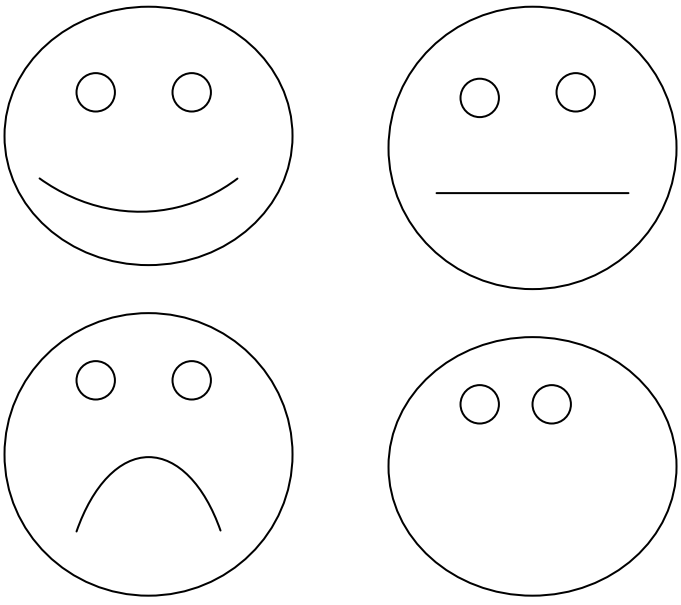


Young Child Session Rating Scale (YCSRS)

(Age 5 and under)

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

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



Group Session Rating Scale (GSRS)

(ages 13 to adult)

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

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

Relationship

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

Goals and Topics

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

Approach or Method

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

Overall

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

Child Group Session Rating Scale (CGSRS)

(Ages 6-12)

Name _____Age (Yrs):____Session # ____ Date: _____

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

Listening

The leader or group did not listen to me or like I----------I The leader and group listened to me and liked me.


How Important

We did not talk about or do important things**.** I----------I We talked about and did important things.


What We Did

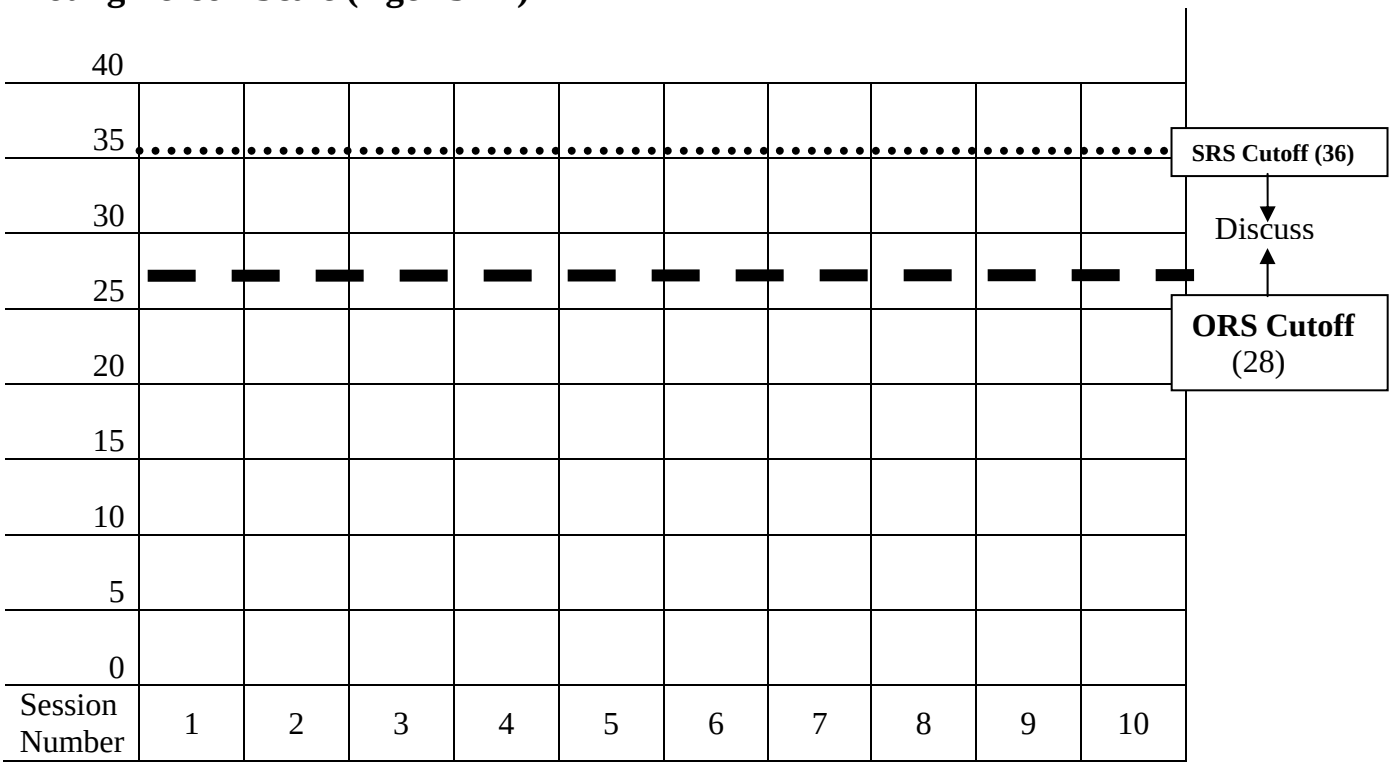
I did not like what we did today. I----------I I liked what we did today.


Overall

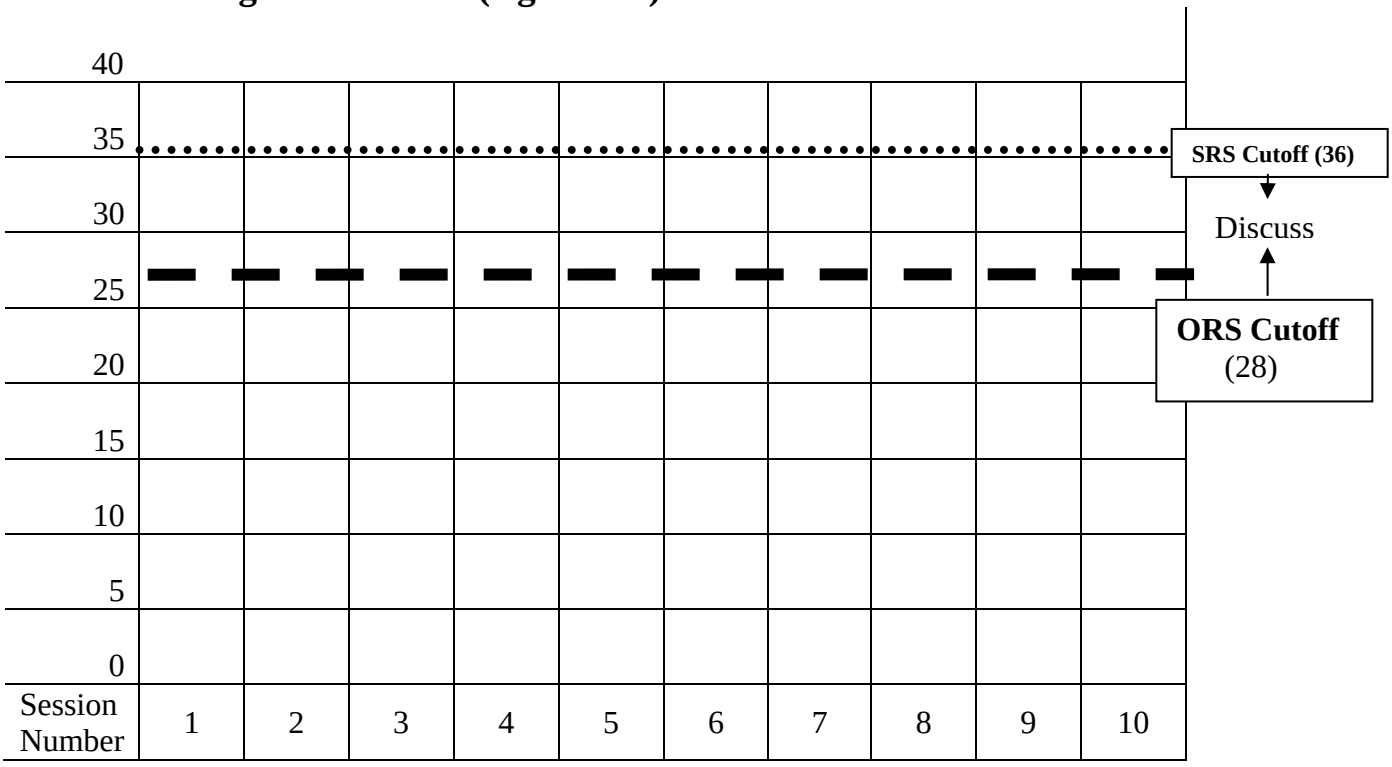
Today was not good for me—I did not feel like a part of this group. I----------I Today was good for me—I felt like a part of this group.


ORS/SRS Graphs

Young Person Scale (Age 13-17)

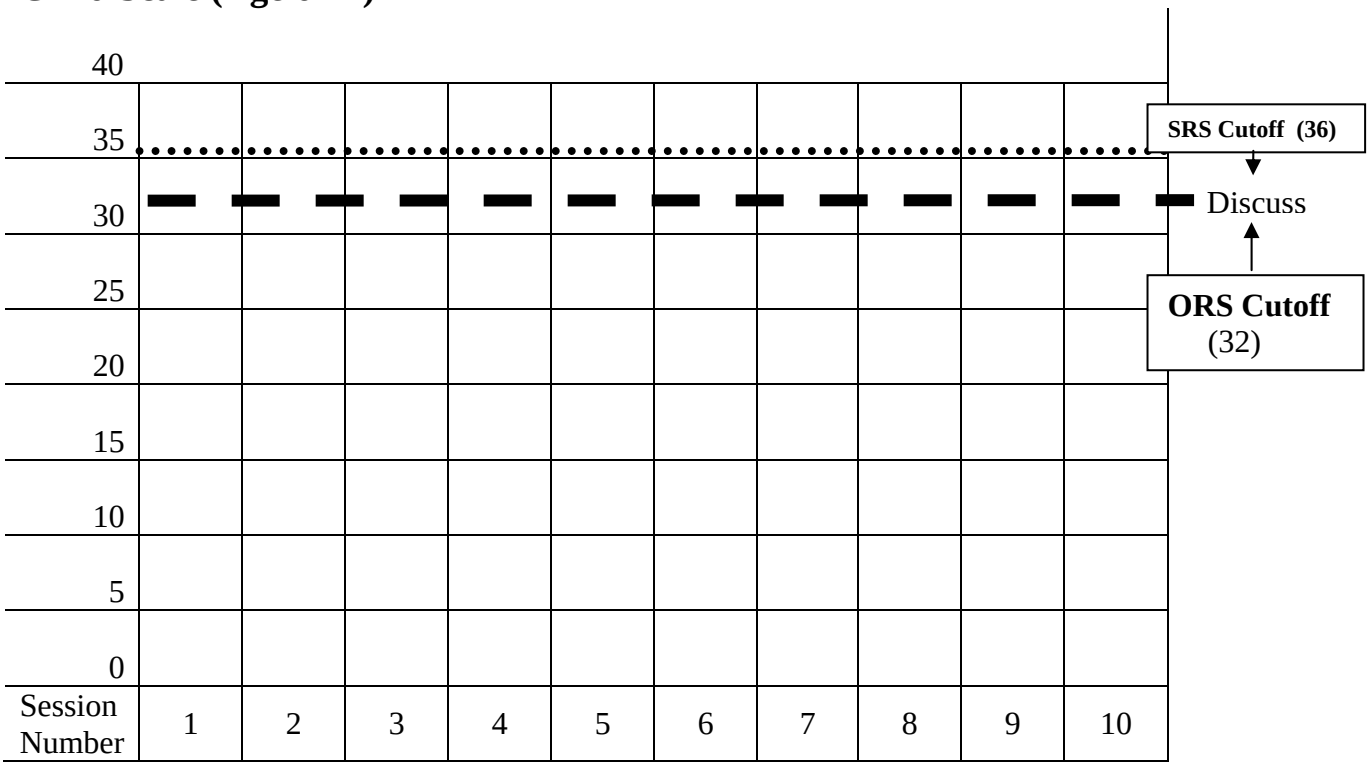


Parents Young Person Scale (Age 13-17)

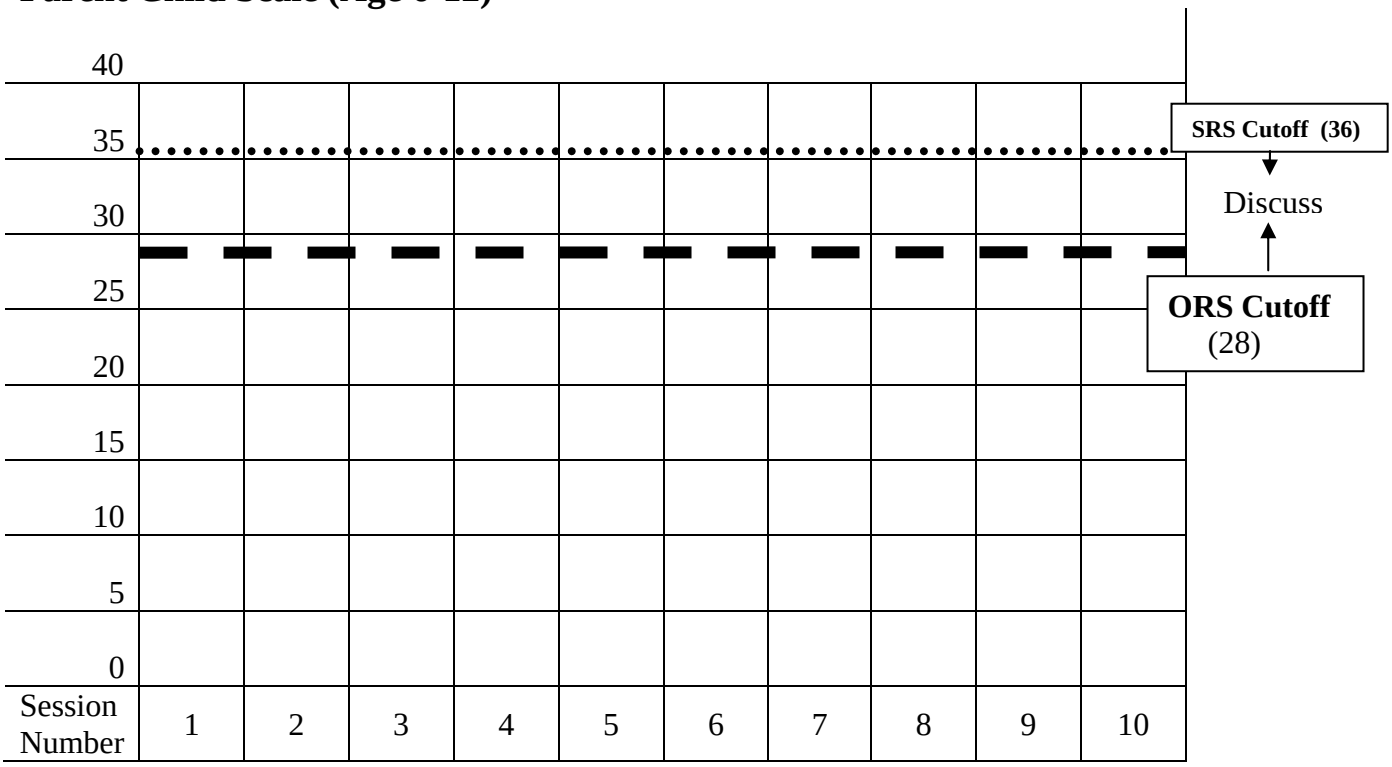


CORS/CSRS Graphs

Child Scale (Age 6-12)



Parent Child Scale (Age 6-12)



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