The Outcome Rating Scale (ORS) and the Session Rating Scale (SRS)

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The Outcome and Session Rating Scales are brief measures which can be used to track client functioning and the quality of the therapeutic alliance over the course of psychotherapy. Versions of the scales are available for adults, children, adolescents and groups in 18 different languages. The Outcome Rating Scale (ORS) is designed to assess the individual, interpersonal, and social functioning of the client, whereas the Session Rating Scale (SRS) assesses the quality of the relational bond between the client and therapist, the degree of agreement between the client and clinician regarding treatment goals, and their agreement regarding the methods and approach employed in care. The tools do not require that practitioners adhere to a particular model or approach and administering and scoring the measures is simple and straightforward. In this paper, the authors present the two measures, discuss the domains they assess, and describe how they can be used in routine clinical practice to aid in service plan development. In addition, the authors discuss the psychometric properties of the scales and describe the resources available to clinicians who wish to use them.

Keywords: Outcome Rating Scale; ORS; Session Rating Scale; SRS; treatment outcome; progress monitoring; psychotherapy

The Outcome and Session Rating Scales (ORS and SRS) are brief measures for tracking client functioning and the quality of the therapeutic alliance. Each instrument takes less than a minute for consumers to complete and for clinicians to score and interpret. Both scales were developed in clinical settings where longer, research-oriented measures had been in use and deemed impractical for routine use. Versions of the ORS and SRS are available for adults, children, adolescents and groups in 18 different languages, including French. Individual clinicians may download the scales free-of-charge after registering online at: http://www.scottdmiller.com/?q=node/6. A significant and growing body of research shows the scales to be valid, reliable, and feasible for assessing progress and the alliance across a wide range of consumers and presenting concerns.

Domains Assessed

The ORS is designed to assess the individual, interpersonal, and social functioning of the consumer. On the other hand, the SRS assesses three elements of the alliance, including: (1) the quality of the relational bond; (2) the degree of agreement between consumer and clinician regarding goals; and (3) consumer and clinician agreement regarding the methods and approach employed in care. The tools neither assume nor require that practitioners adhere to a particular model or approach. Instead, clinicians from any background or discipline may solicit feedback from consumers regarding the working relationship and outcome of care and use the resulting information to inform and tailor service delivery. Routinely monitoring of progress and the quality of the relationship is not only consistent with but also operationalizes the American Psychological Association's definition of evidence-based practice, which includes, "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, 2006, p. 273, 276-277).

Use and Procedures

Administering and scoring the measures is simple and straightforward. The ORS is given at the beginning of the session. The scale asks consumers of therapeutic services to think back over the prior week (or since the last visit) and place a hash mark (or "x") on four different lines, each representing a different area of functioning (e.g., individual, interpersonal, social, and overall wellbeing). The

SRS, by contrast, is completed at the end of each visit. Here again, the consumer places a hash mark on four different lines, each corresponding to a different and important quality of the therapeutic alliance (e.g., relationship, goals and tasks, approach and method, and overall). On both measures, the lines are ten centimeters in length. Scoring is a simple matter of determining the distance in centimeters (to the nearest millimeter) between the left pole and the client's hash mark on each individual item and then adding the four numbers together to obtain the total.

In addition to hand scoring, several computer-based applications are also available which can simplify and expedite the process of administering, scoring, and aggregating data from the ORS and SRS. As just one example, consider the web-based application, www.fit-outcomes.com. Briefly, the system organizes treatment outcome and therapeutic alliance data, and compares the scores to the expected treatment response (ETR) of the client. Importantly, the client and therapist receive feedback in real time, indicating whether treatment is on or off track. Additionally, the system aggregates outcome and alliance data across episodes of care, thereby providing clinicians and agencies with an overall measure of effectiveness as well as the ability to compare the outcomes of individual clinicians and programs. With regard to privacy and security, all data entered into fit-outcomes.com is first anonymized and then encrypted according to current international standards.

Assessment and Treatment Planning

Soliciting clinically meaningful feedback requires more than administering two scales, the ORS and SRS or otherwise. Clinicians must work at creating an atmosphere where consumers feel free to rate their experience of the process and outcome of services: (1) without fear of retribution; and (2) with a hope of having an impact on the nature and quality of services delivered. Beyond displaying an attitude of openness and receptivity, creating a "culture of feedback" involves taking time to introduce the measures in a thoughtful and thorough manner. Providing a rationale for using the tools is critical, as is including a description of how the feedback will be used to guide service delivery (e.g., enabling the therapist to catch and repair alliance breaches, prevent dropout, correct deviations from optimal treatment experiences, etc). With regard to interpreting the ORS, low scores correspond to a poor sense of well-being (or high level of distress). Note that the average ORS intake score in outpatient mental health settings is between 18 and 19. Over time, whatever the initial score, the number should increase in response to services offered. A lack of movement, deterioration, or seemingly random pattern of scores is cause for concern and should be discussed with the client at the time of service delivery. Between 25-33% of people completing the measure will fall above a total score of 25 at intake—a number known as the cutoff, or the dividing line between a clinical and non-clinical population (Miller & Duncan, 2000, 2004). The most common reason for such a score is that the consumer has been mandated into treatment. Another is that the person desires help for a very specific problem—one that does not impact the overall quality of life or functioning, but is troubling nonetheless. Less frequent causes for a high initial ORS include: (1) high functioning people who want therapy for growth, self-actualization, and optimizing performance; and (2) people who may have difficulties reading and writing or who have not understood the meaning or purpose of the tool. With regard to the latter, it should be noted that a validated oral version of the ORS is available and can be administered. Research and experience document that consumers scoring above 25 at intake are at a heightened risk for deterioration. Therefore, care should be taken to clarify the wishes of the person in treatment. In order to maintain engagement, the best approach is a cautious one. In particular, using the least invasive and intensive methods needed to resolve the problem at hand.

With regard to interpreting the SRS, research to date shows that the majority of clients score relatively high. Thus, the cutoff on the measure is 36. It is important to keep in mind that a high score (36+) does not necessarily confirm the presence of a strong alliance. The best response to a high score is thanking the consumer and remaining open to the possibility of feedback in the future. Scores that fall at or below 36 are considered "cause for concern" and should be discussed prior to ending the visit. Single-point decreases in SRS scores from session to session have also been found to be associated with poorer outcomes at termination—even when the total score consistently falls above 36—and should therefore be addressed in the session

(Miller, Hubble & Duncan, 2007). Interestingly, there is growing evidence that the process of responding to a client's negative feedback, even about an aspect of therapy that may seem relatively trivial, can contribute to the strength of the therapeutic alliance and set in place a strong foundation for future work. There is also evidence that the most effective therapists elicit more negative feedback from their clients. Whatever the circumstance, openness and transparency are central to successfully eliciting meaningful feedback on the SRS.

Technical Support

An international, online community is available to support the use of the scales for informing, evaluating, and improving the quality of behavioral healthcare. Membership in the International Center for Clinical Excellence (ICCE) is free-of-charge, open to clinicians from all disciplines and approaches, and no selling or promotion of products or particular treatment approaches is allowed. The site features hundreds of discussion groups, articles, and how-to videos in many different languages. Members also have access to the "Get Answers" feature to obtain specific help quickly from community members. Certified trainers and associates are available for consultation and training. To register, go to: www.centerforclinicalexcellence.com.

A series of six manuals are available that cover the most important information for practitioners and agencies implementing the ORS and SRS are available (International Center for Clinical Excellence FIT Manuals Development Team, 2011a,b, c, d,e,f [http://www.scottdmiller.com/?q=node/5]). The manuals are written in clear, practical, step-by-step, and easy-to-understand language and cover:

(1) the empirical foundation;
(2) basics of administration, scoring, and interpretation;
(3) use of the measures in supervision;
(4) aggregation and interpretation of data generated by the ORS and SRS;
(5) application of the ORS and SRS with special populations; and
(6) implementing the measures in agencies and systems of care.

As mentioned previously, several computer and web-based applications are available for administering, scoring, interpreting, and aggregating data from the ORS and SRS. The most current information about such applications can be found online at: http://www.scottd miller.com/?q=node/6.

Psychometric Properties

The ORS has been shown to be sensitive to change among those receiving behavioral health services. Numerous studies have documented concurrent, discriminative, criterion-related, and predictive validity, test-retest reliability, and internal-consistency reliability for the ORS (e.g., Anker, Duncan & Sparks, 2009; Bringhurst, Watson, Miller & Duncan, 2006; Campbell & Hemsley, 2009; Duncan, Miller, Reynolds, Brown & Johnson, 2003; Duncan, Sparks, Miller, Bohanske & Claud, 2006; Miller, Duncan, Brown, Sparks & Claud, 2003; Reese, Norsworthy & Rowlands, 2009). The SRS has been shown to assess the qualities of the alliance as first defined by Bordin (1976). Numerous studies have documented the concurrent validity, test-retest reliability, and internal consistency of the SRS (e.g., Duncan et al. 2003, Miller, Duncan, Brown et al. 2003). Several randomized clinical trials have documented the significant impact that both measures have on the outcome of and retention in treatment (e.g., Anker et al., 2009; Miller et al., 2006; Reese et al., 2009).

Institutional Implementation

Worldwide, there are currently 30,000+ registered individual practitioners, and 100's of licensed agencies and treatment settings using the scales. Since 2009, the membership of the International Center of Clinical Excellence (ICCE) has grown exponentially. The ICCE community is where most users receive training and support in the use of the measures. Each year, the ICCE conducts two intensive training events: (1) the "Advanced Intensive"; and (2) the "Training of Trainers" course. Attendance at both trainings, submission of a sample training video, and passing the "core competency" exam enable participants to become ICCE Certified Trainers. Currently, the ICCE has "Certified Trainers" available for consultation in the USA, Canada, Australia, New Zealand, Western and Eastern Europe.

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