



Use of the Outcome and Session Rating Scales in Clinical Social Work Supervision

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ABSTRACT: This paper explores the use of the Outcome Rating Scale (ORS) and the Session Rating Scale (SRS) in clinical social work supervision. These assessment tools are designed to provide clinicians with direct feedback from clients about the clients' views on progress in therapy and their views on the quality of each session provided by the clinician. This type of feedback can be useful for beginning therapists as well as experienced therapists. This paper discusses helpful ways that these assessment tools can be used by clinical supervisors to increase the competence and self-awareness of clinical social workers in training. Supervisors can work with their trainees to help those in training better assess their own practice and what changes they might need to make based upon the results from the ORS and the SRS.

Keywords: Clinical social work, supervision, rating scales



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1. Introduction

The strength of the worker-client therapeutic alliance has consistently predicted psychotherapeutic outcome, regardless of theoretical approach (Horvath & Luborsky, 1993; Ogles, Anderson, & Lunnen, 1999; Wampold, 2001). Fortunately, there is evidence that clinicians can examine their own practices to determine if they have formed an effective working alliance with their clients and if the work they are engaging in with clients is leading to desirable changes from the clients' perspectives. This information can be drawn directly from clients through the use of simple, inexpensive, and easy-to-use tools, the Session Rating Scale (SRS) and the Outcome Rating Scale (ORS) designed by Duncan, Miller, and Sparks (2004), which can provide clinicians with ongoing feedback from their clients. These two scales have been shown to exhibit strong internal consistency and good concurrent validity with other, longer, measures of therapeutic relationship and outcomes (Campbell & Hemsley, 2009). This paper demonstrates how social work clinical supervisors can use the SRS and ORS with their supervisees to enhance self-awareness and effectiveness in their practice.

2. Innovation in social work.

The first tool to be discussed is the Outcome Rating Scale (ORS). This is a four-item visual analogue instrument (See Appendix A) that was developed as a brief alternative to the Outcome Questionnaire (OQ) 45 (Lambert, et al., 1996) by Duncan et al. (2004). The purpose of this instrument is to afford clients an opportunity to provide feedback to their clinicians on vital areas

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of their functioning from week-to-week between sessions. The four items on the scale correspond to the following areas: (a) individual (or symptomatic) functioning, (b) interpersonal relationships, (c) social role performance (work adjustment, quality of life [Lambert & Hill, 1994]), and (d) an "overall" rating (general sense of well-being). The four areas of client functioning are translated into visual analog scales in 10 cm lines with instructions for the client to place a hash mark on each line with low estimates to the left and high estimates to the right (see Duncan et al., 2003 for scoring instructions). A recent study (Miller, Duncan, Brown, Sparks, & Claud, 2003) found that the ORS has adequate validity, solid reliability, and high feasibility.

The second assessment tool is the Session Rating Scale (SRS) and was also developed by Duncan et al. (2003). The SRS is a scale that focuses on the client's view on the effectiveness of an individual clinical session. The four items assessed on the scale are (a) relationship with clinician, (b) goals and topics of the session, (c) approach or method used by the clinician, and (d) the overall rating of the session by the client. The four areas of client functioning are translated into visual analog scales in 10 cm lines with instructions to place a hash mark on each line with low estimates to the left and high estimates to the right.

The most compelling research on the effectiveness of the ORS and SRS can be found in a study by Miller, Duncan, Brown, Sorrell & Chalk (2006). Their study involved 75 therapists and 6,424 clients over a two-year period. The study found that "providing formal, ongoing feedback to therapists regarding clients' experience of the alliance and progress in treatment resulted in significant improvements in both client retention and outcome" (p. 10). They found that access to the client's experience of progress in treatment effectively doubled the overall effect size of services. It was also found that improving a poor alliance during at the beginning of intervention was associated with significantly better outcomes at the conclusion.

The two scales are intended to be used every session, both at the onset and at the end. They are brief and take approximately two minutes to administer and score (there are computer versions that make it very time efficient). It has been noted that abbreviated analog scales such as the ORS and SRS can actually demonstrate better face validity than their longer counterparts. (Duncan et al., 2003; Miller et al., 2003. The scales help to provide a steady stream of feedback to the clinician as the worker measures client responses at every session.

3. Rationale

The use of ORS and SRS can help clinicians focus on both client outcomes and relationships in ways that they may find both challenging and rewarding (Duncan, Miller, & Sparks, 2004). The ORS provides session-to-session feedback to clinicians on their clients' views of the progress that is being made toward their therapeutic goals. The SRS provides clinicians with immediate feedback on how their clients viewed the clinicians' behaviors during the session. Using these tools invites clinicians to engage in a continuous feedback loop in which information flows from client to clinicians to assist clinicians in increasing their understanding of the effectiveness of the therapeutic alliance and the overall progress being made toward client goals. Clinicians have the opportunity to reflect on the weekly scores on these measures and adjust their behaviors accordingly.

For example, if a clinician feels that a certain modality, e.g., Cognitive Behavior Therapy, is

the best approach for a client but see no signs of progress, it is probably time for the clinician to focus both internally and externally on his or her beliefs about therapy in order to attain help from the client on what else might work for the client. It could be said that clinicians are in the field to “know” they help. Part of burnout is “not knowing” clearly the progress that is being made in therapy. The ORS and SRS provide feedback about the therapeutic process that is clinically reliable and valid (Duncan, et al., 2003). Through the use of these tools, clinicians can reasonably know if the client is doing better and if they are being effective in their work. The potential for growth from attending to the feedback from the client and then processing this feedback with both the supervisor and, more importantly, the client can fuel both personal and professional growth.

The primary premise is that using ORS/SRS can lead to clinician growth, which will help client growth. However, these tools should not be part of the overall formal evaluation of the clinician. Once these tools become part of the formal evaluation of the clinician, the information becomes compromised. For example, the information may be compromised if clinicians are hesitant to share/divulge complete information for fear of negative consequences. This can be a narrow line to walk. It is necessary to note that these tools are intended for both client and clinician growth. It could be useful for any clinician that worked with a supervisor and organization that could be trusted to walk the line between clinician growth and formal evaluation. On one hand it is helpful to grow and develop as a clinician through the use of tools such as the ORS and SRS, but on the other hand, the clinician may fear that a low rating may lead to low grades (for student clinicians) or job loss (for working clinicians).

4. How to Use the Scales in Supervision

This activity introduces clinicians to the ORS and SRS tools as means of increasing their levels of self-awareness and clinical competence. Clinicians from a variety of experience levels and personal circumstances can benefit from this activity but it is preferred that beginning clinicians have at least a year of schooling and have begun seeing clients. This activity consists of asking clinicians in training to use the ORS and SRS as feedback tools in their own growth and development as clinicians. Clinicians will have their client(s) complete the ORS and SRS. These scales can either be administered via a paper and pencil mode or entered directly into a computer program by the client. The benefit of using a computer program is that it will produce a graphic display of every scale score, providing a useful visual image of how therapy is progressing. Once these scores are available, the clinicians will work with their supervisors to monitor and track their ratings. This activity can either be self-assigned or assigned by a supervisor as part of an individual supervision session, a training exercise, a class requirement, or a workshop training. Since a supervisor is vital to the success of the activity, the steps below are directed to the activity supervisors.

1. The first step in using the ORS and the SRS as supervision tools is helping the supervisee understand the origin and purpose of these tools. Supervisors can provide their supervisees with key articles that will provide the background and rationale for using these tools in therapy sessions (e.g., Duncan, et al., 2003; Miller, Duncan, Brown, Sparks, & Claud, 2003). It is helpful if supervisors inform trainees the ORS covers four areas of client functioning: (a) individual (or symptomatic) functioning, (b) interpersonal relationships, (c) social role performance (work

adjustment, quality of life), and (d) an overall rating (general sense of well-being). Supervisors should also inform their supervisees that the SRS assesses four elements of the therapeutic alliance including (a) the quality of the relational bond, (b) the degree of agreement between client and clinician regarding goals, (c) client and clinician agreement regarding the methods and approach employed in care, and (d) an overall rating that assesses the general health of the alliance.

Next, supervisors should teach supervisees how to use these scales in their sessions with clients. It is important that supervisees understand the rationale for using the tools and how the feedback will be used to improve service delivery and increase the clinician's self-awareness and competency. They also need to understand how to convey this rationale to clients, as this will help increase cooperation from clients completing the scales. The ORS is administered at the beginning of each session and is meant to be a record of how clients view their functioning during the previous week. The SRS is given at the end of each session and is meant to indicate how clients view the alliance with their clinician for that session.

2. Supervisors also need to teach supervisees how to interpret the results that they receive from clients from each tool. This is a vital step in the activity as it builds the basis for assisting supervisees to make sense of the scoring in relationship to their own self-awareness and competence as a clinician. For the ORS, low scores correspond to a poor sense of client well-being (or high level of distress). The average ORS intake score in outpatient mental health settings is between 18 and 19, with a range of 0 to 40. Over time, whatever the initial score, the number should increase in response to services offered. A lack of upward movement, deterioration, or an apparently random pattern of scores is cause for concern and the supervisee should be instructed to discuss this with the client at the time of service delivery. For supervisees, this could be a sign that their intervention techniques are not working with this particular client. The supervisor will need to assist that supervisee explore the ORS scores in relation to the supervisees growth as a clinician.

With regard to interpreting the SRS, research to date shows that the majority of clients rate the clinician relatively high therefore creating a somewhat skewed, non-normative distribution in which it is not as useful to discuss an "average" rating as compared to the ORS. Thus, the cutoff on the measure is set at 36, with a score below 36 representing a cause for concern. It is important to remind supervisees that a high score (36 or above) does not necessarily confirm the presence of a strong alliance. Supervisees should be aware that the best response to a high score is thanking the client and remaining open to future feedback. While it may be tempting for supervisees to feel pleased with scores of 40, they should be reminded by the supervisor that there is evidence that criticism of clinicians in early sessions is a good indication of the likelihood of positive change later in therapy (Miller, Duncan, Brown, Sorrell, & Chalk, 2006). Thus, if the client rates the worker with three "10s" and one "9," the clinician can focus on the "9" rating by asking how the clinician could serve the client better in that area. If the client offers a suggestion, the clinician needs to attend to, clarify, make note of, and refer to this issue in the next session. Scores that fall at or below 36 should be discussed prior to ending the visit. This discussion can start with a reminder that the use of these tools is to find ways to improve the quality of work through supervisee enhanced self-awareness and growth as a clinician. The supervisor can then

proceed to review the specifics on the area that was rated low and then assist the supervisee to consider ways to improve in that area. For example, if the client noted that the supervisee did not talk enough about family relationships, then it can be a logical starting point for the supervisor to discuss ways that the supervisee can bring that issue into focus with the client. For the supervisee, this could be a sign that the working alliance is not firmly in place and that more effort needs to be exerted to improve the relationship. It might even be a sign that a change in clinicians might be in order.

In both the ORS and SRS, it is vital that supervisees learn how to process the scores with clients and with their supervisors in order to discern what these scores mean for client success and their own self-awareness and growth as clinicians. If supervisees simply administer the scales and never make any attempt to bring the results into the work of the client or supervisory sessions, they will not get the full benefit of using the scales. The processing of the scores allows for clients to feel they are being heard, and it provides the clinician with opportunities for growth. Processing the scores with supervisors allows the supervisee to get the full benefit of discussing what is working and not working in their developing practice skills. We want supervisees to feel that criticism should be genuinely appreciated; after all, as noted earlier, criticism generally increases the possibility of success for that client (Miller et al., 2006). It is possible that there is an underlying variable here, such as a positive clinician response to criticism that could be leading to a greater possibility of success. It is also important to note that criticism could also indicate a poor therapeutic alliance. Regardless, the point of appreciating feedback on what they might do better provides clinicians with an opportunity for change and growth, which allows for progress to happen. Utilizing this feedback also contributes to clinician self-awareness.

3. In the next step, it is vital that supervisors help the supervisees understand that feedback can help clinicians get unstuck from their model and move to something new. After receiving feedback, supervisees should assess if it is time to refer the client to someone else, involve a group approach, or take a different approach within the therapy. Supervisees need to be aware that there is a risk of filling session hours in ways that may be pleasant and good for productivity levels but that are unlikely to produce change. Supervisees can grow by attending to their desires to help rather than by only focusing on their desires to meet agency productivity standards or get a passing grade in a clinical course. Making a change in treatment is not a negative reflection on either the supervisee or the client; rather, it reflects that similar intervention methods do not always lead to the same outcomes, so the current model of therapy may not help.

There are other issues that the supervisor will need to consider when using this activity with their supervisees. First is the type of supervision that would be ideal for the completion of this activity. It would seem that individual supervision might be the best-suited to this activity. Individual supervision would allow for the supervisor and supervisee to develop the type of relationship in which very difficult and challenging clinical issues could be discussed and resolved.

Second, supervisors should consider how long this activity should take in an ideal circumstance. Adopting the perspective that discussion of the ORS and SRS will become the basis of the supervisee's clinical supervision session, and then it becomes apparent that this activity is meant to be an ongoing aspect of every clinical supervision meeting, just as it is meant to be the basis upon the clinician's work with his or her client.

Third is the issue of "safety" for the supervisee. What rules should be put in place to ensure that the supervisee is safe? It would seem that the most fundamental rule is that the scores on the ORS and SRS are not to be used to determine a grade for a student clinician or to evaluate job performance for the employee. The rule is that the scores are only to be used for clinical improvements. Supervisors should try to help the supervisee realize that we should not be afraid to identify "failures" in the clinical supervision setting; it is only through learning from our failures that we can achieve success as a clinician.

Finally, it would be useful to consider any recommendations for follow-up analysis of the experience. Journaling would be a very helpful activity for supervisees to engage in following their supervision sessions. This would assist the supervisee to keep the internal dialogue and self-reflection going past the end of the scheduled supervision session. Writing and reflecting upon their experiences in using the ORS and SRS could help supervisees gain increased understanding and enhance their growth as clinicians between supervision sessions.

5. Example of Use in Supervision

A clinical social worker in training was working with a 40-year-old, single, white female who had been in therapy with the worker for several weeks without making significant progress. She was depressed and was also physically disabled and could not return to work. The clinician was operating from a solution-focused therapy modality, which the client seemed to enjoy. The client consistently rated the clinician at "40" on the SRS, and she remarked that she felt better after her sessions with the clinician and looked forward to seeing him. However, her ORS scores started at 8, but even after eight sessions, they varied no more than 2 points. The supervisee discussed this situation with the supervisor and was instructed that normative data for the ORS reports that the fiftieth percentile of change on the scale for someone starting at "8" is "18." The supervisor and supervisee agreed that the client was not making any progress. The supervisor suggested that the supervisee begin a discussion with the client regarding what else could be done to improve things. The supervisee changed approaches and worked with the client in a manner that was more focused on cognitive behavior and involved a group intervention; changing clinicians was also discussed, but the client had no interest in that option. Several weeks went by and there was still little change in the ORS scores. The client did not appear to be improving. At this point, the supervisor suggested that the supervisee work with the client to transfer to a different worker. This time the client agreed to the transfer. The new clinician tried Dialectical Behavioral Therapy with the client, and the ORS began improving rather rapidly. By the 10th session, she and the new clinician agreed she was, for now, done with therapy.

In this example, the use of the ORS by the supervisor and supervisee was vital in helping both the supervisee and client acknowledge that, while their time together was perhaps enjoyable, it was not leading to significant therapeutic progress for the client. The ORS opened the door to an honest discussion about the merit of the therapy for the client and empowered her to realize that she deserved to be connected with a clinician that would be a better fit for finding ways to make progress. In a similar vein, the supervisee learned a valuable lesson about the difference between clients having an enjoyable experience in therapy versus having a therapeutic experience.

6. Tracking Growth in Supervisees: How the ORS and SRS Can Help

The most obvious way to monitor clinicians' progress is to track the scores reported by clients on the SRS and ORS. The supervisor and supervisee can easily note the trends in the scoring and then discuss strategies to either maintain the gains or to find other ways to improve the working relationship (SRS scores) and/or improve the outcomes as perceived by the client (ORS scores). Of course, these tools can only be useful if the supervisee is committed to obtaining the feedback from clients.

Other measures of progress are largely qualitative and could include clinicians regularly incorporating client feedback into their sessions, becoming more comfortable requesting feedback from clients, or demonstrating a willingness to switch treatment modalities. For example, one supervisee indicated, "The support of my supervisor was important; otherwise, at first it was just a tool that was more work. Once I formed the habit, the tool was not just useful but essential for me to understand how the client was progressing and how the client viewed our working alliance." Supervisees also said they felt more comfortable requesting feedback from clients. Other supervisees became more comfortable discussing actual progress and became less concerned about the intervention "manual" or doing their therapeutic orientation in the "correct" manner.

Supervisors must be ready to work with supervisees about the issue of workload as some supervisees may report that there does not seem to be enough time to complete these scales because of productivity demands and paperwork overload. Supervisors must try to help supervisees maintain a sense of balance in their professional lives and encourage supervisees to see the value in continued self-improvement and self-awareness in their profession. This trend of being preoccupied with production and paperwork seems ongoing in the mental health field. Supervisors must remind their supervisees to focus on the quality of care, which includes the quality of self-awareness care and the quality of client care.

7. Benefits for the Supervisee: In Their Own Words

An exploratory study on the benefits for the supervisee from using the ORS and SRS was conducted in a behavioral health clinic in the Midwest. Ten current trainees at the center were interviewed about their experiences in supervision using these assessment tools. This was a convenience sample, so the ability to generalize beyond this exploratory study is limited. Following are excerpts from the information that was collected.

Supervisees do seem to find this experience helpful in their growth and development as clinicians. One supervisee noted the usefulness of the ORS:

I believe the ORS allowed me to really grow as a therapist and as a person in general. I believe it helped me with my therapeutic skills to really focus on what people needed in their lives. It helped me really pinpoint where my attention needed to go towards with my clients, whether it was with self, others, or their environment.

Another supervisee noted the monitoring and tracking value of the scales:

I could see if a session was off target and assess what could have been better. I could better assess when termination was the best course for the client....

Another supervisee discussed the clinical feedback benefits of the scales:

I think it was a good vehicle to begin conversations and to ensure quality of care. Instead

of the clinician counting on their perception of how things were going, the clinician still has information from the client's perspective on how things are going. And that point is key - the client needs to drive the counseling. This tool helps ensure that throughout the process, the client is always in the driver's seat.

Another supervisee also spoke to the value of the use of the ORS and SRS for his clinical work as well as for supervision:

First of all, using the ORS/SRS with clients and in supervision helped me become more comfortable with requesting feedback from clients. I learned how to ask for clients' suggestions, remain non-defensive and genuinely interested in their input, and take it more seriously than I might have done otherwise. I think talking about the measures in supervision really helped me "get" the idea that clients' satisfaction with and progress in treatment is crucial and much more important than, for example, sticking to a manual or a theoretical agenda.

It seems clear from these comments that clinicians in training can see the value of using both the ORS and SRS for their clinical work as well as for their growth and development in their supervisory sessions. The tools help to provide a clear focus on a clinician's strengths and areas to improve, thus creating a habit of ongoing self-reflection and improvement for a clinician throughout his or her career.

8. Conclusion

Using Client Directed Outcome Informed (CDOI) tools, namely ORS and SRS, can benefit clinician awareness. There is a direct ability to attend to feedback from clients in meaningful ways, both about outcome and about relationship. In this way, the conversation becomes more equal and one of attending to clients in new ways.

In addition, clinical social workers in training can use these tools through supervision to figure out the meaning of feedback from clients and how to incorporate suggestions into their overall approach to helping clients. This process helps to facilitate self-awareness and growth in the supervisee. In addition, supervision becomes more meaningful when it is really about clients and not strictly about theories of psychotherapy.

9. Additional Resources

Individual clinicians may download the scales free of charge under the "Scholarly Publications, Handouts, Vitae" tab after registering online at <http://www.scottdmiller.com/?q=node/6>

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 and is open to clinicians from all disciplines and approaches. No selling or promotion of products or particular treatment approaches is allowed. This community can be found online at: www.centerforclinicaexcellence.com

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