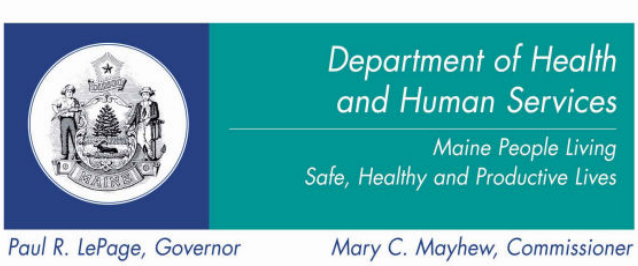
Y-OQ® Clinician Manual

Customized
For The



State of Maine

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THIS MAINE CLINICIAN MANUAL FOR IMPLEMENTATION OF THE OQ® INSTRUMENTS WAS CUSTOMIZED FOR THE STATE OF MAINE DEPARTMENT OF HEALTH AND HUMAN SERVICES BASED ON THE Y-OQ® CLINICIAN MANUAL, AUTHORED BY DR. GARY M. BURLINGAME AND STEPHEN D. THAYER FROM BRIGHAM YOUNG UNIVERSITY.

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Introduction

The practice of checking vital signs is common in health care. Heart rate, blood pressure, and temperature are good examples. Information gleaned from these simple tests provides physicians with important information quickly—information that influences clinical decision-making. This manual will introduce you to how the tracking of *mental health* vital signs using standardized outcome instruments can support the case management and mental health services that you provide.

The standardized outcome instruments that we will be discussing are the Y-OQ® 2.01 and the Y-OQ® SR, which have been through rigorous scientific testing to ensure that it meets standards of validity and reliability. Once researchers determine an instrument meets these standards, it can be trusted to provide valuable information about changes in symptoms, disruptive or dangerous behaviors, and other important domains of functioning relevant to the services offered in your setting.

Using standardized instruments to inform clinical practice is called "practice-based evidence." This approach is independent of diagnostic or theoretical orientation. Instead, service providers inform treatment and service delivery based on information gathered directly from consumers. This information also allows service providers to systematically track change in consumer functioning over time. Quite literally, your "practice" becomes "based" on the "evidence" you receive from consumers through standardized outcome measures.

Information about a consumer's mental health vital signs has diverse utility. It can be useful to clinicians, case managers, administrators, and any other service provider involved in helping consumers progress toward recovery. This manual will demonstrate how the Y-OQ® 2.01 and Y-OQ® SR can help you and those for whom you provide care achieve this goal.

1. *What is the value of using standardized instruments to measure clinical change?*

There are several reasons for employing standardized outcome instruments to measure change in mental health functioning:

To provide objective and quantitative feedback about a person's current status or, in other words, their mental health vital signs. This information can be used to supplement clinical impressions of progress. Furthermore, since the results are quantified, the OQ®-Analyst software compares each person's progress against the progress of other children and adolescents who began services/treatment with similar levels of symptomatic distress. Of course, measurements of change using standardized outcome instruments should never be used as a substitute for clinical judgment or without consideration of the person's own desired path to recovery. They are most useful as adjuncts to service provider assessment and consumer self-report that corroborate other evidence and agreements between the service provider and consumers. The OQ®-Analyst offers information that has been shown to enhance service/treatment outcomes.

To streamline communication between the consumer, clinician and all other team members involved in a person's care. When all team members, as well as the consumer, are looking at the same standardized set of results, you have a shared point of reference. This way communication can become simplified and more concise – as it relates to dimensions assessed by the OQ® .family of instruments.

Purchasers of mental health services (individual consumers, families, employers, and governments) are more frequently requiring objective and quantitative evidence of the effectiveness of services/treatment delivery. There are at least three major trends that are converging to increase purchasers' demands for this kind of accountability from mental health managed care companies and providers.

- The first trend is the tightening of financial resources available for mental health services/treatment.
- The second is the increasing societal awareness of the potential effectiveness of mental health services/treatment, when delivered appropriately.
- The third trend is that consumers are asking for and expecting services that assist them in their recovery and in achieving the goals in their person-centered plan.

The feedback provided by the OQ®-A software has been shown in six randomized clinical trials in North America to have beneficial results on consumer outcomes. These trials show that when clinicians' awareness of the mental health vital signs is increased by simply reviewing the OQ®-A report described below, 50-66% of those consumers who otherwise leave treatment without receiving therapeutic benefits will stay in treatment. This information is particularly helpful where the consumer has not self-identified challenges to recovery and where such barriers have not become

evident via the therapeutic relationship.

Clinical trials have also established that providing consumers with objective feedback about their outcomes assessments actually helps to improve their progress during services/treatment, compared to consumers who don't receive such feedback.

Finally, the OQ®-A is recognized as an evidenced based practice in the federal government's (SAMHSA) registry of evidence-based practice. However, what is not commonly known is that it is one of the most cost efficient evidence-based practices to implement when compared to being trained in a particular evidence-based practice. Dr. Bruce Wampold at the University of Wisconsin, an expert in the field of evidence based treatments has compared the OQ®-A with training individual clinicians in an evidence-based treatment method using a commonly deployed method of workshop with follow-up supervision. Here are his conclusions using 20 therapists with a case load of 600 patients.

Workshop method	Implementing OQ®-A
Total Cost=$57,000 Workshop = $7,000 Supervision 1/wk for 15 weeks $45,000 Fidelity/adherence checks $5,000 Total gain predicted by randomized trials 8% more successful (d=.2) or 48 cases Marginal cost $57,000/48 = $1188/success $7,000/48 = $146/success (workshop)	Total cost $1/patient—less for large agencies Total gain predicted by randomized trials 17% more successful (d=.4) or 102 cases 26% more successful with CST (d-.7) or 156 cases Marginal cost $600/102 = $5.88/success $600/156 = $3.85/success

2. *What does the Y-OQ® 2.01 Measure?*

The Y-OQ® 2.01 is a parent/self-report questionnaire designed to measure symptom distress in 6 areas thought to be crucial factors related to myriad problems adolescents struggle with. The following are descriptions of these areas or "subscales" taken from the *Administration and Scoring Manual for the Y-OQ® 2.01*:

- *Intrapersonal Distress (ID)*: The purpose of this scale is to assess the level of emotional distress in the child/adolescent. Anxiety, depression, fearfulness, hopelessness, and self-harm are aspects measured by the ID subscale. Since depression and anxiety are frequently correlated in assessment instruments no attempt was made at differentiating these symptoms. High scores indicate a considerable degree of emotional distress in the patient.

- *Somatic (S)*: This scale assesses the somatic distress that a child/adolescent may be experiencing. Items address symptoms that are typical presentations in mental health settings, including headaches, dizziness, stomachaches, nausea, bowel difficulties, and pain or weakness in joints. High scores indicate that the child/adolescent's caregiver [or the child/adolescent] is aware of a large number of somatic symptoms while low scores indicate either absence or unawareness of such symptoms.

- *Interpersonal Relations (IR)*: The purpose of this scale is to assess issues relevant to the child's/adolescent's relationship with parents, other adults, and peers. Assessment is made regarding their attitude towards others, communication and interaction with friends, cooperativeness, aggressiveness, arguing, and defiance. High scores indicate that the caregiver [and the child/adolescent] is reporting significant interpersonal difficulty while low scores reflect a cooperative, pleasant interpersonal demeanor.

- *Social Problems (SP)*: This scale assesses troublesome social behaviors. Many of the items describe delinquent or aggressive behaviors that are frequently the cause for bringing a child or adolescent into treatment. Although aggressiveness is also assessed in the IR scale, aggressive content found in this scale is of a more severe nature, typically involving the breaking of social rules. Items include truancy, sexual problems, running away from home, destruction of property, and substance abuse. Another feature of items in this scale is that they are slow to change, whereas content tapped by many of the other scales often changes over a period of time as a result of treatment intervention.

- *Behavioral Dysfunction (BD)*: This scale assesses change in the child's/adolescent's ability to organize tasks, complete assignments, concentrate, and handle frustration, including times of inattention, hyperactivity, and impulsivity. Although many of the items on this scale tap features of specific disorders (e.g., Attention Deficit Hyperactivity Disorder) the scale is not intended to be diagnostic but rather to track change suggested by the literature, focus groups, and hospital records.

- *Critical Items (CI)*: This scale describes features of children and adolescents often found in inpatient services where short-term stabilization is the primary change sought and in other settings where behaviors are dangerous and may need immediate attention. It addresses paranoia, obsessive-compulsive behaviors, hallucination, delusions, suicide, mania, and eating disorders. High scores are indicative of those who may need immediate intervention beyond standard outpatient treatment (inpatient, day treatment or residential care). A high score on any single item should receive serious attention.

In addition to these six subscales, the Y-OQ® 2.01 produces a total score that is a summation of all items. It reflects total distress in a child's/adolescent's life. For more detail, service providers are encouraged to read the *Administration and Scoring Manual for the Y-OQ® 2.01*.

3. *Why use the OQ® instruments specifically?*

Various properties of the Y-OQ® 2.01 make them excellent instruments for measuring service/treatment effectiveness and for treatment planning:

The OQ® instruments are user friendly to both the consumer and to the service provider. For the consumer, they are brief (generally completed in 5-10 minutes) and easy to understand (questions are written at a fifth grade reading level). For the service provider, they are easy to administer (e.g., in outpatient settings support staff typically hand the instrument to the consumer before a visit/session). Because of these practicalities, the OQ® instruments do not take valuable time away from service/treatment yet still provide service providers with a real-time "snap shot" of the consumer's level of distress and sense of well-being.

Research documents the strong validity and reliability of the Y-OQ® 2.01 (see the *Administration and Scoring Manuals* for more details).

3.1 Y-OQ 2.0

Designed to cover the wide range of symptoms and behaviors found in child and adolescent mental disorders, the Y-OQ® 2.01 allows all children and adolescents seen in psychotherapy to be measured with a single instrument. It reflects total distress in a child/adolescent's life, incorporating the six most salient content areas of a child or adolescent's behavioral and subjective experiences, as well as his or her ability to function in society. This can assist the service provider in developing their "base rate" of effectiveness in supporting the consumer over time.

The Y-OQ® 2.01 was constructed to be sensitive to change over short periods of time while maintaining high psychometric standards of reliability and validity. Recent research has found that it is more sensitive to change (improvement as well as deterioration) than other commonly used outcome measures (e.g., CBCL and BASC). For a more detailed discussion of the measure's development and psychometric properties, please refer to the *Administration and Scoring Manual for the Y-OQ® 2.01*.

The six subscales and the total score of Y-OQ® 2.01 are easy to interpret. While the subscale scores and responses to individual items provide the consumer and service provider with a *qualitative* picture of the consumer's current symptoms and functioning, the total score is tracked as a *quantitative* measure of clinical change. The Critical Items subscale is particularly useful, as it screens for severe symptoms that are often not reported to service providers due to hesitancy, defensiveness, or embarrassment.

3.2 Y-OQ® SR

The Y-OQ® SR is designed for youth ages 12 to 18 years. The Y-OQ® allows adolescents an opportunity to evaluate their own level of distress. Similar to the Y-OQ® 2.01 for caregivers, it is brief and written at a fifth grade reading level. It reflects the same total distress and six subscales as the caregiver form. Generally, the caregiver version of the Y-OQ® is the primary instrument measuring a child/youth's level of distress and well-being. However, for youth who are capable of responding and understanding the Y-OQ®, the additional information gathered by the self-report instrument may be valuable. For younger adolescents, ages 12-15, the comparison of parent with self-report may provide additional insight into treatment success or roadblocks. For youth ages 16 to 18, the Y-OQ® SR may be critical to understanding the youth's situation and treatment picture.

4. *Guidelines for administering the OQ® instruments to consumers*

4.1 Scope of use

Both measures have been used in a variety of settings including inpatient, residential, educational, case/medication management, wilderness, and juvenile justice settings. Relevant findings and norms germane to these different populations can be found in the *Administration and Scoring Manual for the Y-OQ® 2.01*and the *Admininistration and Scoring Manual for the OQ®-45.2.*

4.2 Which OQ® instrument to use

The following OQ® instruments are available for Arkansas Service providers to utilize with their consumers:

Instrument	Number of Items	Completed By	Change Metrics	Treatment Failure Alerts	Community Normative Score Range	Clinical Score Range
Y-OQ® 2.01 Youth Outcome Measure (Ages 4-17)	64	Parent or Caregiver	√	√	-16 to 46	47 to 240
Y-OQ® 2.0 SR Youth Outcome Measure (Ages 12 -18)	64	Self	√		-16 to 46	47 to 240

Note: Change Metrics refers to the outcome measure's ability to use a Reliable Change Index (RCI) and cutoff score to define standards for clinically significant change achieved during mental health treatment (i.e. classifying patient change as recovered, improved, no change or deterioration).

Treatment Failure Alerts refers to the outcome measure's ability to use rational or empirically-based algorithms to detect possible treatment failures and alert clinicians accordingly.

4.3 Frequency of administration

It is best when the Y-OQ® 2.01 and Y-OQ® 2.01 SR are administered at the beginning of an episode of care when possible to capture initial levels of distress. This provides the youth, family and service provider with real time information on consumer status as well as critical items (e.g., suicide, drug use, etc.). We also find that giving the OQ® instrument at each significant service contact provides valuable information about the real-time status of consumers. In settings having longer average length of care, frequency of administration can be guided by other parameters. For instance, in long-term residential care settings, the OQ® instrument is often administered on a 30-day cycle. Conversely, in acute short-stay settings administration could take place weekly.

4.4 Recommendations for how to present the OQ® instruments to the consumer

The service provider should explain to the consumer that the OQ® instrument can be thought of as a routine questionnaire that monitors the consumer's sense of distress and well being, just like a lab test on blood or blood pressure measurement answers questions about a consumer's physical health. The youth or family should be informed that completing the Y-OQ® 2.01 or Y-OQ® 2.01 SR is encouraged, but voluntary. They should be told that completing the tools are a routine part of treatment for all consumers and that they are not being singled out. Experience shows that the attitude of consumers toward completing the measures is highly dependent on service provider's positive or negative attitudes. Few consumers reject the measures if service providers suggest they will be valuable to the service they receive.

Whoever instructs the consumer to fill out the instrument should encourage him or her to do so in an honest and conscientious manner, and to be careful to complete all items. It is critical that anyone who administers an OQ® instrument to consumers understands and accepts the use of these questionnaires because any negative feelings or beliefs they may convey about the instruments may impair the validity of the results. Staff members need to be well acquainted with answers to common consumer questions about the instrument.

4.5 Developing a standard administration process

Service providers have found that the administration of the OQ® instruments integrates most smoothly into the flow of their work if they develop a standard administration process. Toward this end, we suggest that each service provider develop a standard process where consumers can complete the questionnaire shortly before receiving services. Use of the OQ®-A enables the questionnaires to be taken on a hand held PDA, Netbook, tablet, kiosk, or in standard paper format that is later manually entered into the OQ®-A system by the support staff. Time motion studies have shown that after support staff become accustomed to the OQ®-A, administration procedures typically take 30 seconds per consumer. This includes handing the instrument/PDA to the consumer and uploading the data into the OQ®-A.

It is also important to develop procedures for sharing OQ® information amongst a consumer's treatment team. If a consumer reveals critical and timely information on an OQ® instrument (such as suicidal ideations) it is imperative that there is an existing procedure that makes certain the consumer's voice is quickly, clearly, and responsibly heard by members of the treatment team.

4.6 Anticipating situations where administration can be challenging

- **Missing items on the tests:** The OQ®-A automatically estimates missing items that do not exceed 10% of the total number of questions. It also flags missing items for the service provider so that they can follow up on them in the early minutes of a contact. Experience has shown that missing information—particularly critical items (e.g., suicide, weight loss, drug use)—are indicators that should be addressed by service providers.

- **Forgetting or losing the questionnaire:** If there is time, give the consumer another questionnaire and ask them to fill it out before beginning services. If there is inadequate time, you may want to have the consumer take a few minutes after the service contact to fill it out so that you can make use of the information as soon as possible.

- **Partially completed questionnaire:** If the consumer has begun the questionnaire, but has not completed it, it is recommended that the first few minutes of services be used to complete the form.

- **Refuses to complete questionnaire:** If at any time the consumer refuses to fill out the questionnaire, or is highly resistant to it, it may be useful to identify the reasons and discuss them therapeutically. If misconceptions exist, the provider can clear these up and can reiterate to the consumer how the results will be useful in their recovery.

- **Illiteracy:** The reading level required for the OQ® instruments is that of the fifth grade. It is written in simple, jargon-free language created from consumer focus groups so that most can easily understand the content addressed. In some settings, consumer advocates or peers have been used to assist consumers completing the instrument. In other settings, service providers

have assisted consumers in completing the instrument. The effect of assistance on the veracity of the scores at this time is unknown.

- **Lack of fluency in English:** The Y-OQ® 2.01 is available in a variety of languages. Identify the most common native languages and contact the OQ® Measures' office for alternative forms. In some instances, the results may need to be "keyed" into the OQ®-A manually. The effect of cultural differences on test scores is addressed in the *Administration and Scoring Manuals*.

- **Symptoms of dementia or psychosis:** The Y-OQ® 2.01 should not be administered to consumers who are unable to comprehend the meaning of questions due to psychosis, dementia, or if they are in a highly agitated state. If the symptoms are sufficiently mild that the service provider feels that the consumer is able to understand what is being asked, the questionnaire can be administered. If the consumer's symptoms of psychosis or dementia fluctuate from one session to another, have the consumer fill out the questionnaire only when he/she is able to understand the meaning of the questions.

- **Time pressure:** If the consumer is late and has not filled out the questionnaire, the service provider is advised to consider whether the 5-7 minutes for completing the instrument would provide useful clinical information for the service contact. In some cases, consumers arrive late to avoid completing the questionnaire and revealing information covered in critical items that may prove useful to discuss. In cases where a child/adolescent is in therapy, service providers might also consider having the parent/guardian complete the Y-OQ® 2.01 while the child/adolescent is receiving services. In field settings where the service provider catches the consumer with a limited amount of time, again the service provider must judge how the time would best be spent. Sometimes the information gleaned by the Y-OQ® 2.01 will provide the service provider with precisely what they need to know if all they have time for is a "check in."

- **Consumer is in state of extreme upset or crisis:** If the consumer has not already filled out the questionnaire and arrives, for whatever reason, in a state of upset or crisis, the service provider must judge whether the consumer's frame of mind allows him/her to fill out the answers accurately, and whether administration of an OQ® instrument is appropriate at that particular time. In some instances, completing the questionnaire provides a stimulus for communicating specific symptoms that are causing the crisis or upset.

- **Physically handicapped:** If a consumer is physically challenged in such a way so as to make filling out the questionnaire very difficult or impossible, it can be administered verbally.

- **Change of parent/guardian bringing child into treatment:** The same parent or guardian should fill out the questionnaire at each visit because use of multiple responders may adversely affect the validity of the results. The initial reporting parent or guardian becomes the "designated parent/guardian" for purposes of questionnaire completion. If the same parent/guardian will not be able to bring the consumer in each time for appointments, it is

suggested that questionnaires are sent home to be completed by the designated parent/guardian within 24 hours before each appointment. In some settings, the OQ®-A is available as a web-based application and parents can complete the Y-OQ® 2.01 on line the night before their child/adolescent's service contact. The OQ®-A tracks the respondent to indicate their relationship to the consumer (e.g., father, mother, guardian, etc.). If the provider notes that the questionnaire has been completed by multiple respondents, they will need to study ratings made by the same respondent in order to understand the respondent's perception of the consumer.

- **Child dropped off by non-custodial adult:** If the designated parent/guardian will not be able to bring the consumer in each time for the appointment, have the designated parent/guardian fill out the questionnaires within 24 hours before the appointments and give the forms to who ever will be transporting the child/adolescent.

- **Determining episodes of care:** The OQ®-A has empirically derived algorithms that base prediction of change upon the number of service contacts received (see section 6). At times, there can be extended delays between visits. If a delay is extensive (e.g., 180 days), the service provider may administer the instrument and recode the OQ®-A to accept it as the first contact, beginning a new episode of care. There is no empirical research to guide service providers on this practice although it occurs frequently.

5. *Guidelines for administering the OQ® instruments to consumers*

There are numerous ways to administer the OQ® instruments:

The consumer can key their responses directly into the OQ®-A system via a kiosk.

The Y-OQ® 2.01 or Y-OQ® 2.01 SR can be administered through the use of a Netbook or PDA (handheld personal digital assistant). In this administrative format, a service provider enters the Consumer Medical Record Number (MRN), Consumer Birth date – MM/DD/YYYY format, Clinic (selected from drop down list), Instrument, and Setting of Care (all selected from drop down lists).

NOTE: If the service provider does not know the Consumer MRN or Birth date, they can use the "Search" button to find the desired consumer using their Last name; however the Netbook or PDA must be connected to the internet before using the search feature.

After a consumer completes the Y-OQ® 2.01 or Y-OQ® 2.01 SR, they typically hand the device back to a designated staff member. In wireless environments where there is internet access, the consumer or staff member can transmit the information by simply "syncing" the Netbook or PDA with the OQ®-A. In the field where internet access is not available or in facilities that are not wireless, connecting the Netbook or docking the PDA automatically triggers a data download into OQ®-A. Transmission by both methods take approximately 3 seconds and then the information is available for the clerical staff to print out or for the service provider to review on their own computer if it is "linked" to the OQ®-A "host system."

Service providers who do not have direct access to the OQ®-A software on their computer may want to examine their consumer's scores so that they can be discussed during the contact (rather than waiting for return of results from OQ®-A). In this instance, a Clinician Report (see Figure 1 in Section 7) can be printed from the clerical staff's computer and provided to the service provider within 3 seconds of data entry.

There is also a brief Client Report (see Figure 3 in Section 7) that contains a graphic display of progress along with a message to the consumer. These messages range from suggestions that the consumer is doing quite well, is progressing but in need of further help, or is not progressing as expected and encouraged to discuss progress with their service provider. Feedback is, by design, encouraging as well as empirically tested. Limited research has shown that consumers find the feedback desirable and would like to have it, if given the option. Research also shows that feedback given directly to consumers in the form provided in the Client Report has a positive effect on treatment outcome. As a practical matter it is a good idea to have service providers personally provide the feedback to the consumer or at least be aware of what feedback was given to the consumer. Although it is not common practice in clinical settings to share feedback with consumers about their treatment progress and service providers may be uncomfortable with a formal feedback report that they did not create, research has shown that such feedback promotes communication about goals and tasks of successful treatments.

6. *Interpreting the results: Using the OQ® instruments to monitor consumer progress*

Service providers will want to consult the *Administration and Scoring Manual for the Y-OQ® 2.01* for detailed background on the instrument and the interpretation of results. However, we would like to offer providers some specific suggestions for interpreting results. In general, there are two ways that providers can use the results from these questionnaires.

First, Quantitative tracking of overall change using the Y-OQ® 2.01 total score. Second, Qualitative tracking of specific symptoms or behaviors using subscale scores or ratings on individual questionnaire items

6.1 Quantitative tracking of overall change using the total score

Using the initial total Y-OQ® 2.01 score as a baseline, the OQ®-A software computes a change in total score for subsequent visits. The change in score is compared to the Reliable Change Index, which is 13 points for the Y-OQ® 2.01. The basis for these Reliable Change Indices is explained in the *Administration and Scoring Manual for the Y-OQ® 2.01*. A small amount of change from visit-to-visit can be explained by chance. However, changes in total score that equal or exceed the Reliable Change Index can be assumed, with a high degree of certainty, to represent true change in the consumer's functioning and level of distress.

Using the Reliable Change Index, at any point in treatment, a service provider and consumer is presented with one of the five (5) following situations:

1. *Reliable Improvement:* The total score has declined since the first visit by equal to or more than the Reliable Change Index.
2. *Possible Improvement:* The total score has declined since the first visit, however by less than the Reliable Change Index.
3. *No Change:* The total score is identical to the first visit.
4. *Possible Worsening:* The total score has increased since the first visit, however by less than the Reliable Change Index.
5. *Reliable Worsening:* The total score has increased since the first visit by equal to or more than the Reliable Change Index.

Thus, a change in Y-OQ® 2.01 total score is used to quantitatively inform the service provider of the consumer's progress and determine which consumers may need reevaluation of their treatment plans if negative or no progress has occurred. Consumers in group #5, Reliable Worsening, should receive a treatment plan review. This should not be interpreted as a suggestion that service providers replace their clinical assessments with Y-OQ® 2.01 results. Instead, we are suggesting that the questionnaire results be used to provide an additional objective and quantitative perspective on the consumer's progress.

6.2 Ways in which the total score should not be used clinically:

The total Y-OQ® 2.01 score should never be used as the sole determinant of whether a consumer needs treatment. As is shown in the *Administration and Scoring Manual for the Y-OQ® 2.01*, consumer and non-consumer samples both show wide and overlapping ranges of total scores. Thus, the absolute score, at any point in time, cannot be taken alone as an indicator of treatment necessity. The determination of need for treatment is based on the entire clinical assessment, of which the OQ® total score is just one part.

We do not recommend use of the subscale scores by themselves as indicators of reliable change. As is described in the *Administration and Scoring Manual*, the subscales are highly correlated, such that when a consumer changes on one subscale he/she tends to change in the same direction on the other subscales as well.

6.3 Qualitative tracking of specific symptoms and behaviors

As was noted above, for each episode of care for which a completed Y-OQ® 2.01 is entered into OQ®-A, service providers will receive a report of results that includes the total score, the subscale scores, and any critical items with elevated scores. A companion report can also be produced for review by the consumer. The subscale scores and ratings on critical items will alert the service provider and consumer to clinical areas that should receive particular attention. As mentioned above, service providers report value in tracking consumer progress on subscales that may reflect particular areas of difficulty (e.g., trouble in relationships or significant behavioral difficulties).

6.4 Interpreting the OQ®-A Clinician and Client Reports

The following excerpt from the OQ® Analyst Quick Start User Guide is provided for your convenience because of their direct application to clinical interpretation. For more information on how to use OQ®-A, please see the Quick Start User Guide.

The Clinician Report (Figure 1) is intended to give the clinician a summary of the consumer's progress to-date. The Clinician Report is comprised of five sections:

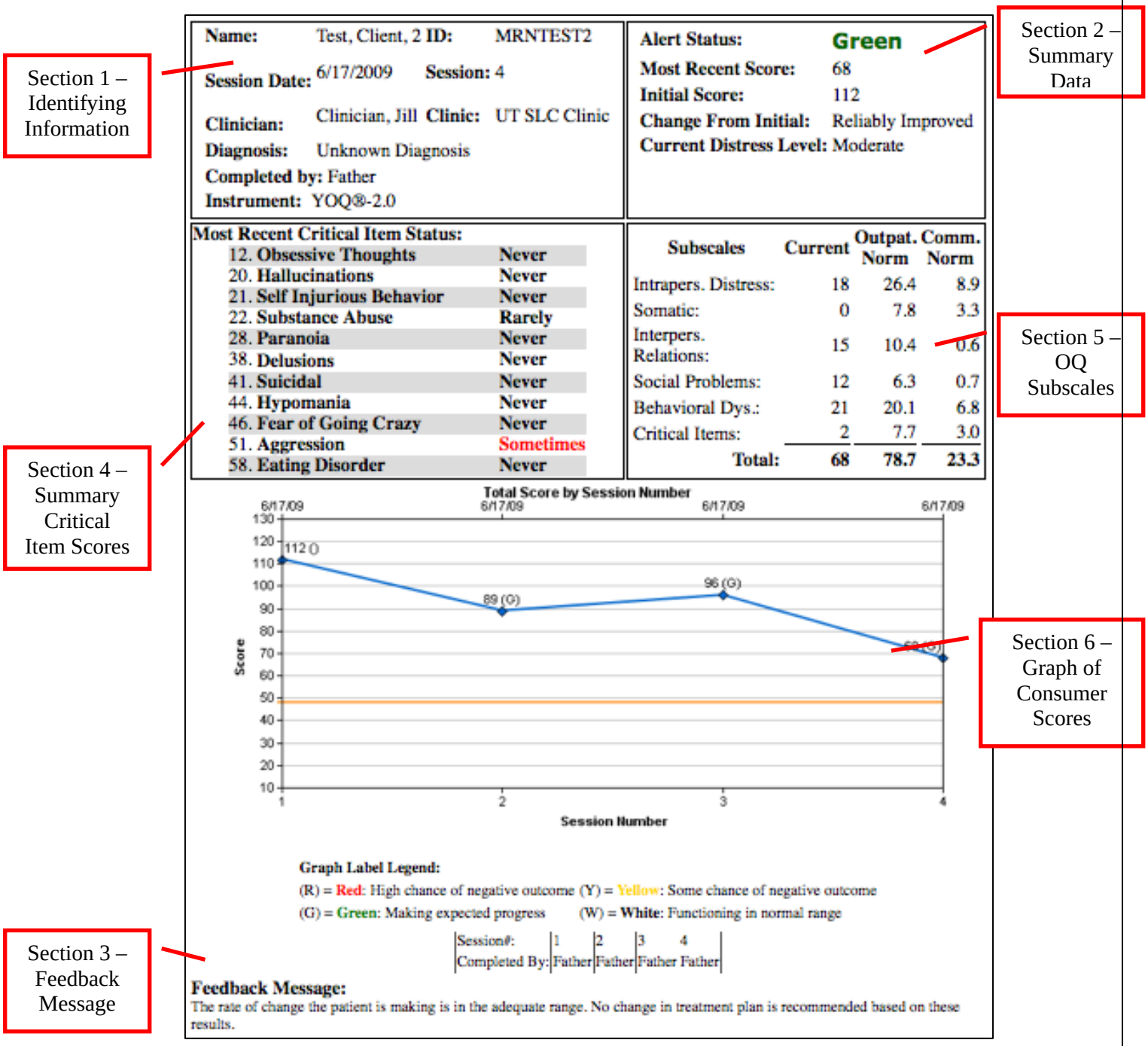


Figure 1 Clinician Report

Section 1 *Identifying Information*: consists of consumer identification and service contact information. Please verify this information to make sure the correct consumer and service contact was selected.

Section 2 *Summary Data*: provides summary data including:

Alert Status – Conveys information about consumer treatment response as determined by statistical algorithms. Alert Status may be White, Green, Yellow, or Red. Some consumers may also receive a Blue signal in addition to one of the other signals. The Blue signal indicates that the consumer's change from intake at the service contact of interest is so dramatically positive that there is a very high probability the consumer will end treatment with clinically significant change and maintain the change for a minimum of one year following termination.

Most Recent Score – Total score for the most recent administration of the questionnaire

Initial Score – Total score for the initial administration of the questionnaire.

Change From Initial – A classification of change based on calculations of clinically significant change using Jacobson & Truax formulas (see *Administration and Scoring Manuals* for cutoffs). Change may be Recovered, Reliably Improved, No Reliable Change, or Deteriorated.

Current Distress Level – A classification of distress level. Distress Level may be Low, Moderate, High, or Very High

Section 3 *Feedback Message:* provides a feedback message consisting of a verbal summary of the Alert Status. Of most significance in the Alert Status, are signals that are Yellow or Red. As the messages that accompany them suggest, research has shown that consumers who get either signal anytime during treatment are at risk for leaving treatment with a negative outcome. Research also suggests that a Red signal is much more often associated with consumer deterioration than a Yellow signal.

Section 4 *Most Recent Critical Item Status*: provides summary scores for the consumer's response to questionnaire items that are intended to screen for risk of suicide, substance abuse, violence at work and a variety of other disturbing symptoms. It is recommended that service providers consider any response other than Never as an alert to possible risk in these areas.

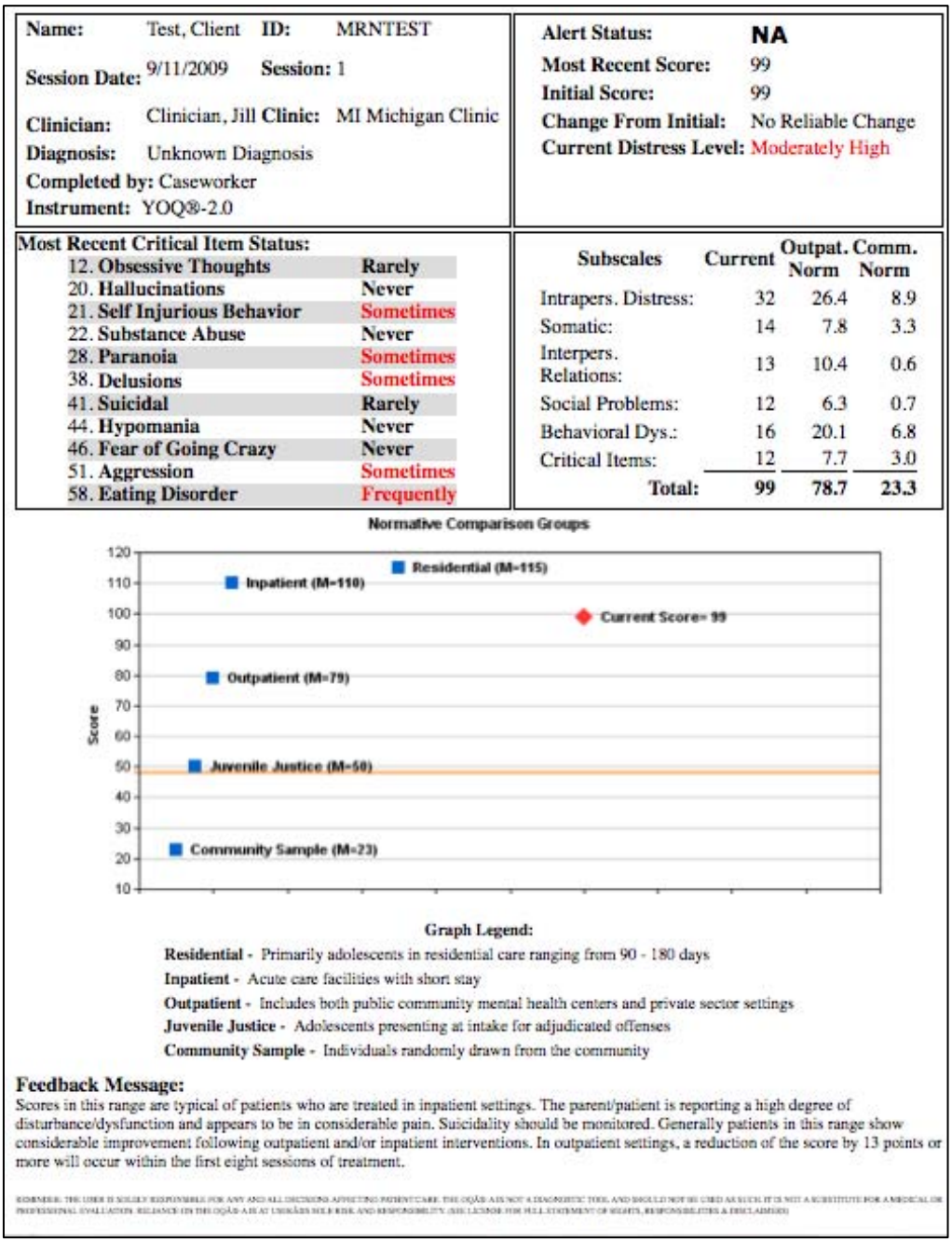
Section 5 *OQ Subscales*: provides a comparison of the consumer's current subscale scores for the selected instrument. Summary benchmark data based on both non-consumer and consumer samples are provided in order to compare the consumer under consideration with other groups of persons (see *Administration and Scoring Manual* for the instruments for technical details).

Section 6 *Graph of Consumer Scores*: provides a graph of consumer scores from the first administration through the most current administration of the questionnaire. The horizontal line drawn across the graph represents the Jacobson-Truax cut off for being in either the Functional Range or Dysfunctional Range. (See Administration and Scoring Manuals for technical justification). In general, one goal of treatment is to help consumers feel well enough to report

symptom scores that do not exceed the cutoff score. Signal Alert status is indicated by the letter inside parentheses - W, G, Y, or R. The graph displays the results of the ten previous service contacts. Graphs displaying earlier sessions for consumers with more than 10 sessions may be seen by viewing Clinician Reports from earlier treatment sessions. Some reports include a dark straight line that gradually slopes down, indicating the expected recovery curve for consumers that begin services with intake scores similar to this consumer. The expected recovery line helps service providers visualize the average change per session of treatment that is typical of treated consumers. Fifty different expected recovery curves representing different intake scores are incorporated into the empirical algorithms. These curves provide a benchmark for contrasting the recovery of the consumer of interest. It is deviations from this curve that provide the foundation for predicting treatment failure and success.

Note: Since the Y-OQ® 2.01 may be completed by the consumer or others and different respondents may be used during different service contacts, the bottom section indicates the person completing the Y-OQ® 2.01 for each session. This knowledge helps the clinician keep track of who is reporting progress. Obviously, it is highly desirable for weekly ratings on consumer progress to come from a single informant. As this is not always possible, this software helps the service provider keep track of who is rating consumer symptoms.

The Clinician Report for the first administration of the questionnaire emphasizes interpretation of the test score and implications for treatment planning, and is intended to help the service provider recognize the consumer's degree of overall disturbance. Figure 2 Initial Report is an example of a typical report that is delivered to the service provider when the first Y-OQ® 2.01 is taken by a consumer. In general, the more disturbed that the consumer is, the more service contacts that will be necessary for the consumer to return to a normal state of functioning.



Name: Test, Client **ID:** MRNTEST
Session Date: 9/11/2009 **Session:** 1
Clinician: Clinician, Jill **Clinic:** MI Michigan Clinic
Diagnosis: Unknown Diagnosis
Completed by: Caseworker
Instrument: YOQ®-2.0

Alert Status: NA
Most Recent Score: 99
Initial Score: 99
Change From Initial: No Reliable Change
Current Distress Level: Moderately High

Most Recent Critical Item Status:

12. Obsessive Thoughts	Rarely
20. Hallucinations	Never
21. Self Injurious Behavior	Sometimes
22. Substance Abuse	Never
28. Paranoia	Sometimes
38. Delusions	Sometimes
41. Suicidal	Rarely
44. Hypomania	Never
46. Fear of Going Crazy	Never
51. Aggression	Sometimes
58. Eating Disorder	Frequently

Subscales	Current	Outpat. Norm	Comm. Norm
Intrapers. Distress:	32	26.4	8.9
Somatic:	14	7.8	3.3
Interpers. Relations:	13	10.4	0.6
Social Problems:	12	6.3	0.7
Behavioral Dys.:	16	20.1	6.8
Critical Items:	12	7.7	3.0
Total:	**99**	**78.7**	**23.3**

Normative Comparison Groups

Graph Legend:

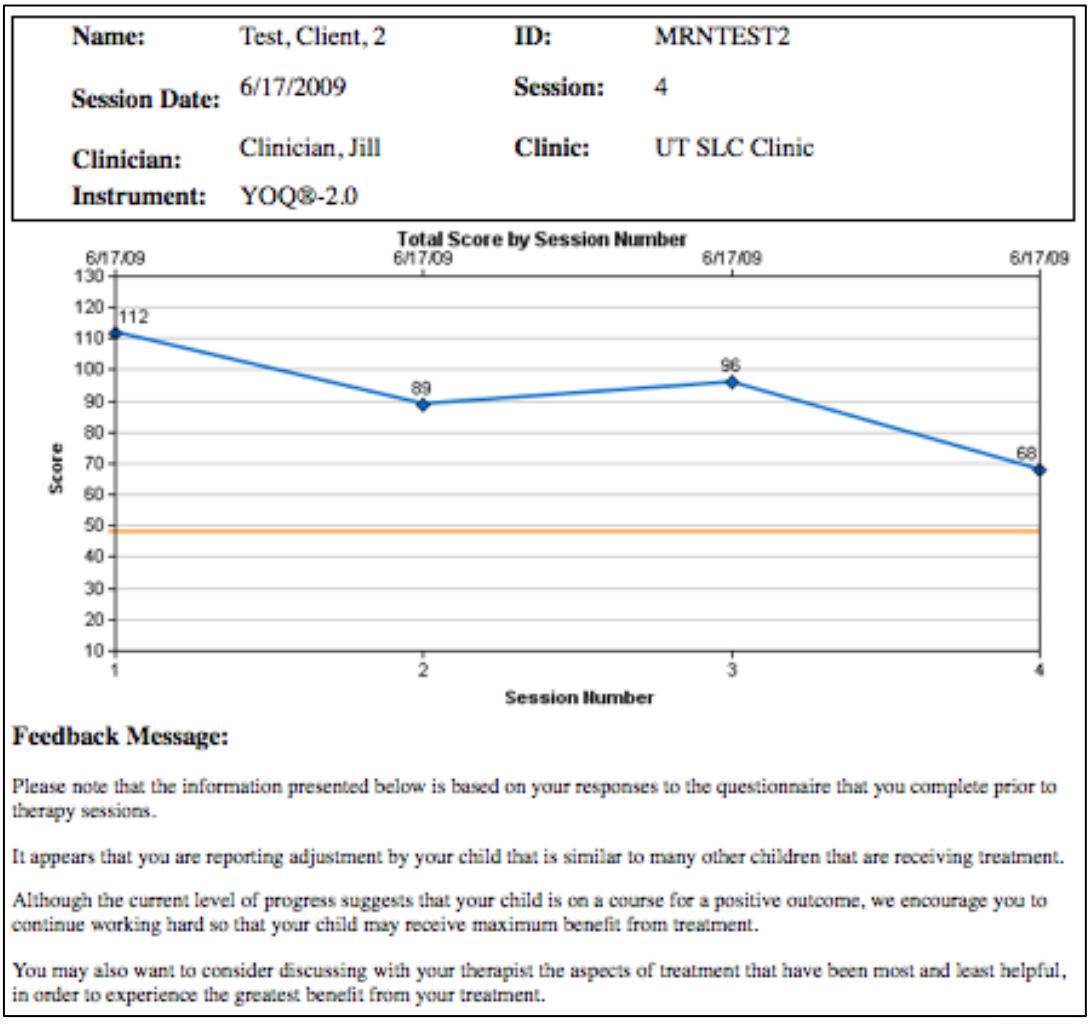
Residential - Primarily adolescents in residential care ranging from 90 - 180 days
Inpatient - Acute care facilities with short stay
Outpatient - Includes both public community mental health centers and private sector settings
Juvenile Justice - Adolescents presenting at intake for adjudicated offenses
Community Sample - Individuals randomly drawn from the community

Feedback Message:
Scores in this range are typical of patients who are treated in inpatient settings. The parent/patient is reporting a high degree of disturbance/dysfunction and appears to be in considerable pain. Suicidality should be monitored. Generally patients in this range show considerable improvement following outpatient and/or inpatient interventions. In outpatient settings, a reduction of the score by 13 points or more will occur within the first eight sessions of treatment.

Figure 2 Initial Report

The Client Report (Figure 3) may be used to provide consumers with a brief progress report. The Client Report provides a series of statements and a graph displaying consumer progress that is based upon the same algorithms used to generate the Clinician Report. The feedback in the report varies as a function of the degree of disturbance initially reported by the consumer, the amount of change reported at the follow-up service contact of interest, and the degree of alarm, if any, that the change suggests. Messages range from suggestions that the consumer is functioning quite well, is progressing but in need of further help, or is not progressing as expected and encouraged to discuss progress with the service provider. Feedback is, by design, encouraging as well as empirically based.

Limited research has shown that consumers find the feedback desirable and would like to have it, if given the option. It also shows that feedback given directly to consumers in the form provided in the Client Report has a positive effect on treatment outcome. It is important for service providers to know which feedback message is going to the consumer. As a practical matter it is a good idea to have service providers personally provide the feedback form to the consumer or at least be aware of what feedback was given to the consumer. Although it is not common practice in clinical settings to give consumers feedback about their treatment progress and service providers may be uncomfortable with a formal feedback report that they did not create (especially if the report indicates a lack of progress), research has shown that such feedback promotes interaction about goals and tasks of successful treatments.



7. *Using Y-OQ® 2.01 results to guide treatment*

In addition to both quantitatively and qualitatively tracking symptom severity, Y-OQ® 2.01 results can be clinically helpful in a number of ways.

7.1 Case conceptualization

The initial Y-OQ® 2.01 scores, both total and subscale, can give service providers a good read on their consumer's "mental health vital signs." Early indicators like these scores are useful when determining the appropriate type, duration, and intensity of services. They can also focus clinical efforts on a consumer's most salient areas of concern. In today's world of managed care where consumers are not always able (or willing) to commit to months of therapy, any reliable information that allows service providers to conceptualize a case faster allows for more efficient use of precious clinical resources.

7.2 Setting and tracking specific treatment goals

Service providers should explain the purpose of the Y-OQ® 2.01 to their consumers during the first contact. As service providers go over Y-OQ® 2.01 scores with their consumers in subsequent contacts, total score elevations, specific scale elevations, and even answers to specific items can provide a concrete basis upon which to set focused treatment goals.

Service providers and consumers should have open discussions regarding whether treatment is producing the desired results in terms of these goals. Having a common metric with which consumers can track their progress can engender confidence that they are improving and create motivation. Of course, each individual case is different and service providers are encouraged to use their own knowledge of the consumer in addition to clinical judgment to determine when it is most appropriate to share Y-OQ® 2.01 and scores.

7.3 Attending to critical items

Consumer responses to particular items can draw the provider's attention to areas that need investigation during the current episode of care. The consumer's responses to the critical items should be given the highest priority in this regard. Sometimes consumers are not forthcoming about their drug/alcohol abuse, psychotic ideation, or suicidal ideation when speaking to service providers face-to-face. Some of these consumers will perceive the Y-OQ® 2.01 as a less threatening method of disclosing such sensitive information.

7.4 Integration with case notes

Y-OQ® 2.01 scores can be included as part of a consumer's medical records. Since the questionnaire results contain a great deal of specific clinical information, service providers' case notes can reference the questionnaire results, thereby reducing case note length. In some applications, Y-OQ® 2.01 results can be automatically integrated into existing electronic medical record systems.

7.5 Utilizing the OQ® instruments when results seem counter intuitive

Sometimes Y-OQ® 2.01 scores do not turn out as expected, perhaps because the way a consumer responds seemingly produces invalid results. The OQ® instruments can still prove useful even when it does not appear to be "working."

7.5.1 Persistently low scores in spite of obvious distress

Sometimes consumers will produce OQ® scores that fall well below the clinical cut-off score even though you, as a service provider, know that they are experiencing significant distress. Because there are several reasons that a consumer might be approaching the Y-OQ® 2.01 in this way, it is important that the service provider discusses their scores with them. Service providers are encouraged to discuss specific subscale and item scores that they believe are particularly disingenuous. As consumers are confronted with specific details from the OQ® instrument in a non-threatening manner, they are often willing to concede that their current responses do not accurately reflect their symptom distress.

In instances like this, the Y-OQ® 2.01 become more than an outcome-tracking tool—it becomes an intervention. It becomes an avenue for communication, or even a "co-therapist" who asks the questions that sometimes go overlooked.

7.5.2 When an increasing score is a good thing

Service providers like to see their consumers recover. When it is working like it is supposed to, the Y-OQ® 2.01 reflects recovery—scores go down, suggesting the consumer is experiencing less symptomatic distress. However, like in the previous section, sometimes scores are *too* low. Perhaps some consumers are in denial or lack introspective insight. For whatever reason, they are not realistically appraising their level of distress. When service providers share these concerns with these consumers, backed up by evidence from the Y-OQ® 2.01, we often find that scores go up. In this instance, such an increase represents a more realistic appraisal rather than recidivism.

7.5.3 Dramatic fluctuations in scoring patterns over time

Dramatic peaks and valleys in a consumer's OQ® scores instead of a gradual decline might be indicative of a particular type of pathology (e.g., Bipolar Disorder, Borderline Personality Disorder) or psychosocial stressor (e.g., tumultuous relationship). In either case, Y-OQ® 2.01 scoring patterns could be used as an emotional seismograph, warning both service provider and consumer when the next peak or valley of distress and functioning has appeared. In other words, as the service provider shares the session-by-session OQ® scores with the consumer they can anticipate patterned increases/decreases in emotional distress. Such a warning will help consumers gain insight into what might be causing or exacerbating their symptoms.

8. *Case examples*

The following vignettes are based on actual cases from community mental health center service providers. Names and identifying information have been changed to protect anonymity. For a detailed description of how to interpret the reports produced by the OQ®-A featured in the figures, please see the User Guide.

8.1 "When good means bad and bad means good"

Ms. Smith and her 5-year-old daughter, Suzie, are victims of domestic violence and Ms. Smith is addicted to methamphetamines. Ms. Smith reports that Suzie has symptoms typical of Post Traumatic Stress Disorder that appear to be related to witnessing her father physically abusing her mother. In spite of these presenting concerns, Ms. Smith's initial Y-OQ® 2.01 scores consistently fall well below the clinical range (see Figure 4).

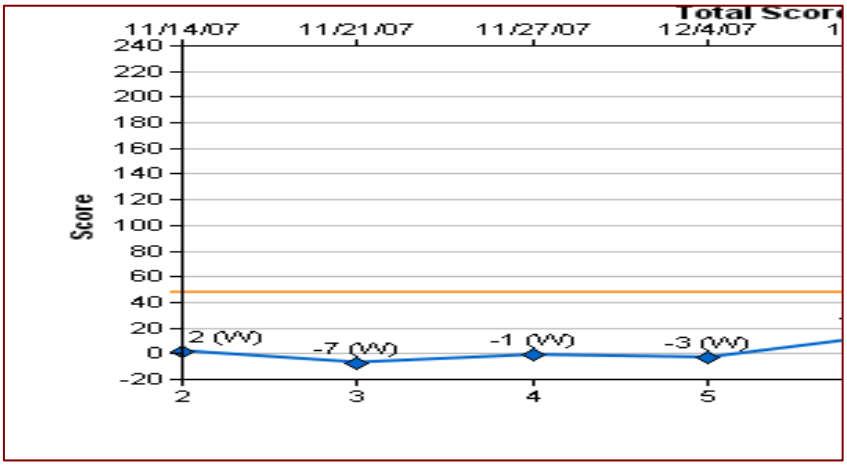


Figure 4

After a few episodes of care it becomes apparent that Ms. Smith feels guilty that her daughter has experienced so much trauma. This guilt results in a response bias on the Y-OQ® 2.01—Ms. Smith consistently underreports the severity of her daughter's distress. It is as if Ms. Smith's responses to the Y-OQ® 2.01 reflect what she *wants* her daughter to be like rather than an accurate assessment of her functioning. In a sense, Ms. Smith is afraid that by admitting to the severity of her daughter's symptoms she is admitting responsibility for them.

The service provider discusses this low scoring pattern with Ms. Smith and goes over specific responses that appear particularly unrealistic given Suzie's experiences. The service provider also facilitates effective communication between Ms. Smith and Suzie about the domestic violence and Suzie's fears. As Ms. Smith is able to shed some of her guilt she is able to perceive and thereby rate her daughter's symptoms more realistically. Subsequently, Ms. Smith's ratings of Suzie's distress increase (see Figure 5).

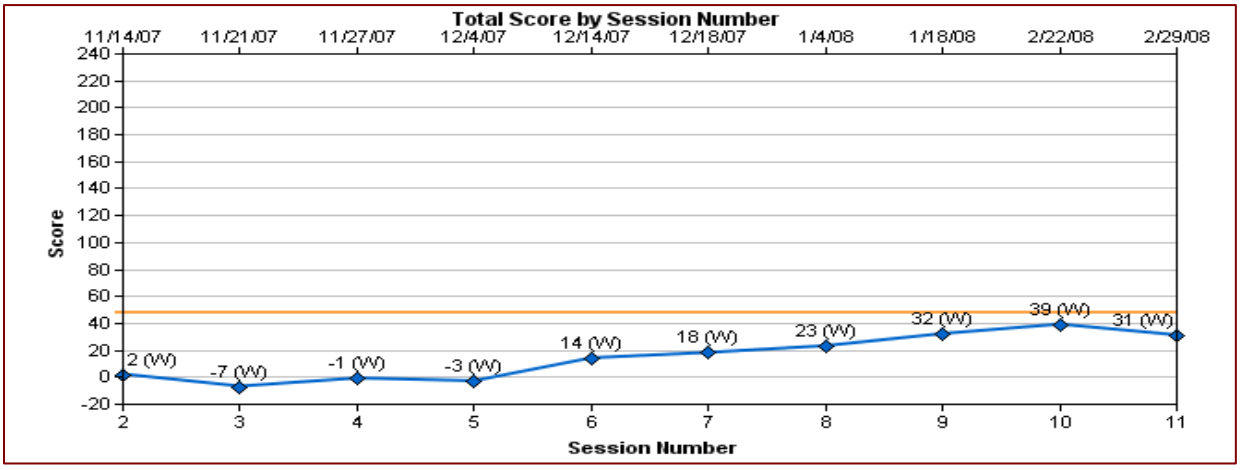


Figure 5

Service providers want to see their consumers get better and an increase in Y-OQ® 2.01 scores does not typically represent improvement. However, as it relates to some consumers, an increasing score can represent a mother's developing ability to deal with her own guilt and realistically appraise her child's level of distress. In other words, a "good" or low score was indicative of obstacles to recovery, while a "bad" or higher score represented therapeutic improvement.

8.2 "When it looks like it's over, we're just getting started"

Kate is a teenager who was sexually abused when she was 6-years-old and now suffers from depression and anxiety. She is hesitant to discuss her sexual abuse and is very negative about herself. She appears to be in an enmeshed relationship with her mother through which she has taken on a great deal of undue stress. Over the first few contacts, Kate's Y-OQ® 2.01 scores decrease substantially (see Figure 6).

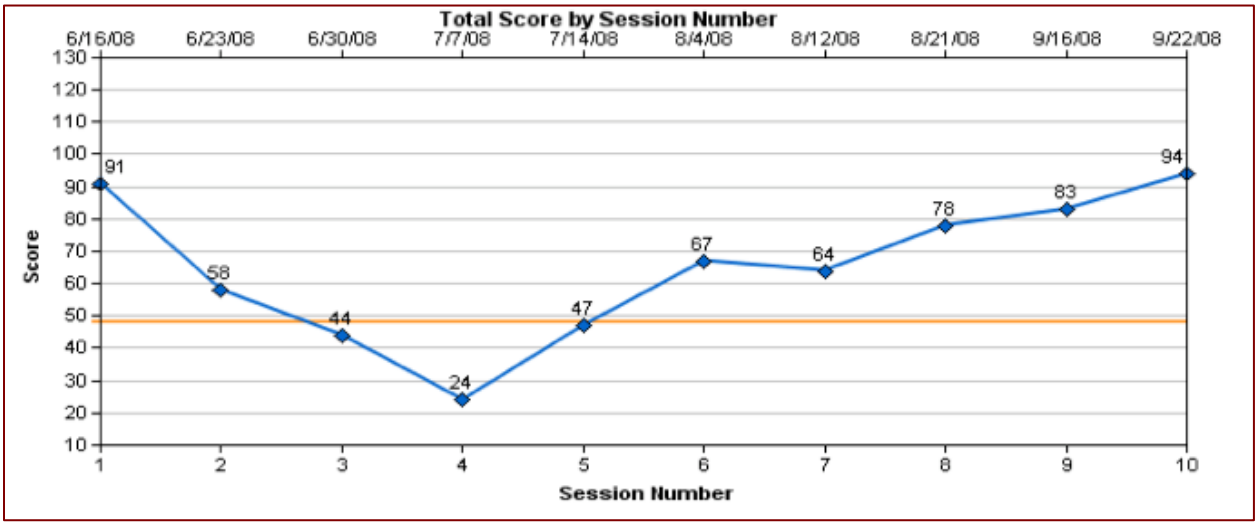


Figure 6

When Kate's score reaches 24, Kate receives feedback about how quickly her scores have dropped and how low her most recent score is. After receiving this feedback, Kate produces progressively higher scores. When Kate's score exceeds that of her initial score, the service provider gives her more feedback, asking what has changed.

Kate explains that she is afraid of happy feelings because of what they imply. She says that she was happy before she was abused and that if she is happy again it might make her vulnerable to more abuse. She also worries that if she is happy and other bad things happen in her life then she will end up "crashing" and feeling more depressed than she ever has before. In a sense, Kate is implementing a defensive pessimism to protect her from disappointment and other negative feelings.

After processing these feelings with Kate, Kate's service provider uses the Y-OQ® 2.01 subscale and individual item scores to help Kate set reasonable treatment goals. Kate is encouraged her to take it slowly by setting weekly goals. She and the service provider discuss the content from two or three questions that Kate would need to focus on for the week in order to reach her goals.

Kate's scores start to decrease slightly as she is encouraged to take it slowly (see Figure 7). After maintaining a score of 74 for two consecutive episodes of care, the service provider asks Kate what she would need to do to decrease her symptomatic distress even further. Kate says that talking about her sexual abuse would help, but she is not ready yet. Kate explains that perhaps when her total score

falls to about 50 she will feel safe enough to discuss her sexual abuse. The service provider recognizes that what might appear to be an arbitrary number set by Kate is actually right around the community normal cut-off score (46). As a representation of safety, working toward a total score of 50 allows Kate and her service provider to use the Y-OQ® 2.01 as an intervention, not just to track symptomatic change.

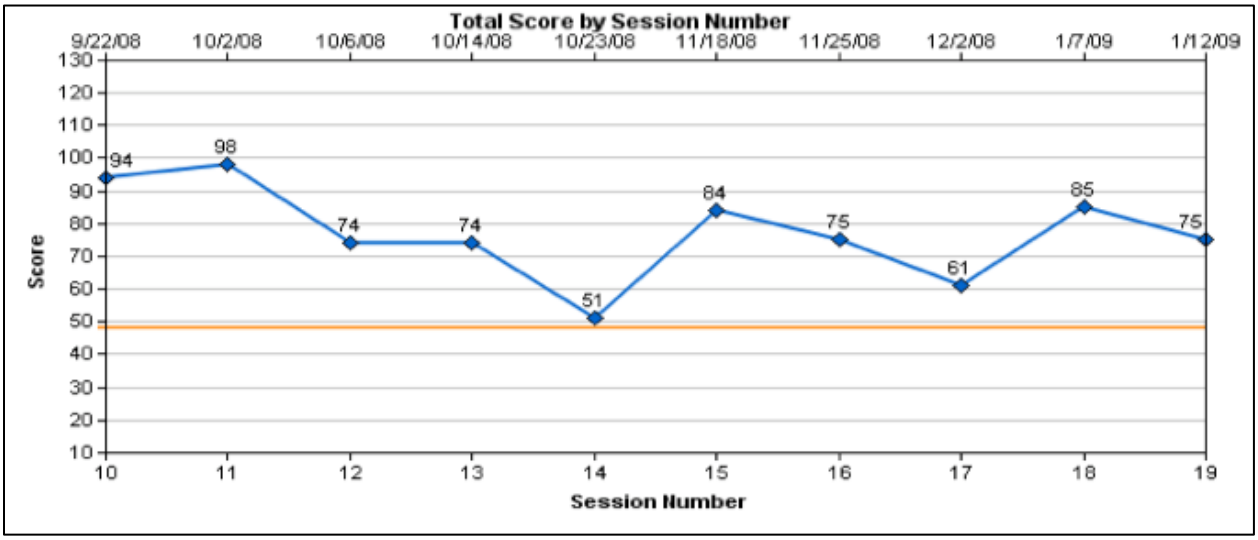


Figure 7

8.3 "Seeing the forest for the trees"

Mrs. Stewart's six-year-old son, Joel, is not coping well with the fact that his father has a terminal illness. He obsesses over the notion that his father will die soon and is acting out aggressively. Each week she brings Joel in for services, Mrs. Stewart discusses her son's progress with his service provider. Each week she reports that nothing has changed. However, her Y-OQ® 2.01 scores suggest otherwise (see Figure 8).

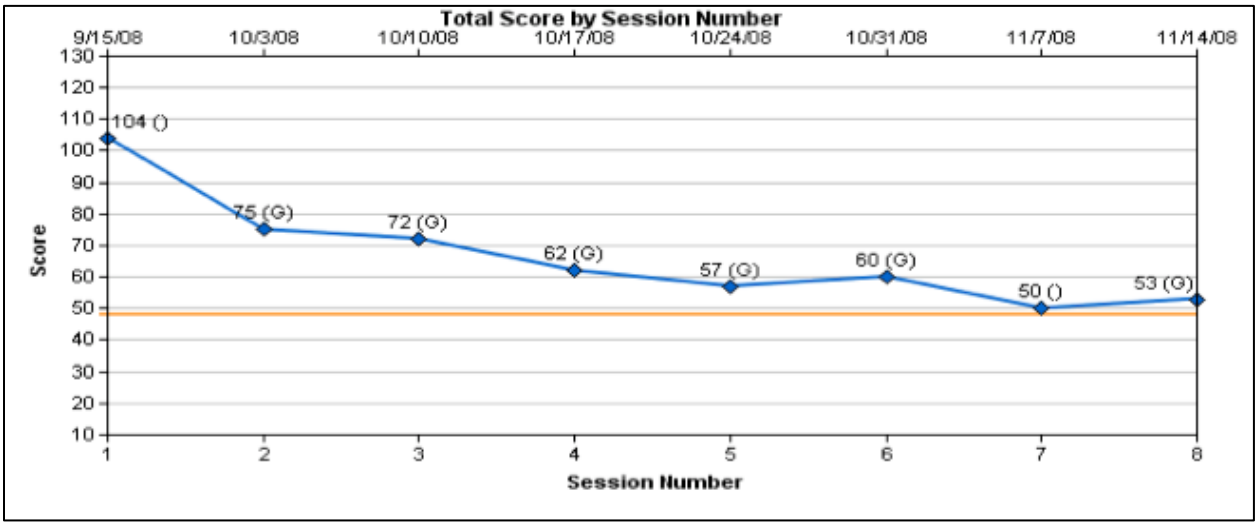


Figure 8

Joel's service provider shares these scores with Mrs. Stewart and discovers that Mrs. Stewart is so overwhelmed at home that when asked how her son is doing she struggles to process the details. Instead, she produces a global description that resembles her outlook on life in general: "Oh, about the same." However, using the Y-OQ® 2.01, Mrs. Stewart can cut through these stress-induced generalities and provide more accurate details about Joel's current symptoms. Without this feedback, the service provider would be left to assume that the interventions were not working. However, because this feedback is available, the service provider can more accurately conceptualize the case and calibrate interventions.

After Mrs. Stewart receives feedback about her Y-OQ® 2.01 scores, she starts to notice and report the improvements her son is making. This puts both she and the service provider on the same page and boosts morale in the home.

8.4 "Denial ain't just a river in Egypt"

At 16, Sam already has a long history of drug abuse, aggressive acting out, theft, sexual promiscuity, and other problematic behaviors. He has been court-ordered into services and comes every week. He often fails his drug tests, landing him in big trouble with his parents and probation officer. In spite of the chaotic nature of his life, Sam's Y-OQ® 2.01 scores are persistently low (see Figure 9).

Sam's service provider is concerned that Sam is grossly underreporting his level of distress, so she shares Sam's Y-OQ® 2.01 scores with him. The service provider explains to Sam that what he reports on the Y-OQ® 2.01 does not makes sense in light of his current life circumstances. For instance, Sam indicated that he "never" had legal problems, but he was actually in jail for violating probation that week.

With the evidence that the Y-OQ® 2.01 provides, the service provider is better able to broach this therapeutic issue and Sam feels accountable for the disconnect between his Y-OQ® 2.01 scores and reality.

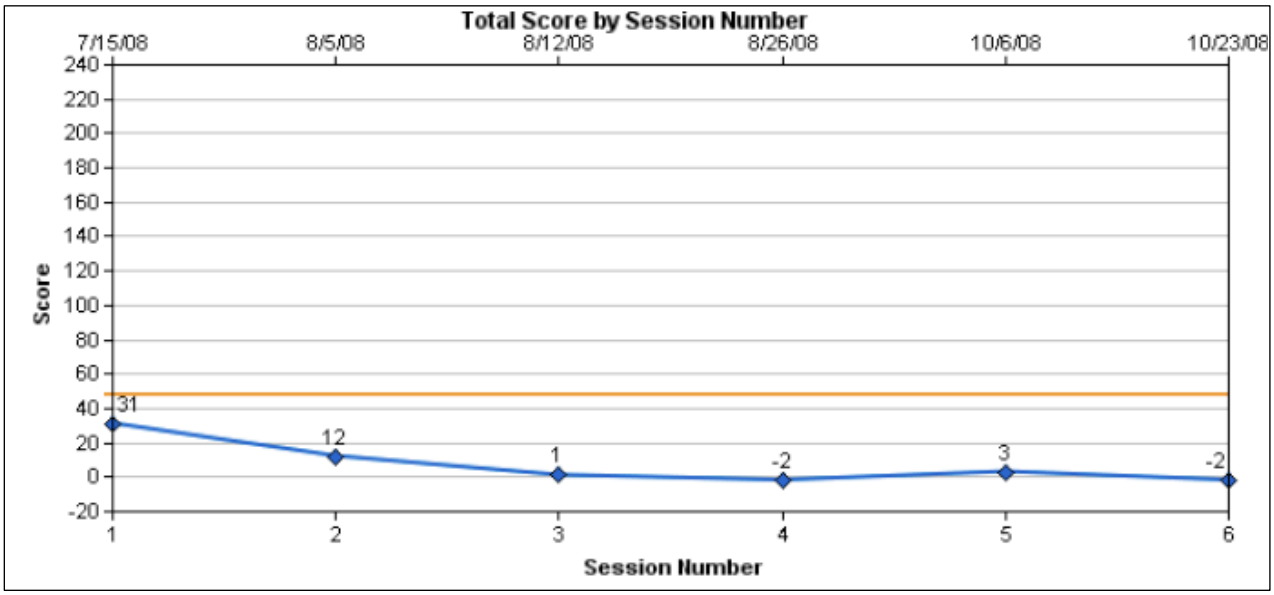


Figure 9

8.5 "From skeptic to believer"

Howard is a 58-year-old seasoned clinician delivering school-based services and does not care for questionnaire-based measurement. When the administration at his clinic mandated that he use the Y-OQ® 2.01, he reluctantly complied. Delegating all issues of Y-OQ® 2.01 administration to his case manager, Howard never looked at any of his consumer's scores.

After ignoring the Y-OQ® 2.01 for months, Howard noticed how his colleagues were using the measure as they presented their cases at weekly staff meetings. He noticed how they were using it to guide case conceptualization and to give feedback to consumers. He noticed how some clinicians were using Y-OQ® 2.01 scores in sessions to set treatment goals and to track progress. He saw the Y-OQ® 2.01 make a difference in the way his colleagues practiced and in the way consumers recovered.

Howard decided to test his colleagues experience with a few consumers and has since seen the Y-OQ® 2.01 shift his practice. Now he finds it particularly useful with adolescents who take a passive approach to therapy (e.g., responding with "I don't know" or "nothing" when they are asked about their lives and problems). By going over subscale and item scores with these adolescents, he finds that they are more willing to engage in therapy. Indeed, some of his consumers have now become accustomed to providing a mental health vital sign "check in" and begin their school-based contacts with Howard asking "where they're at today."