

The Partners for Change Outcome Management System: A Both/And System for Collaborative Practice

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Systematic client feedback (SCF) is increasingly employed in mental health services worldwide. While research supports its efficacy over treatment as usual, clinicians, especially those who highly value relational practices, may be concerned that routine data collection detracts from clinical process. This article describes one SCF system, the Partners for Change Outcome Management System (PCOMS), along a normative (standardized measurement) to communicative (conversational) continuum, highlighting PCOMS' origins in everyday clinical practice. The authors contend that PCOMS represents "both/and," providing a valid signal of client progress while facilitating communicative process particularly prized by family therapists steeped in relational traditions. The article discusses application of PCOMS in systemic practice and describes how it actualizes time-honored family therapy approaches. The importance of giving voice to individualized client experience is emphasized.

Keywords: Systematic Client Feedback; PCOMS; Partners for Change Outcome Management System

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INTRODUCTION

Systematic client feedback (SCF) is increasingly used in varied psychotherapy settings to provide real-time and pre-post client progress information to therapists, administrators, and funders. SCF involves the routine collection of consumer feedback to track improvement, identify at-risk clients, and facilitate adjustment of therapy to prevent treatment failure. The need for SCF is based on findings that many clients quit therapy prematurely (Swift & Greenberg, 2012) or have negative outcomes (Reese, Duncan, Bohanske, Owen, & Minami, 2014). Moreover, clinicians are overly optimistic about their effectiveness (Walfish, McAlister, O'Donnell, & Lambert, 2012) and are unable to predict which clients are likely to do poorly (Chapman et al., 2012). SCF systems aim to identify treatment failures before they occur, allowing time for clinicians to restore therapy to a positive trajectory.

Evidence that SCF can improve outcome is now well established. Randomized clinical trials (RCT) and cohort studies indicate significantly better outcomes for feedback conditions compared with treatment as usual in individual (Lambert, 2015), couple (Anker,

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Duncan, & Sparks, 2009; Reese, Toland, Slone, & Norsworthy, 2010), family (Cooper, Stewart, Sparks, & Bunting, 2012), and group therapy (Schuman, Slone, Reese, & Duncan, 2014; Slone, Reese, Mathews-Duvall, & Kodet, 2015). The increasing body of evidence prompted the American Psychological Association Taskforce on Evidence Based Treatments (2006) to recommend that clinicians routinely collect and utilize client-report data to inform treatment. Concurring, the American Association for Marriage and Family Therapy Task Force on Core Competencies advises therapists to solicit and use client feedback throughout the therapeutic process (Nelson et al., 2007).

Two SCF systems, the Partners for Change Outcome Management System (PCOMS; Duncan & Reese, 2015) and the Outcome Questionnaire System (OQ; Lambert, 2015), are listed by the Substance Abuse and Mental Health Administration in the National Registry of Evidence-based Programs and Practices. Only PCOMS has demonstrated significant improvement in outcomes with couples and families. PCOMS (Anker et al., 2009; Duncan & Sparks, 2002), the evidence-based methodology of using the Outcome Rating Scale (ORS; Miller, Duncan, Brown, Sparks, & Claud 2003) and the Session Rating Scale (SRS; Duncan, Miller, Sparks, Claud, et al., 2003), directly involves clinicians and clients, including youth, in an ongoing process of measuring and discussing both progress and the alliance, the first system to do so.

Systematic client feedback systems with couples and families are in various stages of development (Sparks & Duncan, in press). In addition to PCOMS, the Systemic Therapy Inventory of Change (STIC) monitors change from a multisystemic perspective with families, couples, and individuals (Pinsof et al., 2015). Contextualized Feedback Systems (CFS; Bickman, Kelley, Breda, de Andrade, & Riemer, 2011) is a web-based, continuous quality improvement system designed for use in youth mental health treatment. The Clinical Outcomes in Routine Evaluation (CORE; Barkham et al., 2001) tracks change in general psychological services; the Young Person's Clinical Outcomes in Routine Evaluation (YP-CORE; Twigg et al., 2009) expands application of the CORE to youth and families. SCORE (Systemic CORE; Stratton, Bland, Janes, & Lask, 2010) is designed specifically to document system health and progress over the course of psychotherapy. The OQ System (Lambert, 2015) also includes the Youth Outcome Questionnaire (YOQ; Dunn, Burlingame, Walbridge, Smith, & Crum, 2005), which permits the identification of not-on-track youth. For many SCF systems, iPads or tablets link to web-based applications providing progress graphs and alerts for at-risk clients.

Systematic client feedback systems can be considered as falling along a continuum. One end emphasizes normative measurement, the other, communicative (Duncan & Reese, 2015; Halstead, Youn, & Armijo, 2013). These dimensions are typically viewed as markedly different. The normative end reflects the positivist paradigm's view that universal structures underlie human behavior and can be discovered and measured (Sales & Alves, 2012). The communicative end represents constructivist (Neimeyer & Mahoney, 1995) and social constructionist (Gergen, 1985; McNamee & Gergen, 1992) beliefs that reality is constructed as people perceive and interact with one another and their environments. Normative methods thus aim to locate persons within a population via repeated standardized measurement; communicative approaches use personalized instruments to provide an in-depth understanding of individuals' specific concerns, goals, and experiences.

When viewed as strictly normative, SCF can represent the antithesis of why many couple and family therapists chose their profession. For these, the interpersonal drama played out in every session is sacrosanct; reducing it to graphs and red flags on a computer screen is nothing short of sacrilege. The history of the field of family therapy—from early communication theorists, to structural and strategic joining, solution-talk, collaborative conversations, and unfolding client narratives—has focused largely on interactive process. This communicative bent can be considered at odds with the call to prove the field's

evidence base and outcomes via systematic measurement protocols; continuous collection and interpretation of multisourced data may be viewed as a significant distraction from “the real work.” When viewed in opposition, normative and communicative procedures can lead to a polarizing and potentially paralyzing conundrum for therapists, educators, and policy makers.

This article describes one SCF system, the Partners for Change Outcome Management System (Duncan, 2014), as a way to enhance outcomes *and* foster idiosyncratic interpersonal processes we believe lie at the heart of effective therapy. While much has been written about PCOMS—its components, process, and research—this is the first elaboration of the system’s merging of two traditionally incompatible interests, clinical process and outcome measurement, specifically detailing the connection of revered family therapy traditions and SCF methods to address the demands of modern clinical practice. We describe how PCOMS evolved from its communicative origins to a system accomplishing key normative objectives. We further discuss PCOMS’ applicability to couple and family therapy, suggesting specifically that it is a logical outgrowth of the field’s venerable lineage. Finally, we offer systemic therapists a way to practice “both/and” without sacrificing the benefits of SCF or core relational processes.

THE PARTNERS FOR CHANGE OUTCOME MANAGEMENT SYSTEM

Partners for Change Outcome Management System (Duncan, 2012) is a continuous quality improvement SCF system designed to track client change and the therapeutic alliance at each session. The system was created to offer a valid, feasible option for alerting clinicians to not-on-track clients, allowing time to respond to prevent treatment failure. A hallmark of the system is its valuing of client voice and related collaborative interpretation and integration of scores into ongoing therapeutic conversations.

Historical Context

Outcome measures and feedback systems largely arose from rigorous psychometric research and the desire to prevent treatment failure or to guide intervention from a specific treatment ideology. In contrast, PCOMS (Duncan, 2014) started from everyday clinical practice and a desire to privilege the client in the therapy process. When collection of client feedback was first introduced by Michael Lambert in the mid-nineties (Lambert, 2015), the second author embraced it as a radical development—a methodology that routinely placed the client’s construction of success, his or her view of therapeutic progress as depicted on Lambert’s self-report Outcome Questionnaire 45 (OQ45; Lambert et al., 2004), at the center of therapy. It provided a way to realize what Duncan, Solovey, and Rusk (1992) called “client directed” clinical services. Their call for client-directed therapies emerged from the extensive empirical support for the common factors (Lambert, 1986) combined with an eclectic gathering of historic family therapy ideas: (1) problem-focused pragmatism of the Interactional Approach of the Mental Research Institute (MRI; Watzlawick, Weakland, & Fisch, 1974); (2) client resource activation of Solution Focused Brief Therapy (de Shazer et al., 1986); and (3) cocreation of meaning of Collaborative Language Systems (Anderson & Goolishian, 1988)—all described in iconic articles published in *Family Process*. Duncan et al. advocated for a more intentional use of client views about the reasons for service (the client’s theory of change) as well as what constitutes success to maximize common factor effects (mainly client and alliance factors) and enhance client collaboration.

Systematic feedback offered a way to make “client directed” happen, a focused, transparent process to honor the client’s perspective about outcome and the alliance. PCOMS

arose, then, from an intent to make manifest what mattered most to therapy outcomes, a set of values about client privilege, and an interactional and linguistic view of problems and their resolution. From these origins, and concerns regarding the feasibility of longer measures, the Outcome Rating Scale (ORS; Miller et al., 2003) and Session Rating Scale (SRS; Duncan, Miller, Sparks, Claud, et al., 2003) were codeveloped. Thereafter, based on 2 years of private practice as well as multiple team supervisions in a family therapy community clinic, Duncan created the clinical process of using the ORS and SRS and detailed it first in Duncan and Sparks (2002). Over time, it became evident that families would be unable to benefit from feedback protocols without a measure for children, resulting in the Child Outcome Rating Scale (CORS; Duncan, Sparks, Miller, Bohanske, & Claud, 2006) and Child Session Rating Scale (CSRS; Duncan, Miller, & Sparks, 2003).

Measures

Each of the four primary instruments that comprise the basic PCOMS measurement set, the ORS, SRS, CORS, and CSRS (Figures 1 and 2), is a visual analogue scale consisting of four 10 cm lines. The ORS and SRS are used with adults and adolescents, aged 13–17. Children aged 6–12 use the CORS and CSRS. Adult caregivers provide feedback for their child or adolescent on either the CORS or ORS based on the child's age. Because of the desire to create a system feasible for everyday clinical practice, PCOMS instruments are brief, generally requiring no more than 3–5 minutes to administer, score, and discuss. (Duncan, 2014). The four 10 cm lines of the ORS total to a score of 40, three around major domains assessed by the OQ45 (*Individually*, *Interpersonally*, and *Socially*) and a fourth, *Overall*; *Individually* captures client personal distress or well-being; *Interpersonally*, clients' significant relationships; and *Socially*, clients' work, school, friends, and other social arenas. The lower the score, the higher the distress. The CORS retains the same domains, but uses language suitable for its intended age group: *Me*, *Family*, *School*, and *Everything*, with smiley/frowny faces at either ends to aid comprehension.

The SRS, like the ORS, was designed to facilitate routine monitoring and to encourage therapeutic conversations that privilege the client's experience of therapy. This instrument also consists of four 10 cm lines: *Relationship*, *Goals and Topics*, *Approach or Method*, and *Overall*, assessing clients' views of the therapeutic alliance according to Bordin's (1979) classic definition. The CSRS monitors 6- to 12-year-olds' views of four domains: *Listening*, *How Important*, *What We Did*, and *Overall*, again with smiley/frowny faces at each end. The SRS/CSRS encourages all client feedback, positive and negative, creating a safe space for clients to voice their honest opinions about their connection to their therapist, specifically aiming to identify alliance ruptures before they negatively impact outcome.

The ORS/CORS are administered at the beginning of every session, either via paper/pencil or on iPads/tablets. Clients place a mark or move a cursor on each line according to their perception of how they are doing (or how they perceive their child doing) on each dimension of the ORS or CORS. The SRS and CSRS are administered during the last 5 minutes of a session.

Process

Partners for Change Outcome Management System is not a rote measure administration; it is a light-touch, checking-in process via the ORS that serves as a basis for beginning conversations. With PCOMS, client involvement is routine and expected; ORS scores are openly shared and discussed immediately after they are collected. Given the transparency of measure scoring and subsequent discussion, the system provides a client-defined, mutually understood reference point for reasons for seeking service, progress,

Outcome Rating Scale (ORS)

Name _____ Age (Yrs.): _____ Gender: _____
 Session # _____ Date: _____
 Who is filling out this form? Please check one: Self _____ Other _____
 If other, what is your relationship to this person? _____

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

-----|-----

Individually
(Personal well-being)

-----|-----

Interpersonally
(Family, close relationships)

-----|-----

Socially
(Work, school, friendships)

-----|-----

Overall
(General sense of well-being)

-----|-----

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Session Rating Scale (SRS V.3.0)

Name _____ Age (Yrs.): _____
 ID# _____ Gender: _____
 Session # _____ Date: _____

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

-----|-----

Relationship

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

-----|-----

Goals and Topics

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

-----|-----

Approach or Method

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

-----|-----

Overall

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

-----|-----

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FIGURE 1. The Outcome Rating Scale (ORS) and Session Rating Scale (SRS). Copyright 2000, 2002 respectively by B. L. Duncan and S. D. Miller. For examination only. Download free working copies in 28 languages at <https://www.betteroutcomesnow.com/>.

Child Outcome Rating Scale (CORS)

Name _____ Age (Yrs.): _____
 Gender: _____
 Session # _____ Date: _____
 Who is filling out this form? Please check one: Child _____ Caretaker _____
 If caretaker, what is your relationship to this child? _____

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

-----|-----

Me
(How am I doing?)

☹️ |-----| ☺️

-----|-----

Family
(How are things in my family?)

☹️ |-----| ☺️

-----|-----

School
(How am I doing at school?)

☹️ |-----| ☺️

-----|-----

Everything
(How is everything going?)

☹️ |-----| ☺️

-----|-----

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Child Session Rating Scale (CSRS)

Name _____ Age (Yrs.): _____
 Gender: _____
 Session # _____ Date: _____

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

-----|-----

Listening

did not always listen to me. ☹️ |-----| ☺️ listened to me.

-----|-----

How Important

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

-----|-----

What We Did

I did not like what we did today. ☹️ |-----| ☺️ I liked what we did today.

-----|-----

Overall

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

-----|-----

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FIGURE 2. The Child Outcome Rating Scale (ORS) and Child Session Rating Scale (SRS). Copyright 2003 by B. L. Duncan and S. D. Miller. For examination only. Download free working copies in 28 languages at <https://www.betteroutcomesnow.com/>.

and engagement. Open-ended visual analog scales allow clients to rate their global levels of distress without the constraints of theory or therapist-derived content domains. Specifics of that distress unfold as clinicians invite clients to give meaning to their scores. From this starting point, the clinical conversation evolves into a specific client-defined representation of the reason(s) for service.

Normative Components

According to Lambert (2015), a viable SCF system requires three components: a reliable and valid measure of client change, a normative-determined signal for notification of at-risk clients, and continuous progress monitoring throughout treatment. Together, these ensure that the system accomplishes the task of identifying not-on-track clients in time for remedial action.

Measure metrics

Despite its brevity, multiple validation studies of the ORS (Bringinghurst, Watson, Miller, & Duncan, 2006; Campbell & Hemsley, 2009; Miller et al., 2003) as well as efficacy studies have found that the ORS generates reliable scores. Coefficient alphas have ranged from .87 to .91 in validation studies and from .83 (Anker et al., 2009; couple therapy) to .92 (Slone et al., 2015; group therapy) in clinical studies. Similarly, Duncan et al. (2006) reported alphas of .93 for adolescents on the ORS, and .84 for children on the CORS.

Research also suggests that the ORS generates valid scores as a measure of general distress. Three studies found evidence of concurrent validity for the ORS by comparing ORS scores to the OQ (Bringinghurst et al., 2006; Campbell & Hemsley, 2009; Miller et al., 2003). Average bivariate correlations were .62 (range .53–.74; Gillaspay & Murphy, 2011). The ORS has also demonstrated moderate-to-strong correlations with symptom and diagnosis-based measures, for example, the Symptom Checklist-90-Revised (Derogatis, 1992; $r = .57$) and the Patient Health Questionnaire 9 (Kroenke, Spitzer, & Williams, 2001; $r = .72$; DeSantis, Jackson, Duncan, & Reese, 2016). Three studies also demonstrated that scores reflect real-world treatment outcomes. Anker et al. (2009) found that couples with higher posttreatment ORS scores were more likely to be together at 6-month follow-up. Schuman, Slone, Reese, and Duncan (2015) report that active-duty soldiers who had higher post-ORS scores received higher behavioral ratings from their commander. According to Reese et al. (2017), inpatient clients achieving reliable change were less likely to be readmitted. The CORS also has demonstrated moderate concurrent validity ($r = .43$) when compared with the YOQ; the ORS for adolescents compares moderately well with the YOQ ($r = .53$). The ORS and ORS/CORS for adolescents and children have been found to be sensitive to change for clinical samples and stable in nonclinical samples, evidence of construct validity (Duncan et al., 2006).

The SRS also has evidence of generating reliable and valid scores. Gillaspay and Murphy (2011) reported the average internal consistency of SRS scores across five studies equaled .92 (range .88–.96). SRS scores also exhibit moderate evidence for concurrent validity with longer alliance measures; $r = .48$ with the Helping Alliance Questionnaire-II (Duncan et al., 2003), $r = .63$ with the Working Alliance Inventory (WAI; Campbell & Hemsley, 2009), and $r = .65$ with the WAI-Short Revised (Reese et al., 2013). The predictive validity of SRS scores has been supported by two studies. Duncan et al. (2003a) found a correlation of $r = .29$ between early SRS scores and outcome, which is consistent with previous alliance-outcome research. More recently, Anker, Owen, Duncan, and Sparks (2010) reported third session SRS scores predicted outcome beyond early symptom change ($d = 0.25$).

Identification of at-risk clients

Several systems have evolved Internet technologies that allow entry and analysis of client scores, although not all contain a dedicated mechanism for rapid identification of clients not improving as expected (Sparks & Duncan, in press). Data collected via PCOMS can be linked to an Excel file, an existing electronic health records system, or a commercial web-based service such as Better Outcomes Now (BON) (https://betteroutcomesnow.com). Immediately after clients enter their scores on a hand-held device, BON displays a client's status in relation to the expected treatment response (ETR) (Figure 3) and normatively determined clinical cutoffs (25, ORS for adults; 28, ORS for adolescents/caregivers; and

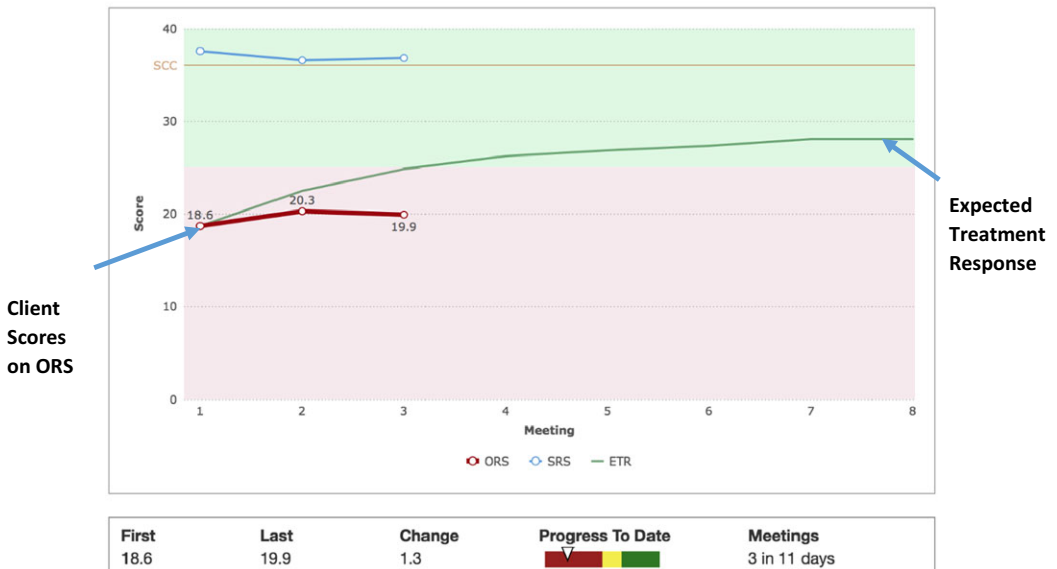


FIGURE 3. The web-based Outcome Rating Scale (ORS) (top) and graph with ORS scores and expected treatment response (ETR) (bottom). Progress meter shows client to be less than 50% of ETR, suggesting a conversation about changing therapeutic directions.

28, CORS, for children/caregivers on the CORS). The client's initial total ORS score generates an ETR line based on algorithms derived from extensive administrations of the instrument. All normative information is readily available in published articles (all available at www.betteroutcomesnow.com) and is nonproprietary except for the algorithms generating the ETR.

The ETR in BON serves as a trail map via a progress meter that reports the percent of the ETR achieved at each session, alerting client and clinician when to become concerned. Graphs depict clients' positions relative to the clinical cutoff, an important indicator of clients' initial level of distress as well as a benchmark for client progress. Improving 6 points or more indicates reliable change and moving from below to above the cutoff (distressed to a nondistressed range), clinically significant change (Jacobson & Truax, 1991). At a minimum, this information helps clinicians and supervisors prioritize their efforts and plan for remedial treatment strategies. More importantly, red flags call attention to the need to immediately discuss new directions with off-track clients. In the case of nonelectronic scoring, reliable and clinically significant change offer nonproprietary standard metrics that can be utilized to monitor client progress.

Continuous monitoring

Alerts of failing clients are of little use if those clients have dropped out of treatment. Evidence consistently shows that most clients change early, usually within eight meetings (Baldwin, Berkeljon, Atkins, Olsen, & Nielsen, 2009); absence of clients' perception of progress early on increases the chance of dropout. Identification of not-improving clients in time to change direction requires monitoring client feedback from the first session and continuously thereafter. Thus, feasibility of the system, although not in itself a normative dimension, is crucial. Otherwise, clinicians and clients may be reluctant to spend the time and effort to use it. Reports of near staff revolt have been noted when clinicians are required to administer lengthy instruments routinely (Hanlon, 2005). In response to the question of when is a measure too long, Duncan and Reese (2013) reply: "When clinicians won't use it" (p. 136).

Besides ease and speed of administration, routine client progress monitoring involves the perception by therapists and clients that the process is clinically meaningful (Duncan & Reese, 2013). It stands to reason that if a system is not viewed as helpful, clinicians and their clients are not likely to use it or, if required to do so, will use it intermittently and half-heartedly. PCOMS is meant to be a conversation opener, inviting clients to tell more of their story to increase the therapist's grasp of the client's perspective and life situation and foster connection with the client; it is not "another piece of paper" or simply more time away from what clients and therapists most value (Duncan, 2014). With PCOMS, data collection and therapeutic conversation are fused, increasing the likelihood it will be used routinely by practicing clinicians.

Communicative Components

Partners for Change Outcome Management System represents a departure from expert-driven formulations that attempt to classify client distress and problems of living from a theoretical or symptom vantage point. Instead, clients are empowered to highlight their views of distress/well-being, refocusing therapy toward individualized problem construction and solution building and away from options based on diagnosis, symptomology, or normative functioning. Unlike other validated outcome instruments, the ORS/CORS are not a list of symptoms or problems checked by clients on a Likert scale; it is not forced choice or symptom oriented. Rather it is an instrument that is individualized with each client to represent his or her idiosyncratic experience and reasons for service. The major

domains of life depicted on the ORS/CORS offer only a framework of life, a skeleton of human experience to which clients add the flesh and blood of their lived experience via the therapeutic conversation. For example, the interpersonal scale could represent conflict with a boyfriend or concerns about an ailing father; the social scale could involve recently being laid off a job, or stress in college. In relating their stories, clients color in the even more specific details of their unique life situations.

Partners for Change Outcome Management System, from its beginnings, was designed to be transparent in all aspects and to promote collaboration with clients in all decisions that affect their care. Inquiring about and honoring clients' perspectives of whether therapy is benefiting is central to the work. This communicative process starts with a shared understanding of the purpose of therapy. Clients rate themselves resulting in a score that only they can interpret; at this point, the coconstruction of meaning begins. The therapist provides reference points (clinical cutoffs, expected treatment response) gleaned from a normative data base to contextualize the client's score and validate the client's experience (e.g., "People who score this low tend to be having a rough time of it, does that fit for you?" Or, "You scored like people who are looking for a change, is that right?"), but the client is the final arbiter of what the score means and what it reports about his or her life. The content-free dimensions of the PCOMS measures allow clients to describe the meaning of their scores without preconceived theoretical or symptom-based constraints. Thus, client accounts retain the richness of real life, including the unique back-stories that contextualize their dilemmas.

Conversations generated by client scores on the ORS/CORS are openings for therapists to inquire about clients' reasons for service, views on precipitating and contextual factors, impact of the problem in clients' lives, and thoughts about general directions for problem resolution. Clients usually score the scale the lowest that represents the reason for service, and the therapist invites them to start there (or anywhere else they find useful). The therapist deliberately connects the client's discussion of the reason for service to how they filled out the ORS, to a specific mark on a specific domain or scale. This helps the client and therapist to collaboratively define a starting point—a shared understanding of the problem, the client's preferred focus of therapy, and what success will look like.

At the moment clients connect the marks on the ORS with the situations that prompt their seeking help, the ORS becomes a meaningful measure of progress and a potent clinical tool calibrated to their idiosyncratic circumstances. The therapist then can ask "What do you think it will take to move your mark just one cm to the right; what needs to happen out there and in here?" These types of questions, inspired by solution-focused brief therapy (e.g., Berg & de Shazer, 1993), allow scores to become springboards for change. Ensuing conversations alone can revitalize clients' hope and belief in their capacity to effect meaningful change, energizing them to become activists rather than passive patients and bringing to bear potent client factors in the resolution of difficulties. After the first session, the client's most recent scores in comparison with those from previous sessions (highlighted in graph format if using electronic scoring or hand-graphed) answer the question: "Are things better or not?" Nonresponding clients are thus engaged while new directions are collaboratively sought. When ORS scores increase, therapists empower change by helping clients see gains as resulting from their own efforts, as advocated by solution-focused therapy.

A more important discussion occurs when ORS scores are not increasing. PCOMS is intended to stimulate all interested parties to reflect on and discuss the implications of continuing a process that is yielding little or no benefit. Although addressed in each meeting in which it is apparent no change is occurring, later sessions gain increasing significance and warrant additional action—what we have called *checkpoint conversations* and *last chance discussions* (Duncan & Sparks, 2002). Checkpoint conversations are conducted

at the third to sixth session and last-chance discussions, in the sixth-to-ninth meeting. This process conforms to trajectories observed in outpatient settings that suggest most clients who ultimately benefit usually reflect change in 3–6 sessions (Duncan, 2014); if change is not noted by then, the client is at a risk for a negative outcome. No change by sessions 6–9 increases the urgency, hence the term “last chance.”

A more nuanced identification of clients at risk is accomplished by comparing the client's progress to the expected treatment response (ETR) available in software products (see Figure 3). The progression of the conversation with clients who are not benefiting goes from talking about *whether* something different should be done to identifying *what* can be done differently. PCOMS makes lack of change impossible to ignore, igniting both therapist and client into action.

The process of noting change or no change necessitated by PCOMS process is a continuous, evolving dialogue between therapist and client that promotes the evolution of new meaning (Goolishian & Anderson, 1987). This linguistic process is aided by normative reference points. Reliable and clinically significant change provides helpful metrics to gauge noted gains for discussion with clients. When clients reach a plateau or likely maximum benefit from service, conversation evolves to planning for continued change outside of therapy. All is negotiable and open for re-evaluation. The numbers never dictate action but rather inform the conversation.

Every conversation about change or the lack of change sets the occasion for unfolding and expanding experiences, constructing new meanings, and unearthing new avenues out of the client's dilemma. PCOMS essentially serves as a communicative catalyst in which client and therapist engage in a constantly evolving conversation about the status of the client's problem and the therapy's role in helping resolve it. PCOMS becomes a potent tool for keeping the conversation going (Goolishian & Anderson, 1987), facilitating all the spontaneous ideas, connections, plans, insights, resolves, and new identities that emerge when two or more people talk together in a room and call it therapy.

Use with Couples and Families

Partners for Change Outcome Management System originated out of concern that a complicated SCF system would not be used outside controlled research environments (Duncan, 2014; Sparks & Duncan, 2010). The time to administer, score, and discuss client ratings using PCOMS are extended with multiple clients in the room, although generally only by several minutes at either end of a session. Similar values and procedures apply to use of PCOMS in systemic practice as in individual work, including a desire to learn each person's perspective, transparency, use of client scores to understand clients' lived experience, and monitoring and strengthening the therapeutic alliance (Duncan & Sparks, 2014).

Partners for Change Outcome Management System has been extensively used and studied with couples and families. The first RCT of PCOMS was conducted with couples (Anker et al., 2009). The Norway Couple Trial enrolled 205 Euro-Scandinavian, heterosexual couples, the largest trial to date, seeking relationship counseling. The couples were randomly assigned to one of two groups—feedback (PCOMS) or treatment as usual (TAU). Anker et al. (2009) found that PCOMS clients reached clinically significant change nearly four times more than nonfeedback couples, and over doubled the percentage of couples in which both individuals reached reliable and/or clinically significant change (50.5% vs. 22.6%). At 6-month follow-up, 47.6% of couples in the PCOMS condition reported reliable and/or significant change versus 18.8% in TAU. The feedback condition not only maintained its advantage at 6-month follow-up, it also achieved a 46% lower separation/divorce rate. Reese et al. (2010) replicated the Anker et al. study with U.S. couples and found

nearly the same results. Overall outcomes were doubled and four times as many couples in the PCOMS condition experienced clinically significant change.

Research also supports use of PCOMS with children. Using a cohort design comparing outcomes in schools with 7- to 11-year olds, their parents, and teachers, Cooper et al. (2012) found that school-based counseling incorporating PCOMS was associated with large reductions in child psychological distress ($N = 288$). In addition, comparing caretaker and teacher ratings on the U.K. standardized measure, the Strength and Difficulties Questionnaire (SDQ; Goodman, 2001), revealed an approximate twofold advantage in effect size (ES) on caretaker-completed SDQ when PCOMS was used and a small but significant advantage on the teacher-completed SDQ.

These studies collectively support the effectiveness of PCOMS with couples and families. The Norway Couple Trial spawned a series of studies using its data and data collected at an additional site ($N = 500$; see, Anker et al., 2010; Anker, Sparks, Duncan, Owen, & Stapnes, 2011; Owen, Duncan, Anker, & Sparks, 2012; Owen, Duncan, Reese, Anker, & Sparks, 2014) to address therapist and alliance issues in couple therapy as well as client experiences of couple therapy (see Sparks, 2015, for a full discussion of the Norway couple studies and their implications for practice). In brief, both individual and partner alliance predicted outcome, the alliance predicted outcome over and above early change, the alliance and specific couple therapy experience accounted for most of therapist differences, couple goals for therapy predicted outcome, and finally, most clients (83% of couples with the goal of improving the relationship) valued the use of PCOMS.

When administering PCOMS measures with couples, both members of the couple score their own ORS at the beginning of every session and their view of the alliance on the SRS at the end. The therapist then displays paper forms or hand-held screens for all to see, including automatically generated graphs depicting progress (or lack of progress) beyond session 1. This process parallels simple session opening questions that ask each person to state how they are doing, or inquiries about perceptions of a given session prior to ending. PCOMS, however, provides the added benefit of having a valid metric assessment of the client's experience to highlight and reinforce these discussions.

Scores of multiple members of a system may or may not coincide—not news to any seasoned systemic therapist. Differing scores are brought into sharp relief by the system, providing ready entry into conversations that explore the meaning of those differences. For example, falling scores on the interpersonal and overall domains of the ORS recorded by a wife and mother recently reunited with her family after a brief separation contrasted with her husband's sharp increase on the same domains. The ensuing conversation prompted the wife to reveal her dissatisfaction with her husband's work schedule and the unequal parenting and chore requirements their home life together entailed for her. From this discussion, a mutual goal took shape—finding a way to be together as a family while balancing the needs of each individual.

When whole families convene, therapists use either paper and pencil (or crayon) with all members, multiple electronic devices, or a shared device. To maintain the integrity of signal alert and outcome data, parent/caregiver scores for an identified adolescent or child and the adolescent/child's scores (or scores for multiple identified youth) are entered into the tracking software; other family members participate with paper and pencil forms, allowing all perspectives to be included in discussion. All participants score the alliance, although only parent/caregivers and an identified child/adolescent are entered into the electronic system, again to ensure proper signaling of at-risk clients.

The logistics of PCOMS administration with families should feel familiar to therapists accustomed to the complexity of family work. To illustrate, in a first session, a father scored his 8-year-old son, Max, well within the distressed range on the CORS while Max and his mother's scores of how he was doing were only slightly below the cutoff. The

therapist displayed the iPad screen with all three scores to the family, opening the door for a discussion of divergent and congruent viewpoints. The father described being called regularly by the school because of his son's defiant behavior. To the mother, whose work required her to travel frequently, these calls were concerning but less urgent. When home, she and her son enjoyed going to the park, playing games, and watching movies together. Max was asked how he thought his teacher might score him, and he admitted it would be lower on the school domain. When the therapist asked each member of the family if that domain would need to improve for them to feel therapy was successful, they all agreed. In a parent meeting, the therapist's inquiry about differences in the parents' scores prompted Max's father to reveal his isolation as a parent, leading to goals of better communication and joint involvement in disciplining.

A major value of PCOMS in systemic work is its capacity to initiate conversations about discrepant views in objective, nonblaming ways. The therapist's inquiry about the differences in CORS scores in the above example set the stage for developing mutual goals and a means to measure success. Effective navigation by the therapist of this family's differences should be reflected in SRS ratings, allowing the therapist a chance to recalibrate ongoing work accordingly. The transparency of the PCOMS process establishes a space where all views are respected (a multiverse) and meanings are coexplored; continuous responsiveness to clients' unique views, grounded in valid, objective data, fosters dialogue, the emergence of mutual solutions, and a built-in safety net for avoiding treatment failure.

BOTH/AND

Given its communicative roots, the field of family therapy likely includes many practitioners who value interpersonal interaction over and above "numbers" and who may be uncomfortable with incorporating measurement systems into their practices. At the same time, systemic therapies have moved decidedly toward evidence-based practice, and clinicians likely also appreciate the guidance provided by reliable and valid measures. Both normative and communicatively bent clinicians presumably believe that they, as well as programs and agencies, should employ valid technologies as a measure of accountability, especially to their clients (Sparks, Kisler, Adams, & Blumen, 2011).

We believe PCOMS offers a point of reconciliation for those wanting to embrace SCF without compromising deeply held convictions about the value of relational process. PCOMS started purely as a clinical tool. The measures were developed to encourage therapeutic conversation about progress and the alliance and to operationalize client privilege in determining the nature and status of these variables. Psychometrics and randomized trials were not on the landscape. The numbers on the ORS and SRS had no normative meaning and were only related to the client's specific circumstance. Over time, psychometric studies were published (e.g., Duncan et al., 2003; Duncan et al., 2006; Miller et al., 2003), five RCTs completed resulting in PCOMS designation as an evidence-based practice (Anker et al., 2009; Reese et al., 2009; Reese et al., 2010; Schuman et al., 2015; Slone et al., 2015), a cohort study with children, caregivers, and teachers (Cooper et al., 2012), two benchmarking studies demonstrating effectiveness in public behavioral health (Reese et al., 2014, 2017), and hundreds of thousands of administrations analyzed to create expected treatment response trajectories.

PCOMS enacts pioneering family therapy concepts and thus may increase the likelihood of its acceptance by systemically trained practitioners. For example, PCOMS quickly identifies when the solution to the problem becomes the problem, prompting the golden rule of the MRI, if it does not work, do something different (Watzlawick et al., 1974). The ORS/CORS' 0–10 lines provide metrics to actualize solution-focused scaling and to denote change and next steps (Berg & de Shazer, 1993). The system's focus on change encourages

clients to own and expand their progress. PCOMS generates and informs ongoing dialogue, creating a linguistic system in which new meanings and avenues for problem dissolution emerge (Anderson & Goolishian, 1988). Finally, encouragement for clients to unfold idiosyncratic meanings invites clients, not clinicians or diagnostic manuals, to author their own stories, consistent with key narrative approach principles (White & Epston, 1990).

As this story reflects, PCOMS evolved from a clinical, relational, and value-driven starting place to an empirically validated methodology for improving outcomes and a viable quality improvement strategy. That is, it changed from a purely communicative system to one that was also normative—a both/and system. Rather than sacrificing one function for the other, PCOMS empowers a relational context and an empirically sound signal system, bridging the either/or process/outcome divide (Table 1). In this way, it continues the conversation between those holding divergent views about what the field ought to be doing now and in the future.

DISCUSSION

There is increasing recognition that systematic client feedback improves outcome. As a result, practice standards, including JCAHO, CARF, and COA, are calling for the collection and use of client-generated outcome data. In response, clinicians, administrators, and

TABLE 1
Dimensional Assessment of the Partners for Change Outcome Management System (PCOMS)^a

PCOMS: Normative	PCOMS: Communicative
ORS/CORS Reliability: Average alpha .85 (clinical samples) and .95 (nonclinical samples) across four studies; ORS alpha .93 for adolescents; CORS, .84 for children 6–12	Gives personal and idiosyncratic information about clients' individual concerns and goals, <i>from the client's point of view</i>
ORS/CORS Concurrent Validity: Moderate with the OQ, Depression Anxiety Stress Scale, Quality of Life Scale, PHQ9 & BDI; CORS: moderate concurrent validity with YOQ	Content-less, nonsymptom-based, non-forced-choice format facilitates conversations about clients' reasons for service and aspirations for change
ORS/CORS Construct Validity: Sensitive to change for clinical samples and stable in nonclinical samples; distinguish clinical and nonclinical samples	Is a clinical tool for unwrapping client perspectives, values, cultural context, and ideas about change
SRS Reliability: Average alpha .92–.96 across four studies	Provides a methodology to partner with clients, to ensure client voice remains central to the work; levels the therapy hierarchy
SRS Concurrent Validity: Moderate with Helping Alliance Questionnaire and Working Alliance Inventory; predicts outcome like other alliance measures	Fosters client engagement and strengthens the therapeutic alliance
Clear signal for no change and deterioration using Better Outcomes Now (BON) based on hundreds of thousands of ORS administrations	Conversation about lack of change explores possibilities and helps unearth new avenues out of the client's dilemma
Five RCTs show superiority over TAU; Two benchmarking studies indicate effectiveness in real clinical settings, outpatient, and inpatient, comparable to RCTs	Helps unfold and expand client experiences that lead to new meanings, connections, and plans for action
Listed as an evidence-based practice by Substance Abuse and Mental Health Services Administration (SAMSHA) and in National Registry of Evidence-based Programs and Practices (NREPP)	Invites discussion of differing views in systemic counseling; provides a way to give equal voice to all, including youth

^aResource: www.betteroutcomesnow.com.

educators face choices in how best to respond to this call. These decisions are particularly complex for settings where families or couples are primary service recipients. We believe a communicative/normative evaluation provides a template for assessing and adopting a SCF system that addresses the interests of multiple stakeholders.

Concomitant to this discussion is a growing interest in client-generated measures that understand clients as experts with a legitimate voice to inform the status of their outcomes. Barkham (2016) notes that if client-generated measures are to have a seat at the table, there needs to be less emphasis on the psychometric properties of symptomatic and diagnostic instruments and more attention to individualized accounts of problems and change. Using the metaphor of bandwidth, he asserts that what is needed is a clear high fidelity signal derived from a psychometrically sound measure and a more personalized, individual signal that may have less clarity (reduced psychometrics) but greater meaning to the listener, the client. We believe PCOMS represents these objectives as a single system, although other symptom or diagnostic-based measures can also be used depending on the needs of a given setting.

In contrast with family systems measures that favor a particular theoretical point of view (i.e., systems theory), PCOMS is a platform for privileging the unique voices of members of a given system. As such, amplification of often divergent client views in couple and family applications of PCOMS gives clinicians a potent tool for facilitating systemic dialogue, and, as proposed by systems theory, change in the system as a whole. While not a relationship measure, congruence or discrepancies of client scores through time offer a means of discussing and evaluating relational change. In addition, data from PCOMS can be statistically aggregated to report systemic change (e.g., analysis of both-in-couple in Anker et al., 2009). Other measures that specifically measure relationships could be added for use concurrently, as in the use of the Locke-Wallace Marital Adjustment Test (Locke & Wallace, 1959) in the Norway couple trial (Anker et al., 2009).

Partners for Change Outcome Management System does not embrace any single theory or approach; it is a-theoretical and can be applied to any therapy orientation. Nevertheless, many of its essential components were inspired by family therapy's history and identity. Postmodern approaches that stimulated creation of the PCOMS process sought to elicit, expand, and incorporate client-generated content—ideas, values, and goals—unconstrained by formal theoretical strictures. Even the types of questions recommended by solution- and problem-focused therapies aimed to elicit client views as cornerstones of therapeutic directions and solutions. The inspiration for the PCOMS process thus relies on the dialogical generation of client content, not preconceived theoretical notions of normalcy and required intervention. Given this, we believe it represents a way to continue family therapy's traditions while addressing demands for empirically justified practice. Finally, while no system can guarantee the right of clients to be heard, we believe PCOMS' privileging of client voice over manuals and theories promotes the values of social justice, fostering idiosyncratic and culturally responsive practice with diverse clientele.

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