The Partners for Change Outcome Management System Manual (4th Ed.)

The Evolution of Measurement Based Care

Cover credit: *"Chariot of Fire," by Reggie McGee.*

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This PCOMS manual is dedicated to Dr. Jacqueline A. Sparks, my closest friend and colleague, who exemplified client privilege, cultural responsiveness, social justice, and everything else that is good about not only psychotherapy, but also humanity.

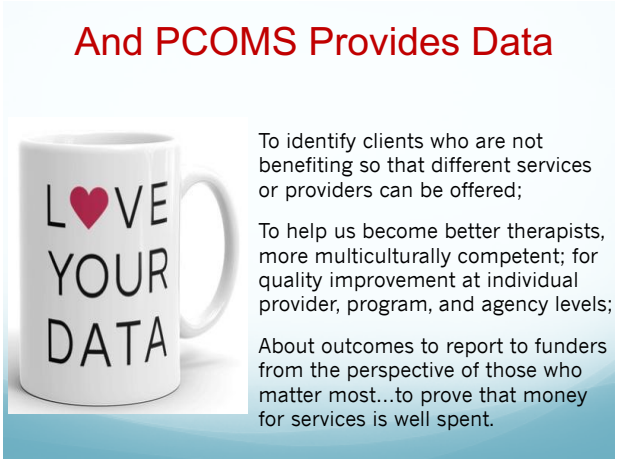
In Jackie's words, our mission:

We are on a quest to replace client-diminishing practices with client-directed ones: services that are based in a relational model instead of a medical one, are more informed by client-rated outcomes than expert opinion, best guesses, or wishful thinking, and are more guided by client preferences, culture, and ideas than theory, model, and technique. We see PCOMS and BON as vehicles for these changes.

We honor Jacqueline Sparks and the first edition with that same cover of many years ago.

Preface

PCOMS stands for Partners for Change Outcome Management System. PCOMS incorporates the most robust predictors of success into an outcome management system that partners with clients while honoring the daily pressures of front-line workers. PCOMS uses two, four item scales to solicit service user feedback regarding factors proven to predict success regardless of provider model, orientation, or presenting problem: client assessment of early progress (using the Outcome Rating Scale or ORS) and the quality of the alliance or match with the provider (using the Session Rating Scale or SRS). Unlike other methods of measuring outcome, this system truly gives clients the voice they deserve and assigns consumers key roles in determining how services are delivered. It is the first (and only until recently, see below) system to include a transparent discussion of the results with clients and the only system to include routine measurement of the alliance. Assessment, rather than an expert-driven evaluation of the client, becomes a pivotal part of the relationship and change itself. PCOMS is much more than flicking forms; it operationalizes client privilege and cultural responsiveness.



The field has come a long way since the original conceptualizations of feedback by pioneers Michael Lambert and Kenneth Howard. In 2001, the year of the first feedback RCT (by Michael Lambert), in a special section of the *Journal of Consulting and Clinical Psychology*, Lambert described patient focused research:

> …endeavors to improve psychotherapeutic outcome by monitoring patient progress and using this information to guide ongoing treatment…patient-focused research attempts to answer the question, Is this particular treatment working for this patient? (pp. 147-148).

Thus, if an at-risk client can be reliably identified before dropping out or deteriorating, then therapists

will have an opportunity to modify treatment accordingly.

Fast forward to a 2023 special section of the journal, *Psychotherapy*. Boswell et al. (2023) propose measurement-based care (MBC), the current in fashion term, as a Professional Practice Guideline, partially based on MBC's "fundamental provision of feedback and empowering patient engagement..." (p. 3).

> Consistent with calls to deliver person-centered, transparent, and collaborative care that empowers patients to be active participants in shaping their treatment…, MBC allows for treatment to be tailored to the individual patient according to their specific needs. It also provides a structure that facilitates exchange of information and supports shared decision-making about treatment goals and course of care… (pp. 6-7).

This attention paid to collaborative clinical processes and shared decision-making is also highlighted in other recent MBC articles. Illustrating the evolution of thought regarding feedback, compare the recent trend to the 2015 *Psychotherapy* special issue on "Progress Monitoring and Feedback." Although instructions to the authors requested discussion of clinical application of their systems, only one, PCOMS, provided detail about accompanying collaborative processes. The included approaches conceptualized feedback as mainly a normative, expert driven endeavor while PCOMS included collaborative and client privilege components as the nuts and bolts of the approach.

Collaborative clinical processes have been a part of PCOMS since its beginning, depicted in the first PCOMS manual (Duncan & Sparks, 2002). In the special *Psychotherapy* issue, Duncan and Reese (2015) suggest:

> PCOMS is distinguished by its routine involvement of clients; client scores on the progress and alliance instruments are openly shared and discussed at each administration… With this transparency, the measures provide a mutually understood reference point for reasons for seeking service, progress, and engagement (p. 347).

MBC approaches largely arose from psychometric research and a desire to prevent treatment failure. In contrast, PCOMS emerged from everyday practice and an aspiration to privilege the client and incorporate social justice in the psychotherapy process. Concerns regarding the feasibility of longer measures and a desire to honor client privilege and apply the common factors (Duncan & Moynihan,

1994) provided the impetus for the Outcome Rating Scale and the Session Rating Scale. The clinical process of PCOMS was developed from Duncan's clinical practice and supervision of graduate students in a multicultural clinic and detailed in the first PCOMS manual (Duncan & Sparks, 2002; now in its fourth edition, the one you are reading now). Over time, psychometric studies were published, and Duncan, Reese, Chapman, and colleagues completed eight RCTs. PCOMS, while starting as a purely clinical process evolved to be both a normative and collaborative system (Sparks & Duncan, 2018). The feedback field, in general, started as a normative process and has evolved to include collaborative processes.

Consider again the evolution of the feedback literature, this time regarding multicultural competence. In that 2015 *Psychotherapy* special issue, none of the approaches, except PCOMS, discuss multicultural competence or social justice beyond providing data to examine differential effectiveness. An examination of recent articles, however, reveals an emphasis on cultural sensitivity and adaptation of the measures, content, and processes of MBC to benefit diverse populations. While an important step forward, and an example of the evolution of the field, the specifics of how adaptation of MBC can occur are yet to be explored—by others than PCOMS.

Attention to individual experience, "amplifying client voice" and "socially just practice" (Duncan & Sparks, 2002, p. iii) have been part of PCOMS since the beginning, but more fully articulated in later publications. For example, Duncan (2012) asserts:

> PCOMS seeks to level the psychotherapy process by inviting collaborative decision making, honoring client diversity with multiple language availability, and valuing local cultural and contextual knowledge; PCOMS provides a mechanism for routine attention to multiculturalism and social justice. (pp. 98-99).

Valuing clients as credible sources of their own experiences, a central PCOMS value, is a necessary precursor to multicultural competence, enabling therapists to critically examine assumptions and practices and allow clients to teach clinicians how to be most effective with them.

We're glad the MBC field has finally caught up and caught on to the values of client privilege, collaboration, and social justice. Welcome to PCOMS!

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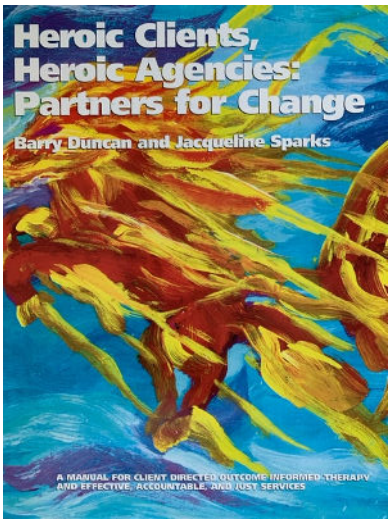
This manual is the latest in a notable lineage of how to practice these fundamental values while improving outcomes, reducing dropouts, and honoring the workflow demands of everyday practice. From the creation and validation of brief client-report measures to clinical trials and eventual designation as an evidence-based practice, PCOMS has grown into a mature method designed to improve psychotherapy and social services by centering client views. Capitalizing on the common factors, the "Partners" aspect of PCOMS emphasizes the creative and evolving collaboration between clients and providers in fashioning goals and approaches that fit clients' unique preferences. Thus, PCOMS embodies a means to ensure that services not only are effective but just, accounting for client culture, social context, and preferences each step of the way.



The first PCOMS manual published in 2002 with the tagline: "A Manual for Client Directed Outcome Informed Therapy and Effective, Accountable, and Just Services."

The PCOMS manual series began in 2002 with *Heroic Clients, Heroic Agencies: Partners for Change*, followed by a digital revision in 2007 and a digital 2nd edition in 2010. The third edition appeared in 2018 bringing an integration of online webinars, videos, and the web-based application of PCOMS, Better Outcomes Now (BON). A revised edition incorporating a new version of BON followed in 2019. The current 4th edition manual also coincides with a new version of BON.

We honor Jacqueline Sparks and the first edition with that same cover of many years ago. This fourth edition reflects the evolution of the ethics and science of systematic client feedback (our favored term) in psychotherapeutic and social services. From the start, PCOMS aimed to promote clients as heroes, not only because empirical evidence rightfully places them in this role but because of our witnessing their courage so many times in daily practice. This manual exemplifies the same attitude. From a promising

approach that appealed to helpers disenchanted by rote delivery of pre-packaged models, PCOMS has now arrived mainstream, backed by ten clinical trials and disseminated in diverse treatment/service settings in 20 countries across the globe. The American Psychological Association's Presidential Taskforce on Evidence Based Practice has recommended that clinicians routinely collect and act on client feedback and it is soon to become a Professional Practice Guideline for psychologists. 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. Moreover, there is increasing recognition that measurement-based care improves outcome and reduces dropouts. As a result, practice standards, including JCAHO, CARF, and COA are calling for the collection and use of client-generated outcome data. The call for measurement-based care will continue and expand over the next decade.

It has been twenty-two years since the original Heroic Clients, Heroic Agencies was published. What began as a simple way to privilege client voice and encourage therapists to talk about outcome and the alliance with clients has evolved to an evidence-based practice of using the ORS/SRS called the Partners for Change Outcome Management System (PCOMS)—a systematic way to both operationalize the values of client privilege and dramatically increase the number of clients who benefit from services. Ten randomized controlled trials (RCT), three benchmarking studies in public behavioral health, and a cohort study have unequivocally shown that PCOMS delivers with youth and adults, in individual, couple, and group therapy, with both mental health and substance abuse problems, and with the impoverished and disenfranchised. These studies bring top tier journal credibility to not only the measures but also to the whole transparent, collaborative process we call PCOMS, and of course, enabled PCOMS to be recognized as an evidence-based practice.

PCOMS answered these calls. Meanwhile, advances in technology have offered new ways to collect and effectively utilize client feedback, precipitating refinements in clinical process, data collection, and analysis. Despite innovations, the core value remains—clients lead the way and service providers can improve outcomes by safeguarding this imperative.

With a now mature body of research, a priority becomes how best to implement PCOMS. Since the first manual in 2002, the first articulation of the PCOMS clinical process, it has been our intent to provide a practical, user-friendly guide, adaptable to a variety of settings. A system is good only if it is used. This is the purpose of this manual—to facilitate effective implementation of PCOMS. PCOMS provides a broad, over-arching practical umbrella for realizing our long-held ambition to transform therapeutic and social services from provider to client-driven. The current version aims to further PCOMS' assimilation and our client-directed ambitions into everyday practice.

The fourth edition is divided into four sections designed to be easy to navigate and responsive to a particular question or need in the moment. This edition has been streamlined for easier access to the information you want most. Those wanting more information are directed, via links, to online resources. Section I covers the meat and potatoes of PCOMS, "The 10 Skills of PCOMS." Each skill of PCOMS is broken down into manageable bitesize chunks with clear step-by-step instructions for realizing the maximum benefit. Although cultural responsiveness and attention to social justice has always been a part of PCOMS, as discussed above, the first section more fully articulates how the skilled use of the ORS and SRS operationalizes these values at the therapist-client level. PCOMS provides a method to attend to marginalization as well as differences of social location between client and therapist.

Section II addresses Special Applications of PCOMS, how PCOMS collaborates with couples, families, groups, case management, and child protection. When you have more than one person in the room or other outside agencies involved, things can get complicated in a hurry. And a lot of questions emerge: "How do you use the measures with children and parents? What about siblings? How can you manage PCOMS in a large group? What about child protection? PCOMS can't possibly be used in these potentially hostile situations?" These questions are all addressed in this volume. But seemingly paradoxically, PCOMS can help smooth out the rough spots and actually expedite the helping process. Section II articulates the particulars thanks to three of PCOMS' finest, Jacqueline Sparks, George Braucht, and Robyn Pope who combine PCOMS knowledge with much in the trenches experience.

Section III addresses implementation and supervision, and the secrets therein. With 25 plus years of implementation experience with thousands of organizations across the globe, Barry details what it really takes for successful implementation—not the least of which is leadership and commitment to client privilege and quality improvement.

Finally, Section IV provides an "all in one place" compendium of resources related to PCOMS: the seven rationales for doing it, the extensively researched psychometrics of the PCOMS instruments, and the randomized clinical trial and benchmarking science that support it—with youth & adults, in individual, couple, and group therapy, with both mental health & substance abuse problems, with the impoverished and disenfranchised, and cross-culturally. Also covered are the not-so-common, "Common Factors" as well as the therapist qualities we most like to see. Stay tuned to Barry's Facebook page, the Better Outcomes Now Facebook page, or the betteroutcomesnow.com blog for the latest.

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Section I: The Ten Skills
PCOMS Provider Adherence Scale

1. Introduce, administer, and score (if applicable) the Outcome Rating Scale (ORS) each visit or unit of service. Ensure that the client understands that the ORS is intended to: 1) privilege their voice and bring them into the decision-making process; and 2) will be collaboratively used to monitor progress in each encounter.

Never	Sometimes	Often	Regularly	Always
1	2	3	4	5

2. Discuss the clinical cutoff and contextualize the client's score. Check with the client to see if the score matches their experience. Explain the expected treatment response, what is hoped will happen if therapy/service/treatment is successful. Invite the client to start with the lowest scale or wherever they would like.

Never	Sometimes	Often	Regularly	Always
1	2	3	4	5

3. Connect the client's marks/clicks/touches on the ORS to the described reasons for service. Invite discussion of the larger social context of the presenting concerns. Ensure that the ORS is not used as an "emotional thermometer" or an account of how life is going. Refer to the ORS during the encounter.

Never	Sometimes	Often	Regularly	Always
1	2	3	4	5

4. Get an accurate rating of the ORS, i.e., a rating that matches the client's description of their life circumstance and reasons for service. Immediately clarify mismatches and redo the ORS.

Never	Sometimes	Often	Regularly	Always
1	2	3	4	5

5. Introduce, administer, and score (if applicable) the Session Rating Scale (SRS) each visit or unit of service. Depersonalize or externalize the introduction. Express a sincere desire for feedback.

Never	Sometimes	Often	Regularly	Always
1	2	3	4	5

6. Build a culture of feedback in which the client understands that the SRS is intended to create a dialogue that individually tailors the service—and that there is no *bad* news on the measure.

Never	Sometimes	Often	Regularly	Always
1	2	3	4	5

7. Use the SRS to discuss whether: the client feels heard, understood, and respected; the service is addressing the client's goals; and whether the therapy/service/treatment approach matches client preferences, culture or worldview, or theory of change. Gracefully accept feedback no matter what it is and do whatever possible to address it. Ask about and be responsive to any ethnic/racial/cultural/orientation differences and concerns.

Never	Sometimes	Often	Regularly	Always
1	2	3	4	5

8. After the first encounter, review client graph and progress at the beginning of the meeting or session. Involve consumers in all decisions that affect their care. Let the outcome dictate what happens thereafter.

Never	Sometimes	Often	Regularly	Always
1	2	3	4	5

9. If clients are progressing (Progress in the Green), validate the client's contribution to the change and empower clients to take responsibility for the change (a result of their efforts). If change is Reliable or Clinically Significant, or if change has plateaued, discuss spacing out sessions or ending therapy/service/treatment.

Never	Sometimes	Often	Regularly	Always
1	2	3	4	5

10. If clients are not progressing (Progress in the Red or Yellow), discuss whether services should continue as is or should be changed. If no change persists, discuss the SRS and identify any problems. Revisit any ethnic/racial/cultural/gender or sexual orientation differences between the client and therapist. Discuss and develop options such as including others from client's support network, different approaches, supervision, a colleague or team involvement, or changing to a different provider. If no change continues, transfer the client to another provider.

Never	Sometimes	Often	Regularly	Always
1	2	3	4	5

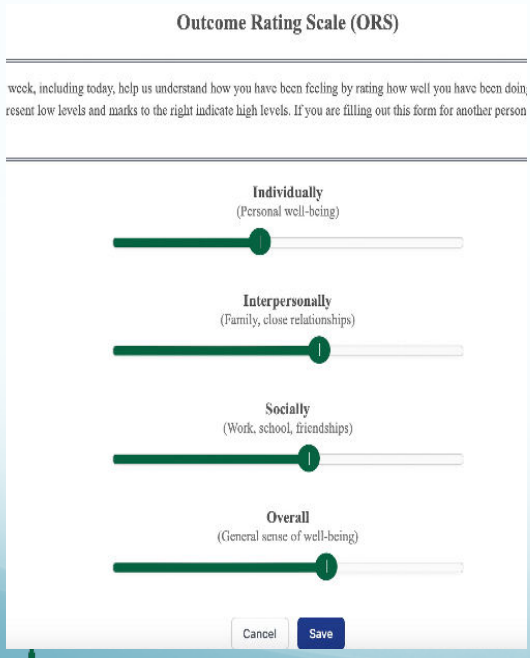
Total: PCOMS Provider Adherence Scale _____ Date_____

Provider: _____

NOTE: Out of a total possible 50 points, adherence is considered acceptable at 40 or above at the 6-month mark and 45 or above at one year after implementation. High adherence is ensured by the PCOMS supervisory process and attention to data integrity.

Chapter One

The Nuances of the ORS
PCOMS Skills 1-4



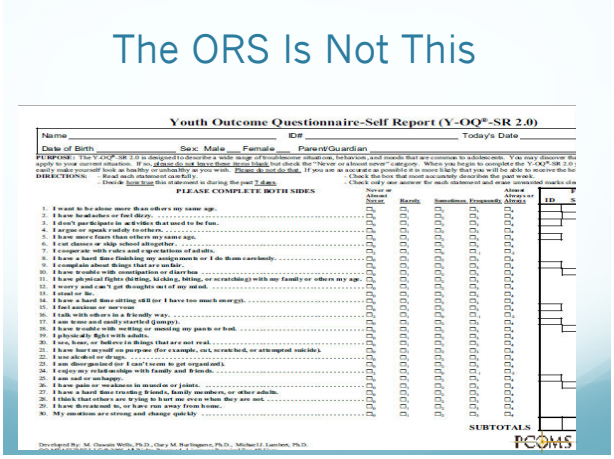
1. Introducing the ORS.
2. Discussing the Score, Clinical Cutoff, & ETR; Making Sense of the Score.
3. Connecting the Scales to Client's Experience & Reasons for Service.
4. Getting a GOOD Rating.

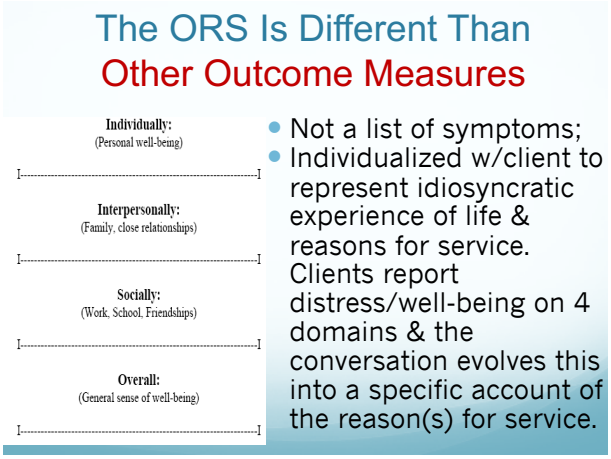
Skill One: Introduce the Outcome Rating Scale

Introduce, administer and score (if applicable) the Outcome Rating Scale (ORS) each visit or unit of service. Ensure that the client understands that the ORS is intended to: 1) privilege their voice and bring them into the decision-making process; and 2) will be collaboratively used to monitor progress in each encounter to ensure benefit.

Before we get into the specifics of Skill One, some general comments about the ORS. The ORS is a visual analogue instrument that is individualized with clients to represent their distress and the reasons for service on four domains (personal, interpersonal, social, overall). Clients click or tap on each ten-cm line to represent their functioning in each domain. Scores range from 0 to 40, with lower scores signaling higher distress.

The major domains of life depicted on the ORS offer a general framework of human existence to which clients add the intimate details of their lived experience via therapeutic conversation. The ORS contextualizes presenting problems beyond diagnostic categories, running counter to practices that pathologize clients of color and other historically marginalized groups at higher rates. Putting client reasons for service in context also promotes consciousness raising for both client and therapist, helping to identify forms of oppression and marginalization that may contribute to distress.





Given that at its heart, PCOMS is a collaborative intervention, everything about the use of the measures and the results attained are shared with clients. Consequently, the client needs to understand what it's

all about, and especially these two points:

- the ORS will be used to collaboratively track outcome in every session to ensure the client benefits.
- it is a way to make sure that the client's voice is not only heard but also remains central to services.

The ORS is given at the beginning of each encounter. In the first meeting, the ORS pinpoints where the client sees themselves, allowing for an ongoing comparison in later sessions. Residential or intensive outpatient settings may give the ORS at the first encounter of the week.

Beginning with the intake call, it is important to convey commitment toward improving the client's situation as well as to the highest quality of collaborative care:

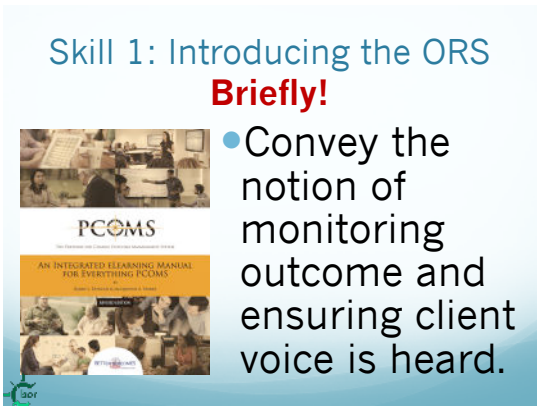
> *We are committed to you reaching your goal, so our services monitor whether clients are benefiting by using two very brief forms. These take only a couple minutes to fill out but yield a great deal of information about how things are going and whether the service should set a different course. It's good to know these things sooner rather than later so that you and your therapist/worker can do something about it—it also lets us know if you would be better served by someone else. We will explain this in greater detail when you arrive for your first meeting. Is this something you can help us out with?*

The above "script" is just a suggestion. Feel free to be creative in your explanation. Put it in your own words and natural way of communicating.

Continue building a culture of feedback in the first meeting and administer the ORS as an invitation into a collaborative partnership. Avoid technical jargon, and instead explain the purpose of the measures and their rationale in a natural, commonsense way. Make the administration, scoring, and discussion part of a relaxed and ordinary way of having conversations and working. The specific words are not important. Your interest in the client's desired outcome speaks volumes about your commitment to the individual.

Convey that:

- The measures are specifically designed to empower client voice in all aspects of therapy and include them in all decisions that affect their care.
- The ORS will be used to monitor progress to ensure that they reach their desired goals.



When I work with people I like to start off with this very brief form, it's called the Outcome Rating Scale, and it is a way for me to get a snapshot of how you are viewing how things are going for you right now, and a way that you and I can check in each time to make sure that our work together is beneficial for you. So it's a way to track progress and it's also a way to make sure that how you are viewing things stays central to the way we are working together. You just tap on each of those four areas of your life, where taps to the left mean things are not going well and taps to the right mean that they are going very well. Would you be willing to do that for me?

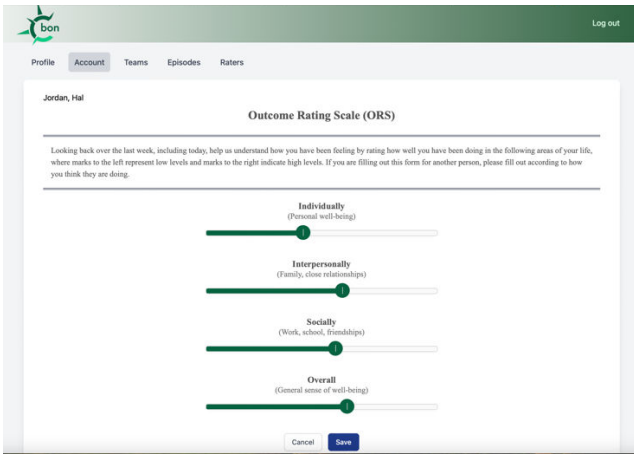
These are just examples, not mandates or research protocols. Put the introduction in your own words, the way that you talk and interact with clients. But don't overdo it!

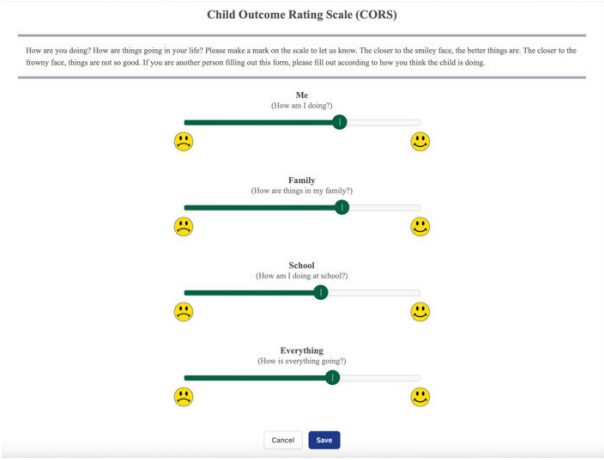
This Outcome Rating Scale is used for two reasons: The main reason is to ensure that your viewpoint about things stays very central to the way the work is done, your viewpoint about whether you are benefiting essentially will drive the therapy. The other reason is that if we monitor your benefit together every time you come in and you are not doing well, we can put our heads together and figure something else to do. Put a touch where you see yourself on these major areas of your life where this side means things are going very well and this side means things are going not so well.

To a child: Here is that screen with smiley and frowny faces I mentioned to you. This funny form allows us to track where you're at, how you're doing, how things are changing, or if they are not. It allows us to know whether I am being helpful. It only takes a minute to do, and most kids find it to be very helpful. Would you like to give it a try? Great!

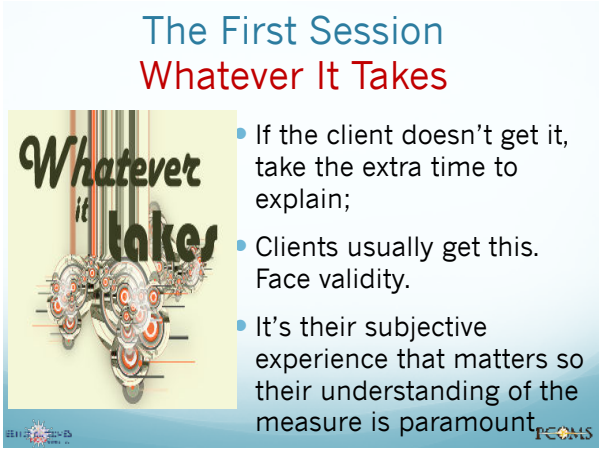
Here are the provided instructions on the ORS (But don't read the instructions to the client):

> *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.*



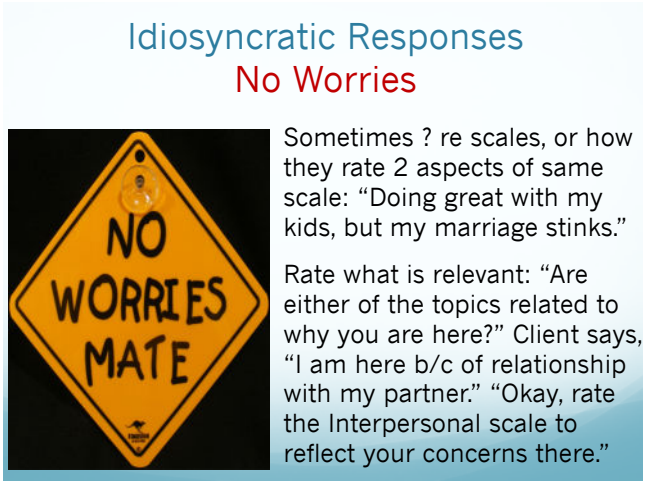


Most understand the measures with minimal explanation, but you can't over-explain the measures, so do whatever it takes to ensure the client understands what it is about. Given that the ORS is intended to make sure the client's perspective is not lost in the shuffle, the whole point is missed if the client doesn't get what the measures and PCOMS are about.



The ORS has very good face validity—the domains make common sense, so clients very quickly apply their lived experience to the different areas of functioning. Whatever explanation clients give in their own words is okay. Some clients will say: "You mean like poor to well?" or "Like 0 on the left and 10 on

the right?" Keep in mind it's their subjective experience we are interested in, so their understanding of the measure in the context of their lives is paramount. Your efforts to understand the meaning of the client's ratings also contribute to the client ultimately "getting" what the ORS is all about.



Sometimes clients ask for clarification between scales or how they should rate two aspects of the same dimension. For example, regarding the *Interpersonally* line, which looks at close relationships such as partners and immediate family, clients may say something like, "I am doing great with my kids, but my relationship with my spouse stinks;" or on the *Socially* dimension, "My work is the only thing going right, but I have no friends—should I average this?" Here you simply ask the client to rate the dimension relevant to their decision to seek therapy, because you want the measure to reflect progress in that area. So, you say something like, "Are either of the topics related to why you are here?" (Client responds that he is here because of his relationship with his partner, or she is here because of her troubles making friends.) "Okay, please rate the line to reflect your concerns there because we want to see when progress is made."

It's also okay to orient the client to how you would like them to rate the ORS. For example, if you work in a substance abuse program, you might ask the client to score the ORS relative to their substance use. Think about what makes clinical sense to your practice. Some like to orient clients in the first session to fill out the ORS relative to their reasons for therapy. That's okay too. But everyone in your setting must do it the same way or the data won't make any sense. My preference is for the client to complete the ORS without additional instructions and allow their reasons to emerge from how they filled it out in the clinical conversation. But that's just my preference. It's okay to provide more context if you find that

more helpful and if it is done consistently.

Although 99% of the time you will be using Better Outcomes Now to administer and score the ORS, there will be some clients or occasions that will require you to administer the paper ORS. So, you will need to manually score the client's marks. This is easy and only requires a centimeter ruler or template so you can score to the millimeter. Just practice it a few times until you feel like you can do it with confidence.

Final Note, the Intake Meeting: Many agencies conduct an "intake" session to complete all the necessary documentation before a client is assigned to a therapist or other provider, which begs the question, "Should the ORS be given in this intake session?" The answer: It depends. There are some clear advantages to giving the ORS in the intake session. Often there is a change made between that first encounter and the next, so called "pre-treatment" change, that captures the positive expectations of the client that can get channeled into action about the reasons for service. That is a great way for the provider to begin their service, building on the already positive actions of the client. If done correctly, PCOMS can engage the client into the service in an empowering way that gives the client the strong message that they are in the right place. The key words here, however, are "if done correctly." If the ORS becomes just another part of the documentation, another compulsory paper completed in a lackluster way without attention to its purposes (ensuring client voice and collaborative monitoring of benefit) and without connection to the client's story about the reasons for service, then there is little reason to do it and it may ultimately turn off the client. So, if it is done in a meaningful way by a sincere worker desiring to understand client distress and reason for service, then go for it. If not, then…