

The Partners for Change Outcome Management System (PCOMS): The Heart and Soul of Change Project

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Two continuous monitoring and feedback models have demonstrated gains in randomized clinical trials (RCTs): Lambert's Outcome Questionnaire (OQ) System and the Partners for Change Outcome Management System (PCOMS). This article chronicles the evolution of PCOMS from a simple way to discuss the benefit of services with clients to its emergence as an evidenced based practice to improve outcomes. Although based in Lambert's model, several differences are described: PCOMS is integrated into the ongoing psychotherapy process and includes a transparent discussion of the feedback with the client; PCOMS assesses the alliance every session; and the Outcome Rating Scale, rather than a list of symptoms rated on a Likert Scale, is a clinical tool as well as an outcome instrument that requires collaboration with clients. The research supporting the psychometrics of the measures and the PCOMS intervention is presented and the clinical process summarised. Examples of successful transportation to public behavioural health are offered and an implementation process that values consumer involvement, recovery, social justice, and the needs of the front-line clinician is discussed. With now nine RCTs and American Psychological Association endorsements to support it, it is argued that client-based outcome feedback offers a pragmatic way to transport research to practice.

Keywords: client-based outcome feedback, patient-focused research, PCOMS, practice-based evidence

The only man (sic) I know who behaves sensibly is my tailor; he takes my measurements anew each time he sees me. The rest go on with their old measurements and expect me to fit them.

—George Bernard Shaw

It is often reported that the average treated person is better off than approximately 80% of the untreated sample (Duncan, Miller, Wampold, & Hubble, 2010; Lambert & Ogles, 2004), which translates to an effect size (ES) of about 0.8. In short, the good news is that psychotherapy works. Unfortunately, this is a “good, bad, and ugly” situation. The “bad” is twofold: First, dropouts are a significant problem in the delivery of mental health and substance abuse services, averaging at least 47% (Wierzbicki & Pekarik, 1993). Second, despite the fact that the general efficacy is consistently good, not everyone benefits. Hansen, Lambert, and Foreman (2002), using a national database of over 6,000 clients, reported a sobering picture of routine clinical care in which only 20% of clients improved compared with the 57%–67% rates typical of randomized clinical trials (RCTs). Whichever rate is accepted as more representative of actual practice, the fact remains that a substantial portion of clients go home without help.

And the ugly: Perhaps explaining part of the wide range of results, variability among therapists is the rule rather than the exception

(Beutler et al., 2004). Some therapists are simply much better than others. In a study of managed care treatment, for example, Wampold and Brown (2005) reported that 5% of outcome was attributable to therapist variability. In addition, therapists overrate their effectiveness. Dew and Riemer (2003; reported in Sapyta, Riemer, & Bickman, 2005) asked 143 clinicians to rate their job performance from A+ to F. Two-thirds considered themselves A or better; not one therapist rated him or herself as below average.

So despite overall efficacy, dropouts are a substantial problem, many clients do not benefit, and therapists vary significantly in outcomes and are poor judges of their effectiveness. A relatively new research paradigm called *patient-focused research* (Howard, Moras, Brill, Martinovich, & Lutz, 1996) addresses these problems. Howard et al. (1996) advocated for the systematic evaluation of client response to treatment during the course of therapy and recommended that such information be used to “determine the appropriateness of the current treatment . . . [and] the need for further treatment . . . [and] prompt a clinical consultation for patients who [were] not progressing at expected rates” (Howard et al., 1996, p. 1063). Although several systems have emerged that answer Howard's original call (for a review, see Lambert, 2010), only two have demonstrated treatment gains in RCTs. The pioneering work of Michael Lambert and colleagues stands out—not only for the development of measurement systems and predictive algorithms, but also for their groundbreaking investigations of the effects of providing therapists feedback about client progress in treatment.

In a meta-analytic review of the Outcome Questionnaire 45.2 (OQ) system, Shimokawa, Lambert, and Smart (2010) reanalyzed the combined dataset ($N = 6,151$) from all six feedback studies (Harmon et al., 2007; Hawkins, Lambert, Vermeersch, Slade, & Tuttle, 2004; Lambert et al., 2001; Lambert et al., 2002; Slade,

Duncan is a coholder of the copyright of the Outcome Rating Scale/Session Rating Scale family of measures. The measures are free for individual use but Duncan receives royalties from licenses issued to groups and organizations. In addition, the Web-based system, MyOutcomes.com is a commercial product and he receives royalties based on sales.

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Lambert, Harmon, Smart, & Bailey, 2008; Whipple et al., 2003). When the odds of deterioration and clinically significant improvement were compared, those in the feedback group had less than half the odds of experiencing deterioration while having approximately 2.6 times higher odds of attaining reliable improvement than the treatment as usual (TAU) group.

All six trials realised significant gains for feedback groups over TAU for at-risk clients. Three of the six studies suggested that feedback enhances outcome for clients who are at risk but yield little impact for other clients (Lambert, 2010). Three studies (Harmon et al., 2007; Hawkins et al., 2004; Slade et al., 2008) found that using continuous assessment was helpful to all clients, although those who were predicted to not succeed in treatment benefited more. Whipple et al. (2003), Harmon et al. (2007), and Slade et al. (2008) found that adding measures of the alliance, motivation to change, and perceived social support for clients identified as not on track demonstrated incremental effectiveness over the continuous feedback model alone. Two studies looked at whether providing feedback to both therapist and client influences effectiveness. Hawkins et al. (2004) found that giving feedback on progress to both clients and therapists was associated with significant gains in outcome. However, Harmon et al. (2007) failed to replicate these results. In total, this research makes a strong case for routine measurement of outcome in everyday clinical practice (Lambert, 2010).

The other RCT supported method of using continuous client feedback to improve outcomes is the Partners for Change Outcome Management System (PCOMS; Duncan, 2010, 2011; Duncan, Miller, & Sparks, 2004; Duncan & Sparks, 2002, 2010; Miller, Duncan, Sorrell, & Brown, 2005). Much of this system's appeal rests on the brevity of the measures and therefore its feasibility for everyday use in the demanding schedules of front-line clinicians. The Outcome Rating Scale (ORS) and the Session Rating Scale (SRS) are both four-item measures that track outcome and the therapeutic alliance, respectively. PCOMS was based on Lambert et al.'s (1996) continuous assessment model using the OQ, but there are differences beyond the measures. First, PCOMS is integrated into the ongoing psychotherapy process and includes a transparent discussion of the feedback with the client (Duncan, 2010; Duncan & Sparks, 2002). Session by session interaction is focused by client feedback about the benefits or lack thereof of psychotherapy. Second, PCOMS assesses the therapeutic alliance every session and includes a discussion of any potential problems. Lambert's system includes alliance assessment only when there is a lack of progress. Moreover, unlike most other outcome instruments, the ORS is not a list of symptoms or problems checked by clients or others on a Likert Scale. Rather it is an instrument that evolves from a general framework of client distress to a specific representation of the client's idiosyncratic experience and reasons for service. It therefore requires collaboration with clients as well as clinical nuance in its application.

This article chronicles the development of PCOMS from its beginnings as a simple way to discuss the benefit of services with clients to its emergence as an evidenced based practice to improve psychotherapy outcomes. The research supporting the psychometrics of the measures and the PCOMS intervention is presented and the clinical process summarised. Finally, examples of successful transportation of PCOMS to public behavioural health are offered and an implementation process that values consumer involvement,

recovery, social justice, and the needs of the front-line clinician is discussed.

PCOMS: Measure Development and Validation

Scott Miller and I started using the OQ (Lambert et al., 1996) not long after its development in our practices as well as in consultation with mental health agencies (see Duncan & Miller, 2000). I also supervised graduate students in a community clinic and used the OQ there as well. Despite its obvious strengths, many clinicians complained about the length of time needed to complete the measure and that it did not seem to fit many of the concerns that clients brought to therapy. It became apparent that in spite of the quality of the measure, the benefits of outcome monitoring would not occur if therapists didn't use it.

Measure development, therefore, arose from the practical need to make a clinician friendly instrument. The ORS emerged from two ideas. First was scaling questions commonly used in solution focused therapy to assess client perceptions of problems and goal attainment ("On a scale of 0 to 10, with 0 being the worst it's been with this concern and 10 being where you want it to be, where are things right now?"; Berg & deShazer, 1993). Client-based scaling provides instant feedback and privileges the client's voice when assessing the effectiveness of therapy (Franklin, Corcoran, Nowicki, & Streeter, 1997). After repeated occurrences of therapist nonadherence to outcome measurement protocols (see Miller, Duncan, Brown, Sparks, & Claud, 2003), I suggested to Miller that we simply ask scaling questions based on the major domains from the OQ to enable a total outcome score.

Later, after researching different formats, Miller suggested the use of a visual analog scale because of its demonstrated face validity instead of scaling questions, and the ORS (Miller & Duncan, 2000) was born. Thereafter, based in two years of independent practice experience as well as the multiple teams that I supervised in the community clinic, the clinical process of using the ORS was detailed in Duncan and Sparks (2002) and further articulated in Duncan et al., 2004 and Duncan, 2010. Later, it became evident that families would be unable to participate in feedback protocols without a valid measure for children. With this as an impetus, the Child Outcome Rating Scale (CORS; Duncan, Miller, & Sparks, 2003a) was developed. (All the measures discussed here are available for free download for individual use at www.heartandsoulofchange.com).

The ORS assesses four dimensions: (1) Individual—personal or symptomatic distress or well being, (2) Interpersonal—relational distress or how well the client is getting along in intimate relationships, (3) Social—the client's view of satisfaction with work/school and relationships outside of the home, and (4) Overall—a big picture view or general sense of well-being. The ORS translates these four dimensions into a visual analog format of four 10-cm lines, with instructions to place a mark on each line with low estimates to the left and high to the right. The four 10-cm lines add to a total score of 40. The score is the summation of the marks made by the client to the nearest millimeter on each of the four lines, measured by a centimeter ruler or template. Because of its simplicity, ORS feedback is immediately available for use at the time the service is delivered. Rated at a seventh-grade reading level and translated into multiple languages, the ORS is easily understood by adults and adolescents from a variety of different

cultures and enjoys rapid connection to clients' day-to-day lived experience.

On par with its clinical usefulness, the utility of the ORS and its ultimate transportability depends on the reliability and validity of its scores. In addition to the ORS/SRS manual (Duncan, 2011; Miller & Duncan, 2004), four validation studies of the ORS have been published (Bringhurst, Watson, Miller, & Duncan, 2006; Campbell & Hemsley, 2009; Duncan, Sparks, Miller, Bohanske, & Claud, 2006; Miller et al., 2003). Across studies, average Cronbach's alpha coefficients for ORS scores were .85 (clinical samples) and .95 (nonclinical samples) (Gillaspy & Murphy, 2011). Duncan et al. (2006) reported that internal consistency for the CORS was .93 for adolescents and .84 for children. As an indicator of treatment progress, ORS/CORS scores have been found to be sensitive to change for clinical samples yet stable over time for nonclinical samples (Bringhurst et al., 2006; Duncan et al., 2006; Miller et al., 2003). Statistically significant differences between pretreatment and posttreatment ORS scores support the ORS's sensitivity to change (Duncan et al., 2006; Miller et al., 2003).

The concurrent validity of ORS scores has primarily been examined through correlations with established outcome measures. The average bivariate correlation between the ORS and OQ across three studies (Bringhurst et al., 2006; Campbell & Hemsley, 2009; Miller et al., 2003) was .62 (range = .53–.74), indicating moderately strong concurrent validity (Gillaspy & Murphy, 2011). Campbell and Hemsley (2009) reported moderately strong relationships (.53 to .74) between the ORS and the Depression Anxiety Stress Scale (Lovibond & Lovibond, 1995), Quality of Life Scale (Burckhardt & Anderson, 2003), and Rosenberg Self-Esteem Scale (Rosenberg, 1989). Duncan et al. (2006) found that the CORS also demonstrated moderate concurrent validity with the Youth Outcome Questionnaire (YOQ; Burlingame et al., 2001) for adolescents ($r = .53$) and children ($r = .43$). In addition, Miller et al. (2003) reported that pretreatment ORS scores distinguished clinical and nonclinical samples, providing further support for the validity of ORS scores. Like most outcome instruments, the ORS appears to measure global distress.

In the real world of delivering services, finding the right outcome measure means striking a balance between the competing demands of validity, reliability, and feasibility. The development of the ORS and CORS reflects an attempt to find such a balance (Duncan et al., 2006; Miller et al., 2003).

The Session Rating Scale (SRS)

Routine assessment of the alliance enables therapists to identify and correct potential problems before they exert a negative effect on outcome or result in dropout (Sharf, Primavera, & Diener, 2010). Recognising the much replicated findings regarding the alliance as well as the need for a brief clinical tool, we developed the SRS (Miller, Duncan, & Johnson, 2002), the Child Session Rating Scale (CSRS) (Duncan, Miller, & Sparks, 2003b), the Relationship Rating Scale (RRS) for peer services and self help (Duncan & Miller, 2004), the Group Session Rating Scale (GSRS; Duncan & Miller, 2007), and the Group Child Session Rating Sale (GCSRS; Duncan, Miller, Sparks, & Murphy, 2011) as brief alternatives to longer research-based measures to encourage routine conversations with clients about the alliance.

The SRS simply translates what is known about the alliance into four visual analog scales, based in Bordin's (1979) classic delineation of the components of the alliance: the relational bond and the degree of agreement between the client and therapist about the goals and tasks of therapy. First, a relationship scale rates the meeting on a continuum from "I did not feel heard, understood, and respected" to "I felt heard, understood, and respected." Second is a goals and topics scale that rates the conversation on a continuum from "We did not work on or talk about what I wanted to work on or talk about" to "We worked on or talked about what I wanted to work on or talk about." Third is an approach or method scale requiring the client to rate the meeting on a continuum from "The approach is not a good fit for me" to "The approach is a good fit for me." Finally, the fourth scale looks at how the client perceives the encounter in total along the continuum: "There was something missing in the session today" to "Overall, today's session was right for me." Like the ORS, the instrument takes only a couple of minutes to administer, score, and discuss. The SRS is scored similarly to the ORS, by adding the total of the client's marks on the four 10-cm lines.

A factor analysis by Hatcher and Barends (1996) revealed that in addition to the general factor measured by all alliance scales (i.e., strength of the alliance), two other factors were predictive: *confident collaboration* and *the expression of negative feelings*. Confident collaboration speaks to the level of confidence that the client has that therapy and the therapist will be helpful. Although overlapping with question three on the SRS, the fourth scale of the SRS directly addresses this factor. The other factor predictive beyond the general strength of the alliance is the client's freedom to voice negative feelings and reactions to the therapist. Clients who express even low levels of disagreement with their therapists report better progress (Hatcher & Barends, 1996). The entire SRS is based on encouraging clients to identify alliance problems, to elicit client disagreements about the therapeutic process so that the clinician may change to better fit client expectations.

For SRS scores, internal consistency estimates were reported in four studies with an average alpha of .92, range .88 (Anker, Owen, Duncan, & Sparks, 2010; Duncan et al., 2003; Reese et al., 2010) to .96 (Miller & Duncan, 2004) (Gillaspy & Murphy, 2011). These alpha coefficients suggest that the SRS assesses a single, global alliance construct. This is consistent with research on other alliance measures such as the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989). Three studies (Miller & Duncan, 2004; Duncan et al., 2003; Reese et al., 2010) reported test-retest reliability of SRS scores from the first to second session. The average reliability coefficient was .59 (range = .54–.64), indicating adequate stability (Gillaspy & Murphy, 2011).

Two studies have investigated the concurrent validity of SRS scores. Duncan et al. (2003) reported a correlation of .48 between the SRS and the Helping Alliance Questionnaire (HAQ-II; Luborsky et al., 1996). Campbell and Hemsley (2009) found that SRS scores correlated .58 with the WAI-S (Tracey & Kokotovic, 1989). These findings indicate moderate concurrent validity with longer alliance measures. Finally, the predictive validity of the SRS was supported by Duncan et al. (2003). Early SRS scores (2nd or 3rd session) were predictive of posttreatment ORS scores ($r = .27$), which is consistent with previous research linking early client perceptions of alliance with outcome (Horvath & Bedi, 2002).

Further support of both the feasibility and impact of monitoring the alliance is demonstrated in a large study (250 couples) of the alliance in couple therapy (Anker et al., 2010). The alliance significantly predicted outcome over and above early change, suggesting that the alliance is not merely an artifact of client improvement. The study also found that those couples whose alliance scores ascended attained significantly better outcomes than those whose alliance scores did not improve. Together these findings suggest that therapists should not leave the alliance to chance but rather routinely assess it with clients in each session.

PCOMS: The Research

After development of the measures and the clinical process, and validation of the instruments, it was time to see if PCOMS made a difference in outcomes. Four studies have demonstrated the benefits of client feedback with the ORS and SRS. Although two of the studies focused on individual therapy (Miller, Duncan, Brown, Sorrell, & Chalk, 2006; Reese, Norsworthy, & Rowland, 2009), Anker, Duncan, and Sparks (2009) and Reese, Toland, Slone, and Norsworthy (2010) extended evaluation of PCOMS to couples therapy. All studies evaluated treatment outcome based on reliable change or clinically significant change (Jacobson & Truax, 1991). Cohen's *d* effect sizes were reported in all studies.

The first (Miller et al., 2006) was a quasi-experimental, ABB design; the other three were between-subjects, RCTs. Miller et al. (2006) explored the impact of feedback in a large ($n = 6424$) culturally diverse sample utilizing a telephonic EAP. Although the study's quasi-experimental design qualifies the results, the use of outcome feedback doubled overall effectiveness (ES at baseline = .37; follow-up = .79) and significantly increased retention. Three RCTs used PCOMS to investigate the effects of feedback versus TAU. Anker et al. (2009) randomized couples seeking couples therapy ($n = 410$) to PCOMS or TAU; therapists served as their own controls. This study, the largest RCT of couple therapy ever done, found that feedback 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 feedback condition reported reliable and/or significant change versus 18.8% in TAU ($ES = .50$ after treatment, .44 at follow-up). The feedback condition maintained its advantage at 6-month follow-up and achieved a 46% lower separation/divorce rate. Feedback improved the outcomes of nine of 10 therapists in this study.

In an independent investigation, Reese et al. (2009) found significant treatment gains for feedback when compared to TAU. This study was two small trials in one. Study 1 occurred at a university counselling centre ($n = 74$) and Study 2 at a graduate training clinic ($n = 74$). Clients in the PCOMS condition in both studies showed more change versus TAU clients (80% vs. 54% in Study 1, 67% vs. 41% in Study 2; ES from .49 to .54). In addition, clients in PCOMS achieved reliable change in significantly fewer sessions than TAU. The last RCT (Reese et al., 2010) replicated the Anker et al. study with couples and found nearly the same results. Finally, a recent meta-analysis of PCOMS studies (Lambert & Shimokawa, 2011) found that those in feedback group had 3.5 higher odds of experiencing reliable change and less than half the odds of experiencing deterioration.

These studies collectively support the effectiveness of PCOMS across various treatment sites and models. The average effect size for PCOMS versus TAU was .52, representing a medium treatment effect. PCOMS is designated as an evidenced based treatment in Colorado and Arizona and is currently under review by the Substance Abuse Mental Health Services Administration (SAMHSA) for listing in the National Registry of Evidence-based Programs and Practices. Three more RCTs are in various stages of completion.

The Clinical Process

PCOMS is a-theoretical and may be added to or integrated with any model of practice. The clinical process of PCOMS boils down to this: identifying clients who aren't responding to clinician business as usual and addressing the lack of progress in a positive, proactive way that keeps clients engaged while therapists collaboratively seek new directions. To retain clients at risk for slipping through the proverbial crack requires embracing what is known about change in therapy. Time and again, from the pioneering work of the late Ken Howard (Howard, Kopta, Krause, & Orlinsky, 1986) to current sophisticated investigations using the latest statistical methods (Baldwin, Berkeljon, Atkins, Olsen, & Nielsen, 2009), studies reveal that the majority of clients experience the majority of change in the first six to eight visits. Clients who report little or no progress early on will likely show no improvement over the entire course of therapy, or will end up on the drop-out list—early change predicts engagement in therapy and a good outcome at termination (Brown, Dreis, & Nace, 1999). Some clients do take longer, but importantly not for change to start, but rather for change to plateau (Baldwin et al., 2009). Monitoring change provides a tangible way to identify those who are not responding so that a new course can be charted.

A second robust predictor of change solidly demonstrated by a large body of studies (Norcross, 2010), is that tried and true but taken for granted old friend, the therapeutic alliance. Clients who highly rate their partnership with their therapists are more apt to remain in therapy and benefit from it.

Exhibit 1 delineates the 12 therapist competencies/skills required for implementation. 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 two points: that the ORS will be used to collaboratively track outcome in every session and that it is a way to make sure that the client's voice is not only heard but remains central.

The ORS is given at the beginning of each session. In the first meeting, the ORS pinpoints where the client sees him or herself, allowing for an ongoing comparison in later sessions. The ORS is not an assessment tool in the traditional sense. Rather it is a clinical tool intimately integrated into the work itself. It requires that the therapist ensure that the ORS represents both the client's experience and the reasons for service—that the general framework of client distress evolves into a specific account of the work done in therapy. Clients usually mark the scale the lowest that represents the reason they are seeking therapy, and often connect that reason to the mark they've made without prompting from the therapist. Other times, the therapist needs to clarify the connection between the client's descriptions of the reasons for services and the client's

marks on the ORS. This enables the therapist and the client to be on the “same page” regarding what the marks say about the therapeutic work and whether the client is making any gains. 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.

The SRS opens space for the client’s voice about the alliance. It is given at the end of the meeting, but leaving enough time for discussing the client’s responses. The SRS is not a measure of competence or ultimate ability to form good alliances, or anything else negative about therapists or clients. It is about the fit of the service and any lower rating is an indication that the client feels comfortable to report that something is wrong. Appreciation of any negative feedback is a powerful alliance builder.

At second and subsequent sessions, interpretation of the ORS depends on both the amount and rate of change that has occurred since the prior visit(s). The longer therapy continues without measurable change, the greater the likelihood of drop out and/or poor outcome. The scores are used to engage the client in a discussion about progress, and more importantly, what should be done differently if there isn’t any.

When ORS scores increase, a crucial step to empower the change is to help clients see any gains as a consequence of their own efforts. This requires an exploration of the clients’ perception of the relationship between their own efforts and the occurrence of change (Duncan et al., 1992). When clients have reached a plateau or what may be the maximum benefit they will derive from therapy, planning for community connection and continued recovery outside of therapy can start. This could mean just reducing the frequency of meetings and continuing to monitor the client’s goals. For others, it could mean referral to self help groups or other community supports.

A more important discussion occurs when ORS scores are not increasing. The ORS gives clients a voice in all decisions that affect their care including whether continuation in therapy with the current provider is in their best interest. The ORS stimulates such a conversation so that both interested parties may struggle with the implications of continuing a process that is yielding little or no benefit. The intent is to support practices that are working and challenge those that don’t appear to be helpful. Although addressed in each session in which it is apparent that no benefit is occurring, later ones gain increasing significance and warrant additional action—what we have called the checkpoint conversations and last chance discussions (Duncan, 2010; Duncan & Sparks, 2002).

In a typical outpatient setting, checkpoint conversations are conducted at the third to sixth session and last-chance discussions are initiated in the sixth to ninth meeting. This is simply saying that the trajectories observed in most outpatient settings suggest that most clients who benefit from services usually show it in 3–6 sessions; and if change is not noted by then, then the client is at a risk for a negative outcome. The same goes for sessions six to nine except that the urgency is increased, hence the term “last chance.” Although not required to achieve the feedback effect, a web-based system, MyOutcomes.com, provides a more sophisticated identification of clients at risk. It graphs and compares the client’s progress to the expected treatment response of clients with the same intake score (the 50th percentile trajectory based on 300, 000

administrations of the ORS) and provides suggestions for clients and therapists to consider (Figure 1).

The progression of the conversation with clients who are not benefiting goes from talking about whether something different should be done to identifying what differently can be done, to doing something different. Doing something different can take as many forms as there are clients: inviting others from the client’s support system, using a team or another professional, a different conceptualisation of the problem or another treatment approach; or referring to another therapist or venue of service, religious advisor, or self-help group—whatever seems to be of value to the client.

Implementation in Public Behavioural Health

Although no experimental studies are available, several agencies have conducted systematic analyses of a variety of variables of interest to the provision of services in public behavioural health. (For a full discussion of implementation in public health settings, see Bohanske & Franczak, 2010.) In the first study of agency efficiency and PCOMS, Claud (2004; reported in Bohanske & Franczak, 2010), discussed how his agency, the Centre for Family Services (CFS) in West Palm Beach, Florida, struggled to cope with limited resources, lengthy episodes of care, and high no show and attrition rates. After implementing PCOMS, average length of stay (LOS) decreased more than 40%, and cancellation and no-show rates dropped by 40 and 25%, respectively. Moreover, the percentage of clients in long-term treatment that experienced little or no measured improvement fell by 80%. In one year, CFS saved nearly \$500,000, funds that were used to hire additional staff and provide more services.

Similarly, Community Health and Counselling Services in Bangor, Maine, experienced increases in the effectiveness and efficiency of services provided to clients characterised as “severely and persistently mentally ill.” Over a three year period, no-show and cancellation rates were reduced by 30% while the LOS decreased by 59%. At the same time, LOS in residential treatment and case management dropped by 50% and 72%, respectively, while consumer satisfaction with services markedly improved (Haynes, 2006, reported in Bohanske & Franczak, 2010).

Finally, perhaps the largest single agency implementation to date is Southwest Behavioural Health Services (SBHS), a non-profit, behavioural health organisation in Arizona that employs over 500 direct care staff with an annual budget of 36 million dollars. SBHS implemented PCOMS in an effort to increase efficiency and effectiveness as well as operationalize recovery principles (see below). Compared with adult clients who received services before implementation ($N = 839$), clients who received services including PCOMS ($N = 3420$) had a 46% less LOS and 50% fewer cancelled and no show appointments. At the same time, clinician evaluation of “full resolution” increased by 44% while consumers rated themselves as achieving a reliable change in 52% of the cases (Bohanske & Franczak, 2010).

Implementation of PCOMS in public health agencies is happening across the US (e.g., Bluegrass Regional Mental Health) and Canada (e.g., Saskatoon Health Region), as well as around the globe: Norway (e.g., Bufetat), the United Kingdom (e.g., Lincolnshire Child and Adolescent Mental Health Services), and New Zealand (e.g., Wesley Community Action), to mention a few. Over 100,000 clients a year participate with PCOMS.

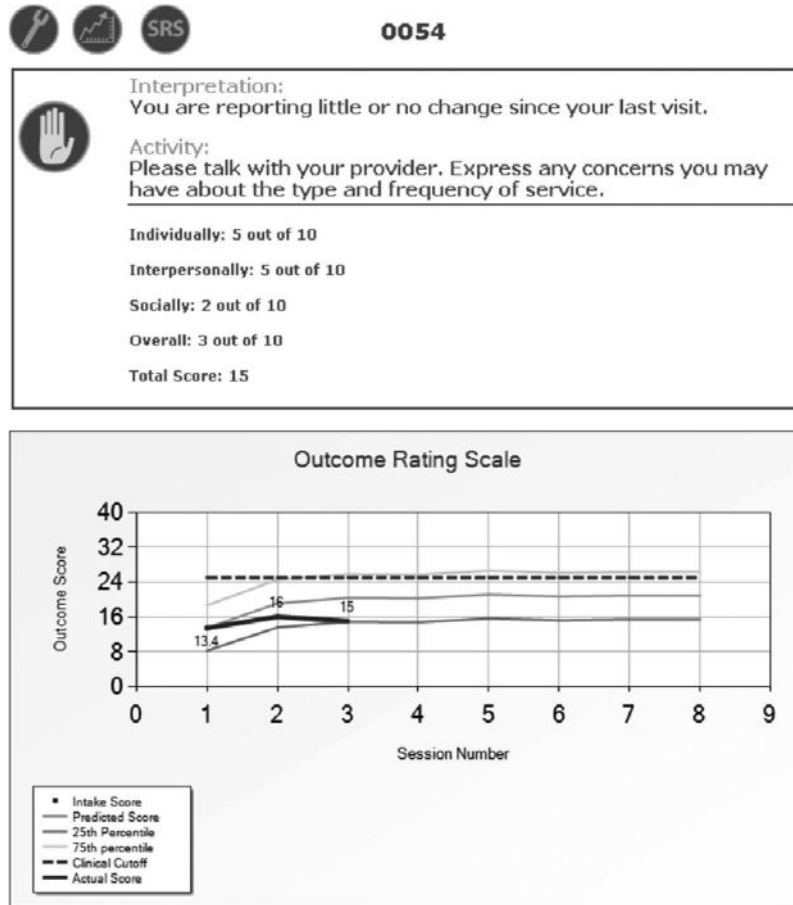


Figure 1. Screenshot of the electronic feedback system, MyOutcomes.com.

The Heart and Soul of Change Project

The Heart and Soul of Change Project (HSCP; www.heartandsoulofchange.com) is a practice-driven, training and research initiative that focuses on improving outcomes via client based outcome feedback, the PCOMS intervention. The website is a major dissemination vehicle with over 150 free downloads (articles, handouts, slide packages, videos, and webinars) on the use of the PCOMS feedback intervention. While PCOMS is not based in any model-based assumptions and can be incorporated in any treatment, it does promote a set of service delivery values: client privilege in determining the benefit of services as well as in all decisions that affect care including intervention preferences; an expectation of recovery; an attention to those common factors that cut across all models that account for therapeutic change; and an appreciation of social justice in the provision of care—or what is called client-directed, outcome-informed (CDOI) clinical work (Duncan, 2010; Duncan et al., 2004; Duncan, Solovey, & Rusk, 1992; Duncan & Sparks, 2002, 2010).

Two of the above values have gained global traction and are interwoven into HSCP implementation of PCOMS: consumer involvement and recovery-oriented services that tailor treatment to the individual needs of the client. In the US, for example, the President's New Freedom Commission (NFCMH; 2003) report

pointed out that, "Successfully transforming the mental health service delivery system rests on two principles" (NFCMH, 2003, p. 4): First is:

... a consumer- and family driven system, [where] consumers choose their own programs and the providers that will help them most . . . Care is consumer-centered, with providers working in full partnership with the consumers they serve to develop individualized plans of care (p. 28).

Consumer involvement in all decisions that affect care also speaks to the issues of multiculturalism and social justice. Client-centered or directed care necessarily includes a recognition of the disparate power that exists between the provider and consumer of services, especially for those not of the dominant culture as well as the traditionally disenfranchised, and transparently seeks to address the disparity. Despite well-intentioned efforts, the infrastructure of therapy (paperwork, policies, procedures, and professional language) can reify noncontextualized descriptions of client problems and silence client views, goals, and preferences.

In addition, the infrastructure of mental health itself (i.e., diagnosis and prescriptive treatment) often leaves little room for the unique views of those whose culture, race, gender, gender expression, ability, age, or socioeconomic status differ from typical providers steeped in mainstream psychology (Duncan et al., 2004;

Sparks, 2012). Routinely requesting, documenting, and responding to client feedback transforms power relations in the immediate therapy encounter by privileging client beliefs and goals over culturally biased and insensitive practices. Outside the therapy dyad, client feedback protocols undermine inequities built into everyday mental health service delivery by redefining whose voice counts. Use of client feedback applies the principles of social justice that, until now, have largely existed only in the pages of training manuals, textbooks, and academic journals (Sparks, 2012). PCOMS seeks to level the psychotherapy process by inviting collaborative decision making, honouring 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.

The second guiding principle of the NFCMH was that care needed to move away from treating illness and toward facilitating and supporting recovery. A sharp departure from customary discourse on mental illness, recovery-driven services shift away from professional-directed treatment based on diagnostic labels and prescriptive practices to individually tailored, consumer-authored plans. Shortly after the NFCMH report, with the participation of consumers, advocates, family members, providers, academicians, and researchers the “National Consensus Statement on Mental Health Recovery” (NCSMHR) was tendered:

Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential (National Consensus Statement on Mental Health Recovery, 2004, p. 1).

Together with consumer directed services, the shift away from illness toward recovery means that mental health professionals must be both responsible and responsive to their customer base and directly involve clients in decision making. PCOMS is embedded in the aims and philosophy of “recovery” as delineated by the NCSMHC (see Exhibit 2) and provides a way to operationalize client driven, recovery-oriented services (Bohanske & Franczak, 2010; Sparks & Munro, 2011).

Successful transportation of PCOMS to public behavioural health requires organisational commitment at all levels (Exhibit 3 details a readiness checklist). Implementation also requires an attention to front-line clinicians. For some who have been in the field for a while, outcome management is a totally foreign concept while others have been turned off by cumbersome measures that seem far removed from their day-to-day work with clients. Still others are fearful that “pay for performance” or similarly motivated strategies will punish those who do not measure up to some arbitrary standard. Implementation is enhanced when it makes sense to therapists and appeals to their nearly universal desire to do good work. In an attempt to motivate practitioners to consider the benefits of feedback, the implementation process of the Heart and Soul of Change Project also includes an attention to: (a) the common factors; (b) a nuanced clinical process; and (c) therapist development.

The common factors, those elements of psychotherapy running across all models that account for change (Duncan, 2010; Duncan et al., 2010), provide an overarching framework for the PCOMS intervention. Integrating the use of PCOMS within the larger literature about what works in therapy promotes therapist understanding of the feedback process and adherence to the feedback

protocol. PCOMS is presented as the tie that binds these healing components together, allowing the factors to be expressed one client at a time. Soliciting systematic feedback is a living, ongoing process that engages clients in the collaborative monitoring of outcome, heightens hope for improvement, fits client preferences, maximizes chances for a strong alliance, and is itself a core feature of therapeutic change (Duncan, 2010). An attention to common factors also reflects the recommendations of the NCSMHR (see Exhibit 2).

Although the over 300,000 administrations of the ORS/SRS has yielded invaluable information regarding the psychometrics of the measures, trajectories, algorithms, and so forth, PCOMS remains a clinical intervention embedded in the complex interpersonal process called psychotherapy. For successful implementation and ongoing adherence, PCOMS must appeal to therapists in ways that the numbers or data or even the research never can. Consequently, PCOMS is described as the clinical process that it is—one that requires skill and nuance to achieve the maximum feedback effect. PCOMS speaks to therapists “where they live” by providing a methodology to address those clients who do not benefit from their services.

Similarly, a focus on therapist development provides a positive motivation for therapists to invest time and energy in PCOMS. There will always be organisational motivations for PCOMS in terms of improved outcomes and reduced costs—the language of “return on investment” and “proof of value.” But there is also the personal motivation of the therapist, the very reason most got into this business in the first place: to make a difference in the lives of those served. The groundbreaking research by Orlinsky and Rønnestad (2005) about therapist development (now over 11,000 therapists included) demonstrates that nearly all therapists want to continue to improve throughout their careers and harnessing this motivation is part and parcel to successful implementation. PCOMS appeals to the best of therapist intentions and encourages therapists to collect ORS data so that they can track their development and implement strategies to improve their effectiveness (Duncan, 2010).

Including these additional aspects allows therapists to see that the intentions of PCOMS go well beyond management or funder’s cost or efficiency objectives—client based outcome feedback is about client privilege and benefit, and helping therapists get better at what they do. In addition, it is also critical that therapists know that management only intends to use data to improve the quality of care that clients receive, that there will be no punitive use of the data in any way, shape, or form. Given that most therapists improve their outcomes with feedback (recall that 9 of 10 therapists improved in the Anker et al. trial), a positive, noncompetitive approach goes a long way to assuage therapists’ fears.

After an initial 2-day training for all staff, implementation relies heavily on a “training of trainers” model, encouraging agencies to build a core set of therapists, managers and/or supervisors to provide ongoing training and supervision. Collecting data and ongoing supervision are of primary importance to successful implementation. The data tell all, allowing rapid information about not only who is using the measures but also whether the measures are being used properly thus allowing data integrity. Data indicators of correct and incorrect use are easily taught and integrated into the supervisory process allowing supervisors to monitor and build therapist skill level. A four step supervisory process (Duncan

& Sparks, 2010) that focuses first on ORS identified clients at risk, and then on individual clinician effectiveness and how improvement can occur, strengthens the possibility of successful implementation.

Conclusions

However beautiful the strategy, you should occasionally look at the results.

—Sir Winston Churchill

The time for client-based outcome feedback seems to have arrived (Lambert, 2010). For example, the American Psychological Association (APA) Presidential Task Force (hereafter Task Force) on Evidence-Based Practice in Psychology (EBPP) defined EBPP as “the integration of the best available research with clinical expertise in the context of patient (sic) characteristics, culture, and preferences” (American Psychological Association Presidential Task Force on Evidence-Based Practice, 2006, p. 273). Two parts of this definition draw attention to client feedback and to tailoring services to the individual client. First, regarding clinical expertise, the Task Force submitted:

Clinical expertise also entails the monitoring of patient progress . . . If progress is not proceeding adequately, the psychologist alters or addresses problematic aspects of the treatment (e.g., problems in the therapeutic relationship or in the implementation of the goals of the treatment) as appropriate. (American Psychological Association Presidential Task Force on Evidence-Based Practice, 2006, pp. 276–277)

And second, “in the context of patient characteristics, culture, and preferences,” emphasizes what the client brings to the therapeutic stage as well as the acceptability of any intervention to the client’s expectations. The Task Force said:

The application of research evidence to a given patient always involves probabilistic inferences. Therefore, ongoing monitoring of patient progress and adjustment of treatment as needed are essential. (American Psychological Association Presidential Task Force on Evidence-Based Practice, 2006, p. 280)

Outcome, in other words, is not guaranteed regardless of evidentiary support of a given technique or the expertise of the therapist. Client-based outcome feedback must become routine.

Further support comes from APA’s Division 29 Task Force on Empirically Supported Relationships who advised practitioners “. . . to routinely monitor patients’ responses to the therapy relationship and ongoing treatment.” (Ackerman et al., 2001, p. 496). Finally, two other recent endorsements of outcome management by APA have emerged. First the American Psychological Association Commission on Accreditation (2011) states that students and interns: “Be provided with supervised experience in collecting quantitative outcome data on the psychological services they provide . . .” (2011, C-24). And second, APA recently created a new outcome measurement database to encourage practitioners to select outcome measures for practice (<http://practiceoutcomes.apa.org>).

PCOMS provides a way to transport research to everyday clinical practice. It also is a vehicle to operationalize a recovery and consumer-driven philosophy, and encourage providers to follow their natural proclivities to improve over the course of

their careers. PCOMS calls for a more sophisticated and empirically informed clinician who chooses from a variety of orientations and methods to best fit client preferences and cultural values. Although there has not been convincing evidence for differential efficacy among approaches (Duncan et al., 2010), there is indeed differential effectiveness for the client in the room now—therapists need expertise in a broad range of intervention options, including evidence based treatments, but must remember that however beautiful the strategy, that one must occasionally look at results.

Exhibit 1. PCOMS Therapist Competency Checklist

1. Administer and score the Outcome Rating Scale (ORS) each session or unit of service.
2. Ensure that the client understands that the ORS is intended to bring his or her voice into the decision-making process and will be collaboratively used to monitor progress.
3. Ensure that the client gives a good rating; that is, a rating that matches the client’s description of his or her life circumstance.
4. Ensure that the client’s marks on the ORS are connected to the described reasons for service.
5. Use ORS data to develop and graph individualized trajectories of change.
6. Plot ORS on individualized trajectories from session to session to determine which clients are making progress and which are at risk for a negative or null outcome.
7. Use ORS scores to engage clients in a discussion in every session about how to continue to empower change if it is happening and change, augment, or end treatment if it is not.
8. Administer and score the Session Rating Scale (SRS) each session or unit of service.
9. Ensure that the client understands that the SRS is intended to create a dialogue between therapist and client that more tailors the service to the client—and that there is no bad news on the measure.
10. Use the SRS to discuss whether the client feels heard, understood, and respected.
11. Use the SRS to discuss whether the service is addressing the client’s goals for treatment.
12. Use the SRS to discuss whether the service approach matches the client’s culture, preferences worldview, or theory of change.

Exhibit 2. National Consensus Statement on Mental Health Recovery

Self-direction. Consumers lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path toward those goals.

Individualized and person-centered. There are multiple pathways to recovery based on an individual’s unique strengths and resiliencies as well as his or her needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result as well as an overall paradigm for achieving wellness and optimal mental health.

Empowerment. Consumers have the authority to choose from a range of options and to participate in all decisions—including the allocation of resources—that will affect their lives, and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires, and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organisational and societal structures in his or her life.

Holistic. Recovery encompasses an individual's whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and health care treatment and services, complementary and naturalistic services, addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organisations, systems, communities, and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.

Nonlinear. Recovery is not a step-by-step process but one based on continual growth, occasional setbacks, and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.

Strengths-based. Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships.

Peer support. Mutual support—including the sharing of experiential knowledge and skills and social learning—plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.

Respect. Community, systems, and societal acceptance and appreciation of consumers—including protecting their rights and eliminating discrimination and stigma—are crucial in achieving recovery. Self-acceptance and regaining belief in one's self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.

Responsibility. Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps toward their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.

Hope. Recovery provides the essential and motivating message of a better future—that people can and do overcome the barriers and obstacles that confront them. Hope is internalized; but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process. Mental health recovery not only benefits individuals with mental health disabilities by focusing on their abilities to live, work, learn, and fully participate in our society, but also enriches the texture of American community life. America reaps the benefits of the contributions individ-

uals with mental disabilities can make, ultimately becoming a stronger and healthier nation.

Exhibit 3. PCOMS Organisational Readiness Checklist

1. The Agency/Organisation/Behavioural Health Care System (hereafter agency) has secured Board of Director approval and support for PCOMS.
2. The agency has consensus among the agency director and senior managers that consumer partnership, accountability, and PCOMS are central features of service delivery.
3. The agency has a business/financial plan that incorporates PCOMS.
4. The agency infrastructure promotes regular communication with funders about PCOMS data as it applies to agency effectiveness and efficiency.
5. The agency has a human resource training and development plan that supports ongoing PCOMS education of staff at all levels, and that intends to integrate PCOMS into individual development plans, performance appraisals, and hiring practices.
6. The agency has the infrastructure (support staff, IT, computer hardware, etc.) to support the collection and analysis of PCOMS data at the individual consumer, therapist, program, and agency levels.
7. The agency has a supervisory infrastructure that allows PCOMS data to be used to individualize treatment planning, identify at risk clients and proactively address treatment needs, and monitor/improve therapist performance.
8. The agency has a structure for and policy addressing clients who are not progressing that insures rapid transfer and continuity of care.
9. The Mission Statement incorporates consumer partnership and accountability as central features of service delivery.
10. "Client Rights and Responsibilities" include the importance of consumer feedback and partnership to guide treatment planning.

Résumé

Deux modèles de surveillance et de rétroaction en continu révèlent des gains dans le cadre d'essais cliniques aléatoires (ECA) : le Outcome Questionnaire (OQ) System, de Lambert, et le Partners for Change Outcome Management System (PCOMS). L'article rappelle l'évolution du PCOMS, depuis une façon simple de discuter des avantages des services avec les clients jusqu'à son émergence comme pratique factuelle pour l'amélioration des résultats. Quoiqu'il s'inspire du modèle de Lambert, on y décèle des

différences : le PCOMS est intégré au processus de psychothérapie en cours et inclut une discussion transparente de la rétroaction avec le client; il évalue l'alliance à chaque rencontre; l'échelle Outcome Rating Scale, plutôt qu'une liste de symptômes évalués sur une échelle Likert, est à la fois un outil et un instrument d'aboutissement requérant la collaboration du client. L'article présente la recherche à l'appui des caractéristiques psychométriques des mesures ainsi que l'intervention du PCOMS, suivies d'un sommaire du processus clinique. Des exemples de la transposition réussie à la santé comportementale sont offerts. On y décrit ensuite le processus de mise en vigueur qui favorise la participation du client, le rétablissement et la justice sociale, et les besoins du clinicien de première ligne sont discutés. Forte de neuf ECA et de l'appui de l'American Psychological Association, la rétroaction du client sur les résultats offre une façon pragmatique de passer de la recherche à la pratique.

Mots-clés: rétroaction du client axée sur les résultats, recherche axée sur le patient, PCOMS, observations basées sur la pratique.

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Received December 5, 2011

Revision received January 23, 2012

Accepted February 6, 2012 ■