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The Partners for Change Outcome Management System

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Introduction

Despite overall couple and family therapy efficacy, many clients do not benefit from treatment, dropouts are a problem, and therapists vary significantly in success rates, are poor judges of negative outcomes, and grossly overestimate their effectiveness (Duncan 2014). Progress Feedback (sometimes called "client feedback") offers one solution. It refers to the continuous monitoring of client perceptions of benefit throughout therapy and a real-time comparison with an expected treatment response to gauge client progress and signal when change is not occurring as predicted. With this alert, clinicians and clients have an opportunity to shift focus, revisit goals, or alter interventions before deterioration or dropout.

One of the two progress feedback interventions included in Substance Abuse and Mental Health Administration's (SAMHSA) National Registry of Evidence-based Programs and Practices is the Partners for Change Outcome Management System (Duncan 2012). Only the Partners for Change Outcome Management System (PCOMS) has demonstrated significant improvement in outcomes with couples and families. Emerging from clinical practice and designed with the front-line clinician in mind, PCOMS employs two, four item, reliable and valid scales, one focusing on outcome (the Outcome Rating Scale; Miller et al. 2003) and the other assessing the therapeutic alliance (the Session Rating Scale; Duncan et al. 2003). PCOMS 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. PCOMS assesses the client's response to service and feeds that information back to both the therapist and client to enhance the possibility of success via identification of clients at risk for a negative outcome. Widespread implementation of PCOMS has enabled the development of algorithms for expected treatment response based on extensive databases as well as an electronic system for data collection, analyses, and real-time feedback.

Studies report that clients receiving PCOMS have 3.5 times higher odds of experiencing reliable change and less than half the chance of deterioration, making a strong case for clinician use of progress feedback in general and PCOMS specifically. PCOMS evolved from a clinical, relational, and value-driven starting place in its developer's practice (Duncan 2014) to an empirically

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validated methodology for improving outcomes and a viable quality improvement strategy.

Theoretical Framework

PCOMS is an evidenced based practice, but it is not what typically comes to mind – it is not a specific treatment model or intervention for a specific client diagnosis or problem. Rather, PCOMS is a-theoretical and not diagnostically based. PCOMS has demonstrated significant improvements for both clients and therapists regardless of the theoretical orientations of therapists or the diagnoses of the clients. More importantly, PCOMS is evidence based at the individual client-therapist level, promoting a partnership that monitors whether *this* approach provided by *this* therapist is benefiting *this* client or family. In other words, it is *evidence-based practice one client at a time.*

Rationale for the Strategy or Intervention

The purpose of PCOMS is to partner with clients to identify those who are not responding and address the lack of progress to keep clients engaged while new directions are collaboratively sought. There are six rationales for PCOMS. First, PCOMS is supported by five randomized clinical trials (RCT) conducted by the Heart and Soul of Change Project that demonstrate that client progress and alliance feedback significantly improves outcomes across modalities and therapies (Duncan and Reese 2015). These RCTs led to the SAMHSA designation of PCOMS as an evidence-based practice, distinguishing it from other couple and family progress feedback systems. Second, PCOMS has demonstrated that it is a viable quality improvement strategy in real world settings and may be more cost effective and feasible than transporting evidence-based treatments for specific disorders (Reese et al. 2014). Agencies implementing PCOMS have enjoyed outcomes comparable to those achieved in RCTs. Third, PCOMS addresses the problems of the field by reducing dropouts, cancelations, no shows, length of stay, and therapist variability while providing objective information about clinician and agency effectiveness (Duncan and Reese 2015).

Fourth, PCOMS incorporates two known predictors of ultimate treatment outcome, early change (Baldwin et al. 2009), and the therapeutic alliance (Horvath et al. 2011). Studies reveal that the majority of clients experience the majority of change in the first eight visits. Couples and families who report little or no progress early on will likely show no improvement over the entire course of therapy. A second robust predictor of change solidly demonstrated by a large body of studies is the therapeutic alliance. Clients who highly rate their partnership with their therapists are more apt to remain in therapy and benefit from it. Monitoring progress and the alliance provides a tangible way to identify nonresponding clients and relationship problems before clients drop out or achieve a negative outcome. Fifth, PCOMS directly applies the research about what matters in therapeutic change, the common factors (Duncan et al. 2010). Collaborative monitoring of outcome engages the most potent source of change, clients, heightening hope for improvement, and tailors services to client preferences thereby maximizing the alliance and participation (Duncan 2014).

Finally, a sixth rationale speaks to consumer rights and the foundations of couple and family therapy practice. Despite well-intentioned efforts, the infrastructure of couple and family therapy (paperwork, procedures, and professional language) can reify noncontextualized descriptions of client problems and silence their views, goals, and preferences. Routinely requesting, documenting, and responding to client feedback has the potential to transform power relations by privileging client beliefs and goals over potentially culturally biased and insensitive practices. Valuing clients as credible sources of their own experiences of progress and relationship allows consumers to teach clinicians how to be the most effective with them and reverse the hierarchy of expert-delivered services. PCOMS provides a readymade structure for collaboration with

consumers and promotes a more egalitarian therapeutic process.

Outside the therapy dyad, client-generated data help overcome inequities built into everyday service delivery by redefining whose voice counts. Without the data, client views do not stand a chance to be part of the real record – that is, critical information that guides decisions or evaluates eventual outcomes at larger programmatic or organizational levels. The data, as concrete representations of client perspectives, offer a direct way to describe benefit at clinician and agency levels as well as keep client voice primary to how services are delivered and funded.

Description of the Strategy or Intervention

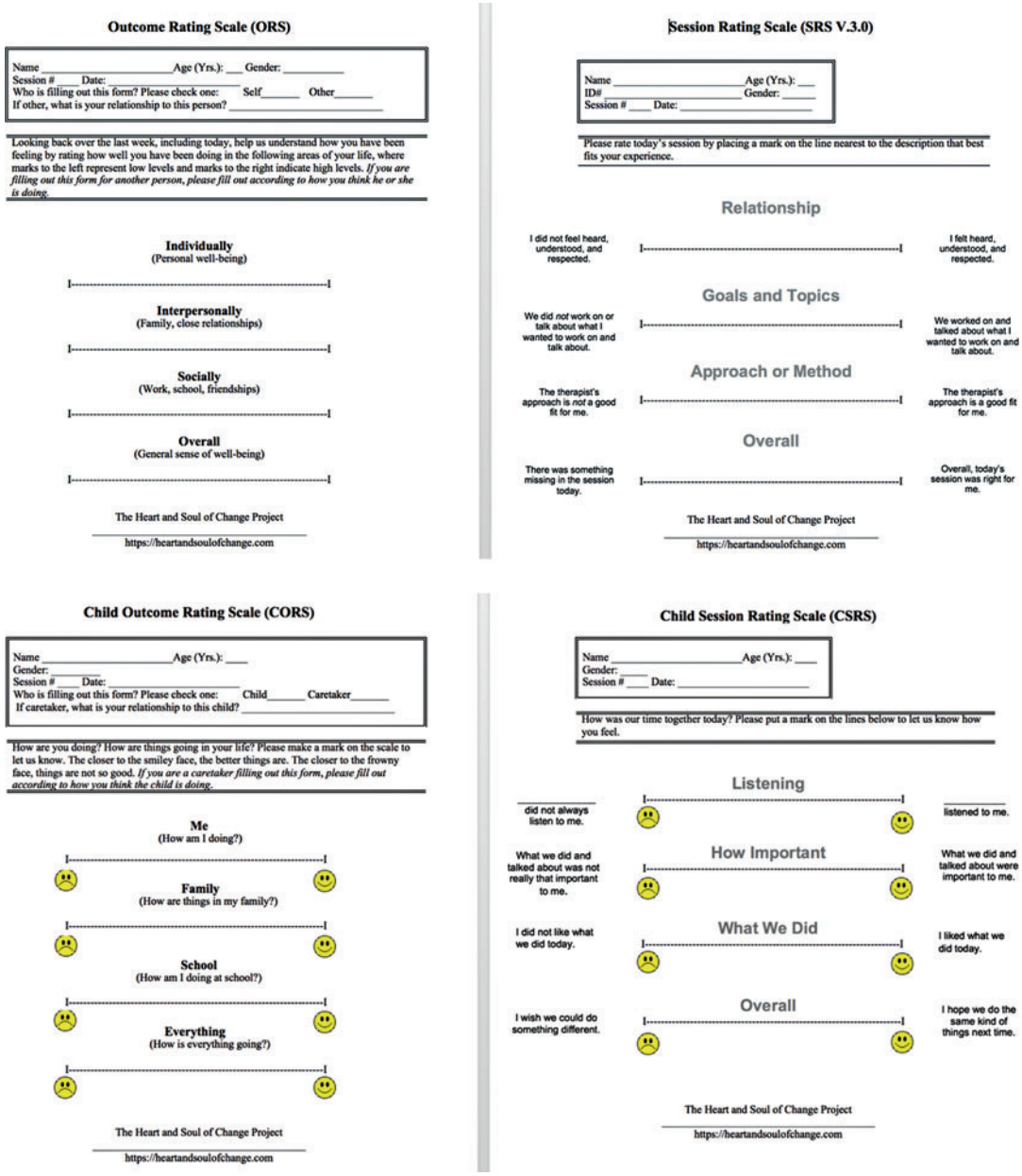
PCOMS is a light-touch, checking-in process that usually takes about 5 min but never over ten for administering, scoring, and integrating into the therapy. PCOMS gently guides models and techniques toward the client's perspective, with a focus on outcome. Besides the brevity of its measures, PCOMS also differs from most systems in that client involvement is routine and expected; client scores on the progress and alliance instruments are openly shared and discussed at each administration. Client views of progress serve as a basis for beginning therapeutic conversations, and their assessments of the alliance mark an endpoint to the same. With this transparency, the measures provide a mutually understood reference point for reasons for seeking service, progress, and engagement.

PCOMS and the session start with the Outcome Rating Scale for adolescents and adults and the Child Outcome Rating Scale (CORS: Duncan et al. 2006) for children ages 6–12, which provide client-reported ratings of progress.

As Fig. 1 reveals, rather than a symptom checklist on a Likert Scale, the ORS and CORS are visual analog scales consisting of four 10 centimeter lines, corresponding to four domains (individual, interpersonal, social, and overall), allowing for the client's idiosyncratic rendering of his or her life circumstance. Clients place a mark on each line to represent their perception of their functioning in each domain if using a paper and pencil version or touch or click an iPad or other device if using the web based application of PCOMS. In the case of a family entering services because of a problem related to a child or adolescent, the parent or caregiver scores only the CORS (for a child) or ORS (for an adolescent) based on his or her perception of how the child or adolescent is doing. Asking the parent or caregiver to score his or her own ORS sends the message that the therapist is interested in their functioning, even though that is not the reason for service. This could risk the alliance as parents or caregivers may believe that the therapist is not aligned with their view of the problem but, instead, has a covert belief that the parent or caregiver themselves are the problem. The primary point is to ensure that the therapist accepts the reason for seeking help and communicates that as clearly as possible through both verbal and nonverbal means to clients.

Parental and caregiver scores of a youth presented as the reason for service provide crucial perspectives of how therapy is going. Parent/caregiver change scores are significantly correlated with children's and adolescent's scores. In other words, when youth record change, caregivers typically report similar amounts and directions of change and vice versa. In some circumstances, it is also useful to get others who are significantly involved with a child, or so-called collateral raters, to score their views using the CORS/ORS. For example, a teacher instrumental in referring a child for counseling or a probation officer assigned by a court to monitor a youth charged with a delinquency offense are good candidates to bring into the process. People who play pivotal roles in the child's life can become witnesses to and advocates for positive change. Periodic meetings with these individuals, the youth, and family can facilitate support for the child or adolescent's efforts and collaboratively contribute to goal setting and strategies for problem resolution.

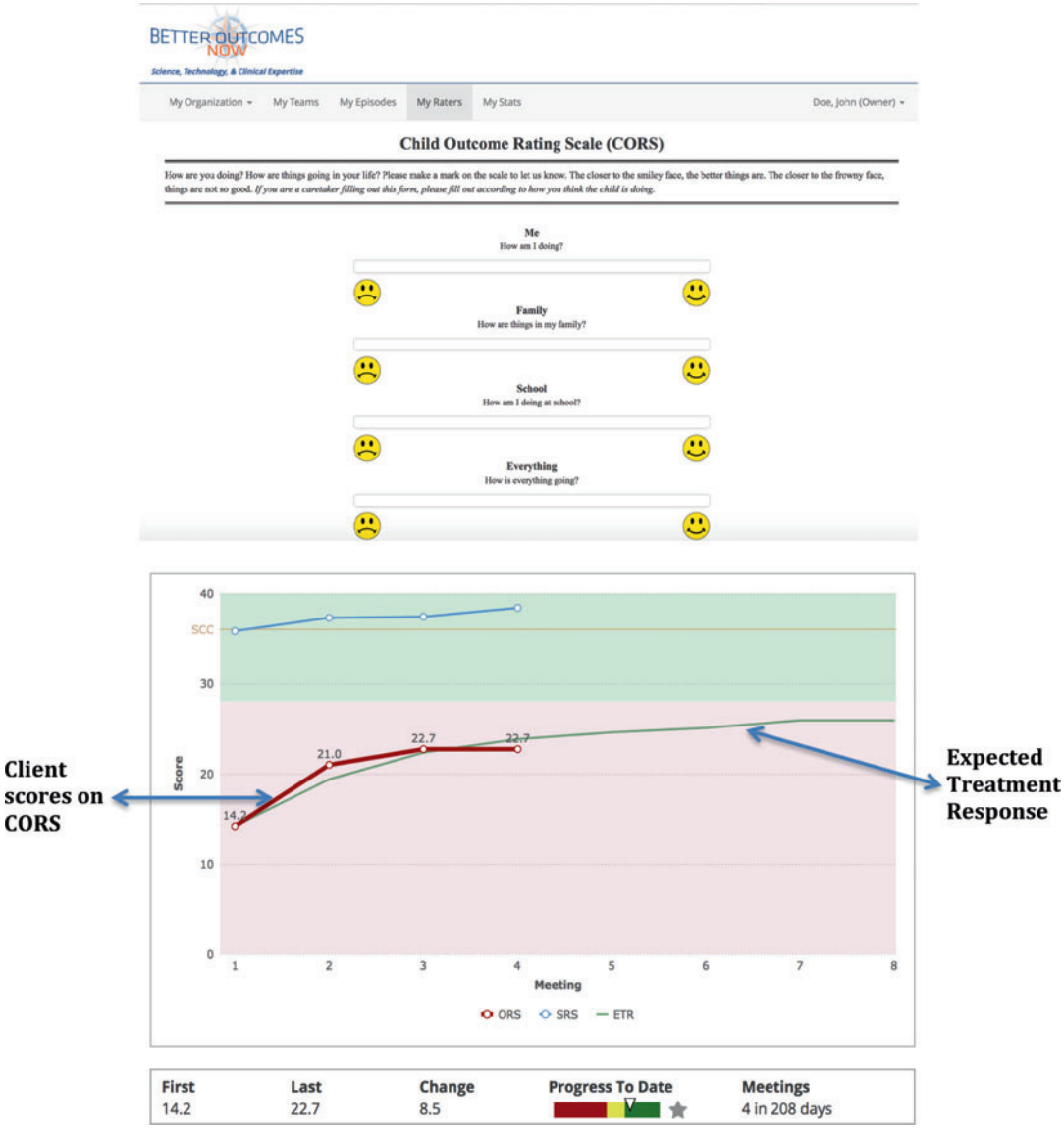
Therapists use a centimeter ruler to sum the client's total score, or the web version automatically totals and graphs the score, with a maximum score of 40 (see Fig. 2). Lower scores reflect more



The Partners for Change Outcome Management System, Fig. 1. The Outcome Rating Scale (ORS), Session Rating Scale (SRS), Child ORS, and Child SRS (Copyright 2000, 2002, 2003, and 2003 by B. L. Duncan and S.D. Miller. For examination only. Download free working copies in 24 languages at https://heartandsoulofchange.com)

distress. The paper and pencil PCOMS family of instruments are free for individual use at heartandsoulofchange.com which also contains free resources regarding implementing PCOMS at clinician and agency levels. The web version is a commercial product available at betteroutcomesnow.com

Given that at its heart, PCOMS is a collaborative intervention, it is important that couples and families understand two points at the start: (1) the



The Partners for Change Outcome Management System, Fig. 2. The web-based Child Outcome Rating Scale (CORS) (*top*) and graph with CORS scores and expected treatment response (ETR) (*bottom*)

ORS and CORS will be used to track outcome in every session and (2) the ORS and the CORS provide a way to make sure that the client's voice about progress is not only heard but remains central. Introducing the ORS to families requires tailoring the talk to the age, understanding capability, and level of attention of multiple family or couple members. In the first meeting, the ORS/CORS pinpoints where the client sees him or herself, allowing for an ongoing comparison in later sessions.

The task after the score is totaled is to make sense of it with the final authority – the client. Everyone needs to understand what their score means and have a shared understanding of how the scores reflect their reason for seeking therapy. It helps to put the forms (or laptop or other device) out on an open surface (e.g., coffee table) where

everyone can see. This is a powerful gesture communicating that the work is collaborative, the therapist will not be the private keeper of special information, and everyone's point of view will be known and valued. It is not unusual for children to flock around a set of scores with a natural curiosity for who scored what. Couples are often similarly curious about their partners' scores and will readily make comments about similarities or differences with their own. The PCOMS outcome scales allow everything to be literally on the table right from the beginning – the agreements and disagreements that everyone knows about, except the therapist, until now. The ORS/CORS bring an understanding of the couple and family's experience to the opening minutes of a session.

The "clinical cutoff" facilitates a shared understanding of the ORS/SRS and is often a step toward connecting the scores to the reason for seeking or receiving services. Twenty-five (out of 40) is the cutoff for adults, meaning that, on average, persons seeking clinical services will fall below that, and those not typically seeking counseling will score above. Although adolescents use the ORS, their cutoff is slightly higher, 28. Children's cutoff on the CORS is also 28 as well as when parents/caregivers are scoring the CORS for children and the ORS for an adolescent. The therapist lets each person know, in everyday language that is understandable to them, whether they are above or below the cutoff. For those showing below cutoff scores, the therapist assures them that they made a good decision to come in. For those scoring above the cutoff, clinicians simply validate their score by saying that it looks like things are going pretty well, which leads to the next logical question – what are the reasons for meeting at this time?

Clients usually score the scale that reflects the reason for service lower than the rest. Of note, when a child or adolescent scores above the cutoff, they will often still provide a clue to what is troubling them by placing one mark lower than others. Finally, the domain scores offer a glimpse of what is going well in a person's life. It is worthwhile to briefly mention this when reviewing the ORS/CORS scores, or, at least, make a mental note to inquire more about these areas at some point later in the interview.

The next vehicle for connecting the ORS and CORS to the reasons for service relates to the specific domains. The ORS/CORS is individually tailored by design, requiring the practitioner to ensure that the measure represents both the client's experience and the reasons for service. Simply seeing which domain or domains are scored lower allows the therapist to hone in on the most distressed dimension. The therapist can comment on this area and to ask if the score on that domain represents the reason for seeking counseling or being referred for counseling. Or the therapist can allow the conversation to reveal the reason for service and then make the connection to the lowest domain. Once that is established, there is a shared understanding regarding which domain is the focal point for tracking change. For example, typically couples will come in with the interpersonal domain scoring lower than others. It is not hard to confirm that this is what they want to address through counseling. It also reveals who is more distressed about the relationship and who likely set up the appointment – and perhaps who was dragged in by their partner. At the moment clients connect the marks on the ORS/CORS with the situations that prompt their seeking help, the ORS becomes a meaningful measure of progress and a potent clinical tool. And that moment facilitates the next question: "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?" The ORS sets the stage and focuses the work at hand.

Couples and families either agree about their views of the level and areas (domains) of distress or they do not. When they agree, therapists can comment on it as a strength, highlight the commonality, and use it as a stepping stone to establish mutual goals. Different scores are to be expected and simply represent the reality and complexity of working therapeutically with more than two in the room. For starters, different scores are concrete and visible, allowing therapists to inquire early on about everyone's unique perceptions and beliefs. The sooner this is done, the quicker goals for each person can be identified and efforts made to link these into a common strategy and mutually

desired endpoint. Alternatively, discrepant scores may persist, and therapists can successfully validate those differences and still work toward a positive outcome.

Disagreements between clients in their scores on the ORS/CORS simply speak to the dynamics frequently present in couple and family therapy. The instrument just puts those differences front and center in the first minutes of the session. The ORS/CORS gives an instant read on things like who is in the most distress about relationship and/or youth problems and who perhaps was coerced into therapy. Not surprisingly, in couple work the one wanting to work on or save the relationship is often the one demonstrating more distress on the ORS. Similarly, the youth, who is essentially mandated to therapy, will often score higher on the outcome measure (in less distress) than the parent or caregiver's rating of the youth. Also not surprising is that the one who is dragged to therapy is often over the cutoff. The discussion of distress via ORS scores shines a light on these important issues allowing their open discussion and subsequent planning for how therapy can meet each individual's needs.

The Session Rating Scale (SRS; Duncan et al. 2003) or Child Session Rating Scale (CSRS; see Fig. 1), also four item visual analog scales, cover the classic elements of the alliance (Bordin 1979) and are given toward the end of a session. Similar to the ORS/CORS, each line on the SRS/CSRS is 10 cm and can be scored manually or electronically. Use of the SRS/CSRC encourages all client feedback, positive and negative, creating a safe space for clients to voice their honest opinions about their connection to their therapist and to therapy. Introducing the SRS/CSRS works best as a natural extension of the therapist's style. For clients to feel comfortable giving alliance feedback, it has to be clear that there is no "bad news" on the alliance measure and that the therapist truly wants to know how he or she can improve the client experience of the therapy – and is not looking for compliments or is fearful about receiving feedback.

Clients tend to score all alliance measures very high and the SRS/CSRS is no exception. For clients scoring above the cutoff of 36, the therapist need only thank the client, inquire about what the client found particularly helpful, and invite the client to please inform the therapist if anything can improve the therapy. For clients scoring below 36, the conversation is similar but also attempts to explore what can be done to improve the therapy. The SRS/CSRS provides a structure to address the alliance, allows an opportunity to fix any problems, and demonstrates that the therapist does more than give lip service to forming good relationships.

After the first session, PCOMS simply asks: Are things better or not? The longer therapy continues without measurable change, the greater the likelihood of drop out and/or a poor outcome. The ORS/CORS scores are used to engage the couple or family in a discussion about progress, and more importantly, what should be done differently if there is not any. While there may be agreement regarding the two possible change scenarios, it may be that there are different views. For example, as depicted below, a spouse may be seeing things improve because his partner has returned to live in the home, but her view of the situation indicates deterioration. This is of course the challenge – to create a therapeutic context where everyone, different views and all, benefits. The best way to judge success is when both persons in a couple benefit or when both the youth and caregiver demonstrate gains in therapy.

Regardless of the congruence or discrepancy between client scores, the task of the therapist from session to session is to identify client perceptions of progress and the alliance and respond appropriately. When ORS/CORS scores increase, a crucial step to empower the change is to help clients see any gains as a consequence of their own efforts. It is interesting to see how a simple jump of even a few points on the ORS can spur conversation about how small changes can be carried forward to address the problems at hand. Reliable and clinically significant change provides helpful metrics to gauge noted gains. Reliable change is a change of 6 points or more on the ORS/CORS and is likely not due to chance or measurement error. Clinically significant change is a change of 6 points or more on the ORS/CORS *and* crossing the clinical cutoff (25 for adults;

28 for youth and caretakers). The client starts in the "clinical" range and transcends the cutoff to the nonclinical range. When clients reach a plateau or what may be the maximum benefit they will derive from service, planning for continued recovery outside of therapy starts.

A more important discussion occurs when ORS/CORS scores are not increasing. The longer therapy continues without measurable change, the greater the likelihood of dropout and/or poor outcome. PCOMS is intended to stimulate all interested parties to reflect on 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 Duncan and Sparks (2002) have called *checkpoint conversations* and *last chance discussions*.

Checkpoint conversations are conducted at the third to sixth session and last-chance discussions are initiated in the sixth to ninth meeting. The trajectories observed in outpatient settings suggest that most clients who benefit usually show it in 3–6 sessions (Duncan 2014); and if change is not noted by then, then the client is at a risk for a negative outcome. The same goes for sessions 6–9 except that the urgency is increased, hence the term "last chance." An available web-based system provides a more sophisticated identification of clients at risk by comparing the client's progress to the expected treatment response of clients with the same intake score.

The progression of the conversation with couples and families who are not benefiting goes from talking about whether something different should be done, to identifying what can be done differently, to doing something different. Doing something different can include, for example, inviting others from the client's support system, using a team, developing a different conceptualization of the problem, trying another approach or model, or referring to another therapist or venue of service such as a religious advisor or self-help group – whatever seems to be of value to the client.

PCOMS spotlights the lack of change, making it impossible to ignore, and often ignites both therapist and the couple or family into action – to consider other treatment options and evaluate whether another provider may offer a different set of options and perhaps a better match with client preferences, culture, and frame of reference.

The feasibility of two four-item scales has resulted in over a million administrations of the PCOMS measures in electronic data bases. PCOMS is used in every state, by the eight largest public behavioral health organizations in their respective states, and in over 20 countries including province-wide implementation in Saskatchewan and national implementation in couple agencies in Norway. Over 200,000 consumers per year use PCOMS as part of their service. Five RCTs demonstrate a significant advantage of PCOMS over treatment that does not include progress feedback. Clients using PCOMS achieved more pre–post treatment gains, higher percentages of reliable and clinically significant change, faster rates of change, and were less likely to drop out.

Routinely measuring outcome and the alliance with every couple and family ensures that neither issue is left to chance. This allows both transparency and true partnership with clients, keeping their perspectives the centerpiece. In addition, it serves as an early warning device that identifies clients who are not benefiting so that the client and the therapist can chart a different course. This, in turn encourages the family clinician to step outside of business as usual, do new things, and therefore continue to grow as a therapist.

Case Example

Roberto was distraught that his wife, Nancy, had moved out, leaving him to care for their two daughters. At the first session, Roberto's ORS score was 17.5 and Nancy's 12.7, with the *interpersonal* scale coming in the lowest at 5.4 and 2.2, respectively, confirming that these were two distressed individuals with a marriage on the brink. When the therapist invited each to tell the story behind the numbers and explain their marks on the *interpersonal* scale, Roberto described his loneliness and said he just wanted his wife to come back home. Nancy pointed to her mark on the ORS and

recounted his late nights at work and indifference to her needs. SRS scores reflected a rocky start. When the therapist asked about what was needed to move the SRS in a more positive direction, Roberto said he wanted the therapist to focus more on Nancy moving back home. Nancy said she wanted the therapist to help them talk together so that Roberto would hear her.

At the next session, Roberto's ORS indicated nearly a four-point jump, as he felt more hopeful that Nancy would return given that she attended therapy; by session three, his ORS surpassed the cutoff, because Nancy, perhaps succumbing to Roberto's pleas, moved back. With a note of relief, Roberto described their home life as more or less "back to normal." His SRS scores for sessions two and three increased, indicating a strengthening therapeutic alliance. Meanwhile, despite a similar rise in SRS scores for Nancy, her third session ORS score was a paltry 13. Clearly, something was gravely amiss in her life and therapy was failing to help.

In session four, Nancy's ORS plummeted to a dismal 9.2 while Roberto's ORS at session four continued to increase to 27.8. The therapist showed the couple a graph of their two change trajectories, reflecting in sharp relief the dramatic difference. The two ORS paths provided a compelling rationale to inquire about Nancy's decline corresponding with her return home. With encouragement, Nancy opened up about her dreams to pursue a meaningful career and to have time away from household responsibilities. Though these were not new themes, there was an urgency and clarity absent from previous sessions. The therapist supported Nancy's dreams and encouraged Roberto to respond to his wife in a way that showed that he took her seriously. At the same time, Roberto was asked to talk about his needs to manage the demands of his job, the primary financial support for the household, and his limited ability to share equally in home tasks. This time the conversation was real, significantly different than their usual stalemated communication. Nancy's ORS scores significantly increased over the next three sessions as the couple continued to make necessary adjustments in their relationship.

This therapy may have reached this point without PCOMS but the chances of dropout were high, particularly after the first session without prompt alliance feedback and the fourth session without concrete evidence of their disparate views. Different scores on the ORS in couple or family work may be interpreted as cause for concern when, in truth, they are cause to rejoice; therapists and their clients are given the opportunity to unambiguously face the reality of their different views and then to gauge and celebrate convergences when they occur. In the case of Roberto and Nancy, session four proved a turning point for strategies to meet their conflictual needs.

Cross-References

- ▶ Alliance Scales in Couple and Family Therapy
- ▶ Progress Research in Couple and Family Therapy
- ▶ SCORE
- ▶ Systemic Therapy Inventory of Change

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