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Systematic Feedback through the Partners for Change Outcome Management System (PCOMS)

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

Sir Winston Churchill

THIS CHAPTER DISCUSSES

- Systematic feedback and the Partners for Change Outcome Management System (PCOMS)
- PCOMS as a way to truly privilege clients, include them as full partners in decision-making and operationalize social justice and a pluralistic approach

Psychotherapy is a good news, bad news scenario. The good news is that therapy works – the average treated person is better off than about 80% of the untreated sample. The bad news is that, despite overall efficacy, many clients do not benefit,

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dropouts are a problem, and therapists vary significantly in success rates, are poor judges of client negative outcomes and don't have a clue about their effectiveness (Duncan, 2014).

The Partners for Change Outcome Management System (PCOMS) offers a solution to these problems (Duncan, 2012). PCOMS employs two, four-item scales: one focuses on outcome (the Outcome Rating Scale) and the other assesses the therapeutic alliance (the Session Rating Scale). It includes a real-time collaborative comparison of client views of outcome with an expected treatment response that serves as a yardstick for gauging client progress and signalling when change is not occurring as predicted. With this alert, counsellors and clients have an opportunity to shift focus, re-visit goals, or alter interventions before deterioration or dropout. PCOMS has been shown to improve outcomes in five randomized controlled trials (RCT) and is included in the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Registry of Evidence-based Programs and Practices (NREPP).

PCOMS is one approach of what is called *systematic feedback*. Although systematic feedback systems vary significantly in the measures used, empirical support and clinical processes, all share the desire to measure the client's response to service (the outcome), and feed that information back to the therapist (or to both client and counsellor) to enhance the possibility of a positive outcome. Two other systems are worthy of note and exploration. First is the Outcome Questionnaire-45.2 System (OQ; Lambert, 2010). Michael Lambert is the pioneer of systematic feedback, evolving the idea of outcome measurement to a 'real time' feedback process with a proven track record of improving outcomes. The central measure is the OQ-45, a self-report measure with 45 items targeting symptoms, emotional states, interpersonal relationships and social role performance. With seven RCTs supporting it, the OQ System is the only other system included in the SAMHSA National Registry. For more information, see www.oqmeasures.com. Second is the Clinical Outcomes in Routine Evaluation-Outcome Measure (CORE-OM; Barkham, Hardy, & Mellor-Clark, 2010). This is a practical and widely used system in the UK. The central measure is the CORE-OM, a 34-item self-report questionnaire, tapping the domains of subjective well-being, problems, functioning and risk. It is administered before and after therapy (10- and 5-item versions are used for tracking in between). For more information, see www.coreims.co.uk.

If someone told you that by having your clients answer four brief questions at the beginning and end of each session you triple their chances of having a successful outcome, would you say: 'Na, too much trouble?' That's exactly what PCOMS brings to the table. A meta-analytic review (Lambert & Shimokawa, 2011) of three of the five PCOMS studies ($N = 558$) reported that clients in the feedback group had 3.5 times higher odds of experiencing reliable change and less than half the chance of experiencing deterioration than treatment as usual (TAU). This chapter intends to give you enough about the Partners for Change Outcome Management System to get you started. In addition to its empirical support and feasibility, PCOMS offers a way to operationalize a therapy that privileges the client, prioritizes the relationship and seeks full partnership with clients about all decisions that affect their care – or in other words, a pluralistic approach.

PCOMS AND A PLURALISTIC APPROACH

> To exchange one orthodoxy for another is not necessarily an advance. The enemy is the gramophone mind, whether or not one agrees with the record that is being played at the moment.
>
> George Orwell

PCOMS boils down to this: partnering with clients to identify those who aren't responding and addressing the lack of progress in a proactive way that keeps clients engaged while new directions are collaboratively sought. Five RCTs, the largest benchmarking study ever conducted in public behavioural health, and a cohort study have unequivocally shown that PCOMS improves outcomes with youth and adults, in individual, couple and group therapy, with both mental health and substance abuse problems, and with the impoverished and disenfranchised (for a review of these studies conducted by the Heart and Soul of Change Project, see Duncan, 2014; to download these studies, visit https://heartandsoulofchange.com).

Although PCOMS is designated as an evidence-based practice, it is not your average evidence-based practice – not a specific treatment model for a specific client diagnosis. PCOMS has demonstrated significant improvements for both clients and counsellors regardless of therapist theoretical orientation or client diagnosis. More importantly, PCOMS is evidence-based at the individual client–counsellor level, promoting a partnership that monitors whether *this* approach provided by *this* therapist is benefiting *this* client. In other words, it is *evidence-based practice one client at a time*.

PCOMS, consequently, lines up very well with both a *pluralistic perspective* and *pluralistic practice* (Cooper & McLeod, 2011). A pluralistic perspective posits that different clients are likely to benefit from different things, and that therapists should work closely with clients to help them identify what they want from therapy and how they might achieve it. *Pluralistic practice* is an approach to therapy based on a pluralistic perspective that draws on techniques from a multiple orientations, and is characterized by ongoing negotiation with clients about the goals, tasks and methods of therapy.

PCOMS operationalizes a pluralistic approach in several ways. First, PCOMS does not drag any theoretical baggage to the therapeutic journey – it neither explains client problems nor offers any solutions. PCOMS is consequently pluralistic in its scope and encourages an individually tailored therapy that emerges from the client's idiosyncratic strengths, cultural worldview and theory of change (Duncan, Solovey, & Rusk, 1992). When services are provided without intimate connection to those receiving them and to their responses and preferences, clients become cardboard cut-outs, the object of our professional deliberations. Valuing clients as credible sources of their own experiences of progress and relationship allows clients to teach us how we can be the most effective with them, consistent with a pluralistic perspective.

A pluralistic approach values dialogue and negotiation and PCOMS provides a ready-made structure at the top and bottom of the hour for that to happen. It ensures therapy's match with a client's preferred future via monitoring progress on the ORS.

And it provides a way to ensure therapy's alignment with a client's goals and preferred way of achieving goals via monitoring the relationship with the SRS. Thus, PCOMS promotes the values of social justice by privileging client voice over manuals and theories enabling idiosyncratic and culturally responsive practice with diverse clientele. Clients determine the fit and benefit of services as well as intervention preferences. This is the essence of a pluralistic approach.

THE PARTNERS FOR CHANGE OUTCOME MANAGEMENT SYSTEM

> The only man 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

PCOMS embraces two known predictors of ultimate treatment outcome. Time and again, studies reveal that the majority of clients experience the majority of change in the first eight visits (e.g., Baldwin, Berkeljon, Atkins, Olsen, & Nielsen, 2009). 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. 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, is that 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.

PCOMS starts with the Outcome Rating Scale (ORS; Miller, Duncan, Brown, Sparks, & Claud, 2003) or the Child ORS (Duncan, Sparks, Miller, Bohanske, & Claud, 2006), which is used for children aged 6–12 and their caregivers.


Outcome Rating Scale (ORS)

Name _____ Age (Yrs):___ Sex: M / F
Session # ____ Date: _____
Who is filling out this form? Please check one: Self_____ Other_____
If other, what is your relationship to this person? _____

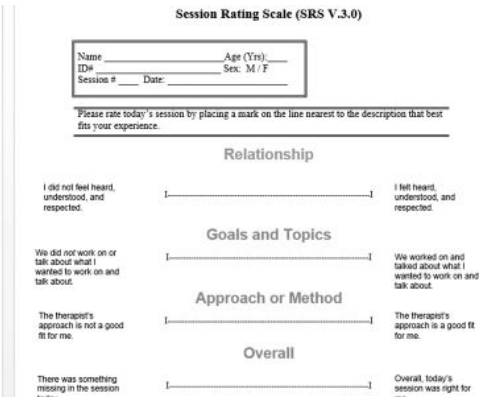
Looking back over the last week, including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels. *If you are filling out this form for another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

Individually
(Personal well-being)

Interpersonally
(Family, close relationships)

Socially
(Work, school, friendships)

Overall
(General sense of well-being)


Session Rating Scale (SRS V.3.0)

Name _____ Age (Yrs):___
ID# _____ Sex: M / F
Session # ____ Date: _____

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

Relationship

I did not feel heard, understood, and respected. — I felt heard, understood, and respected.

Goals and Topics

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

Approach or Method

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

Overall

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

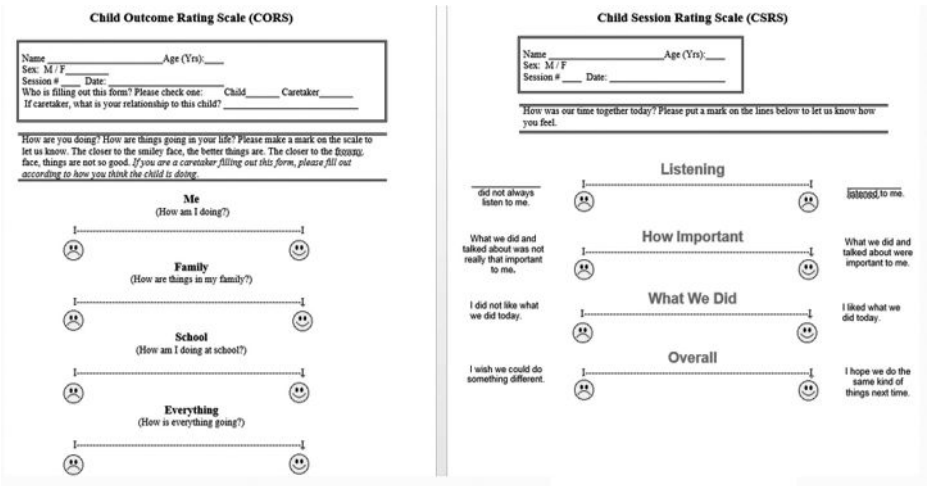


FIGURE 5.1 *The Outcome Rating Scale (ORS), Session Rating Scale (SRS), Child ORS and Child SRS. Copyright 2000, 2002, 2003 and 2003, respectively by B. L. Duncan, S.D. Miller (for the ORS, SRS, CORS, CSRS), and J.A. Sparks (for the CORS and CSRS). Reprinted with permission. For examination only. Download free working copies at https://heartandsoulofchange.com.*

Adolescents use the ORS (both measures are free for individual use and inexpensive for groups; download at https://heartandsoulofchange.com). The ORS and CORS are given at the beginning of a session and provide client-reported ratings of progress (as well as caregiver ratings for youth). An inspection of Figure 5.1 reveals that the ORS and CORS are visual analogue scales consisting of four 10 centimetre lines, corresponding to four domains (individual, interpersonal, social and overall). Clients place a mark on each line to represent their perception of their functioning in each domain. Therapists use a 10 cm ruler (or available software) to sum the client's total score, with a maximum score of 40. Lower scores reflect more distress.

The Session Rating Scale (SRS) (Duncan et al., 2003) and Child SRS, both four-item visual analogue scales covering the classic elements of the alliance (Bordin, 1979), are given toward the end of a therapy session. The CSRS is for children 6–12 years; adolescents use the SRS. Similar to the ORS, each line on the SRS or CSRS is 10 cm and can be scored manually or electronically. Use of the SRS encourages all client feedback, positive and negative, thus creating a safe space for clients to voice their reactions to therapy and expectations for it.

THE CLINICAL PROCESS

PCOMS is a light-touch, checking-in process that usually takes about 5 minutes but never over 10 to administer, score and integrate into the therapy. PCOMS works best as a way to gently guide models and techniques toward the client's perspective, with a focus on outcome. Besides the brevity of its measures and feasibility for everyday use

in the demanding schedules of front-line clinicians, PCOMS is distinguished by its routine involvement of clients in all aspects of counselling; client scores on the ORS and SRS 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.

Given that at its heart PCOMS is a collaborative intervention, it is important that clients understand two points: (1) the ORS (or CORS) is a way to make sure that the client's voice is not only heard but remains central; and (2) the ORS will be used to track outcome in every session. In the first meeting, the ORS pinpoints where the client sees him- or herself, allowing for an ongoing comparison in later sessions.

Since everything about PCOMS is 100% transparent, the task after the score is totalled is to make sense of it with the final authority – the client. The 'clinical cutoff' facilitates a shared understanding of the ORS and is often a step toward connecting client marks on the ORS to the reason for services. Twenty-five is the cutoff for adults, meaning that, on average, persons seeking therapy will fall below that, and those not typically seeking counselling will score above. For those scoring below the cutoff, the therapist can assure them that they made a good decision to come in. For those scoring above the cutoff, counsellors can 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 now? But importantly, even if clients score above the cutoff there will be one scale lower than the rest that typically signals the reason for service.

Therapist: What I do is I just measure this up, it's four 10 cm lines and it gives a score from 0 to 40 and I just pull out this ruler and add up the scores, and then I will tell you about what this says and you can tell me whether it is accurate or not, and then we will have an anchor point to measure each time and see if you're getting what you came here to get … Okay, you scored a 19.8. And what that means is that this scale, the Outcome Rating Scale, has a cutoff of 25 and people who score under 25 tend to be those who wind up talking to people like me, they're looking for something different in their lives. You scored about the average intake score of persons who enter therapy, so you're in the right place. And it's not hard to look at this and see pretty quickly that it's the family/close relationship area is what you are struggling with the most right now. Does that make sense?

Client: Yes, definitely.

Therapist: So what do you think would be the most useful thing for us to talk about?

Client: Well, I am in the middle of divorce and struggling with figuring this out …

Give the score, say what it might mean, and look for feedback to see if it fits. What you will find in 99 out of 100 administrations in the first meeting is that clients

mark lowest the scale that they are there to talk about. The above client did just that. The initial ORS score is an instant snapshot of how the client views him- or herself. It brings an understanding of the client's experience to the opening minutes of a session.

Unlike other outcome scales, the ORS is not a list of symptoms or problems checked by clients or others on a Likert Scale. It is individually tailored by design. This requires that the counsellor 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 lowest the scale 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 counsellor needs to clarify the connection between the client's descriptions of the reasons for services and the client's marks on the ORS. 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. And that moment facilitates the next question: 'What do you think it will take to move your mark just one centimetre to the right; what needs to happen out there and in here?'

With the same client as above:

Therapist: If I am getting this right, you said that you are struggling with the divorce, specifically about why it happened and your part in it so you are looking to explore this and gain some insight into what perhaps was your contribution. You marked the Interpersonally scale the lowest [*Therapist picks up the ORS*]. Does that mark represent this struggle and your longing for some clarity?

Client: Yes.

Therapist: So, if we are able to explore this situation and reach some insights that resonate with you, do you think that it would move that mark to the right?

Client: Yes, that is what I am hoping for and that's what I think will help me. I know I wasn't perfect in the relationship and I want to understand my part. I already know his part!

The SRS (or CSRS) opens space for the client's voice about the alliance. It is given at the end of the meeting, leaving enough time for discussing the client's responses. Given that clients tend to score high on alliance measures, a total score below 36 signals the possibility of a problematic alliance and prompts a frank discussion about steps needed to increase client connection to the therapist and the process. Regardless of the score, the SRS focuses attention on the alliance, and therefore helps build strong ones.

After the first session, PCOMS simply asks: are things better? We are hoping for a six-point increase on the ORS, what is called a *reliable change*, or a six-point increase *and* crossing the clinical cutoff, what is called a *clinically significant change*. ORS 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 counselling, planning for continued recovery outside of therapy can start.

A more important discussion occurs when ORS scores are not increasing. The longer therapy continues without measurable change, the greater the likelihood of drop out and/or poor outcome. 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. Although addressed in each meeting in which it is apparent that no benefit is occurring, later sessions gain increasing significance and warrant additional action including referral of the client to another counsellor – what we have called *checkpoint conversations* and *last chance discussions* (Duncan, 2014).

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 sessions 3–6; 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 clients 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 therapy approach, or referring to another counsellor or venue of service such as a religious adviser or self-help group – whatever seems to be of value to the client.

CASE EXAMPLE

Ken

Ken, a 35-year-old construction supervisor, was convinced that he was going crazy because panic attacks were becoming ever more intrusive. He scored a 14.2 on the ORS at intake, indicating a high level of distress. Ken said he was at a loss about what to do and looked to the therapist for something to manage the anxiety. Trying to address his request, the therapist called up training in CBT (see Chapter 9, this volume) and strategic therapy and suggested a combination of relaxation training, challenging the beliefs that led to the panic, and some strategic monitoring (symptom prescription). But nothing happened, and none of these approaches seemed to resonate much with Ken – his scores on the ORS hovered around 14.

So, in the fourth meeting, the therapist and client renegotiated, via the *approach* scale on the SRS. Ken intimated that maybe he could try to understand why he was having panic attacks. Ken also shared during this quiet negotiation that in tough times he always talked to his dad, but his dad had passed away some 6 months before. He noted that he felt alone in his struggles, although he knew that really wasn't true because his wife was supportive and he had some good friends. The therapist enquired if Ken believed there was a connection between his father's death, his feeling of aloneness and the panic. Ken replied with tears, and a quiet yes.

A different kind of discussion ensued, drawing on the therapist's existential training (see Chapter 11, this volume), of not only Ken's confrontation of his own mortality but also the incredible dread that accompanies the realization of our essential aloneness in the world. A new theory of change evolved, one that seemed to make a lot of sense within the four big existential givens: death, freedom, isolation and meaninglessness. Ken found these conversations useful, and after four more meetings his panic attacks subsided and ultimately stopped; his ORS scores increased to 24.6 (a reliable change nearly to the clinical cutoff).

What PCOMS brought to the table is that it spotlighted the lack of change. Impossible to dismiss, it brought the risk of a negative outcome front and centre. Without the findings from the ORS, the therapist might have continued with the same strategies for several more sessions, hoping that these reasonable methods would eventually take hold. As it was, the evidence obtained through PCOMS pushed both Ken and the therapist to explore different options.

This story, of course, says nothing about the value of CBT, strategic, or existentially informed therapy – all approaches provide useful ideas to pursue. Rather, Ken's therapy illustrates that first identifying clients who are not responding, and then re-exploring the client's perspectives about change, things that resonate better with the client, can enable different, more fruitful directions. This is what pluralistic, or what we have called 'client-directed', counselling is all about.

LIMITATIONS OF PCOMS

Even though the research is compelling, most counsellors do not monitor outcomes. There are several reasons. First, finding out how effective you really are can be a risky business. You might learn something that you might not want to – but the only way to get better is to know where you are now versus where you would like to be; to aspire for the best results, and take action to get them. But the good news here is that we know it works. In our large feedback study with couples, 9 of 10 therapists improved their outcomes with feedback (Anker, Duncan, & Sparks, 2009).

Another reason is that, on the whole, counsellors don't like the idea of 'assessment' or numbers. But this is different because PCOMS invites clients into the inner circle, amplifying their voices in any decisions about their care. The numbers don't mean reducing clients to statistics. Rather, the numbers represent clients' own assessments of progress. Without them, clients' views do not stand a chance to be part of the real record – that is, critical information that guides moment-by-moment, week-by-week, decisions or evaluates eventual outcomes.

A third reason is that many believe they already know the information PCOMS is designed to provide. In fact, in the couple study (Anker et al., 2009), all 10 of the therapists indicated that they already informally acquired outcome and alliance information and, moreover, that systematic feedback would not improve their effectiveness. Nine of ten *did* improve their outcomes, so only one of them was correct.

Finally, a concern sometimes voiced before PCOMS is tried is that some clients won't want to do PCOMS. In truth, clients very rarely say 'no' to PCOMS when a sincere, authentic therapist conveys that the ORS and the SRS are to ensure their voice stays central as well as making sure they benefit. But the therapist has to believe that this is true and use the measures in a way that makes them meaningful to the work. If the ORS is treated as a perfunctory piece of paper that is not related to the therapeutic process, then clients will see it similarly. However, if the client persists in refusal after further clarification of the purpose of PCOMS, then it is likely best to move on with the session.

CONCLUSIONS

> At bottom every man [*sic*] knows well enough that he is a unique being, only once on this earth; and by no extraordinary chance will such a marvellously picturesque piece of diversity in unity as he is, ever be put together a second time.
>
> Friedrich Nietzsche

Routinely measuring outcome and the alliance with every client ensures that neither issue is left to chance. This allows both transparency and true partnership with clients, keeping their perspectives the centrepiece. 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 counsellor to step outside of business as usual, do new things and therefore continue to grow as a therapist. Finally, PCOMS improves focus on what matters most to the client both in terms of what needs to change outside of therapy as well as during the hour. Although it sounds like hyperbole, identifying clients who are not benefiting is the single most important thing a therapist can do to improve outcomes – 12 RCTs (both PCOMS and OQ System) now support this assertion.

But it requires the therapist to show up. If the counsellor doesn't authentically value clients' perspectives and believe that they should be active participants, PCOMS will fall flat. In addition, without therapist investment into the spirit of partnership of the feedback process, little gain is likely to happen. It's not enough to flick the forms in the face of the client – the feedback must be used and allowed to influence the work.

PCOMS and pluralistic practice call 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, 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, one must occasionally look at the results.

SUMMARY

The key points of this chapter are:

- Twelve RCTs (both OQ System and PCOMS) demonstrate that systematic feedback improves outcomes by recapturing clients who are headed toward a negative end.
- PCOMS is the only system that includes routine alliance monitoring and that is, by design, intended to be collaborative and transparent.
- PCOMS operationalizes a pluralistic approach (and social justice) by providing a methodology for individually tailoring counselling to client goals and preferences, and privileging client perspectives over model and theory.

EXERCISES/POINTS FOR REFLECTION

1 Download the PCOMS family of measures from heartandsoulofchange.com or pcoms.com. The measures are free for individual use. Simply click on 'Get measures' on the homepage, indicate your understanding of the License Agreement, register your email (no marketing materials sent), and download the measures in 24 languages.
2 Watch the free webinars at heartandsoulofchange.com. Click on 'PCOMS 101' on the cascading slide or on 'Training' on the menu. 'PCOMS Video' is a good place to start and includes the nuts and bolts of using the measures.
3 Reflect whether systematic feedback fits into your value system and can become integrated into your authentic practice of psychotherapy. PCOMS (or anything else) doesn't 'work' without your investment of yourself and your genuine desire to partner with clients and appreciate their feedback.

FURTHER READING

https://heartandsoulofchange.com. Contains more than 250 free resources including webinars, articles, chapters and slide handouts.

Duncan, B. (2014). *On becoming a better therapist: evidence-based practice one client at a time* (2nd ed.). Washington, DC: American Psychological Association. 'All in one' source for PCOMS, the common factors, and how to become a better therapist.

Duncan, B.L., & Reese, R.J. (2012). Empirically supported treatments, evidence based treatments, and evidence based practice. In G. Stricker & T. Widiger (Eds.), *Handbook of psychology: Volume 8: Clinical psychology* (2nd ed., pp. 977–1023). New York: Wiley. Comprehensive resource covering the controversy about evidence based treatments.

Duncan, B., & Sparks, J. (2010). *Heroic clients, heroic agencies: partners for change* (2nd ed.). Jensen Beach, FL: Author. Practical, how-to 'manual' for client-directed work and PCOMS that is consistent with a pluralistic approach. The first edition (2002) presented the original articulation of the clinical use of the ORS/SRS.

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