Using Technology to Enhance Clinical Supervision

edited by

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Chapter 9

Using PCOMS Technology to Improve Outcomes and Accelerate Counselor Development

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However beautiful the strategy, you should occasionally look at the results.
—Sir Winston Churchill

In the not too distant past, the only discussion of client outcomes was in the context of psychotherapy efficacy studies. And that was unbelievably confusing, leaving many with the idea that measuring outcomes had no applicability to everyday practice. Then in the late 1990s, a new era was ushered in by the pioneering work of Michael Lambert and the Outcome Questionnaire 45.2 (Lambert et al., 1996). Over time, Lambert demonstrated not only that monitoring client-reported outcomes enhanced client benefit but also that getting feedback from clients could be a routine part of counseling. In other words, measuring outcomes was not just for researchers anymore—it was for frontline counselors and supervisors.

This process, called *systematic client feedback,* refers to the continuous monitoring of client perceptions of progress and the counseling alliance throughout the course of counseling. It involves real-time comparison of client views of outcome with an expected treatment response (ETR), which serves as a yardstick for gauging client progress and signaling when change is not occurring as predicted. With this alert,

[1]Barry L. Duncan is a coholder of the copyright for the Partners for Change Outcome Management System (PCOMS) instruments. The measures are free for individual use at https://heartandsoulofchange.com, but Duncan receives royalties from licenses issued to groups and organizations. In addition, the Web-based applications of PCOMS, MyOutcomes.com and BetterOutcomesNow.com, are commercial products, and he receives either royalties or profits based on sales.

counselors and their clients have an opportunity to shift focus, revisit goals, or alter interventions before deterioration or dropout. Technological advances in data collection have enabled the expansion of client feedback to the supervision process.

The general purpose of supervision is to promote the developmental needs of the supervisee and ensure that clients receive ethical and competent treatment (Bernard & Goodyear, 2014). Achieving this balance can be a challenge. Holloway and Neufeldt (1995) suggested that more emphasis is typically placed on the interpersonal processes and development of the supervisee in supervision. Similarly, in the empirical literature on supervision, much more research has focused on supervisee development and the supervision process compared to investigating how supervision translates into client benefit (Lambert & Hawkins, 2001; Watkins, 2011).

Clinical supervision is a distinct competence area, and yet there is little research to address a fundamental question first posited by Stein and Lambert (1995), namely, Does supervision matter? For example, Watkins (2011) identified 18 studies on the efficacy of supervision (1981–2011). He noted that only three studies were methodologically worthy of mention, and two of them were conducted with psychiatric nurses and yielded mixed results. The remaining study, Bambling, King, Raue, Schweitzer, and Lambert (2006), was the only randomized controlled trial (RCT) that evaluated the impact of supervision on client outcome. Experienced therapists ($N = 127$) were randomly assigned to a supervision or no-supervision condition. Therapists in the supervision condition had significantly higher alliance scores, and their clients had significantly lower scores on the Beck Depression Inventory. Client dropout rates were also significantly lower in the supervision condition. The results of this study are encouraging, but the lack of a larger research focus in this area is surprising given the centrality of supervision to training and ultimately performance.

Technology and routine collection of client feedback could provide the means to move supervision more toward outcomes and therefore holds great promise for both client benefit and counselor development. It also could allow for a more focused research direction that could finally answer the question of whether supervision actually matters where it counts most—client benefit. Research on technology-assisted supervision to date, however, has focused on evaluating whether it can approximate the experience of traditional supervision (Rousmaniere, 2014), and therefore, like the traditional literature, has largely ignored client outcomes.

This chapter describes a way that supervision technology can address Stein and Lambert's (1995) question in both practice and research via systematic client feedback. Although several systems are available that collect and analyze data (see Rousmaniere, 2014, for a review), only two are designated as evidence based: Lambert's Outcome Questionnaire System (Lambert, 2010) and the one presented in this chapter, the Partners for Change Outcome Management System (PCOMS; Duncan, 2012, 2014; Duncan & Reese, 2013). After a summary of PCOMS practice and empirical support, including its application to supervision, available technology is reviewed and its benefits detailed. We assert that supervision enhanced by PCOMS technology strikes a balance between supervisee and client benefit and offers an objective way to answer whether supervision matters, allowing the field to move beyond wishful thinking and best intentions. We describe a four-step supervisory process designed to empower client voice, improve outcomes, and accelerate counselor development regardless of experience level or model practiced.

PCOMS[2]

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 boils down to this: partnering with clients to identify those who are not responding to counselor business as usual and addressing the lack of progress in a positive, proactive way that keeps clients engaged while new directions are collaboratively sought. PCOMS embraces two known predictors of ultimate treatment outcome. Time and again, studies have revealed 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 counseling or will end up on the dropout list. Monitoring change provides a tangible way of identifying those who are not responding so that a new course can be charted. Another robust predictor of change solidly demonstrated by a large body of studies is the therapeutic alliance (Crits-Christoph, Connolly Gibbons, & Mukherjee, 2013). Clients who rate their partnerships with their counselors highly are more apt to remain in therapy and benefit from it.

PCOMS is a light-touch, checking-in process that usually takes about 5 minutes but never more than 10 to administer, score, and integrate into the counseling. 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 therefore its feasibility for everyday use in the demanding schedules of frontline counselors, PCOMS is distinguished by its routine involvement of clients in all aspects: Client scores on the progress and alliance instruments are openly shared and discussed at each administration. Clients' views of progress serve as a basis for beginning 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.

The Outcome Rating Scale (ORS) and Session Rating Scale (SRS)

PCOMS starts with the ORS (Miller, Duncan, Brown, Sparks, & Claud, 2003), which is given at the beginning of a session and provides client-reported ratings of progress. The ORS is a visual analog scale consisting of four 10-cm 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. Counselors 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.

Unlike other outcome scales, the ORS is not a list of symptoms or problems checked by clients on a Likert scale. It is individually tailored by design, requiring the counselor to 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 counseling work. This enables the counselor and

[2]For more information about PCOMS, visit https://heartandsoulofchange.com or www.pcoms.com. This website contains more than 250 free resources, including webinars, articles, chapters, and slide handouts about PCOMS and the common factors.

the client to be on the same page 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, leading to the next question: What do you think it will take to move your mark just 1 centimeter to the right? What needs to happen out there and in here?

The SRS (Duncan et al., 2003), a 4-item visual analog scale covering the classic elements of the alliance (Bordin, 1979), is given toward the end of a session. Similar to the ORS, each line on the SRS 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 honest opinions about their connection to their counselor and to counseling.

After the first session, PCOMS simply asks, Are things better or not? ORS scores are used to engage the client in a discussion about progress and, more important, what should be done differently if there is not 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, Solovey, & Rusk, 1992). When clients have reached a plateau or what may be the maximum benefit they will derive from service, planning for continued recovery outside of counseling can start. This could mean just reducing the frequency of meetings and monitoring 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 longer counseling continues without measurable change, the greater the likelihood of dropout and/or poor outcome. The ORS gives clients a voice in all decisions that affect their care, including whether continuing in counseling 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. Although this is 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 counselor—what we have called *checkpoint conversations* and *last chance discussions* (Duncan, 2014). These are also points that indicate supervisory input.

In a typical outpatient setting, checkpoint conversations are conducted in 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 three to six sessions and that if change is not noted by then, the client is at risk for a negative outcome. The same goes for Sessions 6–9, except that the urgency is increased, hence the term *last chance.* Software and Web technology provide for a more sophisticated identification of clients at risk by comparing a client's progress to the ETR 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; try-

ing another approach; or referring to another counselor or service, such as a religious advisor or self-help group—whatever seems of value to the client.

Occasionally Looking at the Results: Empirical Support for PCOMS

PCOMS is a designated evidence-based practice by the Substance Abuse and Mental Health Services Administration (http://nrepp.samhsa.gov/ViewIntervention.aspx?id=250). But PCOMS is not a specific treatment model for a specific client diagnosis (Duncan & Reese, 2012). It is atheoretical and therefore may be added to or integrated with any model of practice, and it applies to all diagnostic categories. Collecting client feedback monitors whether *this* approach provided by *this* counselor is benefiting *this* client. It provides a seemingly contradictory way of becoming evidence based across all clients while tailoring services to the individual client's needs, preferences, and culture—*evidence-based practice one client at a time* (Duncan, 2014).

All five RCTs that have used PCOMS to investigate the effects of feedback were conducted by those affiliated the Heart and Soul of Change Project (https://heartandsoulofchange.com).[3] Three trials are discussed here, addressing individual, couples, and group psychotherapy. Reese, Norsworthy, and Rowlands (2009) found that individual clients in a PCOMS condition showed significantly more reliable change in significantly fewer sessions than treatment-as-usual (TAU) or nonfeedback clients. Anker, Duncan, and Sparks (2009), in the largest RCT of couples therapy to date, randomized 205 couples to PCOMS or TAU. Feedback clients achieved clinically significant change nearly 4 times more than TAU couples, and in more than twice as many feedback couples, both individuals achieved reliable and/or clinically significant change (RCSC). Regarding group psychotherapy, Schuman, Slone, Reese, and Duncan (2014) conducted an RCT (N = 263) of soldiers returning from Iraq and Afghanistan and active-duty soldiers struggling with alcohol and drug problems. Soldiers in the feedback condition achieved significantly more improvement on the ORS, higher rates of clinically significant change, and higher ratings of success from both clinicians and commanders and attended significantly more sessions than TAU.

A meta-analysis (Lambert & Shimokawa, 2011) of PCOMS studies found that those in a feedback group had a 3.5 higher odds of experiencing reliable change and less than half the odds of experiencing deterioration. Finally, PCOMS has been demonstrated to be a viable quality improvement strategy. A benchmarking study (N = 5,179) of a large public behavioral health agency (Reese, Duncan, Bohanske, Owen, & Minami, 2014) that implemented PCOMS found comparable outcomes with RCTs of both depression and feedback.

Client Feedback in Counseling Supervision

The use of client feedback data in supervision has been suggested as a way of addressing the lack of focus on client outcome in both practice and research (Reese, Usher, et al., 2009; Sparks, Kisler, Adams, & Blumen, 2011; Worthen & Lambert, 2007). Lambert and Hawkins (2001) were the first to suggest that su-

[3]The Heart and Soul of Change Project is a training and research initiative that focuses on what works in therapy and, more important, how to deliver it on the front lines via client-based outcome feedback, or PCOMS.

pervision could use client outcome data as a means of discussing client progress and informing future treatment. Furthermore, they asserted that client outcome data could help shape how time in supervision was spent, providing information to both facilitate training and ensure that clients were benefitting.

Other advantages of using client data are also apparent for both supervisees and supervisors. Specific to supervisees, particularly those early in training who are often uncertain of where to start, the use of the ORS readily identifies what is most salient to the client and helps frame the session. Beginning counselors also want to know if they are being helpful to clients, often asking,"Am I any good at this?"Utilizing outcome and alliance data provides a specific means of broaching this question. Without outcome feedback, a trainee could complete his or her training without really having an answer beyond some general notion. More troubling is that a counselor may not have an answer over the course of an entire career!

From a supervisor perspective, using client outcome and alliance data in supervision makes more efficient use of supervision time. Accurately assessing a supervisee's caseload can be challenging and time consuming when one is working with multiple supervisees. PCOMS data provide a quick dashboard indicator (see below) for a supervisee's client load and can quickly identify clients who require more attention. Not only can using client outcome and alliance data provide key information for assisting supervisees who are struggling with clients, it can also highlight and reinforce the growth of supervisees with clients who are faring well in therapy.

Outcome data also grant supervisors more direct access to trainees' performance. For example, in many practicum settings, supervisees are not allowed to record sessions. Supervisors are then left to rely on the trainee's perspective. Research has consistently shown that therapists, regardless of experience, have difficulty judging whether their clients are deteriorating (e.g., Hannan et al., 2005). This difficulty is perhaps exacerbated by any evaluative context in which supervisees may tend to present their performance in a positive light.

Another advantage for supervisors is that PCOMS helps provide data-based feedback to supervisees. Effective supervision is generally assumed to require both positive and challenging feedback (Falender & Shafranske, 2004). Worthen and Lambert (2007) reasoned that the use of client outcome data may foster specific supervisory feedback that is value neutral given that it was derived from the client. This subtle shift may allow for responses from the supervisor that seem more collaborative rather than evaluative, and feedback may perhaps be better heard given that it arises from clients rather than just the supervisor's opinion.

[AU1] Two studies examined PCOMS in supervision. Reese et al. (2009) assigned trainees (n = 28) to either a feedback condition (client feedback was used and the results were discussed with the supervisor) or a no-feedback condition (client feedback was not used). Trainees in both conditions demonstrated significant improvement in client outcomes (client sample, n = 110), but those in the feedback condition exhibited almost twice as much. The supervisees in the feedback condition also demonstrated more improvement across their caseloads from fall to spring semester. In a follow-up study, Grossl, Reese, Norsworthy, and Hopkins (2014) isolated the influence of using client feedback data in supervision. In all, 44 trainees were randomly assigned to a supervision condition in which client feedback data were discussed or a supervision-as-usual condition. All

trainees used feedback with their clients. No significant differences were found on client outcome, but trainees in the feedback supervision condition reported increased supervision satisfaction when discussing the data.

PCOMS Supervision and Technology

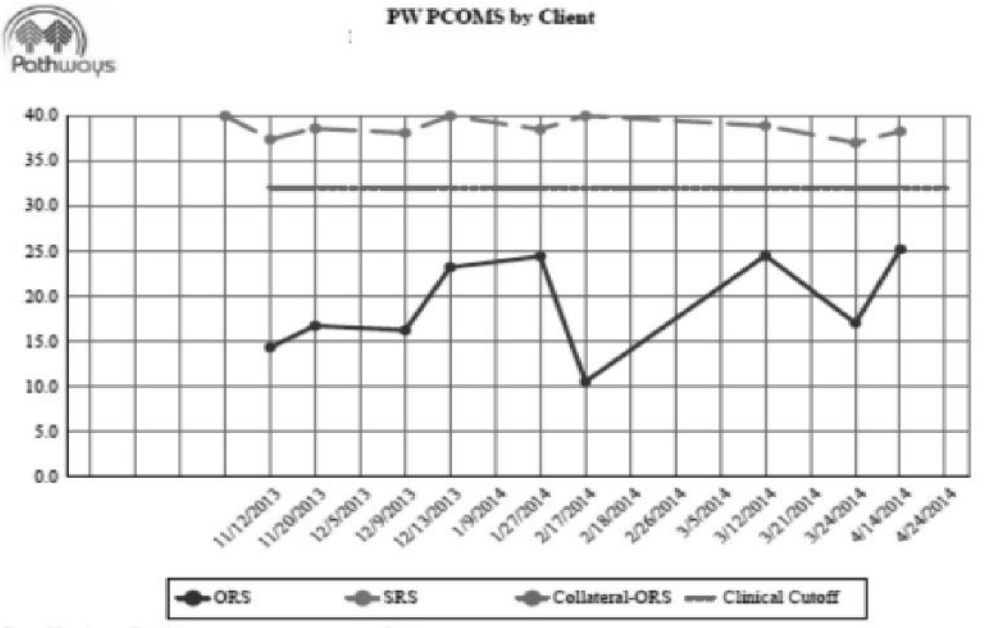
> *To exchange one orthodoxy for another is not necessarily an advance. The enemy is the gramophone mind, whether or not one agrees with the record that is being played at the moment.*
>
> —George Orwell

Although counselors can use paper-and-pencil versions of the PCOMS measures and can manually graph ORS scores, not having the ability to systematically identify clients at risk and aggregate outcome data over time limits the benefits of PCOMS. Technology brings unlimited advantages to the table via the ability to collect and analyze practice data and make it immediately available to both frontline counselors and supervisors. Technology allows for a real-time, positive methodology for supervision and research to address both client benefit and counselor growth. PCOMS technology is used in mental health and substance abuse training institutions and settings across the United States and in 20 countries, with more than 1.5 million administrations in its database.

Using technology in supervision does not have to be complicated or expensive. Excel offers a viable way to get started. Simply enter anonymized ORS data into an Excel file. Supervisors can review Excel spreadsheets, looking at first- and last-session ORS scores and number of sessions to identify clients who are not benefitting for supervisory discussion. The downside is that the data will have to be entered by someone, usually the counselor, so there is an increase in workload. However, Excel allows the ability to graph, track outcomes over time, and calculate key performance indicators, which is invaluable for helping supervisees improve with experience. Excel can calculate average intake and final-session scores, number of sessions, dropout rates (more on this later), average change score (the difference between average intake and final-session scores), and, ultimately, effect size and the percentage of clients who reach RCSC. These performance indicators provide a detailed look at both clients who are not benefitting and the supervisee's performance over time.

Reliable change is 6 points on the ORS, and clinically significant change is a 6-point change on the ORS plus crossing the clinical cutoff (25 for adults), the score that differentiates a clinical from a nonclinical population. Average change on closed cases provides a ready snapshot of how things are going. If average change is 6 points or more, it means that on average clients achieve reliable change from their encounters. The percentage of clients who achieve RCSC provides an easily understood metric of effectiveness and a good way to track supervisee development over time. Effect size is another way to understand change.

There are easier ways to identify at-risk clients and track supervisee outcomes, but they do involve some cost. Most agencies and university clinics use some variety of electronic health record. These programs (see Figure 9.1) often have open data fields as well as graphing and data analysis functions. Consult your information technology department, if you have one, or the electronic health record company to see whether ORS scores can be entered, graphed, and



Pathways

Client	# of Sessions	Consecutive Sessions No PCOMs	# PCOM Notes	Initial Ors	Last Ors	ORS Above Cutoff	Initial C-Ors	Last C-Or
256077 -	7	2	7	24.8	28.5	0		
258370 -	8	3	8	19.8	30.3	0		
295509 -	9	2	9	29.4	30.7	0		
299158 -	9	1	9	17.9	17.9	0	8.0	8.0
310577 -	3	1	3	29.0	29.0	0		
402591 -	16	3	16	31.0	30.1	0	14.2	14.
407205 -	10	0	10	28.5	30.0	0		
408101 -	9	1	9	36.4	33.4	0		
410310 -	9	1	9	25.8	35.2	0		
414331 -	1	1	1					
416581 -	2	2	2					
420054 -	8	0	8	11.0	35.2	0	24.0	24.
421947 -	2	2	0					
422166 -	12	0	12	39.3	24.3	0		
424891 -	3	3	3					
425337 -	14	2	8	27.1	16.8	0	21.3	21.
427269 -	13	2	7	33.7	25.8	0		
428296 -	1	1	1					
430389 -	13	0	13	28.5	11.4	0		
434497 -	13	0	13	25.5	20.3	0		
435332 -	7	0	7	39.2	32.2	2	31.2	31.
439133 -	6	1	6	36.9	21.3	0		
444819 -	4	0	4	38.0	34.5	1		

[AU2]

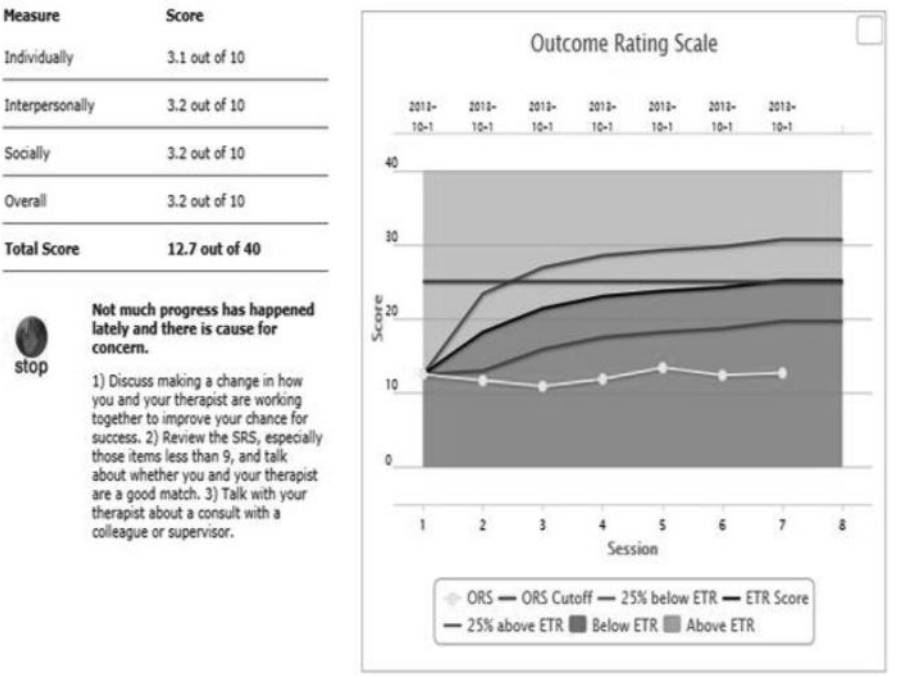
Figure 9.1

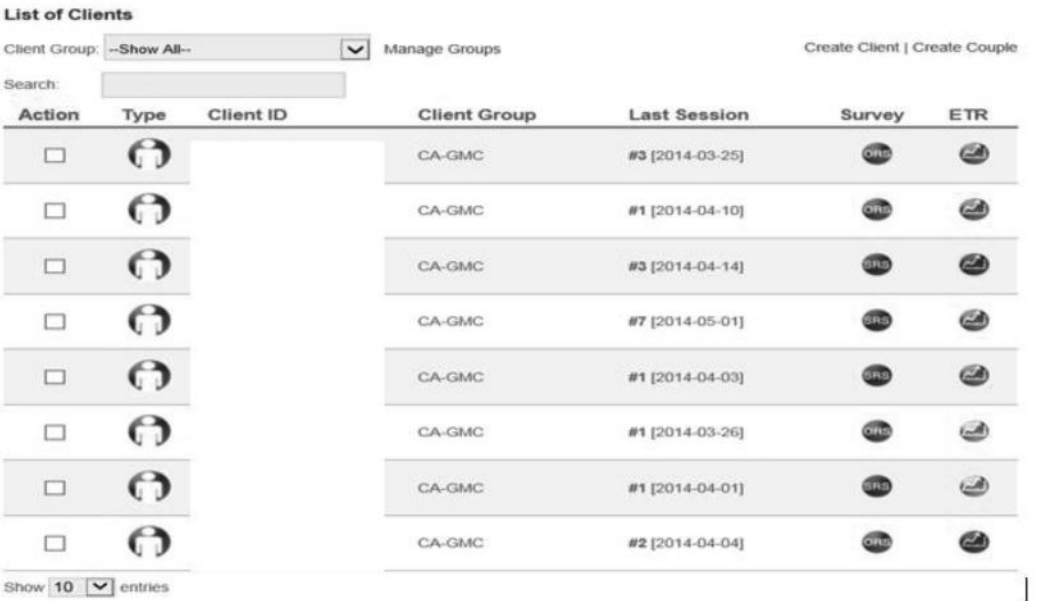
PCOMS Integrated Into Electronic Health Records at Pathways, Inc.

Note. The top depicts the graphing of Outcome Rating Scale and Session Rating Scale data. The bottom is the client list showing number of sessions and first and last Outcome Rating Scale scores. PCOMS = Partners for Change Outcome Management System.

analyzed to yield average change, percent reaching RCSC, and effect sizes. A summary page or client list that includes first- and last-session ORS scores and number of sessions provides all of the necessary ingredients for supervisors to identify clients needing attention. This could involve programming costs. Such a system would not administer the measures or include the algorithms discussed below unless a license were purchased to include these elements.

There are also Web-based systems of tracking outcomes: MyOutcomes.com (see Figure 9.2) and BetterOutcomesNow.com (see Figure 9.3). Both systems include tablet and phone applications and administer the measures, compare the client's progress to the ETR, graph the scores, and aggregate the data at counselor





[AU2]

Figure 9.2

The PCOMS Web Application MyOutcomes.com

Note. The top depicts the graphing of Outcome Rating Scale and Session Rating Scale scores as well as the feedback message. The bottom is the client list with icons identifying clients at risk. PCOMS = Partners for Change Outcome Management System.

and organizational levels. Everything therefore is automated, which places minimal burden on clients, counselors, and supervisors. Both systems identify clients who are not benefiting from treatment and enable a wide range of data collection and statistical reporting possibilities. The single bit of information that is likely the easiest to understand and use is the percentage of clients who reach the target. That is simply the percentage of clients who reached or exceeded the average change trajectory, or ETR, for clients entering services with the same intake score based on the database of administrations of the ORS. Tracking either or both percentage of target or RCSC provides an ongoing commentary about effectiveness.

Dropout is also an important outcome to monitor in supervision. *Dropout* is a rather pejorative description. It places the onus on the client and essentially blames him or her for not attending some unspecified number of sessions. Client benefit seems a far better way to look at clients who have not returned for service. What we are trying to avoid is the client who discontinues service, in an unplanned way, without experiencing reliable change or the ETR target. If it is planned, then we have referred the client to another provider or venue of service; if it is unplanned but the client has reached target benefit or reliable change, then that is okay too.

Supervision for a Change (in Both Clients and Counselors)

Client feedback increases in value exponentially and consumer privilege becomes a reality when ORS scores extend past the counseling session to supervision and are used to proactively address those who are not responding. A four-step supervisory process (Duncan, 2014; Duncan & Sparks, 2010) focuses first on ORS-identified clients at risk and then on individual counselor effectiveness and development. Based on outcome data instead of theoretical explanations or pontifications about why clients are not changing, supervision is aimed at identifying clients who are not benefiting so that services can be modified in the *next* session. This type of supervision is a departure from tradition because rather than the supervisee choosing who is discussed, the clients are choosing themselves by virtue of their ORS scores and lack of change. So the ORS brings the client's voice into supervision as well.

An important initial step in using data in supervision is building a culture around numbers and data. For those who have statistics as part of their training, the reporting parameters will be familiar. For those who do not, the numbers can be daunting. Helping supervisees to become comfortable with simple statistics and to love their data encourages further exploration and reflection. Building a culture of comfort about the data includes helping counselors understand that the numbers do not mean reducing clients to statistics. Rather, the numbers represent clients' own assessments of their progress. Without them, clients' views do not stand a chance of being part of the real record—that is, critical information that guides moment-by-moment, week-by-week decisions or evaluates eventual outcomes. Numbers on the measures, as concrete representations of client perspectives, offer a direct way of describing client benefit at counselor and agency levels.

Step 1. Counselor Fidelity and Data Integrity: Supervisee and Supervisor Review the Excel Spreadsheet, Electronic Health Record, or Web-Based Client Lists

The first order of business of supervision is to ensure counselor fidelity and data integrity. If this is not done, PCOMS will not do its job of identifying cli-

ents at risk or tracking and accelerating counselor development. PCOMS is somewhat paradoxical. On the one hand, it uses two 4-item instruments that could not be more simple and straightforward. On the other hand, there are nuances involved that must be implemented by the supervisee for the data to be valid. There are three indicators of data integrity. The first is the percentage of intake scores that are over the clinical cutoff. If more than 30% of intakes are over the cutoff, it is likely that the counselor is not introducing the ORS so that the client understands it and/or is not connecting it to the work of counseling. If the supervisee primarily works with mandated clients or youth, then the percentage over the cutoff will be higher.

Second, scores 35 and higher are rarely valid. People generally leave some room for improvement on the ORS. There are two reasons that clients score so high—either they do not understand the measure, or they are angry and blowing it off. Both are training issues and easily addressed. The supervisor has to make sure the counselor knows how to introduce the ORS and integrate it into the work. The supervisee may need coaching regarding how to follow up with a high score to make sure that it matches the client's descriptions of his or her experience of life. Connecting clients' marks to their reasons for service provides assurance that the scores will be a valid representation of client distress.

Finally, the third scenario that quickly reflects improper use of PCOMS is the seesaw pattern, in which the client's scores go up and down week to week. This typically means that the client does not understand that the measure is designed to monitor progress about the reasons for service, not how he or she feels that day or how life is going week to week; in other words, the ORS has become an emotional thermometer. Here the supervisee needs coaching to ensure that the ORS is integrated into the work and that the client views the measure as a reflection of how counseling is addressing, for better or worse, the reasons for service.

The data quickly highlight these training needs so that the supervisor can focus on the skills necessary for data integrity. The PCOMS Provider Adherence Scale (https://heartandsoulofchange.com/content/training/) lists the competencies required of counselors. Supervision that holds counselors accountable on these data validity parameters allows PCOMS to do what it was designed to do. For example:

Supervisor: In looking over your ORS scores, I am noticing a couple of things that are concerning regarding data integrity. Let's start with this client who scored a 37.2 at intake. Can you tell me about this client please?

Supervisee: Sure, this client is struggling with an abusive relationship and is considering whether or not she should leave. She . . .

Supervisor: Let me stop you there. Where is her distress about that very troubling situation reflected in her ORS score?

Supervisee: I guess it's not.

Supervisor: Do you see her as being in distress?

Supervisee: Yes, very much so.

Supervisor: Okay, great, so it is your job to make sure that her score on the ORS matches her presentation, that it accurately represents her experience from her point of view. First, let's look at how you are introducing the ORS and how you are explaining the clinical cutoff. Perhaps a role play would help us.

Step 2. Identification of At-Risk Clients and Shaping of the Conversation: Supervisor and Supervisee Review Nonresponding Clients, and Supervisor Guides the Discussion Toward Developing a New Plan

Once data integrity is consistent, the focus in supervision turns to those clients who are not benefiting. To use the data to their full advantage, supervisors will need to get over any squeamishness about ETR curves or reading graphs in general. The ETR is the average trajectory of clients entering counseling with the same intake score (see Figures 9.2 and 9.3). The ETR is what is hoped to occur if counseling is successful. Both Web systems automatically identify clients at risk on the individual counselor's list of clients. Clicking on those clients and reviewing the graphs provides the story of the client's counseling at a quick glance. If using Excel or an electronic health record system, the supervisor can identify those clients who have not reached a reliable change on the ORS and look at the graphs from there.

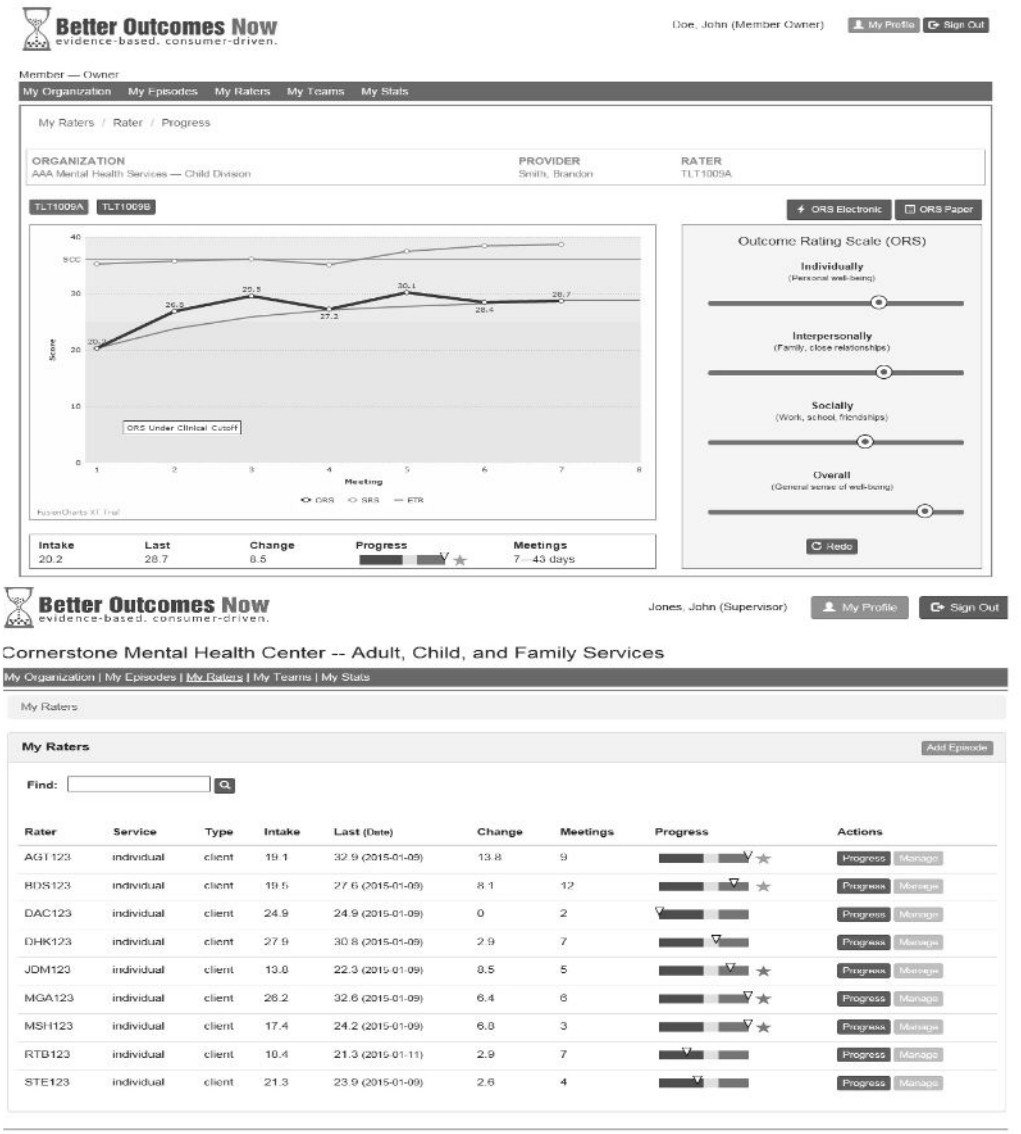
Supervision focuses on those clients who have been receiving counseling the longest without benefit. As supervision progresses over time, such clients will decrease, allowing for earlier delineation of and dealing with at-risk clients. Each at-risk client is discussed, and options are developed to present to clients, including the possibility of consultation with or referral to another counselor or service. This is perhaps the most traditional role of supervision, but here there are objective criteria to identify at-risk clients as well as subsequent ORS scores to see whether the changes recommended by the supervisory process have been helpful to the client.

To maximize efficiency and enable multiple consumers to be addressed, it is helpful for the supervisor to shape the way that supervisees present nonresponding clients. The goal is for counselors to leave supervision with a plan to do something different with the clients in question. Steering the conversation away from why clients are not changing to what can be done differently is harder than it sounds. Our field [is] very good at explaining why clients do not change (usually related to client psychopathology). The supervisory process, when based on outcome data, eschews such explanations in favor of these questions:

- What does the client say about the lack of change?
- Is the client engaged in purposive work to address the problems at hand in ways that resonate? In other words, what does the SRS say about the alliance?
- What have you done differently so far?
- What can be done differently now? Have you exhausted your repertoire?
- What other resources can be rallied now from both your support system and the client's?
- Is it time to fail successfully (i.e., to transfer the client to another counselor)?

When supervisees come prepared to answer these questions, many clients can be discussed. It only takes encouragement and follow-through to implement, and of course holding supervisees accountable for knowing this information.

This process is intended to be the antidote for blaming clients or counselors. Not all clients benefit from services. No counselor serves all clients. Lack of client response to a given counselor is the reality of providing services. If the field accepts that without blame to the client or counselor, it can move on to the more productive conversation of what needs to happen next to enable the client to benefit.



[AU2]

Figure 9.3

The PCOMS Web Application BetterOutcomesNow.com

Note. The top depicts the graphing of Outcome Rating Scale and Session Rating Scale scores and progress summary. The bottom is the client list with a progress meter identifying clients at risk in yellow and red. PCOMS = Partners for Change Outcome Management System.

This acceptance includes the ability to transfer clients without shame or blame. For example, chief operating officer, supervisor, and licensed mental health counselor at the Center for Family Services Barbara L. Hernandez reported that practicum students, interns, and experienced counselors alike welcome this process after initial concerns of vulnerability are assuaged (Duncan, 2014). In addition, she said that recognizing that clients will ultimately benefit from the transfer appeals to counselors' best intentions: Once counselors see that these transfers most often conclude with client benefit (about two thirds of transferred

clients achieve ETR), both those they transfer and those they receive, the benefits become manifest. Finally, Hernandez noted that given that these transfer situations are often breaking new ground, they provide many opportunities for counselor growth via the supervisory process. For example:

Supervisor: Okay, looks like we are still struggling with this client . . . he's been in counseling for nine sessions and still not realized any benefit. [Supervisee and counselor look at the graph of this client] What does the client say at this point?
Supervisee: Well, he is pretty much at a loss and doesn't have any other ideas. He feels pretty hopeless, which goes along with his overall presentation of feeling very depressed.
Supervisor: What do you think about the alliance? Is the client engaged and working in your counseling?
Supervisee: Definitely. SRS scores are good, and I know that he trusts me.
Supervisor: Great. Please summarize for me what you have done so far to try to turn things around. We have discussed this client before and have tried a couple of different plans.
Supervisee: Well, I started working with him from a more cognitive perspective, but after discussion with the client, that didn't seem a very good fit, and he thought, for lack of a better word, a more humanistic approach might help. A couple of supervisions ago, we developed a plan to more specifically identify the key factors he thought were contributing to his depression based on his lowest score on the ORS being on the interpersonal domain. We did that, and I thought we were on the right track, but the client didn't want to bring in his partner. And our discussions about the malaise in his relationship haven't resulted in any changes.
Supervisor: Do you think that you have gone as far as you can go with this client?
Supervisee: Yes.
Supervisor: Okay, let's look at what we can do to bring in more resources from your side. We can have a colleague of yours sit with you to interview your client, or perhaps a team, or I could sit with you and see if the new blood might stimulate a different kind of conversation and generate new leads. And I know you have discussed with the client that another counselor may be a better fit, so it is also time to revisit that discussion as a real possibility. Make sense?

Step 3. Statistics and Counselor Development: Supervisor Reviews Supervisee Performance Indicators, Discusses Ways to Improve, and Encourages Action

Although most of the supervision hour applies to improving services to clients, the final two steps shift attention from the client to the supervisee, drawing on Orlinsky and Rønnestad's (2005) sources of counselor development. A focus on *career development,* or the improvement in counseling skills, increasing mastery, and gradual surpassing of past limitations, is ready made for PCOMS supervision technology. ORS data provide an objective way of knowing whether career development is actually happening as well as the impetus for the counselor to take charge of it. Supervision provides the structure and encouragement to

monitor and accelerate supervisee development via a transparent discussion of counselor effectiveness.

Supervision then promotes the open discussion of statistics with the intent of codeveloping a plan for improvement. It starts with helping the supervisee to understand the statistics and the key performance indicators and how they will be used to monitor effectiveness and development over time. Recall that perhaps the easiest statistic to consider is the percentage of clients who attain RCSC, or who achieve ETR if one is using an electronic system. Comparing this statistic to a previous period of time of closed cases gives a quick look at overall performance and development. It is important to remind supervisees of the realities of practice: First, the very best clinicians in some studies achieve about 44% RCSC rates (Okiishi et al., 2006); and second, wherever he or she starts, it is just that—a beginning point. By discussing the statistics transparently, supervisors encourage counselors at every level of experience to use the data for their specific benefit. In so doing, supervisees work through any fear of numbers and looking at their performance. Over time, counselors will monitor their own statistics and use the information to improve their practice.

From the frank discussion of statistics and the supervisee's ideas about improvement, a plan is formed for the counselor to be proactive about his or her development. The plan is then implemented, monitored in supervision, and modified if outcomes are not improving. For example:

Supervisor: I know you have a good handle on these performance indicators, and given that you have been here for a while and accumulated some closed clients, we can look at your effectiveness stats. So based on your 30 closed clients in your Excel file, your average change is 4.5 and your RCSC rate is 37.6%.

Supervisee: That doesn't look so good.

Supervisor: Not really. It's a pretty good starting point. Remember the studies of counselor effectiveness we have discussed—you are not that far off the pace. Also keep in mind that you are very likely to see a bump in effectiveness because you are now identifying clients who are not benefiting in a consistent way.

Supervisee: That's true. So you think the next 30 will be better?

Supervisor: I do. What else do you think might enhance your outcomes?

Supervisee: Well, I don't think I am that great at forming alliances with clients who present more affectively. I am better at cognitive stuff.

Supervisor: Okay great, let's look at ways that you might get better at that.

Step 4. Mentoring and Professional Reflection: Supervisor Mentors via Skill Building, Harvests Client Teachings, and Encourages Ongoing Reflection About the Work and Counselor Identity

This final component brings the supervisor more actively into the process of accelerating counselor development. Supervision can provide the context for building skills in a variety of areas that are identified in the counselor's improvement plan, from specific models to alliance skills to understanding clients from a variety of conceptual vantage points. Here any number of ways to build skills can be used, from focused video reviews to role plays to article discussions.

More important, this aspect of supervision sets the stage for harvesting client teachings and enhancing the most powerful influence on development identified by Orlinsky and Rønnestad (2005), the counselor's sense of *current growth.* Here the supervisor inquires about what has been learned from successful and unsuccessful clients, about anything that happened that was new or different, and about the supervisee's thoughts about his or her identity—helping the counselor experience current growth, value the daily work with clients and the opportunities for development and replenishment they offer, and stay invested in the work he or she loves.

It is important to incorporate discussion/reinforcement of what the supervisee is doing right with clients who are progressing. Such inclusion promotes development by encouraging supervisees to understand what their role is in client improvement. This can stimulate confidence and can help supervisees discover their approach or style in counseling. The process begins with asking these questions about clients who are progressing:

- What is working with these clients?
- What is client feedback telling you about progress and the alliance?
- How are you interacting with these clients in ways that are stimulating, catalyzing, or crystallizing change?
- What are these benefiting clients telling you that they like about your work?
- What are they telling you about what works?

And asking questions about the clients who are not benefiting:

- What is working in the conversations about the lack of progress?
- What is client feedback telling you about progress and the alliance?
- How are you interacting with these clients in ways that open discussion of other options, including referral?
- What are these not-benefiting clients telling you that they like about how you are handling these tough talks?
- What are they telling you about what works in these discussions?
- What have you done differently with these not benefiting clients? How have you stepped out of your comfort zone and done something you have never done?

The idea here of course is not punitive in any way; rather, the aim is to promote professional reflection and encourage continued growth. Clients who are not benefiting provide the best opportunities for accelerating development and for encouraging supervisees to do things they have never done and embrace the uncertainty endemic to the work as to life. For example:

Supervisor: Your data and your reflections suggest that a lot of things are going well for you. I was wondering if you did anything different since the last supervision when a client wasn't benefiting that stands out?

Supervisee: Yeah, that client we discussed earlier in supervision who wound up benefitting, there is a story there for sure. She hadn't said much when I asked her for her ideas when we were stuck, so I kept coming up with new plans, really very structured ways for us to pursue her feeling unassertive

and unhappy. I don't know why, but she finally spoke up when I asked her what she thought about her lack of progress, and she said something that really blew me away. She said she wondered if we didn't have such a concrete plan but explored more what was bothering her, that maybe something might come out of that.

Supervisor: Wow! That seems really important, especially given that she had identified her unassertiveness as a concern.

Supervisee: Yes, and during our conversation about what was bothering her, her job became much more prominent in the mix of things, which actually was reflected on the ORS on the social domain. And right in the middle of the conversation, the client said that she needed to get a different job and get a new start where people didn't already have her pegged as a loser. She smiled immediately when she said that. And as you know, she did just that and her ORS scores went up substantially.

Supervisor: So how was that different for you? What do you take from that experience?

Supervisee: I guess I am used to taking the lead in figuring out what to do, and perhaps I haven't been as collaborative as I thought in the counseling process. This was definitely different. This time I allowed things to emerge rather than following a set way to work or a defined strategy.

Supervisor: Very cool. Seems like you learned the value of shared responsibility, purpose, and true collaboration.

Supervisee: I think so. I think I also learned that not everything has to be structured, that sometimes not knowing what to do can be a good thing.

Supervisor: Amen to that. What do think this says about your identity as a counselor?

Supervisee Feedback and Future Research

When we mention client feedback in supervision, it is often assumed that we mean adapting the PCOMS measures for supervision. Monitoring supervision processes and outcomes similar to counseling sessions makes intuitive sense. Yet the question is: What is your purpose? Supervision and counseling are different endeavors with their own unique processes and outcomes. Although there may be some overlap, supervision is not counseling. Monitoring client outcome and the alliance was developed to prevent premature termination, improve outcomes, and foster working collaboratively with clients. Supervisees generally do not terminate supervision prematurely, and although working collaboratively with a supervisee is desirable, there is often an evaluative component of the supervisory role that precludes complete equality. Moreover, the research literatures are also different: The psychotherapy outcome literature provides a solid foundation for using PCOMS in counseling. We simply know less about the supervision process and what constitutes good supervision. We would define good supervision as a process that enables supervisee development in service of promoting improved client outcomes.

Given the current lack of a compelling theoretical and research-based rationale, we are uncertain whether formally monitoring supervision outcomes/process is a *great* idea, but we do think it is at least a potentially *good* idea. For example, the supervisory relationship has consistently been found to be an important variable in effective supervision. Ellis (1991) found that counseling train-

ees rated the relationship with their supervisor as the single most important component of a positive supervisory experience. Although there are exceptions, the supervisory alliance has been found to be related to satisfaction with supervision (Reese, Usher, et al., 2009; Son & Ellis, 2013), counseling self-efficacy (Efstation, Patton, & Kardash, 1990), supervisory feedback (Lehrman-Waterman & Ladany, 2001), and even client outcome (Patton & Kivlighan, 1997). Based on the available research, monitoring the supervisory relationship makes the most sense among the supervisory outcome and process constructs.

Deciding on other processes and outcomes to monitor is less straightforward. For example, is there a supervisee outcome analogous to client outcome? Supervision researchers have commonly used performance evaluations of trainees or supervisee self-evaluations (e.g., counseling self-efficacy, multicultural counseling competence) to evaluate counseling trainee effectiveness. Results from studies using these measures have been mixed, revealing a great deal of variability from study to study (Larson & Daniels, 1998; Larson et al., 1992). In addition, research has shown that supervisors and trainees themselves may not be accurate in their appraisals of counselor performance, highlighting the importance of client-based counseling outcomes. Studies have shown that supervisor ratings are biased by interpersonal relationships with their supervisees and that generally supervisors have difficulty differentiating between effective and ineffective counselors (Dodenhoff, 1981; Najavits & Strupp, 1994).

Research has also shown that counselors generally have overly optimistic views of their work with clients (Walfish, McAlister, O'Donnell, & Lambert, 2012). Reese, Usher, et al. (2009) found that trainees in feedback and no-feedback conditions had similar self-efficacy ratings, despite those in the no-feedback condition having clients with much lower outcome scores. Thus, a counselor's optimistic outlook on client progress and his or her own ability without a direct method of measuring performance is problematic. However, if trainees self-evaluate in the presence of client outcome data, then this is potentially a powerful way for trainees to reflect on their perceptions of their ability and creates important grist for the supervision mill. The Reese, Usher, et al. study found that trainees who used client feedback with clients were more accurate in self-appraisals of counseling ability. That is the danger with using proxy outcome measures to evaluate effective supervision or counselor development. For example, counselor self-efficacy is important, but as the previous research has noted, it should be rooted in how one is actually performing with clients rather than simply trying to have more confidence.

Our conclusion, based on the literature and supervisory experience, is that monitoring the supervisory working alliance seems to be a worthy process. Not only is there some preliminary evidence that the alliance is related to client outcomes, but it is important for promoting trust that can promote a supervisee's willingness to self-disclose (Ladany, Hill, Corbett, & Nutt, 1996). This willingness to disclose offers the potential to discuss fears, concerns, or other issues that may impede counselor development and, simultaneously, client progress. We are less certain about the inclusion of other process or outcome measures to monitor supervision. Much of it may depend on the development of the supervisee (e.g., beginning student vs. postdoctoral intern vs. licensed counselor) and the nature of the supervisory relationship (e.g., faculty/student, agency supervisor–staff mem-

ber, peer). We believe that monitoring constructs of particular importance (e.g., multicultural self-efficacy) may be quite meaningful provided it occurs within the context of client outcome data. Of course, future research should address these questions directly to evaluate whether the monitoring of such processes and constructs contributes to effective supervision and trainee development.

More broadly, research should continue to address the utility of client feedback in supervision. Research in this area offers the potential to better understand how feedback promotes supervisee development *and* positive outcomes. Little is currently known regarding the benefits of supervision for either, but the inclusion of client outcome in supervision research could address important processes at both the counseling and supervisory levels. We would like to see future research that replicates the previous supervision feedback studies with larger sample sizes and more attention given to treatment fidelity. Anecdotally speaking, there also seems to be resistance (discussed below) on the part of some supervisors to altering the supervisory process. Formally evaluating the extent of this concern and the reasons for resistance would be helpful for better understanding supervisor concerns and reluctance.

Limitations of PCOMS

We have thus far focused on the advantages of including systematic client feedback in the training of counselors. There are also possible challenges and limitations that come along with this process. One challenge we have encountered is resistance from both supervisors and, to a lesser extent, supervisees. Even though the research is pretty compelling, most counselors do not monitor outcomes. It follows that supervisors often fail to see the utility of adding such a process to their training paradigm. Some supervisors have expressed concern that it will shift the focus of supervision or detract from what is typically done; others have suggested that it is cognitive overload for trainees to add something new when they are simply learning to be comfortable with a client or learning the process of therapy.

Supervisees, in contrast, occasionally worry that supervisors are going to use the outcome data as part of the evaluation process—even if the supervisor says that this is not the case. We typically find this to be a lack of clear communication, and this concern fades with time. On a related note, this evaluation press can influence how trainees perceive the feedback they receive. They will sometimes personalize the feedback they receive, such as, "The SRS was low; the client just does not like me" or "My client is not improving. I don't know what I am doing." Beginning students often do not have the context and the experience to draw on to realize that sometimes there is not a good counselor–client match or that the feedback is about the process rather than the client or the counselor. Supervisors have to make sure to provide this context and frame it as an opportunity to learn and grow.

A practical limitation of implementing PCOMS is that you have to get buy-in at the client, counselor, and supervisor levels. One break in the link of this chain, and the utility of the data is lessened. Commitment is key. It is not a process that yields much benefit if it is not tended to at each level. It does add work, albeit brief, to an already robust process and can represent a paradigm shift for business as it is usually conducted. We are biased in believing that disruptions are minimal, but

we acknowledge that adding anything new in the context of an already full curriculum with busy lives of faculty, supervisors, and students is a challenge.

Conclusion

It's never too late to be who you might have been.

—George Eliot

Outcome technology generated by systematic client feedback about benefit and the alliance sheds new light on both counseling practice and supervision. The ability to collect, analyze, and disseminate real-time information about client outcomes and counselor effectiveness allows both service provision and supervision to move beyond speculation and wishful thinking. PCOMS technology provides a research-proven quality improvement strategy that enhances client outcomes via the systematic identification of at-risk clients while focusing supervisees on professional development with an objective standard of effectiveness throughout their career—enabling trainees to start being who they want to be right from the beginning. Perhaps most important, it not only privileges the client in the counseling process but carries a consumer-first priority into the supervisory process and ultimately to the way that effectiveness at all levels of service is evaluated.

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