

## Using PCOMS Technology to Improve Outcomes and Accelerate Counselor Development

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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 enter the late 1990s and a new era was ushered in by the pioneering work of Michael Lambert and the Outcome Questionnaire 45.2 (OQ; 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 wasn't just for researchers anymore—it was for front line counselors and supervisors.

This process, called “systematic client feedback” refers to the continuous monitoring of client perceptions of progress and the alliance throughout the course of counseling. It involves real-time comparison of client views of outcome with an expected treatment response which serves as a yardstick for gauging client progress and signaling when change is not occurring as predicted. With this alert, counselors and their clients have an opportunity to shift focus, re-visit goals, or alter interventions before deterioration or dropout. Technological advances in data collection have enabled an easy 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) suggest that more emphasis is typically placed on the interpersonal processes and development of the

supervisee in supervision. Similarly, in the supervision empirical literature, much more research has focused on supervisee development and supervision process compared to investigating how supervision translates into client benefit (Lambert & Hawkins, 2001; Watkins, 2011).

Counselor 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 (1981-2011) and noted 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), is 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 achieved significantly lower scores on the Beck Depression Inventory. 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 a more focused research direction that could finally answer the question of whether supervision actually matters where it counts most—client benefit. Technology assisted supervision research to date, however, has focused on evaluating whether it can approximate the experience of traditional supervision (Rousmaniere, 2013), 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 both in practice and research via systematic client feedback. Although several systems are available that collect and analyze data (see Duncan & Sparks, in press or Rousmaniere, 2013 for a review), only two are designated as evidence based: Lambert's OQ 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 its empirical support, including PCOMS application to supervision, available technology is reviewed and its benefits detailed. We will 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 us to move beyond wishful thinking and best intentions. A four step supervisory process is described that is designed to empower client voice, improve outcomes, and accelerate counselor development regardless of experience level or model practiced.

### **The Partners for Change Outcome Management System (PCOMS)<sup>ii</sup>**

*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 can be boiled down to this: partnering with clients to identify those who aren't 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 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 counseling, 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 (Crits-Christoph, Connolly Gibbons, & Mukherjee, 2013), is the therapeutic alliance. Clients who highly rate their partnership with their counselors are more apt to remain in therapy and benefit from it.

PCOMS is a light-touch, checking-in process that usually takes about five minutes but never over ten 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 front-line 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. Client 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 and Session Rating Scale**

PCOMS starts with the Outcome Rating Scale (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 centimeter 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. This requires that the counselor 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 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 one cm to the right; what needs to happen out there and in here?”

The Session Rating Scale (SRS) (Duncan et al., 2003), a four 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 centimeters 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 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 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 drop out and/or poor outcome. The ORS gives clients a voice in all decisions that affect their care including whether continuation 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 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 at the third to sixth session and last-chance discussions are initiated in the sixth to ninth meeting. This is simply saying that the trajectories observed in most outpatient settings suggest that most clients who benefit from services usually show it in 3–6 sessions; and if change is not noted by then, then the client is at a risk for a negative outcome. The same goes for sessions 6-9 except that the urgency is increased, hence the term “last chance.” Software and web technology provide 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 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 of 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 a-theoretical 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 to become 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 used PCOMS to investigate the effects of feedback were conducted by those affiliated the Heart and Soul of Change Project (<https://heartandsoulofchange.com>). Three trials are discussed here, addressing individual, couple, and group psychotherapy. Reese, Norsworthy, and Rowland (2009) found that individual clients in the PCOMS condition showed significantly more reliable change in significantly fewer sessions than treatment as usual (TAU) or non-feedback clients. Anker, Duncan, and Sparks (2009), the largest RCT of couple therapy to date, randomized 205 couples to PCOMS or TAU. Feedback clients reached clinically significant change nearly four times more than TAU couples, and over doubled the percentage of couples in which both individuals reached reliable and/or clinically significant change. Regarding group psychotherapy, Schuman, Slone, Reese, and Duncan (2014) conducted an RCT ( $N = 263$ ) of

returning Iraq and Afghanistan veterans 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, higher ratings of success by both clinicians and commanders, and attended significantly more sessions than TAU.

A meta-analysis (Lambert & Shimokawa, 2011) of PCOMS studies found that those in feedback group had 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 ( $N = 5179$ ) of a large public behavioral health agency (Reese, Duncan, Bohanske, Owen, & Minami, 2014) that had 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 to address the lack of focus on client outcome both in 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 supervision could use client outcome data as a means to discuss client progress and to inform future treatment. Further, 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 are benefitting.

Other advantages 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 provide a specific means for 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. Accurate assessment of a supervisee's caseload can be challenging and time-consuming when dealing with multiple supervisees. PCOMS data provides 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 grants 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 a 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 where 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 it was derived from the client. This subtle shift may allow for responses from the supervisor to seem more collaborative rather than evaluative, and perhaps better heard given that it arises from clients rather than just the supervisor's opinion.

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 of 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. Forty-four trainees were randomly assigned to a supervision condition where 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 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

While counselors can use the paper and pencil versions of the 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 front line counselors and supervisors. Technology allows 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 US and in 20 countries, with over 750,000 administrations in its data base.

Using technology in supervision doesn't 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, look 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 data entry will have to be done by someone, usually the counselor, so there is an increase in work load. With that in mind, Excel allows the ability to graph, track outcomes over time, and calculate key performance indicators, invaluable for helping supervisees improve with experience. Excel calculates 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 reliable and/or clinically significant change (RCSC). These performance indicators provide a detailed look at both clients who are not benefitting and 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 which differentiates a clinical from non-clinical 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 that achieve RCSC provides an easily understood metric of effectiveness and a good way to track supervisee development over time. Effect size (ES) 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. First, most agencies and university clinics use some variety of an electronic

health record (EHR). These programs (see Figure 1) often have open data fields as well as graphing and data analysis functions. Consult your IT department if available or the EHR company to see if ORS scores can be entered, graphed, and analyzed to yield average change, percentage 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 the necessary ingredients for supervision to identify clients needing supervisory attention. This could involve programming costs. Such a system would not administer the measures or include the algorithms discussed below unless a license was purchased to include these elements.

Then there are the Web-based systems of tracking outcomes, MyOutcomes.com (see Figure 2) and BetterOutcomesNow.com (see Figure 3). Both systems include tablet and phone applications, and administer the measures, compare the client's progress to the expected treatment response (ETR), graph the scores, and aggregate the data at counselor and organizational levels. Everything, therefore, is automated and places minimal burden on clients, counselors, and supervisors. Both systems identify clients who are not benefiting 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 data base of administrations of the ORS. Tracking either or both percentage of target or RCSC provides an ongoing commentary about effectiveness.

Dropouts are 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's planned, then we have referred the client to another provider or venue of service; if it is unplanned but the client 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 don't, the numbers can be daunting. Helping supervisees 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 see that 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. Numbers on the measures, as concrete representations of client perspectives, offer a direct way to describe client benefit at counselor and agency levels.

*1. Counselor Fidelity and Data Integrity: Supervisee and supervisor review Excel spread sheet, EHR, 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 clients at risk or tracking and accelerating counselor development. PCOMS is somewhat paradoxical. On one hand, it uses two four-item instruments that couldn't 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—they either don't 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 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, where the client scores go up and down week to week. This typically means that the

client doesn't 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.

*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.*

*2. Identifying at Risk Clients and Shaping the Conversation: Supervisor and supervisee review non-responding clients and supervisor guides 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 its full advantage, supervisors will need to get over any squeamishness about expected treatment response (ETR) curves or reading graphs in general. 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 this client's counseling at a quick glance. If using Excel or EHR 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 an 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 if 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 non-responding 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 aren't changing to what can be done differently is harder than it sounds. We are very good at explaining why clients don't 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, both from your support system and the client's?*
- *Is it time to fail successfully? (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 the above 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 we accept that without blame to the client or counselor, we can move on to the more productive conversation of what needs to happen next to enable the client to benefit.

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, reports that practicum students, interns, and experienced counselors alike welcome this process after initial concerns of vulnerability are assuaged. In addition, she said that recognizing that clients will ultimately benefit from the transfer appeals to our 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.

*Example: Supervisor: Okay, looks like we are still struggling with this client...he's been in counseling for 9 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, more humanistic approach might help. A couple of supervisions ago, we developed a plan to more specifically identify what 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 difference kind of conversation and generate new leads. And I know you have discussed it 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?*

3. *Stats 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 upon 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 with PCOMS supervision technology. ORS data provide an objective way to know 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 stats with the intent of co-developing a plan for improvement. It starts with helping the supervisee to understand the stats, the key performance indicators, and how they will be used to monitor effectiveness and development over time. Recall that perhaps the easiest stat to consider is the percentage of clients who attain reliable or clinically significant change, or who achieve ETR if using an electronic system. Using this stat to compare to a previous period of time or closed cases gives a quick look at how things are going. 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, that wherever he or she starts, it is just that, a beginning point. By discussing the stats transparently, supervisors encourage counselors at every level of experience to use the data for their specific

benefit. In so doing, supervisees will get over any fear of numbers and looking at their performance. Over time, counselors will monitor their own stats and use the information to the greatest advantage.

From the frank discussion of stats 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.

*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 so 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 that present more affectively. I am better at cognitive stuff.*

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

*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 skill building about a variety of areas that are identified in the therapist'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 importantly, this aspect of supervision sets the stage for harvesting client teachings and enhancing the most powerful influence on development identified by Orlinsky and Rønnestad, 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 an 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/style in counseling. The process begins with 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 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 but rather to promote professional reflection and encourage continued growth. Clients who are not benefiting provide the best opportunities for accelerating development, encouraging supervisees to do things they have never done and embrace the uncertainty endemic to the work as it is to life.

*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 that 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 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 also I learned that not everything has to be structured, that sometimes not knowing what do it 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 we mean adapting the PCOMS measures for supervision. Intuitively, monitoring supervision processes and outcomes similar to counseling sessions makes 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 to foster working collaboratively clients. Supervisees generally don't terminate supervision

prematurely and, while 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 if 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 trainees 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 et al., 2009; Son & Ellis, 2013), counseling self-efficacy (Efstation et al., 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 process 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) as methods 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). Additionally, research has shown that supervisors and trainees themselves may not be accurate in their appraisal 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 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 et al., 2012). Reese et al. (2009) found that trainees in the feedback and no-feedback conditions had similar self-efficacy ratings, despite the no-feedback condition having clients with much lower outcome scores. Thus, a counselor's optimistic outlook on client progress and their ability without a direct method of measuring performance is problematic. On the other hand, if you have 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 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 into 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 also important for promoting trust which 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 staff counselor) and the nature of the supervisory relationship (e.g., faculty/student; agency supervisor-staff member; peer supervision). We believe that monitoring constructs of particular importance (e.g., multicultural self-efficacy) may be quite meaningful provided it is within the context of client outcome data. Of course, future research should address these questions directly to evaluate if the monitoring of such processes and constructs contribute 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, there also seems to be resistance (discussed below) on the part of some supervisors with 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 to 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 it is cognitive overload for trainees to add something new when they are simply learning to be comfortable with a client or to learn the process of therapy.

Supervisees, on the other hand, occasionally worry that supervisors are going to use the outcome data as part of the evaluation process—even if the supervisor says that is not the case. We typically find this to be a lack of clear communication and that this concern fades with time. Relatedly, this evaluation process 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 upon to realize that sometimes there is not good counselor-client match or 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 are 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 to an already robust process, albeit brief, and can represent a paradigm shift for business as it is usually conducted. We are biased in believing that disruptions are minimal, but acknowledge that adding anything new in the context of an already full curriculum with busy lives of faculty, supervisors, and students is a challenge.

## Conclusions

*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 providing service 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 the supervisee on professional development with an objective standard of effectiveness throughout his or her career—enabling trainees to start being who they want to be right from the beginning. Perhaps most importantly, it not only privileges the client in the counseling process, it carries a consumer first priority into the supervisory process, and ultimately to the way that effectiveness at all levels of service are evaluated.

## References

- Anker, M., Duncan, B., & Sparks, J. (2009). Using client feedback to improve couples therapy outcomes: A randomized clinical trial in a naturalistic setting. *Journal of Consulting and Clinical Psychology, 77*, 693–704.
- Baldwin, S., Berkeljon, A., Atkins, D., Olsen, J., & Nielsen, S. (2009). Rates of change in naturalistic psychotherapy: Contrasting dose-effect and good-enough level models of change. *Journal of Consulting and Clinical Psychology, 77*(2), 203–211.
- Bambling, M. King, R., Raue, P., Schweitzer, R., & Lambert, W. (2006). Clinical supervision: Its influence on client-rated working alliance and client symptom reduction in the brief treatment of major depression. *Psychotherapy Research, 16*, 317-331.  
doi:10.1080/10503300500268524
- Bernard, J. M., & Goodyear, R. K. (2014). *Fundamentals of clinical supervision* (5<sup>th</sup> ed.). Upper Saddle River, New Jersey: Pearson.
- Dodenhoff, J. T. (1981). Interpersonal attraction and direct-indirect supervisor influence as predictors of counselor trainee effectiveness. *Journal of Counseling Psychology, 28*, 47-52. doi:10.1037/0022-0167.28.1.47
- Duncan, B. (2014). *On becoming a better therapist: Evidence based practice one client at a time* (2<sup>nd</sup> Ed.). Washington, DC: American Psychological Association.
- Duncan, B. (2012). The partners for change outcome management system (PCOMS): The heart and soul of change project. *Canadian Psychology, 53*, 93-104
- Duncan, B., Miller, S., Sparks, J., Claud, D., Reynolds, L., Brown, J., et al. (2003). The Session Rating Scale: Preliminary psychometric properties of a “working” alliance measure. *Journal of Brief Therapy, 3*(1), 3–12.

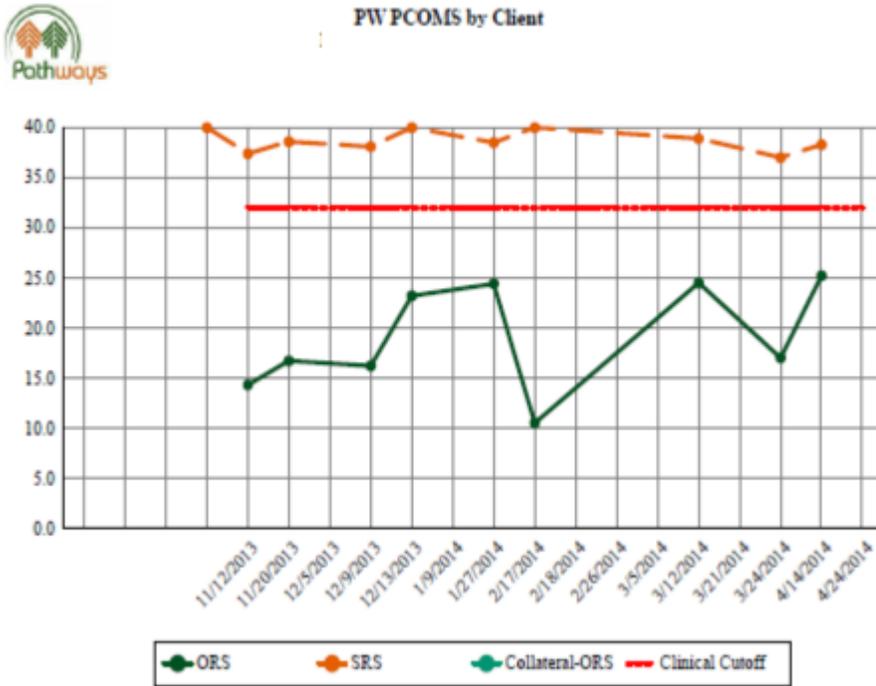
- Duncan, B.L., & Reese, R. J. (2012). Empirically supported treatments, evidence based treatments, and evidence based practice. In G. Stricker and T. Widiger (Eds.), *Handbook of Psychology: Clinical Psychology* (2<sup>nd</sup> ed., pp. 977-1023). Hoboken, NJ: John Wiley.
- Duncan, B., & Reese, R. J., (2013). Clinical and scientific considerations in progress monitoring: When is a measure too long? *Canadian Psychology*, 54, 135-137.
- Duncan, B., & Sparks, J. (2010). *Heroic clients, heroic agencies: Partners for change* (2<sup>nd</sup> ed.). Jensen Beach, FL: Author.
- Duncan, B., & Sparks, J. (in press). Systematic feedback: Incorporating outcome and process measures in a pluralistic approach. In M. Cooper & W. Dryden (Eds.), *Handbook of pluralistic counselling and psychotherapy*. London: Sage.
- Efstation, J. F., Patton, M. J., & Kardash, C. M. (1990). Measuring the working alliance in counselor supervision. *Journal of Counseling Psychology*, 37, 322–329.  
doi:10.1037/0022-0167.37.3.322
- Ellis, M. V. (1991). Critical incidents in clinical supervision and in supervisor supervision: Assessing supervisory issues. *Journal of Counseling Psychology*, 38, 342-349. doi: 10.1037/0022-0167.38.3.342
- Falender, C. A., & Shafranske, E. P. (2004). *Clinical supervision: A competency-based approach*. Washington, DC: American Psychological Association.
- Friedlander, M. L., Siegel, S. M., Brenock, K. (1989). Parallel processes in counseling and supervision: A case study. *Journal of Counseling Psychology*, 36, 149-157.  
doi:10.1037/0022-0167.36.2.149

- Grossl, A. B., Reese, R. J., Norsworthy, L. A., & Hopkins, N. B. (2014). Client feedback data in supervision: Effects on supervision and outcome. *Training and Education in Professional Psychology, 8*, 82-88.
- Hannan, C., Lambert, M. J., Harmon, C., Nielsen, S. I., Smart, D. W., & Shimokawa, K. (2005). A lab test and algorithms for identifying clients at risk for treatment failure. *Journal of Clinical Psychology/In Session, 61*, 1-9. doi:10.1002/jclp.20108
- Hoffman, M. A., Hill, C. E., Holmes, S. E., & Freitas, G. F. (2005). Supervisor perspective on the process and outcome of giving easy, difficult, or no feedback to supervisees. *Journal of Counseling Psychology, 52*, 3-13. doi:10.1037/0022-0167.52.1.3
- Holloway, E. L., & Neufeldt, S. A. (1995). Supervision: Its contributions to treatment efficacy. *Journal of Consulting and Clinical Psychology, 63*, 207-213. doi: 10.1037/0022-006X.63.2.207
- Iberg, J. R. (1991). Applying statistical control theory to bring together clinical supervision and psychotherapy research. *Journal of Consulting and Clinical Psychology, 59*, 575-586.
- Ladany, N., Hill, C. E., Corbett, M. M., & Nutt, E. A. (1996). Nature, extent, and importance of what psychotherapy trainees do not disclose to their supervisors. *Journal of Counseling Psychology, 43*, 10-24. doi: 10.1037/0022-0167.43.1.10
- Lambert, M. J. & Hawkins, E. J. (2001). Using information about patient progress in supervision: Are outcomes enhanced? *Australian Psychologist, 36*, 131-138. doi:10.1080/00050060108259645
- Lambert, M. J., Hansen, N.B., Umphress, V., Lunnen, K., Okiishi, J., Burlingame, G., ...Reisinger, C. (1996). *Administration and scoring manual for the OQ 45.2*. Stevenson, MD: American Professional Credentialing Services.

- Lambert, M.J., & Shimokawa, K. (2011). Collecting client feedback. *Psychotherapy, 48*, 72-79.
- Larson, L. M., & Daniels, J. A. (1998). Review of the counseling self-efficacy literature. *The Counseling Psychologist, 26*, 179-218. doi:10.1177/0011000098262001
- Larson, L. M., Suzuki, L. A., Gillespie, K. N., Potenza, M. T., Bechtel, M. A., & Toulouse, A. (1992). Development and validation of the Counseling Self-Estimate Inventory. *Journal of Counseling Psychology, 39*, 105-120. doi:10.1037/0022-0167.39.1.105
- Lehrman-Waterman, D., & Ladany, N. (2001). Development and validation of the Evaluation Process Within Supervision Inventory. *Journal of Counseling Psychology, 48*, 168–177. doi:10.1037/0022-0167.48.2.168
- Miller, S. D., Duncan, B. L., Brown, J., Sparks, J., & Claud, D. (2003). The outcome rating scale: A preliminary study of the reliability, validity, and feasibility of a brief visual analog measure. *Journal of Brief Therapy, 2*(2), 91–100.
- Najavits, L. M., & Strupp, H. (1994). Differences in the effectiveness of psychodynamic therapists: A process-outcome study. *Psychotherapy: Theory, Research, Practice, Training, 31*, 114-123. doi:10.1037/0033-3204.31.1.114
- Okiishi, J. C., Lambert, M. J., Eggett, D., Nielsen, L., Dayton, D. D., & Vermeersch, D. (2006). An analysis of therapist treatment effects: Toward providing feedback to individual therapists on their clients' psychotherapy outcome. *Journal of Clinical Psychology, 62*, 1157-1172.
- Orlinsky, D. E., & Rønnestad, M. H. (2005). *How psychotherapists develop: A study of therapeutic work and professional growth*. Washington, DC: American Psychological Association.

- Patton, M. J., & Kivlighan, D. M. (1997). Relevance of supervisory alliance to the counseling alliance and to treatment adherence in counselor training. *Journal of Counseling Psychology, 44*, 108-115. doi:10.1037/0022-0167.44.1.108
- Reese, R.J., Duncan, B., Bohanske, R., Owen, J., & Minami, T. (2014). Benchmarking outcomes in a public behavioral health setting: Feedback as a quality improvement strategy. *Journal of Consulting and Clinical Psychology*, <http://dx.doi.org/10.1037/a0036915>
- Reese, R. J., Norsworthy, L. A., & Rowlands, S. R. (2009). Does a continuous feedback system improve psychotherapy outcome? *Psychotherapy: Theory, Research, Practice, Training, 46*, 418-431.
- Reese, R. J., Usher, E. L., Bowman, D. C., Norsworthy, L. A., Halstead, J. L., Rowlands, S. R., & Chisolm, R. R. (2009). Using client feedback in psychotherapy training: An analysis of its influence on supervision and counselor self-efficacy. *Training and Education in Professional Psychology, 3*, 157-168. doi: 10.1037/a0015673
- Rousmaniere, T. (2013). Using technology to enhance supervision and training. In C. E. Watkins & D. L. Milne (Eds.), *The Wiley Blackwell international handbook of clinical supervision* (204-237). New York: Wiley
- Schuman, D., Slone, N., Reese, R.J., & Duncan, B. (2014). Using client feedback to improve outcomes in group psychotherapy with soldiers referred for substance abuse treatment. *Psychotherapy Research*, <http://dx.doi.org/10.1080/10503307.2014.900875>
- Sparks, J. A., Kisler, T. J., Adams, J. F., & Blumen, D. G. (2011). Teaching accountability: Using client feedback to train effective family therapists. *Journal of Marital & Family Therapy, 37*, 452-467. doi:10.1111/j.1752-0606.2011.00224.x

- Stein & Lambert, M. (1995). Graduate training in psychotherapy: Are therapy outcomes enhanced? *Journal of Consulting and Clinical Psychology, 63*, 182-196.  
doi:10.1037/0022-006X.63.2.182
- Watkins, C. E. (2011). Does psychotherapy supervision contribute to patient outcomes? Considering thirty years of research. *The Clinical Supervisor, 30*, 235-256.  
doi:10.1080/07325223.2011.619417
- Worthen, V. E., & Lambert, M. J. (2007). Outcome-oriented supervision: Advantages of adding systematic client tracking to supportive consultations. *Counselling and Psychotherapy Research, 7*, 48-53. doi:10.1080/14733140601140873



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

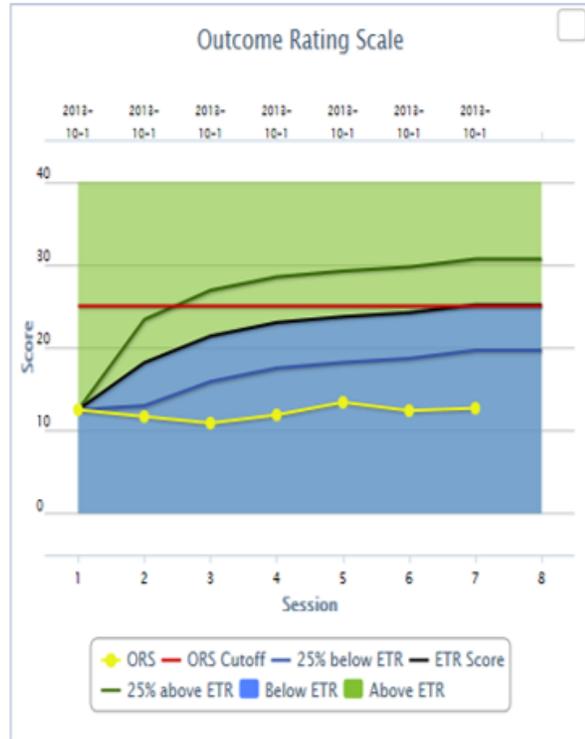
Figure 1. PCOMS integrated in Electronic Health Record at Pathways, Inc. The top depicts the graphing of ORS and SRS data. The bottom is the client list showing number of sessions and first and last ORS scores.

Measure	Score
Individually	3.1 out of 10
Interpersonally	3.2 out of 10
Socially	3.2 out of 10
Overall	3.2 out of 10
<b>Total Score</b>	<b>12.7 out of 40</b>



**Not much progress has happened lately and there is cause for concern.**

- 1) Discuss making a change in how you and your therapist are working together to improve your chance for success.
- 2) Review the SRS, especially those items less than 9, and talk about whether you and your therapist are a good match.
- 3) Talk with your therapist about a consult with a colleague or supervisor.



**List of Clients**

Client Group:  Manage Groups Create Client | Create Couple

Search:

Action	Type	Client ID	Client Group	Last Session	Survey	ETR
<input type="checkbox"/>			CA-GMC	#3 [2014-03-25]		
<input type="checkbox"/>			CA-GMC	#1 [2014-04-10]		
<input type="checkbox"/>			CA-GMC	#3 [2014-04-14]		
<input type="checkbox"/>			CA-GMC	#7 [2014-05-01]		
<input type="checkbox"/>			CA-GMC	#1 [2014-04-03]		
<input type="checkbox"/>			CA-GMC	#1 [2014-03-26]		
<input type="checkbox"/>			CA-GMC	#1 [2014-04-01]		
<input type="checkbox"/>			CA-GMC	#2 [2014-04-04]		

Show  entries

Figure 2. The PCOMS Web application, MyOutcomes.com. The top depicts the graphing of ORS and SRS scores as well as the feedback message. The bottom is the client list with icons identifying clients at risk in yellow and red.

*Figure 3.* PCOMS Web application, BetterOutcomesNow.com. The top depicts the graphing of ORS and SRS scores and progress summary. The bottom is the client list with icons identifying clients at risk in yellow and red.

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<sup>i</sup> The ORS/SRS family of measures are available free for individual use at <https://heartandsoulofchange.com>. While free for individual use, Duncan receives monies for group licenses. Duncan also has a financial relationship with the products discussed. Duncan is a partner in BetterOutcomesNow.com and receives royalties based on sales from MyOutcomes.com. There are other electronic outcome-tracking systems available using other measures (see Duncan & Sparks, in press).

<sup>ii</sup> For more information about PCOMS visit <https://heartandsoulofchange.com>: This website contains over 250 free resources including webinars, articles, chapters, and slide handouts about PCOMS, the common factors, and other topics of interest. Free webinars are available at the top left of the home page under “PCOMS 101.” “PCOMS Video” is a good place to start and includes the nuts and bolts of using the measures.