



The Outcome and Session Rating Scales



The Ten Skills of the Partners for Change Outcome Management System Doing the Measures the Right Way Barry L Duncan

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The Ten Skill of PCOMS

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Chapter One

Skill One: Introduce the Outcome Rating Scale

Introduce, administer and score (if applicable) the Outcome Rating Scale (ORS) each visit or unit of service. Ensure that the client understands that the ORS is intended to: 1) privilege their voice and bring them into the decision-making process; and 2) will be collaboratively used to monitor progress in each encounter to ensure benefit.

Before we get into the specifics of Skill One, some general comments about the ORS. The ORS is a visual analogue instrument that is individualized with clients to represent their distress and the reasons for service on four domains (personal, interpersonal, social, overall). Clients click or tap on each ten-cm line to represent their functioning in each domain. Scores range from 0 to 40, with lower scores signaling higher distress.

The major domains of life depicted on the ORS offer a general framework of human existence to which clients add the intimate details of their lived experience via therapeutic conversation. The ORS contextualizes presenting problems beyond diagnostic categories, running counter to practices that pathologize clients of color and other historically marginalized groups at higher rates. Putting client reasons for service in context also promotes consciousness raising for both client and therapist, helping to identify forms of oppression and marginalization that may contribute to distress.

The ORS Is Not This

The ORS Is Different Than Other Outcome Measures

Given that at its heart, PCOMS is a collaborative intervention, everything about the use of the measures

and the results attained are shared with clients.

Consequently, the client needs to understand what it's all about, and especially these two points:

- ✚ the ORS will be used to collaboratively track outcome in every session to ensure the client benefits.
- ✚ it is a way to make sure that the client's voice is not only heard but also remains central to services.

The ORS is given at the beginning of each encounter. In the first meeting, the ORS pinpoints where the client sees themselves, allowing for an ongoing comparison in later sessions. Residential or intensive outpatient settings may give the ORS at the first encounter of the week.

Beginning with the intake call, it is important to convey commitment toward improving the client's situation as well as to the highest quality of collaborative care:

We are committed to you reaching your goal, so our services monitor whether clients are benefiting by using two very brief forms. These take only a minute to fill out but yield a great deal of information about how things are going and whether the service should set a different course. It's good to know these things sooner rather than later so that you and your therapist/worker can do something about it—it also lets us know if you would be better served by someone else. We will explain this in greater detail when you arrive for your first meeting. Is this something you can help us out with?

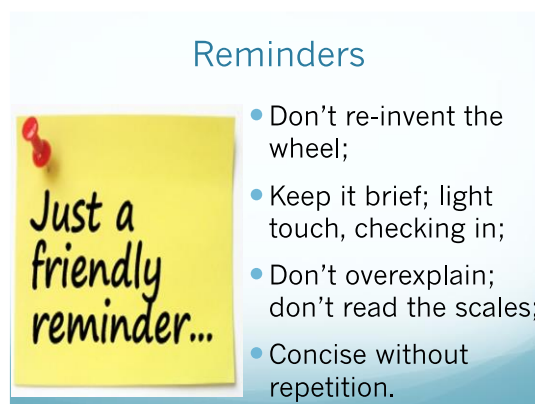
The above “script” is just a suggestion. Feel free to be creative in your explanation. Put it in your own words and natural way of communicating.

Continue building a culture of feedback in the first meeting and administer the ORS as an invitation into a collaborative partnership. Avoid technical jargon, and instead explain the purpose of the measures and their rationale in a natural, commonsense way. Make the administration, scoring, and discussion part of a relaxed and ordinary way of having conversations and working. The specific words are not important. Your interest in the client's desired outcome speaks volumes about your commitment to the individual.

Convey that:

- ✚ The measures are specifically designed to empower client voice in all aspects of therapy and include them in all decisions that affect their care.

- ✚ The ORS will be collaboratively used to monitor progress to ensure they reach their goals.



When I work with people I like to start off with this very brief form, it's called the Outcome Rating Scale, and it is a way for me to get a snapshot of how you are viewing how things are going for you right now, and a way that you and I can check in each time to make sure that our work together is beneficial for you. So it's a way to track progress and it's also a way to make sure that how you are viewing things stays central to the way we are working together. You just tap on each of those four areas of your life, where taps to the left mean things are not going well and taps to the right mean that they are going very well. Would you be willing to do that for me?

This Outcome Rating Scale is used for two reasons: The main reason is to ensure that your viewpoint about things stays very central to the way the work is done, your viewpoint about whether you are benefiting essentially will drive the therapy. The other reason is that if we monitor your benefit together every time you come in and you are not doing well, we can put our heads together and figure something else to do. Put a touch where you see yourself on these major areas of your life where this side means things are going very well and this side means things are going not so well.

These are just examples, not mandates or research protocols. Put the introduction in your own words, the way that you talk and interact with clients. But don't overdo it!

To a child: Here is that screen with smiley and frowny faces I mentioned to you. This funny form allows us to track where you're at, how you're doing, how things are changing, or if they are not. It allows us to know whether I am being helpful. It only takes a minute to do, and most kids find

it to be very helpful. Would you like to give it a try? Great!

Here are the provided instructions on the ORS (But don't read the instructions to the client):

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

Most understand the measures with minimal explanation, but you can't over-explain the measures, so do whatever it takes to ensure the client understands what it is about. Given that the ORS is intended to make sure the client's perspective is not lost in the shuffle, the whole point is missed if the client doesn't get what the measures and PCOMS are about.

The ORS has very good face validity—the domains make common sense, so clients very quickly apply their lived experience to the different areas of functioning. Whatever explanation clients give in their own words is okay. Some clients will say: "You mean like poor to well?" or "Like 0 on the left and 10 on the right?" Keep in mind it's their subjective experience we are interested in, so their understanding of the measure in the context of their lives is paramount. Your efforts to understand the meaning of the client's ratings also contribute to the client ultimately "getting" what the ORS is all about.

Sometimes clients ask for clarification between scales or how they should rate two aspects of the same dimension. For example, regarding the *Interpersonally* line, which looks at close relationships such as partners and immediate family, clients may say something like, "I am doing great with my kids, but my relationship with my spouse stinks;" or on the *Socially* dimension, "My work is the only thing going right, but I have no friends—should I average this?" Here you simply ask the client to rate the dimension relevant to their decision to seek therapy, because you want the measure to reflect progress in that area. So, you say something like, "Are either of the topics related to why you are here?" (Client responds that he is here because of his relationship with his partner, or she is here because of her troubles making friends.) "Okay, please rate the line to reflect your concerns there so we can see when progress is made."

It's also okay to orient the client to how you would like them to rate the ORS. For example, if you work in a substance abuse program, you might ask the client to score the ORS relative to their substance use. Think about what makes clinical sense to your practice. Some like to orient clients in the first session to fill out the ORS relative to their reasons for therapy. That's okay too. But everyone in your setting must do it the same way or the data won't make any sense. My preference is for the client to complete the ORS without additional instructions and allow their reasons to emerge from how they filled it out in the clinical conversation. But that's just my preference. It's okay to provide more context if you find that more helpful and if it is done consistently.

Although 99% of the time you will be using an electronic system to administer and score the ORS, there will be some clients or occasions that will require you to administer the paper ORS. So, you will need to manually score the client's marks. This is easy and only requires a centimeter ruler or template so you can score to the millimeter. Just practice it a few times until you feel like you can do it with confidence.

Final Note, the Intake Meeting: Many agencies conduct an "intake" session to complete all the necessary documentation before a client is assigned to a therapist or other provider, which begs the question, "Should the ORS be given in this intake session?" The answer: It depends. There are some clear advantages to giving the ORS in the intake session. Often there is a change made between that first encounter and the next, so called "pre-treatment" change, that captures the positive expectations of the client that can get channeled into action about the reasons for service. That is a great way for the provider to begin their service, building on the already positive actions of the client. If done correctly, PCOMS can engage the client into the service in an empowering way that gives the client the strong message that they are in the right place. The key words here, however, are "if done correctly." If the ORS becomes just another part of the documentation, another compulsory paper completed in a lackluster way without attention to its purposes (ensuring client voice and collaborative monitoring of benefit) and without connection to the client's story about the reasons for service, then there is little reason to do it and it may ultimately turn off the client. So, if it is done in a meaningful way by a sincere worker desiring to understand client distress and reason for service, then go for it. If not, don't.

Skill Two: Make Sense of the Client's Score

Discuss the clinical cutoff and contextualize the client's score. Check with the client to see if the score matches their experience. If provided, explain the expected treatment response, i.e., what is hoped will happen if therapy/service/treatment is successful. Invite the client to start with the lowest scale or wherever they would like.

Given that everything about PCOMS is 100% transparent, the task now is to discuss the number and make sense of it with the final authority—the client. The “clinical cutoff” provides a way to do this. “Clinical cutoff” is a statistical term that represents nothing ominous, nor does it say anything negative about the client. It is only the dividing line between people who typically do not find themselves in therapy/service and those who do, differentiating between a so-called “clinical” population from a “non-clinical” one. The cutoff for the ORS is 25 (for adolescents, children, and caretakers, 28). The ORS is really a measure of distress (or wellbeing), so the number 25 out of 40 generally means that those under 25 are reporting the level of distress typically associated with being a client, and those over 25 are reporting a level of distress generally associated with *not* being a client.

The client's score in relation to the clinical cutoff provides a real-time picture of the client's experience and the first opportunity for feedback. Use the cutoff to set the stage for the work, validate the client, and focus your efforts.

The average intake score of an outpatient setting is from 18 to 20, but anywhere between 20 to 30% of your clients will come in over the clinical cutoff. People who score under the cutoff are typically looking for change, something different in their life, while those who score higher or over the cutoff tend to be folks more satisfied with the status quo and therefore may require a bit more context to understand what they are looking for from therapy/service. Once we have the score, it's time to say what the number means—to contextualize the client's score using the cutoff as a jumping off point to promote understanding and best use.

Discussing the cutoff:

- 🚦 Helps check out whether the score makes sense to the client and fits what they were trying to convey in their marks or touches—to make sure you have a good rating.
- 🚦 Allows you to validate the client and convey that they are in the right place.

There are only two choices: the client's initial score on the ORS is either above or below the clinical cutoff. Scores that are under the cutoff may seem a bit more straightforward. The client is reporting distress at a level like other persons seeking mental health or substance abuse or social services—the lower the score, the higher the distress. These folks are looking for a change on the horizon, and a very low score is saying that the sooner the change happens, the better.

Client (Jane) example: Barry saw this client as a consultant on a “stuck case.” A 28-year-old, incredibly resilient woman was struggling mightily and her year-long recovery was in jeopardy. She had just been date-raped, fired from her job, and was experiencing intense periods of what she called her “depression and anxiety.” She scored an 10.7 on the ORS, which pretty much told the story. The client scored all the scales about equally low. This is neon sign saying that she is in significant distress. Clients who score this way are usually in crisis and likely affected by a recent traumatic experience.

Barry: (Client hands the therapist the iPad). Okay, it populates this graph. People tend to score in the mauve part of this graph (under the cutoff) when they are looking for a change in their life, they are looking for something different. And you are scoring in that range and actually a person who scores as low as you did is having a really hard time of it, a lot of distress in their life. Does that fit you? (Client whispers “Yes.”). People scoring in the green (over the cutoff) tend to be people who don't end up talking to people like me. They tend to think that life is going okay and are not looking for a change. (Client still looking at graph). This bold green line (ETR) here is what we are hoping will happen for you if our work is successful. It's a way to help us stay on track. Looks like you scored all the scales about equally low. So what do you think would be most useful for us to talk about?

Client: My depression and anxiety are getting in the way of everything.

Give the score, say what it might mean using the cutoff as a reference point, and look for feedback to see if it fits. If it doesn't fit for the client, then it's good that you found out so you take another pass and ensure a good rating, one that represents the client's experience of distress. Explain the ETR, if your system has one, as what we hope will happen.

What you will find in 95 out of 100 administrations in the first meeting is that the scale clients mark the lowest is the one they are there to talk to you about. The initial ORS score is an instant snapshot of how the client views themselves. It brings an understanding of the client's experience to the opening minutes of a session. With Jane, within 2 minutes, I knew that here was an individual in significant distress, well

under the average intake, and I knew that she was experiencing hardship in all the domains of her life.

What about folks over the clinical cutoff? There are two reasons that scores are above the cutoff:

- 🚦 While most things are going well, there is a specific concern or issue for which help is desired.
- 🚦 Most clients scoring above the cutoff are folks who someone else has either suggested or required their participation in therapy.

Clients who are mandated (or coerced) to therapy from the courts, their employers, partners, or child protective services, etc. (and nearly all kids are mandated) represent the lion's share of clients scoring over the cutoff. In these instances, it is very helpful to have clients complete the ORS twice, once as themselves, and once as if they were the referral person. If possible, it is preferable to get the referral person's actual rating. Many systems allow the remote administration of the ORS if needed. This not only helps you track progress from the set of eyes that can make a difference for your client but also helps you identify what specifically the referral source is looking for as sign of improvement.

Once the client has taken the ORS the second time from the perspective of the referral source:

- 🚦 Note which score is lower reflecting more distress or problems (the referral score is almost always lower).
- 🚦 Ask the client to help you make sense of how the referral source's rating is so different than their view.
- 🚦 Discuss what needs to happen to bring the referral source's view more in line with their own view.

After the client fills out the ORS from the referral source's perspective and you discuss the meaning of the differences and implications for the service, then ask:

"Given the referral's perspective, do you want to re-take the ORS or use your original scores?"

Whatever the client wants is okay, but this offers an opportunity for the client to reconsider their ORS rating in the context of the referral's rating. Mandated clients are no different from voluntary clients with regard to the alliance. Attaining the client's rating *as if* they were the referral source is a great way to bring in the other view without challenging the client's perspective. Almost always, clients will rate the referral source's rating lower (more distressed) than they rated themselves. Often, in

reconsideration, they will rate themselves lower on a second pass. In a sense, the ORS allows the referral source's view to be externalized, represented by the form itself, making it easier to talk about, and not risking the alliance. Few things are worth that risk.

One last thing to note about clients who enter therapy scoring over the cutoff: Even though the client may be reporting that things are going well, there will still be one scale that is lower than the rest, and that is often your invitation to collaborate.

Skill Three: Connect the ORS to the Reasons for Service

Connect the client's marks/clicks/touches on the ORS to the described reasons for service. Invite discussion of the larger social context of the presenting concerns. Ensure that the ORS is not used as an "emotional thermometer" or an account of how life is going. Refer to the ORS during the encounter.

This is the most important clinical nuance of PCOMS. The ORS and SRS are not like bread to a sandwich, separate from the real meat of the session. Rather, they are clinical tools intimately integrated into the work itself. The ORS is not an emotional thermometer that rates how the client is feeling at the moment it is given nor is it intended to be an ongoing account of how the client's life is going week to week. Rather, the ORS is designed to measure how things are going in the client's life relative to the reasons for service.

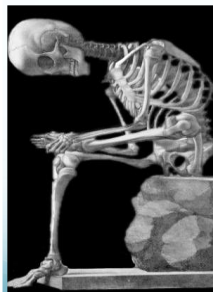
First Session: Connect to the Client's Described Experience



At some point, **connect** the client's reason for service to their marks on the ORS.

PCOMS

The ORS The Bare Bones



- No specific content other than domains—a skeleton to which clients add the flesh & blood of their experiences.
- At the moment clients connect the marks with what they find distressing, the ORS becomes a meaningful measure of their progress and potent clinical tool.
- What will it take to move your mark 1 cm to the right?

PCOMS

The ORS, by design, is a general outcome instrument and provides no specific content other than the broad domains. It offers a bare skeleton to which clients must add the flesh and blood of their experiences, into which they breathe life with their perceptions. At the moment in which clients connect

the marks on the ORS with the situations that are distressing, and to what they would like to accomplish, the ORS becomes a meaningful measure of their progress and a potent clinical tool.

Because the ORS has face validity, as noted, clients usually mark the scale the lowest that represents the reason they are seeking services, and often connect that reason to the mark they've made. Although some will refer to their taps on the ORS, with other clients, you may need to clarify the connection between the client's descriptions of the reasons for service and the client's marks on the ORS. This entails eliciting the client's perspective on what the marks mean so that you are on the "same page" regarding what the marks say about the work and whether the client is making any gains. This way, both you and the client know what the mark on the line represents to the client and what will need to happen so that the client will both realize a change *and* indicate that change on the ORS.

At some point in the meeting, the provider needs only to pick up on the client's comments and explicitly connect them to the ORS:

Okay, it sounds like dealing with the loss of your job (or relationship with partner, sister's drinking, or anxiety attacks, discrimination at work etc.) is an important part of what we are doing here. Does the distress from that situation account for your mark here on the _____ scale on the ORS? Okay, so what do you think will need to happen for that mark to move just one centimeter to the right?

It is important that the client understands that the marks on the scales should be connected to and reflect those issues that are the grist for the mill. From the get-go, ensure that the measure is relevant to both the client's experience and the work that will ensue. If that connection isn't made explicit, then the ORS becomes an emotional thermometer reading of weekly moods in response to the inevitable ups and downs of life. And then it is worthless.

As mentioned, most of the time there is one scale that is lower than the rest that represents the reasons for service. In those instances, you just ask if the client's articulation of their concern is reflected on the lowest scale. At other times, like when clients are in crisis and very distressed, all the scales are about equally low. That requires one more question to identify where therapy should ultimately focus. That is, where would we see the gain first if our work together is successful?

Recall that the client above (Jane) rated all the scales low.

Jane: Leading up to when I got fired from my job, I felt a big decline in my mental health. The big

chunk that is keeping me down is the depression and anxiety. My issues with mental health are holding me back from all the things I want to do.

Barry: Help me understand (referring to the graph screen), is there a scale that represents the depression and anxiety more than the others?

Jane: I feel that the depression and anxiety affect all these aspects of my life.

Barry: Okay, if our work together was successful, where do you think you would likely see the gain first? Or where do think you would feel the impact of the change first?

Jane: Probably socially, then individually.

Barry: Okay, let's start with socially since you said that first, what would it look like if it changed just 1 cm to the right, if there was just a little clearing in the fog, what might that look like?

Jane: I think I would not be isolating like I am now...If that part of the scale would go up, then potentially I might have more friends. I don't have many friends because I don't put myself out there.

Barry: Do you have any ideas how you would maybe start reaching out a bit more and try to make friends?

Jane: Well, I attend my recovery group every week and they always socialize afterward but I always bolt. So maybe when I see my sponsor midweek, I can force myself to tell her I'll go even if I don't want to because I know if I tell her that, I will do it.

Most of the time, there will be one scale lower than the rest, one that reflects the greatest distress. You can note the lowest scale at the start of the conversation when you invite the client to start with that scale or wherever they would like. Then as the client discusses the issue that is represented by that distress, explicitly connect that mark or touch on that line with the client's description of the distress. Follow this with questions about what it would take to move the mark just 1 cm to the right. The client below exemplifies this discussion. When all scales are low, and after the client describes the distress in their life, ask the client where they will likely see the gain first if your work with them is successful. Then proceed with goal and theory of change questions as the client above exemplifies.

There is nothing heavy-handed or cast in stone about this. Client reasons for service can change. The space between the client's marks and the far right represent the zone of potential gains and where new reasons of service can be connected on a given scale. Keep in mind that everything is negotiable. It just must make sense to the client and you, and it must provide a way that you can collaboratively monitor

whether the service or therapy is helping. So, if the client's reasons for service change, just reconnect the new reasons to a mark on a scale on the ORS with enough space to depict change. If the client has already achieved change on a different reason for service, it may make sense to close out that episode and start a new one. This is a judgment call. What makes clinical sense is the principle.

Finally, connecting the client's experience to the ORS has other benefits. It can help you and the client stay on track by providing a way to focus the session back on the lowest rated scale when the conversation goes astray—the ORS helps prioritize topics as well as thematically tie different elements of the discussion together. Simply pick up your device displaying the graph page and ORS and redirect to the issue at hand as well as what can be done in session and beyond to move the mark to the right. Remember, this is what you don't want: a see-saw graph which depicts that the ORS was not connected to the reasons for service:

PCOMS, the ORS, and Multicultural Competence

Beyond ensuring representative diversity and educating dominant culture practitioners about privilege and other biases, less has been proposed about *doing* culturally responsive work with *this* client with *this* therapist. PCOMS provides a way to address client experiences of marginalization and discrimination as well as differences between client and therapist.

Inquiring about and honoring client perspectives of outcome starts with a shared understanding of the purpose of therapy. Clients rate themselves resulting in a score that only they can interpret. The therapist provides reference points (clinical cutoff, expected treatment response) gleaned from normative data to understand the client's score and validate their experience (e.g., "People who score this low tend to be having a rough time of it, is that right?" Or "You scored like people who are looking for a change, is that right?"), but the client is the final arbiter of meaning.

The content-free dimensions of the ORS allow clients to describe the meaning of their scores without preconceived theory, symptom, or therapist-derived constraints. Thus, client accounts retain the richness of real life, including the unique back-stories that contextualize their dilemmas, including the possibility of oppression and discrimination.

Conversations generated by client scores on the ORS are openings for therapists to inquire about clients' reasons for service, views on precipitating and contextual factors, the impact of the problem in clients' lives, and thoughts about general directions for problem resolution. The ORS contextualizes presenting problems beyond diagnostic categories, running counter to practices that pathologize clients of color and other historically marginalized groups at higher rates.

Putting client reasons for service in context also promotes consciousness-raising for both client and therapist, helping to identify forms of oppression and marginalization that may contribute to distress. Consequently, the Outcome Rating Scale creates opportunities for cultural humility and responsiveness. It provides a logical place for such conversations to occur if they do not do so naturally during treatment, enabling the space to make humble attempts at getting closer to the client's unique experience. The following client example summarizes the first three skills of the ORS and demonstrates how the ORS can also include discussion of larger social impacts in clients' lives.

The ORS. The client, Maria, is a 32-year-old cisgender woman, a recent immigrant from Mexico. The therapist, Barbara, a 45-year-old cisgender, Cuban American woman, introduces the ORS and explains the rationale for doing it, a key component of engaging clients in a collaborative, transparent psychotherapy. The therapist asked the client if she preferred to conduct the session in Spanish, but she declined saying she needed to practice her English. She did, however, prefer the ORS in Spanish.

Barbara: This Outcome Rating Scale is used for two reasons: The main reason is to ensure that your viewpoint about things stays central to the way the work is done, your viewpoint about whether you are benefiting essentially will drive the therapy. The other reason is that if we monitor your benefit together every time you come in and you are not doing well, we can put our heads together and figure out something else to do. (Hands client the ORS in Spanish on an iPad.) Put a touch where you see yourself in these major areas of your life where this side means things are going very well and this side means things are going not so well. (Client fills out the ORS and hands the iPad back to therapist).

The therapist notes the client's score and suggests what it might mean using the clinical cutoff as a reference point, and then looks for client feedback to see if it is an accurate depiction of the client's experience. Finally, the ETR, if provided by the system you are using, is explained to continue total

transparency. The introduction of the ORS already demonstrates a dimension of cultural humility, overtly noting the desire to keep the client's perspective central to the process.

Barbara: Okay, you scored a 14.7 (Therapist and client look at graph.) People tend to score in the mauve part of this graph (under 25) when they are looking for a change in their life, when they are looking for something different. And you are scoring like a person who is having a really hard time of it, a lot of distress in your life. Does that fit you? (Client whispers "Yes."). People scoring in the green (over 25) tend to be people who don't end up talking to people like me. (Client looking at graph). This bold green line (the ETR) is what we are hoping will happen for you if our work is successful. It's a way to help us stay on track. Looks like you scored the "Socialmente" scale the lowest. Start there or wherever you would like.

Maria: I am overwhelmed. I can't sleep worrying about everything, how we are going to make it. I've just been in the U.S. for about a year. Found a place to live, got my daughter enrolled in school, and found a job. I thought that after all I had been through, especially traveling across the desert with a 5-year-old (client elaborates harrowing story of leaving Mexico to travel to the U.S.) to get here, that things were going well. Then the things at work started.

Barbara: Wow, what a story, you have been through some tough times and have prevailed looking for a better life for your daughter. What is happening at work?

The initial ORS score is an instant snapshot of how clients view themselves, bringing an understanding of their experience to the opening minutes of a session. With this client, within two minutes, the therapist knew that she was in significant distress, well under the average outpatient psychotherapy intake (18-20), and that she was especially experiencing hardship in in the social (work, school, friendships) domain of her life. A cultural opportunity was also presented which is followed up in the exchange below.

Maria: Thanks, that is what I am looking for. Work is really getting me down. I started at a real estate company as a receptionist because they wanted someone who spoke Spanish. I thought it was going great and I could eventually get my real estate license. But the manager said that people were complaining about my English, that I had too much of an accent. I think it is him, that he thinks I have too much of an accent. I don't think he likes immigrants, especially from Mexico. The previous receptionist was Spanish speaking from the U.S. and spoke English without an accent. He makes me repeat everything at least three

times. No one else does that. So he moved me off reception and cut my hours. I can't afford that! He says it's because things are slow now, but I think it is because he doesn't like my English. I think it is, what do you call it, discriminaci3n?

Barbara: Yes, discrimination. No wonder you are distressed and feeling overwhelmed. After all you have been through, you now face a boss who is discriminating against you because you are Spanish speaking. (Therapist holds up iPad and Points to ORS). So, does your lowest mark on the "Socialmente" scale represent this situation at work where you are being discriminated against because of your English? (Client says yes). And that situation (therapist points to other domains on the ORS) is affecting all these other aspects of your life? (Client nods yes.)

Conversations generated by client scores on the ORS are openings for therapists to inquire about reasons for service, views on precipitating and contextual factors, impact of the problem in clients' lives, and thoughts about general directions for problem resolution. The ORS not only helped create an opportunity to discuss the discrimination but also facilitated the therapist's ability to follow the client's lead and enhance cultural comfort. Clients usually score the scale the lowest that represents the reason for service, and the therapist invites them to start there (or anywhere else they find useful). The therapist connects the client's discussion of the reason for service to how they filled out the ORS, to a specific mark on a specific domain. This helps the client and therapist to collaboratively define a starting point—a shared understanding of the problem, the client's preferred focus of therapy, and what success will look like.

Therapist: What do you think it would take or what would be different at work that would lead to your mark on the Socialmente scale moving just one cm to the right?

Client: I think if I had some kind of plan that would increase my confidence to face the boss and somehow deal with the discrimination differently.

Therapist: Okay, that makes sense. Let's talk about what you can do at all levels of this, from how you interact with him to what options you have on a larger scale. But first, what are your ideas about how to approach this so that you feel less overwhelmed and more confident?

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 calibrated to their idiosyncratic circumstances. The therapist then can ask, "What do you think it will take to move your

mark just one centimeter to the right; what needs to happen out there and in here?” Asking clients about their theory of change not only privileges client perspectives above theoretical predilections, but also honors potential cultural and indigenous solutions. Ensuing conversations can revitalize clients’ hope and belief in their capacity to effect meaningful change, bringing to bear potent client factors in the resolution of difficulties.

After the first session (see Chapter Three), the client’s score answers the question , “Is therapy working?” Nonresponding clients are engaged in a collaborative search for new directions, while benefitting clients are empowered to see gains as resulting from their own efforts. Every conversation about change or the lack of change sets the occasion for not only unfolding and expanding experiences, constructing new meanings, and unearthing new avenues out of the client’s dilemma, but also for opportunities for cultural humility. PCOMS essentially serves as a communicative catalyst in which client and therapist engage in a constantly evolving conversation about the status of the client’s problem and the therapy’s role in helping resolve it.

Skill Four: Get an Accurate Rating on the ORS

Skill Four: Get an accurate rating of the ORS, i.e., a rating that matches the client’s description of their life circumstance and reasons for service. Immediately clarify mismatches and redo the ORS.

Given that the first ORS provides the comparison point for all future work with the client, it is essential to get a good rating. This means striving to get the most accurate rating of the client’s experience possible, a sincere appraisal of their life. Encourage a frank discussion of the issues involved, express your desire to be helpful, and get the idea across that therapy works best when the ORS is an accurate reflection. In general, any score above 32 is not a good rating, certainly one to be cognizant of whether it matches the client’s description of their life. Even people who consider themselves doing very well in life do not tend to rate this high.

There are three reasons that people score above 32 on a first meeting ORS:

- ✚ They don’t understand the ORS.
- ✚ They are disgruntled and are blowing it off.

- ✦ Or they are frightened about the consequences of showing any distress.

None of these reasons is difficult to overcome. For example: Barry was doing a consult for an agency that was already using PCOMS, so he incorrectly assumed that the client understood the ORS. He administered the measure and the client scored a 38.1. He was surprised given that he was purportedly doing a consult because the therapist and client felt stuck. But he said that things must be going really well, and the client just looked at him in a confused way and launched into a horror story of what she had to go through to get to the appointment. She had to get up 4 hours earlier than usual and had experienced two panic attacks. In fact, she said her life was riddled with panic making every day an ongoing battle. He simply picked up the ORS and asked, “Where do I see the rather extreme struggles that you are describing on the ORS?” To which she answered, “Is that what that’s for?” Barry asked her to redo the ORS and she scored a 12.9.

But please take clients at face value unless you have evidence from them—not referral sources or family members—to the contrary. Err on the side of believing that there is a good reason for the client to rate it as they did.

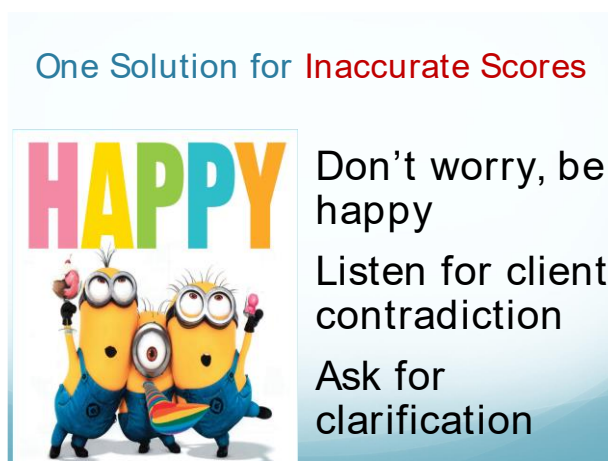
The ORS must have meaning arising from their specific life circumstances. Clients who rate the ORS over 32 and then after a few minutes start telling you how badly their life is going do not understand the measure. All you have to do is ask about it and perhaps the easiest way is to simply inquire where the distress that the client is describing can be found on the ORS.

How about folks who just blow off the ORS because they are angry about being in your office or who are disgruntled for some reason? For example, Barry saw Darrell, a referral from the DUI court, who jerked the ORS from Barry’s hand and completed it in about a nanosecond. He just took the pencil and drew a line down the right side of the page. Barry dutifully measured the marks and totaled them to a score of 38.8. He commented on how well Darrell was doing, especially considering his recent arrest, which he had opened the conversation by angrily saying how he was forced to be there by the courts because of a DUI. When Barry asked him how the referring PO would rate him, he said he did not give a flying f about what his PO thought.

Even with this inauspicious start, after a while of talking about things, Darrell lightened up when he figured out that Barry wasn’t there to nail him about his drinking. Darrell told him through tears that his girlfriend had kicked him out and he was very sad about that. Darrell also reported that he had been

sleeping in his truck and was also concerned about losing his job. After commiserating a while, the therapist asked him to help him understand how his life could be so hard while his ORS looked like he just won the lotto and spent a week in Hawaii with Angelina Jolie. He laughed and said that he was pissed off in the beginning and rated the ORS without thinking much about it—that he had just blown it off. Barry asked Darrell if he would do it again because it would help keep track of the work and make sure he was getting where he wanted to go. And he did. His score was 18.3 with a 3.4 on the *Interpersonally* scale. The impact of Darrell’s drinking on his relationship with his partner became the focus of the work. And when he was sober for 3 months, he invited his ex-partner to join him in therapy. Sometimes you have to work at that first ORS—to secure a good rating that reflects what is going on in the client’s life. It is worth the effort.

Finally, the same methods apply to the person who scores high because of fear of the consequences of looking bad to a referral source like the courts or child protection. As discussed earlier in the chapter, asking the client to complete the ORS from the perspective of the referral source can start a useful conversation about the differences between the ratings and the purpose of the ORS (ensuring their voice and monitoring their benefit). Such conversations can help assuage the client’s fears and lead to a more candid re-taking of the ORS. And the method of this skill, simply waiting until the client reports something that contradicts the high score, and then respectfully asking for clarification, can lead to a conversation that builds the trust necessary to ask the client to redo the ORS.



Getting a good rating on the ORS that reflects the client’s described experience and reasons for service is critical to PCOMS. It’s up to you to make that happen. Transparency is the rule. Just ask clients for help

if their scores don't make sense, if the score doesn't match their presentation of distress. If not, ask the client to redo the ORS. When all else fails, don't argue with the client or enter invalid data.

Chapter ONE Summary

PCOMS starts with the simple act of introducing and administering the ORS, which requires: (a) building a culture of feedback, (b) understanding that there is no bad news on the measures and viewing feedback as a gift that can only improve outcomes, and (c) fitting the introduction into your own language and style, ensuring that clients understand that the ORS is designed to keep their perspective front and center and will be collaboratively used to monitor their benefit. Then there is the more clinically nuanced aspect of integrating the ORS: (a) discussing the client's score in relation to the clinical cutoff, allowing the client to make sense of it, including the impact of social location, and explaining the ETR, what we hope services will accomplish, (b) connecting the client's described experience of the reason for service to their marks on the different scales, (c) ensuring that the client's rating represents their described experience—that you have a good rating on the ORS.

What People Forget Not Just Flicking a Form



- A Clinical Process Fully Integrated into the Work Itself
- Like Everything Else, Success Is up to the Therapist: Have to Believe in It, Use It Sincerely, and Make It Their Own
- Worthless Unless Data Used to Identify at Risk Clients...and then Do Something about Them.

Chapter TWO

Skill Five: Introduce the Session Rating Scale

Skill 5: Introduce, administer, and score (if applicable) the Session Rating Scale (SRS) each visit or unit of service. Depersonalize or externalize the introduction. Express a sincere desire for feedback.

The use of the SRS continues the culture of client privilege and opens space for the client's voice about the alliance. The SRS encourages ethnic/cultural/racial/orientation differences to be transparently and routinely discussed. It provides a mechanism to address cultural beliefs and ideas that may be salient to therapy and the relationship. By routinizing the asking for and receiving client feedback about their experience of therapy, the SRS promotes openness to client perspectives, laying the foundation for cultural comfort and humility.

The best thing about the SRS is that it helps you build a strong alliance. It encourages you to not leave the 1000 studies demonstrating the relationship between a strong alliance and positive outcome to chance.

The SRS or CSRS is given at the end of the meeting but leaving enough time for discussing the client's responses. This is important because clients drop out for two primary reasons: one is that the service is not helping (hence the importance of monitoring outcome), and the other is alliance problems—they are not engaged or turned on by the process. The most direct way to improve your effectiveness is simply to keep people engaged. Traditionally, clients give their evaluation of the alliance with their feet—they walk out and don't come back.

The SRS, like the ORS, is best presented in a relaxed way that is seamlessly integrated into your typical way of working. And like the ORS, it designed to be a light-touch, checking-in process that exemplifies the culture of client privilege and feedback.

Here are some example introductions:

Before we end today, I want to take a few minutes and ask you to fill out another brief form. It's called the Session Rating Scale. It's kind of like taking the temperature of our meeting today. Was it too hot or too cold? Do I need to adjust the thermostat to make you feel more comfortable? The ultimate purpose is to make every possible effort to make our work together beneficial for you and to make it go the way you want it to. If something is amiss, you would be

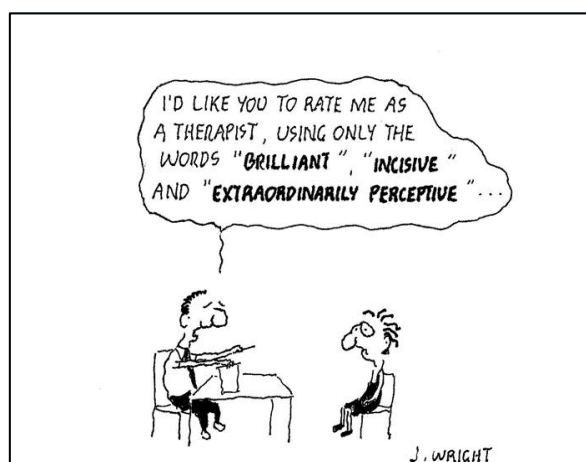
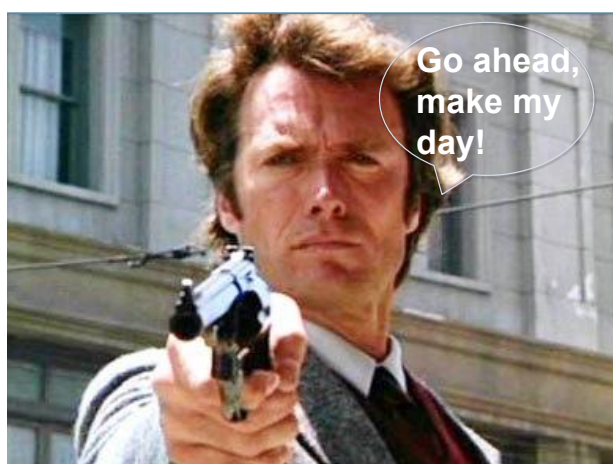
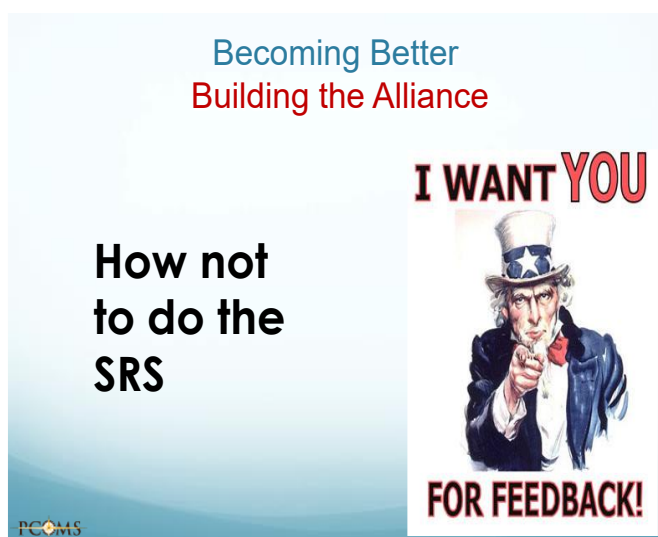
doing me the best favor if you let me know because then I can do something about it. Would you mind doing this for me?

This form, the Session Rating Scale, looks at how it went for you today, with the idea being that I really want to know whether you think we are on the right track, that we are talking about the right stuff, and whether my style and approach are a good fit for you—so I could do something about it if it wasn't working out for you. When clients and therapists talk about these things, it tends to make the outcome come out better

To a child: Before we wrap up I would like to ask you to fill out another one of those forms that has faces on it. This one deals with how you think I am doing. That's right—you get to grade me! It is very important to me to make sure that this is going well for you. Can you help me out?

Those are just examples, and you need to do the introduction in your natural way of communicating with clients and the flow of your meetings. One way is to do your wrap up of the meeting, give the take home message (perhaps a homework assignment or what you want the client to remember or reflect on about the session), and then administer the SRS. One thing that I learned over the years is that I have gotten a lot more response from clients when I have de-emphasized that the SRS is about their “feelings” about the “relationship” because it is hard for folks, in general, to talk about these things. If you want people to run out of your office shrieking, say something like, “The SRS enables you to share your inner most feelings about our relationship.” Instead, I have found introductions that don't mention relationship, like the temperature metaphor, or that call it a rating of the meeting itself, instead of me or the relationship (except for kids—they like the idea of grading us), yield better discussions.

The SRS itself is a bit of an externalization of the alliance. It is a lot easier to mark the scales lower than to talk about it. That's the whole idea. People will indicate a concern on the SRS when they never would have brought it up otherwise. Beyond being an alliance measure, the SRS represents a nuanced relational process designed to ensure that clients feel safe about offering feedback. This requires therapist comfortability about asking for feedback and a graceful response that accommodates the work to the feedback—an authentic desire for a frank discussion about client preferences regarding the alliance.



You don't want the client to think that you will be angry with their feedback or that it will hurt your feelings. You need to be comfortable in your own skin asking for feedback. Here is where your interpersonal skills come in handy. Getting feedback on the SRS is a nuanced relational process that requires you to finesse a response from clients by making them feel comfortable about offering you feedback. You must build the culture for feedback, the next skill.

Skill Six: Building a Culture of Feedback

Skill 6: Build a culture of feedback in which the client understands that the SRS is intended to create a dialogue that individually tailors the service—and that there is no bad news on the measure.

Building a culture of feedback means this whole process of securing feedback comes back to—us! This includes being comfortable in our own skin when we ask for feedback, to really want it, to respond gracefully and do our best to accommodate our work to the feedback, and finally our genuine desire for a frank discussion about their preferences regarding our work with them.

A concern often arises regarding the high scores on the SRS. Folks worry that clients do not rate the SRS honestly because they don't want to hurt the practitioner's feelings or because they are filling it out in the presence of the therapist or worker. Or in other words, clients will inflate their scores because of social desirability and/or demand characteristics. It makes sense that some would have this concern given that the suggested cutoff is 36 out of 40 and most clients do tend to score the SRS very high.

Keep in mind that this is not like having work done at your car dealer and being told about the forthcoming customer survey: "Make sure you mark all the questions 'excellent' or 'extremely satisfied' or they will take it as a bad rating." Just remember that you want a "negative" rating, you want the client to be comfortable enough to tell you if something is wrong. Don't be the therapist depicted in the cartoon of the last skill.

These concerns are reasonable but come from misunderstandings of both the SRS and alliance measurement in general. First, there is no bad news on the SRS. It is not a measure of competence or ultimate ability to form good alliances. It is a gift from the client, actually, that allows you the opportunity to both alter the service and be a better counselor with that client. And of course, unless you really want negative feedback, you are very unlikely to get it. So, if you are striving for feedback and not putting any value on positive scores—in fact quite the opposite—then social desirability and demand characteristics don't make much sense. In that case, the desire to please, to be socially appropriate, would lead to a demand for lower scores, not inflated ones.

Second, all alliance measures tend to be scored high by clients. This is not just a phenomenon of the SRS but runs across alliance scales in general. So, what does that mean? It could say that clients score alliance measures so high because of social desirability or demand characteristics. But the fact of the matter is that clients score alliance measures high regardless of whether you are present or not.

The Alliance Traditionally



Told us with their feet
Will let us know on SRS
before telling/ bolting.

Takes work for candor.

Disparity in power &
socio-economic, ethnic,
or racial diff., can make
it tough. When was the
last time you told your
physician, "You're
making a big mistake"?

So, what do the high scores mean? Our preferred interpretation is that it is just plain hard to give critical interpersonal feedback. It's hard enough in our closest relationships! But perhaps even harder to give negative feedback to someone trying to help us especially given the disparity in power, combined with any socioeconomic, ethnic, or racial differences. When was the last time you told your physician, "Listen, you're making a big mistake with me"? So, we should recognize the difficulty of the task and give clients a break. It's all good. High scores are good, low scores are even better.

Another thing to keep in mind is that the high scores just plain make sense if you put yourself in the shoes of your client. How can they know that you won't use their feedback against them? How can they know that you won't somehow alter or limit service, that there will be a negative consequence? Self-protection is a valid response any way you look at it.

Skill Seven: Discuss the Score and the 3 Elements of the Alliance

Use the SRS to discuss whether: the client feels heard, understood, and respected; the service is addressing the client's goals for service/ treatment; and whether the service approach matches client preferences, culture or worldview, or theory of change. Gracefully accept feedback no matter what it is and do whatever possible to address it. Ask about and be responsive to any ethnic/racial/cultural/orientation differences and concerns.

If you don't have an electronic system, the SRS is easily scored by measuring the client's marks on the line in a similar fashion as the ORS. Each line is 10 centimeters long. Just pick up on an item or two on the SRS and make comment on it. If there are any scores lower than 9 centimeters, or any scale lower than the others, follow up on it. A total score of less than 36 should be discussed. Keep in mind that children and adolescents show more variability of scores than adults, and it is likely that when there is a problem with the alliance, the score will drop dramatically. Children and adolescents are far less likely to be reluctant to let practitioners know that something is amiss. The best thing that the SRS can do for you is to allow you to fix any alliance problems that are developing.

The SRS shows clients that you do more than talk the talk—you are REALLY interested in their feedback and want to know what they think.

The cutoff of 36 may be a bit of overkill given the average first meeting SRS scores range from 33.5 to 33.9 and increase from there. But given the importance of the alliance, erring on the side of caution is warranted. Moreover, exploration of the alliance in and of itself helps build the alliance. So, if a client scores less than a total of 36, or less than 9 cm on any dimension on the SRS, or one scale is lower than the others, there is a *potential* problem that should be discussed, as well as an opportunity to enhance your relationship. Given these parameters, you can do a very quick visual check and then integrate the results into the conversation.

This is not complicated or heavy-handed. There are only two choices. Either the SRS is 36 or above, or not. And your actions are equally simple: Either you thank the client for the feedback and invite them to share any future concerns—letting them know it's the best favor they could do for you; or you thank the client for the feedback and explore why the ratings are a bit lower so that you can try to fit what they are asking for. But don't stress about it. Remain open and keep encouraging the client to let you know if there's anything else you can do. But don't think for a minute that you will get critical feedback from everyone. Some clients will never do it.

A high rating is a good thing but can be difficult to interpret unless you unfold it a bit more. A lower rating is cause for celebration and can yield information that makes the difference between success and failure.

Good initial alliances that stay good portend a positive outcome, but those that start off lower and improve over time are even a more robust predictor. The SRS provides a structure to systematically address the alliance, gives you a chance to fix any problems, and demonstrates that you

do more than give lip service to forming good relationships. Your appreciation of any negative feedback is a powerful alliance builder.

Thanking and Inviting: *Let me just take a second here to look at this SRS—it's kind of like a thermometer that takes the temperature of our meeting here today. Wow, great, looks like we are on the same page, that we are talking about what you think is important and you believe today's meeting was right for you. Please let me know if I get off track, because letting me know would be the biggest favor you could do for me. Is there anything in particular that you found helpful today that you want to make sure I continue?*

The idea here is simply to say thanks and continue to invite any feedback to improve the service. Getting at what the client liked about the session can also be useful. Anything that helps a conversation about the alliance is good. As you gain experience with using the SRS, you will figure out more ways to have conversations about the alliance in a way that increases client engagement and partnership.

The Session Rating Scale

A Quick Visual Check



Scores < 36 or 9cms should be discussed.

SRS is good or it's not. If > 36, thank the client for the feedback, invite them to share future concerns, & ask if they liked anything in particular; or, if < 36 or if 1 scale is lower, thank client & explore if you can do anything to improve.

Building the Alliance

How about when it falls below 36 or any individual scale is below 9? The only difference in your response is that you thank and explore, instead of thank and invite. Don't be expecting specific feedback or grand revelations, although they do happen from time to time. Usually, the feedback is somewhat vague and general. Remember it is hard, for nearly all of us, to give interpersonal feedback, especially critical; so, any feedback is communicating something. Just try to get at what it is. "Is there anything else I could have done differently, something I should have done more of or less of, some question or topic I

should have asked but didn't?" Another useful question is, "Do you have any advice for me for next time, anything that would make it a little better?"

Thanking and Exploring: *Let me quickly look at this other form here that lets me know how you think we are doing. Okay, seems like it could have gone better. Thanks very much for your honesty and giving me a chance to address what I can do differently. Was there something else I should have asked you about or should have done to make this meeting work better for you? What was missing here?*

Let me quickly look at this other form here that lets me know how you think we are doing. Okay, seems like I am missing the boat here. Was there something else I should have asked you about or should have done to make this meeting work better for you? What was missing here?

When time seems to be an issue, set the expectation that the SRS score will increase as time goes on, as you are able to address anything specific the client has noted. A good question to ask if clients suggest that not enough time has passed for them to know or to develop trust is "is there anything I can do to make trust evolve quicker?" Sometimes you just get a shrug or "I don't know." No worries. If you have a hunch about what may have led to the lower rating, now is the time to mention it and check it out with the client. Just keep the lines of communication open and continue to invite. Clients may say that nobody's perfect and that's the best you can do. Or they will rate you low but never let you know why, or rate you high all the way through not matter what you do. It's all good. Remember, no bad news on the SRS. Continue to leave space for feedback, continue to want it, and many clients will take advantage of it. Even if they don't, your attention to the alliance will help secure a strong one. Clients appreciate our efforts here, especially when we do our best to accommodate their feedback. This is one of the rare areas in life that we even get points for trying.

An SRS score: *that is poor and remains poor predicts a negative outcome; that is good and remains good predicts a positive outcome; that is fair and improves predicts a positive outcome; that is good and decreases predicts a negative outcome.*

All answers are good and the practitioner needs only to extend the open invitation to the client to continue the feedback process. Thanking the client for this feedback and soliciting continued conversation keeps the avenues of communication open. Your appreciation of any negative feedback is a powerful alliance builder. In fact, alliances that start off negatively but result in practitioner flexibility to client input tend to be very predictive of a positive outcome.

Graceful acceptance of any problems and a willingness to be flexible speaks reams to the client and usually turns things around. Punctuating this point is the finding that clients who report alliance problems are twice as likely to achieve a successful outcome. Negative scores on the SRS, therefore, are good news and should be celebrated. Practitioners who elicit negative feedback tend to be those with the best effectiveness rates.

Talking about the relationship is hard; building a culture of feedback takes a concerted effort. Don't expect too much but recognize that your authentic attention to the alliance via the SRS builds a strong partnership that will keep the client engaged through the inevitable ups and downs.

Reasons to do the SRS

Session Rating Scale (SRS)

Placing a mark on the line nearest to the description that best fits your experience.

Relationship

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

Goals and Topics

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

Approach or Method

Zhuang's approach is not a good fit for me. Zhuang's approach is a good fit for me.

Overall

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

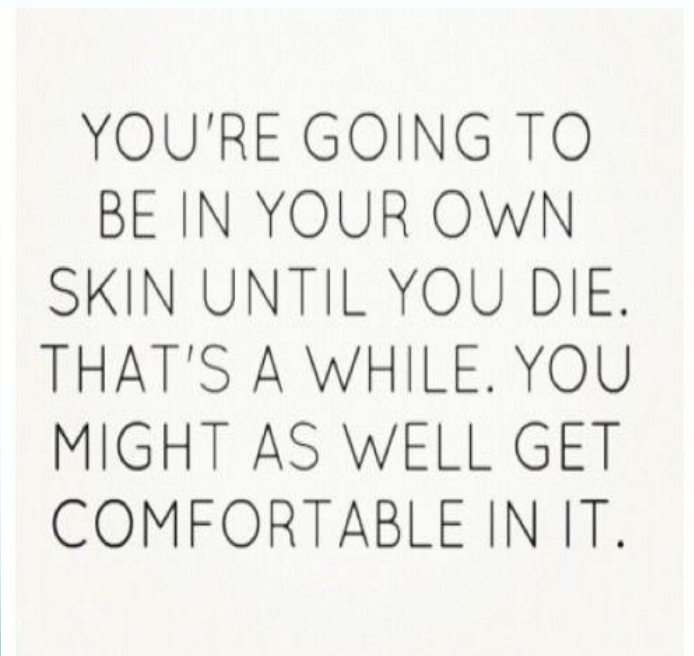
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- The alliance is a robust predictor of outcome.
- It is the client's perspective that is predictive; we are poor judges of client experience.
- Sets up space for collaboration and the structure to build the alliance—sends message that client experience matters; promotes discussion of cultural and other differences btw client/therapist;
- Provides opportunity for clients to use their voice in a safe space which may empower them to speak up in other situations; allows us to model accepting critical feedback.
- Helps us expand our relational repertoire and form better alliances across clients—to get better results.

Although the alliance is discussed at each session, it gains additional priority if the client is not benefiting. We discuss this in Skill 10.

Chapter TWO Summary

The Session Rating Scale is deceptively nuanced. It really requires you to show up and be present with your clients. The SRS allows you to have a structured space in each encounter to discuss and build the alliance. But you have to be comfortable in your own skin. You have to really want the feedback. Know that when clients trust you enough to report an alliance problem, you have truly arrived at a different level of engagement, and your outcomes will likely reflect it.



YOU'RE GOING TO
BE IN YOUR OWN
SKIN UNTIL YOU DIE.
THAT'S A WHILE. YOU
MIGHT AS WELL GET
COMFORTABLE IN IT.

- The SRS is about our willingness to embrace feedback and the ability to convey that willingness so that clients trust that no harm will come their way.

Chapter Three

Skill Eight: Review Client Graph and Progress

After the first encounter, review client graph and progress at the beginning of the meeting or session. Involve consumers in all decisions that affect their care. Let the outcome dictate what happens thereafter.

While there are more granular benefits to PCOMS such as its focus on change and client-directed problem and goal formation, PCOMS really earns its keep by: identifying clients who are changing, helping them see the changes as related to their efforts, and discussing when to space meetings out or end them altogether; and, more importantly, identifying clients who are not benefiting, keeping them engaged while you collaboratively brainstorm what can be done differently.

At second and subsequent sessions, this is accomplished by administering the ORS/CORS and reviewing the progress with the client, the progress since the prior visit as well as since the first encounter. The longer services continue without change, the greater the likelihood of drop out and/or poor outcome. 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.

While reliable and clinically significant change (see the box) are useful metrics to guide your discussions with clients, the expected treatment response (ETR) provides a more sophisticated and easier way to structure the conversation. After the client takes the ORS, the score is plotted on the graph and the current score is compared to what we are hoping will occur if the work is successful, the ETR. With this, at a glance you and the client can see and discuss the amount of change that has happened so far and if the client is progressing as we are hoping. This allows both you and the client to know exactly how things are going so that a meaningful conversation can occur.

There is a huge value added to showing the ETR graphs and ORS scores to clients. Graphs provide a visual component to the feedback process that many clients find helpful. Just as the client's initial ORS score tells you how the client is viewing their life, a graph tells the

A way to understand the amount of change that you are hoping for is via a statistical metric known as the reliable change index (RCI). The RCI indicates change that is greater than chance, error, or maturation of the client. The RCI on the ORS is 6. The RCI is just a benchmark that provides an easy way to know if you are on the right track. Change that both exceeds the RCI and crosses the clinical cutoff (25 on the ORS) is considered "clinically significant." Reliable change is sometimes called "improved," and clinically significant change is at times referred to as "recovered."

story of the client's progress. It offers an additional way to focus on the client's benefit and what may need to happen if there isn't any. Graphing is indispensable when working with a couple or family, helping to manage multiple viewpoints about change while offering a method to discuss what the similarities and differences mean.

The idea is simple. You receive input from the client regarding benefit or lack thereof to start the meeting, and that feedback informs how you conduct this encounter with the client. When we say that we involve clients in all decisions that affect their care, it is not just something that sounds good—it is what PCOMS does. If things are improving, then, with client approval, we keep on doing what we are doing. If things are not improving, we involve the client in a discussion of whether we should continue business as usual, or we should discuss other options.

This isn't rocket science—there are only two possibilities: either the client is improving or not, the ORS score is increasing or it's not. Guidelines for these conversations are the topics of the next two skills.

Skill Nine: When Clients Are Progressing

If clients are progressing), validate the client's contribution to the change and empower clients to take responsibility for the change (a result of their efforts). If change is Reliable or Clinically Significant, or if change has plateaued, discuss spacing out sessions or ending therapy/service/treatment.

When ORS scores increase, a crucial step is to empower the change by helping clients see any gains as a consequence of their own efforts, perhaps even as a part of a newly emerging identity. This requires an exploration of client perceptions of the relationship between their own efforts and the occurrence of change; it is also helpful to encourage clients to reflect about the meaning of the change in the context of their unfolding life story. At the least, it is important that clients come to view the change as resulting from something they did and can repeat in the future.

Even if clients resolutely attribute change to luck, fate, your expertise, or a medication, they can still be asked to consider in detail: (a) how they took advantage of what was offered by others, (b) what they did to use the changes to their benefit, (c) what they will do in the future to ensure their gains remain in

place, and (d) how the changes reflect new chapters in their lives. The point here is that it is helpful for clients to see that although other factors were involved, the change was a result of some inner or outer action that they precipitated.

Helping clients take credit for steps in the right direction casts them in their rightful roles as the main characters in their stories of change, the heroes or heroines of their own life journeys. You shine a spotlight on any accomplishments and request that the client take a bow for their creativity, courage, and good ideas. Basking in the limelight of success keeps the positive performances coming.

My good friend and colleague, John Murphy has a great way to accomplish the task of helping clients see gains arising from their efforts derived from solution focused therapy that he calls the “The Four E’s:”

1. Elicit. An increase in ORS score does this for you but otherwise:

Listen for or ask about exceptions to the problem.

Between the time you made the appointment and today, have you noticed any changes in the problem that brought you here?

When does the problem not occur?

When is the problem less noticeable?

When is the problem a bit more bearable?

What things are happening that you would like to see continue?

How have you managed under these circumstances?

Between sessions, ask clients to:

Note the things in their lives that they would like to see continue or observe (a child, a spouse, a relationship) and note what they would like to see continue.

Pay attention to the times the problem does not occur and what they are doing to make that possible.

Pay attention to the times they overcome the urge to (drink, smoke, yell, etc.).

2. Elaborate

Explore in detail the conditions and circumstances that are related to the discovered change, the increase in ORS score. Put the change under a magnifying glass.

In what ways is it different, more bearable, or less noticeable?

Who is involved when things are different?

How is that helpful?

How do you do that?

How do your friends, family, or others treat you differently when the problem is not occurring?

If your friend, family, or significant other were here, what would they say is different about you during times of the change?

3. Expand

Keep track of everything the client has noted that is helpful in any way. Encourage clients to "do more of" the changes. Amplify or apply the identified solutions, what is already working for the client.

How can you do more of what you are doing that is helpful?

How can you apply what is working in this situation to that situation?

4. Empower the client

Blame the client for the solution. Help them take responsibility for their own creativity and good ideas. Get the client on a roll of positive self-talk. Ask questions that invite the client to reflect on the changes they have made.

How did you arrive at the conclusion that now was the time for action?

What does this say about you, that you took the bull by the horns at this time?

How did you do it? How will you maintain the gains you have made?

Another way to focus on the client's efforts is to make "before-and-after" distinctions. The idea is to encourage client reflection and to distinguish between the way things were *before* the change and how things are now, *after* the change. Invite clients to explore the significance of their actions and tell a different story about their lives—one of triumph, enlightenment, and tenacity. The change itself is a landmark on the landscape of the client's life—something that they can always point to as the place in the journey where a different path was taken. At its best, fleshing out all the nuances of success creates a newfound identity of wisdom and competence gained from the school of hard knocks.

When clients reach a plateau or what may be the maximum benefit they will derive from service, it is time to start planning for continued recovery outside of therapy, treatment, or service. This could mean

just reducing the frequency of meetings and continuing to monitor the client's goals. For others, it could mean referral to self-help groups, peer supports, or other community resources. Although most clients are ready to move on once their distress has been reduced enough for them to see a clearing, a few will want to stay on. Consequently, it is also useful to include a culture of recovery in your work. This simply means conveying the attitude that there is a beginning and an end to services and that recovery is a lifelong journey. Remember that when scores plateau, it doesn't mean catapulting the client out of services but rather that it's time to discuss stepping down services or termination.

If clients are not stepped down after they have reached maximum benefit, the graph can start to look like a saw with ORS scores rising and falling with the everyday vicissitudes of life—the ORS becomes an emotional thermometer, and therapy or services becomes an ongoing commentary of life events. When the ORS represents life in general instead of connecting the client's perception of his or her life to the purpose of the service, problems can ensue. Clients can walk away feeling less empowered to handle life's ups and downs, believing themselves to be reliant on the therapy. Ongoing service in the absence of continued benefit can have other negative effects as well such as dependency and overall disempowerment.

After the First Session
When Clients Are Changing

- Note the increase in score;
- Ask the client what has changed, what is different;
- Ask how they were able to make the change;
- Ask if anyone else noticed the change;
- Ask how they are going to keep the change going;
- Ask if anything learned here can apply to other areas they want to change.
- By doing this, they keep the ORS relevant to the reasons for service and an active tool throughout the session.

Skill Ten: When Clients Are Not Progressing

If clients are not progressing, discuss whether services should continue as is or should be changed. If no change persists, discuss the SRS and identify any problems. Revisit any ethnic/racial/cultural/gender or sexual orientation differences between the client and therapist. Discuss and develop options such as including others from client's support network, different

approaches, supervision, a colleague or team involvement, or changing to a different provider. If no change continues, transfer the client to another provider.

A more important discussion occurs when ORS scores are not increasing. The ORS gives clients a voice in all decisions that affect their care including whether continuation with the current provider is in their best interest. But ORS scores are never an indication of worker ineffectiveness, absolute or otherwise, but rather an expression of the benefit the client is reporting from the services provided—for this pairing of client and provider. When the ORS is not demonstrating change, it allows both interested parties to reflect about the implications of continuing a process that is yielding little or no benefit. The intent is to support practices that are working and challenge those that don't appear to be helpful. The progression of the conversation with clients who are not benefiting goes from talking about whether something different should be done to identifying what differently can be done, to doing something different, and ultimately to referral if change does not happen.

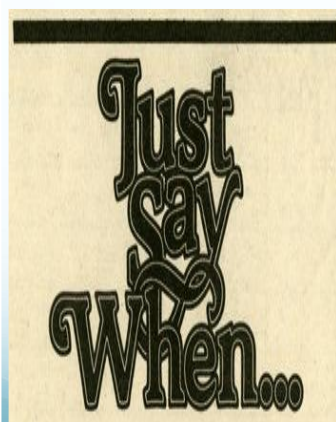
Hosting Therapeutic Conversations When the Client Isn't Benefitting



- Involve the client in the decision about what to do next, to elicit his or her ideas & formulate a plan.
- The discussion repeated in all meetings, but later ones gain significance and warrant additional action: Checkpoint and Last Chance Discussions.

Okay, so things haven't changed since the last time we talked. How do you make sense of that? Should we be doing something different here, or should we continue on course steady as we go? If we are going to stay on the same course, how long should we go before getting worried? When will we know when to say "when?"

Becoming Better When to Say When



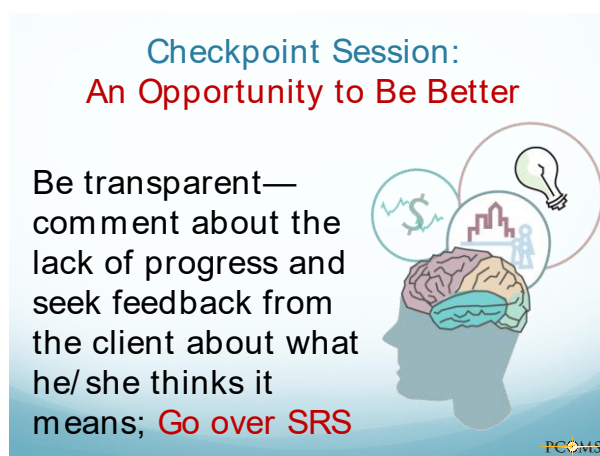
- Stimulates both client and therapist to struggle with continuing a process that is yielding little or no benefit.
- To support what is working & challenge what is not. Urgency increases over time

Later sessions gain increasing significance and warrant additional action—what we have called “checkpoint conversations” and “last-chance discussions.” In a typical setting, checkpoint conversations are usually conducted between the third and sixth meeting and last-chance discussions are initiated between the sixth and ninth session. This is simply saying that by the third to sixth encounter most clients who benefit from services usually show it on the ORS, and if change is not noted by then, the client is at a risk for a negative outcome. Ditto for the sixth to ninth session, except that, then, everything just mentioned has an exclamation mark. Different settings—such as inpatient or residential, case management, and other services that tend to be longer term—will have different checkpoint and last-chance numbers.

The same thing can be accomplished more precisely with the expected treatment response. It is safe to say, however, that the three/six and six/nine meeting benchmarks are pretty accurate for most settings, because even if clients are in service for longer periods of time, they have likely *begun* to change by these benchmarks. Keep in mind that the two identified points of action are a call for conversation and not for rote referral, termination, or anything else.

If change has not occurred by the checkpoint conversation or progress is less than 50% of the ETR, the first-line approach is to focus on the alliance. Simply go through the SRS item by item. Alliance problems are a significant contributor to a lack of progress. Sometimes it is useful to say something like, “It

doesn't seem like we are getting anywhere. Let me go over the items on this SRS to make sure you are getting exactly what you are looking for from me and our time together." Going through the SRS and eliciting client responses in detail can help you and the client get a better sense of what may not be working. Such occurrences create a cultural opportunity to entertain how culture, including therapist and client differences, are contributing factors to the lack of success.



Before we provide an example of how the SRS can promote cultural humility and multicultural competence, one caveat: Implementing cultural responsiveness takes a sustained effort to include clients and embrace their feedback—to not reduce psychotherapy to the medical model equation of diagnosis plus prescriptive treatment equals cure, nor clients to cultural, ethnic, racial, or gender stereotypes or pharmaceutical sponsored checklists, nor the proclivities of enlightened psychotherapists who know better than clients what they need.

The SRS. The client, James, a 42-year-old African American, cisgender man, and therapist, Barry, a 64-year-old white, cisgender man illustrate how racial differences can be explored via discussion of the alliance. The client presented with general feelings of malaise, marital troubles, and a lack of motivation at work. His initial ORS score was 19.2, reflecting distress typical of clients entering outpatient psychotherapy. The therapist and client, over the first two sessions, agreed to approach the client's concerns from an existential framework highlighting the thematic meaning of his malaise and angst as well as cognitive strategies to address the client's stated propensity to "make mountains out of molehills." The client declined marital therapy.

At the beginning of the fourth session, the client's graph was a flat line with no benefit depicted. The therapist reviewed what had been done so far and asked the client if he had any ideas about the lack of benefit and what could be done differently at this point.

Barry: Doesn't look like things have improved. (Therapist and client look at graph.) What do you think that means, particularly regarding what we should do today?

James: I am not sure. I find our conversations helpful, and the exploration of meaning has been thought provoking, but nothing has put a dent in my problems or how I feel. I can see that the self-talk and relaxation strategies could be useful, but maybe not for me.

Barry: Let's explore some possibilities for things we might do differently in this session to get things turning in the right direction. But first, with your agreement, I'd like to go over the items on this SRS to make sure you are getting what you are looking for from me and our time together. I know that you rated our previous sessions as going well but sometimes alliance concerns can contribute to a lack of benefit, that somehow the therapy or me specifically are not on target in some way.

James: Sure, anything that might help.

Barry: Great. Thanks. The first item covers whether you feel heard, understood, and respected. Do you think I am getting where you are coming from? Am I missing something here? I perhaps should have addressed this directly in our first meeting. I was wondering if you thought it might be helpful to address our racial difference and if I needed to adjust anything because of it. I would greatly appreciate your help in understanding these things because coming from a white privileged position, I am certain that I have inevitable blind spots. Is my whiteness getting in the way here?

James: You know, that's a good question. I never really think much about it because, you know, as a Black man, I deal with the white majority every day, especially in my work, and have dealt with it all my life. So, I didn't give your whiteness any space in my head because it is ubiquitous, as they say, like the air that I breathe. But now, I am wondering how you can understand me as a Black man, the pressures I feel in my all-white law firm, both colleagues and clients, and the enormity of the burden I feel to make my marriage work coming from both my wife and our deeply religious families, as well as my position in our church.

Barry: You, of course, are right. There is no way I can completely understand what you have been through as a Black man in a white majority world. Similarly, your experience of burden

resulting from your position in the Black community, church, and family are also impossible for me to understand the complexities and pressures involved. Do you think if we explore these issues more fully so that I might achieve a better understanding, that it will help and enable you to benefit from therapy? Or do you think we should discuss you moving on to a different therapist, a person more in tune with your experience as a Black man?

James: I think we should discuss what I am going through as a Black man experiencing the concerns I have raised. Adding that dimension, I think, will help you understand more. I like talking to you and I think this will be the part that has been missing.

This conversation, of course, could have happened without the SRS. Like the ORS provides a platform for understanding the client's experience, to discuss client benefit and collaboratively alter therapy, the SRS enables a structure for conversations about the relationship and alliance—to demonstrate a sincere curiosity and desire to understand the client's experience, including how their social locations may be salient. Specific to this client, the SRS promoted cultural humility with the open stance to learning about his perspective of the therapeutic alliance through a multicultural lens. Within this process, a cultural opportunity arose due to the lack of benefit that enabled the therapist to better understand the client's unique challenges as a Black man. The SRS can also facilitate a sense of cultural comfort in that it provides a mechanism to initiate conversations that might be more difficult for therapists to broach without a structure in place. Finally, the SRS empowers therapists to elicit and embrace feedback and therefore may enhance cultural comfort. It provides a logical place for such conversations to occur if they do not do so naturally during treatment, enabling the space to make humble attempts at getting closer to the client's unique experience.

Back to the ORS: A lack of progress at this stage may simply indicate that you need to try something different—nothing specific may come of your conversation with the client about the alliance. Don't worry about that. Just making the effort to discuss the alliance can yield dividends, especially about the goals and methods of service. Doing something different can take as many forms as there are clients: inviting others from the client's support system, using a team or another professional, a different conceptualization of the problem or another approach, or referring to another worker, religious advisor, peer services, or self-help group—whatever seems to be of value to the client. Here the main goal is to identify and discuss what the options may be. If any resonate with the client, that strategy or idea is then implemented, and progress is monitored.

Checkpoint Conversation

Do Something Different



Nothing may come of talk about the alliance. Don't worry. Making effort helps.

Invite others from support system, use a team or co-therapist, a different approach; referral to another helper, religious advisor, or self-help group—whatever seems of value.

Any ideas are implemented, and progress is monitored.

Finally, it is worth exploring the client's sensibilities about what needs to happen—or what I have called the “client's theory of change”. The client's theory of change unfolds from a conversation structured by your curiosity about the client's ideas, attitudes, and speculations about change.

✚ *Many times people have a pretty good hunch about not only what is causing a problem but also what will resolve it. Do you have a theory of how change is going to happen here? Or, perhaps something that has worked for you in the past? Or even something that you think might be helpful that you heard about from family, friends, or the media?*

If you and the client have implemented different possibilities and the client is still without benefit, it is time for the last-chance discussion. As the name implies, there is some urgency for something different because most clients who benefit have already achieved change by this point, and there is significant risk for a negative conclusion.

A metaphor we like is that of the practitioner and client driving into a desert and running on empty, when a sign appears that says “last chance for gas.” The metaphor depicts the necessity of stopping and discussing the implications of continuing without the client achieving the desired change. At the very least, supervision or a co-helper should be considered. And that, too, can turn things around. There is no last chance for the client, just for this counselor–client pairing.

Becoming Better The Last Chance Discussion

Driving into desert running on empty, “last chance for gas.”

Depicts the necessity of stopping and discussing the implications of continuing w/o change.



Becoming Better Never the LAST CHANCE



□ Doesn't mean the “last chance” for your client—but rather the last chance of a change plan or pairing. No last chance for your client—referral can make the difference!

Here are several questions to reflect about in last chance circumstances. The longer the service goes without change, the quicker that the last option should be exercised.

- ✚ *What does the client say about the lack of change? Remember that you are in this thing together.*
- ✚ *Is the client engaged in purposive work to address the problems at hand? In other words, what about the alliance and the SRS? In both the client's and your heart of hearts, do you think this service/therapy with you is going to make a difference?*
- ✚ *What have you done differently so far? What of the identified options have you already employed?*
- ✚ *What can be done differently now? We all have limits. Have you exhausted your repertoire?*
- ✚ *What other resources can be rallied, both from your support system and the client's? How can you bring in fresh blood—new ideas and directions?*
- ✚ *Is it time to fail successfully?*

The last-chance discussion is the time when a referral and other available resources should be discussed. If you have created a feedback culture from the beginning, then this conversation will not be a surprise.

Rarely is there justification for continuing to work with clients who have not achieved change in a period typical for a particular practitioner or setting. But rarely is not never. These situations are highly

idiosyncratic and should be negotiated on an individual basis. The ORS helps keep us honest and addresses the lack of change transparently.

Becoming Better The Last Chance Discussion  At the least, consultation Referral seriously discussed. Rarely justified to continue past typical period. Rarely is not never. Highly idiosyncratic & uniquely negotiated. Keeps us honest, addresses the lack of change transparently. PCOMS	When Change Doesn't Happen Failing Successfully  - Repeat commitment to help them achieve goals. - Failure says nothing about them or their potential. - If client wants, meet until arrangements are made. - But rarely continue with clients who show no improvement. PCOMS
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It's often possible to change course and make the experience productive for clients. But what happens when you have implemented new or different strategies and there is still no benefit? What if you have exhausted all you know to do? This can be singularly confusing if the alliance is strong—after all, referring someone on who you don't like or doesn't like you is likely a relief, but when you genuinely connect with the person, this can be more difficult. It may be hard to believe that stopping a great relationship is the right thing to do, but it is. No matter how competent, trained, or experienced you are, you can't be effective with everyone. If we hold people in service with us, we could actually *be* the problem, because they might be better served with someone else. It's time to *fail successfully*.

When you reach this point, it's time to reiterate your commitment to help them achieve the outcome they desire. Stress that this encounter says nothing about them personally or their potential for change.

Sometimes the folklore of clinical practice includes the notion that clients need maintenance or sustenance work, or that a positive relationship is enough of a thing to provide a client in tough circumstances. While this may make sense at times, we are not doing clients any favors by thinking that our services are what is holding them together. Instead of holding them together, we could very well be holding them up, perhaps keeping them from recovery by miring them in services that are not promoting growth. The idea that the client is damaged goods and will not follow a recovery path—that they need us to survive—is surely implicit in the concept of maintenance work.

Becoming Better Guard Against Finger Pointing



Guard against explaining client response thru theoretical filters & folklore— puts us right back where we have traditionally been— attributing lack of change to the client. Client non-response means something else should be done.

PCOMS

The client is the final arbiter of what the ORS scores mean, but we must at least ask the hard question: are we helping or hindering? The scores are catalysts for conversations with clients that rarely happened before. PCOMS is a way to support what is working and challenge what is not, providing more than just another theory to guide practice and perhaps the antidote to the poisonous pontifications about why clients are not responding to therapy, what our profession has become so adept at.

The thing to guard against here is the tendency to explain client nonresponse to services through theoretical filters and clinical folklore—that puts us right back where we started, where the field has traditionally been—attributing the lack of change to the client. Client nonresponse simply means something else should be done.

PCOMS gives helpers, consumers, and third-party payers a different and reliable way to maximize time, effort, and results in therapy. One caveat is necessary. PCOMS helps providers and clients enjoy the most productive relationship possible. We are not suggesting that you become automatons enslaved to the worship of the measures, but rather that you partner with your clients to either support efforts that are working or challenge those that are not.

What People Forget



Not Just Flicking a Form...

A Clinical Process Fully Integrated into the Work Itself

Like any Clinical Process, Success Rests on the Provider: Have to Believe in It, Use It Sincerely, Make It Their Own

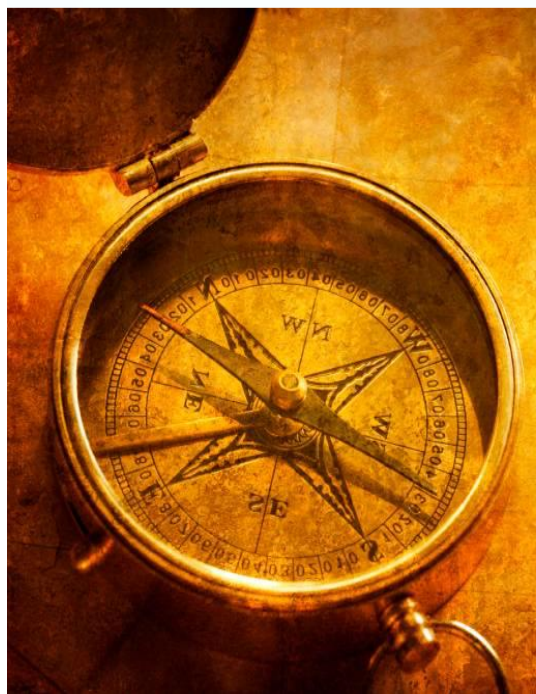
Worthless Unless Data Are Used to Identify at Risk Clients...and then Do Something about Them.

PCOMS

Chapter Three Summary

Only two options: there is change, or there isn't. If there is change, work with clients to take responsibility for the change and empower their ability to continue progress. Facilitate discussions to tease out before-and-after distinctions. Begin to space out sessions and discuss termination when the client reaches a plateau. If there is no change, discuss what needs to happen next. If no change persists, the discussions increase in urgency, represented by the Checkpoint Conversation and the Last-Chance Discussion, both intended to brainstorm options and entertain the possibility of referring the client elsewhere. If no change persists, it is time to fail successfully, or gracefully move the client on to another provider or venue of service and exercise your ability to help clients in a different but equally important way.

Becoming Better Feedback Is My Compass



Not an uninhabited terrain of technical procedures, nor the predictable path of diagnosis, prescription, & cure. Cannot be described w/o the client & therapist, co-adventurers in a journey across uncharted territory. Common factors provide landmarks for this interpersonal & idiosyncratic trip, & specific models provide well-traveled directions to consider, but feedback provides the compass, showing the way to the desired destination.

PCOMS Provider Adherence Scale

1. Introduce, administer, and score (if applicable) the Outcome Rating Scale (ORS) each visit or unit of service. Ensure that the client understands that the ORS is intended to: 1) privilege their voice and bring them into the decision-making process; and 2) will be collaboratively used to monitor progress in each encounter.

Never	Sometimes	Often	Regularly	Always
1	2	3	4	5

2. Discuss the clinical cutoff and contextualize the client's score. Check with the client to see if the score matches their experience. Explain the expected treatment response, what is hoped will happen if therapy/service/treatment is successful. Invite the client to start with the lowest scale or wherever they would like.

Never	Sometimes	Often	Regularly	Always
1	2	3	4	5

3. Connect the client's marks/clicks/touches on the ORS to the described reasons for service. Invite discussion of the larger social context of the presenting concerns. Ensure that the ORS is not used as an "emotional thermometer" or an account of how life is going. Refer to the ORS during the encounter.

Never	Sometimes	Often	Regularly	Always
1	2	3	4	5

4. Get an accurate rating of the ORS; i.e., a rating that matches the client's description of their life circumstance and reasons for service. Immediately clarify mismatches and redo the ORS.

Never	Sometimes	Often	Regularly	Always
1	2	3	4	5

5. Introduce, administer, and score (if applicable) the Session Rating Scale (SRS) each visit or unit of service. Depersonalize or externalize the introduction. Express a sincere desire for feedback.

Never	Sometimes	Often	Regularly	Always
1	2	3	4	5

6. Build a culture of feedback in which the client understands that the SRS is intended to create a dialogue that individually tailors the service—and that there is no *bad* news on the measure.

Never	Sometimes	Often	Regularly	Always
1	2	3	4	5

7. Use the SRS to discuss whether: the client feels heard, understood, and respected; the service is addressing the client's goals; and whether the therapy/service/treatment approach matches client preferences, culture or worldview, or theory of change. Gracefully accept feedback no matter what it is and do whatever possible to address it. Ask about and be responsive to any ethnic/racial/cultural/orientation differences and concerns.

Never 1	Sometimes 2	Often 3	Regularly 4	Always 5
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8. After the first encounter, review client graph and progress at the beginning of the meeting or session. Involve consumers in all decisions that affect their care. Let the outcome dictate what happens thereafter.

Never 1	Sometimes 2	Often 3	Regularly 4	Always 5
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9. If clients are progressing, validate the client's contribution to the change and empower clients to take responsibility for the change (a result of their efforts). If change is Reliable or Clinically Significant, or if change has plateaued, discuss spacing out sessions or ending therapy/service/treatment.

Never 1	Sometimes 2	Often 3	Regularly 4	Always 5
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10. If clients are not progressing, discuss whether services should continue as is or should be changed. If no change persists, discuss the SRS and identify any problems. Revisit any ethnic/racial/cultural/gender or sexual orientation differences between the client and therapist. Discuss and develop options such as including others from client's support network, different approaches, supervision, a colleague or team involvement, or changing to a different provider. If no change continues, transfer the client to another provider.

Never 1	Sometimes 2	Often 3	Regularly 4	Always 5
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Total: PCOMS Provider Adherence Scale _____ Date _____

Provider: _____

NOTE: Out of a total possible 50 points, adherence is considered acceptable at 40 or above at the 6-month mark and 45 or above at one year after implementation. High adherence is ensured by the PCOMS supervisory process and attention to data integrity.