

## *Improving Retention, Outcomes and Supervision with PCOMS*

Presenter: George Braucht

**Are you recommending that the ORS is used in clinical supervision w/ supervisees? Could a supervisor invite supervisees to use the ORS just as clinicians might employ w/ client?**

A: The ORS is administered during direct services not clinical supervision. Better Outcomes Now ([www.betteroutcomesnow.com](http://www.betteroutcomesnow.com)) is the preferred tool for organizing PCOMS-informed services data for clinical supervision and program process and outcome evaluations. That being said, a visual analogue proficiency scale (novice-to-expert) with specific skills or abilities and an appreciative review process could be useful for supervisee tracking of specific skills - like the PINK OARSIs – techniques, goals or, perhaps most importantly, the supervisee’s identified reason(s) for seeking supervision. Similarly, the SRS/GSRS could provide the supervisor vital feedback to inform supervision improvements.

**Do you prescribe to the moral/correctional or disease or trauma model of substance use disorders?**

A: Yes, and more! For me what works is exploring the client’s worldview, theory of change and associated resources and invoking pertinent assistance instead of trying to convince her/him that my view, or bias, is “right” or “best.”

**How does the model differ for use with children/adolescents?**

A: First, based on the research, the ORS clinical cutoffs are 25 for adults and 28 for adolescents (who also use the adult ORS) and for the Child ORS (uses facial icons to denote both ends of each subscales.) The Young Child ORS uses facial icons instead of lined scales. Second, the nuances of explaining the purpose of the scale’s clinical cutoffs and the resulting scores differ depending on the ages and who besides the identified client provides ratings, e.g., parent, caregiver, spouse, etc. Remember, “the clinical cutoff facilitates a shared understanding of the measures and is often a step toward connecting the scores to the reasons for seeking or receiving services.” [Duncan. (2014). *On becoming a better therapist*. p. 112]

**In a community where there is a low availability of mental health resource facilities and a high level of dual diagnosis clients, how and where do you find resources to refer clients on?**

A: Perhaps ask clients/former clients and significant others to participate in Asset-based Community Development (ABCD) sessions. Select a desired type of resource (food, medication-assisted treatment, psychotherapy, housing, recreation, clothing, yoga, faith or worship centers, family- or recovery-friendly fun, etc.) and 1) ask participants to identify 3-5 criteria – what makes for a “good” resource, e.g., accessible by public transit, no or low cost, folks like us are present, people there are friendly, etc. – and list on a flipchart page; 2) add to the page exactly where (so others can find it) participants have experience with such a resource including a contact person – this is essential for warm connections - a manager or other employee/participant who is reliably present and available for a chat, while rating (0-5; good better, best; or some other scale) how well it meets each listed criteria (no resource is likely to be perfect for everyone), then 3) create an Resource Exploration sheet containing the criteria (not the participant ratings) and send folks to check out the resources and report back to the group. Compile the sheets into a Peer-developed Resources manual (PDR, not to be confused with the other one) to which new assessments and resources can be added or removed as you conduct periodic ABCD group sessions.

**Using progress scale, when is the best way to discuss, review, and compare your estimate of progress with the client without doing harm if your views are less than clinical?**

A: It is best to review the client's view of progress – no change, improvement or deterioration from the last session and since beginning services - at the start of each session in which an ORS is completed. "Doing no harm" is accomplished by being curious about and reflecting the client's view of change, or the lack thereof, while consistently revisiting the relevance of the presenting concern(s) and recent (last week's) lived experiences compared to the actual marks on the associated subscales. It's like holding up a mirror as a carefrontation – that may not be a word but you probably get my drift. Not sure what "less than clinical" means but when using Better Outcomes Now ([www.betteroutcomesnow.com](http://www.betteroutcomesnow.com)) the software automatically calculates and displays an expected progress rate that is based on the initial ORS scores of hundreds of thousands of cases - the difference between the client's total ORS scores and the expected rate from session to session invites productive discussions.

**Can you say a bit about how mandated clients who are resistant to treatment respond to these ratings?**

A: All clients are "mandated" or, another way of putting it, motivated intrinsically and extrinsically so that distinction has limited relevance with regard to trust concerns and people on criminal or juvenile justice supervision are not significantly different than those who aren't in this regard. Some people are better at mentalizing or reflecting on and reporting past experiences yet research shows that everyone can improve how well they do this. The social desirability influence, some call it lying or manipulating, is easily challenged with a supportive curiosity regarding mismatches between marks – more typically high marks - on the subscales and actual described experiences that indicate less-than-desired events occurred. That being said, work is required to intentionally create and sustain trusting cultures that promote the perceived safety of disclosures and individual responsibility in individual and group sessions – this simply doesn't happen because you say at the beginning of every session something like, "what you say here stays here except...." How you use your authority to invoke clients' personal responsibility is as much an art as it is a skill. This would be a great topic for a future webinar!

**Is PCOMS recognized by the Joint Commission accreditation process (formally JCAHO) as a valid measurement of client satisfaction and progress?**

A: Not as a satisfaction scale but yes as an outcome measure.

**Is there any information or research on extending PCOMS outcome data collection post-treatment at 3, 6, 9, 12, 18 & 24 month intervals?**

A: Yes, see the outcome and benchmarking studies at [www.heartandsoulofchange.com](http://www.heartandsoulofchange.com).