Psychological Services

ISSN: 1541-1559

2020, Vol. 17, No. 4, 497–498
http://dx.doi.org/10.1037/ser0000419

REPLY

The Evidence for the Partners for Change Outcome Management System Is Insufficient: Reply to Duncan and Sparks (2020)

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In their recent article in *Psychological Services*, Duncan and Sparks (2020) criticize our meta-analysis on the Partners for Change Outcome Management System (PCOMS; Østergård, Randa, & Hougaard, 2020) and judge it to be misleading and flawed. This reply points out omissions and mistakes in Duncan and Sparks (2020) and highlights our decisions regarding inclusion criteria, choice of outcome measures, and analytical strategy. We argue that the use of the PCOMS Outcome Rating Scale might inflate effect sizes because of social desirability. Therefore, independent outcome measurement is necessary for a stringent evaluation of the PCOMS as a routine outcome monitoring system.

Keywords: client feedback, routine outcome monitoring, Partners for Change Outcome Management System, meta-analysis, outcome measurement

In their recent article in *Psychological Services*, Duncan and Sparks (2020) criticize the "study selection, quality of evidence, and appropriateness of interpretation" in our meta-analysis: "The Effect of Using the Partners for Change Outcome Management System as Feedback Tool in Psychotherapy—A Systematic Review and Meta-Analysis."

Our meta-analysis included 18 primary studies: 13 peer-reviewed, two in peer-review, and three gray literature. It found a small overall effect (Hedge's $g = 0.27$) of the Partners for Change Outcome Management System (PCOMS; Østergård et al., 2020). There was no significant effect in psychiatric settings, and the positive effect in counseling settings ($g = 0.45$) might be biased because of researcher allegiance and the use of the PCOMS Outcome Rating Scale (ORS) as the only outcome measure. The ORS is not an independent outcome measure because it is used in the intervention. When the ORS is filled out in the session with the presence of the therapist, it might inflate the effect size estimation because of social desirability (i.e., pleasing the therapist with a better score). Our meta-analysis found that the incremental effect of the PCOMS was $g = 0.11$ larger when he outcome was measured with the ORS compared with an independent outcome measure in seven studies using both types of measurement. Larger effects on the ORS, compared with independent measures, have also been found in other studies not included in the meta-analysis (Seidel, Andrews, Owen, Miller, & Buccino, 2017; Østergård, O'Toole, Svendsen, & Hougaard, 2019).

Duncan and Sparks's (2020) criticism of our meta-analysis is based on a qualitative case-based analysis of selected studies. They argue that half of the included studies in our meta-analysis contained significant limitations, including an inadequate dose of treatment and/or adherence problems. However, our meta-analysis reported the risk of bias for each study, showing that almost all primary studies had a high risk of bias, primarily because of lack of blinding of outcome assessment, and incomplete outcome data. In all the primary studies, adherence to the PCOMS was insufficiently reported, which prevented us from testing Duncan and Sparks (2020) claim that the lack of PCOMS effect is due to adherence problems. We found no association between PCOMS effect and amount of therapists' training in the PCOMS or dose of treatment. Duncan and Sparks (2020) also failed to mention that we conducted sensitivity analyses answering some of their critiques: Excluding studies without randomization, gray literature, or studies not using the PCOMS Session Rating Scale did not change the results. Our definition of researcher allegiance was transparent, easy to verify, and based on objective criteria, which makes it possible to check and evaluate for anyone interested. The well-designed study (they criticized us for not including in our analysis [Cooper, Stewart, Sparks, & Bunting, 2013]) is not a comparative study with a non-PCOMS control group (inclusion criterion).

We did not discuss and compare our findings with Lambert, Whipple, and Kleinstäuber's (2018) meta-analysis because it was published after we finished our meta-analysis. Lambert et al. (2018) included nine studies on the PCOMS (contrary to the claim of Duncan and Sparks [2020] randomization was not an inclusion criterion). All nine studies were also included in our meta-analysis,

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whereas nine studies from our meta-analysis were not included in Lambert et al. (2018) (two were in peer review, three were gray literature, and one was not reported in English, whereas we do not know why three other studies were not included). Lambert et al. (2018) found a moderate overall effect of the PCOMS ($g = 0.40$), which is somewhat larger than what we found ($g = 0.27$). The most likely explanation for the difference is that Lambert et al. (2018) primarily relied on the ORS as the outcome measure (in eight of nine studies), whereas we prioritized independent, general symptom outcome measures. Neither Lambert et al. (2018) nor Østergård et al. (2020) found that the PCOMS reduced the number of deteriorated clients.

It is indeed possible that the lack of a PCOMS effect is due to adherence problems, as suggested by Duncan and Sparks (2020), because all primary studies had insufficient information on adherence. We did mention this as a limitation in our study and acknowledged that the substantial study heterogeneity might reflect that the clients received very different treatments of varying duration. The primary studies with a positive effect also had limitations in the implementation of the PCOMS and serious methodological problems, including lack of intention-to-treat analysis and applying the ORS as the only outcome measure. Duncan and Sparks (2020, p. 493) acknowledge that the PCOMS is challenging to implement and that "... the understanding that it requires that high level of fidelity may mean that some, if not many, settings cannot implement it effectively." However, meta-analyses can be conducted only on existing studies. Our inclusion of gray literature addressed the file-drawer problem and may give a more realistic picture of how the PCOMS works in practice.

We appreciate Duncan and Sparks (2020) feedback and agree that findings in meta-analyses should not be accepted uncritically. The results depend on crucial decisions, especially regarding inclusion criteria, choice of outcome measures, and analytical strategy. However, our meta-analysis is conducted with a well-established, transparent, and prespecified methodology (Østergård, Randa, & Hougaard, 2017). We welcome further meta-analyses with a focus on independent outcome measures, which we beleve is necessary for a stringent evaluation of the PCOMS as a routine outcome monitoring system.

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Received December 6, 2019
Accepted January 17, 2020 ■