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The Role of Practice-Based Evidence and Feedback Informed Treatment for Improving Therapy Outcomes

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Attrition rates and deterioration of counselling and psychotherapy clients are two major concerns for those delivering psychological therapies across differential modalities. While a variety of correlations are said to contribute to attrition and deterioration such as, client, therapist and clinical level, identifying and improving outcomes for this cohort of people in routine practice is difficult. Even with the addition of hundreds of empirically supported treatments added to the profession, outcomes have not improved in line with these new approaches. Methods to limit the extent of poor outcomes has been established in the extent literature, thus, practice-based evidence is put forward focusing on Feedback Informed Treatment (FIT)

KEYWORDS: practice-based evidence, Feedback Informed Treatment, therapy outcomes

Outcome research

In the years since Eysenck's (1952) spurious claims that psychotherapeutic practices were not effective healing agents, much has been debated. Discourses have evolved, shifted and reflected on several key debates. Although we now know that psychotherapy is effective (Hansen, Lambert, & Forman, 2002; Lambert, 2013; Lambert & Ogles, 2004; Wampold & Imel, 2015), in fact, therapists in naturalistic settings reach the often cited 0.80 benchmark from highly controlled randomised control trials (Lambert, 2013; Wampold & Imel, 2015).

Nonetheless, there remains several key issues regarding the fields' progress. For example, attrition rates are extremely high, that is, the unilateral decision by clients to end therapy average about 47% across different outpatient settings (Daniels & Johnson, 2003; Wierzbicki & Pekarik, 1993); for children drop out is anywhere between 28% to 85% (Garcia & Weisz, 2002; Kazdin, 1996). Moreover, approximately 10% of adult clients deteriorate whilst in our care (Hansen & Lambert, 2005; Hansen, Lambert & Foreman, 2002; Lambert & Ogles, 2004). For children and adolescents these numbers average about 24% (Nelson et al., 2013). So, while the average treated client does relatively well from therapy, only about 50% reach what can be termed reliable change (Clark, 2018). While not all cases termed drop out can be considered in a negative light (O'Keefe et al. 2019) it is apparent that attending to attrition and deterioration rates can impact positively upon the overall effectiveness of the field, thus, identifying and keeping those at risk of poor outcomes in therapy becomes very important.

Practice based evidence

In response to some of the concerns regarding the effectiveness and methodologies behind the empirically supported treatment movements, some proponents have suggested a practice-based evidence framework; that is, eliciting feedback from service users using standardised measures on a session to session basis to develop, guide and evaluate behavioural healthcare interventions and improve outcomes. Swisher (2010, p.2) elucidates the concept of practice-based evidence in the following manner; "the real, messy, complicated world is not controlled. Instead, real world practice is documented and measured, just as it occurs, "warts" and all. It is the process of measurement and tracking that matters, not controlling how practice is delivered".

Intentionally eliciting live feedback from clients within sessions can improve therapy outcomes, reduce dropout rates, and identify those at risk for deterioration or null outcomes (Bratland et al, 2018; Harmon et al., 2007; Hawkins, Lambert, Vermeersch, Slade, Tuttle, 2004; Lambert et al, 2018) and that its use can cut rates of those at risk of deterioration and drop out by up to fifty percent (Harmon et al., 2007; Hawkins et al 2004). Moreover, research posits that practitioners do not adequately predict the deterioration of clients or those at risk of dropping out when they assess clients informally (Hannan et al, 2005; Hatfield et al., 2010). Moreover, therapists vastly overestimate their effectiveness when working with clients (Chow et al, 2015). Okiishi et al. (2006) demonstrated that clients of the top 10% of practitioners were twice as likely to recover and 50% less likely to deteriorate than clients seen by the least effective, regardless of type of qualifications or theoretical orientation.

While numerous measures exist to track outcomes (e.g., Connell & Barkham, 2007; Lamber,2004; Miller et al, 2005); it is Feedback Informed Treatment (FIT) based on the work of Scott Miller and colleagues that is the focus here; the rationale for this choice is due to the utility and brevity of the instruments and an alliance measure is also included. FIT is an empirically supported, trans-theoretical approach used for assessing and improving the effectiveness of behavioural health interventions and systems of care. It involves routinely soliciting feedback from clients regarding the therapeutic alliance and outcome of care and utilising this information to inform and adapt interventions and care. It has been demonstrated that adapting care using feedback results in better outcomes for clients.

Miller and Bargemen (2012) discuss these two shorts four question instruments to measure outcomes based on a shortened version of the Outcome Questionnaire 45. The Outcome Rating Scale (ORS) captures data on client progress that can be aggregated in order to determine a therapist's overall effectiveness. The scale is based on a large standardised dataset with clinical cut-off that distinguishes between clinical and non-clinical populations. Providing therapists and clients with feedback regarding outcomes has shown to improve effectiveness of therapy

The Session Rating Scale (SRS) assesses the quality of the therapeutic alliance, which is a key indicator of the effectiveness of therapy (Wampold, 2014); it is based on a shorter version of the Working Alliance Inventory (Horvath & Greenberg,1989). Like the Outcome Rating Scales, the Session Rating Scale is based on a large standardised dataset with cut-off scores that identify those at risk of poor outcomes.

Research on the alliance is well established, in fact, it is probably one of the most studied variables in therapy, and one of the strongest predictors of therapy outcome (Horvath et al, 1991; Martin et al, 2000; Safran, et al, 2009; Anker et al, 2009; Norcross, 2011; Orlinsky et al, 2004). Hence, the importance of measuring this construct is extremely important to the therapy endeavour.

In a key study of the therapeutic alliance, Baldwin et al (2007) elucidates the power of this construct by suggesting that 97% of the difference in client outcomes between therapists can be attributed to the alliance. Moreover, it was the clients rating of the alliance that was the important factor, and notably, the clients' contribution was not a variable for outcomes. Said another way, the difference in therapist outcomes is mainly due to their ability to build an alliance with different clients, who rate that alliance strongly, while clients' contribution has little in the way of impact on alliance contribution. Conversely, clients of therapists who cultivate weaker alliances tend to drop out at higher rates and experience poorer outcomes (Hubble et al., 2010; Lambert et al, 2010).

Thus, monitoring of the therapeutic alliance would seem to be one method to improve outcomes, of course this can also be viewed in an ethical light. In fact, Baldwin et al (2007:2) draws the following conclusions "clinical implications include therapists monitoring their

contribution to the alliance, clinics providing feedback to therapists about their alliances, and therapists receiving training to develop and maintain strong alliances”. Consistent with Baldwin (2007), Tunner, Strand and Sacristan (2019) in a study of social worker graduates clinical competencies suggest, that only 30% felt prepared to use standardised instruments. Moreover, Jensen-Doss et al. (2018) showed that only 13.9% of clinicians use progress measures monthly.

Ethics of measurement

Muir et al (2019) consider feedback systems as potentially mitigating against ethical issues, such as using evidence to identify those deteriorating in our care; those at risk of dropping out of treatment early; and matching clients to individuals and systems of care that show effectiveness. These evidence-based decision-making opportunities are pivotal when we consider therapists lack of proficiency in identifying those clients at risk of poor outcomes (Ostergard, Randa & Hougaard, 2018; Lambert, 2017). Boswell et al. (2017) go further and suggest that the use of feedback can be operationalised to refer clients to specific practitioners and systems of care who have shown their pedigree in certain domains or with certain therapies. This may be one of the more important utilisations of feedback systems due to the between-therapists outcome variability (Muir et al, 2019; Baldwin et al, 2007). If we consider some of the other ethical obligations, not often based on research that we mandate clinicians to undertake in the name of regulation, then tracking client progress surely must be of paramount importance as a duty of care process at the very least?

Discussion

Clinical interventions are effective healing agents for those who engage in, and complete, a course of treatment. However, several issues remain, amongst them, attrition rates and clients who deteriorate while in care. The present review put forward practice-based evidence through the utilisation of outcome measurements to help improve poor outcomes. The extant literature demonstrates robust evidence for the effectiveness of practice-based evidence. Yet, the uptake of such methods are extremely low. An ethical question has been posed regarding the use of such instruments as they pertain to practitioners’ difference, or, therapist effects working with differentiated constructs and populations. While Feedback Informed Treatment (FIT) was the focus of this review, practitioners may want to explore the differential measures available to them, as practice, funding and reimbursement issues may influence their choice.

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