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Improving Access to Psychological Therapies

Using outcome feedback in psychological therapy:
A guideline for IAPT practitioners

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What is outcome feedback (OF)?

- Outcome tracking technology helps to identify patients who are not progressing as expected, and who may be at risk of poor outcomes.

- Real-time feedback is provided to therapists and patients, indicating if therapy is 'on track' or 'not on track'.

- This feedback informs the therapeutic process and plan.

- Essentially, it's a trouble-shooting aid that helps to improve outcomes.

Why do therapists need outcome feedback?

- Although psychotherapy helps many people, it is also true that some patients don't reliably improve and up to 10% of patients deteriorate.

- Studies show that most therapists can't predict treatment outcomes very accurately, and often fail to detect deterioration in their patients. Especially if they mainly rely on their clinical judgement, without reference to objective data or outcome measures.

- This might be explained by the fact that many therapists tend to be over-optimistic about their practice, looking for the 'silver lining' even in the most difficult cases.

- Optimism is a good thing, and probably helps therapists to instil hope in many patients and to prevent burnout. However, over-optimism may not enable them to detect obstacles and to trouble-shoot early enough in some cases at risk of poor outcomes. According to the outcome feedback method, these cases are referred to as risk 'signal' cases.

https://www.psychotherapy.net/interview/preventing-treatment-failures-lambert
http://onlinelibrary.wiley.com/doi/10.1002/jclp.20108/abstract
http://onlinelibrary.wiley.com/doi/10.1002/cpp.656/abstract
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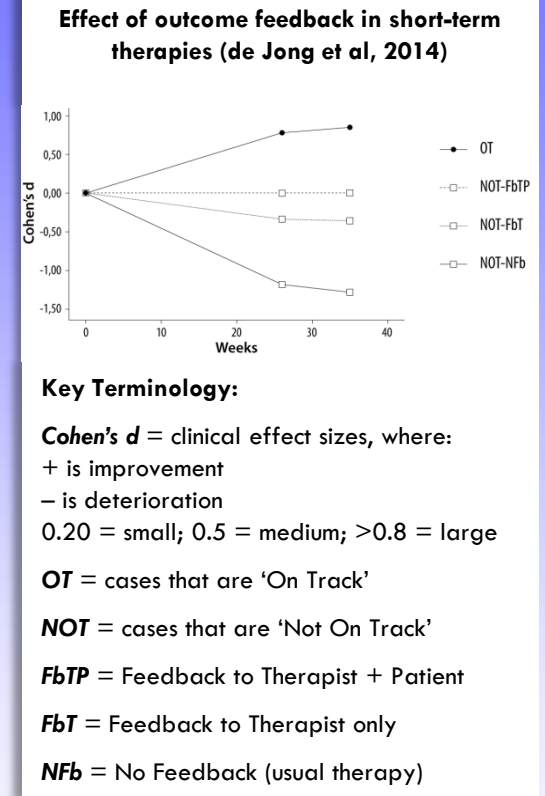http://psycnet.apa.org/journals/law/2/2/293/

Does outcome feedback improve outcomes?

- Several trials published in the last decade show that treatment outcomes can be improved if therapists use OF methods. Most of this evidence comes from USA, although recent European studies also show similar findings.

- A meta-analysis of 6 major trials estimated that patients who were classified as 'not on track' during treatment were 2.3 times more likely to deteriorate in usual therapy, by comparison to therapy + OF.

- In published controlled trials, effect sizes favouring OF range between $d = 0.2$ and $d = 0.9$.

- Basically, OF helps to prevent deterioration.

Effect of outcome feedback in short-term therapies (de Jong et al, 2014)

Key Terminology:

Cohen's d = clinical effect sizes, where:
+ is improvement
– is deterioration
0.20 = small; 0.5 = medium; >0.8 = large

OT = cases that are 'On Track'

NOT = cases that are 'Not On Track'

FbTP = Feedback to Therapist + Patient

FbT = Feedback to Therapist only

NFb = No Feedback (usual therapy)

http://psycnet.apa.org/journals/ccp/78/3/298/
http://www.tandfonline.com/doi/abs/10.1080/10503307.2013.871079
http://www.tandfonline.com/doi/abs/10.1080/10503307.2014.928756
http://www.tandfonline.com/doi/abs/10.3109/08039488.2012.736534

How do I make sense of outcome feedback?

- **E**xpected **T**reatment **R**esponse (**ETR**) models tell you how your patient's progress compares to that of (hundreds of) patients with similar characteristics, using depression (PHQ-9) and anxiety (GAD-7) measures.
- ETR models include an upper and a lower boundary, which are like 'confidence intervals'.
- If symptoms are within the boundaries, therapy is likely to be generally 'on track' (OT) and progressing as expected, since 80% of similar cases show symptom scores in this range.
- If symptoms are above the upper boundary, this is a risk signal indicating that therapy is 'not on track' (NOT). The patient's response is more like 10% of cases that deteriorate or don't improve.
- Scores below the lower boundary suggest remarkable improvement.
- Also consider that reliable change (symptom reduction greater than 5 points) by session 4 can be a useful indicator of whether or not a patient is likely to respond and recover.
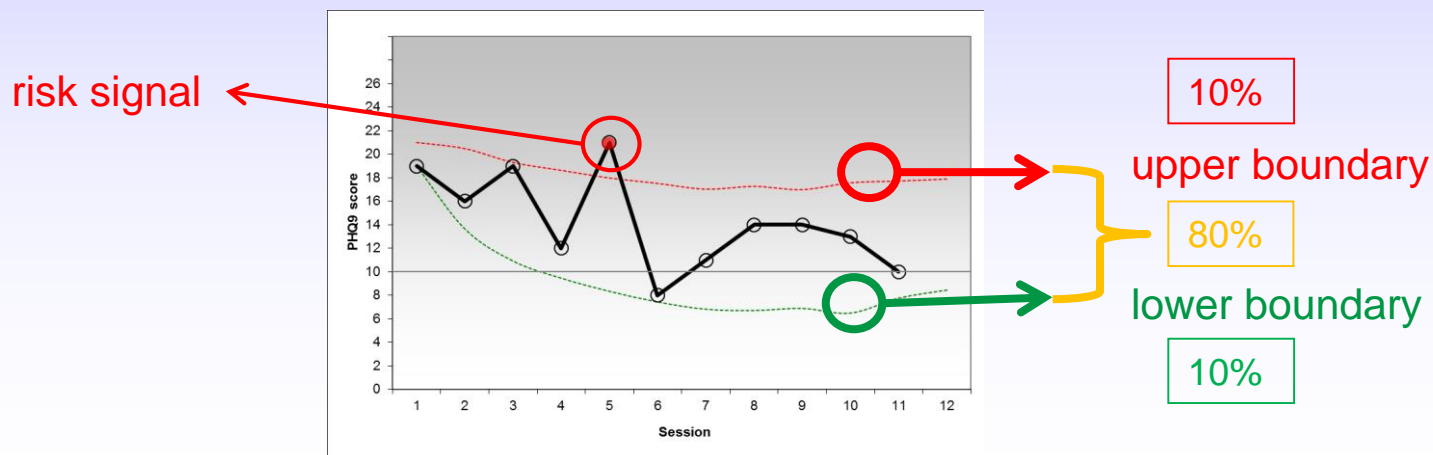
How do I make sense of outcome feedback?

- ETR models will help you to detect cases that are 'not on track' (NOT), so that you can review progress, identify and overcome obstacles to improvement.
- ETR models can also help you to learn about your own practice, and about therapy processes and mechanisms of change.

Case example: "Initially NOT, but responded after sudden gain"

Actual graph from PCMIS system, for a patient with moderate OCD who accessed 18 sessions of CBT

Annotated graph to explain how to interpret it
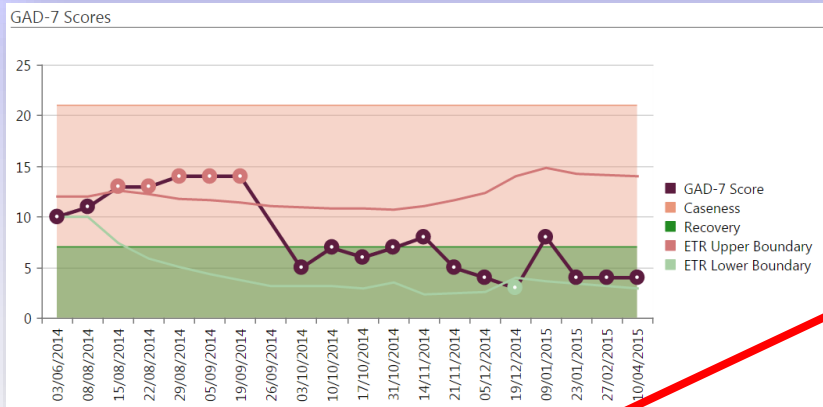
NOT during sessions 2 – 6

Something important happened after session 6, which led to a sudden and reliable improvement, and points to a key process of change
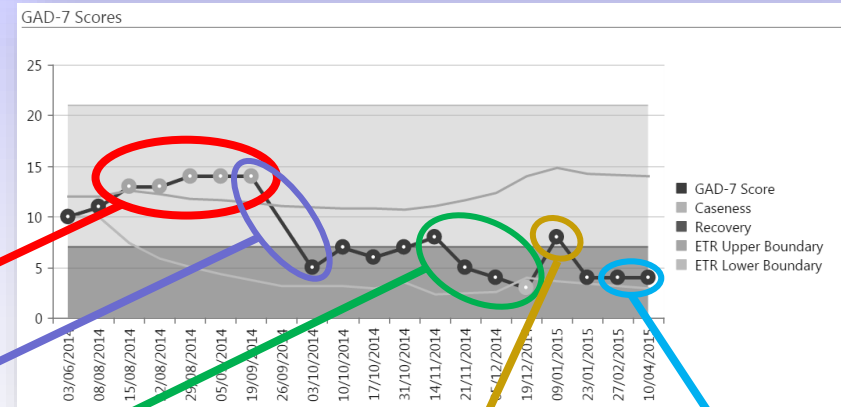
Effortful practice of change methods and coping skills led to remarkable improvement between sessions 11 – 14

Watch out for sudden spikes! This helped us to learn how to plan a successful relapse prevention strategy

Booster sessions confirmed stability of improvement over time

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Why are some cases not on track?

NOT signals could be due to one key barrier, or an interaction of multiple factors.

- Over-confidence
- Over-reliance on intuition + neglect of external feedback
- Coping deficits, low resilience
- Tendency to avoid tackling problems directly
- Lack of deliberate & disciplined practice to improve skills / performance
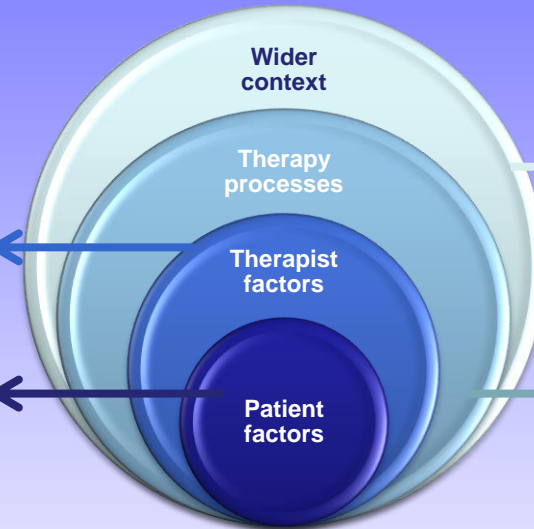
- Severe functional impairment
- Comorbidity
- Self-reported disability
- Long-term medical conditions
- Younger age (<20)
- Minority ethnic status
- Single (as opposed to married or cohabiting)
- Personality disorder traits

Wider context
Therapy processes
Therapist factors
Patient factors

- Life problems and events that exacerbate psychopathology
- Unemployment, socioeconomic deprivation
- Lack of social support

- Therapeutic alliance deficits or ruptures
- Difficulties with empathy and/or positive regard in specific cases
- Failure to promote expectancy
- Motivational deficits, failure to promote readiness for change
- All of the above get in the way of applying evidence-based change methods

http://eu.wiley.com/WileyCDA/WileyTitle/productCd-1118038207.html
https://www.routledge.com/products/9780805857092
http://onlinelibrary.wiley.com/doi/10.1002/cpp.594/abstract
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http://bjp.rcpsych.org/content/early/2015/11/05/bjp.bp.115.171017
http://www.tandfonline.com/doi/abs/10.1080/10503307.2012.673023
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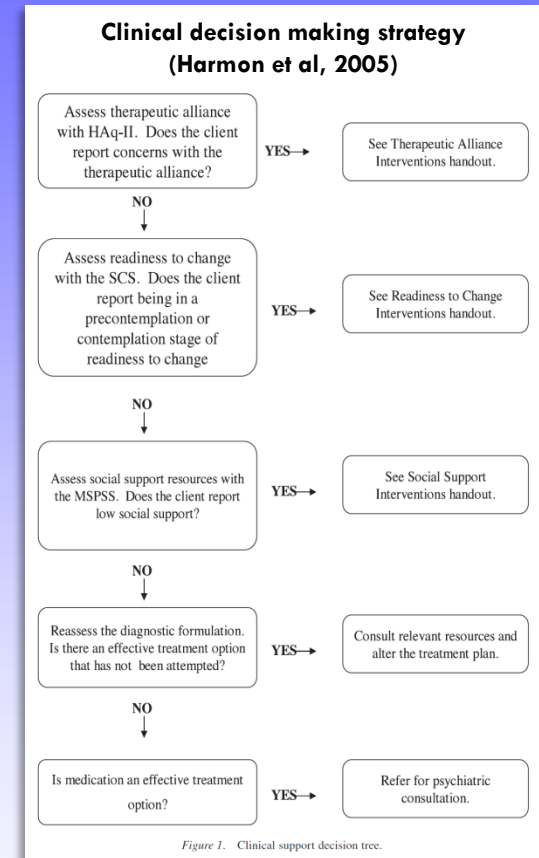http://onlinelibrary.wiley.com/doi/10.1002/cpp.1977/full

What can I do to prevent deterioration?

- A crucial aspect of using outcome feedback methods is to strive to understand the possible causes of NOT signals and (if possible) to minimise the impact of obstacles.

- Some studies have successfully applied formal methods known as 'clinical support tools' to measure and address key obstacles related to:

- **therapeutic alliance** (agreement on goals and tasks + quality of relational bond)

- **motivation** (cognitive dissonance + expectancy + self-efficacy = readiness to change)

- **social support**

- **external life events**

Clinical decision making strategy (Harmon et al, 2005)

Assess therapeutic alliance with HAq-II. Does the client report concerns with the therapeutic alliance?	YES→ See Therapeutic Alliance Interventions handout.
NO	
Assess readiness to change with the SCS. Does the client report being in a precontemplation or contemplation stage of readiness to change	YES→ See Readiness to Change Interventions handout.
NO	
Assess social support resources with the MSPSS. Does the client report low social support?	YES→ See Social Support Interventions handout.
NO	
Reassess the diagnostic formulation. Is there an effective treatment option that has not been attempted?	YES→ Consult relevant resources and alter the treatment plan.
NO	
Is medication an effective treatment option?	YES→ Refer for psychiatric consultation.

Figure 1. Clinical support decision tree.

http://onlinelibrary.wiley.com/doi/10.1002/jclp.20109/pdf
http://www.ncbi.nlm.nih.gov/pubmed/23656489
http://www.ncbi.nlm.nih.gov/pubmed/23972415
http://scholarsarchive.byu.edu/etd/1587/

TROUBLE-SHOOTING TIPS

If your patient is NOT, **then:**

Check reliability
Are scores consistent with other information? Did insight into symptoms cause change in self-reported scores? Are scores influenced by social desirability or secondary motives?

Assess possible obstacles
Which context, process, therapist or patient factors may be getting in the way of progress?

Form hypotheses
Are these factors modifiable? How could we try to influence these factors? If we modified this, what would we expect to see as a result?

Make a plan
Can I set up a way to observe what happens before and after modifying potential obstacles? If the obstacles are not modifiable, can we revisit and re-formulate our outcome expectations, therapy goals and tasks?

Consider alternatives
Augment treatment with medication? Multi-disciplinary care? Time to step-up or try a different treatment?

Preventing deterioration

Although formal methods like 'clinical support tools' can be useful, it is evident that less complex methods are also effective. For example, research has shown that simple feedback (just providing risk signals to therapists) can help to prevent deterioration in NOT cases.

This leads us to think that most therapists have the skills and ability to formulate and modify obstacles to therapeutic progress, but may just need a 'nudge' (risk signal) to activate their trouble-shooting abilities.

Nevertheless, informed by contemporary literature, we offer you a series of suggested steps and questions to consider (see tips on the left).

We would encourage you to discuss these steps in clinical supervision.

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http://psycnet.apa.org/journals/ccp/78/3/298/
http://www.tandfonline.com/doi/abs/10.1080/14733140601140873
http://psycnet.apa.org/journals/pst/52/2/185/
http://psycnet.apa.org/journals/pst/52/2/180/

Useful references for clinical supervisors

Talking about outcome feedback

- Introduce the rationale for OF as early as possible (ideally at session 1), otherwise discussing NOT signals can be difficult later in therapy.
- Review OF graphs with patients regularly
- Discuss NOT cases in clinical supervision.

Tips

- Practice providing a rationale for OF and describing how to interpret graphs.
- Use non-technical language, analogies (e.g. thermometer of distress, like weather forecasts: expect certain temperatures at different seasons).
- Use non-threatening language (Don't say YOU'RE *not on track*), de-personalise NOT signals, reframe as an opportunity to learn.
- Use NOT signals as a prompt to explore obstacles in a collaborative way.
- Print-out or e-mail OF graphs prior to therapy and/or clinical supervision sessions.
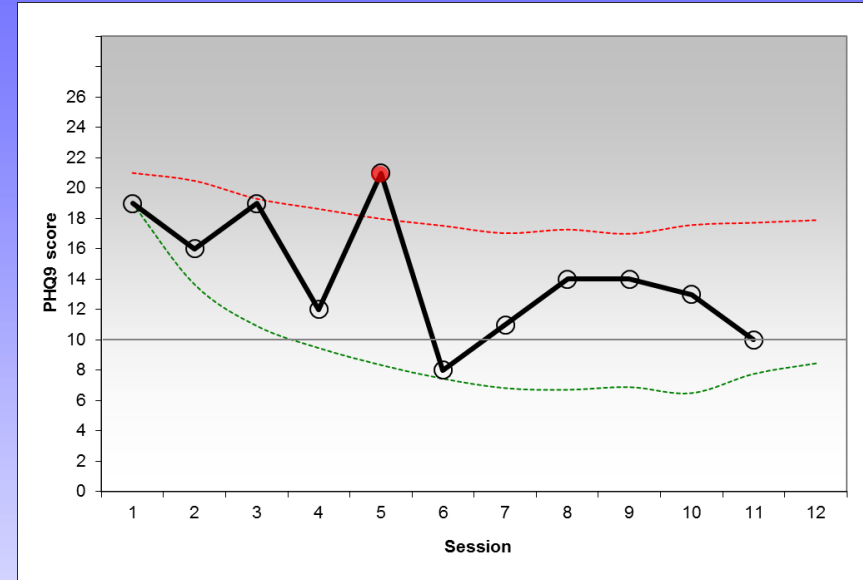
IMPLEMENTATION TIPS

If you find yourself avoiding or forgetting to discuss OF with your patients or supervisor
Then:

- Remind yourself that OF has improved patients' well-being across several studies in several countries. Read references in pg. 4.

- Ask yourself: does your intuition turn out to be correct all of the time? What's the evidence?

- Take some time to review the OF graphs of a handful of completed cases, you'll be surprised how much you can learn from this!

- Practice or role-play what to say in preparation for OF discussions. Consider how to use metaphors and terminology that will make NOT feedback less daunting.

- Seek advice from colleagues who use OF.

- Bring time or organisational obstacles to the attention of managers. The service has a duty to make changes that may improve patient outcomes (IAPT key performance indicator 6).

- Consider printing or e-mailing anonymised screen shots of feedback graphs to share them easily with patients and supervisors.

http://www.tandfonline.com/doi/full/10.1080/10503307.2015.1051163
http://www.tandfonline.com/doi/full/10.1080/10503307.2012.673023
http://link.springer.com/article/10.1007/s10488-014-0589-6#/page-1
http://www.tandfonline.com/doi/full/10.1080/10503307.2013.817696