

Routine Outcome Monitoring in Psychotherapy: Clinical and Cost Implications

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Abstract: *Psychotherapy outcomes have not appreciably improved over the past four decades. Findings from previous studies reveal that a significant percentage (30% to 50%) of clients do not benefit from therapy, deterioration rates among adult clients range between 5% and 10% (for children and adolescents, rates of deterioration vary between 12% and 20%). Moreover, it's estimated that the clients who do not benefit or deteriorate while in psychotherapy are responsible for 60-70% of the total expenditures in the health care system. Within this current socioeconomic context, increased pressures to answer these questions have resulted in the demand among clinicians, administrators, policy makers, and third-party payers to more regularly monitor progress to better meet client needs and also identify those clients that may not be benefitting from treatment. Feedback Informed Treatment (FIT) is an evidenced-based routine outcome monitoring approach which includes methods of measuring, integrating, and analyzing client progress to better inform clinical decisions and treatment planning on a session-by-session basis and can be applied to any discipline or approach. Given the lack of improvement in psychotherapy over the past 40 years, coupled with increasingly scarce resources among providers and agencies which has resulted in therapists having to do more with less, it is critical that the field consider, study, and implement more efficient and effective ways of conducting therapy.*

Keywords: *Psychotherapy outcome, routine outcome monitoring, clinical outcomes, psychotherapy*

COMMENTARY

Historically, psychotherapy outcome literature has been dominated by questions such as, "Does this treatment work?" or "Which is treatment is best?" In fact, the quest to evaluate clinical effectiveness is the primary objective of most privately and government funded clinical research in the U.S. and throughout the world. Clearly, this question has been refined, modified, narrowed, or broadened, depending on the nature of the intervention under study, the population being treated, and the conditions under in which the treatment is delivered; in other words, under what circumstances and for whom does this treatment work and how do we know?

Unfortunately, the exclusive focus on clinical outcomes in therapy research trials implicitly ignores an equally compelling question which often has a greater impact on whether or not a person engages in the therapy process; that is, what is the cost-benefit, cost-effective of this service? Concerns about costs might be mitigated, at least to some extent, if the amount of expenditure was positively (and strongly) related to quality; sadly, this is not the case. Health care quality in the U.S. is not measurably

better than many other industrialized countries that spend far less on these costs (Reinhardt, Hussey, & Anderson, 2004). Psychotherapy outcomes have not appreciably improved over the past four decades Even with well-trained and supervised clinicians, a significant percentage (30% to 50%) of clients do not benefit from therapy (Miller, Hubble, & Chow, 2020).

Deterioration rates among adult clients range between 5% and 10% (Hansen, Lambert, & Forman, 2002; Lambert & Ogles, 2004). Regarding children and adolescents, rates of deterioration vary between 12% and 20% (Warren et al., 2010). It is estimated that the clients who do not benefit or deteriorate while in psychotherapy are responsible for 60-70% of the total expenditures in the health care system (Miller, 2011). Moreover, clinicians routinely fail to identify clients who are not progressing, deteriorating, and at most risk of dropout and negative outcome (Hannan et al., 2005).

Although quality and cost tend to be seen as directly proportional, a sort of 'you get what you pay for' mentality, there may be another way to consider this. Perhaps the question for providers and payors has shifted from not only, "does this treatment work?" to also include "how much

does it cost? “Is it working?” “And when should we consider other treatment options (rather than investing more money into something that isn’t working)?” More specifically, perhaps the key question is not *how much* is spent on health care, but rather *how* it is spent. It’s worth noting that previous research has found that a relatively small percentage of clients do not report progress, yet occupy a significant portion of the therapists’ caseloads and result in an excessive use of agency resources compared to the costs associated with treating most clients (Miller, 2011). Within this current socioeconomic context, increased pressures to answer these questions have resulted in the demand among clinicians, administrators, policy makers, and third-party payers to more regularly monitor progress to better meet client needs and also identify those clients that may not be benefitting from treatment and if necessary refer accordingly – either within or outside the agency.

Psychotherapists strive to deliver interventions that are both effective *and* efficient; that is, to provide the most positive benefit for the least cost to the most people. Routinely monitoring outcome provides an opportunity for therapists and clients to not only better understand whether or not therapy is working, but also a mechanism for modifying treatment to better meet client’s needs. Feedback Informed Treatment (FIT) is an evidenced-based routine outcome monitoring approach which includes methods of measuring, integrating, and analyzing client progress to better inform clinical decisions and treatment planning on a session-by-session basis and can be applied to any discipline (psychology, social work) or approach (Acceptance and Commitment Therapy, Psychodynamic). The question is not what is the right treatment approach, rather, is my client responding to the treatment approach that I’m using right now? FIT represents an opportunity for the field to more sensitively assess the therapeutic process and better allocate resources based on client’s perceptions on an ongoing basis and may be utilized to inform clinical practice and resource allocation. If clients do not feel as if they are making progress, this can lead to disengagement, clients waiting for us to figure out what to do to help them without any real change or progress, or dropout.

Administering the FIT measures are not enough to improve outcomes. The measures help create awareness of progress (or lack thereof); however, a culture must be created where clients

feel comfortable to freely express their experience of the process and outcome of treatment. Simply put, it is the environment and attitude displayed by the practitioner including how he or she responds to and uses the feedback to inform clinical decision-making that actually has the greatest impact on outcomes (Miller, Maeschalck, & Bargmann, 2019). The literature demonstrates that FIT does work; however, it takes time and training to implement this practice effectively. If FIT is successfully implemented, the outcome monitoring system can decrease premature termination for clients at risk of dropping out and improve (refer to Anker et al., 2009; Brattland et al., 2019; Miller et al., 2019). The more clients that experience a positive outcome in a shorter amount of time, the less money clients have to spend on mental health services. Moreover, practitioners can see more clients, meeting the increased demand for mental health services following the COVID-19 pandemic.

In addition to using the FIT, the psychotherapy setting must also be considered. Research indicates that many clients are likely to seek out mental health treatment in their primary care office, particularly clients of color (Bridges et al., 2019). This may be due to stigma, discrimination, beliefs about care, lack of health insurance, and insufficient Medicaid specialty services in low-income and minority-identified neighborhoods (Caplan & Munet-Vilaro, 2016). Research indicates that offering brief behavioral health services in primary care increases engagement, treatment adherence to psychological disorders (Thota et al., 2012; Unutzer et al., 2002), improves both clinical and functional patient outcomes (Gilbody et al., 2006; Rost et al., 2001; Thota et al., 2012; Unutzer et al., 2002), improves patient satisfaction with care (Rost et al., 2001; Unutzer et al., 2002), and increases cost efficiency, including primary and specialty costs for physical healthcare (Gilbody et al., 2006; Jacob et al., 2012; Katon et al., 2008; Katon et al., 2002; Unutzer et al., 2008). Integration of behavioral health in medical settings has also shown a 40-50% reduction in emergency department utilization compared to non-integrated practices (Reiss-Brennan et al., 2010). Unutzer and colleagues (2008) have demonstrated that a \$580 per patient cost to implement a collaborative care model led to an average of \$3300 decrease in total cost of care over four years. On days when a behavioral

health provider was in the office, Gouge et al. (2016) report a 42% increase in client volume of all types, resulting in \$1142 more revenue generated. Research on therapeutic alliance and treatment outcomes by Corso et al. (2012) report that clients receiving 2-4 visits in an integrated care clinic showed broad improvements in symptoms, functioning, and overall well-being. Clients in this study also reported having a stronger connection to the mental health provider than to traditional, specialty therapists (Corso et al., 2012). These results are supported by Ray-Sannerud et al. (2012), who demonstrate client's improvements in clinical symptoms and global mental health functioning from a 4-session behavioral health intervention in an integrated primary care clinic as long as 3 years post-treatment. Research has further highlighted the efficacy of low-cost feedback technology services in reducing symptom severity in clients who are at risk of treatment attrition (Delgadillo et al., 2018). Therefore, feedback informed behavioral health programs delivered within primary care offices (adults and pediatric) may increase access and engagement, be more cost-effective and result in more effective and efficient outcomes for both the client and practitioner compared to traditional therapy.

FIT may be best conceptualized as a meta-approach to treatment which can be applied to any model or discipline. As such, FIT is not exclusive to only the client and their mental health provider, but can also be extended to other systems of care. For example, Pringle and Fawcett (2017) report that using FIT in pharmacist-patient interactions can significantly improve patient medication adherence, which improves health outcomes and reduces mortality. Given the lack of improvement in psychotherapy over the past 40 years, coupled with increasingly scarce resources which has resulted in therapists having to do more with less, it is critical that the field consider, study, and implement more efficient and effective ways of conducting therapy.

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