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COMMENTARY

Measurement-Based Care Professional Practice Guideline: Don't Forget the Therapists!

Matteo Bugatti[1], Zachary Richardson[2], Wendy Rasmussen[2], Douglas Newton[2], and Jesse Owen[1]
[1] Department of Counseling Psychology, Morgridge College of Education, University of Denver
[2] SonderMind, Inc., Denver, Colorado

Boswell et al. (2022) professional practice guideline builds an excellent, evidence-driven argument in favor of the routine implementation of measurement-based care (MBC). Nonetheless, as learned from the attempted implementation of evidence-based psychotherapies, presenting empirical evidence does not affect therapist behavior. As such, we argue for an *actionable* and *practical* professional practice guideline. We review some of the most hindering barriers to the implementation of MBC, and we offer guidance introducing some of the efforts needed to overcome them.

Clinical Impact Statement

Question: Does the professional practice guideline (PPG) presented by Boswell et al. (2022) outline a clear path for MBC's implementation in routine practice? ***Findings:*** Although thoroughly summarizing findings from the extant literature, the PPG fails to provide therapists and clinical administrators with actionable and practical suggestions. ***Meaning:*** To foster the implementation of MBC, an actionable and practical guideline that is perceived as accessible by therapists at all levels of training is needed. ***Next Steps:*** The first step in bridging the research-practice gap is to conduct therapist-centered, clinically relevant, and ecologically valid research.

Keywords: routine outcome monitoring, measurement-based care, technology, therapist effects

Measurement-based care (MBC) is an evidence-based practice (EBP) in psychotherapy that is supported by robust evidence (Scott & Lewis, 2015). Boswell et al. (2022) do an outstanding job, summarizing the product of over a quarter-century's worth of MBC research, which conveys an unequivocal take-home message: MBC works. Although this galvanizing compendium might spring some of us (i.e., scholars, academics) into action, we question its effectiveness at reaching who should be the targeted audience: full-time therapists and clinical administrators. In this commentary, we highlight a select (i.e., far from comprehensive) number of issues hindering the implementation of MBC in routine practice, while also discussing potential future steps (see Table 1). The ultimate goal of this article is to spark a novel, *actionable*, and *practical* approach to overcoming barriers to the use of MBC by therapists in everyday clinical practice.

The Psychology Inferiority Complex: We Cannot Just Copy Medicine's Homework

Perhaps in a search for legitimacy, the fields of clinical and counseling psychology have historically turned to medicine as a source of inspiration for empirically driven approaches. For instance, the inception of manualized, disorder-specific treatments, as well as the embrace of randomized controlled trials (RCTs), are often seen as products of this tendency. Decades of research have shown that, methodologically, the delivery of psychotherapy is not similar to the provision of a pill of a precise dosage, and it is instead characterized by significant variability at the therapist level (e.g., Baldwin & Imel, 2013). Likewise, the value of RCTs for understanding what makes psychotherapy work in everyday clinical settings has often being

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Matteo Bugatti https://orcid.org/0000-0001-5640-0992

Douglas Newton is the chief medical officer at SonderMind, Inc. Wendy Rasmussen is the director of clinical strategy at SonderMind, Inc. Zachary Richardson is a senior data analyst at SonderMind, Inc. These three individuals are employees of SonderMind, Inc., a platform that was mentioned in this article. However, direction of the project was led by Matteo Bugatti. Matteo Bugatti is a Research Assistant Professor at the University of Denver. Jesse Owen is a Professor at the University of Denver. Matteo Bugatti and Jesse Owen have a contract with SonderMind, Inc., which funded part of their effort on the project.

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Correspondence concerning this article should be addressed to Matteo Bugatti, Department of Counseling Psychology, Morgridge College of Education, University of Denver, 1999 East Evans Avenue Denver, CO 80208, United States. Email: matteo.bugatti@du.edu

Table 1
To-Do List for Promoting the Implementation of Measurement-Based Care

Problem	Proposed action
Therapists do not find research to be relevant to routine practice.	Conduct ecologically valid research in naturalistic settings with minimal disruption of routine clinical procedures.
Therapists recruited for studies are not representative of the therapist population.	Conduct research with full-time therapist samples, emphasizing master's level clinicians.
MBC research in psychotherapy is not therapist-centered.	Conduct research examining therapists' perceptions and preferences relevant to MBC.
MBC works, but we can't get therapists to engage in it.	Shift the emphasis to implementation studies (vs. efficacy trials).
Most therapists are not consumer of research published in scholarly outlets.	Formulate dissemination plans that realistically and impactfully reach therapists. Increase the availability of these guidelines to therapists of all backgrounds and training levels (e.g., promote the distribution through local associations).
Professional practice guidelines are not pragmatic.	Provide therapists with practical guidelines on how to use MBC, clarifying: • What measures to administer • When to administer measures • How often to review scores • How to discuss scores with clients • How to respond to observed changes with specific interventions
Therapists are not aware of systems that facilitate implementation/integration of MBC.	Create a list of MFSs listing the features of each system, cost, where and how to access them, and how to integrate them with other software, such as those for clinical notes and scheduling.

Note. MBC = measurement-based care; MFS = measurement feedback system.

questioned (Wampold & Imel, 2015). Nevertheless, the current approach to the study and implementation of MBC in psychotherapy is still grounded in this oversimplified, translational perspective. Within medicine, the ideographic effectiveness of most treatments can be measured objectively thanks to the presence of tangible indicators. Furthermore, the modification of treatment based on changes observed in the administered measures is underlain by direct links between treatment, measurement, disease, and provider behavior. Diabetes management exemplifies this sequence, where A1C is an objective, direct measure for the disease, which is used by providers to make specific clinical decisions (i.e., augment or diminish medication) that directly affect what is measured. However, this process is rarely (if ever) applicable to psychotherapy. What brings clients to our office is seldom a well defined or single condition. Instead, the frequency of assignment of "unspecified" disorder diagnostic codes underscores the vast variability in clinical presentation. And even when specific conditions can be diagnosed, comorbidity, and/or co-occurrence are the norm rather than the exception. When asked about what they wish to achieve from psychotherapy, clients infrequently mention any of the symptoms listed in *Diagnostic and Statistical Manual of Mental Disorders-5* (American Psychiatric Association, 2013). Yet, the most common application of MBC in psychotherapy relies predominantly, and often exclusively, on symptom-based measures. To further complicate matters, research to date has repeatedly failed to demonstrate that specific therapist behaviors (e.g., interventions) lead to well defined and predictable changes in specific symptoms or psychological processes (e.g., Boswell & Bugatti, 2016; Boswell et al., 2014). Thus, while the MBC paradigm in medicine can directly assist provider clinical decision-making, the same cannot be said about psychotherapy. This fundamental difference ultimately affects the value of MBC that is perceived by therapists and clients alike.

Preaching to the Choir

Given the well-established effectiveness of MBC, its empirical evidence is most often relied upon as primary means of persuasion. This professional practice guideline (PPG) certainly appears to follow this trend. However, trying to close the research–practice gap by presenting more research findings to practicing therapists has never proven to be a successful strategy. This same approach had been employed for promoting the implementation of other EBPs, with unsatisfactory results (Gallo & Barlow, 2012). While presenting empirical evidence might induce great excitement and motivation among scholars, its effect on the clinical community is far less impactful. Many practicing psychologists do not devote a significant amount of time to consuming scholarly literature for numerous reasons (e.g., time constraints, cost, degree of familiarity with research methodology; Rønnestad & Skovholt, 2003). However, the openness to EBPs of the clinical settings where they practice, and the availability of training opportunities have been found to significantly affect therapists' implementation of EBPs (Nelson & Steele, 2007). Thus, if we truly intend to turn the tide, we need to stop preaching to the choir (i.e., scholars and academics), and focus on targeting the right audience, namely clinical administrators, and full-time therapists, instead. In addition, an effort on our part is needed to provide this audience with what is needed: clinically relevant findings presented in digestible formats and accompanied by suggestions for feasible and specific action.

In summary, our guidelines need to be actionable. Moreover, a greater awareness of the professional characteristics of this audience is desperately needed. Many full-time practicing therapists are not active consumers of research published in scholarly, psychology outlets. Indeed, the vast majority of therapists are master's-level clinicians, often stemming from fields other than psychology (e.g., social workers). Thus, if we truly intend for our implementation efforts to be effective at a broader level, we ought to ensure that our approach is tailored to the intended audience.

Therapists Rule!

As it is often the case in psychotherapy research, we have been extremely proficient at measuring and reporting to therapists their

own behavior (in this case the use of MBC). Likewise, we have barely started to scratch the surface when trying to figure out therapists' perceptions, needs, and preferences relevant to MBC, as well as their perceived barriers to implementation. Although notable exceptions can be found in the literature (e.g., Hatfield & Ogles, 2007; Jensen-Doss et al., 2018; Jensen-Doss & Hawley, 2010), more studies expanding this line of inquiry are sorely needed. Among the many questions that need to be investigated, it is paramount to understand what monitorable treatment processes therapists would find to provide the most clinically useful information. After all, therapists' feelings toward symptom-based measures appear to be rather lukewarm (e.g., Jensen-Doss et al., 2018), and while alternative approaches have been explored (e.g., Bugatti & Boswell, 2022), therapists' needs, and preferences have yet to be clearly identified. These research questions are crucial because, although MBC relying primarily on symptom-based measure seems to lead to better outcomes, it is not perceived to be worth the effort by therapists. Since presenting therapists with evidence supporting the use of MBC is not enough to foster its implementation, an alternative, collaborative approach should instead be explored. Therapists ought to be included in the design of measurement feedback systems and in the selection or creation of routinely administrable measures quantifying the processes they deem to be relevant and useful to their clinical work.

We Have Tried the Stick—Now It Is Time for Some Carrot

Unfortunately, Boswell et al.'s (2022) PPG does not discuss any strategies that might enhance therapists' motivation for engaging in MBC, thus excluding any suggestions for system-level action. Since the ultimate goal of the PPG is to foster behavior change, this is a significant omission. At present, most efforts to promote therapists' use of MBC rely on positive and negative punishment. Some insurance companies refuse to reimburse therapists for their services unless they administer specific measures. Likewise, some hospitals and clinics require the administration of outcome measures in order to allow clinicians to complete clinical documentation. Ultimately, it might be safe to say that most therapists are currently already obliged to administer outcome measures. This form of MBC, however, embodies the spirit of the retrospective quality assurance approach. On the other hand, very few (if any) entities provide therapists with palatable incentives for engaging in "true" MBC. "True" MBC differs significantly from the mandated administration and documenting of symptom measures on client charts—which is consistent with the quality assurance approach—which does not promote the use of client outcome information to inform therapists' clinical decisions. Although extrinsic motivators can be effective at promoting initial engagement in new practices, the ultimate goal for the implementation of MBC should be to allow therapist to appreciate its intrinsic value. The quality assurance approach, however, instills fear in therapists who worry about falling short of required clinical standards. Instead of relying on this punitive method, system-level interventions should reward therapists for engaging in MBC-consistent behaviors, such as routinely reviewing client scores prior to sessions, by providing an array of incentives.

Conclusion

The past few decades have seen the accumulation of a significant body of literature demonstrating the effectiveness of MBC in psychotherapy. However, presenting therapists with this empirical evidence has proved to be ineffective at fostering the implementation of this practice. We argue for an alternative, therapist-centered approach to implementation, grounded in the collaborative identification of therapist perceptions, needs, and preferences. Future attempts at PPGs should focus on outlining actionable and practical procedures that will bolster the perceived clinical utility and practicality of MBC in psychotherapy.

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