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How can measurement-based care improve psychotherapy processes and mental health service delivery? A synthesis of expert perspectives

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Measurement-based care (MBC) is an evidence-based multi-component practice in which: a) patient-reported outcome measures are routinely collected; b) the feedback from these measures is shared with the patient; and c) the therapist and the patient use this feedback to make shared decisions regarding treatment[1-3].

Although MBC has been recognized as a key ingredient to improving mental health care[4], its effect size varies substantially among studies, from negligible to large[5]. MBC effectiveness seems to depend on type of feedback, treatment setting characteristics, implementation quality, and cultural differences[1]. To optimize MBC, we need a research and development agenda to understand the mechanisms involved for the various stakeholders in different treatment settings and cultures.

There are established ethical, clinical and institutional rationales for using MBC. Its tools can be used to model change, assess treatment response, personalize care, and prevent treatment failure. MBC can help patients feel more engaged, thereby improving their self-reflection and sense of ownership of the therapeutic process. By improving patient-therapist communication and collaboration, MBC can improve outcomes. Aggregated MBC data can support organizational goals such as quality monitoring and improvement efforts and satisfy accreditation or other accountability standards. However, due to a variety of implementation barriers, the empirically based promise of MBC remains under-realized in real-world practice in health care systems around the globe.

The International Network for Psychotherapy Innovations and Research into Effectiveness (INSPIRE) is a group of leading researchers, developers and clinicians from Europe, Asia and the US who have been collaborating since 2017. The group focuses on developing scientific knowledge about improving mental health outcomes for patients by integrating MBC in clinical practice. The group is system-agnostic, has

experience researching and developing many of the most widely used MBC systems used today, and prioritizes collaboration over competition in a shared aim for scientific knowledge integration.

The group recently synthesized collective insights to suggest a conceptual framework for how MBC works and how it needs to develop. There are three key themes in how MBC works to improve psychotherapy and mental health service delivery: adding perspectives; prompting action; and activating resources.

MBC provides information or perspectives not otherwise available to the therapist and the patient in the natural flow of the therapeutic interaction. For instance, it allows a comparison of various elements of the individual patient's clinical picture to relevant groups.

MBC provides prompts and support for therapists changing or adjusting their approach to an individual patient. A core example comes from MBC with clinical support tools[6,7], which offer feedback that one should address the therapeutic alliance or establish shared expectations. Direct alliance feedback prompts therapeutic focus on collaboration and the patient's needs in situations where an alliance rupture has occurred.

MBC activates resources within the patient, for example by providing insights and reflection, or supporting involvement in care. Responding to MBC measures may increase the experienced dose of treatment, in that it allows patients to reflect on their progress outside the sessions. Moreover, MBC supports collegial and professional discussion, interdisciplinary collaboration, and team competence. As such, this is both an individual stakeholder and a systems level process. In summary, activating resources works by empowering patients, therapists and systems in a program evaluation approach, aimed to improve treatment.

Five sub-themes were identified by INSPIRE collaborators as needed developments to enhance implementation and clinical use of MBC. First, technological innovation refers to the need for user-friendly, safe, equitable and available digital solutions to support MBC implementation. Too often, clinically and psychometrically sound MBC systems do not gain broad acceptance due to technological delivery barriers. Second, the MBC approach should be integrated into training and practice improvement efforts, such as graduate and professional training, coaching and supervision, to emphasize MBC as a dyadic process that demands clinical attention, skill and finesse. Third, dissemination and implementation refer to

the need for translational practices. Advocacy is an important part of these efforts and may include communication and education directed toward patient end-users, to develop awareness and, ideally, a mandate for data-informed treatment. Fourth, broadening scope refers to the need for innovative research to explore applications beyond symptom measurement to inform MBC, to ensure the inclusion of other relevant patient experiences. Fifth, there is a need for evidence-based models of MBC as a vehicle to support organizational learning and development.

In this letter, we have synthesized the perspectives of an international group of experts to inform current MBC practice. We hope to contribute useful heuristics and language to structure trainings, communication and implementation processes for MBC. Better integration into clinical training programs, allowing for MBC to be part of basic clinical skills and identity, may be particularly beneficial[8]. The idea that MBC can activate therapeutic resources within the patient seems especially important, considering current resource restraints of health care systems. Furthermore, clinical support tools, such as advice based on nearest neighbor and other machine learning approaches[9], are available in MBC research but not widely implemented in practice.

We suggest that research and development concerning MBC needs greater coordination across settings, cultures and systems, to balance the mutually dependent processes involved. Parallel investments in specific measure development, technological development, implementation science, clinical training and end-user dissemination can support greater forward movement, if they are coordinated. Measure-agnostic approaches, in which concepts co-develop rather than compete, and in which anonymous data on clinical use and implementation processes can be shared in the network, seem necessary for development of the field as a whole. MBC, as a shared technology that spans diagnoses and clinical orientations, supports the needed transition from a standard atomistic model of care to a continuous clinical research model of care in learning organizations, in which all patients are invited to have their data part of ongoing clinical studies and innovations.

In conclusion, MBC has the potential to add perspectives, prompt action, and activate resources, all of which can lead to better patient outcomes. We suggest that the field of MBC needs to adopt a strategic approach to learning and knowledge transfer across many current boundaries.

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