Core Competencies of Feedback Informed Treatment

Feedback-Informed Treatment (FIT) is an evidence-based approach for evaluating and improving the quality and outcome of behavioral health services applicable across a wide and diverse range of clients, treatment methods and settings, and cultures.

FIT practitioners demonstrate knowledge and skills in four different areas: (1) empirical foundations; (2) FIT implementation and practice; (3) data collection and analysis; and (4) continuous professional development.

Each competency is summarized below. Detailed descriptions follow.

Core Competency Summaries

Competency 1: Empirical Foundations

1. FIT practitioners understand the meaning of terminology commonly used in outcome research.

2. FIT Practitioners are familiar with the empirical evidence regarding the efficacy of behavioral health services (e.g., mental health, substance abuse, and disease management).

3. FIT Practitioners are familiar with the empirical evidence regarding the nature and impact of the therapeutic relationship.

4. FIT Practitioners are familiar with the empirical evidence about "Feedback Informed Treatment" (FIT).

5. FIT Practitioners are familiar with empirical findings on implementation of evidence-based practices (including FIT).

6. FIT Practitioners are familiar with empirical findings on expert performance and its application to professional development.

Competency 2: FIT Implementation and Practice

1. FIT Practitioners follow the evidence-based stages associated with the successful implementation of FIT in agencies and systems of care.

2. FIT Practitioners embody the principles of feedback-informed treatment in their daily clinical work.

3. FIT Practitioners use valid, reliable, and feasible measures to obtain client feedback regarding their experience of and progress resulting from care.

Competency 3: Data Collection and Analysis

1. FIT Practitioners have a system in place for ensuring outcome and alliance data are collected consistently and transparently from the beginning (e.g., intake) to the end of service delivery (e.g., discharge).

2. FIT practitioners are familiar with available, authorized software systems for administering, scoring, aggregating, and analyzing data generated by the outcome and alliance measures they employ in service delivery.

3. FIT practitioners provide detail sufficient to enable others to assess the accuracy and representativeness of the data collected and any results/analysis reported (e.g., demographic and descriptive information, frequency of measurement, criteria for choosing which data is included or excluded, and accounting for missing data).

Competency 4: Continuous Professional Development

1. FIT practitioners work continuously to improve their knowledge about and the effectiveness of the services they provide.

2. FIT practitioners regularly engage in deliberate practice outside of service delivery.

3. FIT practitioners continuously assess the impact of their professional development activities by monitoring changes to their baseline level of performance.

Competency 1: Empirical Foundations

1. FIT practitioners understand the meaning of terminology commonly used in outcome research:

    a. Effect size

    b. Severity adjusted effect size

    c. Relative effect size

    d. Deterioration and dropout rates

    e. Research design (e.g., randomized controlled trial, meta-analysis, direct versus TAU or no treatment control comparisons)

    f. Evidence-based practice, empirically-supported treatments and practice-based evidence

2. FIT Practitioners are familiar with the empirical evidence regarding the efficacy of behavioral health services (e.g., mental health, substance abuse, and disease management):

    a. Behavioral health services are effective in improving well-being and alleviating psychological distress

    b. All “bona fide” therapeutic approaches work about equally well

    c. The effectiveness of behavioral health services is accounted for by a core group of factors, including extra-therapeutic (e.g., premorbid functioning, chance events, existing support network), the therapeutic relationship, therapist allegiance, client hope and expectancy, and the specific treatment method employed (including explanatory rationale and associated techniques)

    d. Strong predictors of the effectiveness of behavioral health services include:

        i. Early positive change

ii. Improving client ratings of the therapeutic relationship

iii. High levels of client engagement in the treatment process

iv. The location and provider of treatment

e. Weak or non-predictors of the effectiveness of behavioral health services include:

i. Client age, gender, diagnosis, and prior treatment history

ii. Clinician age, gender, licensure, professional discipline, degrees earned, participation in personal therapy, and amount of training or clinical supervision

iii. The degree of match between the client and therapist on personal or demographic qualities

iv. The therapeutic approach or technique employed (including adherence, competence, and matching technique or approach to diagnosis)

3. FIT Practitioners are familiar with the empirical evidence regarding the nature and impact of the therapeutic relationship:

a. The therapeutic relationship is comprised of four empirically established components (agreement on the goals, treatment approach or method, bond, and client preferences)

b. Client ratings of the therapeutic relationship on a standardized measure are more highly correlated with outcome than clinician ratings

c. Client ratings of the therapeutic relationship are a significant predictor of treatment outcome:

i. Improvements in client ratings of the therapeutic relationship from intake to termination are associated with better outcomes

ii. Decreases in client ratings of the therapeutic relationship are associated with higher dropout rates and poorer outcomes

d. A significant portion of the variability in effectiveness between clinicians is due to differences in their ability to establish therapeutic relationships with a broad and diverse clientele and address ruptures in the relationship when they occur

e. Monitoring the client's experience of the therapeutic relationship with a standardized measure increases the likelihood of clinicians identifying clients at risk of dropout and poorer treatment outcome

4. FIT Practitioners are familiar with the empirical evidence about "Feedback Informed Treatment" (FIT):

a. Behavioral health professionals' assessment of their own effectiveness across a variety of metrics (e.g., outcomes, retention, quality of the alliance) are frequently inaccurate and at odds with clients

b. FIT practitioners are familiar with the psychometric properties of outcome and alliance measures used to inform treatment and can articulate the trade-offs between feasibility, and reliability, validity, and sensitivity of standardized measurement scales

i. Longer outcome measures tend to be more reliable and valid, but:

- Result in lower rates of compliance in real-world clinical settings
- Provide little additional predictive information if the instrument measures the same single factor (i.e., general distress) as a shorter tool

c. Randomized clinical trials and meta-analytic studies shows routinely monitoring and using client feedback in real time regarding progress and the quality of the alliance can:

i. Significantly improve client outcomes

ii. Reduce dropout and deterioration

iii. Shorten the length of time clients spend in treatment

d. FIT has been successfully applied across a wide range of treatment settings (e.g., outpatient, inpatient university counseling centers, public mental health, substance abuse treatment center, correctional facilities and programs), age groups (adults, adolescents, and children), diverse populations and cultures

e. The impact of FIT varies depending on:

i. Individual therapist responsiveness to feedback.

ii. The quality and stage of implementation.

5. FIT Practitioners are familiar with empirical findings on the implementation of evidence-based practices (including FIT), including:

a. General findings from implementation science:

i. Implementation occurs in a series of stages (exploration, installation, initial implementation, full implementation, and sustainability)

ii. Moving through the stages of implementation most often takes between 2 and 7 years

iii. Success depends on the size of the agency, degree of planning, ongoing onsite training and consultation, an accountable implementation team, management buy-in and support, and focus on organizational change versus the specific evidence-based practice or practitioner development.

b. Emerging empirical evidence regarding the implementation of FIT:

i. The most significant barriers to implementation are:

- Lack of financial resources (e.g., funding for training and access to computerized feedback systems)

- Practitioner fears regarding the potential misuse of outcome data

- Lack of knowledge about, and time (and time-saving technology), for administering and processing the FIT measures

- Supervisor and management lack of understanding and failure to use and integrate FIT in clinical decision making and agency policy

- The absence of a sustainable implementation plan

ii. FIT is likely to have less impact (e.g., outcome, retention, deterioration, length of stay) during the first two years of implementation

iii. The superiority of FIT over treatment-as-usual (TAU) increases if training and supervision is sustained over time (i.e., 3 or more years)

6. FIT Practitioners are familiar with empirical findings on expert performance and its application to professional development.

   a. Expert performance across a wide range of human endeavors (music, sports, chess, mathematics, etc.) is achieved from ongoing engagement in deliberate practice

      i. To be effective, deliberate practice must be focused on achieving specific targets just beyond a performer's current abilities, guided by the conscious monitoring of outcomes, and carried out over extended periods of time

   b. Behavioral health professionals need to engage in deliberate practice because:

      i. Participation in a host of traditional professional development activities (e.g., continuing education events, attainment of advanced degrees, licensure, supervision, personal therapy) are unrelated to therapeutic effectiveness

      ii. Research on psychotherapy shows the effectiveness of the "average" helper plateaus and begins to decline early in their careers

   c. A deliberate practice program should include the following:

i. Establishment of a valid baseline of practitioner effectiveness (e.g., effect size, dropout and deterioration rate, treatment length)

ii. The identification of practitioner performance deficits relative to established norms

iii. The development of individualized learning objectives aimed at targeting performance deficits

iv. The use of an expert coach to develop remedial practice exercises specific to the individual practitioner and their learning objectives

v. Successive refinement of performance via targeted practice by the practitioner, and ongoing monitoring and feedback from the coach

Competency 2: FIT Implementation and Practice

1. FIT Practitioners apply the evidence-based stages associated with the successful implementation of FIT in agencies and systems of care by:

    a. Encouraging agencies to develop a step-by-step plan for implementing FIT consistent with the stages of implementation (e.g., exploration before installation, installation before implementation)

    b. Securing leadership buy-in and involvement prior to and throughout the implementation process

    c. Setting a realistic time frame and ensure adequate resourcing

    d. Establishing the necessary infrastructure to sustain implementation, including policies, procedures, and an agency culture that actively promotes seeking and using feedback across all levels of interaction within the organization and larger system of care (e.g., clients, practitioners, supervisors, management, funders)

    e. Establishing a policy and process for overseeing and ensuring the quality (e.g., consistency, completeness) of data collection (e.g., entering data for all clients, deactivating at discharge, coding dropout) by FIT practitioners

    f. Using a gap assessment tool (e.g., the Feedback Readiness Index and Fidelity Measure [FRIFM]) to assess agency readiness, identify potential barriers, and monitor the implementation progress

    g. Using the experience and data generated by FIT to facilitate transformation of organizational policies and procedures that hinder client engagement and therapeutic effectiveness

2. FIT Practitioners embody the principles of feedback-informed treatment in their daily clinical work, including:

    a. The therapist is responsible for the effectiveness of the care they provide

    b. Client goals, preferences, culture, engagement in and experience of treatment are the central guiding focus of care

    c. The measured effect of care takes precedence over treatment protocols, external mandates (e.g., legal, medical, school, parental), clinicians preferred approaches and

agency or payer policies

d. No one treatment approach, setting, or provider works for all clients

e. Practitioners adapt services and refer based on client feedback regarding the alliance and outcome

3. FIT Practitioners use valid, reliable, and feasible measures to routinely obtain client feedback regarding their experience of and progress resulting from care by:

   a. *Introducing* outcome and alliance measures in a manner that secures client engagement and provision of open and transparent feedback about progress and the quality of the therapeutic relationship

   b. Seamlessly *integrating* outcome and alliance measures and resulting feedback (e.g., scores, cutoffs, graphs, trajectories, and aggregate data) into their clinical work across clients, problem types, treatment modalities and settings

      i. Have a range of options for processing alliance and outcome feedback (e.g., discussion with client, consultation with peers, access to FIT supervision, team meetings)

   c. Using outcome and alliance measures and resulting feedback (e.g., scores, graphs, normed trajectories, and aggregate data) to *inform* treatment planning and decision making for:

      i. Identifying problems/concerns in the therapeutic relationship

      ii. Understanding when and how to seek internal and external collateral ratings (e.g., mandated clients, family therapy, work with children)

      iii. Adjusting service delivery in response to alliance or outcome feedback (e.g., changing the dose, intensity, type, location, and provider)

Competency 3: Data Collection and Analysis

1. FIT practitioners have a system/process in place for ensuring outcome and alliance data are collected consistently and transparently from the beginning (e.g., intake) to the end of service delivery (e.g., discharge)

    a. Familiarity with and abiding by all copyright and licensing terms of the measures they employ

    b. Understanding the psychometric properties and limitations of the measures they employ

    c. FIT practitioners have a clear standard designating how often and from whom measures are gathered and are able to determine the degree of compliance with the standard for administration of measures

2. FIT practitioners are familiar with available and authorized software systems for administering, scoring, aggregating, and analyzing data generated by the outcome and alliance measures they employ in service delivery, including:

    a. Utilizing *only* authorized systems containing valid formulas and established norms to evaluate the quality of the therapeutic relationship and progress of individual clients in real time and determine therapist, program, and agency effectiveness

    b. Understanding and being able to articulate the meaning, purpose, and limitations of any analysis generated by authorized systems to measure the quality of the relationship, individual client progress, and other treatment benchmarks (e.g., graphs, effect size, relative effect size, dropout rate)

3. FIT practitioners provide detail sufficient to enable others (e.g., clients, supervisors, managers, funders, referral sources) to assess the accuracy and representativeness of the data collected and any results/analysis reported (e.g., demographic and descriptive information, frequency of measurement, criteria for choosing which data is included or excluded, and accounting for missing data)

Competency 4: Continuous Professional Development

1. FIT practitioners work continuously to improve their knowledge about and the effectiveness of the services they provide, including:

    a. Staying current with empirical findings on behavioral health outcomes, the therapeutic relationship, feedback-informed treatment, implementation science, and expertise and expert performance (i.e., Competency 1)

    b. Participating in FIT training, consultation, data analysis and supervision

    c. Engaging with a FIT community of practice

2. FIT practitioners regularly engage in deliberate practice outside of service delivery, including:

    a. Determining their baseline level of performance (e.g., effectiveness [effect size, relative effect size, percentage of clients achieving reliable and clinically significant change], level of engagement [e.g., dropout and retention rates, skipped/missed sessions, intake alliance rating], treatment duration [e.g., length stay, number of treatment sessions])

    b. Comparing their baseline level of performance to the best available norms, standards, or benchmarks to identify performance deficits and professional development opportunities

    c. Developing clear and concrete learning objectives aimed at addressing performance deficits and improving their established baseline performance level

    d. Creating and executing an individualized deliberate practice plan, including practice exercises specific to the individual clinician and their learning objectives

    e. Actively seeking out coaches with knowledge/expertise specific to their performance deficits who can:

        i. Analyze their performance, develop exercises, obtain corrective feedback, evaluate the impact of professional development efforts, and refine their deliberate practice plan

3. FIT practitioners continuously assess the impact of their professional development activities by monitoring changes to their baseline level of performance