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# Using Measurement-Based Care to Enhance Any Treatment

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*Measurement-based care (MBC) can be defined as the practice of basing clinical care on client data collected throughout treatment. MBC is considered a core component of numerous evidence-based practices (e.g., Beck & Beck, 2011; Klerman, Weissman, Rounsaville, & Chevron, 1984) and has emerging empirical support as an evidence-based framework that can be added to any treatment (Lambert et al., 2003, Trivedi et al., 2007). The observed benefits of MBC are numerous. MBC provides insight into treatment progress, highlights ongoing treatment targets, reduces symptom deterioration, and improves client outcomes (Lambert et al., 2005). Moreover, as a framework to guide treatment, MBC has transtheoretical and transdiagnostic relevance with broad reach across clinical settings. Although MBC has primarily focused on assessing symptoms (e.g., depression, anxiety), MBC can also be used to assess valuable information about (a) symptoms, (b) functioning and satisfaction with life, (c) putative mechanisms of change (e.g., readiness to change), and (d) the treatment process (e.g., session feedback, working alliance). This paper provides an overview of the benefits and challenges of MBC implementation when conceptualized as a transtheoretical and transdiagnostic framework for evaluating client therapy progress and outcomes across these four domains. The empirical support for MBC use is briefly reviewed, an adult case example is presented to serve as a guide for successful implementation of MBC in clinical practice, and future directions to maximize MBC utility are discussed.*

The observation that it takes 17 years for only 14% of research to reach consumers (Balas & Boren, 2000) has prompted the scientific study of successful strategies for integrating evidence-based practices (EBPs) into real-world settings. Unfortunately, research suggests that clinicians may not use full-package, complex EBPs due to the burden associated with training, negative attitudes toward manuals or protocols, and beliefs that these EBPs may not be appropriate for clients in the settings in which they practice (e.g., Simons, Rozek, & Serrano, 2013). Moreover, research indicates that even if initially implemented with success, these complex EBPs are not likely to be sustained over time (Stirman et al., 2012). To address these barriers to full–package EBP implementation, Chorpita, Daleiden, and Weisz (2005) developed an innovative methodology for reviewing the treatment literature that focused on distilling EBPs down to their core or common practice elements (Chorpita et al., 2005). Outcomes of this distillation methodology have been used to develop modular treatment approaches that enable clinicians to systematically apply a variety of practice elements matched to client characteristics (PracticeWise, 2013; Weisz, Ugueto, et al., 2011). A second approach is the use of evidence-based practice frameworks such as the Collaborative Assessment and Management of Suicidality (CAMS; Jobes, 2006). Specifically, the CAMS framework encourages clinicians to continue treatment-as-usual while collaboratively engaging the client in open but semistructured communication to effectively manage and resolve suicidal ideation. Given the difficulties associated with implementing full-package EBPs, implementation of modular treatments or frameworks could serve as an effective and resource-efficient method for enhancing treatment as usual. Preliminary evidence suggests clinicians receive these approaches (Comtois et al., 2011) more favorably than full-package, manual-based approaches (e.g., Borntrager et al., 2009).

## Measurement-Based Care

Incorporating systematic measurement of client outcomes into treatment has been referred to in the published literature as progress monitoring, outcome monitoring, measurement-based care, or the use of feedback systems (Bickman, 2008; Lambert, Harmon, Slade, Whipple, & Hawkins, 2005; Saggese, 2005; Trivedi et al., 2006; Valenstein et al., 2009). In many but not all cases, these terms refer to a process in which the clinician obtains client progress and outcome data by administering validated measures across treatment. Throughout this paper, we will adopt the term measurement-based care (MBC) to refer to a procedure that can be broadly defined as the use of systematic data collection to monitor client progress and

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directly inform care decisions (Morris & Trivedi, 2011; Trivedi et al., 2006). Preliminary research suggests that MBC, when used as a framework to guide practice, results in superior client outcomes when compared to usual care (Lambert et al., 2002). Given MBC's potential to improve outcomes, it may be one of the minimum interventions necessary for change (MINC; e.g. Kessler & Glasgow, 2011) that could be implemented in lieu of more complex and burdensome full-package EBPs.

The goal of this paper is to highlight relevant literature that summarizes the effectiveness and applicability of MBC as a practice framework for enhancing usual care (Trivedi & Daly, 2007). The term "framework" is used to describe MBC given that it may be implemented in the context of many different treatment modalities or approaches. This paper addresses five specific aims: (a) to discuss the utility of MBC across stakeholder levels; (b) to discuss the broad reach and flexibility of MBC as a transtheoretical and transdiagnostic framework; (c) to expand MBC coverage across four domains (symptoms, life satisfaction, theorized mechanisms of change, and the therapeutic process) and provide resources for psychometrically validated measures; (d) to present a case example showcasing the utility of MBC for guiding treatment with complex adult clients; and (e) to elucidate potential challenges associated with MBC implementation.

## MBC Utility Across Stakeholder Levels

### Utility of MBC for Clients

Progress and outcome monitoring are key elements of numerous EBPs, including cognitive behavioral therapy (CBT; Beck & Beck, 2011) and interpersonal therapy (Klerman et al., 1984). Research has shown that adding MBC to usual care can result in significant improvement in client outcomes with respect to psychological disturbance, interpersonal problems, social role functioning, and quality of life, especially for clients identified as likely to experience treatment failure (Lambert et al., 2003). Additionally, youth clients with clinicians who received feedback about treatment progress have demonstrated faster improvement in symptoms than clients with clinicians who did not receive feedback (Bickman, Kelley, Breda, de Andrade & Riemer, 2011). MBC also appears to encourage the active involvement of clients in the treatment process. Eisen, Dickey, and Sederer (2000) demonstrated that clients assigned to clinicians who reviewed the self-report Behavior and Symptom Identification Scale in session were more likely to endorse a greater sense of involvement in decisions about treatment than clients receiving treatment as usual (i.e., no review of self-report symptom monitoring). Dowrick and colleagues (2009) found that clients who completed self–reports of depressive symptoms expressed that the measures allowed them to quantify their symptoms and gain a better understanding of their experience with depression.

### Utility of MBC for Clinicians

These observed improvements in client outcomes have been tied to MBC's role in alerting clinicians to lack of progress, which then encourages the clinician to alter the intervention accordingly (Lambert et al., 2003; Morris & Trivedi, 2011). That is, depending on the measure (e.g., established, psychometrically validated depression symptoms) or approach (e.g., idiographic assessment) used, MBC can provide important information about targets for clinician intervention. Moreover, MBC can streamline the assessment process and aid clinicians in making differential diagnoses (e.g., Kroenke, Spitzer, & Williams, 2001). Additional support for MBC suggests that it may be useful for enhancing the accuracy of clinician judgments by providing an objective assessment of client treatment progress (Sapyta, Riemer, & Bickman, 2005).

MBC may also be a valuable tool for facilitating collaborative care among providers within and across organizations. Katon and colleagues (2010) used a standardized depression measure to assess symptom severity in clients with comorbid depression and medical conditions, with results demonstrating that depression outcomes improved when scores were communicated to both the primary care physician and nurses involved in the client's care. Additionally, the IMPACT trials found that improvement in depression outcomes occurred when the same depression measure was administered weekly and the attending psychiatrist used the data to make treatment recommendations across a team (nurse practitioners, case workers, etc.; Unützer et al., 2002).

### Utility of MBC for Mental Health Organizations

If used routinely by all clinicians, MBC can also provide evaluative data for the organization and serve as an indicator of overall performance that can be reported to accreditation organizations (Bickman, 2008; Garland, Kruse, & Aarons, 2003). This performance assessment may then serve to inform funding decisions, provide additional quality-of-care management, and ultimately improve client care through the addition of new programs (Garland et al., 2003; Goebel, 1997). MBC may also encourage clinicians within organizations to follow standardized treatment guidelines, thereby maximizing the likelihood that evidence-based care is provided to all clients seeking mental health services (Trivedi & Daly, 2007).

## The Broad Reach and Flexibility of the MBC Framework

### Transtheoretical Relevance

There is emerging evidence that clinicians can implement MBC regardless of their theoretical orientation or training background. Clinicians who have participated in studies demonstrating MBC's (also referred to as the use of