Feedback-Informed-Treatment: A Deliberate Approach to Responsible Practice

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Abstract

As research continues to proliferate about the effectiveness of psychotherapy, mental health clinicians appear to be limited in their effectiveness and growth. If clinicians hope to meet their ethical responsibilities of beneficence and accountability, new methods to ensure client success are needed. Within the framework of deliberate practice, clinicians can use the methods of Feedback-informed treatment (FIT) to effectively modify treatment and improve their own performance, resulting in improved client outcomes. This manuscript will provide the evidence supporting the use of deliberate practice and FIT, the major aspects of each, and the potential that these approaches offer to mental health clinicians to meet their ethical responsibilities to meet client needs through effective and empirically supported methods.

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Mental health professionals are in a difficult position in modern healthcare. The overall effectiveness of mental health treatment has been established in laboratory and real-world settings, where most clients show reliable improvement when compared with non-clients (Wampold & Imel, 2015). At the same time, researchers continue to find little quality improvement compared to previous decades; for psychotherapy as a treatment and individual clinicians, there is no demonstration that clients are receiving better care than they were in the 1980s. Researchers and clinicians are thus presented with an intriguing problem: psychotherapy appears to be both effective but also resistant to improvement.

For many years, researchers of psychotherapeutic effectiveness asked what seemed to be an obvious and important question, “Which theoretical treatment approach works best?” However, researchers have consistently found that client outcomes often have little to do with the treatment approach a clinician uses. Instead, the common factors of psychotherapy (Frank & Frank, 1991) that emphasize clinician factors like warmth, empathy, collaboration, and flexibility have a stronger relationship to client outcomes than any particular approach (Wampold & Imel, 2015). In order to provide effective care, some researchers are now urging clinicians to gather data from clients to measure and track how clients are improving each session (Maeschalck & Barfknecht, 2017; Miller, Duncan, Brown, Sorrell, & Chalk, 2006; Miller, Hubble, Chow, & Seidel, 2013). By formally gathering feedback about clients’ outcomes in psychotherapy, these authors show how to monitor client progress, modify treatment in real time, and achieve better outcomes for clients.

In this article, I will argue that mental health clinicians have a responsibility to their clients and the public to utilize the available tools based on client outcomes. I will begin with a brief description of the limitations of psychotherapy’s current approach and posit deliberate practice and feedback-informed-treatment as potential solutions. Finally, I will conclude with a description of the implications current evidence has for the mental health professions.

Psychotherapy’s Problem: Effectiveness without Improvement

Since the late 1970s, the data on the effectiveness of psychotherapy has been clear. Overall, psychotherapy is effective for helping a wide range of people recover from a wide range of problems (Miller et al., 2013; Smith & Glass, 1977; Smith, Glass, & Miller, 1980; Wampold & Imel, 2015). Researchers also continue to find support for the Dodo Bird Hypothesis (Rosenzweig, 1936), which suggests there is no difference among genuine psychotherapeutic treatments (Wampold et al., 1997). Despite the emphasis on cognitive-behavioral therapies in the literature, the evidence suggests that all treatments are similarly effective. This finding holds true even when “therapeutic” components are removed (Frost, Laska, & Wampold, 2014). Because of psychotherapy, people who seek treatment are better off following treatment than 80% of those who do not.

However, in their discussion of the evidence for psychotherapy, Wampold and Imel (2015) argue that despite consistent outcomes, effectiveness has not improved. In fact, there has been little improvement in the field over the last few decades when considering client outcomes (Rousmaniere, Goodyear, Miller, & Wampold, 2017a). Current estimates of effectiveness are roughly similar to Smith and Glass’s findings in 1977. New treatment approaches and modalities have been introduced, but as these all roughly maintain the equivalent effectiveness (Wampold & Imel, 2015).

One avenue for improvement is to examine ways to improve the effectiveness of clinicians in their training, supervision, and ongoing professional development in clinical practice. Significant efforts have been undertaken to provide comprehensive education to incoming professionals, and competency

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1 Researchers have differentiated between “efficacy,” or laboratory results, and “effectiveness,” or real-world results (Wampold & Imel, 2015); the focus in this article is on the clinical application of deliberate practice and FIT in mental health settings, or its effectiveness.
movements have focused on improving training (Fouad et al., 2009; Hatcher et al., 2013) by establishing the important behaviors of clinicians and developing professionals as guidelines. Other professions have implemented comprehensive minimum standards for graduate programs (Council for Accreditation of Counseling and Related Educational Programs [CACREP], 2015) which address the areas in which clinicians should be knowledgeable.

Psychotherapy researchers, however, have called into question the utility of graduate school training for mental health clinicians. While performance expectations are high for students within graduate programs, these efforts have had limited effect on clinicians-in-training’s skills (Erekson, Janis, Bailey, Cattani, & Pedersen, 2017; Owen, Wampold, Kopta, Rousmaniere, & Miller, 2016), and when comparing client outcomes from the beginning and end of clinicians’ training, there appears to be limited growth in the skill level of graduate student clinicians (Erekson et al., 2017). The process of training to be a mental health clinician also appears to have a limited effect on clinicians-in-training’s ability to work with clients with more severe distress (Owen et al., 2016). And supervision, the mental health professions’ signature pedagogy (Bernard & Goodyear, 2019), also has little effect on clinicians-in-training’s effectiveness (Owen et al., 2016; Rousmaniere, Swift, Babins-Wagner, Whipple, & Berzins, 2016; Watkins, 2011). In effect, graduate training does not seem to contribute to clinicians’ ability to aid clients in improving their wellbeing.

The story does not appear to improve as clinicians are followed into their post-graduate careers. Following graduate school, licensed and practicing clinicians appear to peak early in their careers and proceed to worsen in effectiveness as time goes on (Goldberg et al., 2016; Miller et al., 2013). Clinicians are required by licensure bodies to complete continuing education credits, but these educational courses also do not appear to have an effect on treatment quality (Taylor & Neimeyer, 2017). Practicing clinicians are also generally poor assessors of their own ability (Chow, 2017; Walfish, McAlister, O’Donnell, & Lambert, 2012) and of their clients’ wellbeing or risk of deterioration (Hannan et al., 2005). The average clinician appears to have significant difficulty when it comes to moving beyond average performance, and often are no more effective than graduate students (Christensen & Jacobson, 1994; Lambert, 2013).

A Solution to the Problem

A solution may lie not in what makes an “average” clinician effective, but in what makes some clinicians more effective than others, how client outcomes can help differentiate between high-performing and low-performing clinicians, and how individual clinicians can systematically use client feedback to improve their performance. The rise of common factors models (Frank & Frank, 1991; Kiesler, 1966; Wampold & Imel, 2015) and the increased attention to clinician factors (Ackerman & Hilsenroth, 2001, 2003; Anderson, Ogles, Patterson, Lambert, & Vermeersch, 2009; Crits-Christoph et al., 1991) have brought greater attention to the differences between individual clinicians. When clinicians are more capable of expressing empathy, genuineness, and positive regard (Elliott, Bohart, Watson, & Greenberg, 2011; Farber & Doolin, 2011; Kolden, Klein, Wang, & Austin, 2011) and collaborating with their clients (Tryon & Winograd, 2011), they are capable of building stronger relationships with client. When clients and clinicians have better relationships, clients achieve better outcomes.

The skill of the clinician significantly contributes to the relationship between clinician and client. Anderson and colleagues (2009) asserted that tests of these skills were predictive of therapeutic relationships and client outcomes in the future. Research like this has led some authors to argue that clinicians bear the responsibility for the quality of the relationship (Wampold, 2017; Wampold & Imel, 2015). Therapeutic relationship skills, like building the working alliance (Bordin, 1979) have been shown to be sensitive to instruction and practice (Connor & Leahy, 2016). With the advances to our understanding of therapist effects and the importance of common factors, some authors are beginning to see the possibility of clinicians improving their ability to help clients, and the deliberate practice framework provides a potential way forward for mental health clinicians and professions.
Deliberate Practice

The deliberate practice framework was described by Ericsson and Lehmann (1996) and brought into the popular consciousness by Malcolm Gladwell (2008). Deliberate practice, as the name suggests is an intentional, deliberate approach to skill development. Ericsson and Lehmann (1996) define deliberate practice as “individualized training activities especially designed by a coach or teacher to improve specific aspects of an individual’s performance through repetition and successive refinement” (pp. 278-279). Put simply, deliberate practice is the idea that individuals improve in a given area when they are motivated to maintain focus and attention on a task, repetitively practice this task under the guidance of a more expert teacher, and modify, refine and improve their performance based upon feedback they have received. Ericsson and colleagues’ model of expertise development is a series of concentrated practices of discrete skills that slowly approach expert performance, and their model has been applied in a wide range of fields including music (Ericsson, Krampe, & Tesch-Römer, 1993; Platz, Kopiez, Lehmann, & Wolf, 2014), sports (Baker & Young, 2014), and medicine (Ericsson, 2004; Ericsson, 2015).

While researchers have demonstrated skill development in music, games, or sports with deliberate practice, the fields of medicine and medical education may provide a better comparison for the mental health fields. Medicine and medical education are similar to mental health disciplines because they require complex decision-making, fine-tuned skills, and efficient action under pressure. McGaghie (2017) describes the integration of deliberate practice and a similar practice in mastery learning into medical education. He describes the necessity of the field of medical education to improve beyond “see one, do one” which has dominated the field for nearly a century in order to effectively address patient needs and improve patient outcomes. The mental health professions find themselves in a similar position.

While the efforts to implement deliberate practice in the training of mental health clinicians has been limited, there are some efforts taking place. In the first study of its kind, Chow and colleagues (2015) were able to demonstrate that the most effective clinicians spent more solo time outside of sessions practicing, developing their skills as clinicians, and learning. Much like earlier studies in other fields, the top performing clinicians spent almost three times as long practicing each week as the bottom three quartiles. While only an initial exploration of psychotherapeutic deliberate practice, these results suggest that this process is applicable in the mental health professions.

Other researchers have begun to integrate deliberate practice into counseling. Miller, Hubble, and Chow (2017) distilled deliberate practice into four major elements, which include a sustained practice focused on improving performance, the guidance of a teacher or mentor, regular and timely feedback, and refinement through repetitive solo practice. Goodyear and Rousmaniere (2017) describe a similar process. Motivated individuals set baseline levels of performance, and as they practice or perform, they gather feedback about their performance that is timely and specific. With the help of a coach or mentor, they set distinct, incremental goals with clear steps. The coach or mentor—or in the case of counseling, the clinical supervisor or consultant—helps individuals refine practice, develop new strategies, and identify limitations. This iterative process feeds back into itself. Clinicians continue to develop new baselines that inform future practice to develop new baselines. The process of developing expertise through deliberate practice is intensive but produces results.

Feedback-Informed-Treatment

Feedback-informed-treatment (FIT), a counseling approach that involves the practice of systematically collecting feedback from clients about their progress on a regular basis, tracking their responses, and incorporating this feedback about their progress and the relationship into treatment (Maeschalck & Barfknecht, 2017), follows the established principles of deliberate practice. More than just asking each client how they feel their treatment is progressing, FIT uses validated measures to analyze patterns and find weak areas in clients’ overall wellbeing or in the working alliance. FIT is not only the gathering
and tracking of this data, though; mental health clinicians have the responsibility to incorporate this data into their work with clients.

The process of gathering and analyzing data from clients is a step in the right direction to address some of the shortcomings of mental health care. Previous researchers have argued that mental health clinicians struggle to assess their work accurately, and FIT can help clinicians to discharge their responsibility to provide more effective care for their clients. Rather than asking clinicians to make often erroneous assumptions about clients, FIT requires clinicians to directly gather data from clients on their progress or deterioration in treatment. I now examine in more detail the component elements of FIT: Gathering feedback data directly from clients, analyzing feedback data for areas for improvement, and implementing the feedback into treatment (Prescott, 2017).

Gathering Feedback

For FIT to work, feedback must be gathered systematically. While many mental health clinicians may feel like they already informally ask their clients how their treatment is progressing, informal data gathering does not appear to provide any consistent data on which clinicians can act (Prescott, 2017). This aspect is like setting baselines in the deliberate practice framework. Without a baseline and without this feedback, there are no benchmarks with which to compare client or clinician growth. When clinicians do not gather feedback data from clients, their ability to be effective with a wider range of clients is limited.

Some mental health clinicians have demonstrated a reluctance to gather feedback about their work with clients (Gilbody, House, & Sheldon, 2002; Zimmerman & McGlinchey, 2008). Prescott (2017) suggested that this reluctance stems from a few factors, including clinicians’ beliefs that gathering feedback could coerce clients’ responses, perceptions of conflict with the treatment approach or modality, and fears about slowing down the progress of treatment. Other suggestions include the belief that clients should be responsible for providing feedback to clinicians. Some clinicians may even believe they are already soliciting feedback and do not need to formalize their process. These positions have little to no support in the available literature or evidence-based practice.

Tools to Gather Feedback. In order to gather useful data, clinicians and researchers have developed a variety of measures. While there are many different, valid methods to collect data from clients, two major systems are the Outcome Questionnaire-45 (OQ-45; Lambert, 2012) and the Partners for Change Outcome Management System (PCOMS; Duncan et al., 2003; Duncan, Miller, Wampold, & Hubble, 2010; Miller & Duncan, 2006; Miller, Duncan, Brown, Sparks, & Claud, 2003).

The OQ-45 is an assessment tool that asks clients a variety of questions about overall wellbeing, relationship functioning, and symptomology (Lambert, 2015). It consists of 45 questions and takes up to 10 minutes to complete; clients fill it out at the beginning of every session (Lambert, 2012). The OQ-Analyst system is a system that enables mental health clinicians to gather this data and review it quickly. Once the clinician has reviewed the results, they and client are able to use the results to guide the session based on the areas that clients identify on the measure. The OQ-45 is built to categorize clients as “recovered”, “improved”, “unchanged”, or “deteriorated” based on comparing current and previous scores (Lambert, 2015).

In response to the OQ-45’s length and the time it takes to implement, another group of researchers developed the Partners for Change Outcome Management System (PCOMS). The PCOMS is actually two measures, the Outcome Rating Scale (ORS; Miller et al., 2003) and the Session Rating Scale (SRS; Duncan et al., 2003). Much like the OQ-45, both can be used every session—the ORS used at the beginning of the session to monitor client wellbeing and the SRS used at the end to monitor the working alliance. The PCOMS measures are unique because they use Visual Analogue Scales rather than Likert-type or numbered scales. These scales are marked at the appropriate point along a line, and the mental health clinician will measure the distance from the left side to generate a score. Due to their
ease of use, the ORS and the SRS are more commonly used by current FIT-practicing mental health clinicians (Maeschalck & Barkknecht, 2017).

While the OQ-45 and PCOMS are the most common FIT measures, there are additional methods of data collection. Chapman and colleagues (2017) detailed five other quantitative measures, while McLeod (2017) discussed the use of qualitative means to assess client outcomes and the working alliance. None of the available measures is perfect, but they provide a structured, formal assessment of client progress in every session.

Analyzing Feedback

Analyzing feedback from clients helps clinicians further set a baseline level of performance. Not only can clinicians develop an understanding of their average performance, gathering and analyzing data from each client can help identify areas for growth regarding certain client presentations, diagnoses, populations, or modalities. Casting a broad net for feedback allows clinicians to find their strengths and limitations, set realistic goals, and reinforce the effective practice they already have. Feedback can clue clinicians into general trends and help spot red flags that indicate premature termination or the need to modify treatment.

Premature termination is the discontinuation of treatment before reaching client goals or termination that the mental health clinicians was not anticipating (Anderson, Tambling, Yorgason, & Rackham, 2019). Swift and Greenberg’s (2012) meta-analysis suggests roughly one in five clients will prematurely terminate treatment. The role that mental health clinicians have in premature termination appear equal to the role that they have in successful treatment outcomes (Anderson et al., 2019; Zimmermann, Rubel, Page, & Lutz, 2017). By monitoring client outcomes and the quality of the working alliance from the very first session, clinicians can address clients’ concerns immediately (Goodyear & Rousmaniere, 2017; Maeschalck & Barkknecht, 2017). Miller, Duncan, Brown, Sorrell, and Chalk (2006) demonstrated that the use of feedback to address premature termination resulted in an increase in retention.

An advantage to using formal, standardized assessments is that available research can help make sense of clients’ ratings and plan for effective intervention. For example, Bertolino and Miller (2013, as cited in Maeschalck & Barkknecht, 2017) identify “bleeding”, “dipping”, “fluctuating”, and “plateauing” as possible patterns, and offer suggestions for tailoring treatment approaches under these circumstances. These patterns, which include slowly decreasing outcomes scores, sudden dips in scores, rapid increases and decreases in scores, and scores that seem to “stall” can be an indicator that mental health clinicians need to change their strategy. When not gathering feedback, clinicians struggle to see these patterns.

Implementing Feedback

In deliberate practice, practitioners use their baseline performance to set goals and develop incremental steps to reach them. Similarly, using the data to identify areas for improvement involves using the data to set a reasonable goal, adjusting work with clients, and attempting to meet client needs more effectively. There are varieties of ways clinicians can implement their data back into their work, and their choice depends on the available evidence and the needs of their clients.

Once feedback data is gathered, clinicians have several choices for how to use the data. Clinicians can use this data to monitor, guide, or influence the course or treatment. Sharing feedback with clients and using it as initial talking points for can be useful. Individual data points can help begin or end sessions, or data trends can be used to help bridge between sessions or consolidate treatment progress. Finally, clinicians can aggregate the feedback from all their clients to facilitate their own improvement or supervision.

When mental health clinicians track clients’ outcomes, they can track when clients might not be progressing as expected and can adjust their course. Maeschalck and Barkknecht (2017) suggested that
when clients’ ratings appear to plateau or worsen, it might be necessary to change the provided treatment, increase session frequency, or modify the intensity of treatment. They further suggested that if little to no change results from these modifications to treatment, clients’ scores could aid in considering the need for referral or termination.

The Evidence for Feedback

The mental health professions have a history of providing treatments that are discredited, ineffective, or even harmful (Norcross, Roocher, & Garofalo, 2006). Some ill-conceived practices have been dangerous enough that they resulted in clients’ deaths during or following treatment (Mercer, 2001; Serovich et al., 2008). While the evidence supporting deliberate practice in mental health care is limited, FIT has a solid evidence base. This evidence base supports both clinicians and clients having access to their own feedback data and the use of FIT in the treatment of specific disorders.

In some studies about FIT, sharing feedback from clients progress to clinicians can double the effectiveness of treatment (Lambert et al., 2003; Miller et al., 2006; Simon, Lambert, Harris, Busath, & Vazquez, 2012; Whipple et al., 2003). Meta-analyses have suggested that FIT generally results in improved treatment outcomes (Lambert & Shimokawa, 2011; Lambert, Whipple, & Kleinstäuber, 2018; Østergård, Randa, & Hougaard, 2018). In others, while statistical significance was limited, effect size data suggests clinically significant effects of feedback (Hansson, Rundberg, Österling, Öjehagen, & Berglund, 2013; Newnham, Hooke, & Page, 2010; Probst et al., 2013; Shechtman & Tutian, 2017).

Not only is gathering and using feedback useful for mental health clinicians, the evidence suggests that the benefit increases when clinicians share feedback data with clients. When clients are more actively involved in implementing the feedback they provide, they are often more comfortable with the process (Börjesson & Boström, 2019). Clients being involved with FIT have also been shown to have benefits when compared to both treatment without feedback and FIT in which only the clinician has access to the data (Hawkins, Lambert, Vermeersch, Slade, & Tuttle, 2004; Whipple et al., 2003). Tilsen and McNamee (2015) have suggested gathering feedback encourages clients to engage in their treatment with greater self-reflection. This reflexive engagement might explain how this feedback seems to improve client outcomes, lead clients to engage more with the specifics of the treatment and help them feel more connected to their mental health clinician.

Researchers investing the use of FIT in the treatment of specific disorders have found promising results. Crits-Christoph and colleagues (2012) found that the use of client feedback had positive effects in the treatment of alcohol and substance use disorders. Others have shown that outcome feedback served to reduce self-harm behaviors associated with disordered eating (Schmidt et al., 2006). In a large-scale study of low-income clients with depression, the use of FIT was associated benefits greater than treatment without it (Reese, Duncan, Bohanske, Owen, & Minami, 2014). When used with patients identified as highly distressed, FIT did not improve outcomes, but its use was associated with an improvement in the therapeutic relationship (Tzur Bitan et al., 2019). These studies support the use of FIT across modalities and disorders.

The mechanism through which feedback is effective is still a subject of investigation (Wampold, 2015). There have been suggestions that FIT improves performance by allowing session-by-session adjustment of the working alliance (Brattland et al., 2019; Miller, Hubble, Duncan, & Wampold, 2010). Sapyta, Riemer, and Bickman (2005) speculate that when mental health clinicians receive feedback that indicates below-expectation performance, they experience motivation to modify their approach. Because FIT and deliberate practice share many processes, FIT may increase the amount of solo practice in which clinicians engage. Chow and colleagues’ (2015) argue that this solo time is the strongest predictor of improvement.

There is evidence that the use of FIT may be ineffective or contraindicated in some settings and/or with certain individuals. FIT may not be indicated in some inpatient or emergency psychiatric settings.
When clients have experienced previous psychiatric hospitalization or were otherwise experiencing more severe symptoms, feedback about continued high symptomology was harmful (Errázuriz & Zilcha-Mano, 2018). When used with inpatient and day-treatment patients with personality disorder diagnoses, FIT appeared to be either ineffective, or harmful to treatment (de Jong, Segaar, Ingenhoven, van Busschbach, & Timman, 2018). In an emergency psychiatric setting van Oenen and colleagues (2016) found that clients in the feedback condition improved more slowly than clients receiving treatment as usual. Finally, while Østergård and colleagues' meta-analysis (2018) found a positive effect on treatment in outpatient populations, there was no benefit to the use of FIT with inpatient clients.

Overall, the use of FIT appears to improve treatment in a wide variety of settings. When paired with deliberate practice, the possibilities for further improvement appear significant. The evidence for both approaches affirms the need for further inquiry into the possibilities of education and professional development.

Integration of FIT and Deliberate Practice

Feedback-informed-treatment alone has great utility but does not seem to be enough to improve clinical practice. While FIT provides useful data for mental health clinicians, it is not necessarily associated with client improvement (Chow, 2017). Using FIT can help identify clients at risk of deterioration and problems associated with the therapeutic alliance, but it alone cannot produce better clinicians. The broader framework of deliberate practice for mental health clinicians holds unique promise that some prominent researchers have begun to investigate (Chow, 2017; Chow et al., 2015; Miller, Hubble, Chow, & Seidel, 2015; Rousmaniere, 2017, 2019; Rousmaniere, Goodyear, Miller, & Wampold, 2017). Future steps include steps taken by practicing clinicians to engage in continuing education opportunities to learn about deliberate practice and FIT and to use them in their daily practice, development of supervision and educational approaches that emphasize deliberate practice and FIT, and integrating deliberate practice and FIT principles into graduate education programs.

Many mental health clinicians remain resistant to adopting the framework of deliberate practice and incorporating FIT into their clinical work, and there is significant room for these practices to grow. Clinicians have a responsibility to the public to present their work accurately. If more clinicians adopted these practices and shared their outcomes with the public, it would allow clients and potential clients to evaluate their treatment providers. The clear benefit for clients is being able to choose a provider based on more than word of mouth or insurance referral. From the standpoint of clinicians as advocates for their clients, these changes are necessary.

There have been a few models described to implement deliberate practice and FIT into supervision. Bargmann (2017) describes a process to incorporate client feedback into supervision case presentations. Bargmann’s FIT supervision process is brief, but her goal was delineating specific steps to increase effectiveness of supervision and clinicians. Other authors have developed complex models of supervision that incorporate FIT. The Expertise-Developmental Model (EDM; Rousmaniere, Goodyear, Miller, & Wampold, 2017) is based on the integration of deliberate practice with current supervision models. Supervisors using EDM have supervisees collect client feedback to establish a baseline, provide feedback based on video review of supervisees’ work, and work with supervisees to develop practice routines that enable them to improve their skills, and thus improve their clients’ outcomes. Due to their recent development, there is still limited research evidence for the effectiveness of EDM or other supervision models that use deliberate practice or FIT.

The integration of deliberate practice into graduate school curriculum would have a significant impact on the training process. The evidence of the effectiveness of graduate training programs is limited, and results suggest little improvement in clinician skills as a result (Erekson et al., 2017; Owen et al., 2016). While most graduate programs teach students helping and relationship building skills, the methods have come under criticism (Ridley, Kelly, & Mollen, 2011; Ridley, Mollen, & Kelly, 2011). By integrating deliberate practice into these courses alone, graduate programs could provide clinicians-in-
training with a more effective set of skills from the outset. New professionals better equipped with deliberate practice skills may be able to maintain or improve on their skill compared to their peers. When considering effective curriculum design, helping clinicians-in-training develop an appreciation for these practices and the potential they hold could help them integrate them into a lifelong process of learning and growth (Fink, 2013).

Medical education may provide a model for integrating the principles of deliberate practice into graduate programs. Using deliberate practice, mastery learning, and simulated scenarios have led to greater variation in educational experiences and the ability to target discrete skills that need practice (Ericsson, 2015; McGaghie, 2017). Using medical simulations, medical students can engage in role-plays with peers and standardized patients, practice difficult skills, and receive immediate feedback on their performance without potential harm to real patients (Diederich et al., 2019; Welsher et al., 2017). These practices have begun to be used in some mental health professions (Logie, Bogo, Regehr, & Regehr, 2013; Neuderth et al., 2019). Greater adoption of these practices could lead to more effective training methods.

There are practical barriers to adopting deliberate practice and FIT in clinical settings. Deliberate practice and FIT require greater clinician attention to each case, which takes time and energy, and there may be pushback from mental health care administrators. However, these practices can be defended on practical terms. Insurers often require documentation of client progress for reimbursement purposes, and the assessment instruments associated with FIT proved exactly this kind of documentation. Additionally, the argument can be made that using FIT could result in increased client engagement, less premature termination, and higher and more consistent rates of client attendance, indicates that would appeal to clinical supervisors and administrators. In systems where clinicians are constantly under pressure to see more clients and provide more documentation, it is the task of individual clinicians to make the practical and theoretical case for deliberate practice and FIT.

**Conclusion**

The mental health professions have been undergoing change for decades without much observable improvement in client outcomes. Deliberate practice and FIT hold real promise for improving client outcomes by enabling clients and clinicians to communicate more effectively about the progress of treatment. Deliberate practice provides a framework for the development of expert performance, and FIT fills out this framework, providing mental health clinicians with clear instructions about how to set baselines and monitor client progression or regression by systematically gathering, analyzing, and implementing client feedback. As the evidence for these approaches becomes more established, it is the responsibility of clinicians to take up these effective practices, the responsibility of graduate programs to improve their processes and train more effective graduates, and the responsibility of professional organizations to set new expectations for training and practice.
References


