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Ovire in spodbude pri uvajanju povratno informirane obravnave v organizacije: Pregled raziskav

Barriers and facilitators to the introduction of feedback-informed treatment in organisations: A review of research

Povzetek

Uvod: Povratno informirana obravnava (PIO) je način sistematičnega spremljanja in uporabe klientovih povratnih informacij v terapevtskih procesih. Raziskave kažejo, da PIO pozitivno vpliva na terapevtske izide, saj izboljšuje sodelovanje s klienti, povečuje učinkovitost terapije in zmanjšuje osip klientov. Vendar pa organizacije pri uvajanju PIO pogosto naletijo na ovire.

Metode: Raziskava uporablja narativni pregled literature za prepoznavanje ovir in spodbud pri uvajanju PIO v organizacije. Analiza temelji na 43 relevantnih virih, pridobljenih z iskanjem po znanstvenih bazah.

Rezultati: Prepoznano je bilo 9 kategorij ovir, med katerimi so omejeni viri, negativen odnos terapevtov, pomanjkanje usposabljanja in znanja, skrbi glede zasebnosti ter tehnološke in sistemske težave. Med 12 kategorij spodbud spadajo organizacijska podpora in kultura, usposabljanje, prilagodljivost tehnologije ter aktivno vključevanje klientov.

Razprava: Uspešna uvedba PIO zahteva večnivojsko podporo znotraj organizacije, kar vključuje jasno vizijo, ustrezno usposabljanje in podporo terapevtom. Ključni izzivi za terapevte so motivacija in integracija PIO v obstoječ način izvajanja terapij, na nivoju organizacije pa premišljen pristop k razvoju kulture povratnega informiranja. Za organizacije, ki uspešno uvedejo PIO, je to lahko korak k stalnemu izboljševanju terapevtskih izidov.

Zaključek: Uvajanje PIO prinaša izzive, a tudi jasne koristi, zlasti če je

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podprto s celostnim pristopom, kulturo povratnega informiranja in kvalitetnim usposabljanjem.

Ključne besede: povratne informacije klientov, povratno informirana obravnava, rutinsko spremljanje izidov, uvajanje v organizacije, ovire, spodbude, kultura povratnega informiranja

Abstract

Introduction: Feedback-informed treatment (FIT) is a way of systematically monitoring and using client feedback in psychotherapeutic processes. Research shows that FIT has a positive impact on therapeutic outcomes by improving client engagement, increasing treatment effectiveness and reducing client drop-out. However, organisations often encounter barriers when implementing FIT.

Methods: This study uses a narrative literature review to identify barriers and facilitators to implementing FIT in organisations. The analysis is based on 43 relevant sources obtained through a search of scientific databases.

Results: 9 categories of barriers were identified, including limited resources, negative attitudes of therapists, lack of training and knowledge, privacy concerns, and technological and systemic problems. The 12 categories of facilitators include organisational support and culture, training, technological adaptability and active client involvement.

Discussion: Successful FIT implementation requires multi-level support within the organisation, including a clear vision, appropriate training and support for therapists. Key challenges for therapists are motivation and integration of FIT into existing treatment process, and at the organisational level, a deliberate approach to developing a culture of feedback. For organisations that successfully implement FIT, this can be a step towards continuous improvement of therapeutic outcomes.

Conclusion: There are challenges but also clear benefits to implementing FIT, especially when supported by a holistic approach, a culture of feedback and quality training.

Keywords: client feedback, Feedback-informed Treatment (FIT), routine outcome monitoring, implementation in organisations, barriers, facilitators, culture of feedback

Extended abstract

1. Introduction

In order to ensure the effectiveness of psychotherapeutic treatment, therapists should not rely solely on their own assessments. Many clients discontinue therapy prematurely (Swift & Greenberg, 2012) or experience negative outcomes (Reese et al., 2014), yet therapists often struggle to detect lack of progress (Chapman et al., 2012; Hatfield et al., 2010; Schuckard et al., 2017). They tend to overestimate client progress, satisfaction (Hannan et al., 2005; Maeschalck et al., 2019), and the quality of the therapeutic alliance (Lambert & Harmon, 2018). Even with years of practice, therapists do not necessarily gain more knowledge, skills, self-confidence, or empathy. Incorporating clients' perspectives through feedback is crucial for quality treatment, promoting active client participation, co-creation of understanding, and progress monitoring. Clients' assessments of treatment fit, the source of the problem, and their preferred approach (e.g., therapy or medication) contribute to early engagement, continued treatment, and the development of a therapeutic alliance (Elkin et al., 1999; Baldwin et al., 2007; Anker et al., 2010; Krupnick et al., 1996). Early reporting of positive change is important (Horvath & Bedi, 2002; Orlinsky et al., 2004), as lack of improvement in the first few sessions or weeks poses a high risk of unsuccessful outcomes (Brown et al., 1999; Lambert, 2010). Meta-analyses have shown that client feedback is a key factor in all therapeutic approaches, contributing significantly to treatment outcomes (Grencavage & Norcross, 1990; Miller, 2004; Duncan, 2016). Systematic evaluation of client responses and ongoing monitoring of therapy success are recommended to prevent treatment failure and inform appropriate interventions (Sparks & Duncan, 2018).

1.1. Client feedback and feedback-informed treatment

Routine Outcome Measurement (ROM) is the use of standardized measures to guide clinical decision-making and monitor treatment progress. This can include daily questionnaires for a more accurate assessment. Capturing client feedback about the therapeutic relationship through regular monitoring is important. The outcome data and feedback obtained can be used in various ways, such as addressing relevant topics in therapy sessions, influencing ongoing clinical decision-making, and conducting qualitative or quantitative data analysis. These components are typically combined in a comprehensive and integrated approach that includes monitoring outcomes, client feedback, and their use.

What sets feedback-informed treatment apart from other forms of clinical practice monitoring is its systematic and immediate nature, with measurement implemented in each session or at regular intervals. This information is then fed back to the client during the same session, creating a circular flow of information. Feedback-informed treatment thus involves ongoing assessment, client feedback, and the use of collected data to enhance the therapeutic process.

1.2. Different approaches and naming of feedback on the therapeutic process and outcomes

ROM is referred to by various names in the literature, including progress monitoring (PM), continuous progress instruments, patient-reported outcomes monitoring (PROMs), measurement-based care (MBC), measurement feedback system (MFS), feedback-informed treatment (FIT), systematic client feedback (SCF), real-time monitoring (RTM), clinical feedback system (CFS), among others. To simplify, I will use the acronym FIT (feedback-informed treatment) as an umbrella term for all these different descriptions. The focus is on the effect of feedback on treatment rather than the process that enables it. However, specific terms will be used when authors of individual studies refer to them.

1.3. Feedback-informed treatment as evidence-based practice and practice-based evidence

FIT is a type of evidence-based practice (EBP) that is increasingly recognized as a stand-alone tool or psychotherapeutic intervention. It is aligned with the common factors model (e.g. Duncan, 2017; Lambert & Ogles, 2004; Grencavage & Norcross, 1990) and contextual model of therapy (e.g. Wampold & Imel, 2015; Možina, 2020, 2021ab). FIT is widely recommended or even mandated for mental health service providers in the USA (APA, 2006; The Joint Commission, 2018; Nelson et al., 2007), Australia (Burgess et al., 2015), Canada (Tasca et al., 2019), Norway (Knapstad et al., 2018), the UK (Wing et al., 1998, Department of Health, 2010) and elsewhere. FIT is also a form of practice-based research/evidence (PBR/PBE; Barkham et al., 2001; Duncan et al., 2004). It allows practitioners to become involved in research by using a clinical tool and provides valuable data for researchers interested in treatment as usual. Client-focused research explores how clients change throughout treatment and helps therapists monitor progress or deterioration. FIT can be used to guide therapists and clients in determining treatment goals and objectives. The PBE model emphasizes everyday clinical practice and relies on bona fide measurements to improve practice and contribute to the scientist-practitioner model (Castonguay idr., 2013). Practice Research Networks (PRNs) involve collaboration among psychotherapists to collect data and conduct studies in natural settings for rigorous scientific methodology. Therapists play a central role in client-centred research and PBR/PBE by collecting data to improve their practice in real-world conditions.

1.4. Approaches to Feedback-informed treatment

Partners for Change Outcome Management System (PCOMS; Duncan & Reese, 2015), Outcome Questionnaire System (OQ; Lambert, 2015), Systemic Therapy Inventory of Change (STIC; Pinsof et al., 2015), Contextualised Feedback Systems (CFS; Bickman et al., 2011), Clinical Outcomes in Routine Evaluation (CORE; Barkham et al., 2001), Young Person's Clinical Outcomes in Routine Evaluation (YP-CORE; Twigg et al., 2009), and Systemic CORE (SCORE; Stratton et al., 2010) are just some of the approaches to FIT. They can be classified on a continuum from normative to communicative measurement. The first uses standardized measures, while the latter is based on personalized measures to understand the individual's concerns, goals, and experiences.

PCOMS integrates the clinical process and outcome measurement by placing the client's understanding of success and therapeutic progress at the centre of treatment. This approach emphasizes client-directed treatment and individualized client reporting of problems and changes. Feedback-informed supervision (FIS; Bargmann, 2017), also known as outcome-oriented (Worthen & Lambert, 2007) or outcome-informed supervision (Lewis, M. P., 2020), is a promising approach but thus far not enough research data is available to understand its effectiveness in improving the supervision process and clinical outcomes (Grossl et al., 2014; Reese et al., 2009). It is important for supervisors to first introduce FIS into their own practice before implementing it in supervision work (Swift et al., 2014).

In a study conducted at the outpatient clinic of the Ljubljana branch of Sigmund Freud University, the Synergetic Navigation System (SNS) was used to explore the dynamics of the therapeutic, supervision, and metasupervision processes, to see how real-time feedback can contribute to better outcomes and personal development of supervisors and therapists (Kovačević Tojnko et al., 2023).

1.5. Feedback-informed treatment effects

Research in the field of FIT has shown that FIT use has a positive impact on treatment outcomes (Brattland et al., 2018; Harmon et al., 2007; Lambert & Barley, 2002; Lambert et al. 2003; Slade et al. 2008; Tasca et al., 2018; Kelley & Bickman, 2009; Whipple et al., 2003; Duncan, 2016; Bickman et al., 2011; Connolly Gibbons et al., 2015; Lambert, 2007; Unutzer et al., 2002 among others).

Studies have found that the use of FIT contributes to approximately 8% of the effect size of psychotherapy for clients (Barkham et al., 2023a, 2023b; De Jong et al., 2021). The effects of FIT on outcome are independent of measurement or rating systems, and systematic data collection improves outcomes when done in collaboration with clients or by therapists alone. FIT is beneficial for clients with different problems and demographic characteristics, in different clinical settings, and with professionals from different professions and experience levels (Duncan, 2016). It allows for effective monitoring of client progress and helps in making timely and relevant adjustments in treatment (Overington & Ionita, 2012; Scott & Lewis, 2015). FIT has been found to have a positive impact on outcomes regardless of the psychotherapeutic approach or model used. It improves communication and sustains positive effects for longer periods (Carlier et al., 2012; Kwan & Rickwood, 2015), enhances working relationships (Brattland et al., 2018), and reduces dropout rates (Miller et al., 2006). However, others have found no effects on outcomes and other limitations of FIT (Kendrick et al., 2016; Østergård et al., 2020; Solstad et al., 2017; De Smet et al., 2020; Desmet et al., 2021).

1.6. Implementing feedback-informed treatment into organisations

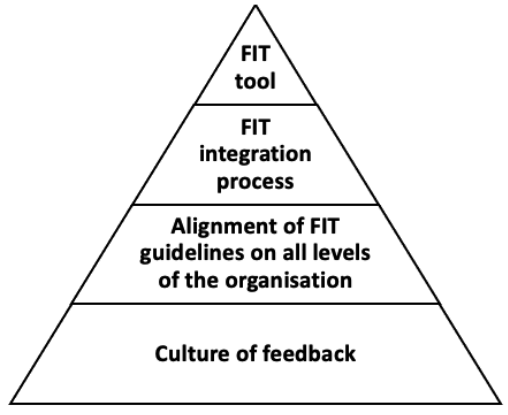
The growing body of research on FIT has led to initiatives for its implementation in various organizational settings in the field of mental health, such as psychiatric hospitals, psychotherapy clinics, teaching organizations, private practices, and school counselling services. Despite the growing research data of effectiveness, the adoption of FIT in clinical practice in organisations has been slow (e.g. Gilbody et al., 2002; Hatfield & Ogles, 2004; Ionita & Fitzpatrick, 2014; Overington et al., 2015; Barkham & Lambert, 2021; Boswell et al., 2015; Wolpert et al., 2013; Jensen-Doss et al., 2018). Various experiments have been conducted (Mackrill & Sørensen, 2020; Oranga Tamariki Evidence Centre, 2019) to learn from trial and error (Vajda, 2023; Vajda & Možina, 2024), but implementation can be challenging due to the diversity of research methodologies and the difficulty of transferring practices between different settings (Mackrill & Svendsen, 2021). For successful implementation, organizations need to understand their own values, needs, and objectives (Håland & Tilden, 2017). A clear plan is required, along with defining the purpose and intended use of FIT. Starting with simple methods, such as pencil and paper (Fleming et al., 2016), and utilizing existing resources can help organizations test and learn from small-scale implementations before a wider rollout. The experience of early adopters can inspire others, and incremental deployment steps can prevent overwhelming administration.

1.7. Culture of feedback

The culture of feedback supports the implementation of FIT and allows for the development of data-informed therapeutic services. It enhances creativity, empowers clients, and promotes a co-creation process. Studies (e.g. Handy, 1993; Meehan et al., 2006; Lewis, C. C. et al., 2019; Van Sonsbeek et al., 2023) have shown that a holistic approach, including the client, therapist, and organization, is the most effective in facilitating change and achieving desired outcomes. A culture of feedback is considered a vital element in FIT implementation, serving as the foundation upon which the alignment of FIT guidelines is built, followed by the process of FIT integration and only at the top of the pyramid the actual FIT tool, as is shown in Image 1. Absence or insufficiency of a culture of feedback presents a significant barrier to implementing FIT. FIT can contribute to the development of a learning organization, where data generated from clinical practice supports continuous improvement. Additionally, FIT can be utilized as a data source for quality control in healthcare. FIT transforms therapeutic practice by enriching knowledge for practice and through demonstrating therapeutic effectiveness towards outside stakeholders.

Image 1

Levels of FIT implementation into the organization by importance, in the form of a pyramid.



2. Methods

A narrative review focusing on the barriers and facilitators to the implementation of FIT in organizations was conducted using various keywords on Google Scholar, EBSCO, and APA PsycInfo, for the last 20 years. 191 potential sources were found. After reviewing titles, abstracts, and introductions, 74 articles from

unrelated fields were excluded, leaving 117 studies. These were further narrowed down based on the criterion that the context of the study involved FIT implementation in an organizational setting, resulting in a final list of 30 studies. Additionally, 26 relevant sources were identified through reference lists, from which 13 were excluded, thus bringing the final number of included studies to 43. The studies were then organized alphabetically by author, and barriers and facilitators mentioned in each study were categorized. The review identified 9 categories of barriers and 12 categories of facilitators. The categorization process was subjective, and the authors' own experience in a FIT implementation project influenced the weighting given to certain barriers or facilitators.

3. Results

3.1. Barriers to feedback-informed treatment implementation into organisations

Barriers to FIT implementation into organisations can be categorized in different ways, for example into individual, organizational, and systemic (Lewis, C. C. et al., 2019); or thematically, to pertain to meaningfulness, burden of measurement, impact on clients and treatment, practitioner concerns and reservations, implementation, and setting (Barkham et al., 2023). Another categorization of barriers is provided by Johnston and Gowers (2005), who identify staffing and resource problems, philosophical barriers, scientific value and measurement problems, usability challenges, and client-related barriers.

Barriers can also be classified based on the intensity of the experience. Emotional barriers involve worries about the ability to use the feedback system, fear of evaluation or sanctions, and concerns about data security and confidentiality. Intellectual barriers revolve around concerns about the applicability and methodology of FIT, citing research showing unsuccessful attempts or no impact on outcomes. Organizational barriers include time pressure and lack of funding or support.

Negative attitudes or resistance from therapists is a commonly mentioned barrier. Therapists may resist FIT (Van Sonsbeek et al., 2023) due to biases, inflated self-perception of effectiveness, or a lack of motivation to use the system. This resistance may outweigh rational reasons for implementing FIT, such as improving outcomes or identifying risky cases.

The use and limitations of measurement also present barriers to implementation. Psychotherapists who view FIT negatively are less likely to use measurements (Wolpert et al., 2016). To capture the complexity of individual cases, the use of multiple measurements is suggested (Jacob et al., 2016; Jacob,

Edbrooke-Childs et al., 2017). Client-related barriers, such as refusal or incomplete participation, can also provide valuable therapeutic insights (Barkham et al., 2023).

Some barriers may appear in several categories or they shift between them depending on who is asked (therapist, client, organization management, administrative support staff). In Table 1, the barriers found in the literature have been organised into 9 categories.

Table 1

Categories of barriers to implementation of feedback-informed treatment in organizations.

BARRIERS	RESEARCH
Limited Resources - Time, Financial, Material, Administrative: additional bureaucracy; administrative procedures; extra time for documentation; time-consuming measurement processes; extended duration of therapy sessions; high costs; lack of resources and/or staff; additional financial burden; lack of support resources; existing high workload and/or time constraints for staff; therapist and leadership turnover; lack of organizational efforts to implement FIT; inadequate organizational support.	Banjtes et al. (2017), Batty et al. (2013), Bickman (2008), Bie et al. (2017), Boswell et al. (2013), Bovendeerd et al. (2021), Campbell & Hemsley (2009), De Beurs et al. (2010), Gleacher et al. (2016), Håland & Tilden (2017), Hatfield & Ogles (2007), Hovland & Moltu (2019), Johnston & Gowers (2005), Kaiser et al. (2018), Ko et al. (2023), Kotte et al. (2016), Lewis C. C. et al. (2019), Lucock et al. (2015), Meehan et al. (2006), Mackrill & Sørensen (2019), Mackrill & Svendsen (2021), Meehan et al. (2006), Solstad et al. (2017), Stone et al. (2019), Troupp (2013), Unsworth et al. (2012), Van Wert et al. (2020)
Negative Attitudes or Resistance from Therapists: negative perception of usefulness; fear of weakening the therapeutic relationship; resistance to new measurements; concerns about therapist response biases; therapist anxiety about using FIT; difficulties in developing culture of feedback; incompatibility between innovation and therapists' needs; doubts about improving clinical judgment; lack of alignment on culture of feedback, meaning, or purpose; concerns that measurements harm the process; concern that FIT exists for its own sake; doubt about clients' willingness to complete measures or discipline for consistent completion.	Abrines-Jaume et al. (2016), Barkham et al. (2023), Batty et al. (2013), Bickman (2008), Bie et al. (2017), Börjesson & Boström (2019), De Beurs et al. (2010), Hovland & Moltu (2019), Jensen-Doss et al. (2018), Johnston & Gowers (2005), Kaiser et al. (2018), Ko et al. (2023), Kotte et al. (2016), Law & Wolpert (2014), Lewis C. C. et al. (2019), Lucock et al. (2015), Mackrill & Sørensen (2019), Overington et al. (2015), Solstad et al. (2017), Troupp (2013), Unsworth et al. (2012), Van Sonsbeek (2023)

BARRIERS	RESEARCH
Lack of Training and Knowledge: insufficient knowledge of usage; limited knowledge of the organization and users; unfamiliarity with the functionality and essence of FIT; unclear how to incorporate measurements into the therapeutic process; challenges in interpretation.	Batty et al. (2013), Bie et al. (2017), De Beurs et al. (2010), Gleacher et al. (2016), Hatfield & Ogles (2007), Jensen-Doss et al. (2018), Johnston & Gowers (2005), Kaiser et al. (2018), Kotte et al. (2016), Lewis C. C. et al. (2019), Mackrill & Sørensen (2019), Stone et al. (2019), Troupp (2013), Van Wert et al. (2020)
Privacy and Ethical Concerns: concerns about data security; ethical concerns; concerns about the use or misuse of collected data; mistrust; doubts about data confidentiality; concerns about biased data use.	Barkham et al. (2023), Bickman (2008), Boswell et al. (2013), Hatfield & Ogles (2007), Johnston & Gowers (2005), Lewis C. C. et al. (2019), Börjesson & Boström (2019)
Technology Access and Issues: complexity or complication of technology or user interface; difficulties in integration into the existing documentation system; issues with computer access; lack of IT support; challenges with virtual meetings; clients' unwillingness or inability to accept new technology and computer illiteracy.	Gleacher et al. (2016), Johnston & Gowers (2005), Ko et al. (2023), Mackrill & Svendsen (2021), Meehan et al. (2006), Stone et al. (2019)
Scientific Skepticism: doubts about scientific value; concerns about the reliability and validity of measurements; questioning whether a single measuring tool can accurately capture client experiences, daily life changes, or case complexity; suitability for specific cases.	Batty et al. (2013), Börjesson & Boström (2019), Hatfield & Ogles (2007), Johnston & Gowers (2005), Kaiser et al. (2018), Kotte et al. (2016), Law & Wolpert, (2014), Mackrill & Sørensen (2019), Meehan et al. (2006), Solstad et al. (2017), Stasiak et al. (2013), Troupp (2013), Wolpert et al. (2013)
Client-Related Obstacles and Characteristics: low education level; limited questionnaire relevance to the complexity of mental health; emotional difficulty in completing measurements for specific populations; clients' fear that demonstrating progress would lead to service withdrawal; unsuitability for specific clients; client inconsistency in completing measurements.	Banjtes et al. (2017), Börjesson & Boström (2019), Ko et al. (2023), Troupp (2013)

BARRIERS	RESEARCH
Challenges and Limitations of Measurement Use: visual analogue measurements require more time for presentation and management; excessive diversity of measurements; low return rates of questionnaires; standardized treatments limit FIT flexibility; fixation on symptom monitoring; challenges in recording consistent documentation due to time intervals between sessions; complexity of the standardized system.	Banjtes et al. (2017), Batty et al. (2013), Brattland et al. (2018), De Beurs et al. (2010), Kaiser et al. (2018)
Political and Systemic Obstacles: political motives for FIT implementation; other management priorities; commercialization of mental health services; promotion of a medical or psychiatric model; misuse of collected data by management; inconsistent cooperation between organizational departments.	Batty et al. (2013), Bickman (2008), Johnston & Gowers (2005), Lewis, C. C. et al. (2019), Meehan et al. (2006)

3.2. Facilitators to implementation of feedback-informed treatment into organisations

FIT can support psychotherapy research, which is an incentive for organisations that want to develop scientific credibility or demonstrate their effectiveness (Kaiser et al., 2018). Mackrill & Sørensen (2020) highlight the importance of increased collaboration and centralisation of resources between local organisations (in the field of psychosocial interventions, and also more broadly, in the field of mental health). Local FIT data can be merged into large databases (e.g. the CORE system in England, or the CCAPS, OQ, TOP systems - see, e.g. Barkham et al, 2006; Boswell et al, 2015; Beckstead et al, 2003; Lambert, 2007; Lo Coco et al, 2008; Martin et al, 2012). These enable PBE and other practice-oriented research approaches (Castonguay et al, 2013).

Table 2

Categories of facilitators to implementation of feedback-informed treatment into organisations.

FACILITATORS	RESEARCH
Financial Resources: increase in funding allocations and financial incentives; external funding sources.	Banjtes et al. (2017), Bickman (2008), Bovendeerd et al. (2021), Campbell & Hemsley (2009), Hatfield & Ogles (2007), Johnston & Gowers (2005), Lewis, C. C. et al. (2019), Unsworth et al. (2012)
Organizational Support and Culture: raising awareness of FIT; strong support and involvement from leadership; organizational efforts to implement FIT; a positive, collaborative environment conducive to FIT; changes in attitudes and perceptions; clear guidelines and protocols for FIT use; staff training on clinical value and use of FIT tools; emphasizing the importance of FIT implementation; incentives and rewards for FIT adoption and use; organizational understanding of its own values, needs, and goals of FIT; understanding and accepting the feasibility and appropriateness of FIT in treatment; support for conducting therapeutic research; access to research and evidence supporting FIT effectiveness; clear (and frequent or ongoing) communication about reasons for FIT implementation.	Barkham et al. (2023), Batty et al. (2013), Edbrooke-Childs et al. (2016), Gleacher et al. (2016), Håland & Tilden (2017), Kaiser et al. (2018), Kotte et al. (2016), Lewis, C. C. et al. (2019), Lucock et al. (2015), Rye et al. (2019), Solstad et al. (2017), Troupp (2013)
Training and Education: regular training; supervision; education on the clinical value of FIT; opportunities for consultation; practice groups for skill development.	Bie et al. (2017), Börjesson & Boström (2019), Brattland et al. (2018), Edbrooke-Childs et al. (2016), Gleacher et al. (2016), Hatfield & Ogles (2007), Jacob, Napoleone et al. (2017), Ko et al. (2023), Kwan et al. (2020), Lewis, C. C. et al. (2019), Lucock et al. (2015), Mackrill & Sørensen (2019), McAleavey & Moltu (2021), Meehan et al. (2006), Stone et al. (2019), Troupp (2013), Unsworth et al. (2012)
Technological Resources: user-friendly systems; improved data security measures; accessibility on electronic case management systems; easy integration into existing documentation systems; promotion of innovation and investment in technology for better system compatibility; IT support for data entry and rapid report generation.	Barkham et al. (2023), Batty et al. (2013), Boswell et al. (2013), De Beurs et al. (2010), Håland & Tilden (2017), Hovland & Moltu (2019), Ko et al. (2023), Lewis, C. C. et al. (2019), Mackrill & Svendsen (2021), Meehan et al. (2006), Van Wert et al. (2020)

FACILITATORS	RESEARCH
Usability, Adaptability, and Relevance: emphasis on clinical benefits; improved result presentation for clients; adaptation to therapist style and client needs; use of visual analogue measurements for clients with low education levels; simpler and more user-friendly tools and measurements; enhanced clinical reflection; graphic presentation of changes.	Banjtes et al. (2017), Bickman (2008), Brooks Holliday et al. (2021), Campbell & Hemsley (2009), De Beurs et al. (2010), Gleacher et al. (2016), Hovland & Moltu (2019), Kaiser et al. (2018), Lewis, C. C. et al. (2019), Lucock et al. (2015), McAleavey & Moltu (2021), Peterson & Fagan (2021), Solstad et al. (2017), Stone et al. (2019), Troupp (2013)
Time and Staffing Resources: more time for treatment; adequate administrative support; dedicated staff for FIT implementation; influential and capable FIT users; incentives to reduce turnover; introducing innovations with greater therapist support throughout treatment duration.	Batty et al. (2013), Boswell et al. (2013), Bovendeerd et al. (2021), De Beurs et al. (2010), Håland & Tilden (2017), Hatfield & Ogles (2007), Ko et al. (2023), Kotte et al. (2016), Lewis, C. C. et al. (2019)
Treatment Effectiveness: innovative measurement usage; mandatory measurement completion; real-time results showing treatment effectiveness; sharing of success stories and data demonstrating improved outcomes; monitoring and visibility of changes; transparency of results and positive changes in clients.	Jacob, Napoleone et al. (2017), Kaiser et al. (2018), Meehan et al. (2006), Troupp (2013)
Client Involvement: active client involvement and alignment; meaningful initial client presentation and good integration into sessions; regular in-session discussion of FIT data.	Bie et al. (2017), Brattland et al. (2018), Brooks Holliday et al. (2021), Hannan et al. (2005), Law & Wolpert (2014), Meehan et al. (2006), Miller et al. (2006), Stasiak et al. (2013), Thew et al. (2015), Troupp (2013)
Inter-organizational Professional Cooperation: existence of guidelines and strong support from national therapeutic organizations for FIT implementation and criteria; increased cooperation and centralization of resources among local organizations.	Johnston & Gowers (2005), Mackrill & Sørensen (2019), Troupp (2013)
Trust: high transparency to increase trust; establishing client trust with data security measures.	Boswell et al. (2013), Lewis, C. C. et al. (2019)
Standardization and Measurements: emphasis on standardized measurements; objectivity and comparability of measurements; measurement appropriateness based on clients.	De Beurs et al. (2010), Jensen-Doss et al. (2018), Kaiser et al. (2018), Van Wert et al. (2020)
Pilot Implementation of FIT: gradual introduction; starting with simpler and more affordable outcome measurement methods.	Barkham et al. (2023), Bie et al. (2017), Overington & Ionita (2012)

Good examples of long-term projects investigating the quality of outpatient psychotherapy using a client-centred research model are, for example, the *Techniker Krankenkasse* project by Strauß et al. (2015), which examined the feasibility of introducing a FIT system as a routine tool (Lutz et al., 2011, 2012); and *Qualitätssicherung ambulanter Psychotherapie in Bayern* (QS-PSY-BAY), where the aim was to validate a new approach by electronically documenting patient characteristics and outcome parameters. The collaborative triangle of therapists, researchers and health insurers proved to be very fruitful in both projects. Many psychotherapists were sceptical about the implementation of FIT and additional incentives were needed from the researchers to overcome their reluctance. The clients were very happy with it and were keen to adopt it. They also found a positive impact of FIT on process duration: clients with an early positive response were able to successfully end treatment earlier, while those with an early negative response were able to prolong therapy. This would not have been possible in the current German system without FIT, with its template-based way of determining the number of sessions that are financed by health insurance. However, several conditions must be met to improve outcomes with FIT: ongoing support from psychotherapists by way of consultations, especially when the course of treatment is not optimal or when the therapist's subjective assessment does not match the feedback received.

4. Discussion

Aafjes-van Doorn and de Jong (2022) point out that the potential benefits of FIT have already been established many times. FIT research is therefore being more and more redirected from the topic of effectiveness towards challenges of FIT implementation (in organizations and in individual private practices). In their review, Mackrill & Sørensen (2020) note that case studies of recent years show heterogeneity of FIT systems, different implementation approaches and uses of FIT, as well as a great variety of contexts, types of treatment (e.g. outpatient and inpatient), theoretical backgrounds, client populations, etc. The spectrum of opinions regarding FIT usefulness (from it being a useful tool to it not reflecting the client's experience) also means that there is inconsistency regarding the interpretation of FIT data or the implementation of FIT in clinical practice.

4.1. Is the organization ready to introduce feedback-informed treatment?

Duncan (2012) categorizes the factors for successful FIT implementation into an organization into individual, administrative and organizational factors.

Multilevel thinking and ensuring a sufficient level of commitment of all stakeholders in the organization, not only clients and psychotherapists, is necessary. Table 3 contains a list of criteria/items (checklist) for assessing an organization's readiness to introduce the PCOMS model (Duncan, 2014), which is equally applicable to other FIT models.

Table 3
List of criteria for evaluating an organization's readiness to implement FIT (adapted from Duncan, 2012).

Criteria for evaluating an organization's readiness to implement FIT
1. The organization has management approval and support for implementing FIT.
2. Management and employees agree that responsibility to clients and the use of FIT is the central foundation of its services.
3. FIT is included in the organization's business/financial plan.
4. Potential financiers are included in the communication about FIT data as one of the bases for measuring the effectiveness of the organization.
5. The organization has a human resources training and development plan that supports ongoing education of employees for FIT at all levels and that intends to include FIT in individual development plans, performance appraisals and hiring practices.
6. The organization has adequate infrastructure (support staff, IT, computer hardware, etc.) to support the collection and analysis of FIT data at the individual client, psychotherapist, department/area and organizational level.
7. Metasupervisors and supervisors in the organization use FIT data to individualize treatment planning, identify at-risk clients and proactively address client needs, and monitor/improve the performance of individual psychotherapists.
8. The organization has a strategy and clearly defined procedures for clients who do not progress, which ensure a quick transition of the client to another psychotherapist and continuity of treatment.
9. The organization's mission statement includes a mention of partnership with clients and responsibility towards them as a central feature of offering services.
10. The „Client Rights and Responsibilities" document includes the importance of client feedback and partnership in guiding treatment planning.

Duncan (2012) emphasizes the importance of considering various factors when implementing a FIT system into an organization. It is crucial to pay attention to the therapists who will be using it, as they may have concerns or show resistance. Some therapists may be unfamiliar with outcome monitoring, while others may have had negative experiences with complex measurements that do not relate to their everyday practice. Fear of how performance measurement will impact their salary, reputation, or hierarchical status in the organization is also a concern. To successfully implement FIT, it should be meaningful to therapists and address their desire to provide quality and useful work. Moreover, the primary

focus of FIT should be the well-being of clients rather than just organizational goals. Professional development and clearly explaining the purpose and use of FIT data can motivate therapists to invest additional time and energy. Data collection should start early, and ongoing supervision is vital for successful implementation. Implementing a „train the trainers" model, where a core team trains and supervises colleagues, as recommended by Duncan (2012), can also contribute to effective implementation of FIT, as well as starting data collection quickly with ongoing supervision.

4.2. Recommendations and guidelines for introducing feedback-informed treatment

Abrines-Jaume et al. (2016) identified three stages of FIT implementation: reluctance/concern (caution about its use), discomfort (when therapists feel awkward about using something new), and integration into practice.

Table 4 shows the three levels of recommendations by McComb et al. (2018) for FIT implementation into training programmes and supervision; the programme/institutional level has been renamed organizational, and the supervisee level renamed psychotherapist level.

Table 4

Recommendations for implementing feedback-informed treatment in organizations at three levels (adapted from McComb, 2018).

Organizational level
1. Client's feedback must be available during the psychotherapeutic treatment and easily accessible to psychotherapists and supervisors.
2. In addition to basic data interpretation and navigation, FIT training should include guidelines for using data in supervision.
3. Multiple levels of organization need to be addressed to promote motivation and use.
Supervisor's level
1. Supervisors must have clear expectations about FIT and its role in clinical work and supervision.
2. Supervisors must have experience using FIT in their clinical practice.
3. Supervisors must be committed to the scientist-practitioner (PBR) model.
4. The organization must promote the motivation and engagement of supervisors.
Psychotherapist's level
1. It is necessary to enable access to FIT already during psychotherapy education.
2. If access to FIT is restricted in any way, its use should be encouraged at least with a limited number of clients.
3. Upgrades (increasingly demanding levels) of training for FIT use must be available to psychotherapists, which are aligned with the development of their competence.

According to Thomas (2013), solution-focused supervision should incorporate FIT use. Supervisors should ask supervisees for FIT data and respond to the information received. Learning organizations should commit teachers and supervisors to increasing their own effectiveness by using FIT and to professional development plans, so they can be role models for students. McComb et al. (2018) and Thomas (2013) both believe that future therapists' training programmes should include monitoring student outcomes and using the collected data to improve training. Organizational leadership should establish a culture of continuous improvement and implement a mandatory FIT system for supervisors and therapists. Furthermore, Thomas recommends that supervision aimed at improving FIT-based performance should be a condition for the renewal of licences for practising psychotherapy. This would require therapists to provide FIT data on their therapeutic performance. The importance of pioneering research that utilizes FIT tools to monitor the psychotherapeutic process at multiple levels simultaneously (e.g. Kovačević Tojnko et al., 2023) should be emphasized.

4.3. Key topics for implementing feedback-informed treatment into organizations

Firstly, FIT is not just a technique or an adjunct to therapy, but it is a therapeutic intervention, integral to the psychotherapeutic process. It can facilitate negotiation with clients regarding treatment goals and can personalize therapy based on self-report metrics and data collected throughout treatment. The client's experience is at the centre of psychotherapy, and the client's progress can be concretized and demonstrated through FIT use.

FIT implementation is a strategic issue for organizations. They need to trial different versions of FIT systems to determine which ones best meet their needs, and they also need to gather feedback from psychotherapists, supervisors, and clients on their use (Cooper et al., 2021). Involving psychotherapists in the decision-making process improves their attitudes towards FIT and can contribute to the success of implementation. Internal guidelines and management practices can also influence the successful deployment of FIT and the potential benefits to psychotherapy practice within an organization.

FIT also raises several methodological issues. There may be differences between symptom assessment and the client's subjective experience (Ogles et al. 2022), and the use of standardized measures may not adequately reflect client experience and progress (Gomez et al., 2022). Some psychotherapists prefer longer, multidimensional measures, while others use shorter, simpler instruments. It is also important to consider whether measurement items need to perfectly match the client's situation at the time of measurement or if they can

act as a thermometer of progress. Standardized measures can be supplemented with idiographic questionnaires to capture a more holistic view of the client's reasons for seeking therapy, their experiences, and their therapeutic goals.

Also important is the role of psychotherapy training and supervision. Psychotherapists should be introduced to FIT early in their careers (e.g. Schaffrath et al., 2022), as it predicts their level of use (De Jong et al., 2016), and their experience with FIT anxiety and discomfort (Aafjes-van Doorn & De Jong, 2022). Educators' experience with FIT influences their subsequent use (Batty et al., 2013; Unsworth et al., 2012) and represents a first contact with the culture of feedback. However, over-reliance on FIT data for decision-making should be cautioned against (Fernando & Hulse-Killacky, 2005; Levine et al., 2017). Supervision is crucial, emphasizing consideration of context and openness to multiple interpretations. Training is an important moderator of FIT implementation effectiveness (e.g. meta-analysis by De Jong et al., 2021).

The COVID-19 pandemic led to a rise in online psychotherapy, allowing for easy video recording of sessions that is a great aid to FIT. Technological advancements in machine learning and artificial intelligence may also enable more comprehensive monitoring of client outcomes. However, the focus should stay on the benefit of collected information for the client rather than on the measurement method or technological solutions.

5. Conclusion

This review has highlighted that the question is no longer whether to implement FIT, but how to best implement it in a specific setting. It is crucial to develop strategies to engage psychotherapists and tailor FIT systems to their preferences and the needs of clients. Existing FIT systems, such as OQ, PCOMS, and CORE-OM, are considered initial versions and will become outdated over time. However, the concept of progress monitoring and using feedback will remain relevant. The latest FIT systems are designed to be minimally disruptive, adaptable to each client, and integrated into electronic documentation systems. There are also new web-based FIT tools being developed, that combine individualized self-report scales with standardized measurements.

One example of an advanced FIT system is the SNS, which displays dynamic phase transitions and supports idiographic measurements based on a client--therapist co-created case conceptualization process. This approach includes identifying relevant variables in the client's life, establishing links between the client's problems and mental and social functioning, and translating this into an idiographic online questionnaire. It thus captures complex patterns of change and encourages collaboration between the client and therapist.

Despite the documented benefits of FIT in improving mental health care, its implementation is slow due to various barriers, including resistance to change from psychotherapists. The research suggests that creating a supportive and positive organizational culture that encourages evidence-based practice and continuous improvement is essential for successful implementation. Choosing an appropriate FIT system that aligns with the organization's needs and integrating it into existing work processes are also crucial. Training and ongoing support for psychotherapists are key factors in successful FIT implementation.

Implementing FIT requires careful consideration, thorough preparation, and gradual behaviour change at multiple levels - client, psychotherapist, and organization. Integrated strategies to improve clinical skills and motivation, strong organizational leadership, and a culture that values and adapts to specific local barriers are recommended for successful implementation.

While the benefits of FIT are clear, there is still uncertainty about the best methods for implementing and utilizing FIT, as well as interpreting the obtained data. Lessons from successful FIT implementations can aid in the preparation process, but there is a lack of studies highlighting the barriers and unsuccessful implementations. These examples could provide valuable insights on how to overcome many of the barriers higlighted in this review.

1. Uvod

Za zagotavljanje kvalitete psihoterapevtske obravnave terapevtova ocena kot edini vir podatkov za evalvacijo ter načrtovanje obravnave ni dovolj. Čeprav veliko klientov prezgodaj zaključi psihoterapevtski proces (Swift in Greenberg, 2012) ali pa ima le-ta negativne izide (Reese idr., 2014), psihoterapevti težko zaznajo odsotnost napredka svojih obravnav (Chapman idr., 2012; Hatfield idr., 2010; Schuckard idr., 2017). Namesto tega večinoma precenjujejo napredek in zadovoljstvo svojih klientov (Hannan idr., 2005; Maeschalck idr., 2019), lastno učinkovitost (Walfish idr., 2012; Parker in Waller, 2015) in kvaliteto terapevtske alianse (Lambert in Harmon, 2018). Tudi leta prakse ne zagotavljajo več znanja, sposobnosti, samozavesti in empatije, kljub temu da psihoterapevti potrebo izboljševanja svojega dela jemljejo kot samoumevno in so se pripravljeni nenehno izpopolnjevati (Goldberg idr., 2016). Njihova povprečna učinkovitost se sčasoma celo zmanjšuje, pripravljenost poglobljenega dela s klienti pa upada (Orlinsky in Rønnestad, 2005).

Vključevanje perspektive klientov v obliki povratnega informiranja je tako za kvalitetno obravnavo nujno (Čeh, 2020; Verbnik in Možina, 2021; Možina, 2024). Poleg tega spodbuja aktivno sodelovanje klientov v psihoterapevtskem procesu, omogoča soustvarjanje razumevanja v terapevtski delovni zvezi in spremljanje napredka v smeri klientovih ciljev. Ocene klientov o ‚ustreznosti obravnave' (angl. *treatment fit*), o izvoru težave in o tem, kaj bi jim bilo v pomoč (npr. psihoterapija ali zdravila), prispevajo k ‚zgodnji aktivaciji' (angl. *early engagement*), nadaljevanju obravnave ter razvoju terapevtske alianse (Elkin idr., 1999; Baldwin idr., 2007; Anker idr., 2010, Krupnick idr., 1996). Pomembno je tudi zgodnje poročanje klientov o spremembah (Horvath in Bedi, 2002; Orlinsky idr., 2004), saj v kolikor ni zaznati pozitivnih sprememb v prvih osmih srečanjih ali tednih, je tveganje za neuspešen izid kar 90 % (Brown idr., 1999; Lambert, 2010). Kjer je več strinjanja med terapevtom in klientom, klienti poročajo o boljšem napredku (Hatcher in Barends, 1996).

Tako so se v metaanalizah povratne informacije klientov pokazale kot eden ključnih skupnih dejavnikov za vse terapevtske pristope (Grencavage in Norcross, 1990; Miller, 2004; Duncan, 2016), saj k izidu prispevajo od 15 % do 31 % (od 13 % skupnega učinka terapevtske obravnave – po Duncan, 2016; Možina, 2021b).

Howard idr. (1996) so bili prvi zagovorniki sistematične evalvacije klientovih odzivov na obravnavo in so priporočali, naj se pridobljene informacije uporabijo za oceno ustreznosti in pogovor o izidih, ki ne napredujejo po pričakovanjih. Sistemi meritev izidov in povratnega informiranja so večinoma izšli prav iz želje preprečevanja neuspešnih obravnav oz. kot pomoč pri odločanju, kakšne

psihoterapevtske intervencije kje in kdaj uporabiti (Sparks in Duncan, 2018). Sodobni načini spremljanja uspešnosti psihoterapije za zajem klientove izkušnje uporabljajo sprotno, sistematično pridobivanje povratnih informacij (izrecno, pisno ali ustno, (vsaj) na vsakem srečanju in skozi celotno trajanje srečevanj) in njihovo uporabo (pogovor o vsebini ter sprotno ali stopenjsko, kvantitativno ali kvalitativno analizo podatkov).

1.1. Povratno informiranje in povratno informirana obravnava

Povratno informiranje o psihoterapevtskem procesu in izidih obsega:

- ‚rutinsko spremljanje izidov' (angl. *Routine Outcome Measurement* = *ROM*), ki ga Pinner in Kivlighan (2018, str. 248) opredeljujeta kot „implementacijo standardiziranih meritev, običajno ob vsakem srečanju, ki usmerja klinično odločanje, spremlja napredek obravnave in nakaže potrebe po prilagajanju obravnave"; pri tem lahko gre tudi za vsakodnevno merjenje, ki tako še bolje zajame t.i. izventerapevtske oz. klientove življenjske dejavnike – npr. s pomočjo ‚sinergetičnega navigacijskega sistema' (angl. Synergetic Navigation System = SNS) (Schiepek idr., 2008);
- zajem klientovih ‚povratnih informacij' (angl. *feedback*) o kvaliteti sodelovanja s psihoterapevtom (razvoju terapevtskega odnosa) s pomočjo rednega sprotnega preverjanja;
- in uporabo pridobljenih podatkov o izidih ter povratnih informacij, ki lahko poteka na različne (med seboj kompatibilne) načine:
  - neposredno kot ‚orodje za pogovor' (angl. *conversational tool*), torej naslavljanje ali poglabljanje relevantnih tem s klientom na istem ali naslednjem srečanju;
  - kot dodatne vhodne informacije za sprotno klinično odločanje o poteku obravnave;
  - za kvalitativno in/ali kvantitativno analizo podatkov (ročno ali s pomočjo različnih računalniških programov) sproti, na določenih točkah obravnave (npr. na vsakih nekaj srečanj ali po potrebi, ko npr. pride do zaznanega poslabšanja ali izboljšanja) ali po njenem zaključku.

Te tri sestavine so največkrat povezane v celovit in obravnavo integriran način dela: spremljanje izidov + povratne informacije + njihova uporaba.

Večina psihoterapevtov zbira in upošteva klientove povratne informacije o napredku in terapevtskem delovnem odnosu na neformalen način (Duncan, 2016). Ključni značilnosti, ki povratno informirano obravnavo razlikujeta od drugih oblik spremljanja klinične prakse, sta predvsem:

- sistematičnost in sprotnost, saj se meritve z istim merilnim inštrumentom izvajajo pred/na/po vsakem psihoterapevtskem srečanju oz. v rednih časovnih razmakih (dnevno, tedensko); in

- ‚uporaba povratnih informacij' (angl. *feeding back* – vračanje informacije nazaj v njeno izhodišče in s tem vzpostavitev krožnosti informacijskega toka) znotraj iste terapevtske obravnave z istim klientom. Taka obravnava je povratno informirana (nadgrajena, obogatena) z od klienta sistematično in sproti pridobljenimi podatki.

1.2. Različni načini in poimenovanja povratnega informiranja o terapevtskem procesu in izidih

Sistematično rutinsko spremljanje oz. merjenje izidov klientov (ROM) (npr. Maeschalck idr., 2019) se v literaturi pojavlja z raznolikimi poimenovanji (Scott in Lewis, 2015):

- ‚spremljanje napredka' (angl. *progress monitoring – PM;* npr. Tasca idr., 2019)
- ‚uporaba instrumentov za spremljanje stalnega napredka' (angl. *continuous progress instruments*; npr. McComb, 2018),
- ‚spremljanje izidov, o katerih poročajo pacienti' (angl. *patient-reported outcomes monitoring – PROM;* npr. Roe idr., 2022),
- ‚oskrba na podlagi meritev' (angl. *measurement-based care – MBC;* npr. Lewis idr., 2019),
- ‚sistem za povratne informacije o merjenju' (angl. *measurement feedback system – MFS;* npr. Douglas idr., 2016),
- ‚povratno informirana obravnava' (angl. *feedback-informed treatment – FIT;* npr. Miller idr., 2015),
- ‚sistematične povratne informacije klientov' (angl. *systematic client feedback - SCF*; npr. Sparks in Duncan, 2018),
- ‚spremljanje v dejanskem času' (angl. *real time monitoring - RTM*; npr. Schiepek, 2008),
- nekoliko redkeje tudi ‚sistem za klinične povratne informacije' (angl. *clinical feedback system – CFS;* npr. Moltu idr., 2021) ter
- kot ena izmed metod procesa ‚na izsledkih utemeljenega ocenjevanja' (angl. *evidence-based assessment – EBA;* npr. Cho idr., 2021).

Za poenostavitev bom v nadaljevanju[2] kot krovni izraz za različna poimenovanja rutinskega spremljanja izidov, združenega z uporabo povratnih informacij, uporabljal kratico PIO (povratno informirana obravnava), kar je prevod angleške kratice FIT (*feedback-informed treatment)*. Primernejši se mi namreč zdi poudarek na učinku povratnega informiranja na obravnavo, kot pa na postopku, ki to omogoča (rutinsko spremljanje izidov, ipd.).

2 Izjema bo, kjer avtorji posameznih raziskav govorijo o točno določenem izrazu (npr. spremljanje izidov, o katerih poročajo pacienti, angl. *patient-reported outcomes monitoring; PROM*).

1.3. Povratno informirana obravnava kot na izsledkih utemeljena praksa in izsledki, utemeljeni v praksi

Različna poimenovanja otežujejo preglednost in raziskovanje, a v vsakem primeru gre pri PIO za vrsto ‚na izsledkih utemeljene prakse' (angl. *evidence-based practice – EBP;* APA, 2006; Dozois idr., 2014), ki je vse bolj deležna pozornosti kot samostojno orodje oz. psihoterapevtska intervencija in ki je usklajena tudi z modelom skupnih dejavnikov (npr. Duncan, 2017; Lambert in Ogles, 2004; Grencavage in Norcross, 1990) ter kontekstualnim modelom (npr. Wampold in Imel, 2015; Možina, 2020, 2021ab). Razširjena in priporočena je tako v ZDA (APA, 2006; The Joint Commission, 2018; Nelson idr., 2007) kot v Evropi (Haro idr., 2014; Emmelkamp idr., 2014), poleg tega je v zadnjih letih ponekod obvezna za izvajalce storitev na področju duševnega zdravja (npr., v Avstraliji: Burgess idr., 2015; v Kanadi: Tasca idr., 2019; na Norveškem: Knapstad idr., 2018; v Veliki Britaniji: Wing idr., 1998, Department of Health, 2010).

PIO je istočasno vrsta ‚raziskovanja oz. izsledkov, utemeljenih v praksi' (angl. *practice-based research/evidence – PBR/PBE;* Barkham idr., 2001; Duncan idr., 2004), in s tem torej dopolnitev EBP. Praktiki z uporabo kliničnega orodja postanejo tudi raziskovalci (‚model znanstvenik-praktik'; angl. *scientist-practitioner model*) oz. oskrbijo raziskovalce, ki jih zanima potek ‚običajne obravnave' (angl. *treatment as usual - TAU*) na področju duševnega zdravja, z zelo uporabnimi podatki (Garland idr., 2010) neposredno iz svoje prakse.

Castonguay idr. (2013) poleg PBE omenjajo tudi druge pristope ‚v prakso usmerjenega raziskovanja psihoterapije' (angl. *practice-oriented psychotherapy research*; nem. *Praxisorientierte Psychotherapie Forschung*; npr. Riess, 2015), npr. ‚na klienta usmerjeno raziskovanje' (angl. *patient-focused research*) in ‚mreže za raziskovanje prakse' (angl. *practice research networks* - PRN; nem. *Praxisforschungsnetzwerke*). Na klienta usmerjeno raziskovanje je prineslo nova spoznanja o tem, kako se klienti spreminjajo glede na obseg obravnave in izid ter kako se razlikujejo njihovi vzorci napredovanja v smeri terapevtskih sprememb. Raziskovanje izidov s pomočjo PIO omogoča psihoterapevtom spremljanje klientovega napredka oz. poslabšanja - tako lahko prej ugotovijo, ali proces poteka v pravo smer. PIO pa lahko služi tudi le kot informacija, ki je psihoterapevtu v pomoč pri vodenju in klientu pri odločanju o ciljih in nalogah, obema pa tudi kot smernica, kdaj nadaljevati, intenzivirati ali zaključiti obravnavo.

Na klienta usmerjeno raziskovanje se v marsičem prekriva z modelom PBE, a je slednji širši in manj fokusiran, saj je njegovo osnovno izhodišče vsakdanja klinična praksa. Glavni pogoj za pridobivanje PBE je sistem t. i. zaupanja vrednih (lat. *bona fide*) meritev in njegova standardizirana uporaba v praksi. Meritve se lahko izvajajo pred začetkom ali po zaključku obravnave, v ponavljajočih se

daljših (npr. enkrat tedensko ali na vsakem srečanju) ali krajših presledkih (npr. vsakodnevno, kar omogoča spremljanje terapevtskih sprememb v klientovem vsakdanjem življenju). Analiza rezultatov pa lahko poteka na dveh ravneh: na ravni posameznega terapevta (v zasebni praksi ali v organizaciji, skupaj z drugimi psihoterapevti) s ciljem izboljšanja njegove ali njihove prakse, ter na kolektivni ravni s ciljem zbiranja podatkov v skupno banko podatkov, ki nato predstavlja vir za raziskave in obogatitev izsledkov o raznih oblikah terapije. Na ta dva načina PBE prispeva tudi k posodabljanju in razvoju modela znanstvenika-praktika (Castonguay idr., 2013).

Terapevti v praksi namreč predstavljajo središče na klienta usmerjenega raziskovanja in PBE, saj so neposredno vpleteni v zbiranje podatkov s ciljem izboljšanja svoje prakse v naravnih pogojih. Vendar je njihov angažma še večji v mrežah za raziskovanje prakse (PRN), ki so definirane kot „skupina psihoterapevtov, ki se ukvarja s klinično prakso in sodeluje pri zbiranju podatkov in izvajanju študij“ in kot „veliko število prakticirajočih psihoterapevtov in kliničnih znanstvenikov, ki so se združili v sodelovalnem raziskovanju o klinično pomembnih vprašanjih v naravnem okolju za zagotavljanje zunanje veljavnosti in uporabe stroge znanstvene metodologije za zagotavljanje notranje veljavnosti“ (Borkovec, 2002, str. 113).

1.4. Pristopi k povratno informirani obravnavi

Obstaja mnogo različnih pristopov k PIO ter posledično modelov, sistemov in načinov merjenja. Med najbolj znanimi in razširjenimi sta *Partners for Change Outcome Management System* (PCOMS; Duncan in Reese, 2015) in *Outcome Questionnaire System* (OQ; Lambert, 2015), ki sta v ZDA uvrščena tudi na nacionalni seznam programov in praks EBP organizacije *Substance Abuse and Mental Health Services Administration* (SAMHSA) (Sparks in Duncan, 2018). PCOMS (Anker idr., 2009; Duncan in Sparks, 2002) je na izsledkih utemeljena metodologija za uporabo ‚lestvice za oceno izida‘ (angl. *Outcome Rating Scale* - ORS; Miller idr., 2003) in ‚lestvice za oceno srečanja‘ (angl. *Session Rating Scale* - SRS; Duncan, idr., 2003), ki sestavljata sistem *Feedback-informed Treatment* (FIT; npr. Miller idr., 2016). Omeniti velja še *Systemic Therapy Inventory of Change* (STIC; Pinsof idr., 2015); *Contextualized Feedback Systems* (CFS; Bickman idr., 2011) – usmerjen predvsem v duševno zdravje mladih; *Clinical Outcomes in Routine Evaluation* (CORE; Barkham idr., 2001), ki spremlja spremembe v npr. psiholoških svetovalnih službah, ter *Young Person's Clinical Outcomes in Routine Evaluation* (YP-CORE; Twigg idr., 2009), ki razširi uporabo CORE na mlade in družine, in SCORE (Systemic CORE; Stratton idr., 2010). Sistem OQ (Lambert, 2015) vključuje tudi *Youth Outcome Questionnaire* (YOQ; Dunn idr., 2005).

Sisteme PIO lahko razvrstimo na kontinuum (Sparks in Duncan, 2018) od normativnega do komunikacijskega merjenja (Duncan in Reese, 2015; Halstead idr., 2013). Prvi temelji na pozitivistični paradigmi (Sales in Alves, 2012), drugi pa na konstruktivistični (Neimeyer in Mahoney, 1995) in socialno konstrukcionistični (Gergen, 1985; McNamee in Gergen, 1992). Pri normativnem pristopu se uporabljajo standardizirane meritve, pri komunikacijskem pa personalizirane (individualizirane, idiografske) meritve za razumevanje posameznikovih skrbi, ciljev in doživljanja (Sparks in Duncan, 2018).

PCOMS povezuje klinični proces in merjenje izidov ter v srčiko obravnave postavlja klientovo razumevanje uspeha in terapevtskega napredka (Duncan, 2014), tako da bi bil vpliv klienta na usmerjanje obravnave večji (angl. *client directed*; Duncan idr., 1992). Gre za bolj namensko uporabo klientove teorije spremembe, ki poteka v sodelovanju s klientom. Iz tega izhaja tudi manjši poudarek na meritvah simptomov ter večji na individualiziranem klientovem poročanju o težavah in spremembah. Barkham (2016) pri tem npr. uporabi metaforo ‚pasovne širine‘ (angl. *bandwidth*), kjer naj bo manj poudarka na sicer jasnem visokokakovostnem signalu iz psihometrično zanesljivih meritev in več personaliziranega signala, ki je sicer manj jasen, a ima večji pomen za „poslušalca“, torej klienta.

Tu velja omeniti tudi ‚povratno informirano supervizijo‘ (PIS; angl. *feedback-informed supervision* (Bargmann, 2017), imenovano tudi ‚na izid usmerjena supervizija‘ (angl. *outcome oriented supervision* (Worthen in Lambert, 2007) ali ‚o izidu informirana supervizija‘ (angl. *outcome informed supervision* (Lewis, M. P., 2020)). PIS se od tradicionalne supervizije razlikuje po usmerjanju glede na izide in povratne informacije klientov ter se iz tega razloga lahko uporablja neodvisno od psihoterapevtskega pristopa ali metode. Medtem ko PIS veliko obeta (Pinsof in Wynne, 2000; Sparks idr., 2011; Worthen in Lambert, 2007), zaenkrat še ne obstaja veliko podatkov[3], ki bi kazali, da PIS tudi izboljša supervizijski proces ali usposobljenost psihoterapevtov pripravnikov ter da vodi do boljših kliničnih izidov (Grossl idr., 2014; Reese idr., 2009). Morda tudi zato, ker se PIS le redko uporablja konsistentno (Worthen in Lambert, 2007). Zatorej je pomembno, da supervizorji najprej uvedejo PIO v svojo lastno terapevtsko prakso in uspejo pridobiti dobre izkušnje, preden jo prenesejo še v svoje supervizijsko delo (Swift idr., 2014).

3 V psihoterapevtski ambulanti ljubljanske podružnice Univerze Sigmunda Freuda (SFU Ljubljana) smo s pomočjo Sinergetičnega navigacijskega sistema (SNS) začeli raziskavo o superviziji in metasuperviziji (Kovačević Tojnko idr., 2023) s ciljem osvetliti dinamiko terapevtskega, supervizijskega in metasupervizijskega procesa z orodjem za povratno informiranje med tremi diadami (klient – terapevt, terapevt – supervizor, supervizor – metasupervizor) ter pokazati, kako lahko sprotno sledenje procesa pripomore k boljšemu izidu ter k osebnostnemu razvoju supervizorjev in terapevtov. Hkrati je cilj razvoj PIS na osnovi uporabe SNS.

1.5. Učinki povratno informirane obravnave

Raziskave na področju PIO dobivajo predvsem v zadnjih letih precejšen pospešek in vključujejo ‚randomizirane nadzorovane študije' (angl. *randomised controlled trials – RCT*; npr. De Jong, K. idr., 2014; Delgadillo idr., 2018; De Jong, R.K. idr., 2019), metaanalize (npr. De Jong idr., 2021), pregledne članke (npr. Barkham idr., 2023a, 2023b) in monografije, namenjene uporabi v praksi (De Jong idr., 2023). Vsi ti raziskovalni napori kažejo okoli 8 % doprinos uporabe PIO k velikosti učinka psihoterapije na kliente (Barkham idr., 2023a, 2023b; De Jong idr., 2021).

Duncan (2016) dodaja:

- učinki PIO na izid so neodvisni od meritev oz. ocenjevalnih sistemov;
- sistematično zbiranje podatkov PIO v največji meri izboljša izide, če poteka v sodelovanju s klienti, a je učinkovito tudi, če jo uporabljajo samo terapevti;
- PIO koristi klientom z različnimi težavami in demografskimi značilnostmi, v različnih kliničnih setingih, s strokovnjaki različnih poklicev in ne glede na to, ali so izkušeni ali začetniki.

Uporaba PIO v terapevtski praksi torej ponuja učinkovito spremljanje napredka klienta in informacij o izvedbi obravnave (Overington in Ionita 2012; Scott in Lewis, 2015). S PIO lahko izvemo, kaj konkretno je posameznemu klientu v pomoč, ob odstopanju od napredka v smeri želenega izida pa se lahko pravočasno in bolj relevantno odločamo ter prilagodimo sodelovanje (Boswell idr., 2015; Carlier idr., 2012; Gondek idr., 2016; Lutz idr., 2022; Barkham idr., 2023).

V primerjavi z običajno obravnavo (TAU) PIO pozitivno vpliva na izide ne glede na psihoterapevtski pristop ali model, o čemer poročajo številne študije (npr. Brattland idr., 2018; Harmon idr., 2007; Lambert in Barley, 2002; Lambert idr. 2003; Slade idr., 2008; Tasca idr., 2018; Kelley in Bickman, 2009; Whipple idr., 2003; Duncan, 2016; Bickman idr., 2011; Connolly Gibbons idr., 2015; Lambert, 2007; Unutzer idr., 2002). PIO ne določa, kako naj terapevt dela, temveč omogoča prilagajanje katere koli metode ali tehnike v klientovo dobro (Duncan, 2016). Tudi RCT in kohortne študije kažejo bistveno boljše izide klientov pri uporabi PIO v primerjavi z običajno obravnavo tako pri individualni (Lambert, 2015) kot tudi partnerski (Anker idr., 2009; Reese idr., 2010), družinski (Cooper idr., 2012; Tilden in Whittaker, 2022) in skupinski psihoterapiji (Schuman idr., 2014; Slone idr., 2015). PIO ima pozitiven vpliv na komunikacijo in ohranjanje pozitivnih učinkov tudi za daljše obdobje (Carlier idr., 2012; Kwan in Rickwood, 2015), pomembno krepi delovni odnos (Brattland idr., 2018) ter poveča uspešnost procesov podpore in pomoči. Zmanjša pa osip (Miller idr., 2006), stopnjo poslabšanja in predčasne prekinitve (Anker idr., 2009; Reese idr., 2009). Omogoča tudi sprotno in pravočasno izboljševanje sodelovanja (Gondek idr., 2016; Tasca idr., 2018). PIO je še posebno učinkovito orodje za tiste kliente, kjer obstaja visoko tveganje za neuspešen izid terapije (Carlier idr., 2012; Lambert, 2010ab; Lambert in Shimokawa, 2011; Lutz idr., 2011, 2013; Newnham in Page, 2010; Shimokawa idr., 2010).

Le nekaj raziskav ni zaznalo učinkov PIO na izide (Kendrick idr., 2016; Østergård idr., 2020; Solstad idr., 2017). Prav tako je potrebno omeniti nekatere omejitve PIO. De Smet idr. (2020) izpostavljajo, da so izidi, kot jih doživljajo klienti, večdimenzionalni in vključujejo nianse, ki jih kategorije izidov ne morejo zajeti v tolikšni meri, kot jih določajo nekateri vprašalniki PIO. To oviro poskušajo premostiti idiografske meritve izida (npr. Elliott idr., 2016, Weisz idr., 2011). Tudi Desmet idr. (2021) menijo, da lahko pretirana sistematizacija, torej uporaba prestroge metode, zakrije ključne informacije glede veljavnosti vprašalnikov. Več raziskav (Ghelfi, 2021; Leibert idr., 2020; Ogles idr., 2022, Top idr., 2018) opozarja na razkorake med poročanjem klientov in rezultati nekaterih vprašalnikov PIO, npr. za zelo razširjen OQ-45 (Lambert, 2015).

1.6. Uvajanje povratno informiranih obravnav v organizacije

Zaradi vedno večjega števila raziskav, ki so kazale pozitivne učinke PIO na izide, so raziskovalci in praktiki začeli pozivati k uvedbi PIO v organizacije (Bickman 2008; Harmon idr., 2007), npr. v psihiatrične bolnišnice, psihološke in psihoterapevtske ambulante ter učne organizacije, zasebne prakse, šolske svetovalne službe, socialnovarstvene organizacije idr. Sprotno spremljanje podatkov o napredku ima lahko kvalitativni vpliv na več ravneh organizacije (Bickman, 2008; Chorpita idr., 2008).

Kljub vse številnejšim izsledkom o učinkovitosti PIO se implementacije v klinično prakso širijo počasi (npr. Gilbody idr., 2002; Hatfield in Ogles, 2004; Ionita in Fitzpatrick, 2014; Overington idr., 2015; Barkham in Lambert, 2021; Boswell idr., 2015; Wolpert idr., 2013; Jensen-Doss idr., 2018), a vztrajno, z različnimi uvajalnimi eksperimenti (npr. Mackrill in Sørensen, 2020). Ti so sicer dobrodošli, saj omogočajo učenje iz poskusov in napak: Vajda (2023) predstavi primer poskusa uvajanja vnaprej določenega sistema PIO (SNS) v klinične prakse organizirane skupine psihoterapevtov, Vajda in Možina (2024) pa uporabo SNS za spremljanje specializantov v psihoterapevtskem izobraževanju, oboje z mešanimi rezultati. Posamezne prakse PIO niso vedno enostavno prenosljive med različnimi setingi (Mackrill in Svendsen, 2021), kar lahko vodi do težav – npr. manj uspešna uvedba pri socialnem delu z otroki in družinami na Novi Zelandiji (Oranga Tamariki Evidence Centre, 2019). Raziskovalci opozarjajo tudi na izjemno pestrost uporabljenih raziskovalnih metodologij (npr. Bickman idr., 2016; Borntrager in Lyon, 2015; Higa-McMillan idr., 2011).

Za uspešno uvedbo naj organizacija najprej čimbolje razume samo sebe - lastne vrednote, potrebe in cilje uvedbe PIO (Håland in Tilden, 2017). Potreben je jasen in podroben načrt uvajanja POI - dober primer opišejo Mellor-Clark idr. (2014) – uvajanje *CORE Outcome Measure* (CORE-OM) v javne zdravstvene storitve v Združenem kraljestvu. Obenem je pomembna določitev namena in vseh vrst predvidene uporabe – npr. po Roe idr. (2015) izboljšanje klinične oskrbe, pridobitev informacij za smernice delovanja, izboljšanje procesa dodeljevanja virov in storitev, ustvarjanje spodbud za izboljšanje storitev, dvig kvalitete odločanja ter pridobivanje podatkov v raziskovalne namene.

Pomembno je predvsem začeti (Jacob, Napoleone idr., 2017), a začeti preprosto. Niso nujne sofisticirane tehnološke rešitve, dovolj je že uporaba svinčnika in papirja (Fleming idr., 2016) ter radovednost. V organizacijah lahko uporabimo obstoječe vire in tiste sodelavce, ki so z nekaj klienti pripravljeni uvesti inovacijo. Preizkušanje PIO v majhnem obsegu nas lahko nauči, kaj moramo upoštevati ob širši uvedbi, in omogoča vpogled v tehnološke, časovne ter kadrovske potrebe. Izkušnje prvih uporabnikov lahko izkoristimo za navduševanje drugih strokovnjakov v organizaciji. S postopnimi koraki uvajanja se ognemo preobsežni administraciji in zato porabimo manj časa. Tako terapevti hitreje odkrijejo, kako jim lahko PIO najbolj koristi (Fleming idr., 2016; Jacob, Napoleone idr., 2017).

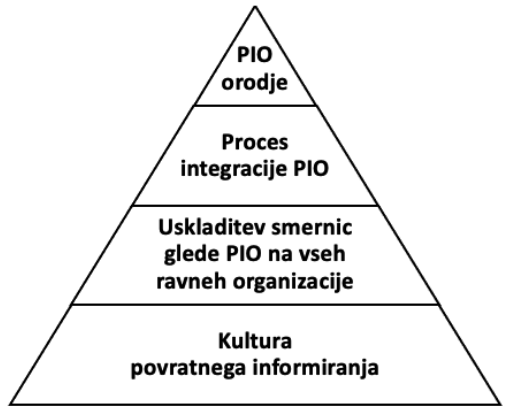
1.7. Kultura povratnega informiranja

Pomemben vidik uvedbe PIO v organizacije je t.i. kultura povratnega informiranja (angl. *feedback culture*). Ta pomaga pri podpori in naslavljanju izzivov uvajanja ter zagotavlja potencial za premik v smeri k ‚s podatki podprtim' (angl. *data-informed*) terapevtskim storitvam, ki tako niso več vožnja z zavezanimi očmi brez kakršnegakoli „navigacijskega sistema" (Miller idr., 2015). Podatki PIO povečujejo ustvarjalnost pri postavljanju delovnih hipotez, klienti pa so zaradi globljega vpogleda v svojo psihodinamiko lahko bolj zainteresirani za proces in spremembe; proces tako ni le opolnomočujoč, temveč tudi vključujoč, saj omogoča soustvarjanje procesa in soodločanje s klientom. Študije (npr. Handy, 1993; Meehan idr., 2006; Lewis, C. C. idr., 2019; Van Sonsbeek idr., 2023) kažejo, da je celosten sistemski pristop na ravneh uporabnika storitve (klienta), izvajalca (terapevta) in organizacije najučinkovitejši pri procesu uvajanja sprememb in pri doseganju rezultatov.

Kultura povratnega informiranja predstavlja kompleksno nadgradnjo siceršnje organizacijske kulture. Ta bi namreč morala biti baza piramide uvajanja PIO v organizacijo (slika 1), na kateri slonijo uskladitev smernic glede PIO na vseh ravneh organizacije, nato proces integracije PIO ter šele kot vrh samo PIO orodje. Pri več avtorjih (npr. De Jong, R. K., 2019; Maeschalck, 2019; Mackrill & Sørensen, 2019; Mackrill in Steensbæk, 2020; Barkham idr., 2023) prepoznavamo vsaj posredno priznavanje najpomembnejše ovire pri uvajanju PIO v organizacijo - (še) neobstoječe ali pomanjkljive kulture povratnega informiranja. Tudi analize (Van Sonsbeek idr., 2023) neuspešnih poskusov uvajanja različnih orodij za raziskovanje procesa in izida so pokazale, da je bilo ravno to ovira pri poenotenju interesa terapevtov, klientov, vodstva ter administrativnega osebja za novo dejavnost v organizaciji.

Slika 1

Prikaz ravni uvajanja PIO v organizacijo po pomembnosti v obliki piramide.



PIO lahko postane eno ključnih načel učeče se organizacije, kjer kot stranski produkt klinične prakse nastajajo izsledki (podatki), ti pa se nato uporabijo kot podpora stalnemu izboljševanju prakse (npr. Guise idr., 2018 na primeru storitev v zdravstvu).

S PIO vsakdanja terapevtska praksa tako ni le način uporabe teoretičnega znanja in praktičnih izkušenj, temveč tudi način preoblikovanja in ustvarjanja novega znanja – gre za bogatenje znanja za ravnanje. S podatki o procesu primeri ostanejo v središču strokovnega interesa, obenem pa isti podatki (v agregirani obliki) omogočajo dokazovanje terapevtske učinkovitosti navzven (politika, javna uprava, mediji, javnost, gospodarstvo). PIO je lahko tudi eden od virov podatkov za sistematični nadzor kakovosti v zdravstvu v smislu ‚na vrednosti temelječe zdravstvene obravnave' (glej npr. Bernik idr., 2022).

2. Metode

Namen tega narativnega pregleda raziskav je predstaviti, katere ovire in spodbude so dosedanji raziskovalci zaznali pri uvajanju PIO v organizacije. Pri iskanju po Google Scholar, EBSCO ter APA PsycInfo so bile uporabljene ključne besede „barriers“, „challenges“, „facilitators“, „drivers“ v kombinaciji s „(client) feedback“, „routine outcome measurement“, „FIT“ in ostalimi poimenovanji za razne PIO (naštetimi zgoraj v poglavju Različni načini in poimenovanja povratnega informiranja o terapevtskem procesu in izidih) ter „implementation“ in „organization“. Časovno obdobje smo omejili na zadnjih 20 let, torej od 2004 do 2024. Najdenih je bilo 191 virov.

Na podlagi pregleda naslovov, povzetkov in uvodov je bilo nato po kriteriju, da je bila raziskava s področja psihoterapije ali svetovanja (v različnih okoljih, tudi npr. v univerzitetnem, v socialnem delu, centrih za otroke in mladostnike, odvisnike ipd.), izključenih 74 člankov, ki so bili z drugih znanstvenih področij (npr. različne veje medicine, delovna terapija, fizioterapija ipd.).

V drugem koraku je bilo preostalih 117 raziskav vključenih v pregled na podlagi kriterija, da je bil kontekst uvajanje PIO v organizacijo (bolnišnico, prakso, ambulanto, svetovalni center,...). Ostalo je 62 virov (v predhodnem koraku torej izločenih 55).

Zadnji kriterij je bil, da je tema članka vrste ovir in/ali spodbud (ne pa npr. preverjanje zanesljivosti določenega inštrumenta, preverjanje razširjenosti uporabe sistema PIO ali ugotavljanje, kako obvezna uporaba PIO vpliva na njegov sprejem pri psihoterapevtih). Glede na ta kriterij je na seznamu ostalo še 30 raziskav (izločenih 32).

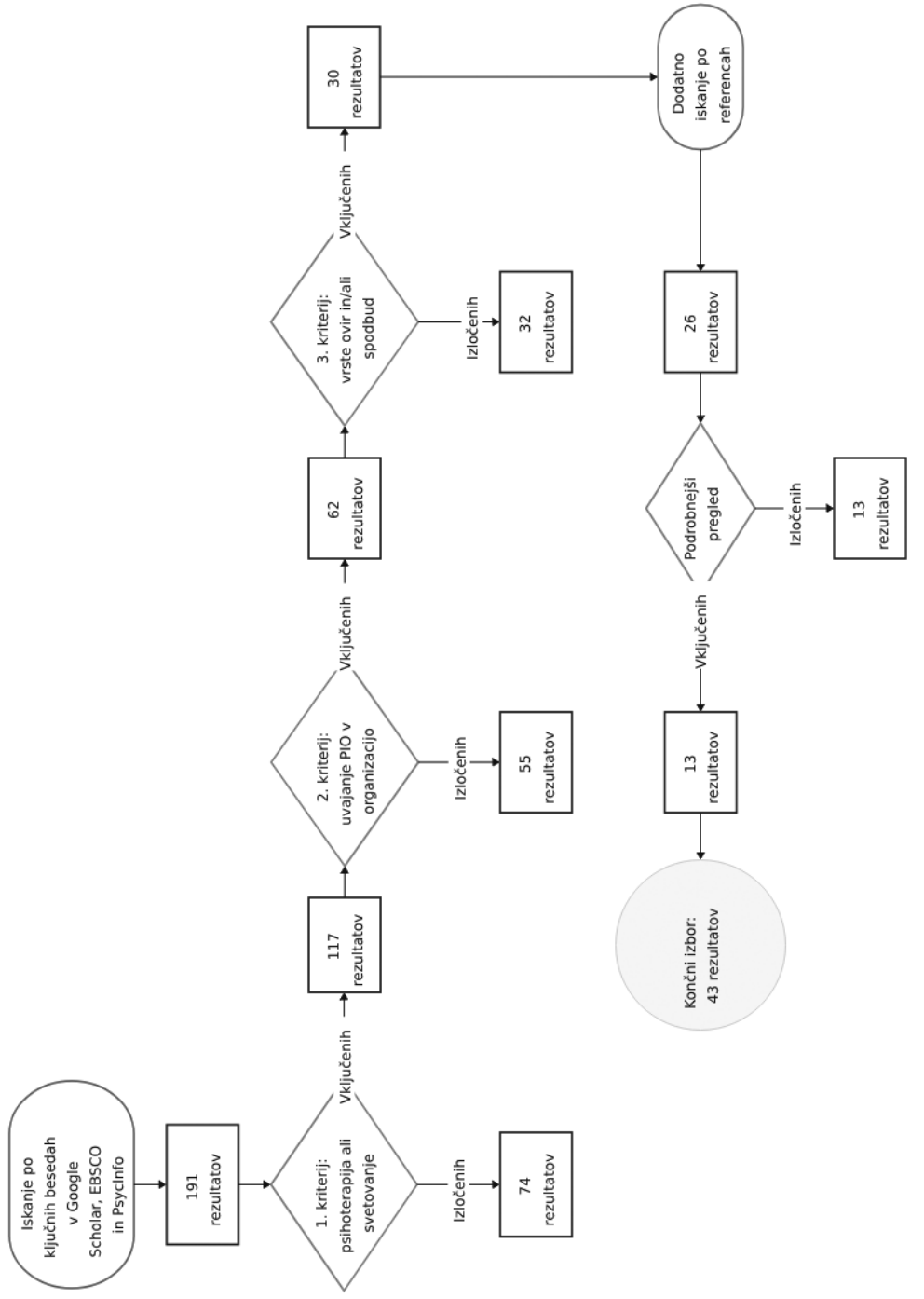
Na podlagi pregleda seznamov referenc končnega seznama člankov je bilo naknadno najdenih še 26 potencialno relevantnih virov, od katerih jih je bilo nato po podrobnejšem pregledu v seznam za pregled dodanih 13. Končni izbor raziskav je štel 43 virov.

Raziskave so bile nato razvrščene v seznam po abecednem vrstnem redu prvega avtorja z izpisanimi ovirami in spodbudami, ki so bile v raziskavi omenjene v ločenih stolpcih. Iz tega sta nastala dva seznama: ovir in spodbud. Sledilo je razvrščanje ovir oz. spodbud v kategorije znotraj posameznega seznama glede na relevantnost. Tako je nastalo 9 kategorij ovir ter 12 kategorij spodbud, ki jih, skupaj s konkretnimi ovirami oz. spodbudami, omenjenimi v raziskavah, ter avtorji, ki jih omenjajo, prikazujemo v poglavju Rezultati.

Predstavljeni pregled je torej povzetek najdenih virov, kjer smo se omejili samo na določene raziskovalne baze in ključne besede, tudi razvrščanje v kategorije je potekalo subjektivno, z upoštevanjem lastnih izkušenj sodelovanja pri projektu uvajanja PIO, kar je zagotovo dalo večjo težo določenim oviram ali spodbudam.

Slika 2

Prikaz procesa izbora virov za pričujoči članek.



3. Rezultati

3.1. Ovire pri uvajanju povratno informirane obravnave v organizacije

Uvajanje PIO v organizacije je zahtevno zaradi številnih ovir, ki jih je pri načrtovanju potrebno upoštevati. Ovire je v kategorije poskusilo sistematizirati že več predhodnih avtorjev.

Lewis, C. C. idr. (2019) so npr. ovire razdelili na individualne, ki se delijo na vidik klienta in terapevta, organizacijske ter sistemske. Umestitev ovire je lahko odvisna tudi od faze uvedbe, npr. pogosta skrb, da ne bo dovolj časa za uporabo meritve, lahko izgine ob ustreznem usposabljanju ali dovolj dolgem poskusnem obdobju, lahko pa se pretvori v dejansko težavo, ki obremeni terapevta.

Barkham idr. (2023) navajajo naslednje tematske sklope ovir pri uvajanju PIO: smiselnost, breme merjenja, vpliv na kliente in obravnavo, skrbi in zadržki praktikov, implementacija ter seting[4].

Johnston in Gowers (2005) sta ovire razvrstila na kadrovske težave in pomanjkanje virov; filozofske ovire oz. odpore osebja; znanstveno vrednost in težave z merjenjem; izzive z uporabnostjo; ter ovire, povezane s klienti.

Rezultati pregleda raziskav kažejo, da lahko ovire kategoriziramo še na druge načine – npr. glede na intenzivnost doživljanja:

- čustvene ovire: skrbi, da terapevti uvedenega sistema PIO ne bodo znali uporabljati; strahove, da bodo rezultati uporabljeni za ocenjevanje njihovega dela oz. za sankcije; ter strahovi glede varnosti oz. zaupnosti pridobljenih podatkov;
- intelektualne ovire: pomisleki/zadržki/dvomi glede uporabnosti in metodologije oz. znanstvene veljavnosti PIO; navajanje izsledkov raziskav o neuspešnih poskusih uvedbe PIO ali pa raziskav, ki kažejo, da PIO nima vpliva na izide; ter
- organizacijske ovire: časovna (pre)obremenitev; pomanjkanje finančnih sredstev ali vsebinske/tehnične podpore.

Nekatere ovire se lahko pojavljajo v več sklopih oz. prehajajo med njimi, odvisno od tega, koga vprašamo (terapevta, klienta, vodstvo organizacije, osebje za administrativno podporo). V tabeli 1 razvrščam v literaturi najdene ovire v 9 kategorij.

Raziskovalci so pogosto omenjali ovire, ki so združene v kategoriji Negativen odnos ali odpor terapevtov. Van Sonsbeek idr. (2023) so se npr. pri uvajanju MBC srečali z odporom terapevtov do uvajanja PIO, povezanim s pristranostjo: za dobre rezultate je zaslužen psihoterapevt sam, če pa kaže slabo, gre to ‚na rovaš' klienta. Psihoterapevti so zase menili, da so nadpovprečni (o tem, kako

4 Ob raziskovanju stališč terapevtov v kontekstu psihosocialnega svetovanja v univerzitetnem okolju Velike Britanije so Barkham idr. (2023) ugotovili, da rezultati presegajo specifike setinga in geografskega okolja ter se lahko prenesejo na večino kontekstov, kjer se izvajajo psihološke terapije.

psihoterapevti precenjujejo lastno učinkovitost, poročajo tudi Walfish idr., 2012 ter Parker in Waller, 2015). Ta prepričanja so se v raziskavi van Sonsbeeka idr. (2023) pokazala kot močnejša od (racionalnih) razlogov za uporabo PIO, npr. da njihovi izidi niso bili tako dobri in da so terapevti slabo prepoznavali tvegane primere ali primere s slabimi izidi. Raziskovalci so se zato spraševali, kaj je oz. kaj bi bila dejanska motivacija terapevtov za uvajanje PIO („*what's in it for me*"). Na kateri problem je odgovor PIO? Ali bi terapevtom koristilo orodje za klientom bolj prilagojeno (personalizirano, idiografsko) obravnavo ali pa meritev spremembe simptomov in njihovih mehanizmov? Avtorji sklenejo, da bi bilo terapevte najbolje obravnavati in usposabljati kot pilote, tako da bi že od prvega dne razumeli, da so zmotljivi in da bodo delali napake.

Ena od kategorij je povezana z uporabo in omejitvani meritev. Wolpert idr. (2016) so identificirali tri ovire za uvedbo PIO z vidika meritev: glede vsebine in oblike meritev, procesa uporabe meritev ter uporabe podatkov iz meritev. Če psihoterapevti PIO ocenjujejo negativno, meritve tudi redkeje uporabljajo (Jensen-Doss idr., 2018). Ker pa nobena meritev ne more zajeti celotne kompleksnosti posameznega primera, pa Jacob idr. (2016) ter Jacob, Edbrooke-Childs idr. (2017) predlagajo istočasno uporabo različnih meritev za ključna področja. Ogles idr. (2022) podobno poudarjajo kombinacijo različnih modelov spremljanja izidov s posebnim poudarkom na tistem, ki je najpomembnejši za klienta - še posebej ko ni pričakovati bistvenega izboljšanja simptomov (Batty idr., 2013).

Če klient zavrne sodelovanje, izpusti, delno izpolni ali se občasno izogne izpolnjevanju vprašalnika (kar so lahko ovire, povezane s klienti), lahko s terapevtskega stališča to razumemo kot pomembno sporočilo, poudarjajo Barkham idr. (2023). Pri PIO ne gre za raziskovanje, sekundarno kliničnemu delu; PIO je integralen del obravnave. Klienta seveda ne smemo siliti v sodelovanje, lahko pa ga spodbujamo, da poskusi in sam preveri koristi takega načina dela; v vsakem primeru pa se z njim lahko pogovorimo in dobimo koristne povratne informacije. Ne glede na klientov odziv ali pridobljene podatke je torej PIO uporabno terapevtsko orodje.

Tabela 1

Preglednica kategorij ovir pri uvajanju povratno informirane obravnave v organizacije.

OVIRE	RAZISKAVE
Omejeni viri - časovni, finančni, materialni, administrativni: dodatna birokracija; administrativni postopki; dodaten čas za dokumentacijo; časovna potratnost izvajanja meritev; podaljšano trajanje terapevtskih srečanj; visoki stroški; pomanjkanje sredstev in/ali osebja; dodatna finančna obremenitev; pomanjkanje virov podpore; obstoječa velika delovna in/ali časovna obremenitev osebja; fluktuacija terapevtov in vodstva; pomanjkanje aktivnega prizadevanja organizacije za uvedbo PIO; neustrezna organizacijska podpora	Banjtes idr. (2017), Batty idr. (2013), Bickman (2008), Bie idr. (2017), Boswell idr. (2013), Bovendeerd idr. (2021), Campbell in Hemsley (2009), De Beurs idr. (2010), Gleacher idr. (2016), Håland in Tilden (2017), Hatfield in Ogles (2007), Hovland in Moltu (2019), Johnston in Gowers (2005), Kaiser idr. (2018), Ko idr. (2023), Kotte idr. (2016), Lewis C. C. idr. (2019), Lucock idr. (2015), Meehan idr. (2006), Mackrill & Sørensen (2019), Mackrill in Svendsen (2021), Meehan idr. (2006), Solstad idr. (2017), Stone idr. (2019), Troupp (2013), Unsworth idr. (2012), Van Wert idr. (2020)
Negativen odnos ali odpor terapevtov: negativen odnos do uporabnosti; strah pred oslabitvijo terapevtskega odnosa; odpor do novih meritev; skrbi glede pristranskosti odgovorov terapevtov; tesnoba terapevtov glede uporabe PIO; težave pri razvijanju kulture PIO; nezdružljivost med inovacijo in potrebami terapevtov; dvomi glede izboljšanja klinične presoje; pomanjkanje usklajenosti glede kulture PIO, smiselnosti ali namena; skrb, da meritve škodijo procesu; skrb, da je PIO sama sebi namen; dvom v pripravljenost klientov za izpolnjevanje meritev PIO oz. v disciplino pri rednem izpolnjevanju	Abrines-Jaume idr. (2016), Barkham idr. (2023), Batty idr. (2013), Bickman (2008), Bie idr. (2017), Börjesson in Boström (2019), De Beurs idr. (2010), Hovland in Moltu (2019), Jensen-Doss idr. (2018), Johnston in Gowers (2005), Kaiser idr. (2018), Ko idr. (2023), Kotte idr. (2016), Law in Wolpert (2014), Lewis C. C. idr. (2019), Lucock idr. (2015), Mackrill & Sørensen (2019), Overington idr. (2015), Solstad idr. (2017), Troupp (2013), Unsworth idr. (2012), Van Sonsbeek (2023)
Pomanjkanje usposabljanja in znanja: premalo znanja o uporabi; omejeno znanje organizacije in uporabnikov; nepoznavanje funkcionalnosti in bistva PIO; nejasnost, kako vključiti meritve v psihoterapevtski proces; težave pri interpretaciji	Batty idr. (2013), Bie idr. (2017), De Beurs idr. (2010), Gleacher idr. (2016), Hatfield in Ogles (2007), Jensen-Doss idr. (2018), Johnston in Gowers (2005), Kaiser idr. (2018), Kotte idr. (2016), Lewis C. C. idr. (2019), Mackrill & Sørensen (2019), Stone idr. (2019), Troupp (2013), Van Wert idr. (2020)
Skrbi glede zasebnosti in etike zaskrbljenost glede varnosti podatkov; etični pomisleki; pomisleki glede uporabe ali zlorabe zbranih podatkov; nezaupanje; dvom v zaupnost podatkov; skrb glede pristranske uporabe podatkov	Barkham idr. (2023), Bickman (2008), Boswell idr. (2013), Hatfield in Ogles (2007), Johnston in Gowers (2005), Lewis C. C. idr. (2019), Börjesson in Boström (2019)

OVIRE	RAZISKAVE
Težave pri dostopu in uporabi tehnologije: kompleksnost ali zapletenost tehnologije oz. uporabniškega vmesnika; težave z integracijo v obstoječi dokumentacijski sistem; težave z dostopom do računalnikov; pomanjkanje podpore informacijske tehnologije; težave ob virtualnih srečanjih; nepripravljenost ali nezmožnost klientov sprejeti novo tehnologijo ter računalniška nepismenost	Gleacher idr. (2016), Johnston in Gowers (2005), Ko idr. (2023), Mackrill in Svendsen (2021), Meehan idr. (2006), Stone idr. (2019)
Znanstveni skepticizem: dvomi o znanstveni vrednosti; pomisleki glede zanesljivosti in veljavnosti meritev; ali lahko en sam merski inštrument dovolj natančno zajame klientove izkušnje, spremembe v vsakodnevnem življenju oz. kompleksnost primera; ustreznost za specifične primere	Batty idr. (2013), Börjesson in Boström (2019), Hatfield in Ogles (2007), Johnston in Gowers (2005), Kaiser idr. (2018), Kotte idr. (2016), Law in Wolpert, (2014), Mackrill & Sørensen (2019), Meehan idr. (2006), Solstad idr. (2017), Stasiak idr. (2013), Troupp (2013), Wolpert idr. (2013)
Ovire, ki so povezane s klienti in njihovimi lastnostmi: nizka stopnja izobrazbe; ozkost vprašalnikov glede na kompleksnost duševnega zdravja; čustvena zahtevnost izpolnjevanja meritev za posamezne populacije; strah klientov, da bi dokazovanje napredka vodilo do umika storitev; neprimernost za specifične kliente; odnos, nedoslednost klientov pri izpolnjevanju meritev	Banjtes idr. (2017), Börjesson in Boström (2019), Ko idr. (2023), Troupp (2013)
Težave pri uporabi meritev in njihove omejitve: vizualne analogne meritve zahtevajo več časa za predstavitev in upravljanje; prevelika raznolikost meritev; nizki deleži vrnjenih vprašalnikov; standardizirane obravnave omejujejo prilagodljivost PIO; fiksacija na spremljanje simptomov; težave pri zajemanju doslednih zapisov zaradi časovnih razmikov med srečanji; zapletenost standardiziranega sistema	Banjtes idr. (2017), Batty idr. (2013), Brattland idr. (2018), De Beurs idr. (2010), Kaiser idr. (2018)
Politične in sistemske ovire: politični motivi za uvedbo PIO; druge prioritete vodstva; komercializacija storitev duševnega zdravja; spodbujanje medicinskega ali psihiatričnega modela; zloraba zbranih podatkov s strani vodstva; nedosledno sodelovanje med oddelki organizacije	Batty idr. (2013), Bickman (2008), Johnston in Gowers (2005), Lewis, C. C. idr. (2019), Meehan idr. (2006)

3.2. Spodbude pri uvajanju povratno informirane obravnave v organizacije

Poleg ovir obstajajo tudi dejavniki, ki uvajanje PIO olajšujejo oz. spodbujajo (angl. *facilitators*) (tabela 2).

Kaiser idr. (2018) omenjajo, da je PIO lahko podpora psihoterapevtskim raziskavam, kar je spodbuda za organizacije, ki želijo razviti znanstveno kredibilnost ali dokazovati svojo učinkovitost. Mackrill in Sørensen (2020) izpostavljata pomen povečanega sodelovanja in centralizacije virov med lokalnimi organizacijami (s področja psihosocialnih intervencij in tudi širše s področja duševnega zdravja). Lokalni podatki PIO lahko tudi napajajo velike banke podatkov (npr. CORE sistem v Angliji, ali sistemi CCAPS, OQ, TOP - glej npr. Barkham idr., 2006; Boswell idr., 2015; Beckstead idr., 2003; Lambert, 2007; Lo Coco idr., 2008; Martin idr., 2012). Ti omogočajo PBE in druge pristope v prakso usmerjenega raziskovanja (Castonguay idr., 2013).

Tabela 2

Preglednica spodbud pri uvajanju povratno informirane obravnave v organizacije.

SPODBUDE	RAZISKAVE
Finančni viri: povečanje dodeljevanja sredstev in finančnih spodbud; zunanji viri financiranja	Banjtes idr. (2017), Bickman (2008), Bovendeerd idr. (2021), Campbell in Hemsley (2009), Hatfield in Ogles (2007), Johnston in Gowers (2005), Lewis, C. C. idr. (2019), Unsworth idr. (2012)
Organizacijska podpora in kultura: osveščanje o obstoju PIO; močna podpora in vključenost vodstva; prizadevanja organizacije za uvedbo PIO; pozitivno, sodelovalno okolje, naklonjeno PIO; sprememba odnosov in dojemanja; jasne smernice in protokoli za uporabo PIO; izobraževanje osebja o klinični vrednosti in uporabi orodij PIO; poudarjanje pomena uvedbe PIO; spodbude in nagrade za uvajanje in uporabo PIO; organizacijsko razumevanje lastnih vrednot, potreb in ciljev PIO; razumevanje in sprejemanje izvedljivosti in primernosti PIO pri obravnavi; podpora izvajanju psihoterapevtskih raziskav; dostop do raziskav in dokazov, ki podpirajo učinkovitost PIO; jasno (ter večkratno oz. sprotno) komuniciranje razlogov za uvajanje PIO	Barkham idr. (2023), Batty idr. (2013), Edbrooke-Childs idr. (2016), Gleacher idr. (2016), Håland in Tilden (2017), Kaiser idr. (2018), Kotte idr. (2016), Lewis, C. C. idr. (2019), Lucock idr. (2015), Rye idr. (2019), Solstad idr. (2017), Troupp (2013)

SPODBUDE	RAZISKAVE
Usposabljanje in izobraževanje: redno usposabljanje; supervizija; izobraževanje o klinični vrednosti PIO; možnost posvetovanja; vadbene skupine za razvoj spretnosti	Bie idr. (2017), Börjesson in Boström (2019), Brattland idr. (2018), Edbrooke-Childs idr. (2016), Gleacher idr. (2016), Hatfield in Ogles (2007), Jacob, Napoleone idr. (2017), Ko idr. (2023), Kwan idr. (2020), Lewis, C. C. idr. (2019), Lucock idr. (2015), Mackrill & Sørensen (2019), McAleavey in Moltu (2021), Meehan idr. (2006), Stone idr. (2019), Troupp (2013), Unsworth idr. (2012)
Tehnološki viri: uporabniku prijazni sistemi; izboljšanje ukrepov za varnost podatkov; dostopnost na elektronskih sistemih za vodenje primerov; enostavna integracija v obstoječ dokumentacijski sistem; spodbujanje inovacij in naložb v tehnologijo za izboljšanje združljivosti sistemov; računalniška podpora za vnos podatkov in hitro ustvarjanje poročil	Barkham idr. (2023), Batty idr. (2013), Boswell idr. (2013), De Beurs idr. (2010), Håland in Tilden (2017), Hovland in Moltu (2019), Ko idr. (2023), Lewis, C. C. idr. (2019), Mackrill in Svendsen (2021), Meehan idr. (2006), Van Wert idr. (2020)
Uporabnost, prilagodljivost in relevantnost: poudarek na kliničnih koristih; izboljšano predstavljanje rezultatov klientom; prilagajanje slogu terapevta in potrebam klientov; uporaba vizualnih analognih meritev za kliente z nizko stopnjo izobrazbe; manj zapletena in uporabniku bolj prijazna orodja ter enostavnejše meritve; izboljšana klinična refleksija; grafični prikaz sprememb	Banjtes idr. (2017), Bickman (2008), Brooks Holliday idr. (2021), Campbell in Hemsley (2009), De Beurs idr. (2010), Gleacher idr. (2016), Hovland in Moltu (2019), Kaiser idr. (2018), Lewis, C. C. idr. (2019), Lucock idr. (2015), McAleavey in Moltu (2021), Peterson in Fagan (2021), Solstad idr. (2017), Stone idr. (2019), Troupp (2013)
Čas in kadrovski viri: več časa za obravnavo, zadostna administrativna podpora; stalno osebje za uvedbo PIO; vplivni in sposobni uporabniki PIO; spodbude za zmanjšanje fluktuacije; uvajanje inovacij z večjo podporo terapevtov v celotnem trajanju obravnav	Batty idr. (2013), Boswell idr. (2013), Bovendeerd idr. (2021), De Beurs idr. (2010), Håland in Tilden (2017), Hatfield in Ogles (2007), Ko idr. (2023), Kotte idr. (2016), Lewis, C. C. idr. (2019)
Učinkovitost obravnav: inovativna uporaba meritev; obvezno izpolnjevanje meritev; sprotni rezultati, ki kažejo učinkovitost obravnav; deljenje uspešnih zgodb in podatkov, ki dokazujejo izboljšane rezultate; nadzor in vidnost sprememb; preglednost rezultatov in pozitivnih sprememb pri klientih; informiranje o prednostih in slabostih različnih meritev	Jacob, Napoleone idr. (2017), Kaiser idr. (2018), Meehan idr. (2006), Troupp (2013)
Vključevanje klientov: aktivno vključevanje klientov in usklajevanje z njimi; smiselna začetna predstavitev klientom in dobra integracija v srečanja; redni pogovori o PIO rezultatih na srečanjih	Bie idr. (2017), Brattland idr. (2018), Brooks Holliday idr. (2021), Hannan idr. (2005), Law in Wolpert (2014), Meehan idr. (2006), Miller idr. (2006), Stasiak idr. (2013), Thew idr. (2015), Troupp (2013)

SPODBUDE	RAZISKAVE
Medorganizacijsko strokovno sodelovanje: obstoj smernic in močna podpora nacionalne terapevtske organizacije glede uvedbe PIO in kriterijev; povečanje sodelovanja in centralizacije virov med lokalnimi organizacijami	Johnston in Gowers (2005), Mackrill & Sørensen (2019), Troupp (2013)
Zaupanje: visoka preglednost za povečanje zaupanja; vzpostavljanje zaupanja klientov z ukrepi za varnost podatkov	Boswell idr. (2013), Lewis, C. C. idr. (2019)
Standardizacija in meritve: poudarek na standardiziranih meritvah; objektivnost in primerljivost meritev; ustreznost meritev glede na kliente	De Beurs idr. (2010), Jensen-Doss idr. (2018), Kaiser idr. (2018), Van Wert idr. (2020)
Pilotna uvedba PIO: postopno uvajanje; začetek z uporabo enostavnejših in cenovno dostopnih metod merjenja izidov	Barkham idr. (2023), Bie idr. (2017), Overington in Ionita (2012)

Dobra primera dolgotrajnih projektov raziskovanja kvalitete ambulantne psihoterapije po modelu na klienta usmerjenega raziskovanja izpostavlja npr. nemška študija Strauß idr. (2015). Projekt *Techniker Krankenkasse*, s katerim so preverjali možnosti uvajanja sistema PIO kot rutinskega pripomočka (Lutz idr., 2011, 2012); ter *Qualitätssicherung ambulanter Psychotherapie in Bayern* (QS-PSY-BAY), kjer je bil cilj preverjanje novega pristopa s pomočjo elektronskega dokumentiranja značilnosti pacientov in parametrov izida. Sodelovalni trikotnik med terapevti, raziskovalci in zdravstvenimi zavarovalnicami se je v obeh projektih pokazal kot zelo ploden. Številni psihoterapevti so bili skeptični do uvajanja PIO in s strani raziskovalcev so bile potrebne dodatne spodbude za premagovanje njihovih odporov. Klienti so bili z njo zelo zadovoljni in so jo radi sprejeli. Prav tako so ugotovili pozitiven vpliv PIO na dolžino obravnav: klienti z zgodnjim pozitivnim odzivom so lahko obravnavo tudi prej uspešno zaključili, tisti z zgodnjim negativnim odzivom pa so lahko terapijo podaljšali. Tega jim obstoječi nemški sistem brez PIO, s šablonskim načinom določanja števila iz zdravstvenega zavarovanja financiranih seans, ne bi omogočil. Izpolnjenih pa mora biti več pogojev za izboljšanje izidov s PIO: stalna podpora psihoterapevtov v obliki konzultacij, predvsem v primerih, ko potek obravnave ni optimalen, ali ko se terapevtova subjektivna ocena ne ujema s prejetimi povratnimi informacijami.

4. Diskusija

Aafjes-van Doorn in de Jong (2022) poudarjata, da so bile potencialne koristi PIO že večkrat ugotovljene. Raziskave PIO se zato od teme učinkovitosti vse

bolj usmerjajo k izzivom uvajanja PIO (v organizacije in v individualne zasebne prakse). Mackrill in Sørensen (2020) v svojem pregledu ugotavljata, da študije primerov zadnjih let kažejo heterogenost sistemov PIO in različne načine uvajanja in uporabe PIO, pa tudi veliko pestrost kontekstov, vrst obravnave (npr. ambulantne in bolnišnične), teoretičnih pristopov, populacij klientov itd. Spekter mnenj glede uporabnosti PIO (od koristnega orodja do tega, da ne odraža klientovih izkušenj) pomeni tudi neenotnost glede interpretacije podatkov PIO ali izvajanja PIO v klinični praksi.

4.1. Ali je organizacija pripravljena na uvedbo povratno informirane obravnave?

Duncan (2012) dejavnike za uspešno uvedbo PIO v organizacijo deli na individualne, administrativne in organizacijske. Potrebno je večnivojsko razmišljanje in zagotavljanje dovoljšnje mere predanosti vseh deležnikov v organizaciji, ne le klientov in psihoterapevtov. V tabeli 3 je seznam kriterijev/točk (angl. *checklist*) za oceno pripravljenosti organizacije na uvajanje modela PCOMS (Duncan, 2014), ki pa je enako uporaben za druge modele PIO.

Tabela 3

Seznam kriterijev za oceno pripravljenosti organizacije na uvedbo PIO (prirejeno po Duncan, 2012).

Kriteriji pripravljenosti organizacije na uvajanje PIO
1. Organizacija ima odobritev in podporo vodstva za uvajanje PIO.
2. Vodstvo in zaposleni se strinjajo, da je odgovornost do klientov in uporaba PIO osrednji temelj njenih storitev.
3. PIO je vključen v poslovni/finančni načrt organizacije.
4. Morebitni financerji so vključeni v komunikacijo o podatkih PIO kot ene od podlag merjenja učinkovitosti organizacije.
5. Organizacija ima načrt usposabljanja in razvoja človeških virov, ki podpira stalno izobraževanje zaposlenih za PIO na vseh ravneh in ki namerava vključiti PIO v individualne razvojne načrte, ocene uspešnosti in prakse zaposlovanja.
6. Organizacija ima ustrezno infrastrukturo (podporno osebje, IT, računalniška strojna oprema itd.), ki podpira zbiranje in analizo podatkov PIO na ravni posameznega klienta, psihoterapevta, oddelka/področja in organizacije.
7. Metasupervizorji in supervizorji v organizaciji uporabljajo podatke PIO za individualizacijo načrtovanja obravnav, prepoznavanje ogroženih klientov in proaktivno obravnavanje potreb klientov ter spremljanje/izboljševanje uspešnosti posameznega psihoterapevta.
8. Organizacija ima strategijo in jasno določene postopke za kliente, ki ne napredujejo, kar zagotavlja hiter prehod klienta k drugemu psihoterapevtu ter kontinuiteto obravnave.
9. Izjava o poslanstvu organizacije vključuje omembo partnerstva s klienti ter odgovornost do njih kot osrednji značilnosti ponujanja storitev.
10. Dokument „Pravice in odgovornosti klientov“ vključuje pomen povratnih informacij klientov in partnerstva pri usmerjanju načrtovanja obravnave.

Duncan (2012) veliko poudarka nameni organizacijskim ter infrastrukturnim dejavnikom, a dodaja, da je potrebno biti zelo pozoren na same (zaposlene) terapevte, ki bodo PIO uporabljali. Nekaterim, posebej tistim z daljšim stažem, je morda koncept spremljanja izidov popolnoma tuj, druge so morda odbile neprijetne izkušnje z zahtevnimi meritvami, ki jih niso znali povezati s svojo vsakdanjo prakso s klienti. Tretji se morda bojijo, da bo merjenje uspešnosti vplivalo na njihovo plačo oz. ugled ali hierarhični status v organizaciji. Uvajanje PIO mora biti za terapevte smiselno, nagovori naj njihovo (univerzalno) željo po opravljanju kvalitetnega in koristnega dela. Za uspešno uvedbo PIO in tudi kasnejšo ‚zavezanost' (angl. *adherence*) novemu načinu dela mora biti PIO terapevtom privlačen. PIO je več kot številke in podatki – je klinični proces, ki za doseganje največjega učinka od terapevta zahteva sposobnost in občutljivost za nianse ter podrobnosti. PIO ponuja metodologijo pomoči klientom, za katere se zdi, da ne dosegajo želenih izidov – za katere pa naj bi bilo terapevtom najbolj mar. Če je ključni vidik uvajanja PIO v organizacijo terapevtov profesionalni razvoj, jih to motivira, ko od njih pričakujemo investicijo dodatnega časa in energije. Motivacija za organizacijo so vedno boljši izidi ter nižji stroški, a poglavitna osebna motivacija terapevta je doprinesti k spremembi v življenju klientov (to je pogosto tudi razlog, da je sploh postal terapevt). Primarni fokus PIO torej niso organizacijski cilji, temveč dobro klientov, pot do tja pa vodi skozi izboljševanje terapevtovega dela. Terapevti morajo vedeti namen in način, kako in za kaj vodstvo uporablja podatke PIO – kar nikakor, nikoli in nikjer ni za kaznovanje terapevtov. Glede na to, da se pri večini terapevtov njihovi izidi z uporabo PIO izboljšajo (Anker idr., 2009), torej pozitiven, netekmovalen pristop blaži strahove terapevtov pred PIO.

Duncan (2012) predlaga model ‚usposabljanja trenerjev' (angl. *train the trainers*), kjer organizacija usposobi jedrni tim terapevtov in supervizorjev, ti pa nato usposabljajo oz. supervidirajo sodelavce. Čimprejšnji začetek zbiranja podatkov ter sprotna supervizija sta ključni za uspešno uvedbo PIO. Duncan in Sparks (2010) priporočata stopenjski supervizorski proces, ki se najprej osredotoči na kliente z izidi, ki kažejo tveganje za poslabšanje, šele nato pa na izboljšanje učinkovitosti terapevta.

4.2. Priporočila in napotki za uvajanje povratno informirane obravnave

Abrines-Jaume idr. (2016) so opredelili tri faze uvajanja PIO: zadržanost/zaskrbljenost (previdnost glede uporabe), občutek nelagodja (ko se terapevti sami sebi zdijo nerodni ob uporabi nečesa novega) in integracija v prakso.

V tabeli 4 so tri ravni priporočil McComb idr. (2018) za uvajanje PIO v programe usposabljanja in supervizijo; v izvirniku programsko/institucionalno raven sem preimenoval v organizacijsko, supervizantovo raven pa v psihoterapevtovo.

Tabela 4

Priporočila glede uvajanja povratno informirane obravnave v organizacije na treh ravneh (prirejeno po McComb, 2018).

Organizacijska raven
1. Klientove povratne informacije morajo biti na voljo v dejanskem času psihoterapevtske obravnave in lahko dostopne psihoterapevtom in supervizorjem.
2. Usposabljanje za PIO mora poleg osnovne interpretacije podatkov in navigacije po njih vključevati smernice za uporabo podatkov v superviziji.
3. Nasloviti je potrebno več ravni organizacije za spodbujanje motivacije in uporabe.
Supervizorjeva raven
1. Supervizorji morajo imeti jasna pričakovanja o PIO in njeni vlogi pri kliničnem delu in v superviziji.
2. Supervizorji morajo imeti izkušnje z uporabo PIO v svoji klinični praksi.
3. Supevizorji morajo biti zavezani modelu znanstvenika-praktika (PBR).
4. Organizacija mora spodbujati motivacijo in angažiranost supervizorjev.
Psihoterapevtova raven
1. Potrebno je omogočiti dostop do PIO že v času izobraževanja iz psihoterapije.
2. Če je dostop do PIO na kakršenkoli način omejen, je potrebno spodbujati njeno uporabo vsaj z omejenim številom klientov.
3. Psihoterapevtom morajo biti na voljo nadgradnje (vedno zahtevnejše ravni) usposabljanja za uporabo PIO, ki so usklajene z razvojem njihove kompetentnosti.

Tudi Thomas (2013) poda nekaj napotkov za k rešitvam usmerjeno supervizijo, ki vljučuje PIO, npr. za supervizorje, naj prosijo supervizante za PIO in se odzivajo na prejete podatke; za učne organizacije, naj bodo njihovi učitelji in supervizorji zavezani večanju lastne učinkovitosti s PIO in z lastnim načrtom strokovnega razvoja, saj so le na tak način lahko zgled svojim študentom, ter da je študente potrebno vključiti v PIO ter jo uporabljati v superviziji. Thomas, kot McComb idr. (2018) tudi meni, da bi morali že izobraževalni programi za bodoče terapevte omogočiti spremljanje rezultatov študentov in razvijati ustrezne metode uporabe teh podatkov za izboljšanje usposabljanja. Vodstvo organizacije bi moralo ustvariti kulturo prizadevanj za nenehne izboljšave (kot npr. v atletiki, glasbi, letalstvu in vojski) ter za supervizorje in terapevte uvesti (obvezen) sistem PIO. Tudi kar se tiče sistema stalnega strokovnega izpopolnjevanja[5] Thomas (2013) priporoča, naj bo pogoj za podaljševanje licenc za opravljanje psihoterapevtske dejavnosti supervizija, namenjena povečevanju uspešnosti na podlagi PIO. Tako bi npr. psihoterapevtska zbornica za obnovo

5 Ta je pomemben del zakonsko urejenega področja psihoterapije oz. bi moral biti – več o tem Slovenska krovna zveza za psihoterapijo (2024).

licenc od terapevtov zahtevala podatke PIO o svoji terapevtski uspešnosti. V tej perspektivi so izrednega pomena pionirske raziskave, ki s PIO orodji spremljajo psihoterapevtski proces na več ravneh istočasno, npr. na ravni metasupervizije, supervizije in terapije (Kovačević Tojnko idr., 2023).

4.3. Ključne teme uvajanja PIO v organizacije

Sledi razmislek o nekaj glavnih temah uvajanja PIO v organizacije: o vlogi PIO v psihoterapevtski obravnavi; potrebi po tem, da je PIO strategija, ne tehnika; metodološkem vidiku uporabe meritev; ter vključevanju PIO v psihoterapevtsko izobraževanje in supervizijo.

PIO ni samo tehnika ali dodatek terapiji, temveč terapevtska intervencija in tako integralni del psihoterapevtskega procesa. Gomez idr. (2022) so pokazali, kako lahko PIO olajša dogovarjanje s klientom o namenu in ciljih obravnave. Schaffrath idr. (2022) na primeru naprednega in z raziskavami močno podprtega sistema Trier Treatment Navigator prikažejo personalizacijo terapije z izbiro meritve za samoporočanje in prilagajanje obravnave na podlagi zbranih podatkov. Demir idr. (2022) podobno kot Schaffrath idr. (2022) spomnijo na prednosti kazalnikov iz zbranih podatkov in sodelovalnega procesa spremljanja klienta. Klientova izkušnja je torej v središču psihoterapije. Klient je heroj terapije tudi po Duncan idr. (2004), saj je največji ekspert z ne samo pomembnim (Sparks in Duncan, 2018), temveč celo ključnim prispevkom k izidu. Ključna je prilagoditev psihoterapevtske obravnave potrebam, ocenam, zaznavam, doživljanju in drugim individualnim značilnostim ter perspektivam posameznega klienta ter seveda sprotni povratni informaciji. Hooke idr. (2022) izpostavijo vlogo PIO pri prikazu znatnega napredka – klientom samim, bolnišničnemu osebju in agencijam za financiranje. PIO torej konkretizira klientov napredek in olajša prikaz učinkovitosti psihoterapije.

Uvajanje PIO je strateško vprašanje. Pri premagovanju ovir organizacija stoji pred več odločitvami: pripravljene morajo biti na preizkus več različic PIO, da ugotovijo, kateri sistemi najbolje ustrezajo njihovim potrebam, pri tem pa morajo zbirati in kritično upoštevati povratne informacije psihoterapevtov, supervizorjev in klientov o uporabi (Cooper idr., 2021). Vključenost psihoterapevtov izboljša njihov odnos do PIO, ki je pomemben dejavnik uspešnosti uvajanja. Na uspešno uvajanje in morebitno korist za psihoterapevtsko prakso znotraj organizacije lahko vplivajo tudi notranje smernice in načini upravljanja. Aafjes-van Doorn in de Jong (2022) naštejeta koristna vprašanja za psihoterapevte, za katera pa je dobro, da si nanja odgovori tudi organizacija ob razmišljanju o uvajanju PIO: Kaj točno pomeni, da pri psihoterapevtski obravnavi uporabljamo PIO? Kako in kdaj naj klientu predstavimo PIO? Kako pogosto in kdaj naj zbiramo podatke?

Kako se odločiti, kateri sistem PIO in katere meritve uporabiti pri posameznem klientu? Kaj naj storimo, če klient ne izpolni vprašalnika? Kako pogosto, kdaj in s kom moramo pregledovati podatke? Kaj moramo (ali želimo) deliti s klientom: posamezne rezultate, trende skozi čas ali vpogled v celoten sistem PIO? Kako so različni sistemi PIO primerljivi med seboj in ali so vsi enako učinkoviti za vse kliente? Kako lahko supervizor najbolje spremlja podatke PIO naših klientov? Skrbno je potrebno razmisliti tudi o klinični razlagi podatkov, zbranih z meritvami. Ali zmanjšanje simptomov vedno pomeni izboljšanje, in če ne, kako zagotoviti, da se PIO ne uporablja kot orodje za ocenjevanje usposobljenosti in učinkovitosti psihoterapevta? (To je ena od skrbi psihoterapevtov ob uvajanju PIO v organizacijo.)

PIO odpira več metodoloških vprašanj. Ogles idr. (2022) poudarijo, da pri PIO lahko pride do razlik med oceno simptomov in klientovim subjektivnim doživljanjem. Gomez idr. (2022) pa poudarjajo neskladje med klientovim poročanjem o napredku na srečanjih in samoporočanjem v podatkih PIO. Sprašujejo se tudi, ali lahko standardizirane meritve (in katere) ustrezno odražajo klientove izkušnje in napredek. Te morda ne zajamejo informacij, ki bi psihoterapevtom pomagale celostno razumeti klientove razloge za vstop v psihoterapevtski proces, njihovih izkušenj ali psihoterapevtskih ciljev. Več simptomov morda odraža več samozavedanja in ne izboljšanja ali poslabšanja (Knapp in Fingerhut, 2012). Vsa vprašanja v standardiziranem vprašalniku morda v celoti ne ustrezajo klientu - ali se morajo postavke meritve popolnoma ujemati s klientovo situacijo v trenutku merjenja ali pa lahko meritev deluje le kot nekakšen termometer klientovega napredka? (Tilden in Whittaker, 2022). Nekateri psihoterapevti raje uporabljajo daljše, večdimenzionalne meritve, ki zajemajo tudi psihosocialno delovanje in terapevtski odnos, drugi pa krajše, enostavne merske instrumente (primer enopostavčnega instrumenta Gonçalves, v tisku). Ni razloga za uporabo samo enega načina merjenja pri določeni obravnavi. Standardizirane meritve lahko dopolnimo z idiografskimi vprašalniki - po Jensen-Doss idr. (2018) so ti ljubši tako klientom kot psihoterapevtom. In skoraj vsi psihoterapevti, ki so v raziskavi uporabljali standardizirane meritve, so istočasno uporabljali tudi individualizirane.

Ključna tema je tudi vloga PIO v psihoterapevtskem izobraževanju in superviziji. Psihoterapevti bi se morali z uporabo PIO seznaniti že na začetku svoje poklicne poti, v izobraževalnem procesu (npr. Schaffrath idr., 2022). Pomembno je zavedanje ambivalentnih občutkov glede uvajanja PIO, saj odnos psihoterapevtov do PIO napoveduje stopnjo aktivnosti njene uporabe (de Jong idr., 2016). Izkušnje psihoterapevtov s PIO bodo sčasoma zmanjšale zaskrbljenost in nelagodje ob uvajanju in uporabi PIO (Aafjes-van Doorn in de Jong, 2022). Izkušnje

edukantov s PIO v izobraževalnih organizacijah vplivajo na njihovo kasnejšo uporabo PIO (Batty idr., 2013; Unsworth idr., 2012), obenem pa predstavljajo prvi stik s kulturo povratnega informiranja. Fernando in Hulse-Killacky (2005) ter Levine idr. (2017) pa opozarjajo na tveganje, da se psihoterapevti in edukanti začnejo preveč zanašati na podatke PIO pri sprejemanju odločitev. Pripravniki imajo morda na začetku svoje poklicne poti nizko samoučinkovitost, PIO pa se jim lahko zdi objektivna meritev, ki pomirja njihovo negotovost, kako in kdaj ukrepati. Pri tem je ključna supervizija, ki poudari aktivno upoštevanje konteksta ter odprtost za več različnih razlag in multikavzalnost. Aafjes-van Doorn in de Jong (2022) opozarjata, da obstajajo določene pomanjkljivosti mnogih študij primerov, ki izpostavljajo potencialne koristi uporabe PIO. Npr. raziskave ne pojasnijo, kako je psihoterapevt delil rezultate PIO s klienti, ravno tako vse ne obrazložijo postopkov usposabljanja in načina izvajanja supervizije s PIO. Kot je pokazal tudi pregled literature (npr. metaanaliza De Jong idr., 2021), je usposabljanje pri uvajanju PIO pomemben moderator učinkovitosti. Glede uporabe PIO v superviziji je nejasno, kako so supervizorji podatke delili, o njih razpravljali in razmišljali, ter tudi, ali so psihoterapevti in/ali klienti lahko sami izbrali uporabo PIO ali pa je bilo to določeno s strani organizacije.

Pomembno je nasloviti tudi tehnološki vidik. Zaradi pandemije COVID-19 se je razširila psihoterapija prek spleta. Nevsiljivo visokokakovostno video snemanje srečanj tako postaja vse bolj običajno, kar je odlična novica za PIO. Znanstveni razvoj in interdisciplinarne raziskave na področju psiholoških znanosti bodo skupaj s strojnim učenjem in umetno inteligenco verjetno kmalu lahko omogočale spremljanje izidov klientov skozi čas na še bolj celovit, natančen in znanstveno veljaven način; v to smer se premika tudi razvoj SNS. V bližnji prihodnosti se morda ne bomo več spraševali, ali uporabljati standardizirane lestvice, temveč bomo lahko iz posnetkov klientovih interakcij ter analizo obrazne mimike ter fizioloških meritev samodejno prejeli povratno informacijo (nekaj podobnega že omogoča prototip Trier Treatment Navigator; Lutz idr., 2024). Seveda pa to ne bo nadomestilo klientovega poročanja o napredku. Pomembnejša od načina merjenja in tehnoloških rešitev je korist pridobljenih informacij za klienta.

5. Zaključek

Glede na dokazane koristi PIO ni več vprašanje, ALI jo uvesti, temveč KAKO to storiti na najboljši način v določenem okolju. Kot kažejo pregledane raziskave, je potrebno razviti boljše načine za navduševanje psihoterapevtov o koristih PIO ter sisteme PIO bolje prilagoditi potrebam in željam psihoterapevtov in klientov. Ravno tako se iz pregleda zdi, da OQ in drugi pogosto uporabljeni

sistemi PIO, kot sta PCOMS in CORE-OM, predstavljajo le začetno različico orodij za spremljanje napredka. Ti sistemi bodo sčasoma zastareli, vendar bo koncept spremljanja napredka in uporabe povratnih informacij zagotovo ostal aktualen. Najnovejši sistemi PIO so minimalno moteči za proces in srečanja, prilagodljivi vsakemu klientu in integrirani v sisteme elektronsko vodene dokumentacije. Poteka tudi intenziven razvoj več novih spletnih orodij PIO z individualiziranimi lestvicami za samoporočanje, ter sistemov, ki združujejo standardizirane meritve z idiografskim prisotopom.

Omenjeni SNS je primer sistema, ki ponuja napredne značilnosti, kot sta možnost prikaza dinamičnih faznih prehodov, ki jih standardizirane meritve sicer ne zaznajo, ter idiografsko spremljanje na osnovi posebnega postopka konceptualizacije primera. Tega soustvarita klient in psihoterapevt. Začneta z določitvijo relevantnih spremenljivk klientovega življenja, nato v asociativnem mrežnem modelu predstavita povezave med najpomembnejšimi značilnostmi klientove težave ter duševnim in socialnim delovanjem, zaključita pa s prevodom te vsebine v postavke idiografskega spletnega vprašalnika, ki ga klient nato dnevno izpolnjuje. Prednost te metode je upoštevanje izbranih kliničnih ciljev ter istočasno zajem kompleksnih vzorcev sprememb. Individualizirane meritve napredka so torej prožnejše od standardiziranih meritev, so bolj osredotočene na za klienta pomembna področja, upoštevajo kontekst ter spodbujajo sodelovanje z aktivnim vključevanjem klientovega pogleda na težave in napredek.

Sistemov PIO je očitno dovolj in vrednost PIO za izboljšanje učinkovitosti in kakovosti oskrbe duševnega zdravja je dobro dokumentirana v raziskovalni literaturi - uporaba v praksi pa le počasi narašča. Na podlagi pregleda raziskav ocenjujemo, da je, tudi zaradi zahtevnega uvajanja v organizacije, ključna ovira pri tem predvsem odpor psihoterapevtov proti uvajanju sprememb.

Kaj pa organizacijam lahko pomaga premagati ovire pri uvajanju PIO? Pregledane raziskave kažejo, da je na prvem mestu podporna in pozitivna organizacijska kultura povratnega informiranja, ki spodbuja EBP in PBE, skupaj z naklonjenostjo nenehnim izboljšavam. Zelo pomembna je posebnostim in potrebam organizacije ustrezna izbira sistema PIO ter premišljena integracija v obstoječe delovne procese, tako tehnološke (npr. elektronski dokumentacijski sistemi), kot tudi strokovne in vsebinske. Usposabljanje in viri so najpomembnejši dejavniki izida pri uvajanju PIO: ustrezno pripravljeno in izvedeno, relevantno in osredotočeno usposabljanje ter stalna podpora psihoterapevtov lahko povečata njihovo zaupanje v PIO (kar sicer ni dovolj ob pomanjkanju drugih spodbud, kot je pokazal pričujoči pregled raziskav).

Kompleksna narava ovir pri uvajanju zahteva natančen premislek, temeljito pripravo ter postopno spreminjanje vedenja na ravni klienta, psihoterapevta in

organizacije. Priporočila za prakso uvajanja PIO vključujejo celostne strategije za izboljšanje kliničnih sposobnosti in motivacije psihoterapevtov, močno organizacijsko vodenje in gojenje kulture povratnega informiranja, ki upoštevajo in se prilagajajo specifičnim lokalnim oviram.

PIO nedvomno zelo poveča učinkovitost psihoterapevtskega dela, manj jasno pa je, kako uspešno uvesti PIO v organizacijo, kako ga najbolj koristno uporabljati ter kako interpretirati pridobljene podatke. Potrebo po PIO lahko delno določajo strokovne smernice, organizacijski interesi in nacionalne politike, a ne glede na kontekst obravnave obstajajo številne klinične odločitve, ki jih mora posamezen psihoterapevt pri uporabi PIO skrbno pretehtati. Zgodbe o uspehu s PIO so uporabno gradivo za pripravo na proces uvajanja PIO, manjkajo pa primeri neuspešnega uvajanja PIO, saj so to lahko dragoceni viri, ki pokažejo, kako se izogniti mnogim v tem pregledu prikazanim oviram.

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