Doubling Therapy Outcomes without Hardly Trying

Scott D. Miller, Ph.D.
Something New

OCTOBER 8, 2014 BY SCOTTM — LEAVE A COMMENT

ICCE is the largest, worldwide, community

http://twitter.com/scott_dm

http://www.linkedin.com/in/scottdmphd
The International Center for Clinical Excellence (ICCE) is a world-wide community of practitioners, healthcare managers, educators and researchers dedicated to promoting excellence in behavioral healthcare services.

Connect to your peers
Find and connect with practitioners or healthcare managers working in your area of expertise who are sharing articles and videos and providing real-time support for challenging clinical situations.

Learn from the best
Receive support about your most challenging clinical situations with peers around the world. Access video instruction addressing every aspect of clinical practice from a select group of international practitioners.

Share with the community
Practitioner-generated content is the heart of the ICCE community. Peers helping and supporting each other with the most highly rated content rising to the top.

Join ICCE
Be a member of the fastest growing online clinical community for mental health and behavioral health clinicians in the world. Required fields are marked with ●.

First name ● Last name ● Email address ● Request invite
“Accountability,” “Stewardship,” & “Return on Investment” the buzzwords of the day.

Part of a world wide trend not specific to mental health and independent of any particular type of reimbursement system.

Question #1:
Research consistently shows that treatment works

True
Study after study, and studies of studies show the average treated client is better off than 80% of the untreated sample.
Effect size of therapy

## Making Treatment Count: The Data

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Effect Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychotherapy</td>
<td>.8 - 1.2 σ</td>
</tr>
<tr>
<td>Marital therapy</td>
<td>.8</td>
</tr>
<tr>
<td>Bypass surgery</td>
<td>.8 σ</td>
</tr>
<tr>
<td>Pharmacotherapy for arthritis</td>
<td>.61 σ</td>
</tr>
<tr>
<td>Family therapy</td>
<td>.58 σ</td>
</tr>
</tbody>
</table>


More good news:
- Research shows that only 1 out of 10 clients on the average clinician’s caseload is not making any progress.

Recent study:
- 6,000+ treatment providers
- 48,000 plus real clients
- Outcomes clinically equivalent to randomized, controlled, clinical trials.

The bottom line?

• The majority of helpers are effective and efficient most of the time.
• Average treated client accounts for only 7% of expenditures.

So, what’s the problem…
Making Treatment Count
The “Bad News”

• Drop out rates average 25%;
• Therapists frequently fail to identify failing cases;
• 1 out of 10 clients accounts for 60-70% of expenditures.


Question #2: False

Stigma, ignorance, denial, and lack of motivation are the most common reasons potential consumers do not seek the help they need.

Second to cost (81%), lack of confidence in the outcome of the service is the primary reason (78%). Fewer than 1 in 5 cite stigma as a concern.

http://www.apa.org/releases/practicepoll_04.html
Making Treatment Count
Pop Quiz

Question #3: Of all the factors affecting treatment outcome, treatment model (technique or programming) is the most potent.

Technique makes the smallest percentage-wise contribution to outcome of any known ingredient.

FALSE
Outcome of Treatment:

- 60% due to “Alliance” ([aka “common factors”] 8%/13%)
- 30% due to “Allegiance” Factors (4%/13%)
- 8% due to model and technique (1/13)

Nonetheless, in spite of the data:
• Therapists firmly believe that the expertness of their techniques leads to successful outcomes;
• The field as a whole is continuing to embrace the medical model.
  • Emphasis on so-called, “empirically supported treatments” or “evidence based practice.”
• Embracing the notion of diagnostic groups.

• Research on the alliance reflected in over 1100 research findings.

Making Treatment Count
An Example

Cannabis Youth Treatment (CYT)
Randomized Field Experiment

Michael Dennis, Ph.D.,
Susan H. Godley, Rh.D.,
Guy S. Diamond, Ph.D.,
Frank M. Tims, Ph.D.,
Thomas Babor, Ph.D.,
Jean Donaldson, M.A.,
Howard Liddle, Ed.D.,
Janet C. Titus, Ph.D.,
Yifrah Kaminer, M.D.,
Charles Webb, Ph.D.,
Nancy Hamilton, M.P.A.,
and the CYT steering committee


Making Treatment Count
An Example

• 600 Adolescents marijuana users:
  • Between the ages of 12-15;
  • Rated as or more severe than adolescents seen in routine clinical practice settings;
  • Significant co-morbidity (3 to 12 problems [83%], alcohol [37%]; internalizing [25%], externalizing [61%]).

• Participants randomized into one of two arms (dose, type) and one of three types of treatment in each arm:
  • Dose arm: MET+CBT (5 wks), MET+CBT (12 wks), Family Support Network (12 wks)+MET+CBT;
  • Type arm: MET/CBT (5 wks), ACRT (12 weeks), MDFT (12 wks).
Making Treatment Count
An Example

Cannabis Youth Treatment Project

• Treatment approach accounted for little more than 0% of the variance in outcome.

• By contrast, ratings of the alliance predicted:
  • Premature drop-out;
  • Substance abuse and dependency symptoms post-treatment, and cannabis use at 3 and 6 month follow-up.

Question #4: Research shows that some treatment approaches are **more effective** than others.

**FALSE**

*All* approaches work equally well with some of the people some of the time.
Making Treatment Count
An Example

• The research says, “NO!”
• The lack of difference cannot be attributed to:
  • Research design;
  • Time of measurement;
  • Year of publication;
• The differences which have been found:
  • Do not exceed what would be expected by chance;
  • At most account for 1% of the variance.

Meta-analysis of all studies published between 1980-2006 comparing bona fide treatments for children with ADHD, conduct disorder, anxiety, or depression:

- No difference in outcome between approaches intended to be therapeutic;
- Researcher allegiance accounted for 100% of variance in effects.

Making Treatment Count
Do Treatments vary in Efficacy?

- Meta-analysis of all studies published between 1960-2007 comparing bona fide treatments for alcohol abuse and dependence:
  - No difference in outcome between approaches intended to be therapeutic;
  - Approaches varied from CBT, 12 steps, Relapse prevention, & PDT.
  - Researcher allegiance accounted for 100% of variance in effects.

• Meta-analysis of all studies published between 1989-Present comparing bona fide treatments for PTSD:

• Approaches included desensitization, hypnotherapy, PD, TTP, EMDR, Stress Inoculation, Exposure, Cognitive, CBT, Present Centered, Prolonged exposure, TFT, Imaginal exposure.

• Unlike earlier studies, controlled for inflated Type 1 error by not categorizing treatments thus eliminating numerous pairwise comparisons;

• The results:

• No difference in outcome between approaches intended to be therapeutic on both direct and indirect measures;

• $D = .00$ (Upper bound E.S = .13)

• NNT = 14;

(14 people would need to be treated with the superior Tx in order to have 1 more success as compared to the “less” effective Tx).

Question #5:
Consumer ratings of the alliance are better predictors of retention and outcome than clinician ratings.

True
Remember the Alamo!
Remember Project MATCH
• The largest study ever conducted on the treatment of problem drinking:
  • Three different treatment approaches studied (CBT, 12-step, and Motivational Interviewing).
  
• **NO difference in outcome between approaches.**

• The client’s rating of the therapeutic alliance the best predictor of:
  • Treatment participation;
  • Drinking behavior during treatment;
  • Drinking at 12-month follow-up.

Question #6:

The bulk of change in successful treatment occurs earlier rather than later.

True

If a particular approach, delivered in a given setting, by a specific provider is going to work, there should measurable improvement in the first six weeks of care.
Making Treatment Count
Project MATCH and Outcome

Last Question!

The best way to insure effective, efficient, ethical and accountable treatment practice is for the field to adopt and enforce:

- Evidence-based practice;
- Quality assurance;
- External management;
- Continuing education requirements;
- Legal protection of trade and terminology.

False
Making Treatment Count
A Tale of Two Solutions...

The Medical Model:
- Diagnosis-driven, “illness model”
- Prescriptive Treatments
- Emphasis on quality and competence
- Cure of “illness”
- Client-directed (Fit)
- Outcome-informed (Effect)
- Emphasis on benefit over need
- Restore real-life functioning

Practice-based Evidence

The Contextual Model

How?
• Formalizing what experienced therapists do on an ongoing basis:
  • Assessing and adjusting fit for maximum effect.
## Making Treatment Count
### Integrating Formal Client Feedback into Care

### The O.R.S

<table>
<thead>
<tr>
<th>Individually:</th>
<th>Interpersonally:</th>
<th>Socially:</th>
<th>Overall:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Personal well-being)</td>
<td>(Family, close relationships)</td>
<td>(Work, School, Friendships)</td>
<td>(General sense of well-being)</td>
</tr>
</tbody>
</table>

### Valid Reliable Feasible

<table>
<thead>
<tr>
<th>Relationship:</th>
<th>Goals and Topics:</th>
<th>Approach or Method:</th>
<th>Overall:</th>
</tr>
</thead>
<tbody>
<tr>
<td>I did not feel heard, understood, and respected</td>
<td>We did not work on or talk about what I felt was important</td>
<td>The therapist's approach is not a good fit for me</td>
<td>Overall, today's session was right for me</td>
</tr>
</tbody>
</table>

### The S.R.S

Download free working copies at: [http://www.scottdmiller.com/](http://www.scottdmiller.com/)
Currently, 20 RCT’s involving 10,000+ clinically, culturally, and economically diverse consumers:

• **Routine outcome monitoring and feedback as much as doubles the “effect size” (reliable and clinically significant change);**
• **Decreases drop-out rates by as much as half;**
• **Decreases deterioration by 33%;**
• **Reduces hospitalizations and shortened length of stay by 66%;**
• **Significantly reduced cost of care (non-feedback groups increased).**

### Shifting from Process to Outcome: Everyone Wins

<table>
<thead>
<tr>
<th>Consumers:</th>
<th>Clinicians:</th>
<th>Payers:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individualized care</td>
<td>Professional autonomy</td>
<td>Accountability</td>
</tr>
<tr>
<td>Needs met in the most effective and efficient manner possible</td>
<td>Ability to tailor treatment to the individual client(s) and local norms</td>
<td>Efficient use of resources</td>
</tr>
<tr>
<td>(value-based purchasing)</td>
<td>Ability to tailor treatment to the individual client(s) and local norms</td>
<td>Better relationships with providers and decreased management costs</td>
</tr>
<tr>
<td>Ability to make an informed choice regarding treatment providers</td>
<td>Elimination of invasive authorization and oversight procedures</td>
<td>Better relationships with providers and decreased management costs</td>
</tr>
<tr>
<td>A continuum of possibilities for meeting care needs</td>
<td>Paperwork and standards that facilitate rather than impede clinical work</td>
<td>Documented return on investment</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Clinical expertise also entails the monitoring of patient progress (and of changes in the patient’s circumstances—e.g., job loss, major illness) that may suggest the need to adjust the treatment (Lambert, Bergin, & Garfield, 2004a). If progress is not proceeding adequately, the psychologist alters or addresses problematic aspects of the treatment (e.g., problems in the therapeutic relationship or in the implementation of the goals of the treatment) as appropriate.

In the Task Force’s recent report (APA, 2006), the following definition for EBPP was set forth: “Evidence-based practice in psychology (EBPP) is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (p. 273; emphasis included in the original text). Regarding the phrase “clinical expertise” in this definition, the Task Force expounded the following (APA, 2006; p. 276-277).

Clinical expertise also entails the monitoring of patient progress (and of changes in the patient’s circumstances—e.g., job loss, major illness) that may suggest the need to adjust the treatment (Lambert, Bergin, & Garfield, 2004a). If progress is not proceeding adequately, the psychologist alters or addresses problematic aspects of the treatment (e.g., problems in the therapeutic relationship or in the implementation of the goals of the treatment) as appropriate.
Are you willing?