Doubling Therapy Outcomes without Hardly Trying

Scott D. Miller, Ph.D.

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OCTOBER 8, 2014 BY SCOTTDM — LEAVE A COMMENT

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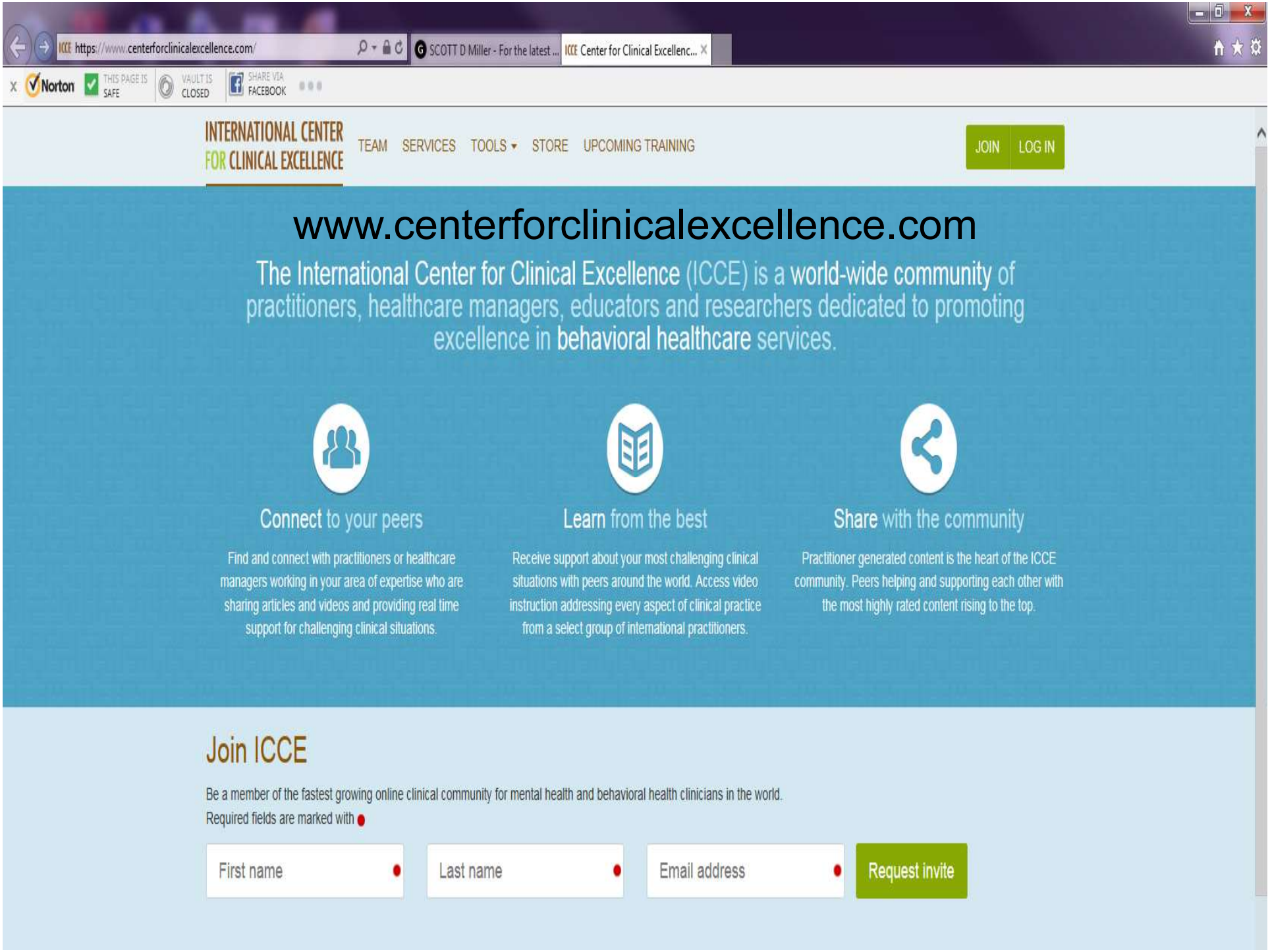
You can scroll through the calendar below to see dates of upcoming ICCE supervision, advanced and implementation training events. For further questions Get in touch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Making Treatment Count

- "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.

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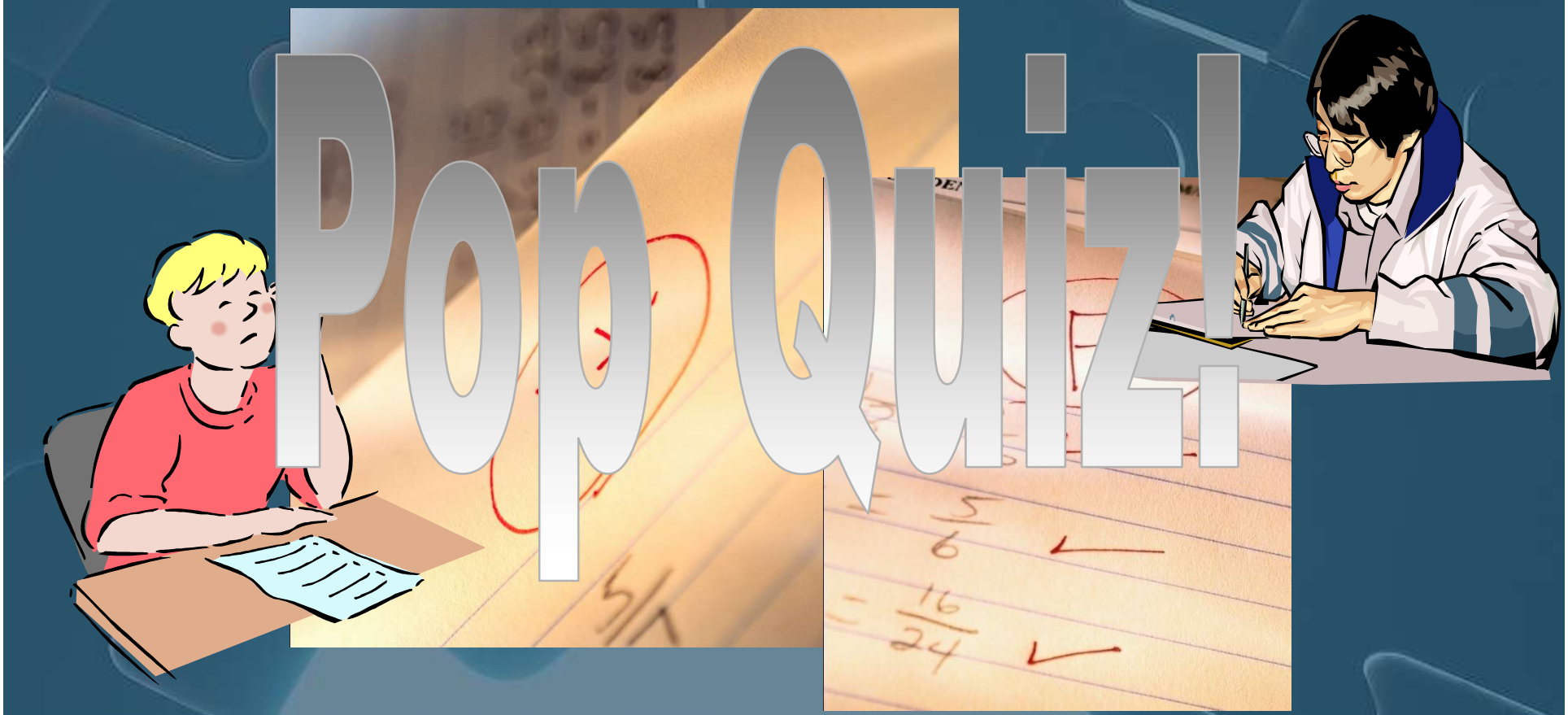
Lambert, M.J., Whipple, J.L., Hawkins, E.J., Vermeersch, D.A., Nielsen, S.L., Smart, D.A. (2004). Is it time for clinicians routinely to track patient outcome: A meta-analysis. Clinical Psychology, *10*, 288-301.

Making Treatment Count



Making Treatment Count:
Pop Quiz

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.

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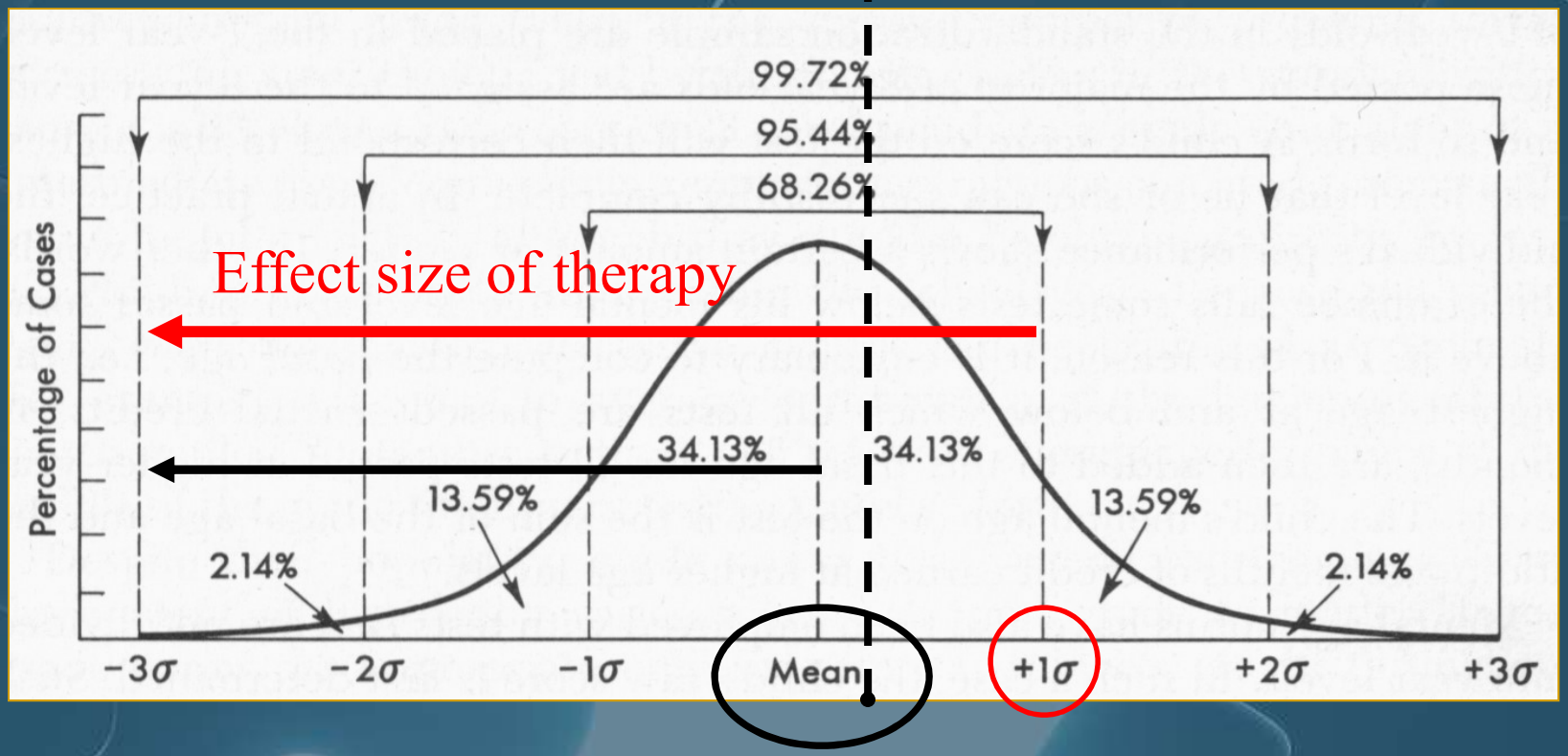
Tutorial on "Effect Size"

Effect size of flouride



Rosenthal, R. (June 1990). How are we doing in soft psychology? *American Psychologist, 45*(6), 775-777.

Duncan, B., Miller, S., Wampold, B., & Hubble, M.A. (2011). *The Heart and Soul of Change* (2nd Ed.). Washington: DC: American Psychological Association.

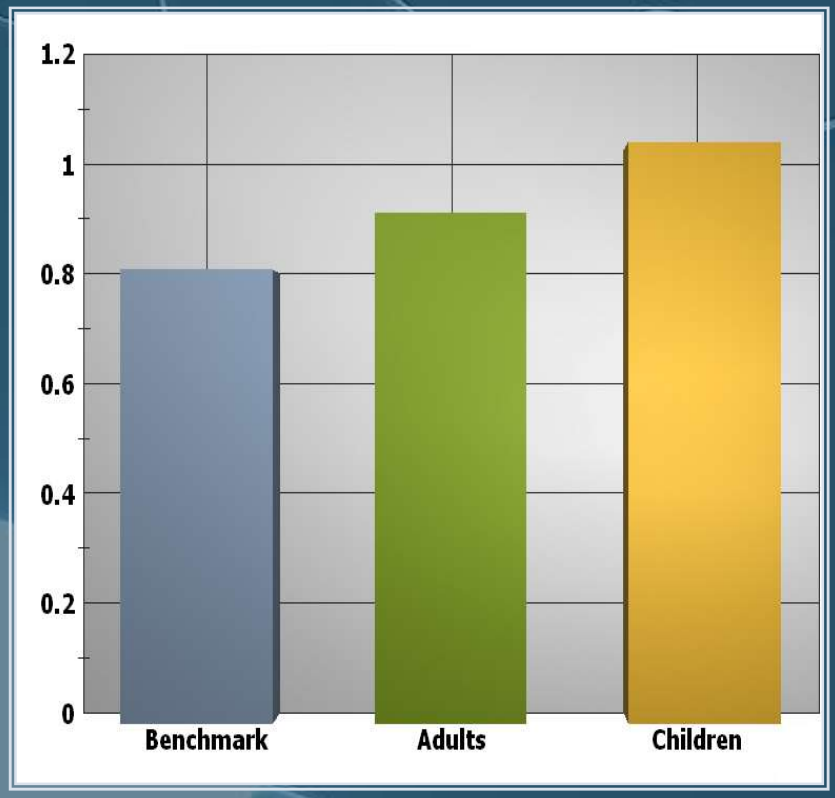
Making Treatment Count:
The Data

Treatment	Effect Size
Psychotherapy	.8 - 1.2 σ
Marital therapy	.8
Bypass surgery	.8 σ
Pharmacotherapy for arthritis	.61 σ
Family therapy	.58 σ

Lipsey, M.W., & Wilson, D.B. (1993). The efficacy of psychological, behavioral, and educational treatment. *American Psychologist, 48,* 1181-1209.
Shadish, W.R., & Baldwin, S.A. (2002). Meta-analysis of MFT interventions. In D.H. Sprenkle (Ed.). Effectiveness research in marriage and family therapy (pp.339-370). Alexandria, VA: AAMFT.

Making Treatment Count
An Example

- 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.



Kendall, P.C., Kipnis, D, & Otto-Salaj, L. (1992). When clients don't progress. *Cognitive Therapy and Research, 16*, 269-281.
Minami, T., Wampold, B., Serlin, R. Hamilton, E., Brown, J., Kircher, J. (2008). Benchmarking the effectiveness of treatment for adult depression in a managed care environment: A preliminary study. *Journal of Consulting and Clinical Psychology, 76(1),* 116-124.
Prescott, D., Maeschalck, C., & Miller, S.D. (eds.) (2017). *Feedback Informed Treatment in Clinical Practice*. Washington, D.C.: APA Press.

Making Treatment Count
The "Good News"

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.

Lambert, M.J., Whipple, J., Hawkins, E., Vermeersch, D., Nielsen, S., & Smart, D. (2004). Is it time for clinicians routinely to track client outcome? A meta-analysis. *Clinical Psychology, 10*, 288-301.

Chasson, G. (2005). Attrition in child treatment. *Psychotherapy Bulletin, 40*(1), 4-7.

Prescott, D., Maeschalck, C., & Miller, S.D. (eds.) (2017). *Feedback Informed Treatment in Clinical Practice*. Washington, D.C.: APA Press.

Making Treatment Count

Pop Quiz

Question #2:

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

False

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.*

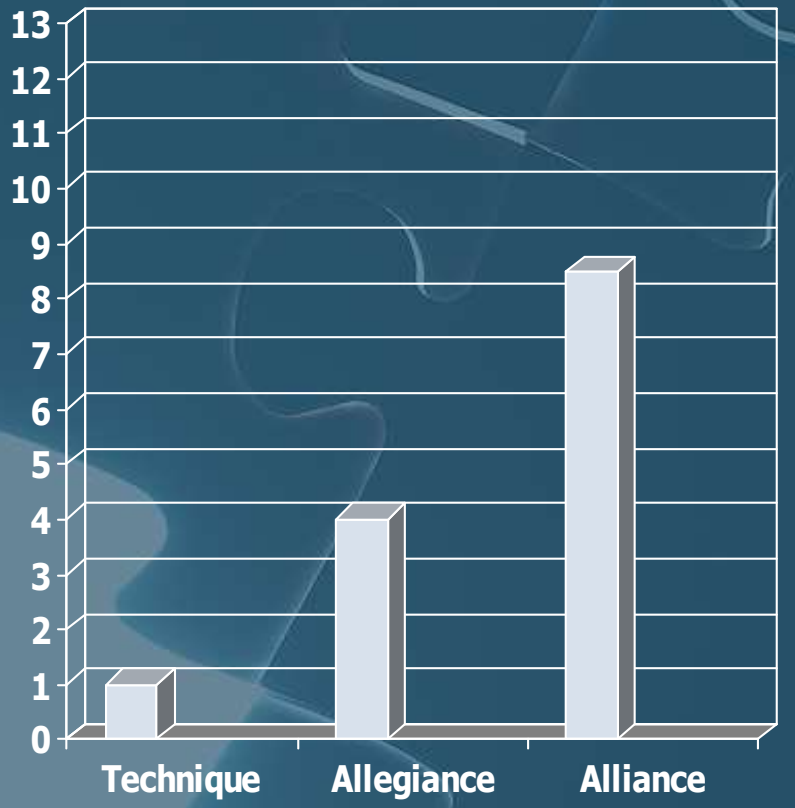
FALSE

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

Making Treatment Count
Factors accounting for Success

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)



Wampold, B., & Imel, Z (2015). *The Great Psychotherapy Debate*. New York: Routledge.

Making Treatment Count

Current State of Clinical Practice

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.

Eugster, S.L. & Wampold, B. (1996). Systematic effects of participants role on the evaluation of the psychotherapy session. *Journal of Consulting and Clinical Psychology, 64*, 1020-1028.

Making Treatment Count
Research on the Alliance

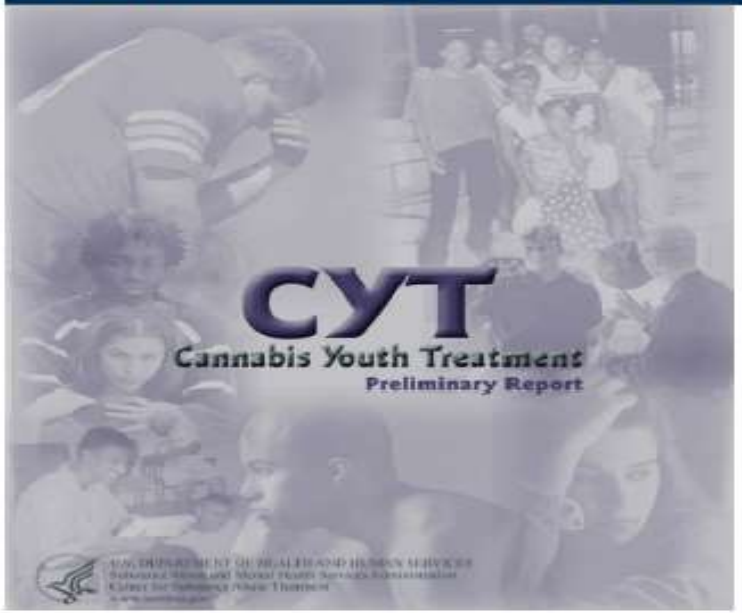
- Research on the alliance reflected in over 1100 research findings.

Client's View of the Therapeutic Relationship

Norcross, J. (2011). The Therapeutic Relationship. In B. Duncan, S. Miller, B. Wampold, & M. Hubble (eds.). *The Heart and Soul of Change* (2nd ed.). Washington, D.C.: APA Press.

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

Presentation in Symposium 64, "State-of-the-Art Adolescent Substance Abuse Prevention and Treatment" at the American Psychiatric Association Annual Conference, Philadelphia, PA, May 18-23, 2002.

Dennis, M. Godley, S., Diamond, G., Tims, F. Babor, T. Donaldson, J., Liddle, H. Titus, J., Kaminer, Y., Webb, C., Hamilton, N., Funk, R. (2004). The cannibas youth treatment (CYT) study: Main findings from two randomized trials. *Journal of Substance Abuse Treatment, 27,* 97– 213.

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

- 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.

Tetzlaff, B., Hahn, J., Godley, S., Godley, M., Diamond, G., & Funk, R. (2005). Working alliance, treatment satisfaction, and post-treatment patterns of use among adolescent substance users. *Psychology of Addictive Behaviors,* 19(2), 199-207.
Shelef, K., Diamond, G., Diamond, G., Liddle. H. (2005). Adolescent and parent alliance and treatment outcome in MDFT. *Journal of Consulting and Clinical Psychology,* 73(4), 689-698.

Making Treatment Count
Pop Quiz

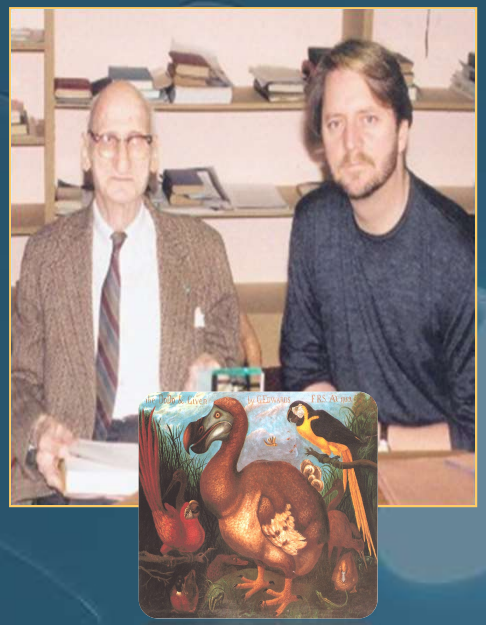
Question #4:

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.

Duncan, B., Miller, S., Wampold, B., & Hubble, M.A. (2011). *The Heart and Soul of Change* (2nd Ed.). Washington: DC: American Psychological Association.

Making Treatment Count
Do Treatments vary in Efficacy?

Psychotherapy Research, January 2008; 18(1): 5–14

Routledge
Taylor & Francis Group

Direct comparisons of treatment modalities for youth disorders: a meta-analysis

SCOTT MILLER[1], BRUCE WAMPOLD[2], & KATELYN VARHELY[3]

[1]*Institute for the Study of Therapeutic Change*, [2]*University of Wisconsin–Madison and*

(Received 7 November 2006; revised 21 May 2007; accepted 23 May 2007)

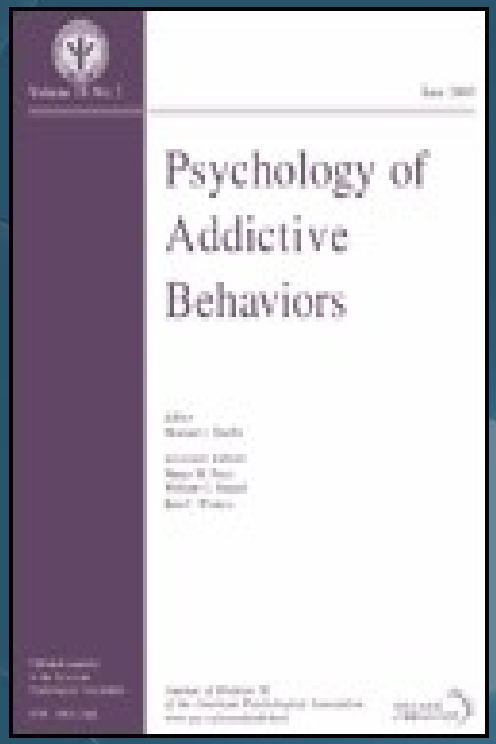
Abstract

A meta-analysis was conducted to determine whether differences in efficacy exist among
youth. Included were all studies published between 1980 and 2005 involving participant
diagnoses of depression, anxiety, conduct disorder, and attention-deficit/hyperactivit
comparisons among two or more treatment methods intended to be therapeutic. Effect siz

- 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.*

Miller, S.D., Wampold, B.E., & Varhely, K. (2008). Direct comparisons of treatment modalities for youth disorders: A meta-analysis. *Psychotherapy Research, 18*(1), 5-14

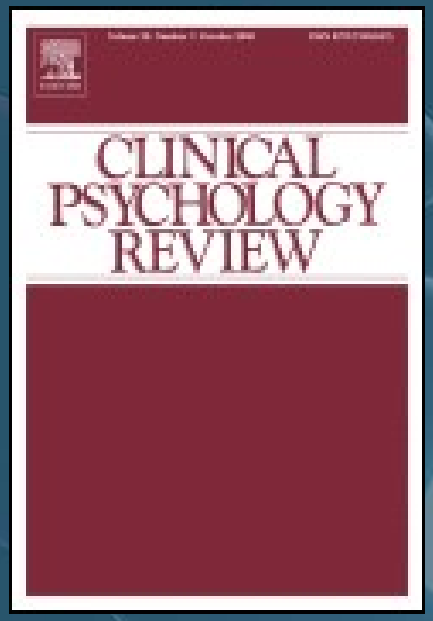
Making Treatment Count
Do Treatments vary in Efficacy?



- 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.*

Imel, Z., Wampold, B.E., Miller, S.& Fleming, R.. (2008). Distinctions without a difference. *Psychology of Addictive Behaviors, 22*(4), 533-543.

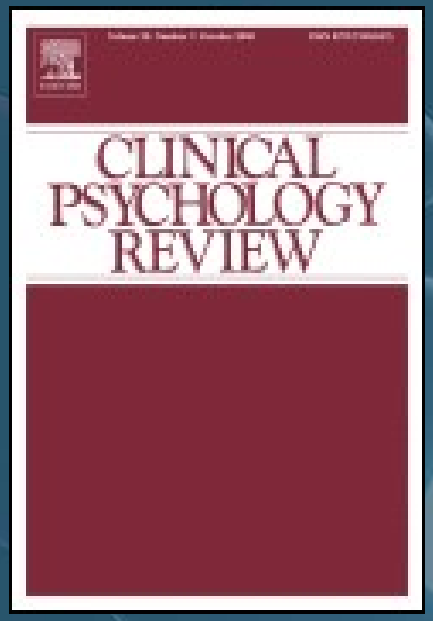
Making Treatment Count
Do Treatments vary in Efficacy?



- 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;*

Bemish, S., Imel, Z., & Wampold, B. (2008). The relative efficacy of bona fide psychotherapies for treating psttraumatic stress disorder: A meta-analysis of direct comparisons. *Clinical Psychology Review, 28,* 746-758.

Making Treatment Count
Do Treatments vary in Efficacy?



- 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).

Bemish, S., Imel, Z., & Wampold, B. (2008). The relative efficacy of bona fide psychotherapies for treating psttraumatic stress disorder: A meta-analysis of direct comparisons. *Clinical Psychology Review, 28,* 746-758.

Making Treatment Count
Pop Quiz

Question #5:

Consumer ratings of the alliance are better predictors of retention and outcome than clinician ratings.

True

~~Remember the Alamo!~~

Remember Project MATCH

Making Treatment Count
Project MATCH and the Alliance

- 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.

Project MATCH Group (1997). Matching alcoholism treatment to client heterogeneity. *Journal of Studies on Alcohol, 58*, 7-29.
Babor, T.F., & Del Boca, F.K. (eds.) (2003). *Treatment matching in Alcoholism.* Cambridge University Press: Cambridge, UK.
Connors, G.J., & Carroll, K.M. (1997). The therapeutic alliance and its relationship to alcoholism treatment participation and outcome. *Journal of Consulting and Clinical Psychology, 65*(4), 588-98.

Making Treatment Count
Pop Quiz

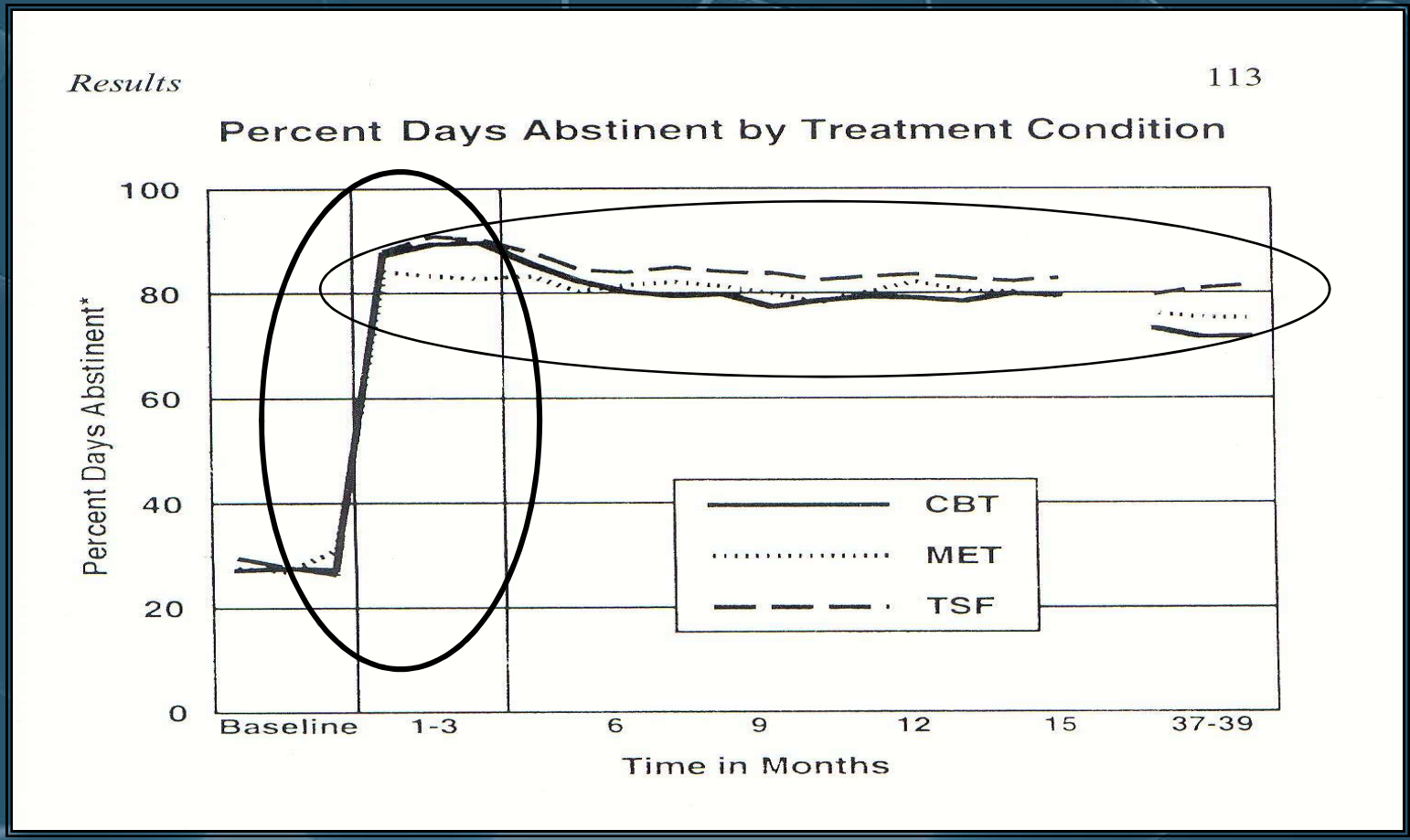
Question #6:

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



Babor, T.F., & DelBoca, F.K. (eds.) (2003). *Treatment Matching in Alcoholism*. United Kingdom: Cambridge, 113.

Making Treatment Count
Pop Quiz

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 [illegible] and competence
- [illegible] "illness"

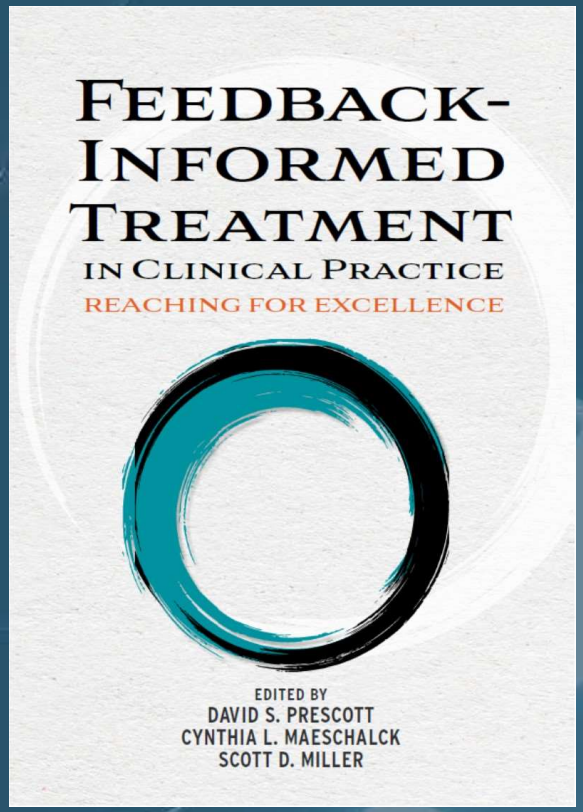
HOW?

The [illegible]

Practice-based Evidence

- Client-directed (Fit)
- Outcome-informed (Effect)
- Emphasis on benefit over need
- Restore real-life functioning

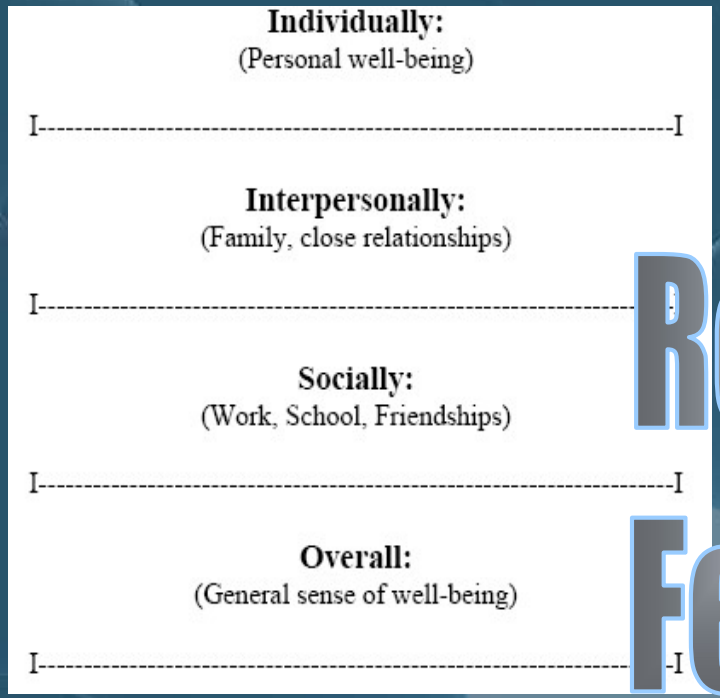
Making Treatment Count
First Step



- Formalizing what experienced therapists do on an ongoing basis:
  - *Assessing and adjusting fit for maximum effect*.

Making Treatment Count

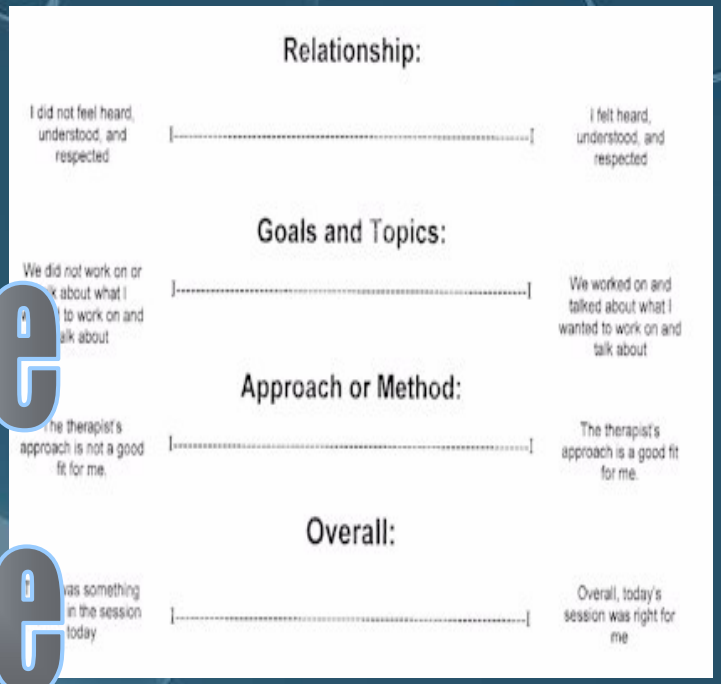
Integrating Formal Client Feedback into Care



Valid

Reliable

Feasible



The O.R.S

The S.R.S

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Making Treatment Count

Integrating Formal Client Feedback into Care

- 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).*

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Miller, S.D., & Schuckard, E. (2016). Psychometrics of the ORS and SRS. Results from RCT's and meta-analyses of routine outcome monitoring and feedback: The available evidence. http://www.slideshare.net/scottdmiller/measures-and-feedback-miller-schuckard-2016

Shifting from Process to Outcome:
Everyone Wins

Consumers:	Clinicians:	Payers:
Individualized care	Professional autonomy	Accountability
Needs met in the most effective and efficient manner possible (value-based purchasing)	Ability to tailor treatment to the individual client(s) and local norms	Efficient use of resources
Ability to make an informed choice regarding treatment providers	Elimination of invasive authorization and oversight procedures	Better relationships with providers and decreased management costs
A continuum of possibilities for meeting care needs	Paperwork and standards that facilitate rather than impede clinical work	Documented return on investment

Making Treatment Count

Integrating Formal Client Feedback into Care

•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.

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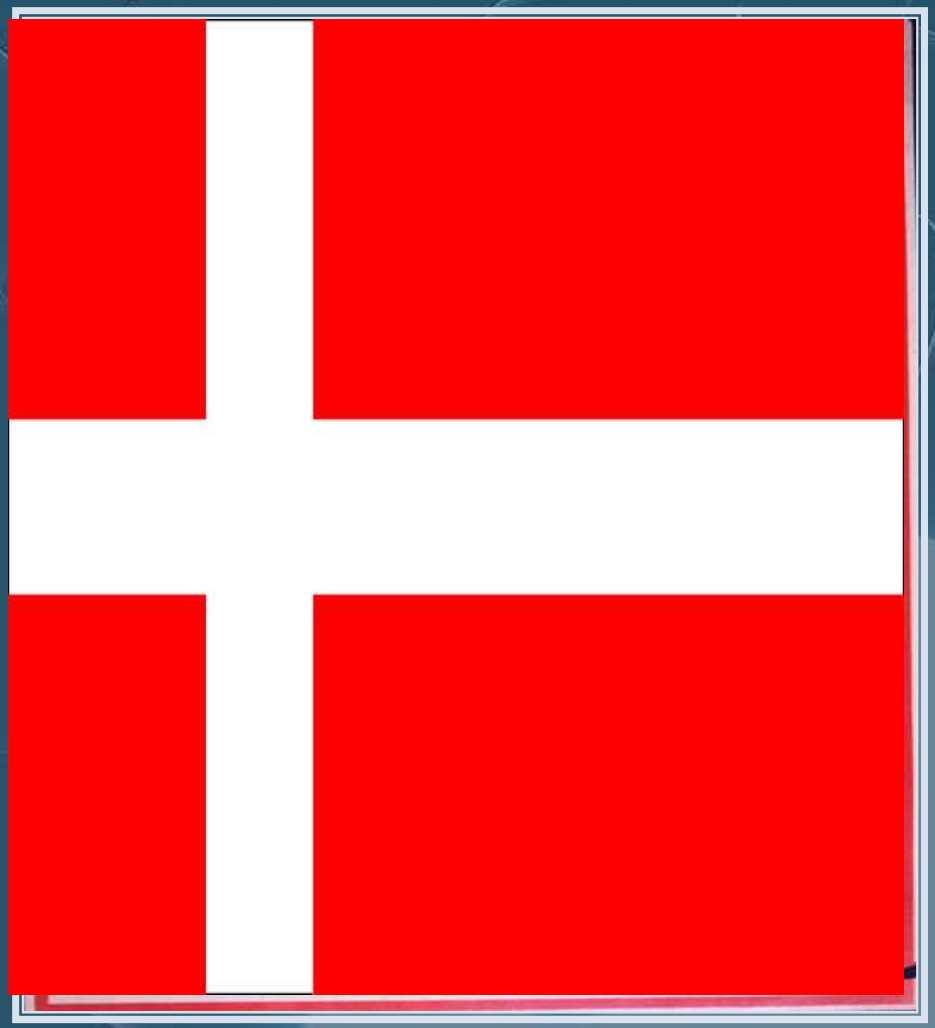
Presidential task force on evidence-based practice. (2006). Evidence-based practice in psychology. *American Psychologist, 61*(4), 271-285.

http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=249

Making Treatment Count

More Research on Feedback



Are you willing?