Snatching Victory from the JAWS of Defeat:
Improving the Effectiveness of your most Challenging Cases

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The “Good News” about Therapy

In most studies of therapy conducted over the last 40 years, the average treated client better off than 80% of the untreated sample.


Effect size of Aspirin

Effect size of therapy

How does “soft” psychotherapy compare?

<table>
<thead>
<tr>
<th>Procedure or Target</th>
<th>Number Needed to Treat (NNT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health (depression in adults or children, aggression, conduct disorder, bulimia, PTSD)</td>
<td>3-7</td>
</tr>
<tr>
<td>Medicine (Acute MI, CHF, Graves Hyperthyroidism, medication treated erectile dysfunction, stages II and III breast cancer, cataract surgery, acute stroke, etc.)</td>
<td>3-7</td>
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*NNT is the number needed to treat in order to prevent one additional negative outcome.

http://www.cebm.utoronto.ca/glossary/nntPrint.html#table
Recent study:
- 6,000+ treatment providers
- 48,000 plus real clients
- Outcomes clinically equivalent to randomized, controlled, clinical trials.

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


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...

Therapists frequently fail to identify “at risk” and failing cases.


The “Bad News” about Therapy
- Average 47% drop out rates accounts for 60-70% of expenditures.

I WANT YOU TO EXPLAIN!
Some Clues to Why we fail

- Study of 6,146 adults seen in real-world clinical practice:
  - Average age of 40
  - Completed an average 6 months of treatment (average sessions = 10)
  - Diagnosis included depression (46.3%), adjustment disorder (30.2%), anxiety (11%), bipolar disorder, PTSD, and other.
  - 581 full-time providers working independently in a networked managed care system:
    - 72.3% female, 27.7% male
    - Average 21 years of experience
    - 30.3% doctoral level, 63.7% master's level, 3.6% medical degrees

Factors widely and traditionally believed to exert strong influence on outcome accounted for little or no variability:
- Client diagnosis after accounting for severity and for case mix (less than 1%)
- Client age and gender (0%)
- Therapist age, experience level, professional degree or certification
- Use of medication
- Within and between therapist regression to the mean

Variability in outcomes between therapists (5-8%) equaled or exceeded the contribution of factors known to exert a significant impact on therapeutic success:
- Quality of the therapeutic alliance (5-8%)
- Alloquence (3-4%)
- Treatment model or method (1%)
- Medication generally helpful only when given by an effective practitioner.
Improving Effectiveness

Evidence-based Practice

- 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

The Medical Model:

Practice-based Evidence

How?

The Contextual Model


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

Improving Effectiveness
40 Years of Empirical Research says...

- Client’s rating of the alliance the best predictor of engagement and outcome.
- The client’s subjective experience of change early in the process the best predictor of success for any particular pairing.

Improving Effectiveness:

- Ongoing, formal client feedback

Cases in which therapists “opted out” of assessing the alliance at the end of a session:
- Two times more likely for the client to drop out;
- Three to four times more likely to have a negative or null outcome.


Improving Effectiveness
Integrating Formal Client Feedback into Care


Percent "recovered"

Improving Effectiveness
Integrating Formal Client Feedback into Care

1. Create a “Culture of feedback”;
2. Integrate alliance and outcome feedback into clinical care;
3. Learn to “fail successfully.”
When scheduling a first appointment, provide a rationale for seeking client feedback regarding outcome:

- Work a little differently;
- If we are going to be helpful should see signs sooner rather than later;
- If our work helps, can continue as long as you like;
- If our work is not helpful, we'll seek consultation (session 3 or 4), and consider a referral (within no later than 8 to 10 visits).

Improving Effectiveness

Step One: Creating a "Culture of Feedback"

- Give at the beginning of the visit;
- Client places a hash mark on the line.
- Each line 10 cm (100 mm) in length.

- Scored to the nearest millimeter.
- Add the four scales together for the total score.
Improving Effectiveness

*When scheduling a first appointment, provide a rationale for seeking client feedback regarding the alliance.*

*Work a little differently;*  
*Want to make sure that you are getting what you need;*  
*Take the "temperature" at the end of each visit;*  
*Feedback is critical to success.*

*Restate the rationale at the beginning of the first session and prior to administering the scale.*
Step One: Creating a "Culture of Feedback"

Improving Effectiveness

Severity Adjusted Effect Size (SAE sample)

First/last alliance

Improving Effectiveness

Step One: Creating a "Culture of Feedback"

Session Rating Scale (SRS V. 3.0)

• Give at the end of session;
• Each line 10 cm in length;
• Score in cm to the nearest mm;
• Discuss with client anytime total score falls below 36
Improving Effectiveness

Step Two: Integrating Feedback into Care

Step Three: Learning to Fail Successfully
Integrating feedback into a flexible continuum of care:

- Treatment contains no fixed content, predetermined lengths of stay or levels of care.
- Instead, a continuum of possibilities is made available to client that includes everything from community resources, natural alliances with family and significant others, to formal treatment and care within healthcare institutions.

Improving Effectiveness

- Higher rates of client dropout or poor or negative treatment outcomes are associated with an absence of improvement in the first handful of visits when the majority of client change occurs.
- Formal feedback provides a structure for reviewing the type, level, and provider of services being offered as well as suggesting alternatives.

Directions for change when you need to change directions:

- What: 1%
- Where: 2-3%
- Who: 5-8%
Improving Effectiveness
Step Two: Integrating Feedback into Care

Collaborative Teaming & Feedback

When?
- At intake;
- "Stuck cases" day;

How?
- Client and/or Therapist peers observe "live" session;
- Each reflects individual understanding of the alliance sought by the client.
- Client feedback about reflections used to shape or reshape service delivery plan.

Improving Effectiveness
Step Two: Integrating Feedback into Care

- SRS Scores are especially important to consider at the first session as the modal number of sessions that people attend is 1!
- Remember: Cases of therapists who opted out of assessing alliance were more likely to drop out and to have a negative or null outcome.
- With scores above 36:
  - Thank client for filling out the form;
  - Display an interest in and openness to feedback.
Improving Effectiveness
Step Two: Integrating Feedback into Care

After the first session:

• Beware of “condemnation with faint praise.” Even a one-point decrease can signal a change in the alliance that can impact the outcome;
• At the same time, be cautious about making changes to the alliance when ORS scores indicate that the client is improving;
• If ORS scores are unchanged or decreasing, and the SRS falls even a single point (whether below 36 or not), address the problems in the alliance before ending the session.
• If ORS scores remain unchanged or continue to decrease in the third or subsequent visits, inquire about the alliance regardless of SRS scores.

Improving Effectiveness

That’s all folks!