More Must Be Better, Right?: Quality and Outcomes in Behavioral Healthcare

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6:00-6:30PM

Statistics Anyone?

- In 1993, the direct costs of treatment of mental illness and substance abuse to Americans amounted to approximately $80 billion (Patricelli and Lee, 1996).

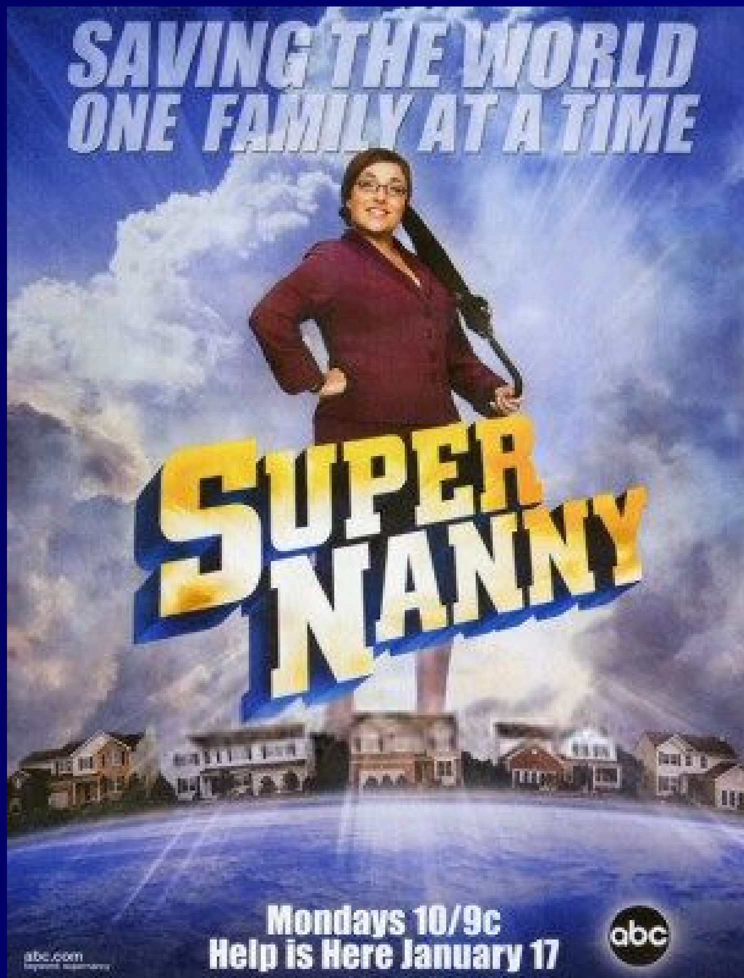
- "American businesses spend $46 billion on depression alone, when the cost of treatment, wage replacement, work site injuries, and productivity diminution are factored in" (Patricelli and Lee, 1996, p. 325).

- The direct and indirect societal costs of mental illness and substance abuse for 1992 have been estimated at $370.4 billion compared to cancer ($104 billion), respiratory disease ($99 billion), AIDS ($66 billion) and coronary heart disease ($43 billion) (Dixon, 1997b).

The Erosion of Mental Health—Is the "Disease" Spreading?

- The number of categories of the American Psychiatric Association's jumped from sixty-six in the first edition (1952) to well over three hundred in its current rendition.
- Witness recent reports (for example, the presidents New Freedom Commission of Mental Health) suggesting that 30 percent of adults and 20 percent of children suffer from a diagnosable mental disorder (Holloway, 2003).

Or are we overlooking the obvious?



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The Quantity of Services Consumed

- Regardless of theoretical approach and treatment setting, the average length of stay for outpatient psychotherapy appears to be between 4 to 6 visits with a mode of 1 visit (Richardson & Austad, 1991).

- The following numbers reported by Frank & McGuire (1995) are based on data from the Center for Mental Health Services and MEDSTAT:
  - (a) 0.2 percent of an insured population stays for more than 30 days inpatient,
  - (b) 0.16 percent stay between 20-30 days,
  - (c) 0.45 percent use more than 25 OP visits, and (d) 84 percent of those who use more than 25 OP visits use no inpatient care.

Quantity is Not Always Quality

- The following quote from Boyle (1996) illustrates the confusion that some clinicians and the public at large may have regarding issues of quality and quantity:

> Sometimes those who critique the quality of managed care's collapse confuse the issue of *quantity* of the care with *quality* of care. Contrary to popular opinion, more service does not necessarily mean better outcomes. More service may actually increase the potential for iatrogenic effects; unneeded inpatient care might have untoward medical, psychological and social consequences (p. 447).

Revisioning Treatment

- Clearly the trend in managed care is toward one of an episodic approach rather than a continuous approach to patient care where “psychotherapy is [seen] as a process that occurs in pieces over time” (Schreter, 1993, p. 326).
- In this model, the patient returns to treatment periodically to conquer new obstacles or when “ having difficulty negotiating emotional crises and developmental transitions” (Stern, 1993, p. 172).
- In such a system, short-term goals are identified, and, when completed, treatment ceases.
- Long-term characterlogical changes are beyond the realm of this system.

Moving Out (patient)

- Hospitals are no longer the preferred location for treatment beyond that necessary for stabilization of the patient to a level where they can tolerate a less structured environment without being dangerous to themselves or others.
- All too often patients who appear to have the strengths and skills necessary to live a life outside of institutions seem to become victims of the system that is meant to protect their welfare.
- The preference for outpatient forms of treatment seems to be supported by Lowman's (1991) summary of the literature which concluded that inpatient psychiatric and substance abuse treatment is generally no more efficacious than outpatient treatment.

The All Too Often Ignored Medical Cost Offset

- Hudson & DeVito (1994) summarize the result of several studies that indicate the existence of a savings in general medical expenses resultant from the provision of psychotherapeutic services. This savings is often referred to as the **medical offset** (Fiedler, 1989; Karon, 1995; Fraser, 1996).
- Of the millions of patients who present to primary care physicians for symptoms attributable to a psychiatric disorder or substance abuse problem, some will see as many as ten different doctors before they receive a correct diagnosis (Slay & Glazer, 1995).
- "50 to 70% of usual visits to primary care physicians are for medical complaints that stem from psychological factors" (APA Practice Directorate, 1996a). Similarly, 60 to 90 percent of patients seen by primary care doctors suffer from symptoms attributable to "stress and lifestyle habits" (Slay & Glazer, 1995, p. 1119).

Examples of the Medical Offset

- The medical literature is replete with examples of the medical offset resultant from providing mental health services to those in need of these services. A few examples will illustrate the point (APA Practice Directorate, n.d., a).
  - One study of 300 veterans who were psychiatric patients as well as high utilizers of the health systems showed a reduction from 5.5 to 3.5 annual outpatient visits following brief mental health treatment while a control group receiving no mental health benefit actually increased utilization of the health system.
  - Another study of 10,000 Aetna enrollees showed a health care savings of 33 percent per person per year two years after the introduction of mental health treatment.
  - A comparison of 20,000 participants in one health plan in Maryland showed that untreated mentally ill patients increased medical utilization by 61 percent while a group who received mental health treatment increased their utilization by only 11 percent during the same one year period.
  - Within the quickly growing elderly population, the availability of mental health treatment provided a reduction of an average of 12 inpatient days per year.

Quality of Life Too

- When measuring the actual cost effectiveness of psychotherapeutic interventions, the costs of implementing these procedures must be weighed not only against projected savings in inpatient and medical costs but also against measures of loss of wages, productivity, and quality of life (Gabbard, Lazar, Hornberger, and Spiegel, 1997).
- When these components are all considered, psychotherapy proves to be a cost effective and valuable product.

What Doesn't Work: The Medical Model Equation

Diagnosis

+

Prescriptive Treatment

=

Cure or Symptom Amelioration

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Fitting a Square Peg Into a Round Hole

- This focus may result in an overly reductionistic search for the microcausative factor involved in each mental disease (Engel,1977; Wyatt & Livson, 1994).
- The medical model fosters an underlying belief that the only "real" cures or treatments must involve chemical or other medically-focused methods (Wyatt & Livson, 1994).
- Third-party payors adhering to this biological bias may provide reimbursement that unfairly favors or provides higher reimbursement for these medical treatment approaches (Boyle, 1996).
- Biolgically-focused treatments fit well with the "quick-fix" mentality of American culture as well as with the cost containment philosophy of managed care (Arena, 1998).
- Furthermore, a purely organic causation model to mental illness discounts the importance of interpersonal and social factors in determining behavior. Albee (1995) points out that the classification of mental disorders as purely organic or biochemical in cause leads to a tunnel-vision-like approach to treatment and research centering upon finding a better drug or organic approach at the costs of ignoring larger "social pathology" that influences the manifestation of these maladies (p. 206).

Badness of Fit

Data from over forty years of increasingly sophisticated research shows little support for:

- utility of psychiatric diagnosis in either selecting the course or predicting the outcome of therapy (the myth of diagnosis)
- The superiority of any therapeutic approach over any other (the myth of the silver-bullet cure)
- The superiority of pharmacological treatment for emotional complaints (the myth of the magic pill)

(Duncan, Miller, & Sparks, 2004, p. 8).

Diagnostic Dys-Order

- ✓Poor Reliability
- ✓Unknown Validity
- ✓Does not predict LOS or outcome
- ✓Little help in treatment selection
- ✓Surveys consistently find that therapists do not like it or find it useful….And attribution creep

Kirk, S.A., & Kutchins, H. (1992). *The selling of DSM: The rhetoric of science in psychiatry*. New York: Aldine
Duncan, B., Miller, S., & Sparks, J. (2004). The Heroic Client. San Francisco: Jossey-Bass.

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I’m a 296.54, What’s Your Code?

- Diagnosis-based reimbursement encourages the provider to fit or stretch their patient into a diagnostic category that the reviewer will approve and reimburse (Pipal, 1995; Brown, 1997).

- Diagnoses come and go, each with its time in the spotlight until the MBHO’s utilization reviewer decides that payment is no longer forthcoming for that particular mental ailment. How quickly those patients’ diagnoses change in an effort to keep that funding stream rolling in.

- The ethical concern and possible liability connected to this fudging or over-diagnosis can not be overlooked particularly in light of a national study’s estimate that nearly 50 percent of adults seeking outpatient mental health treatment had no diagnosable condition (Narrow et.al., 1993).

- Diagnosis as a determinate of length of treatment or amenability to treatment is often irrelevant (Luborsky, Diguer, Luborsky, & McLellan, 1993).

Diagnoses Lack Reliability and Validity

- Twenty-some years after the reliability problem has been declared solved (by lowering standards and only comparing general classes), not one major study has replicated the field trials or shown that regular mental health professionals can routinely use the DSM with high reliability (Kutchins & Kirk, 1997).

- Kendell and Zablansky (2003, p. 7), writing in the American Journal of Psychiatry, conclude that at present there is little evidence that most contemporary psychiatric diagnoses are valid, because they are still defined by syndromes that have not been demonstrated to have natural boundaries." They make the significant point that psychiatric symptoms are continuous with normal human experience and do not coalesce into well-defined clusters.

- There is no correlation between diagnosis and outcome nor between diagnosis and length of treatment (Brown et al., 1999; Beutler & Clarkin, 1990).

- Since the 60's, the # of models has grown from 60 to over 400, multiplying like…
- Each claims superiority in conceptualization and outcome

The result is a fragmentation along theoretical and disciplinary lines

Now over 100 so called evidence based treatments--effectiveness not increased in 40 years, and…

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Evaluations of Treatment Models

- With few exceptions, partisan studies originally designed to prove the unique effects of a given model have found no differences—nor has recent meta-analyses.

- Termed, the "Dodo Verdict"

"Everybody has won and all must have prizes."

Rosenzweig, S. (1936). Some implicit common factors in diverse methods in psychotherapy. *Journal of Orthopsychiatry, 6*, 412-15.
Wampold, B.E. et al. (1997). A meta-analysis of outcome studies comparing bona fide psychotherapies: Empirically, "All must have prizes." *Psychological Bulletin, 122*(3), 203-215.

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What About…

- Evidence Based Practice?

The "Evidence" of Evidence Based Practice

- Must always ask, "Whose evidence is it? and
- "What kind of evidence is it?" (Is it just efficacy over placebo?)

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Cookbook Treatment

- “Concurrently, evidence-based practice has become the buzz word du jour. They represent those treatments that have been shown, through randomized clinical trials, to be efficacious over placebo or no treatment (or in psychiatry’s case, via research review and clinical consensus)” (Duncan, Miller, & Sparks, 2004, p.7).

- Some provider systems resort to “plugging in” patients into “canned” treatment regimes with little or no understanding of the patient as an individual (Mohl, 1996, p. 86).

- Mental illness and substance abuse are too intertwined with the individual’s personality and life situation to be handled by this cookbook mentality. All too often patients are misdiagnosed at the initial intake by poorly trained, inexperienced, bachelor or master level clinicians with inadequate supervision. The appropriateness of subsequent treatment recommendations may be jeopardized by these faulty diagnoses (Arena, 1998).

Allegiance: Whose Evidence Is It?

- Up to 70% of any observed effect is attributable to the belief in (allegiance to) the approach by the researchers
- Even meager differences disappear when researcher allegiance is controlled…

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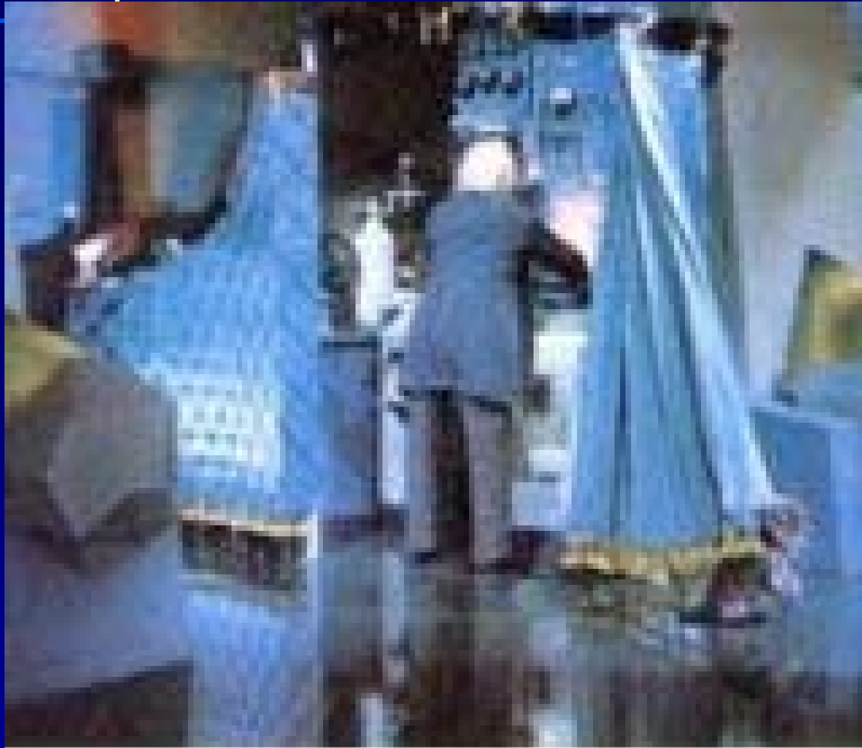
Unfair Comparisons: What Kind of Evidence Is It?

- Is the study really a fair contest?

Conclusion: EBP is a Humbug and Not What It's Cracked Up To Be



"Pay no attention to that man behind the curtain!"

- The assumption that specific techniques result in client change is not supported by the evidence.

- EBP offers choices for clients—but are merely lenses to try that may or may not fit the client's frame and prescription. *Methods and models are neither deity nor demon, but are useful metaphorical accounts of how people can change.*

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Obscures The "Good News" About Therapy

- The average treated client better off than 80% of the untreated sample.
- In the treatment of anxiety and depression, therapy:
  - Is *more* effective;
  - Is *less* expensive;
  - And *more* problem free than medication.

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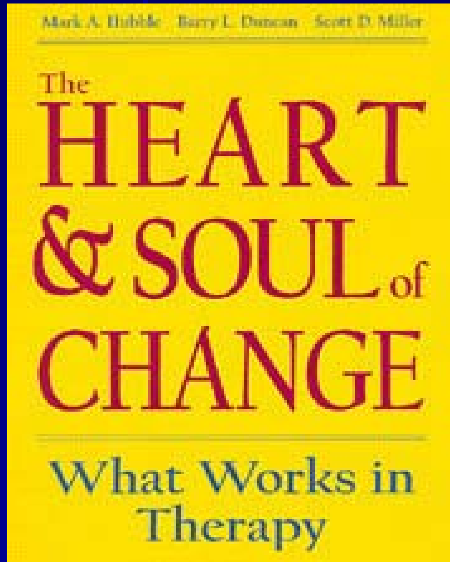
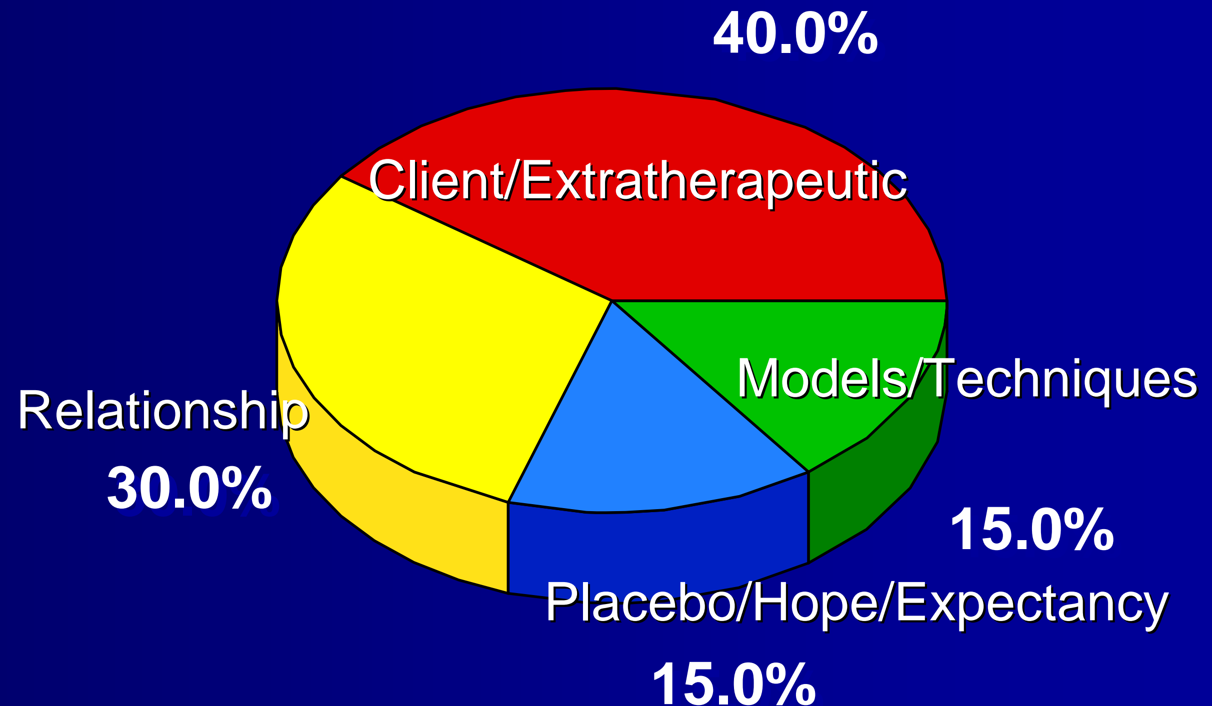
Source: Duncan, B., & Miller, S. (2000). *The Heroic Client*. San Francisco: Jossey-Bass.

Patient/Client/Consumer Centered

- In the quest for acceptance by the scientific community as well as the public, the behavioral sciences seem to have lost touch with a basic tenant upon which these disciplines are grounded—the best interests of the patient must come first.
- Psychotherapy and related treatments centers not on the psychopathology, but on the individual human being who is seeking services.
- The patient must be seen from a holistic perspective that takes into account intrapsychic, social, environmental, as well as biological factors.

The Wheel of Change:
Factors Accounting for Successful Outcome





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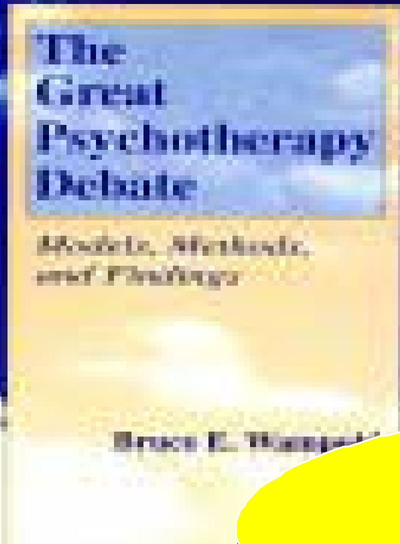
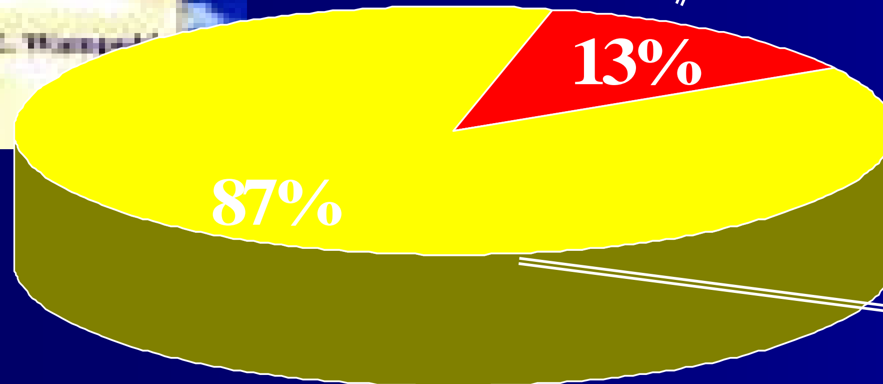
Hubble, M., Duncan, B., & Miller, S. (1999). *The Heart and Soul of Change*. Washington, D.C.: APA Press

Meta-Analytic Research





Treatment:

- 7% due to Alliance factors (or 54% of effects due to tx)
- 1% due to Model and technique (or 8% of effects due to tx)

- Client factors

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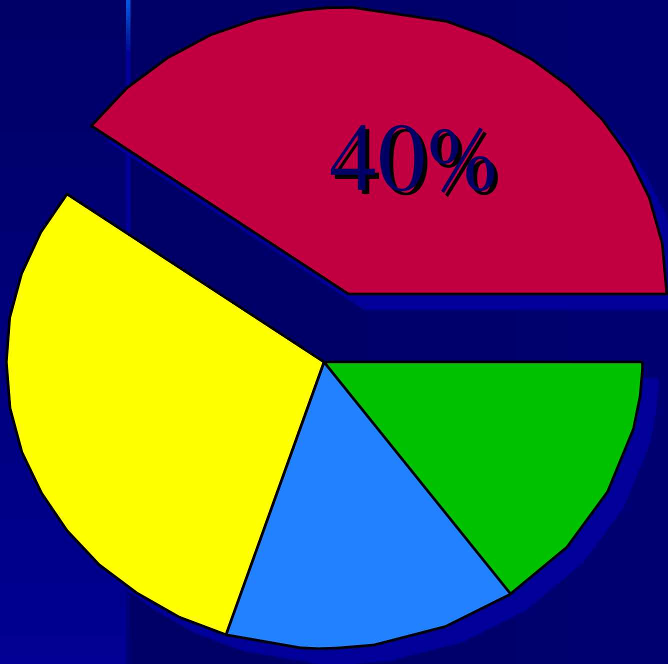
Wampold, B. (2001). *The Great Psychotherapy Debate*. New York: Lawrence Erlbaum.

Client/Extratherapeutic Factors



- Part of the client or client's life circumstances that aid in recovery despite formal participation in therapy, including:
  - Strengths and resources;
  - Social/environmental support;
  - Chance events that occur while they happen to be in therapy.

Lambert, M.J. (1992). Implications of outcome research for psychotherapy integration. In J. Norcross & M.R. Goldfried (eds.). *Handbook of Psychotherapy Integration.* New York: Basic.

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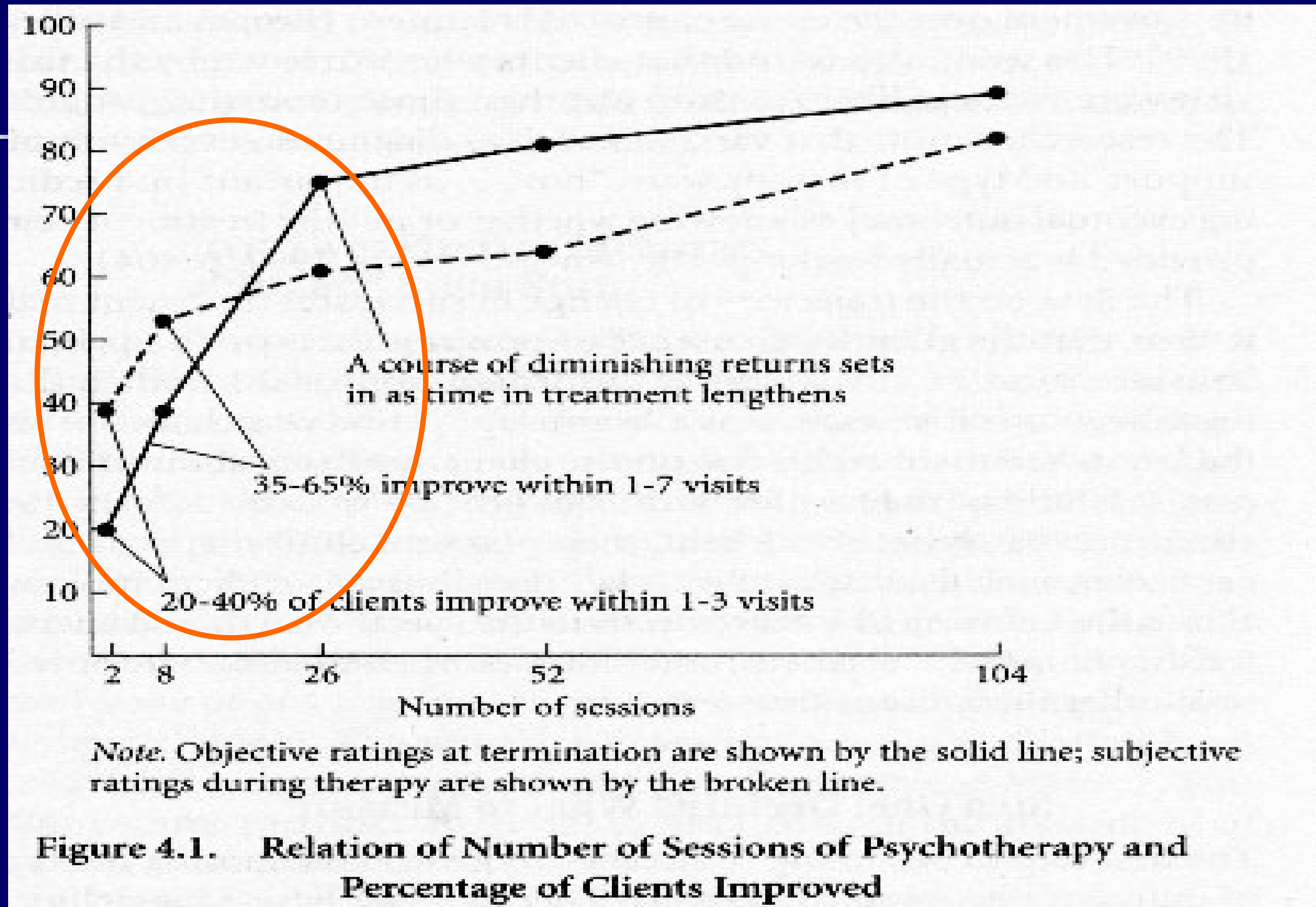
The Call for Outcomes Data

- As managed care companies compile data regarding utilization trends, demographic information, and patient satisfaction, the use of economic credentialing of providers based upon cost effectiveness will become more and more widespread (Petrila, 1996).

- In order to remain active in a preferred provider group, to retain hospital privileges, or to continue to receive referrals from the payor, clinicians will be required to show that their services are cost effective (Arena, 1998).

Change in Treatment



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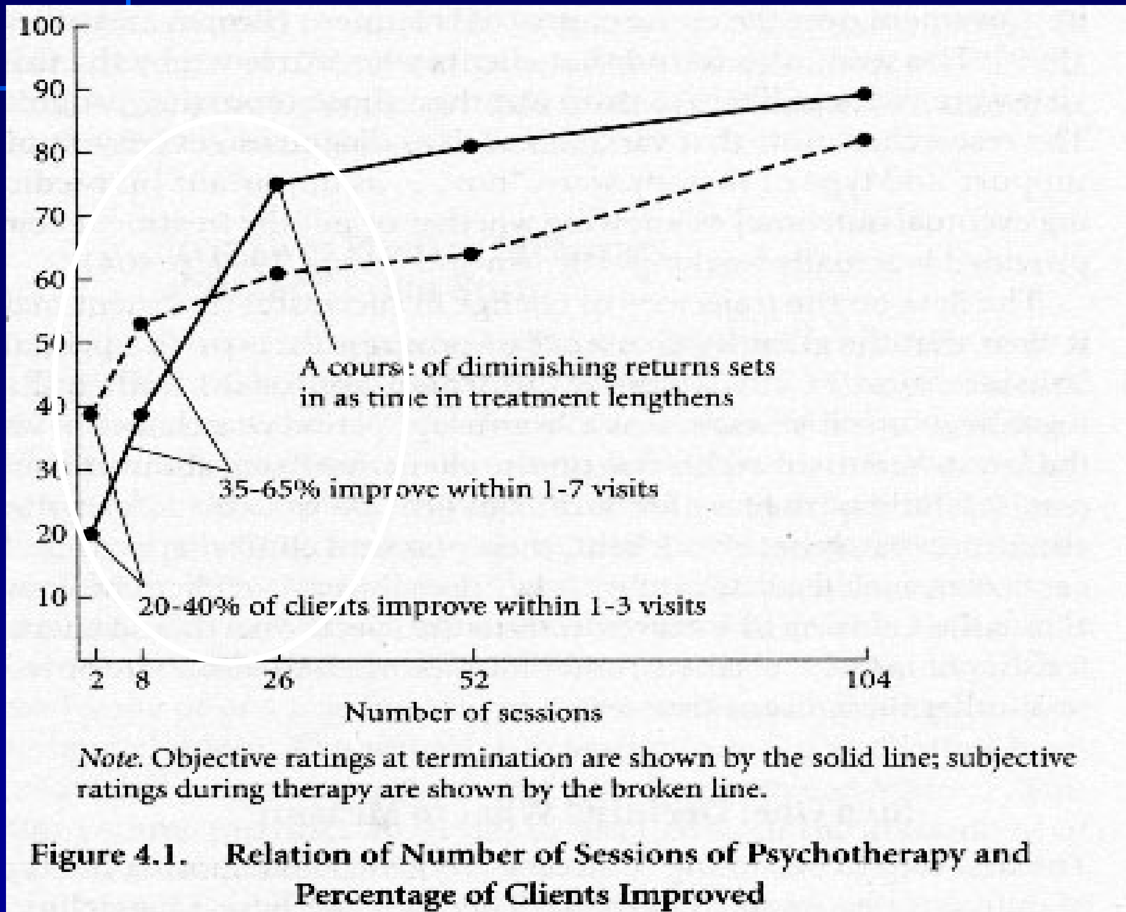
Source: Howard, et al (1986). The dose effect response in psychotherapy. *American Psychologist, 41*(2), 159-164.

When Does Change Happen?



Note. Objective ratings at termination are shown by the solid line; subjective ratings during therapy are shown by the broken line.

Figure 4.1. Relation of Number of Sessions of Psychotherapy and Percentage of Clients Improved

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

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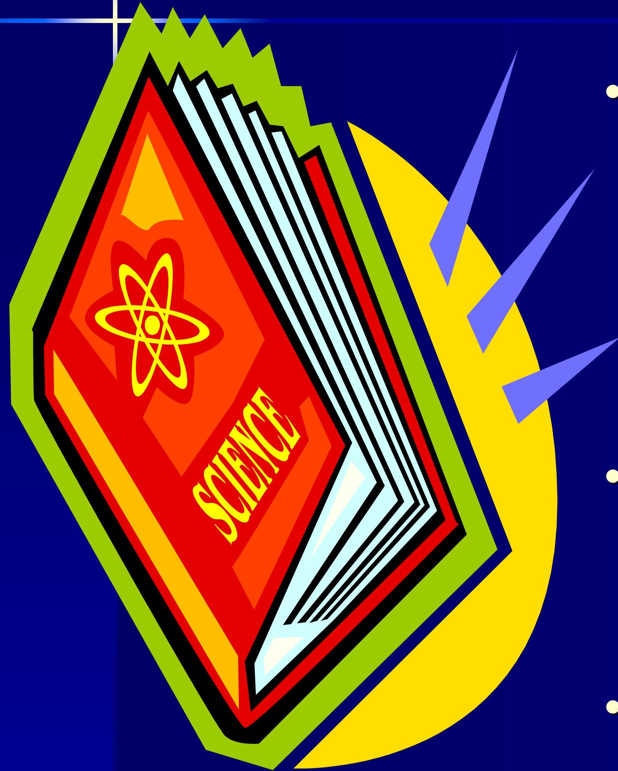
Source: Howard, et al (1986). The dose effect response in psychotherapy. *American Psychologist, 41*(2), 159-164.

Further Support



- In a study of more than 2000 therapists and thousands of clients, Brown found that therapeutic relationships in which no improvement occurred by the third visit did not on average result in improvement over the entire course of treatment.
- Clients who worsened by the third visit were twice as likely to drop out than those reporting progress.
- Variables such as diagnosis, severity, and type of therapy were, "*not* . . . as important [in predicting eventual outcome] as knowing whether or not the treatment being provided [was] actually working."

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Conclusions From This Research

- Feedback about outcome is essential for clinical decision making.
- The diverse approaches in these studies suggests that the type of therapy is of less importance.
- Do not need to know what therapy to use for a given diagnosis as much as whether the current relationship is a good fit and providing benefit, and, if not, to adjust early to maximize the chances of success.
- And the major conclusion that we reached…

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Qualities of a Useful Measure

- Valid
- Reliable
- Feasible

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- A *reliable* measure is one that you can count on.

- A *valid* measure is one that tells you what you need to know.

- A *feasible* measure is one that is user friendly.

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Feasibility

- The average clinician is already overloaded with paperwork--overworked and underpaid.

- Most measures are designed for research.

- Valid and reliable, but complexity, length, and cost render them infeasible.

- Any measure taking more than five
- minutes to complete, score, and
- interpret is not practical.

- Feasibility is as important as reliability and validity.

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Introducing the ORS/SRS: Building A Culture of Feedback and Client Privilege

- Start with the first phone call
- Emphasize importance of client voice and feedback
- Better to know sooner than later
- Continue focus in first session

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The Outcome Rating Scale

Outcome Rating Scale (ORS)

Name ______________________ Age (Yrs):____
ID# ______________________ Sex: M / F
Session # _____ Date: ______________

Looking back over the last week, including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels.

Overall:
(General sense of well-being)

I--I

Individually:
(Personal well-being)

I--I

Interpersonally:
(Family, close relationships)

I--I

Socially:
(Work, School, Friendships)

I--I

- *Client places a mark on the line.*
- *Each line 10 cm in length.*

- *Add the four scales together for the total score.*
- *Give at the beginning of each session or "point of service."*

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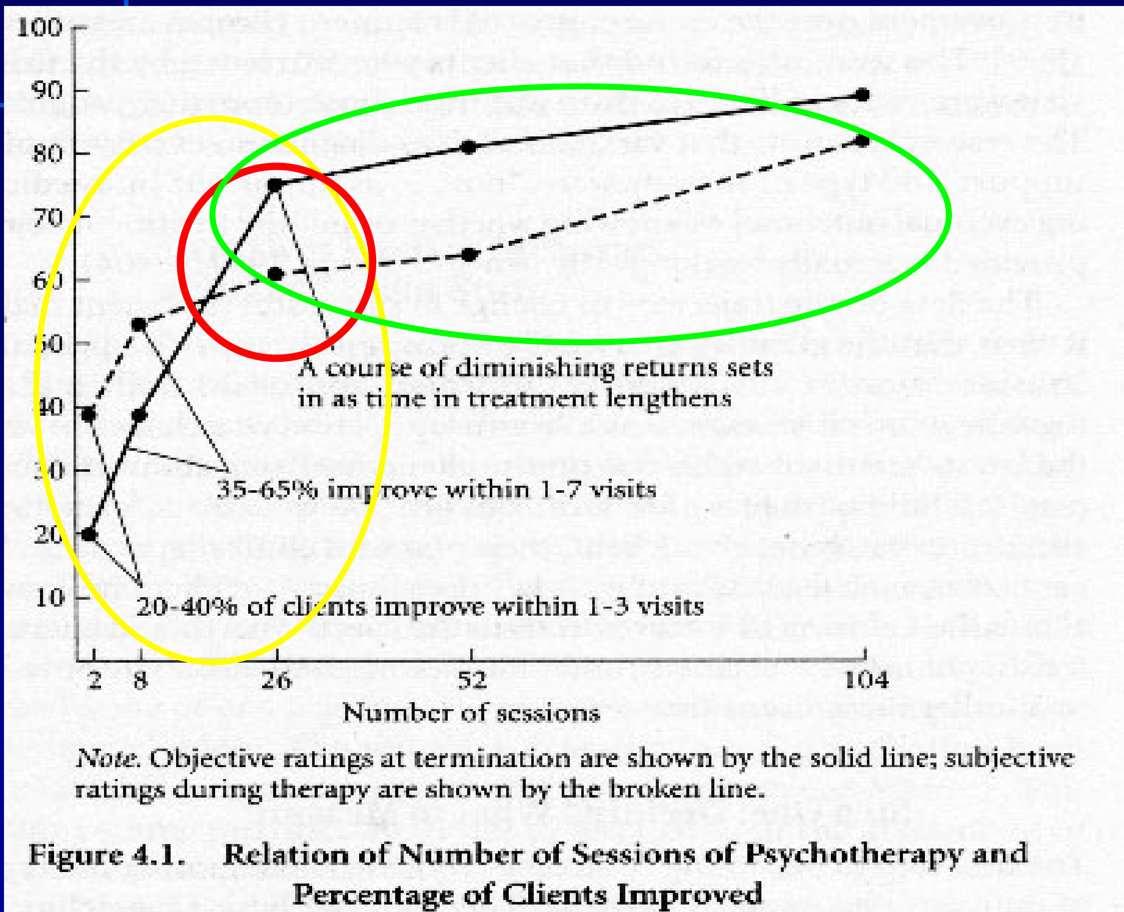
Making the Numbers Count



Note. Objective ratings at termination are shown by the solid line; subjective ratings during therapy are shown by the broken line.

Figure 4.1. Relation of Number of Sessions of Psychotherapy and Percentage of Clients Improved

- See clients *more* frequently when the slope of change is steep.
- Begin to space the visits as the rate of change lessens.
- See clients as long as there is change & they desire to continue.

I.S.T.C.

The Session Rating Scale

Session Rating Scale (SRS V.3.0)

Name ______________________ Age (Yrs):____
ID# ______________________ Sex: M / F
Session # ____ Date: ______________________

Please rate today's session by placing a hash mark on the line nearest to the description that best fits your experience.

- Client places a mark on the line.
- Each line 10 cm length.
- Add the four scales together for the total score.

Relationship:

I did not feel heard, understood, and respected |--------------------| I felt heard, understood, and respected

Goals and Topics:

We did *not* work on or talk about what I wanted to work on and talk about |--------------------| We worked on and talked about what I wanted to work on and talk about

Approach or Method:

The therapist's approach is not a good fit for me. |--------------------| The therapist's approach is a good fit for me.

Overall:

There was something missing in the session today |--------------------| Overall, today's session was right for me

- Give at the end of each session or "point of service."
- Before the client leaves, discuss their responses any time the total score falls at 36 or below.

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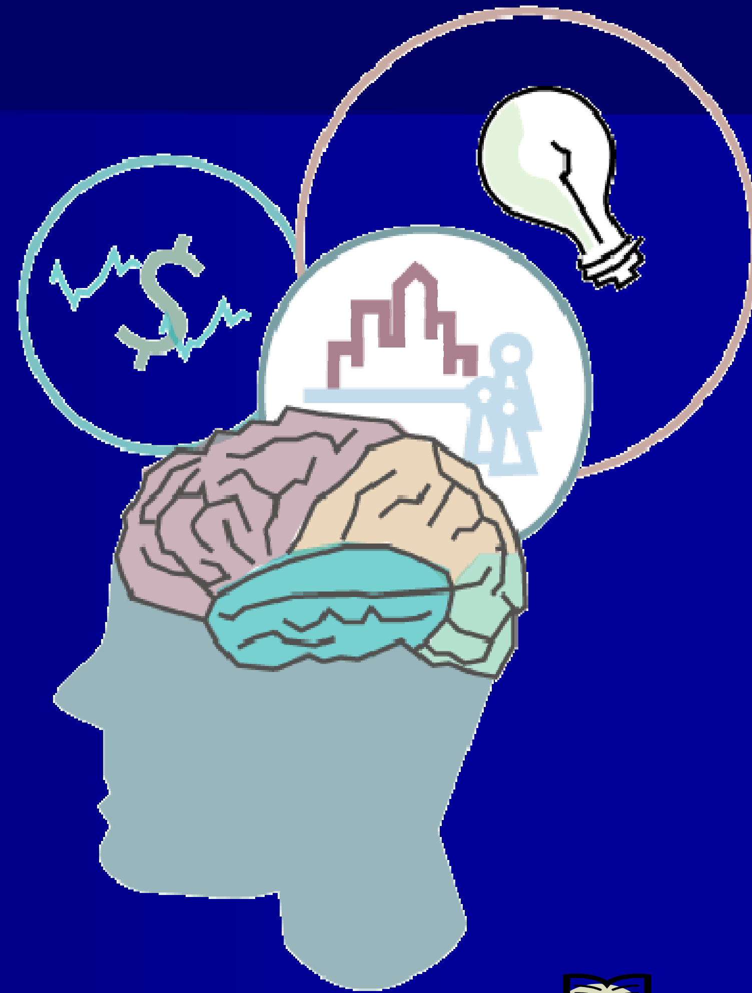
Checkpoint Session: Client not making progress after…

- Be transparent—comment about what the scores mean and seek feedback from the client about what he/she thinks it means
- Go over each item of SRS and discuss
- Brainstorm what should be done next
- Different approach, different venue of service, involve others in support system, change provider, etc…or steady as she goes



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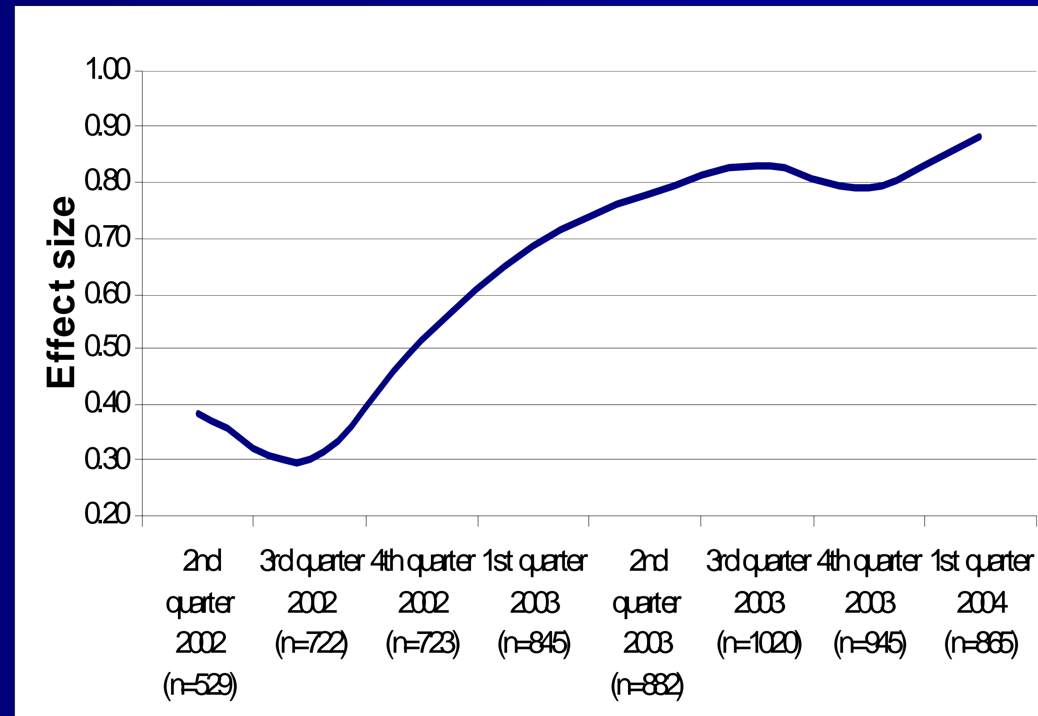
The Benefits of Outcome Management

- One study of 6224 clients, Miller, Duncan, Brown, Sorrell, & Chalk (2004) provided therapists with real-time feedback using the ORS and SRS.

- This "practice-based evidence" resulted in higher retention rates and doubled the overall effect size (baseline ES = .37 v. final phase ES = .79; $\underline{p} < .001$).



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The Revolutionary Benefits

- As incredible as the results may appear, they are entirely consistent with other findings.
- Lambert et al. (2003) reported that those relationships at risk for a negative outcome which received formal feedback were, at the end of therapy, better off than 65% of those without feedback (Average ES = .39,
- $p < .05$).
- Whipple et al. (2003) found that clients whose therapists had access to outcome *and* alliance information were less likely to deteriorate, more likely to stay longer, and *twice as likely* to achieve a clinically significant change.

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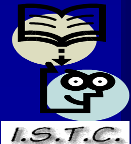
SRS Results so far…

- 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.

- Poor and remains poor predicts negative outcome
- Good and remains good predicts positive outcome
- Poor or fair and improves predicts positive outcome even more
- Good and decreases predicts negative outcome



Miller, S.D., Duncan, B.L., Sorrell, R., & Brown, G.S. (February, 2005). The Partners for Change Outcome Management System. *Journal of Clinical Psychology, 61*(2), 199-208.

The Revolutionary Benefits

- Obtained without any attempt to organize, systematize or control treatment process.
- Neither were the therapists trained in any new modalities, techniques, or diagnostics.
- **Rather the clinicians were completely free to engage their clients in any manner.**
- Availability of formal client feedback provided the only constant in diverse treatment environments

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Effects on Efficiency

- Claude (2004) compared the ave. # of sessions, canc., no shows, and % of long-term cases before and after OM. Sample: 2130 closed cases seen in a public CMHC.
- Ave. # of sessions dropped from 10 to 6, canc. and no show rates were reduced by 40% and 25%, and % of long term cases diminished from 10% to 2%.
- An estimated savings of over $400,000. Such cost savings did not come at the expense of client satisfaction with services—during the same period satisfaction rates improved significantly.

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Prime Providers

- Cummings (1995) defines "prime providers" as:

  Practitioners who … have demonstrated exceptional skills in time-effective therapies … they demonstrate their continued and growing effectiveness by conducting their own outcomes research (p. 11).

Raises Interesting Questions

- Raises questions about training, licensure, reimbursement, and the public welfare.
- Given current standards, it is possible to work an entire career without helping a single person. Who would know?
- Outcome feedback could offer the first protection to consumers and payers.
- Instead of EB therap*ies*, consumers would have access to EB programs and therap*ists*.

I.S.T.C.

Food For Thought

- Therapists have hoped, perhaps, that accommodating the medical model would ensure survival in these tumultuous times of managed care. Complicity, however, merely ensures second-class status for therapists and clients in a climate dominated by the specialized languages of diagnosis and treatment models …The time has come to just say no: no to diagnosis and no to evidence-based treatments. It's time to establish a separate identity, free our adolescent dependence on the medical model, and offer a different equation based in a relational model:

  CLENT RESOURCES AND RESILIENCE +
  CLIENT THEORIES OF CHANGE +
  CLIENT FEEDBACK ABOUT THE FIT AND BENEFIT OF SERVICE

  = CLIENT PERCEPTIONS OF PREFERRED OUTCOMES

  (Duncan, Miller, & Sparks, p. 48).

So I'm Not Crazy?

- Revisioning psychological symptomolgy not as primary disease entities, but as secondary symptoms to primary medical disease and conditions.
- The diagnosis is that of the primary medical condition, thus allowing the patient to seek treatment without the stigma of a psychiatric diagnosis.

Completing the Circle

- Psychologist or masters level professional counselors would appear to be a perfect fit as a member of a disease management team
  - Providing that person to "just listen"
  - Helping provide alternative coping strategies and stress management techniques
  - Helping normalize the psychological symptomology (anxiety, depression, etc.) inherent to chronic medical conditions and medical trauma.
  - Promoting treatment compliance through counseling.

Imagine…

- Imagine clients receiving services based on their feedback; no dx, tx plans, intake forms; no confidential information divulged for payment; or anything else not relevant to outcome.
- Imagine simply submitting outcome data that triggers payment for unlimited meetings as long as clients are benefiting.
- You may say that we are dreamers, but we are not the only ones. These things are already happening.
- Imagine that mental health professionals will not only have proof of effectiveness, but also an identity separate from the medical model.
- It is easy if you try.

I.S.T.C.