The Future of Mental Health:

An Interview with Scott D. Miller, Ph.D.

JIM WALT, M.A.

Scott D. Miller Ph.D., is a co-founder of the Institute for the Study of Therapeutic Change, a private group of clinicians and researchers dedicated to studying "what works" in treatment. He conducts workshops and training in the United States and abroad and is the author of many articles and seven books, including the award-winning *Heart and Soul of Change: What Works in Therapy* (APA, 1999). His most recent works, *The Heroic Client* (2004], and the forthcoming *Making Treatment Count: Outcome-Informed Treatment* (with Michael J. Lambert and Bruce Wampold [LEA Press]), focus on helping therapists improve the effectiveness of their clinical work regardless of preferred therapeutic orientation or professional discipline. The interview was conducted by Jim Walt, M.A. MFT, Professor at John F. Kennedy University, Graduate School of Professional Psychology, Campbell Campus, and current member of the CAMFT board.

J.W.: Scott, welcome. I've had the pleasure of knowing you for about ten years now, first as an author, researcher, and workshop presenter and now as a friend. I've watched your work evolve considerably during that time. Of all you've said and done, written about or published, your current research and writing seems to me to be the most significant.

S.M.: *Thanks Jim.*

J.W.: Your writing and training sessions always seem to be addressing two different levels of clinical practice. The first is the "how to" of therapy. At this level, you are very pragmatic, combing the research literature for information about "what works" and then translating that into skills clinicians can use in their day to day work. I've attended many of your workshops, and this level of the clinical material you present is always enlightening and incredibly entertaining.

S.M.: *Thanks again. I'm a clinician first and foremost...*

J.W.: But, it's the second level that seems far more important in the long term. While you're busy providing therapists with practical strategies for improving their effectiveness, you are also addressing the broader professional context in which they work-in particular the challenges they face staying afloat financially and professionally, and the threats looming on the horizon to the health and well-being of the field as a whole.

S.M.: *Of course. Ideas don't come out of nowhere. So, at the risk of sounding like "Chicken Little," let me tell you a story-a true story, by the way, and one that I believe conveys a mostly silent, but sure-to-be "seismic" shift in the field of mental health.*

J.W.: [Laughing] Be careful of your analogies Scott! Remember, you're speaking here to Californians.

S.M.: *[Laughing]. Ah right! Hmm, and now as you suggest it, maybe in this instance it is a slip of the Freudian variety since, as with earthquakes, most of us aren't aware that anything is afoot until we feel the ground moving under our feet-and by that time, of course, it's too late to do anything other than take cover and hope the worst passes by. In reality, of course, pressures build steadily along fault lines over long periods of time. The good news is that being aware of this gives us the time to prepare for what will eventually happen. And by building stronger, more reliable structures and having a plan,*

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we can better attend to the demands of our daily lives.

J.W.: So, pressures are building along the fault lines of mental-slash-behavioral health?

S.M.: *Yes, and we're "long overdue" as they say in the seismology business. If you think about it, we haven't had a major quake since the advent of managed care over a quarter of a century ago—an event, as every practitioner knows, that fundamentally and irrevocably altered the landscape of clinical practice.*

J.W.: Yes, that was a big one.

S.M.: *In fact, we're still dealing with the aftershocks. Last January, the highly respected* Psychotherapy Finances *released survey results showing that therapists are having a much harder time earning their previous levels of income.*

J.W.: If I recall that survey correctly, the flagging fortunes of the profession follow a decade (1990-2000) of no real growth in incomes.

S.M.: *That's right, and we can't count on the self-pay market to make up the difference either, as the same survey showed the percentage of self-pay clients, on the average clinician's caseload, has dropped off precipitously, from a high of 44 percent in 2000 to just 26 percent in 2006.*

J.W.: Steep.

S.M.: *Are you ready for this? The average social worker, licensed counselor, or marriage and family therapist in private practice is netting around $30,000 per year-that's after expenses but before taxes.*

J.W.: And I guess we can assume that some of those "average" clinicians are part-time, but still I know a lot of therapists who are going to hear that figure and say, "well, that's not true for me…I make much more than that… the 'sky isn't falling.'" How would you respond to them?

S.M: *Well, that brings me back to my story. I was a faculty member at the most recent Evolution of Psychotherapy conference. In addition to presenting a workshop or two, I participated in a number of panel discussions. One addressed the topic, "Psychotherapy: Art or Science?" On that panel were several distinguished and influential people in the field. I knew each speaker, and was not surprised when one strongly advocated for "evidence-based practice." After all, he was one of, if not the primary, architect of the Task Force on the Identification and Dissemination of Psychological procedures—a committee within the American Psychological Association charged with the responsibility of creating the list of "empirically-validated" treatment methods.*

J.W.: So, no surprise there.

The average social worker, licensed counselor, or marriage and family therapist in private practice is netting around $30,000 per year–that's after expenses but before taxes.

S.M.: *No. But, what took me completely by surprise was the reaction of the audience when he predicted that in the future, there would be two payment systems: one funded by insurance companies and the government, that would only pay for a very limited number of specific DSM diagnoses for which an "evidence-based" treatment existed.*

J.W.: And the other?

S.M.: *Self-pay—for everything else. And then, forestalling any chance of misunderstanding, he went on to say what this meant: most of what practicing therapists do and bill for today will not be reimbursable in the future.*

J.W.: And the audience?

S.M.: *Sat there.*

J.W.: You mean they didn't react?

S.M.: *Didn't even flinch. I was stunned. Here's this very influential person—a mover and shaker, as they say—predicting that many, if not most, of the practitioners in the room that day would be out of business in the future—if the ideas and policies he championed continued to guide the field, and they did nothing, they said nothing. A big earthquake was being predicted, and they didn't flinch.*

J.W.: What can the average therapist do really? Most are so busy attending to their clients and trying to make a living that they have little time for anything else, let alone taking on the powers-that-be in their respective professional organizations.

S.M.: *Well, let's talk about that since, interestingly enough, there is something that the average Joe or Jane therapist can do, and without straying very far from what they do best—that is, listening to their clients. The research literature provides overwhelming support for the effectiveness of therapy. The average treated client in most studies published over the last 40 years is better off than 80 percent of those that do not have the benefit of treatment. By the way, such results are not limited to tightly controlled randomized clinical trials but apply to practitioners in real-world settings. A soon-to-be published study examined the outcomes of practicing clinicians (working, for the most part, in California) and found they either met, or exceeded, the outcomes reported in randomized clinical trials. The therapists in the study were a diverse group (professional counselors, psychologists, social workers, marriage and family therapists, and psychiatrists) working in diverse ways (using a variety of approaches) with a diverse population. Unlike most randomized clinical trials, the clients weren't limited to a single diagnosis. Co-morbidity was the rule, not the exception. The bottom line is that most therapists do good work.*

J.W.: OK, so now I can imagine someone reading this, and then scratching their head, wondering, "So if we're already effective, what's all the 'hoopla' about accountability and outcome? Why do we need 'evidence-based' practice?"

S.M.: *Well, two reasons. The first has little*

or nothing to do with the field of mental health per se. Rather, increasingly there is a worldwide interest in and demand for accountability when money is involved. Payers and consumers are demanding evidence of outcomes and "return on investment." And while it's easy to feel picked on, or even singled out as therapists, the truth is that this movement is affecting virtually all businesses (law, investment banking, medicine, and so on). Neither is the movement limited to the American context or commercial payer system. Single payer systems in the U.K., much of Western Europe, and in Canada are also demanding that clinicians provide evidence of effectiveness if they want to be paid.

J.W.: It's not good enough to do good clinical work or to do it in a time sensitive fashion?

S.M.: *Not any more. The days of a simple HCFA 1500 form and treatment plans are rapidly disappearing. Everyone is clamoring for evidence—even clients—and this is the second reason for the popularity for evidence-based practice. Every other year for the last 10 years, the American Psychological Association has surveyed potential consumers of mental health services, asking them in particular to identify the reasons for not going to see a therapist. And every year since 1996, when the survey was first conducted, 76 percent or more of consumers have cited, "lack of confidence in the outcome of the service."*

J.W.: Data from a survey conducted by CAMFT about a year and a half ago reported similar findings: many people question the value of mental health care.

S.M.: *That word you just highlighted "value"—that's an important word. Economists tell us that people estimate the value of something by combining two pieces of information: (1) the outcome or result desired; and, (2) the perceived costs of obtaining that result. And interestingly, the most common reason cited by potential consumers for not going to see a therapist is that it's too costly, and they mean both the actual dollar outlay as well as the time involved in obtaining the service (taking time off work, fighting*

traffic, and so on). Put lack of confidence in the outcome of the service together with the real and perceived costs of going, and many potential consumers simply decide, "It's not worth it. I'll deal with this on my own." Or worse, "I call my primary doc and get a pill."

J.W.: Which I guess would explain why so few people in our culture seek out the help of a therapist.

S.M.: *Yes. And another thing, every year, a study purporting to examine the status of American mental health will get national headlines. It usually goes something like, "A new study says twenty to twenty-five percent of Americans suffer from mental disorder X, Y, or Z, but only five percent get the help they need." Then, of course, the experts are quoted and culprits paraded out, and topping the list are always poor funding, stigma, and ignorance (of consumers). In fact, in the latest APA survey, fewer than one in five potential consumers cited stigma as a major barrier to seeking out a therapist. But the results of the APA and CAMFT surveys, as well as a large study published last year in* Psychology Today*, are very clear: consumers don't utilize our services as often as they might because they question the value of the experience.*

J.W.: And this is, as I said at the outset, the aspect of your work that I find most interesting. You're suggesting that the "evidence-based practice" movement is an attempt to solve the "crisis of confidence" that consumers and payers have about psychotherapy. In essence, the field hopes to claim that practitioners are using methods "shown by science to cure what ails you."

S.M.: *In part, yes, and one that I believe is doomed to fail.*

J.W.: Because?

S.M.: *Because consumers don't care how we work. Neither, the surveys say, do the majority of consumers care if the practitioner is a social worker, psychologist, or marriage and family therapist.*

J.W.: They just want to feel better, to live better, happier lives.

S.M.: *Of course. But as often happens in the marketplace-in-general, competition pushes the makers and sellers of products or services to draw distinctions between their products and others. Branding becomes especially important because the lack of any real or perceived difference between competing products reduces purchasing decisions to a simple matter of cost. And no one wants to compete on cost alone because when the only issue is cost, consumers always think cheaper is better. Think Wal-Mart here.*

J.W.: And so, marriage and family therapists, professional counselors, and clinical social workers peeled off from psychologists who peeled off from psychiatrists, and all are trying to use professional branding as a claim on an increasingly shrinking piece of reimbursement pie.

S.M.: *Yes, in this highly competitive environment the pressure to differentiate is intensified. And please remember, I'm not saying that we therapists don't have something of value to offer. In fact, it is very much the opposite. The research is clear: the majority of people who get treatment are significantly better off as a result. But that's not what we or our professional organizations typically market or "sell" to the broader consumer market. Instead, we promote and sell professional discipline and technology—I do it cognitively, I help families, I repair relationships, I am a doctor, I am a specialist in this or that problem, blah, blah, blah. In other words, we keep acting as if we are in the therapy business—and, frankly, consumers don't care about therapy.*

J.W.: We should be marketing outcomes instead.

S.M.: *That's what consumers care about, that would be truly listening to our clients.*

J.W.: Couldn't one then say, our outcomes as a field would be better if therapists used an "evidence-based practice" versus an approach for which no evidence existed?

S.M.: *Interesting question, but recall the study I cited earlier showing that therapists in real world clinical settings either met or beat results obtained in randomized clinical trials. Also, and more importantly, when the appropriate analyses of the research are done between so-called "evidence-based practices" and any other approach that's intended to be therapeutic—now listen to that—any approach that's intended to be therapeutic, you don't find any difference in outcome between those approaches. I know this can be hard to believe given the current zeitgeist. Unfortunately, at the state and federal oversight level, and for an increasing number of clinicians, it has somehow become "known" that certain treatments work best for clients with certain diagnoses. For people diagnosed with so-called "Borderline Personality Disorder," Dialectical Behavior Therapy is the "best practice" when, in fact, available evidence indicates that it works as well as everything else. We have a meta-analysis currently under review for publication of two and a half decades of research on treatments for childhood disorders (depression, ADHD, conduct disorder and so on) and found…*

The challenge for the practicing clinician is, therefore, not figuring out what approach works for which diagnosis, but what will work for this person sitting with me on this day at this stage in their life.

J.W.: Let me guess-no difference in outcome between the various and competing approaches...

S.M.: *…so long as the approach was intended to be therapeutic. Now, I'm not saying that DBT is not effective or that therapists shouldn't learn about it, or other approaches. Rather, the point here is something that most therapists know intuitively: all approaches work with some people some of the time. The challenge for the practicing clinician is, therefore, not figuring out what approach works for which diagnosis, but what will work for this person sitting with me on this day at this stage in their life.*

J.W.: And in lieu of "evidence-based practice" you and your team suggest what you term "practice-based evidence."

S.M.: *Yes, and this is something that I believe most therapists do albeit informally. No practicing clinician does therapy "by the book." Instead, they listen, sift, experiment, and adjust—in short, they consider the evidence from their actual practice—all in an ongoing and continuous attempt to maximize the fit and effects of the care they are providing. Our team simply formalized this process, using real-time feedback from consumers regarding the quality of the therapeutic relationship and amount of progress to organize, guide, and in some instances, to modify the services given.*

J.W.: I've read the studies your group published as well as those by Lambert, Lutz, and others showing pretty dramatic improvements in the outcome of treatment by formally asking clients for feedback.

S.M.: *By helping therapists do what they do best—listen—our own research shows as much as a 65 percent improvement in outcome…*

J.W.: So, you're saying-continually focus, not on theories and techniques, but on the actual effects of therapy, the outcomes—the issue that all of the surveys show consumers care about most.

S.M.: *Yes. And there's more. The same studies show significant improvements in retention rates. You know, drop out rates are the real scandal of our field. Available evidence shows the nationwide rate is near 50 percent—that is, half of clients who start treatment, attend a session or two, schedule another visit and then never return. Now, to be sure, not all of those who drop out do so because they are dissatisfied. But a conservative figure is that roughly half of those who end treatment leave because they are not improving.*

J.W.: I recall the TARP research on relationships between businesses and consumers, which showed that people were much more inclined to tell others when they had a negative rather than positive experience with a store or business—something like two times more.

S.M.: *Right, and the problem you are talking about is compounded by the fact that available data shows we therapists frequently fail to identify clients at risk for having a negative treatment experience (either dropping out or ending treatment with a negative or null outcome).*

J.W.: Can you say that again and elaborate?

S.M.: *We therapists are generally effective with the broad range of clients that come to our office—except when we're not! And when we are ineffective we frequently fail to identify those cases early enough in the process to do something productive about it. As a result, clients at risk either drop out or go on to become long-term cases that absorb a huge amount of resources but experience little meaningful improvement. This is how, by the way, a very small percentage of people who start treatment—between one and two of 10-end up accounting for the lion's share of expenditures—60 to 70 percent—in mental health.*

J.W.: So, a small percentage of the overall number that go to therapy do poorly, but make up a huge percentage of the overall cost of mental healthcare.

S.M.: *Our own research suggests a single common pathway to poor outcomes: doing more of the same when it isn't helping. We, unfortunately, develop a story or apply a diagnosis that explains the failure (the client is significantly impaired, has underlying or unresolved traumas, brain dysfunction, or so on) and maintains the status quo.*

J.W.: In essence, we map the client's prison when we've been unsuccessful in helping them escape.

S.M.: *Yes. The good news, however, is feedback significantly decreases the number of such cases which, in turn, results in considerable cost savings—a boon for both clients and payers. One public agency in Florida, for example, saved enough money in their first year to fund eight additional full time clinical positions.*

J.W.: What you are proposing sounds simple in both theory, but how elaborate or how much time does it take, and would clinicians do it?

S.M.: *We use two simple scales, one completed at the beginning of the session that measures therapy progress and one at the end designed to assess the quality of the working relationship. By the way, both of these can be downloaded and used by individual practitioners for free from our website (www.talkingcure.com). From start to finish, the entire process takes about two minutes.*

J.W.: Does it get in the way of the therapeutic relationship?

S.M.: *It is the therapeutic relationship—monitoring progress, asking clients about their experience of the service, responding to their feedback, and in some instances altering the course of care based on that feedback. That is the relationship.*

J.W.: This seems to me to be the crux. Say more about that.

S.M.: *Listening and responding to clients is the relationship. That's the beauty of what we are proposing: all we have done is formalize that process, provide a formal structure. Let me give you an example from an analysis of some 30,000 completed cases of treatment we are currently writing up for publication. In all instances, clients had completed our simple scales at the beginning and end of each session. The results were scored and discussed with the therapist. Interestingly, clients who provided negative feedback—expressed some dissatisfaction with the treatment—were significantly more successful than those that did not or took a long time to express concerns. In the latter case, seven times more successful!*

J.W.: Well, it seems to be very much in line with the idea that one of the most important things we do is give clients space to be honest and to tell the truth about their experiences.

S.M.: *Absolutely. I have to say, however, that even we were surprised by the magnitude of the impact. And to underscore your point, let me add that in the same data set, we found that the most effective therapists—that is, the ones with the best outcomes when compared to other practitioners—consistently elicited more negative feedback early in the treatment process.*

J.W.: So, what do these more successful clinicians do when the measures indicate that things aren't working well?

S.M.: *Important question. One, they stay flexible. Two, they do not become defensive. And three, they persist in altering the service until the client says they are satisfied. In essence, they initiate a dialogue guided by and intended to address the client's preferences and concerns.*

J.W.: And if none of that proves helpful?

S.M.: *That's number four: they seek consultation or refer if they are not able to resolve the problem in a reasonable period of time—no-fault transitioning of the client to a different provider, service, or setting.*

J.W.: So, as you said before, it isn't our technologies, our theories and techniques that we should be focusing on and marketing, but the outcomes and experience (here feedback) of each therapist-client relationship?

S.M.: *Yes, exactly.*

J.W.: Obviously, what you are saying has implications beyond day-to-day clinical work that speaks directly to improving the future of the field.

S.M.: *There are many of which have been hinted at throughout our conversation. What I can say is that more and more public and*

private agencies, military treatment programs, behavioral healthcare organizations, and government funding bodies, both in the U.S. and abroad, are doing what we've been discussing. We're talking, in some instances, about giant bureaucracies. In all of the settings, practitioners have seen real decreases in time-consuming paperwork, quality assurance, and other frequently meaningless oversight procedures. Efforts to micro-manage clinicians—tell them what to do, how to do it, and for how long—have in these settings largely disappeared. Since embracing "practice-based evidence" as a "best-practice," two large behavioral healthcare groups have done away with treatment plans, outpatient treatment reviews, and even preauthorization! As a result, therapists have more time to do what they were trained to do: help people live richer, more meaningful, and healthy lives.

J.W.: A happy note on which to conclude this interview. Thanks so very much Scott, for such an eye-opening and, shall I say, [laughing] earth-moving conversation.

S.M.: *[Laughing] Ha…my pleasure.*

Scott D Miller, Ph.D., will be presenting at CAMFT's 43rd Annual Conference at the Marriott Santa Clara in Santa Clara, California. Join him in his workshops, "How to Improve the Effectiveness of Your Clinical Work by 65 Percent," on Saturday, May 19, 2007, "Not Just an Ordinary Keynote—This is a Dramatic Wake-up Call with Scott D. Miller, Ph.D. on the Future of Psychotherapy: Practice is Evidence—Using Your Data" on Sunday, May 20, 2007, and "Working with Addictions" also on Sunday, May 20, 2007. For workshop details, see pages 44, and 47.

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