Something New

OCTOBER 8, 2014 BY SCOTTM — LEAVE A COMMENT

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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 •
WORLDWIDE TRENDS

• Increasing caseloads, regulation, and documentation;
• Funding challenges;
• Demand for accountability.

THE EVIDENCE

• In most studies of treatment conducted over the last 40 years, the average treated person is better off than 80% of the untreated sample.

• The outcome of behavioral health services equals and, in most cases, exceeds medical treatments.

• On average, mental health professionals achieve outcomes on par with success rates obtained in randomized clinical trials (with and without co-morbidity), including PBH settings!


• Over the last century, the best performance for all Olympic events has improved—in some cases by more than 50%!
  
  • Today’s best high school time in the marathon beats the 1908 Olympic gold medal winning time by more than 20 minutes!
  
  • Improvement has nothing to do with size, genetic changes, or performance enhancing drugs.


THE EVIDENCE
THE EVIDENCE

How Do Therapists Develop?

• A massive, 20-year, multinational study of 11,000 therapists;
• Collected and analyzed detailed reports about the way therapists experienced their work and professional development.
• The majority of therapists see themselves as developing professionally over the course of their careers.

THE EVIDENCE
How Do Therapists Develop?

• The effectiveness of the “average” helper plateaus very early.

• Little or no difference in outcome between professionals, students and para-professionals.

• Professional training contributes less than 1%


THE EVIDENCE

Three Stubborn Problems

• Drop out rates average 47%;
• Mental health professionals frequently fail to identify failing cases;
• 1 out of 10 consumers accounts for 60-70% of expenditures.


"In the past, workers with average skills, doing an average job, could earn an average lifestyle. But today average is officially over. Being average just won’t earn you what it used to. It can’t when so many more employers have access to so much more above average, inexpensive labor…"
REACH

• Specific Models and Methods
• Common factors
• Measurement of Outcomes
• Expertise and Excellence
THE BEST AND THE REST

DEEP, DOMAIN-SPECIFIC KNOWLEDGE

Know More  See More  Do More

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REACH

• Research indicates that performers (math, science, sports, chess, etc.) reliant on general cognitive strategies or inference methods behave expertly on almost no tasks;

• Similarly, available evidence shows that training clinicians in “evidence-based,” manualized therapies, diagnosis, and even the alliance has little if any impact on outcome.

• Therapists do not learn from feedback

DELIBERATE PRACTICE

Therapists

Violinists
“Unlike play, deliberate practice is not inherently motivating; and unlike work, it does not lead to immediate social and monetary rewards...and [actually] generates costs...”.

• Deliberate practice includes:
  a. Working hard at overcoming “automaticity”;
  b. Planning, strategizing, tracking, reviewing, and adjusting plan and steps;
  c. Consistently measuring and then comparing performance to a known baseline or national standard or norm.

• Elite performers engage in practice designed to improve target performance:
  a. Every day of the week, including weekends;
  b. For periods of 45 minutes maximum, with periods of rest in between;
  c. The best up to 4 hours per day.

DELIBERATE PRACTICE

BASICS

MISTAKES

Deliberate Practice

Zone of “Proximal Development”:
- Reliable performance inconsistent
- Identification of errors, misperceptions
- Setting small process and outcome objectives
- Involves planning, rehearsal, reflection

Realm of “Reliable” Performance:
- Processes executed quickly, automatically
- Involves recognition, retrieval, execution

Ambit of Admiration:
- Abilities of others appear flawless, magical, dramatic
- Effort and attention focused on easily recognized, but non-causal factors and/or processes (superstition)
- Risk of failure and injury high
DELIBERATE PRACTICE

THINK

ACT

REFLECT


DELIBERATE PRACTICE
T.A.R.

THINK:

• Identify the limits of one’s “realm of reliable performance”

• Develop a specific plan of action and description of the intended outcome


DELIBERATE PRACTICE

T.A.R.

ACT:

• Execute the plan of action
• Note the steps of the plan that were missed
• Identify any actions taken not part of the original plan


DELIBERATE PRACTICE
T.A.R.

REFLECT:

• Review the plan and execution
• Identify errors
• Outline alternative actions


Research on the power of the relationship reflected in over 1100 research findings.

Independent of the approach, diagnosis, researcher allegiance, or time of assessment.


DELIBERATE PRACTICE

- Baldwin et al. (2007):
  - Study of 331 consumers, 81 clinicians.
  - Therapist variability in the alliance predicted outcome (97%).
  - Consumer variability in the alliance unrelated to outcome (0%)
Researchers Anderson, Ogles, Lambert & Vermeersch (2009):

- 25 therapists treating 1100+ clients;
- Variety of demographic variables;
- Measure of interpersonal skills (SSI).

Domain-specific interpersonal knowledge tested by using therapist responses to challenging therapeutic interactions:

- Four problematic therapeutic process segments;
- Multiple challenging interpersonal patterns (e.g., angry, dependent, confused, blaming, controlling, etc.).

DEEP, DOMAIN-SPECIFIC KNOWLEDGE

- Considerable differences in outcome between clinicians (~9%):
  - Age, gender, percentage of work time spent conducting therapy, theoretical orientation not correlated with outcome;
  - General interpersonal skills not correlated with outcome;
  - Only domain-specific interpersonal knowledge predicted outcome

• Give at the end of each session;

• Each line 10 cm in length;

• Score in cm to the nearest mm;

• Discuss each visit but always when:
  • The total score falls below 36.
  • Decreases of 1 point.

http://scottdmiller.com/performance-metrics/
Child Session Rating Scale (CSRS)

Name __________________________ Age (Yrs): ___
Sex: M / F  
Session # _____ Date: _______________________

How was our time together today? Please put a mark on the lines below to let us know if how you feel.

Listening
-- did not always listen to me. I- - - - - - - - - - - - - - - - - - - - - I listened to me.

How Important
-- What we did and talked about was not really that important to me. I- - - - - - - - - - - - - - - - - - - - - I

What We Did
-- I did not like what we did today. I- - - - - - - - - - - - - - - - - - - - - I

Overall
-- I wish we could do something different. I- - - - - - - - - - - - - - - - - - - - - I

International Center for Clinical Excellence
Young Child Session Rating Scale (YCSRS)

Choose one of the faces that shows how it was for you to be here today. Or, you can draw one below that is just right for you.

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Severity Adjusted Effect Size
9000 Episodes of Care

First/last alliance

>1.2 σ

• 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*;
  • *Not interested in perfect scores*;
  • *Feedback is critical to success*.

• Restate the rationale prior to administering the scale at the end of each visit.
DELIBERATE PRACTICE
